DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

December 30, 2020

Daniel Tsai
Assistant Secretary, MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor Room 1109
Boston, MA 02108

Dear Mr. Tsai:

On March 13, 2020, the President of the United States issued a 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, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) as amended (42 U.S.C. 1320b-5). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. We note that the emergency period will terminate, upon termination of the public health emergency (PHE), including any extensions.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020 in State Medicaid Director Letter (SMDL) #20-002[1], on March 24, 2020, Massachusetts submitted a request for a section 1115(a) demonstration to address the COVID-19 PHE. CMS has determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR 431.416(e)(2) and 431.416(g).[2] CMS expects that states will offer, in good faith and in a prudent manner, a post-submission public notice process, including

[1] See SMDL #20-002, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.
[2] Pursuant to 42 CFR 431.416(g), CMS has determined that the existence of unforeseen circumstances resulting from the COVID-19 PHE warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration. States applying for a COVID-19 section 1115 demonstration are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely decisions on state applications for COVID-19 section 1115 demonstrations. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

tribal consultation as applicable, to the extent circumstances permit. This letter also serves as time-limited approval of select components of the Massachusetts COVID-19 Public Health Emergency section 1115(a) demonstration, described below, which is hereby authorized retroactively from March 1, 2020, through the date that is 60 days after the end of the PHE (including any renewal of the PHE). In addition, this letter includes a time-limited approval of an amendment to the existing MassHealth Demonstration.

CMS has determined that the Massachusetts COVID-19 PHE section 1115(a) demonstration – including the waiver and expenditure authorities detailed below – 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 freedom of choice authority promotes the objectives of the program in particular by allowing the Commonwealth to temporarily operate expanded telehealth and mobile testing networks during the COVID-19 PHE, bolstering beneficiary access while conserving limited federal and state resources.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence of the time-limited nature of this demonstration – CMS did not require the state to submit budget neutrality calculations for the Massachusetts COVID-19 PHE 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. Massachusetts 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 PHE, as well as the cost-effectiveness of those expenditures.

The state will be required to complete a final report, which will consolidate monitoring and evaluation reporting deliverables associated with the approved waiver and expenditure authorities and demonstration STCs, no later than one year after the end of the COVID-19 section 1115 demonstration authority. CMS will provide guidance for the evaluation design and final report, specifically developed for the COVID-19 section 1115 to facilitate state compliance with 42 CFR 431.424(c); an evaluation design will be due to CMS within 60 days of demonstration approval.

The state will test whether and how the approved waivers and expenditure authorities affect the state's response to the PHE. 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 PHE.

Requests CMS is Approving at this Time

The state submitted a number of requests, many of which may be or have already been approved under the state plan, 1135 waivers, and Appendix K for 1915(c) waivers, and are not described below. In addition to requested demonstration protocol and technical changes not described

below, Massachusetts requested and CMS approved the following technical changes to the state's MassHealth 1115 demonstration. These do not require additional authority under section 1115(a), but are included for information only:

- Massachusetts requested to extend the deadline for the DSRIP midpoint assessment otherwise due September of 2020 by two months, which CMS approved, as a technical change to the MassHealth demonstration, on April 22, 2020.

- Massachusetts requested to make payments necessary to maintain continued access to health care services during the national emergency in accordance with changes to Attachment E to the MassHealth 1115 demonstration submitted by the state. CMS approved these revisions to the protocol on May 20, 2020.

CMS is also confirming its understanding that MassHealth will not avail itself of its existing waiver of retroactive eligibility in its MassHealth section 1115(a) demonstration (11-W-00030/1) for the duration of the COVID-19 PHE. Therefore, retroactive eligibility must be provided upon request as early as the first day of the third calendar month before the month of application, but no earlier than March 1, 2020, if the applicant received Medicaid services and would have been eligible for Medicaid if the individual had applied.

This letter only addresses requests that CMS is approving at this time. Consistent with the flexibilities described in the SMDL #20-002, and with additional flexibilities requested by Massachusetts, CMS is approving the following requests:

Waiver Authorities

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.

Expenditure Authorities

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).[3]

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

Approval of this demonstration is subject to the limitations specified in the list of approved authorities and the enclosed STCs. The state may deviate from its Medicaid state plan requirements only to the extent that the requirements have been specifically waived or identified as not applicable to the demonstration. This approval is conditioned upon continued compliance with the enclosed STCs which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Ms. Rabia Khan. Ms. Rabia Khan is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Rabia.Khan1@cms.hhs.gov

[3] 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.

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic and we look forward to our continued partnership on the Massachusetts COVID-19 PHE section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Teresa DeCaro, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Seema Verma

Enclosure

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **Project Number 11-W-00348/1**

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-00348/1**

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-00348/1

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-00331/3). 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