

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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## State Demonstrations Group

November 16, 2023

Mike Levine  
Secretary, MassHealth  
Office of Medicaid  
Massachusetts Department of Health and Human Services  
1 Ashburton Place, 11<sup>th</sup> Floor, Room 1109  
Boston, MA 02108

Dear Secretary Levine:

The Centers for Medicare & Medicaid Services (CMS) approved the Evaluation Design for the Massachusetts section 1115 demonstration amendment entitled “Massachusetts COVID-19 Public Health Emergency (PHE) Demonstration” (Project No: 11-W00355/1). We sincerely appreciate the Commonwealth’s commitment to efficiently meeting the requirement for an Evaluation Design as was stipulated in the approval letter for this amendment dated May 8, 2023.

In accordance with 42 CFR 431.424(c), the approved Evaluation Design may now be posted to the Commonwealth’s Medicaid website within 30 days. CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS no later than one year after the end of this COVID-19 section 1115 demonstration authority.

We sincerely appreciate the Commonwealth’s commitment to evaluating the COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Massachusetts COVID-19 PHE Demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

**Danielle Daly -S**

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Date: 2023.11.16 12:02:39 -05'00'

Danielle Daly  
Director  
Division of Demonstration Monitoring and Evaluation

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



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# **Massachusetts Emergency 1115 Demonstration**

## **Draft Evaluation Design (Revised)**

Updated July 2023

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**4/30/2021, updated July 2023**

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## 1. General Background

The first case of COVID-19 in Massachusetts was diagnosed in late January 2020. 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 the 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 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.

EOHHS submitted an additional request to CMS on July 15, 2021, for a COVID-19 Public Health Emergency (PHE) Medicaid Section 1115 Demonstration. On March 8, 2023, EOHHS withdrew the request for flexibilities related to Integrated Care Plans, and on May 8, 2023 CMS approved waivers and expenditure authority to support the remaining item in the request related to cost sharing.

Effective July 1, 2020, EOHHS updated its cost-sharing policy to exempt members with income at or below 50% FPL from copayments. EOHHS is not able to determine the income of individuals who are made eligible for Medicaid through eligibility for another program (such as Supplemental Security Income (SSI) or Emergency Aid to the Elderly, Disabled, and Children (EAEDC)) as income information is not furnished to EOHHS for these members. This COVID-19 PHE Medicaid Section 1115 Demonstration allows

EOHHS to apply \$0 copayments for such individuals whose income appears in the Medicaid source systems at 0 percent of the federal poverty level (FPL) because the application of any copay above \$0 would place such individuals at risk of reaching the aggregate family limit.

This evaluation design addresses four specific areas of the Demonstration: mobile testing, telehealth network providers, retainer payments to adult day health and day habilitation providers, and cost sharing.

In addition to the four 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 State wideness; 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 (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<sup>1</sup> 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.
- **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

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<sup>1</sup> Two ambulance providers were contracted by MassHealth but only one performed mobile testing.

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. 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 administrators	Experiences	Qualitative interview data	Thematic analysis

<sup>2</sup> MassHealth payment is only through August 2020.

Research Questions	Measures	Data Source	Analysis Methods
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 homes, community partners, and nursing facilities). 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. Toward 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 the 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 when 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<sup>3</sup>, 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 from 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.

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	Descriptive analysis, trend analysis

<sup>3</sup> 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.

Research Questions	Affected Populations	Data and Measures	Analysis Methods
		administrative data	
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 of 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. Cost Sharing Exemption for Referred Eligibility Group

### 5.1 Policy Goal and Objectives

Massachusetts received approval for state plan amendments 20-0019 and 21-0025 to update cost-sharing policies and procedures, including tiered drug copayment amounts and \$0 copays for drugs for the most economically disadvantaged Medicaid members whose income is at or below 50% of the federal poverty line. In order to exempt referred eligible members (for whom MassHealth does not receive income information from the referring agencies) from cost sharing, MassHealth requested and received approval for an emergency Demonstration to consider referred eligible individuals to have \$0 FPL income, to be able to apply the policies of the approved SPAs to this group. The referred eligibility groups' Medicaid eligibility is not based on income but on status of receiving the following benefits: children, young adults, and parents and caretaker

relatives who receive Emergency Aid to the Elderly, Disabled, and Children (EAEDC) cash assistance, Title IV-E or foster-care assistance under 42 CFR Section 435.227 and SSA 1902(a)(10)(A)(ii)(VII), former or independent foster care youth, MassHealth Standard members waiting for redetermination of other public benefits, Supplemental Security Income (SSI) benefit from the Social Security Administration (SSA), and Transitional Aid to Families with Dependent Children (TAFDC) cash assistance<sup>4</sup>. The Waiver policy was effective from July 1, 2020, to July 12, 2023.

The goal of the Emergency cost-sharing Demonstration is to relieve financial burdens on Medicaid members with extreme economic hardship. Those in the referred eligibility group may have the lowest income in addition to their disability and other vulnerable statuses. When members cannot afford a copayment, they may be less compliant with filling their prescriptions. Members with chronic medical conditions may experience deteriorating health status. Through this Demonstration policy, the referred eligibility Medicaid members are more likely to access care (i.e., filling drugs as prescribed) without incurring financial burdens.

## 5.2 Evaluation Questions

Our evaluation questions are determined for the areas anticipated to have the most significant policy impact and enlightened by existing evidence. For example, zero-copayments for pharmacy may increase medication adherence rates in community pharmacy settings<sup>5</sup>. Even nominal copayments significantly reduced clinically important drug use by fee-for-service Medicaid populations<sup>6</sup>. According to a study across 38 states, elderly and disabled Medicaid members' drug adherence has decreased significantly due to copayments, especially among those with poor health<sup>7</sup>. Yet, chances are that pharmacists still dispense prescriptions to Medicaid members even if they cannot afford the copayment. Waiving the copayment may not practically change members' medication compliance behaviors, defined as filling prescription drugs, to change Medicaid members' health status. However, indirectly, copayment savings may provide more disposable income for Medicaid members to seek other healthcare or social benefits (e.g., medical intervention, nutrition, transportation to care). In view of these factors, the evaluation questions will include the following.

- 1) How many referred eligibility members would have benefited from the zero copayments for medication annually since the Demonstration program was implemented?
- 2) How has the cost sharing Demonstration policy been implemented and supported MassHealth's goal?

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<sup>4</sup> Approval of COVID19 Demonstration Amendment, May 8, 2023

<sup>5</sup> Jimenez, M.; Alvarez, G. et al. 2019. The Effect of Zero Copayments on Medication Adherence in a Community Pharmacy Setting. *Innovations in Pharmacy*. 10: 2(16)

<sup>6</sup> Hartung, D.; Carlson, M. et al. 2008. Impact of a Medicaid Copayment Policy on Prescription drug and Health Services Utilization in a Fee-for-Service Medicaid Population. *Medical Care*. 46: 6.

<sup>7</sup> Stuart, B.; & Zacker, C. 1999. Who Bears the Burden of Medicaid Drug Copayment Policies. *Health Affairs*. 18: 2

- 3) What is the saving of medication copayment expenses for Medicaid members before and after the Demonstration?<sup>8</sup>
- 4) How does zero copayments impact MassHealth referred eligibility groups members' medication adherence toward certain chronic conditions, especially those who are elderly?

### 5.3 Data Sources

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

- **Medicaid administrative data, including enrollment, eligibility, and claims/encounter file.** This data allows us to determine the referred eligibility group members and examine their copayments before and after the Demonstration policy started.
- **Qualitative interview data.** This evaluation will collect qualitative data (i.e., interviews) from Medicaid program managers and other states which have implemented zero copayments policies earlier to understand the facilitators and barriers of program implementation and whether and how the policy has impacted members' access to services. A handful of interviews with Medicaid referred eligibility members will also be conducted to examine the awareness of the zero copayment policy, changed prescription drug dispensing behavior, likely uses of the savings from copayments, and perceived health status change.
- **Literature review.** If available, evidence of how the policy impacts member's access and use of services will be searched and summarized to provide context for the Demonstration policy.

### 5.4 Analysis Methods

The analysis will use both quantitative and qualitative data. The analysis period will be from July 2018 to June 30, 2023. The analysis of quantitative data will be descriptive in nature. The measures will include the number of referred eligibility groups, and the average cost saving from copays per member per year will be presented and tabulated by time periods, adjusted by members' length of enrollment. We will also review the medication adherence rate of drugs for select chronic conditions (hypertension, diabetes, and high cholesterol). We will conduct a comparison of the rates before and after the policy is implemented.

The analysis of qualitative data will be descriptive narrative analysis and thematic analysis. The data will be collected from MassHealth program staff, other state staff, and Medicaid members.

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<sup>8</sup> The savings for Medicaid members are presented as expenses for Medicaid (as a payer).

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

Research Questions	Affected Populations	Data and Measures	Analysis Methods
1. How many referred eligibility members have benefited from the zero copayments for medication annually since the Demonstration program was implemented?	Referred eligibility group	Medicaid administrative data	Descriptive statistics
2. How has the cost-sharing Demonstration policy been implemented and supported MassHealth's goal?	MassHealth and other states Medicaid program staff; MassHealth members	Interviews and literature review	Descriptive narrative analysis; thematic analysis
3. What is the saving of medication copayment expenses for Medicaid members before and after the Demonstration?	Referred eligibility group	Medicaid administrative data (focus on prescription drugs with zero-copayments)	Descriptive statistics
4. How does zero copayment impact MassHealth referred eligibility groups members' medication adherence behaviors, especially those who are elderly?	Referred eligibility group	Medicaid administrative data	Descriptive analysis; pre-post comparison

### 5.5 Anticipated Limitations

The analysis will focus on the financial impact on MassHealth members instead of their utilization. Because the copay level is relatively small and the pharmacy still dispenses drugs to members regardless of members' capability to pay, the direct impact on members' medication use may be insignificant. However, there is a potential indirect impact on members' healthcare utilization and status. In addition, the temporary pausing

of most member terminations during the COVID-19 pandemic led to a higher roster of Medicaid members, which may show a higher level of total cost savings for Medicaid members; therefore, we will present the average cost savings per member per year. Conversely, the Pandemic may have suppressed members' drug dispensing behaviors, which we can explore through member interviews.

## 6. Reporting

### *6.1 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.

### *6.2 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, 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.