

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

July 8, 2025

Mike Levine  
Medicaid Director  
Commonwealth of Massachusetts  
Department of Health and Human Services, Office of Medicaid  
1 Ashburn Place, 11th Floor Room 1109  
Boston, MA 02108

Dear Director Levine:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Massachusetts's Final Report for the "Massachusetts COVID-19 Public Health Emergency (PHE) Demonstration" (Project No: 11- W00355/1), approved on December 30, 2020, with a subsequent amendment approval on May 8, 2023. This report covers the demonstration period from March 1, 2020, through July 10, 2023. CMS determined that the Final Report, submitted on August 8, 2024 and finalized on June 17, 2025, is in alignment with the requirements set forth in the demonstration's Special Terms and Conditions (STCs), and therefore approves the Commonwealth's Final Report.

The approved Final Report may now be posted to the Commonwealth's Medicaid website within 30 days, per 42 CFR 431.424(c). CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the Commonwealth's commitment to evaluating the COVID-19 PHE demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

**DANIELLE  
DALY -S**

Digitally signed by  
DANIELLE DALY -S  
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Danielle Daly  
Director  
Division of Demonstration Monitoring and Evaluation

Enclosure

cc: Ambrosia Watts, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

# Massachusetts 1115 Emergency Waiver Demonstration Evaluation Final Report

**Prepared for:**

**MassHealth and  
the Centers for Medicare &  
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**5/12/25**

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# 1. Executive Summary

To coordinate the state's response to the COVID-19 public health emergency (PHE), in March 2020 the Secretary of the Executive Office of Health and Human Services (EOHHS) submitted to The Centers for Medicare and Medicaid Services (CMS) a COVID-19 PHE Medicaid Section 1115 Demonstration ("Emergency Waiver Demonstration") request to authorize certain flexibilities. On December 30, 2020 and May 8, 2023, CMS approved Emergency Waiver Demonstrations and expenditure authority to support the states' requests. The four Emergency Waiver Demonstration programs are: (1) Mobile Testing, (2) Telehealth Network Provider, (3) Retainment Payment, and (4) Cost Sharing Exemption for Referred Eligibility Group. In response to CMS' guidance on monitoring and evaluation of approved Emergency 1115 Demonstrations, Massachusetts designed evaluation approaches for the approved items utilized by the state during the COVID-19 PHE.

## A. Mobile Testing

MassHealth implemented the Mobile Testing initiative to timely test populations at high risk of COVID-19 to help contain the spread of the virus. The target populations included residents of nursing facilities and other congregate settings (e.g., residential group homes, shelters, continuing care medical facilities, mental health centers, and recovery treatment centers) who were unable to travel to community-based testing sites. For these congregate facilities, MassHealth contracted with ambulance providers to quickly deploy mobile testing and to facilitate the transfer of specimens to a laboratory for analysis. The initiative ran from April 4, 2020, through October 31, 2020, at which point all invoices had been submitted. The evaluation period was April through July 2020, the timeframe that includes all dates of service for which payment was provided.

**Evaluation Research Questions, Data, and Methods:** The primary evaluation questions were: (1) Did the mobile testing reach the intended populations? (2) What was the total program expenditure by target sites and populations? and (3) What were the experiences with mobile testing among Medicaid program administrators and testing sites? The team conducted a mixed-methods evaluation based on multiple data sources, including ambulance provider test report data, individual-level invoice/payment data, and qualitative interview data. They also conducted a descriptive analysis, trend analysis, and thematic analysis of data.

**Findings and Conclusions:** The Mobile Testing Program allowed a large volume of COVID-19 tests to be conducted in a short period of time (33,542 mobile tests completed at 2,240 congregate sites in the 4-month evaluation period), providing a unique contribution to capture COVID-19 cases and potentially mitigate the spread of disease. The geographic distribution of the tests corresponded to the population density throughout Massachusetts counties. The mobile testing volume began to phase out as more testing became available at local facilities.

A total of \$8.8 million was spent on the Mobile Testing Program from April to August 2020 in the Commonwealth, of which \$2.4 million was spent on testing for MassHealth members. This average cost per person was \$263. Considering the extremely high rate of disease spread, the Emergency Waiver Demonstration expenditure could have saved substantial costs by catching and treating infected individuals very early on while preventing and mitigating the spread of disease.

Interviews with congregate facility site administrators and Mobile Testing Program Managers across participating state agencies revealed overall positive remarks about the program with operational lessons to learn. The testing was implemented quickly and efficiently, despite some initial challenges (e.g., administrative burden, scheduling coordination). The Mobile Testing program rollout allowed stakeholders to effectively monitor and address COVID-19 outbreaks. The coordination across agencies and stakeholders was successful. The testing staff were positive, compassionate, and gentle. Lessons learned from the Mobile Testing Program included the importance of and need for consistent communication among stakeholders (including notice of testing availability and arrival time) and a simplified administrative process.

**Policy Implications:** Using Emergency Waiver Demonstrations to provide rapid services has shown to be an effective way of addressing the COVID-19 public health crisis. Mobile Testing improved access to infectious disease testing and relieved the transportation burdens or barriers that were present amid the pandemic, especially among vulnerable populations. The ability to conduct congregate site testing also was found to maximize the level of testing in a very short time period. Mobile testing services have great potential as a service delivery model for screening, immunization, and prevention purposes. MassHealth's leadership and other state agencies' collaborations in using this policy tool to enable emergency services in an expedited way are well established. Public payers and service agencies can consider developing a process and protocol document to summarize best practices, processes, and lessons learned, which will be helpful for addressing future public health crises for infectious diseases and beyond.

**Key Limitations:** The absence of a comparison group limits our ability to demonstrate the relative effectiveness of the Mobile Testing program compared to other approaches. The sample size for interviews was small compared to the target due to non- and/or declined responses. This is largely because the program was short-term, beginning and ending in 2020. This time gap between the program's end (2020) and our interview period (2022) further posed a limitation in recruiting participants.

## **B. Telehealth Network Provider**

MassHealth developed a new temporary Telehealth Network Provider (TNP) type and contracted with three TNPs to deliver care to populations at risk of COVID-19 to help contain the spread of the virus. 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 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 referrals to testing and treatment as appropriate. MassHealth members could access the TNPs via a web-based application known as Buoy.

**Evaluation Research Questions, Data, and Methods:** The main evaluation questions were: (1) How many MassHealth members accessed the Buoy app over time? (2) How many MassHealth members completed the triage interviews in the Buoy app? (3) What is the utilization level of the TNP program and its physicians? (4) What was the cost to MassHealth of administering the TNP Program? And (5) What are the lessons learned about establishing, maintaining, and using TNP? The team conducted a mixed-method evaluation using multiple data sources: Buoy Health data, TNP encounter and invoicing data reports, and qualitative interview data. They conducted descriptive statistics, trend analysis, and descriptive narrative analysis of data.

**Findings and Conclusions:** The TNP program was a new service model rapidly deployed by MassHealth to support connecting their members with COVID-19 symptoms to the most appropriate care setting. Stakeholders considered the program to have been implemented smoothly and successfully. Almost 5,000 MassHealth members inquired through the Buoy app's triage process, with 1,520 recommended for same-day care and 682 for emergency room care. About 122,000 individuals used the triage tool without providing any insurance information in their interview. In total, there were about 164,000 recorded interviews via the Buoy app that involved providers making recommendations about follow-up care. Between April 2020 to September 2020, a total of 972 encounters were reported to MassHealth because of interactions with the Buoy app and subsequent referrals to TNP vendors. The cost to MassHealth of administering the TNP Program was \$32,760, a small cost relative to the number of MassHealth member encounters resulting in timely access to telehealth for their COVID-19 symptoms or conditions.

Based on the qualitative interviews with TNP providers and MassHealth staff, providers involved applauded the TNP program for facilitating and offering same-day care through telehealth services for such a large member population. Providers also noted that this program implemented a safe way of allowing members to meet with providers while keeping hundreds of families out of the emergency room. They also described the strong partnership with the Massachusetts Board of Registration and Medicine (BORIM) and the very straightforward and efficient licensing process from MassHealth and BORIM.

Members' feedback about their TNP provider experience was generally positive. They expressed ease of access to tele-providers while their own PCPs were unavailable (i.e., too busy during the PHE). The TNP program was also noted as beneficial for members who reported having transportation barriers or no PCP. Members appeared to be pleased with the quality of the TNPs.

Interviewees also noted areas of concern and improvement. Some members questioned the ability of providers to thoroughly diagnose remotely. Others also found it would be beneficial if the providers could have more inclusive language capabilities.



Stakeholders expressed the desire for MassHealth to increase the volume of member encounters through promotion and advertising. Lastly, one provider described the challenge of dealing with a new billing process outside the Medicaid Management Information System (MMIS).

**Policy Implications:** As an innovative and unique model initiated during the early phase of the pandemic in Massachusetts, TNP demonstrated the success of a pioneering partnership between state health systems and telehealth companies. Based on the success of the Massachusetts TNP Program, access to on-demand telehealth services for MassHealth members should be considered for future pandemic or epidemic public health situations. TNPs could also be considered as alternatives to address in-state workforce barriers while encouraging in-person care.

**Key Limitations:** Buoy Health data were self-reported, and access to the site is limited to those who have internet access, potentially impacting the accuracy of results. User demographic data were not included in the raw data generated from the Buoy App, hindering the ability for it to be reported. About 122,000 individuals used the triage tool without providing any insurance information, meaning there could be more MassHealth members who accessed the triage tool whose data were not collected. Lastly, the lower-than-targeted response rate and small sample size influenced the generation of themes across interviews; however, we used descriptive narrative analyses across stakeholders to identify enlightening indicators of program effectiveness.

### **C. Retainer Payment for Adult Day Health (ADH) and Day Habilitation (DH) Providers**

To help prevent the permanent closure of ADH and DH sites, as well as maintain access to these services after sites could reopen, MassHealth offered retainer payments to ADH and DH providers from April through July 2020. Through the state's approved Emergency 1115 Emergency Waiver Demonstration, CMS authorized federal Medicaid funding for the retainer payments made during July. EOHHS utilized CARES Act<sup>1</sup> funding to pay for the retainer payments for April through June. Only providers who held treatment relationships with members at the time that the PHE was declared were eligible to receive retainer payments. By program design, providers would continue to bill for ADH or DH services as though they were still providing these services to those members amid their absence. To receive retainer payments, providers were required to develop or amend individual care plans specifically to meet the members' needs while they remained at home. 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. Providers were also required to contact each member a minimum of 1x/week to identify any health concerns, medication needs, and other ADL or service needs in order to make referrals for those services.

**Evaluation Research Questions, Data, and Methods:** The main evaluation questions were: (1) Did caseloads and expenditures during and after the retainer payment period

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<sup>1</sup> United States Library of Congress. March 19, 2020. Retrieved from <https://www.congress.gov/bills/116/congress/senate-bill/3548/text>



remain consistent with prior caseload trends? (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? And (3) What were the lessons learned from administering the retainer payment Demonstration? The team conducted a mixed-methods evaluation using Medicaid Demonstration program administrative data and qualitative interview data. We also conducted descriptive and trend analysis as well as a thematic analysis of data.

**Findings and Conclusions:** MassHealth's Retainer Payment Program was implemented to help providers sustain operations while keeping members safe at home during the mandated closures of ADH and DH facilities. Program effectiveness results were mixed.

Providers applauded the smooth implementation of the Retainer Payment Program and the availability of MassHealth staff to respond to their questions and concerns. Official communications with MassHealth via bulletins and meetings were valued information sources for providers to receive important news and updates regarding the Retainer Payment Program. Retainer payments served as "economic relief" with a higher than pre-pandemic reimbursement rate. Providers spoke positively about communicating tailored programming and curricula to members via Zoom, WhatsApp, and Facebook Messenger.

Aside from the benefits that the Retainer Payment Program brought to sites, some providers reported challenges in implementing the MassHealth-required administrative protocols and procedures (this was also a common challenge of other Emergency Waiver Demonstration programs to be launched in such a short time period). Some providers reported that, even with the financial support of retainer payments, they still faced financial constraints and challenges with member attrition and employee retention, which continues to limit ADHs' and DHs' ability to provide care similar to pre-pandemic levels.

The caseloads and expenditures for both ADH and DH providers during and after the retainer payment period did not remain consistent compared to pre-COVID-19 caseload and expenditure trends. Caseloads and expenditures after the Retainer Payment Program ended were lower than prior to the onset of the COVID-19 pandemic. The monthly caseloads among both ADH and DH providers declined throughout the COVID-19 pandemic despite the implementation of the Retainer Payment Program. The business status (i.e., open/closed) of the sites that participated in the Retainer Payment Program varied. About 8.6% of the participating ADH and DH programs reported permanent closures while 100% of non-participating programs permanently closed.

**Policy Implications:** Economic relief for ADH and DH providers through the implementation of retainer payments significantly helped them to sustain business operations, although the level of payment may not have been adequate to support all providers coping with fluctuating caseloads, maintaining staff, and sustaining their business. Public payers may consider implementing higher rates and extending the time of financial support(s) to sustain ADH and DH providers and operations, especially

during health provider workforce shortages. Communicating in a timelier manner with quicker turnaround times, as well as investing to raise reimbursement rates and hourly wages, would improve future programming in a similar emergency condition.

**Key Limitations:** The CMS-approved Demonstration was only one month, which is likely too short of an analytical timeframe to reveal any noticeable differences in the payment policy. This also increases the risk for external factors to confound program outcomes. The interview sample sizes were limited due to non-and/or declined responses from prospective interviewees. As a result of incomplete sampling, the findings from the sample we interviewed are not generalizable to the broader target populations.

#### **D. Cost Sharing Exemption for Referred Eligibility Group**

MassHealth implemented the cost-sharing Demonstration policy for the purpose of relieving financial burdens on Medicaid members with extreme economic hardship. Members who cannot afford copayments may be less compliant with filling their prescriptions, which may lead to deteriorating health status for members with chronic medical conditions. Through this policy, the most economically disadvantaged Medicaid members enrolled in MassHealth through “referred eligibility” are more likely to access care (i.e., filling drugs as prescribed) without incurring financial burdens.

Effective July 1, 2020, MassHealth eliminated copayments for members with income below 50% of the federal poverty level (FPL). The Demonstration provided \$0 medication copayments for MassHealth members belonging to a “referred eligibility” group as it authorized MassHealth to consider their income to be 0% FPL. Referred eligibility members are those who are categorically eligible for MassHealth because they are receiving other public assistance including, but not limited to: Supplemental Security Income (SSI) benefits; Transitional Aid to Families with Dependent Children (TAFDC) cash assistance; and MassHealth Standard members waiting for redetermination.<sup>2</sup> MassHealth does not receive income data for referred eligibility members and was therefore unable to determine which of them had incomes <50% of the FPL. To ensure copays were eliminated for the most economically disadvantaged referred eligibility members, MassHealth requested and received approval for an emergency Demonstration waiver to consider referred eligibility members to have 0% FPL income. This cost-sharing Demonstration policy was effective from July 1, 2020, to July 12, 2023.

**Evaluation Research Questions, Data, and Methods:** The primary evaluation questions were (1) How many MassHealth referred eligibility members 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? (3) What are the savings of medication copayment expenses for MassHealth referred-eligible members before and during the

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<sup>2</sup> MassHealth Cost Sharing Policy Update Call June 02, 2020.  
[https://www.masshealthmtf.org/sites/default/files/MH%20Cost%20Sharing%20Call%20Transcript%206.18.20Final\\_0.pdf](https://www.masshealthmtf.org/sites/default/files/MH%20Cost%20Sharing%20Call%20Transcript%206.18.20Final_0.pdf)

Demonstration? and (4) How does zero copayment impact MassHealth referred-eligible members' medication adherence behaviors, especially those who are elderly?

Data consisted of Medicaid administrative data and interview data. The study period was from June 2018 through June 2023. Descriptive analyses explored policy utilization, cost savings, and medication adherence before and after policy implementation and qualitative analyses examined policy implementation and member experience.

**Findings and Conclusions:** Of the more than 325,000 referred eligible members considered to have income less than 50% of the federal poverty line in the evaluation period, the percentage of members who had zero prescription copayments rose from 72-75% before policy implementation to 95-97% after the policy was in place. The zero-copay policy resulted in savings of over \$5 million in copayments for members during the implementation period, reducing the per member per year average copay cost from \$16 to \$1 during that time. Medication adherence for diabetes, hyperlipidemia, and hypertension medications increased across the study period. The policy allowed members to maintain medication use and reduced the stress of medication affordability during the COVID-19 pandemic. Impacted members were not made aware of the zero-copayment policy before the policy was implemented.

**Policy Implications:** The zero-copayment policy relieved financial burdens and increased medication adherence of MassHealth members. Known evidence is that increased medication adherence improves health outcomes and reduces healthcare cost. States that implement such a program should consider continuing the policy after the Public Health Emergency ends.

**Key Limitations:** The analyses did not examine time periods after the Demonstration ended, so our findings are limited to prior to and during the Demonstration when the PHE policy was in place. We were only able to interview 20% of our target sample, which limits our ability to apply the findings to a larger population of Medicaid members. We were unable to identify another state with a similar program to interview program staff about their experiences. Lastly, we did not include members with tiered drug copayments in our interviews, thus we could not do a comparative analysis of these two groups.

## 2. Meet Our Team

### Research and Evaluation Emergency Waiver Demonstration Evaluation Team

<b>Ying (Elaine) Wang, PhD, MPS</b>	Executive Director, Research & Evaluation
<b>Laura Sefton, MPP</b>	Research and Evaluation Associate
<b>Jianying Zhang, MD, MPH</b>	Sr. Biostatistician
<b>Chu-Yuan Luo, MS</b>	Biostatistician II

### Acknowledgments

We would like to thank MassHealth program staff, State agency staff, and all of the participating interviewees for taking the time to contribute to the report and facilitating data acquisition. We would also like to thank our colleagues from MassHealth who gave insight and knowledge that considerably aided the research. In addition, we would like to extend our appreciation to our former colleagues, Willie Frazier, III, MPH, Cheyanne Zappala, MPA, and Cindy Walker, BSC, for their valuable effort and contributions to this evaluation.

### 3. General Emergency Waiver Demonstration Background

To coordinate the state's response to its public health emergency (PHE) declaration related to COVID-19 in March 2020, then-Governor Charlie Baker developed a COVID-19 Command Center, run by the Secretary of the Executive Office of Health and Human Services (EOHHS), Marylou Sudders, and staffed with state agency representatives, to coordinate the statewide response. To support the state's Medicaid and Children's Health Insurance Program (collectively known as MassHealth) to respond to the PHE, EOHHS submitted a COVID-19 PHE Medicaid Section 1115 Demonstration request to CMS to authorize certain flexibilities.

After the Emergency 1115 approval and following CMS's guidance on monitoring and evaluating approved 1115 Emergency Waiver Demonstrations, Massachusetts designed evaluation approaches for the approved items used by the state during the COVID-19 public health emergency. Per CMS requirements, this final report captures data on Demonstration implementation, evaluation measures and interpretation, and lessons learned from the Demonstration.

## 4. Mobile Testing Program

### 4.1 Introduction, Policy Goal, and Objectives

On March 10, 2020, with nearly 100 confirmed COVID-19 cases confirmed statewide, Governor Charlie Baker declared a state of emergency in the Commonwealth. 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 Section 1135 Emergency Waiver Demonstration requests, Disaster SPA requests, Appendix K requests, and, as described below, an Emergency 1115 Demonstration request, all to CMS. The flexibilities approved by CMS under these authorities were invaluable in ensuring the continuation of coverage of services for MassHealth's 1.9 million members at that time.

The Executive Office of Health and Human Services (EOHHS) submitted a request to CMS on April 24, 2020, for a COVID-19 PHE Medicaid Section 1115 Demonstration to authorize certain flexibility to assist with the states' response to COVID-19. On Dec. 3, 2022, CMS approved Emergency Waiver Demonstrations and expenditure authority to support the states' requests. In response to CMS' guidance on monitoring and evaluation of approved Emergency 1115 Demonstrations, Massachusetts designed evaluation approaches for the approved items utilized by the state during the COVID-19 PHE.

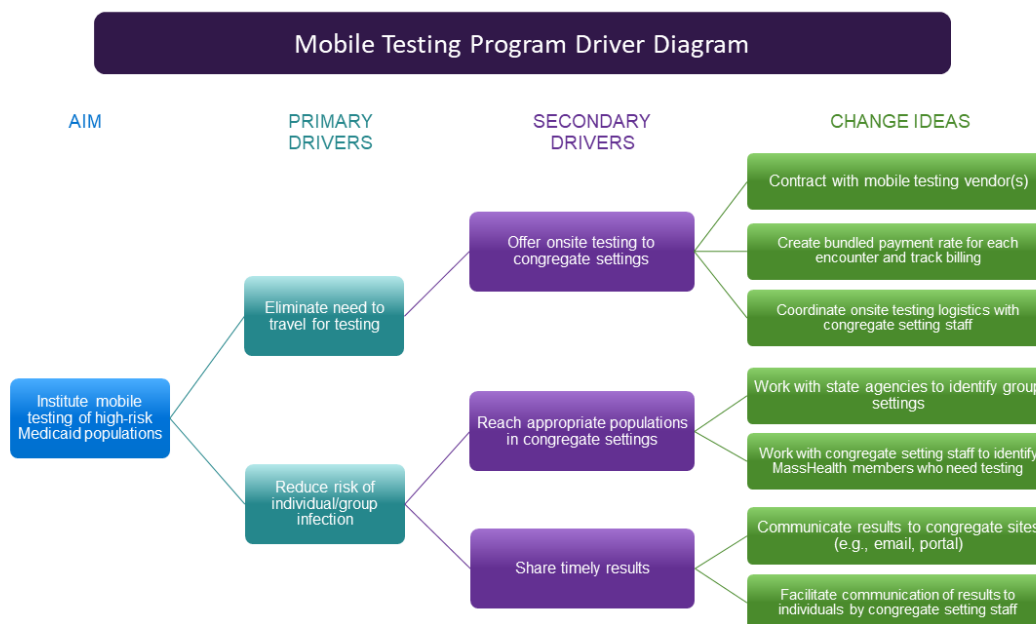
To help contain the spread of the virus, MassHealth implemented the Mobile Testing initiative to institute timely testing of populations at high risk of COVID-19. The target populations included residents of nursing facilities and other congregate settings (e.g., residential group homes, shelters, continuing care medical facilities, mental health centers, and recovery treatment centers) who were unable to travel to community-based testing sites. For these congregate facilities, MassHealth contracted ambulance providers to quickly deploy mobile testing and to facilitate the transfer of specimens to a laboratory for analysis. The initiative ran from April 4, 2020, through October 31, 2020, at which point all invoices had been submitted. The evaluation period was April through July 2020, the timeframe that includes all dates of service for which payment was provided.

### 4.2 Evaluation Questions, Data Sources, and Methods

#### Evaluation Questions

To evaluate the implementation and outcomes of the mobile testing initiative, researchers at ForHealth Consulting at UMass Chan Medical School (UMass Chan)

conducted a mixed methods evaluation. We constructed the diagram on the following page to understand the mobile testing program and guide development of the evaluation questions and methods. The primary drivers of the program were to keep members from needing to travel for testing and to reduce the risk of infection within the congregate setting. Thus, there was a need for identifying and reaching the members in appropriate congregate settings for testing as well as to make timely test results available. The evaluation focused on the change ideas regarding program implementation.



**Research Questions (RQs).** The key evaluation research questions include:

RQ1. Did the mobile testing reach the intended audience?

1a. How many tests that were paid for by MassHealth were performed at mobile testing sites?

1b. How did the volume of testing change during the mobile testing period among those congregate sites?

RQ2. What was the total program expenditure by MassHealth and by target sites and populations?

RQ3. What were the experiences of mobile testing among Medicaid program administrators and testing sites? The RQ includes the following detailed questions:

3a. How were mobile testing sites chosen?

3b. What processes were necessary to stand up the program?



- 3c. Did mobile testing reach the intended populations?
- 3d. What were the facilitators and successes of the mobile testing program?
- 3e. What were the barriers and challenges of the mobile testing program?
- 3f. Did mobile testing help sites to identify COVID-19-positive residents, expedite testing, and contain the spread of the virus?
- 3g. Overall, how effective was mobile testing to help respond to the PHE?
- 3h. What were the lessons learned to inform future testing for other infectious diseases?

## Data Sources

**Data:** The data used include quantitative and qualitative data sources listed below:

- **Ambulance provider test report data:** This data includes the site name, number of tests, test date, the agency responsible for the site, number of staff/MassHealth members projected to be tested, and number of completed staff/MassHealth member tests.
- **Individual-level invoice/payment data:** This data includes invoices detailing the bundled rate/payment per MassHealth member submitted by the ambulance provider to MassHealth. It also includes member-level information such as Medicaid ID, age, payer status, and payment balance.
- **Qualitative interview data:** The team conducted interviews and collected qualitative data from Congregate Facility Site Administrators and Mobile Testing Program managers.

## Methods

### Quantitative Methods

The evaluation of the 1115 Emergency Waiver Demonstration Mobile Testing program aims to describe the implementation of the initiative by using descriptive statistics and trend analysis regarding the utilization of the Mobile Testing program and program-related costs. The analysis period spanned from April 2020 to July 2020. It is important to note that only a post-test-only analysis was completed for the quantitative data of the Mobile Testing program because there was no comparable Mobile Testing program prior to the COVID-19 pandemic.

### Qualitative Methods

We received a list of contact information from MassHealth, to congregate facility site administrators and mobile testing Program Managers to interview for this evaluation. These interviews allowed us to better understand the administrative and programmatic

logistics of mobile testing implementation, including barriers and facilitators, successes, lessons learned, and recommendations for future initiatives. Referrals to site administrators were based on a selected list that we generated using the exclusion criteria below.

### Selection of Congregate Facility Site Administrators

#### *Exclusion Criteria*

A sample of congregate facilities that participated in mobile testing was selected from a database of all 1,750 Executive Office of Health and Human Services (EOHHS) agency congregate facilities visited by an ambulance provider for mobile testing. To limit the sample to only congregate facilities that completed testing, facilities meeting the exclusion criteria below were excluded from the eligible list of potential interviewees.

- **Testing Status** of *pending* or *cancelled*.
- **Date Tested** listed as *reconciliation needed*.
- **Site** listings where no member testing was completed: *staff testing pop-ups, support services, shared living, residential programs, respite programs, pop-up sites, regional offices, and quarantine hotels*.
- **Completed Members** counts of <10 or with empty fields.
  - Exceptions were made for provider organizations in remote areas with low population density (Berkshire County: North Adams, West Stockbridge, Lee; Barnstable County: Hyannis, Barnstable/Centerville; Bristol County: New Bedford, Westport, Fall River; Worcester County: Leominster).

After exclusions were made based on the criteria above, 115 congregate facilities were eligible for inclusion in the target sample. Researchers selected a sample of 15% of these facilities, allowing for the representation of provider organizations across the following categories:

- Agency (Massachusetts Department of Children & Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], and Massachusetts Department of Public Health [DPH])
- Testing Priority Level (low, med, high)
- Region (Western, Central, Northeast, Greater Boston, Southeast, Cape & The Islands)

Site Administrators at the selected congregate facilities received email invitations to be interviewed for this evaluation.

### Selection of Mobile Testing Program Administrators

We received a list of contact information for mobile testing program administrators at MassHealth. We also received a list of contact information for Program Managers within

each EOHHS sister agency (DCF, DDS, DMH, and DPH) who oversaw congregate housing sites and site administrators in their respective agencies. These individuals received email invitations to be interviewed for this evaluation.

### Sample Size

We planned to interview 20 site administrators from the selected list of congregate facilities and five program administrators from each participating EOHHS agency, for a target sample size of 25.

### Recruitment

We initiated contact with prospective interviewees up to five times (three attempts by email and two attempts by phone) to establish contact. If contact was not successfully established by the fifth attempt, the prospective interviewee was removed from the contact list. The removed contacts were only replaced with new contacts if there were eligible candidates in the database with matching inclusion criteria (i.e., same EOHHS agency, and region if possible).

### Data Collection

We conducted web-based interviews with mobile testing site administrators and Program Managers. Researchers developed semi-structured facilitator guides tailored for interviews with each audience (i.e., mobile testing congregate facility site administrators, mobile testing EOHHS agency Program Managers, and mobile testing MassHealth Program Managers). Each interview guide (see **Appendices 8.2.1 – 8.2.3**) included questions designed to elicit detailed feedback about the experiences of administering or implementing mobile testing, according to the interview questions per the evaluation design.

### Thematic Analysis

Audio recordings were professionally transcribed prior to analysis. To organize the information received during the interviews, coders conducted qualitative analyses of the interview transcripts in an electronic qualitative data management software using a coding manual. Coders used thematic analysis to identify key findings present in the transcripts, which were defined in a coding manual. Coders met to compare excerpts and themes present in the data for concordance among the team and trustworthiness. The coding team resolved coding discrepancies using consensus and an iterative process of refining and merging codes. To demonstrate the data-driven nature of the qualitative findings, the coding team extracted excerpts/quotes supporting each theme from the transcripts. These are presented in the Results section.

## **4.3 Evaluation Findings**

### **Quantitative Findings**

Below we describe and provide supporting figures for all findings within the context of each research question.

**RQ1a.** Did the mobile testing reach the intended audience? How many tests that were paid for by MassHealth were performed at mobile testing sites?

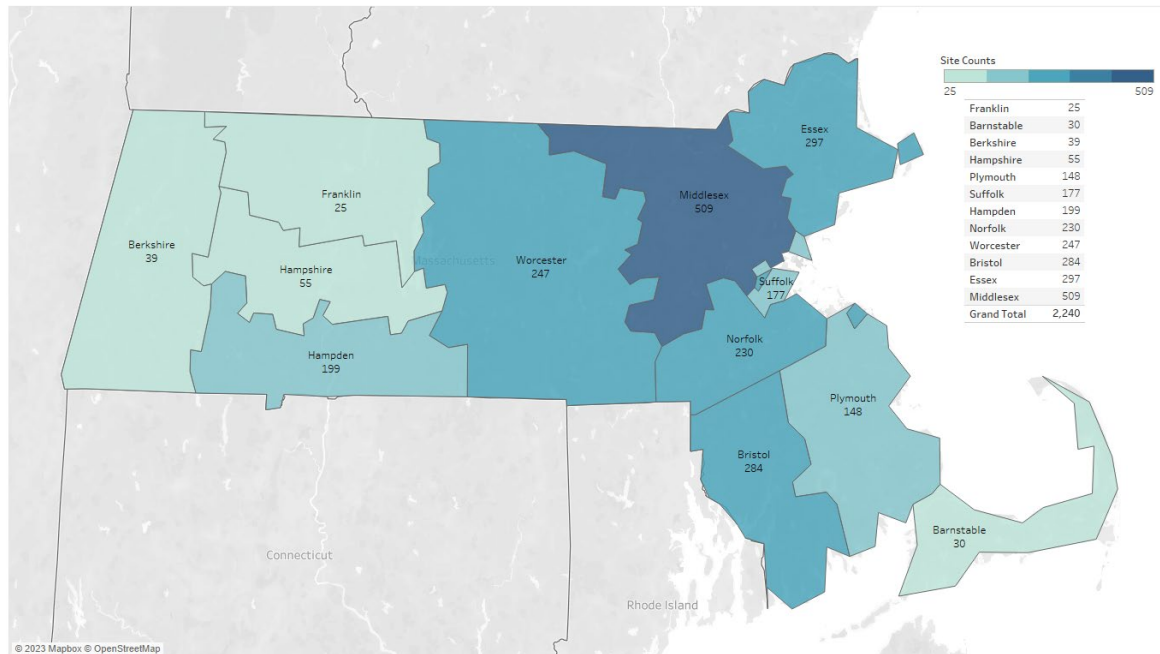
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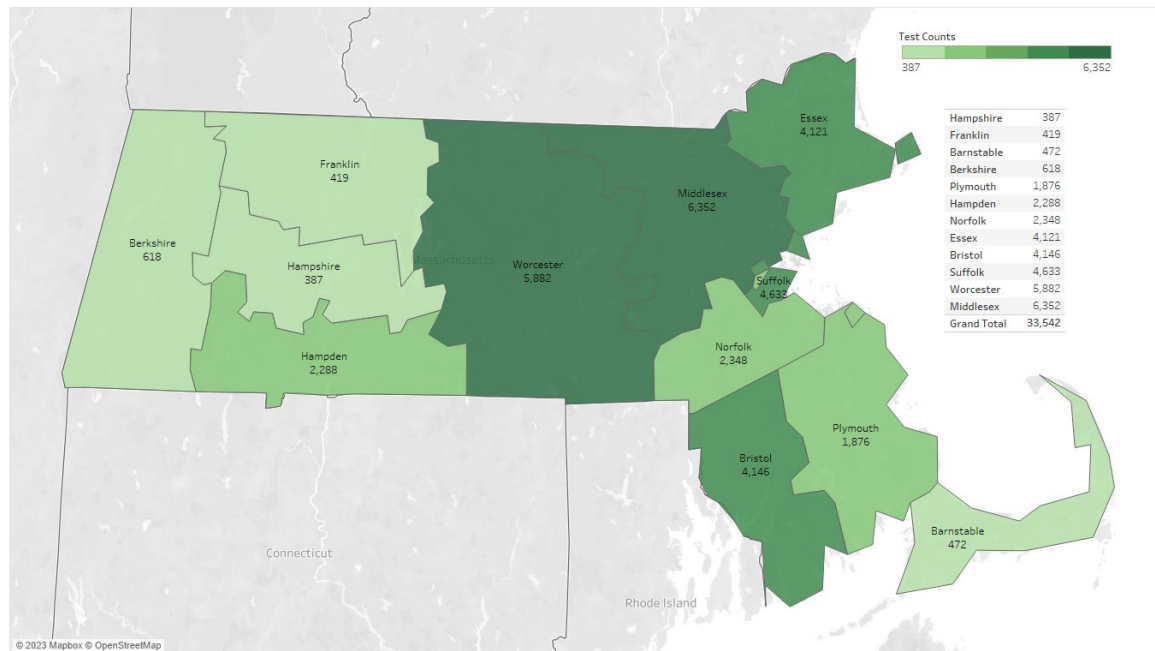
**Across Massachusetts, 33,542 mobile tests were completed, and the total number of sites reached was 2,240.** Nursing and congregate site facilities, including residential group homes, shelters, continuing care medical facilities, mental health centers, and recovery treatment centers were among the sites that participated in the mobile testing program. These sites supported members who were unable to travel to community-based settings to be tested. We describe trends in Mobile Testing coverage throughout Massachusetts during the evaluation period, specifically regarding the number of testing sites by county and the number of completed tests by county (see **Figure 1** and **Figure 2**).

Out of the 12 Massachusetts counties involved, the most testing sites were located in the Greater Boston area in Middlesex County (509), and the lowest number of testing sites were in Western Massachusetts in Franklin County (25) (see **Figure 1**). The largest number of tests were also conducted in Middlesex County (6,352), and the lowest number of tests were in Western Massachusetts in Hampshire County (387) (see **Figure 2**). Barnstable County, in the Cape area, also reported a low number of testing sites (30) (see **Figure 1**) which can be an explanation for the low number of completed tests (472) (see **Figure 2**).

Synthesizing the data from the number of testing sites and the number of completed tests by county correlates to the population density throughout Massachusetts. Trends show that the lowest number of completed tests were where the lowest number of testing sites are located, in both Western Massachusetts and the Cape area. These areas also hold the lowest population density throughout the state. The area with the highest number of completed tests was where the highest number of testing sites were located, in Middlesex County, which also is one of the most populated areas of Massachusetts. Therefore, our analysis suggests that testing frequency corresponds with the state's population density.

**Figure 1: The Number of Mobile Testing Sites by County**



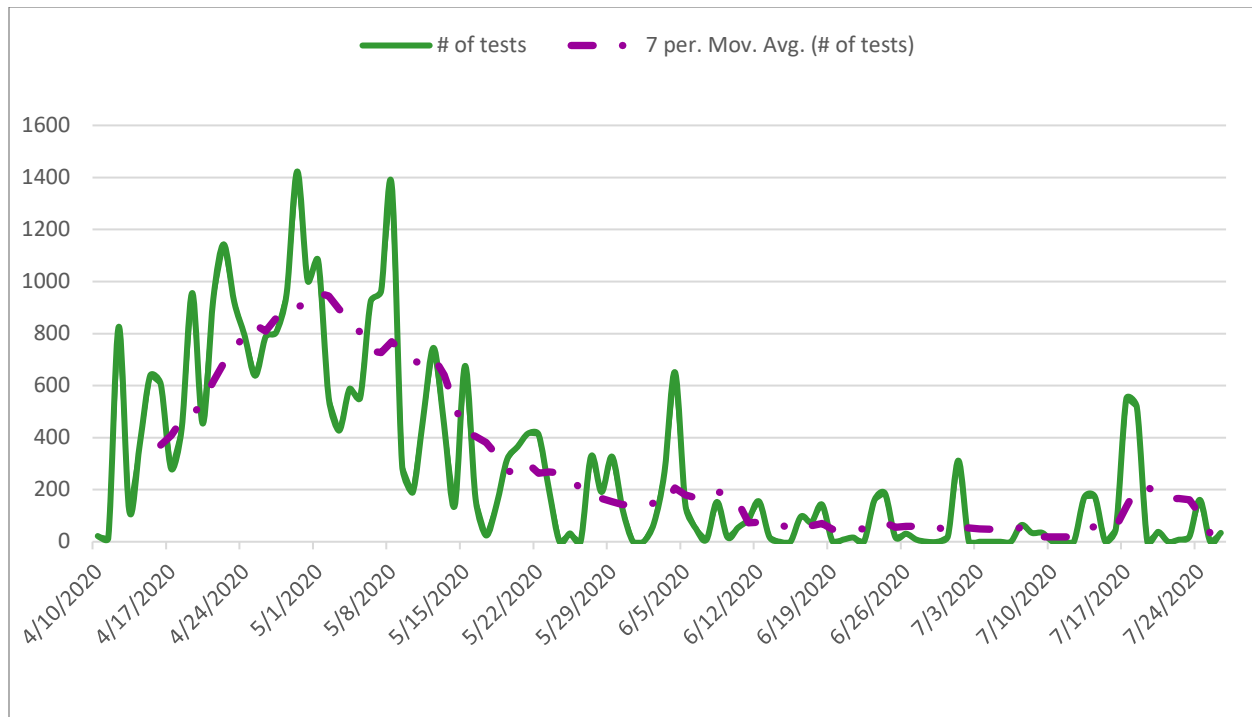
**Figure 2: The Number of Mobile Testing Completed by County**

**RQ1b.** Did the mobile testing reach the intended audience? How did the volume of testing change during the mobile testing period among those congregate sites?

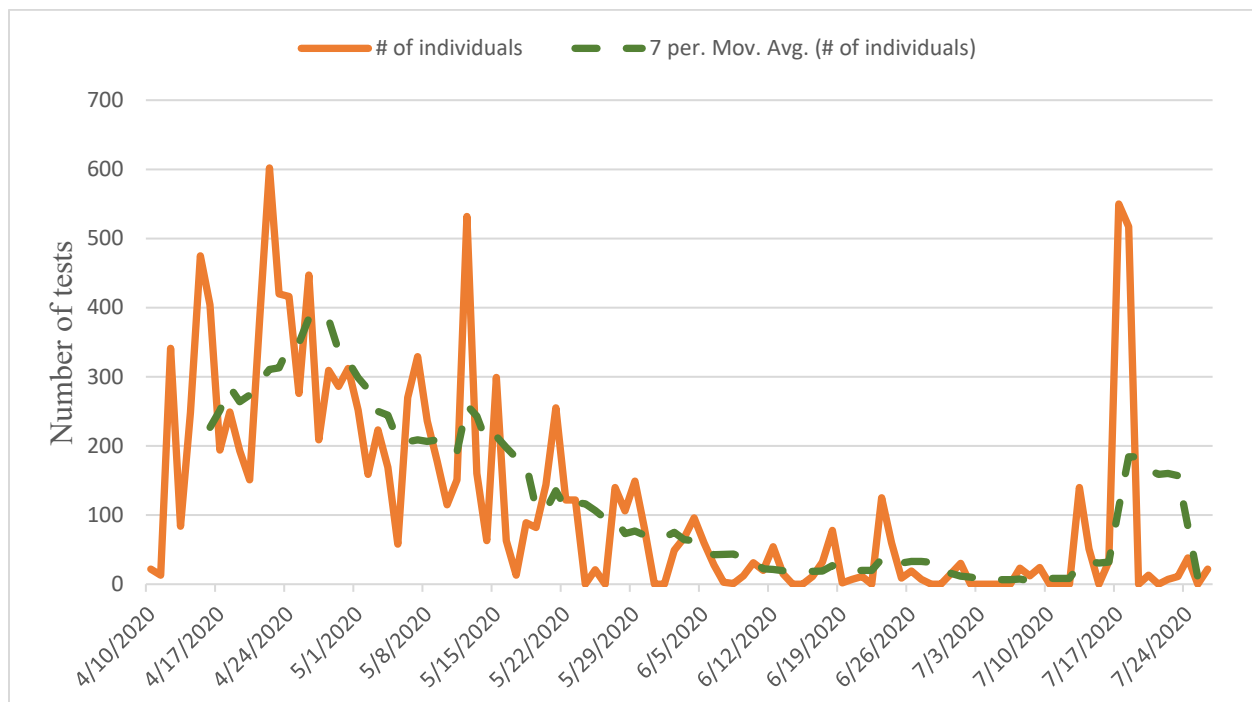
**The volume of testing changed during the mobile testing period among congregate sites, as more testing occurred at the beginning of the program and less testing occurred by the end of the program (See Figure 3).** During the four-month evaluation period, 12,895 individuals and 18,291 staff were tested, totaling 31,186 individuals that were tested (See **Figures 4 & 5**). The highest number of individuals tested in Massachusetts occurred during the months of April, May, and July. On April 24, 2020, the highest number of individuals (602) were tested (see **Figure 4**). The highest number of staff tested in Massachusetts occurred during the months of April, May, and June. May 8, 2020, was the day that the most staff members (1,138) were tested (see **Figure 5**). Starting on May 24, 2020, some days occurred when zero individuals or staff were tested. In total, 31,186 tests were recorded between both individuals and staff members.

Trends in both **Figures 4** and **5** show that the number of tested staff and individuals began to decrease after June 7, 2020. There was a rise in the number of total tests on July 17, 2020, which may be due to reconciliations and payments for earlier dates that were paid by the “bundle” payment methodology. In addition to the absolute numbers of tests by week, the seven-day moving average of the test numbers demonstrates a similar trend.

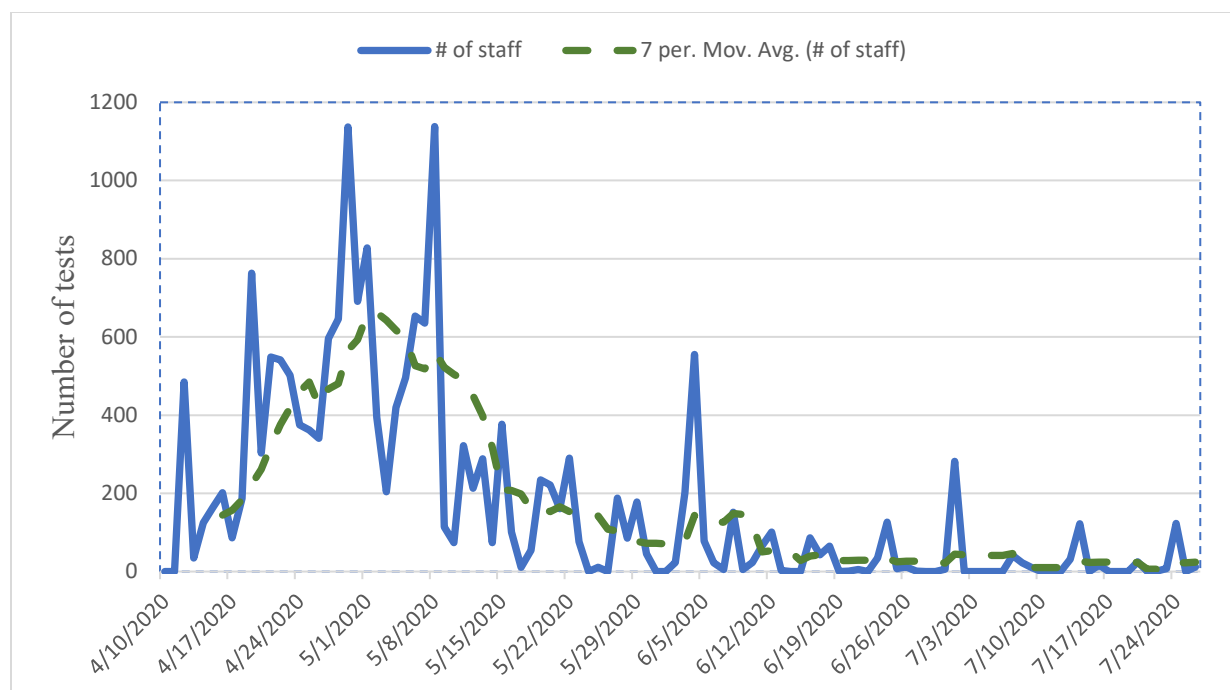
**Figure 3: Total Number of Mobile Tests by Week**



**Figure 4: Total Number of Clients/Members Tested by Week**





**Figure 5: Total Number of Staff Tested by Week****RQ2. What was the total program expenditure by target sites and populations?**

The program spanned from April 2020 to August 2020, and as of Oct. 14, 2020, the reported grand total program expenditure by testing sites was \$8,812,501.80 (see **Table 1**). The analysis period end date was extended to August due to several separate invoices that were received and processed after July, and that information was included in the analysis to provide an accurate overview of the program. All the invoices were totaled to understand that the total program expenditure by MassHealth Members was \$2,418,213.89 (see **Table 1**). The total program expenditure, excluding the MassHealth Member populations and categorized by “Other,” was \$6,394,287.91 (see **Table 1**). The highest expenditure dates of the program occurred between the dates of April 15, 2020, and April 28, 2020 (\$1,738,195.00) (see **Table 1**). The lowest expenditure dates of the program occurred between April 10, 2020, to April 14, 2020 (\$322,385) (see **Table 1**). It is important to note that the invoice date ranges were not all continuous, as invoices six and seven (see **Table 1**) were collected throughout the span of the program while overlapping with the date ranges of other invoices.

**Table 1: Total Mobile Testing Program Expenditure**

Date Range (2020)	MassHealth members	Other	EHS Invoices	Grand Total
4/10 - 4/14	\$198,555.00	\$123,830.00	Invoice 1	\$322,385.00
4/15 - 4/28	\$835,700.00	\$902,495.00	Invoice 2	\$1,738,195.00
4/29 - 5/5	\$378,505.00	\$1,117,825.00	Invoice 3	\$1,496,330.00

Date Range (2020)	MassHealth members	Other	EHS Invoices	Grand Total
5/6 - 5/10	\$122,305.00	\$1,020,530.00	Invoice 4	\$1,142,835.00
5/11 - 5/21	\$61,000.00	\$1,207,190.00	Invoice 5	\$1,268,190.00
5/1 - 7/20	\$563,945.00	\$535,580.00	Invoice 6	\$1,099,525.00
4/10 - 8/31	\$258,203.89	\$1,486,837.91	Invoice 7	\$1,745,042.00
<b>Grand Total</b>	<b>\$2,418,213.89</b>	<b>\$6,394,287.91</b>		<b>\$8,812,502.00</b>

*\*Note: There are seven separate invoices included that occurred within different time frames*

**RQ3.** What were the experiences of mobile testing among Medicaid program administrators and testing sites?

We conducted interviews with 19 congregate facility site administrators and mobile testing Program Managers (76% of our target sample size) (see Table 2 below). We were unable to reach 100% of the target sample size due to non-response or declined participation. Of note, we conducted interviews with two separate mobile testing Program Managers from DMH—one who specialized in inpatient services and one who specialized in outpatient services. See **Appendix 8.3** for the de-identified list of provider organizations interviewed for this evaluation.

**Table 2.** Sample of Congregate Facility Site Administrators & Program Managers

DCF	Target N = 5	Actual N = 2
Congregate Facility Site Administrator	4	2
DCF Mobile Testing Program Manager*	1	0
DDS	Target N = 8	Actual N = 6
Congregate Facility Site Administrator	7	5
DDS Mobile Testing Program Manager	1	1
DMH	Target N = 5	Actual N = 6
Congregate Facility Site Administrator	4	4
DMH Mobile Testing Program Manager	1	2
DPH	Target N = 6	Actual N = 4
Congregate Facility Site Administrator	5	3
DPH Mobile Testing Program Manager	1	1
MassHealth	Target N = 1	Actual N = 1
MassHealth Mobile Testing Program Manager	1	1
<b>Total</b>	<b>25</b>	<b>19</b>

\*DCF Mobile Testing Program Manager did not respond to requests to be interviewed.

## Interview Themes

We analyzed individual transcripts from interviews with Site Administrators and Program Managers. Thematic analyses of interview data generated the following 12 themes.

1. Selection of mobile testing sites required consistent communication between stakeholders.
2. Preparing for mobile testing visits was a multi-pronged and coordinated process between stakeholders.
3. Mobile testing was successful in providing COVID-19 testing to vulnerable populations and those with disabilities.
4. Site administrators and Program Managers maintained positive and optimistic attitudes throughout the testing program.
5. Site administrators praised mobile testing ambulance vendor staff members for their positivity, compassion, and gentleness.
6. Congregate sites at times faced scheduling challenges with the mobile testing vendor regarding limited availability and short notice of arrival times.
7. The administrative process of program implementation was challenging and sometimes burdensome for Site Administrators.
8. Receipt of mobile testing results was challenging initially but became easier once the ePortal launched.
9. Mobile testing was not always sufficient to meet the demand for COVID-19 screening.
10. Mobile testing successfully executed COVID-19 testing quickly and efficiently to implement safety precautions as needed.
11. Mobile testing allowed stakeholders to effectively monitor and address COVID-19 outbreaks through testing and information sharing.
12. Improvements in testing accessibility, administrative support, and stakeholder communication would benefit future testing initiatives for other infectious diseases.

Below we describe and provide supporting excerpts for each theme within the context of each interview question.

### **RQ3a. How were mobile testing sites chosen?**

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**Selection of mobile testing sites required consistent communication between all stakeholders.** Staff at MassHealth worked with Program Managers at EOHHS agencies to identify and select congregate care facilities for mobile testing. Each EOHHS agency lead was responsible for generating a spreadsheet or “referral report,” including the names of congregate facilities within the respective agency and the number of residents at each facility. Early in the pandemic, mobile testing required a physician's order; thus, during this time, the referral tracker also included the names and

MassHealth IDs of each resident and the name of their primary care provider, to obtain testing approval.

The referral reports were sent to MassHealth to queue mobile testing ambulance vendors for dispatch. At the height of mobile testing, MassHealth sent referral reports to the ambulance vendor nightly to queue dispatch. The ambulance vendor would then use the referral reports to schedule mobile testing visits with the point of contact at each congregate facility. The ambulance vendor was also responsible for delivering the collected samples to a diagnostics laboratory for analysis and reporting the results of testing.

- *“At the onset it was direct agency-to-agency outreach to make us aware of needs to which we would be able to compile [...] in a referral report. That referral report would be sent over nightly to [the mobile testing team], to which they would start [...] scheduling times and dates with the leaders at those group homes directly. Once they were scheduled, [the mobile testing team would] get their lab vials labeled and named with all the residents that lived there, go out [to] collect specimens, [then deliver them to the lab for analysis]. Then they would track [the testing status of the specimens] for resulting once the testing was completed.” –MassHealth Mobile Testing Program Manager*
- *“The communication [with the mobile testing staff] was brokered through other people. [We received] notification about when they were coming, what we would need to have available, and how we would need to be prepared. Once we connected with them directly on-site, it went really smoothly.” –DMH Congregate Facility Site Administrator 3*
- *“Communication on a daily basis, sometimes in the middle of the night. Sending messages and emails and that’s just what was required to move the mobile testing forward. We communicated nonstop, and it wasn’t enough.” –DDS Mobile Testing Program Manager*

### **RQ3b.** What processes were necessary to stand up the program?

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**Preparing for mobile testing visits was a multi-pronged and coordinated process among congregate facility staff.** Much coordinated effort went into preparing for a mobile testing visit, starting with the collection of the required client documentation needed for testing approval and insurance verification. Congregate facility staff compiled databases of their clients’ names, MassHealth IDs, and the names of their primary care provider to obtain a physician’s testing approval (before the requirement for having a physician’s order for testing was waived). This process of frontloading the administrative components was noted for improving the efficiency of both the mobile testing and lab requisition process.

To protect the safety of residents, congregate facility staff set up designated testing stations for the ambulance vendor staff to collect specimens. Often, these stations would be set up outside or close to a main entrance. One agency implemented temporary pop-up community testing sites for congregate facility staff testing within the agency, which was noted as an efficient way to test staff from multiple sites all at once.

- *“For some of their group home congregant sites, I would work with the [agency director] and she would let me know [...] how many members they had in their group home, what their MassHealth IDs were, who their primary providers were, so that we could get lab requisitions from their providers. That all changed once they waived the requirement for having a physician’s order for testing. So, it definitely became more efficient as we went through time.”* –MassHealth Mobile Testing Program Manager
- *“You had a list of names for both the client and the individuals who live here, with their date of birth and their health insurance number. So, we provided that list ahead of time.”* –DCF Congregate Facility Site Administrator 1
- *“[We] had to identify a port of entry and set up a station close to the door [to reduce the chance of COVID-19 transmission to our staff and residents.] [...] We tried to keep [the mobile testing staff] from coming all the way into [our facility]. [Our staff were even getting tested outside]. They would come to the tester, get a test, and then go right back [inside].”* –DDS Congregate Facility Site Administrator 1
- *“We began doing what we call pop-up testing where we would identify [...] any number of locations we could find and set up a tent and just have the mobile testing come there, and then we would essentially create a testing site that was temporary that [the mobile testing vendor] would stand up and we would blast it out to all of our staff and say “Come to this parking lot between these hours and get your COVID-19 test.” And so that ended up actually working really well and being a very efficient way to test a lot of people.”* –DDS Mobile Testing Program Manager

### RQ3c. Did mobile testing reach the intended populations?

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**Mobile testing was successful in providing COVID-19 testing to vulnerable populations and those with disabilities.** The mobile testing program was initiated as an infection control mechanism to limit the spread of COVID-19 in congregate care facilities. These facilities were of importance to EOHHS due to the increased risk of spread caused by the density of residents living in a defined space. The population of residents living at congregate care facilities included adult and adolescent individuals with a variety of disabilities and health-related social needs, including developmental disabilities, mental health and substance use disorders, and homelessness. Many of these individuals had mobility limitations preventing them from traveling to community testing sites. Mobile testing also eliminated the risk of COVID-19 transmission between residents and staff during car travel to community testing sites. Thus, site administrators frequently spoke of how invaluable mobile testing services were to the residents and staff.

- *“Mobile testing is most suitable to our population. Many of our constituency cannot get around on their own. They don’t drive. They are very dependent on others for many personal and care needs, so the mobile testing provided an option for the majority of our constituency. [...] We implemented mobile testing as an option to bring tests [...] to a population who didn’t have it otherwise.”* –DDS Congregate Facility Site Administrator 1

- *“These are people living with chronic mental illness. Diagnoses ranging from severe lifelong depression, anxiety, bipolar, to schizoaffective and schizophrenic diagnoses. Especially with the older population that we have [who have] chronic medical comorbidities [and have] trouble ambulating at times. [...] Getting adults with a serious mental illness out of the house to go get tested was pretty much impossible. [...] So to bring testing into the house was really the only way that we would ever know if we were dealing with COVID-19 in the house.”* –DMH Congregate Facility Site Administrator 2
- *“[Our program is] a recovery home serving male-identified clients. [...] They might be on parole, probation, involved in drug court. [We are a residential substance use treatment program] and we used to be a reentry program, so that’s why [this population is] a population we feel really competent in serving.”* –DPH Congregate Facility Site Administrator 1
- *“[Mobile testing] eliminated the need for transportation of an individual who could possibly be infectious. [...] Transporting someone, I mean the logistics of it were just even more challenging because you had to be really careful about infection control practices in any [...] method of transportation you were using. [...] There was significant concern around maintaining infection control and limiting the spread of COVID-19. [...] The ability to bring testing to those locations rather than having those individuals be transported, or for staff to go elsewhere for testing, was really a critical need in the department.”* –DMH Outpatient Mobile Testing Program Manager

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**RQ3d. What were the facilitators and successes of the mobile testing program?**

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**Site administrators and Program Managers maintained positive and optimistic attitudes throughout the testing program.** The positive attitudes, optimism, and professionalism maintained throughout the testing program by site administrators and Program Managers were noted by multiple congregate sites as major facilitators. Interviewees collectively voiced concerns about many unknowns and fears of COVID-19. Nonetheless, it was the optimism and professionalism exhibited by professional stakeholders that allowed the residents to be served more comfortably. Another site shared how their facility celebrated navigating the mobile testing experience with a party, which was noted as morale-boosting.

- *“You can only imagine what those cell phone calls at all hours of the night, consisted of, just trying to make sure that we had a process ironed out that didn’t exist two hours before. It was madness, but having good people working and staying on mission was really a big success. [...] It was always about the people they serve and not necessarily about themselves. [...] And that was a big win from my perspective, that everybody was able to come together and work collaboratively and stay focused on the task at hand.”* –MassHealth Mobile Testing Program Manager
- *“We had one home that had zero staff or residents test positive for COVID, and they had themselves a big party, and they were all thrilled about that. [...] It was kind of a morale builder among my staff and the people that we support. [...] These are little things, but they were little funny things that carried us a long way.”* –DDS Congregate Facility Site Administrator 3



**Site administrators praised mobile testing ambulance vendor staff members for their positivity, compassion, and gentleness.** Another facilitator in the mobile testing program was the positive attitude that testing staff maintained throughout the testing process. Despite the unknowns faced throughout the PHE, mobile testers remained kind and compassionate toward those they were testing, which helped to reduce fears of testing. For example, any member or employee who showed hesitancy about being tested was allowed to watch others undergo the nasal swabbing process to alleviate their fear. The mobile testers were also noted for their exceptional interpersonal skills, namely their compassion, gentleness, and patience with residents.

- *“I think the mobile testers themselves were all excellent. People were extremely sensitive to the unique support needs [of our clients], which was wonderful. And we did have a couple of folks who showed up more than once. So, I felt as though relationships were built with some of the lead testers, which was great.”* –DDS Congregate Facility Site Administrator 3
- *“[The mobile testing staff were] kind, and compassionate, and patient. [...] The feedback I was hearing from staff, and from residents, was that [the mobile testing staff] were really easy to work with, they were professional, and they had a good capture rate. Not everybody would agree to the testing, but by and large, they got most people to agree to it. [...] So that’s a testament to their professional and compassionate approach.”* –DMH Congregate Facility Site Administrator 2
- *“[The mobile testing staff] on-site was amazing. [...] Their interpersonal skills, their interactions with employees, who in the beginning were very scared to have stuff put in their nose, they worked it through with them, and we are grateful for that also.”* –DMH Congregate Facility Site Administrator 3
- *“The testers have been great, in terms of working with the clients and getting them tested. Being very gentle, explaining it, having someone that was maybe a little hesitant watch someone else get tested so they could visually see what was going to happen, they definitely did a really nice job with that.”* –DDS Congregate Facility Site Administrator 2

### **RQ3e. What were the barriers and challenges of the mobile testing program?**

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**At times, congregate sites faced scheduling challenges with the mobile testing vendor regarding limited availability and short notice of arrival times.** Multiple sites experienced barriers regarding the availability of, and communication with, the mobile testing ambulance vendor, which made it difficult for sites to schedule and plan for testing. Regarding arrival times, some sites noted the vendor’s unpredictability, arriving unexpectedly or sometimes not at all, which created confusion for the sites and caused them to conduct follow-ups. Limited hours and availability of vendors also made it difficult for sites to be tested efficiently. Sites noted the vendors’ lack of timeliness, which made it difficult to test everyone on the testing list.

- *“The only negative to [the mobile testing staff] was their availability. They could only [test] at six o’clock in the morning and sometimes they would show up at seven*



*o'clock or eight o'clock because they were delayed at other locations. [...] So, when we arrange for [the mobile testing staff] to come in at 7:00 and we have all the third shift lined up and they don't show up until 7:30 or eight o'clock, half of those staff have left. They did a brilliant job [...] but they were being pulled in a thousand different directions."*—DMH Inpatient Mobile Testing Program Manager

- *"The timing of it. As the program progressed, it did get better, but in the beginning, it was very vague, just, "We'll be there tomorrow." And in order to test staff, I needed to be able to tell staff when the mobile testing would be there, because not all the staff were at the program. So, we lost the ability to test our staff because we didn't have a timeframe. We couldn't say, "Be there Tuesday at two," it was, "Be ready, be on standby all day on Tuesday," So that was a bit of a challenge."*—DDS Congregate Facility Site Administrator 1
- *"We didn't always get a lot of advanced notice about when or what time the mobile testers would arrive. And so, it was really hard to deploy and mobilize the staff to get there [in time] for the testing time. There were a couple of situations that were challenges for me, in that I had scheduled some homes to be done on a certain day, and somehow the priority shifted to either another location, another agency, or they didn't have the number of testers available to do the site on that day."*—DDS Congregate Facility Site Administrator 3
- *"I recall the challenges primarily being around communication of arrival time. We had a lot of last-minute scrambling [...] We'd think [the mobile testing team] were going to be here at ten o'clock, and now it's two o'clock, and all our [members] are waiting around"*—DMH Congregate Facility Site Administrator 2

**The administrative process of program implementation was challenging and sometimes burdensome for site administrators.** Other major barriers experienced during the program stand-up were the challenge of obtaining client-specific documentation, difficulty navigating billing systems, and confusion from multiple directives. Administrative processes were noted to have taken extensive time to complete. Conflicting directives from multiple leaders and agencies made it confusing for sites to follow the correct safety protocols amid the mobile testing program.

Site administrators found the requirement of collecting specific information on employees and residents in preparation for the mobile testing visit to be a major burden on administrators and site providers. This process became more efficient with time, but at the beginning of the program, clients who were tested needed to provide specific information, including their name, date of birth, health insurance number, race, ethnicity, and contact information, to the vendor. Staff phone numbers were also collected to share test results. However, some sites faced difficulties in collecting this information, as some staff were not comfortable disclosing their personal contact information. Sites found that having more administrative assistance on the mobile testing vendor side could have helped streamline the testing process. The administrative barrier of the direct billing and manual reporting process was also noted as a challenge. Direct billing did not allow for traditional billing through the MMIS. Instead, services were billed through invoices, which required manual entry and upload for reporting. This included

matching tracking numbers to referrals, confirming schedules, and accounting to bill for thousands of tests a month.

- *“There was a requirement that we collect information from people ahead of time, which made things more efficient for [the mobile testing staff], but that put a big burden on us and our providers to collect the names and addresses and health insurance numbers of every person who was going to go to a testing site. So that made it just more challenging on the front end for us as an agency to pull these things off. [...] [We] were drowning in spreadsheets for months and months.”*—DDS Congregate Facility Site Administrator 1
- *“We did have to dedicate quite a bit of resources for that short period of time in order to work with [the mobile testing vendor]. And the part that was a resource drain was in the documentation [...] and the information that we had to collect on all the patients and the staff that we were doing the testing on.”*—DMH Congregate Facility Site Administrator 2
- *“[During that time, the mobile testing vendor did not have access to bill] through MMIS. It was all manual invoices. So [the process of] pairing their internal tracking numbers to our internal tracking numbers [was done manually]. [We worked together to coordinate the logistics and] nuances around direct billing via invoice versus Medicaid billing.”*—MassHealth Mobile Testing Program Manager

**Receipt of mobile testing results was challenging initially but became easier once the ePortal was launched.** A barrier faced by sites in the beginning of the program was difficulty with receiving test results. Lab testing sites were described as having both capacity and bandwidth issues, which caused delays in receiving test results at the beginning of the program. Sites explained how initially the mobile testing vendor was unable to share test results directly with clients due to system limitations. Only one person could receive test results at that time, which defaulted to site administrators and gave them the responsibility of notifying each client of their test results. The initial absence of a client ePortal made it difficult for clients to receive their test results as soon as possible. However, the advent of the ePortal, in addition to text message notifications, eliminated this barrier. Turnaround time of test results also improved over time, eventually allowing clients to receive their test results in 48 hours or less.

- *“[The test results] came directly through [the mobile testing vendor]. I remember they sent it through a secured email, but it was just an Excel spreadsheet because they didn’t have the ePortal. But then when we used them again in August, there was a portal, I think it was through text message that a lot of the staff tested got their results.”*—DDS Congregate Facility Site Administrator 4
- *“We had some test result delays, which were common at that time, right? I know they process their tests through [their lab vendor], and they were ramping up their testing capacity at the time, so I understand all the logistics behind the challenges.”*—DMH Congregate Facility Site Administrator 2
- *“We didn’t always know when they were going to come, and I think that was critical because oftentimes when a positive test was identified, you need to really get a test done within 24 hours or you’re really kind of getting yourself in trouble. [...]”*

*Sometimes it was pretty quick and other times it could've been two, three days later."*  
–DMH Outpatient Mobile Testing Program Manager

- *"I think [the ePortal] may have been one of the [best] improvements. [When the results were being given to me over the phone, my employees] had nothing on paper to give to another employer or to give to a school, so having some sort of written result was really important for people."* –DDS Congregate Facility Site Administrator 1

**MassHealth's mobile testing initiative was not always enough to meet the demands for COVID-19 screening.** Despite all the benefits of the mobile testing program, some sites still faced barriers in meeting the demand for COVID-19 screenings. Some sites had a higher demand for COVID-19 screening and supplemented their use of mobile testing with self-administered surveillance testing and visits to community testing sites. Sites acknowledged how beneficial mobile testing was in limiting the spread of COVID-19 within facilities but also expressed a desire for more access to mobile testing visits. Some sites noted that retesting was unavailable due to the lack of available appointments. Of note, with the increased availability of rapid tests, EOHHS eventually transitioned the mobile testing program into mandated self-administered surveillance testing.

- *"I wish we had more of [mobile testing]. (laughs). I wish we had more access and more ability to call and just get them out there to do the testing. I thought it was great and I wish I had more."* –DDS Congregate Facility Site Administrator 1
- *"We used the Stop the Spread sites quite a bit. If I didn't have access to the mobile testing. [...] Once the mobile testing stopped being an option, we then contracted our own lab, and we hired additional nursing staff to do all of our testing [in-house], and we did it in a similar mobile fashion. We would send the nurses out to our sites."* – DCF Congregate Facility Site Administrator 2
- *"[To supplement the mobile testing visits], we didn't yet have access to all the testing we have now [...], so we were having to send people to various testing clinics in the community to get people tested between April and August [2020]. And then in August, [EOHHS said] that you're going to have to do surveillance testing, and at that time, they were telling the providers to pick their own vendor."* –DDS Congregate Facility Site Administrator 4
- *"At that point, surveillance testing wasn't really readily available, and the [mobile testing] supply wasn't readily available to do surveillance testing, so it was really based on if you were symptomatic. We would usually have one staff, full PPE, gown, face shield, KN95, N95, drive an individual to [a community testing site] and we would try to keep it one-to-one. That way if that test came back positive and there was any exposure, we weren't exposing others at the same time."* –DMH Congregate Facility Site Administrator 3
- *"EOHHS shifted over to surveillance testing through [our surveillance testing vendor]. [Using the surveillance testing vendor, we began] testing in-house and shipping out on a weekly basis, which was a much better process. [...] [We] had to get everybody*

*tested and send them out. Our nurses would help manage the testing in-house.” – DMH Congregate Facility Site Administrator 2*

**RQ3f.** Did mobile testing help sites to identify COVID-19-positive residents, expedite testing, and contain the spread of the virus?

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**Mobile testing successfully executed COVID-19 testing quickly and efficiently to implement safety precautions as needed.** Like the goals set by MassHealth for implementing mobile testing, site administrators that utilized mobile testing aimed to reduce the incidence and spread of the virus amongst the clients and residents of their programs. By not needing to travel offsite for testing, residents living in congregate settings could stay in a familiar setting and not risk further exposure. Further, mobile testing allowed site administrators to quickly understand the level of positive cases at their sites and institute protective measures such as quarantining residents who tested positive. The ability for staff to also be tested further reduced the possibility of exposure. Site administrators also noted several strategies for implementing safety precautions, such as quarantining positive cases from other residents or having staff stay onsite for days at a time.

- *“We created a COVID-19 unit in anticipation of this, so we accessed our COVID-19 unit, and we actually had to have two, because of the information at that time, we weren’t sure how infectious people were who were non-symptomatic versus symptomatic, so we separated out symptomatic versus non-symptomatic people. And at that point, they stayed in the isolation unit until they tested negative.” –DCF Congregate Facility Site Administrator 1*
- *“We knew right away our third-floor [residents] here were all positive, we were able to [quarantine them in order] protect the first-floor clients who have COPD and other ailments because they would be more susceptible and vulnerable to a worse illness.” –DMH Congregate Facility Site Administrator 1*
- *“There are many different points COVID-19 can enter the system [...] so testing has been a great tool for us to make sure that we are keeping our community safer by quarantining those who need to be quarantined and isolated but also making sure that those folks have medical care, and we couldn’t have done that without testing.” –DPH Congregate Facility Site Administrator 1*
- *“Well, I think in general, [our experience with the mobile testing program] went well. They got it done, we got results, we got, clear understanding of positives and negatives, and we were able to isolate and quarantine as a result, and I think it absolutely was helpful, no question about it.” –DMH Congregate Facility Site Administrator 2*

**RQ3g.** Overall, how effective was mobile testing to help respond to the PHE?

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**Mobile testing allowed stakeholders to effectively monitor and address COVID-19 outbreaks through testing and information sharing.** The availability of mobile testing allowed MassHealth to effectively respond to the PHE by monitoring and addressing virus outbreaks at a time in the pandemic when rapid onsite testing wasn’t widely

available. The implementation of mobile testing came when site administrators and Program Managers were addressing many organizational and client needs simultaneously to navigate the unknowns and uncertainties regarding their pandemic response. The uniqueness of the situation meant that much of the program was developed without guidance from previous similar experiences and had to be implemented in a compressed timeframe to protect vulnerable populations at risk for COVID-19. The consistent communication and information-sharing across groups (i.e., MassHealth, EOHHS agencies, and congregate facilities) helped stakeholders remain aware of and responsive to outbreaks and emergency protocols.

- *“I think a big concern was, again, it was new. We know a lot more now in 2022 than we did in 2020 when this was all taking place. [We were focused on] trying to identify the spread and where it was coming from across the state so that other providers could enact their own set of emergency protocols.”*—MassHealth Mobile Testing Program Manager
- *“The goal was to identify people who were positive, get them out, and on sick leave so that we would stop the spread within our programs. [...] Data was a huge tool for us. I would recommend that – if people are doing it again, that you find a way to share data as quickly as possible. [...] All of those layers of data, whether it’s high-level data, timely good data translate directly to safety decisions.”*—DDS Congregate Facility Site Administrator 1
- *“So, from early on in the pandemic, we’ve communicated with our area office by way of a report on email. [...] It was daily. [...] We also kept our own daily notes with regards to positive cases, symptoms, especially the first half, when we were really monitoring and trying to prevent outbreaks of entire programs, [...] day symptoms started, day tested positive, day symptoms ended. That was more for safety and when an employee could return to work and what to report to the DPH epidemiologist.”*—DMH Congregate Facility Site Administrator 1
- *“We even created something called the COVID-19 dashboard to maintain transparency with our stakeholders, with our employees. So, on a weekly basis we would put together this one-pager dashboard on the amount of positives that we had per location, whether they were patients or employees. Just for the sake of transparency so people know what we’re doing.”*—DPH Congregate Facility Site Administrator 2

**RQ3h.** What were the lessons learned to inform future testing for other infectious diseases?

**Improvements in testing accessibility, administrative support, and stakeholder communication would benefit future testing initiatives for other infectious diseases.** Interviewees shared several suggestions that could inform future initiatives. Several site administrators noted that they would have liked more availability of testing, such as extended hours beyond what was made available and on-demand testing, and a more seamless process of including staff in the testing. Administratively, making the paperwork and documentation process prior to and during testing days more efficient or offering administrative assistance in this area would have reduced the confusion and



burden of being responsive to the different entities involved, such as the mobile testing vendor, insurers, and laboratories. Suggestions to improve communication were to create a more centralized way to communicate directives across agencies and to share clinical guidance (such as what is documented on the CDC website) regularly with site administrators.

- *“I think if there was more of a centralized approach to it. I think a lot of the confusion came down from a lot of different leads holding a lot of authority over their respective areas of responsibility. So, I know we were working [another state organization] at one point to try to pick up some of their overflow testing, which was a completely separate fiscal source [...] that’s where it got a little confusing [...] to not necessarily try to bleed everything together.”* –MassHealth Mobile Testing Program Manager
- *“I think, looking back, it might have been helpful for DPH to have weekly meetings. Even if they didn’t have the most updated guidance...This was something that we were like, ‘Okay, did someone check the CDC website recently?’ Because [it would change] so it took us a while to get used to that.”* –DPH Congregate Facility Site Administrator 2
- *“We had to figure out each other’s language as we were going. So, for instance, the healthcare world needed certain types of documentation. The labs needed certain documentation and verifications on each person. The health insurance. Those things had to line up.”* –DDS Congregate Facility Site Administrator 1

## 4.4 Conclusions, Policy Implications, and Limitations

### Conclusions

The Mobile Testing program allowed a large volume of COVID-19 tests to be conducted in a short period of time (33,542 mobile tests completed at 2,240 congregate sites), providing a unique contribution to capturing COVID-19 cases and potentially mitigating the spread of the disease. The distribution of the tests also corresponded to the population density throughout Massachusetts counties. The mobile testing volume began to phase out as more testing became available at local facilities.

The Mobile Testing program did cost a substantial amount of resources, as a total of \$8.8 million was contributed from April 2020 to August 2020, among which, \$2.4 million was spent on MassHealth members. This average cost per person was \$263. Considering the extremely high rate of disease spread, the Emergency Waiver Demonstration expenditure could have saved substantial costs by catching and treating infected individuals very early on while preventing and mitigating the spread of disease.

Interviews with congregate facility site administrators and Mobile Testing Program Managers across major state agencies revealed overall positive remarks about the program with operational lessons to learn. The testing was implemented quickly and efficiently despite some initial challenges (e.g., administrative burden and schedule coordination). The Mobile Testing program rollout allowed stakeholders to effectively monitor and address COVID-19 outbreaks. The coordination across agencies and

stakeholders was successful. The testing staff were positive, compassionate, and gentle. Lessons that were learned from the Mobile Testing Program included the importance of and need for consistent communication between stakeholders (including notice of testing availability and arrival time) and simplified administrative processes.

## **Policy Implications**

Using Emergency Waiver Demonstrations to provide rapid services has shown to have been an effective way to address the COVID-19 public health crisis. Mobile Testing improved access to infectious disease testing and relieved the transportation burdens or barriers that were present amid the pandemic, especially among vulnerable populations. The ability to conduct congregate site testing also was found to maximize the level of testing in a very short time period. Mobile testing services have great potential as a service delivery model for screening, immunization, and prevention purposes. MassHealth's leadership and other state agencies' collaborations can use this policy tool to enable emergency services in an expedited way is well established. Public payers and service agencies can consider developing a process and protocol document to summarize best practices, processes, and lessons learned, which will be helpful for addressing future public health crises for infectious diseases and beyond.

## **Limitations**

### Quantitative Evaluation Limitations

During the seven-month evaluation period, the quantitative data reflects that 33,542 mobile tests were completed, and a total of 31,150 individuals were tested. Based on the data, it can be assumed that one person received one test on average, although we did not obtain data to ensure the exact distribution of tests per person. Comparison sites were not included in the analysis, which made the identification of sites comparable to these mobile testing sites with adequate characteristics on which to match not feasible. Therefore, the absence of a comparison group limits our ability to demonstrate the relative effectiveness of mobile testing compared to other approaches. Given that COVID-19 testing did not exist prior to the public health emergency, this analysis could only be done after the onset of the pandemic.

### Qualitative Evaluation Limitations

We received a small sample size for qualitative interviews due to no and/or declined responses from prospective interviewees. As a result of incomplete sampling, we do not know to what degree the findings from the sample we interviewed are representative of the broader target populations. There are many additional mobile testing stakeholders in this state that were not represented in this sample. Finally, our qualitative interviews were limited to staff, thus, our interview findings do not reflect the perspective of members who participated in the mobile testing initiative or their families.



## 5. Telehealth Network Providers

### 5.1 Introduction, 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 an Emergency Waiver Demonstration of Freedom of Choice to permit the state to limit the TNP network to three such providers.

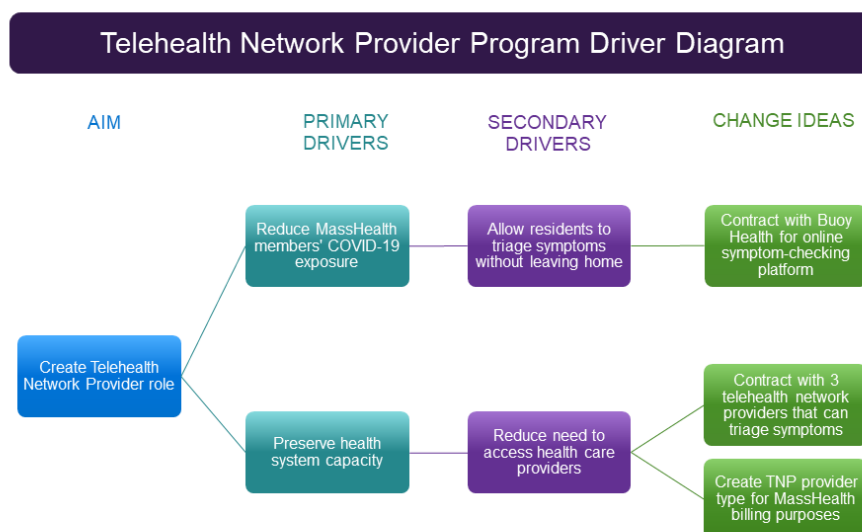
Contracts with the three TNPs were in place from April 1, 2020, through Sept. 30, 2020. TNPs were required to maintain a network of credentialed providers licensed in Massachusetts and to maintain a telehealth platform capable of furnishing covered telehealth encounters to all eligible MassHealth members. 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 coronavirus symptom checker 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 healthcare resources, which could include their own provider, or a provider contracted with a TNP. This service was available to all Massachusetts residents.

### 5.2 Evaluation Questions, Data Sources, and Methods

#### Evaluation Questions

To evaluate the implementation and outcomes of the TNP Program, researchers at ForHealth Consulting at UMass Chan conducted a mixed methods evaluation. We constructed the driver diagram below to understand the program and guide development of the evaluation questions and methods. The primary drivers of the program were to reduce members' exposure to COVID-19 and to preserve health systems' capacity to deal with urgent and severe cases. Thus, members needed access to a way to triage and manage their symptoms at home. The evaluation focused on the change ideas regarding program implementation.



**Research Questions (RQs).** The questions include the following:

RQ1. How many MassHealth members accessed the Buoy app over time?

RQ2. How many MassHealth members completed the triage interviews in the Buoy app?

RQ3. What is the utilization level of the TNP program and their physicians?

3a. 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?

3b. 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?

RQ4. What was the cost to MassHealth of administering the TNP Program?

RQ5: What are the lessons learned about establishing, maintaining, and using TNP? The detailed questions are below:

5a. What were the logistics of implementing the TNP Program?

5b. What were the facilitators and successes of the TNP Program from the TNP's perspective?

5c. What were the barriers and challenges of the TNP Program from the TNP's perspective?

5d. What made MassHealth members choose TNP providers versus their own primary care providers?

5e. What were MassHealth's members' overall experiences with TNP providers?

5f. What are the lessons learned from the TNP Program that will help inform future policy if a similar emergency condition occurs?

## Data Sources

**Data:** The data used include quantitative and qualitative data sources listed below:

- **Buoy Health data:** The Buoy Health app surveys users with a series of questions and may then allow contact with a TNP. The TNP can suggest triage levels, including: 1. self-isolation, 2. self-isolation and recommended evaluation for testing, 3. same-day care, 4. emergency room care, and 5. contacting 911. Data for this analysis includes the daily number of Buoy app encounters (i.e., interactions with the Buoy app) from March 26, 2020, triaged outcomes (e.g., self-isolation, recommended for test evaluation), interviews by county and payer (e.g., MassHealth, commercial payers), and usage of app data (e.g., number of app users, clicks).
- **TNP encounter and invoicing data reports:** These data include the encounter reports of MassHealth members receiving actual TNP services and the invoicing data reports from TNPs to MassHealth.
- **Qualitative interview data:** Qualitative data were collected from interviews conducted by ForHealth Consulting with TNP Program Managers, TNPs, TNP administrators, MassHealth members who accessed the Buoy app, and a MassHealth TNP Program manager.

## Methods

### Quantitative Methods

TNPs were a new type of provider created amid the COVID-19 pandemic. The target population of this provider was MassHealth members who were potentially COVID-19 positive. Therefore, there was no pre-COVID-19 comparison data to utilize for our measures. The analysis of the quantitative data was descriptive in nature, and the analysis period occurred from March to Sept. 2020.

### Buoy Data Set Contents

The aggregate data is one row per day per Massachusetts county per triage level reached in a Buoy Assistant Interview. Interview data were limited to MassHealth members who accessed Buoy via the link designed for Massachusetts residents (i.e.,

buoy.com/mass) and restricted to those where the location is determined (via IP, geolocation, or volunteered information) to be in the state of Massachusetts.

### Important Data Caveats

The Buoy data does not reflect a random sampling of the population. Users may reach Buoy via different channels, such as mass.gov directly, or via articles and social media shares. This means Buoy users skew demographically and are unevenly distributed across age, gender, symptoms of concern, geographies, and other factors. And since articles and social media posts may drive short-lived attention, this skew must be assumed to be constantly changing over time.

### **Qualitative Methods**

We received a list of contact information from MassHealth to three administrative points of contact at all three TNP organizations. We emailed each point of contact to request their assistance with facilitating communication with TNP providers and TNP administrative staff who worked as contracting and billing liaisons between their organization and MassHealth (“TNP administrators”) to invite them to be interviewed for this evaluation. We received a list of MassHealth members who used the Buoy app, from which we selected 72 Massachusetts for whom we were provided contact information. We contacted MassHealth members by mail, email, and telephone to invite them to be interviewed for this evaluation. We also invited (via email) a TNP Program Manager from MassHealth to be interviewed.

### Sample Size

We planned to interview one TNP administrator and four TNP providers from each TNP organization, one TNP Program Manager from MassHealth, and 15 MassHealth members, for a target sample size of 31.

### Recruitment

For TNP stakeholders, we conducted three rounds of email outreach and two rounds of telephone outreach to establish communication with points of contact at each TNP organization. For members, we conducted two rounds of telephone outreach in addition to sending invitations by mail. Members with known email addresses also received two rounds of email outreach. We conducted one round of email outreach to establish contact with MassHealth’s TNP Program Manager.

### Data Collection

We conducted web-based interviews with TNP stakeholders and MassHealth members. We developed semi-structured facilitator guides tailored for interviews with each audience (i.e., TNP providers, TNP provider organization administrators, MassHealth members, and the MassHealth TNP Program Manager). Each guide (see **Appendices 8.2.4 – 8.2.7**) included questions designed to elicit detailed feedback about the experiences of administering, implementing, or accessing TNP services, according to the interview questions, per the evaluation design. The purpose of interviews with TNP

Program Managers was to understand whether and how well the TNP Program worked and what lessons can be drawn about the TNP Program's implementation to inform future policy and programming. Interviews with MassHealth members aimed to learn about their experience accessing TNP services via the Buoy app.

### Narrative Analysis

Interviews were recorded and professionally transcribed verbatim prior to analysis. To organize the information received during the interviews, coders conducted qualitative analyses of the interview transcripts in an electronic qualitative data management software using a coding manual. Coders met to compare excerpts and themes present in the data for trustworthiness and concordance among the team. Coding discrepancies were resolved using consensus and by an iterative process of refining and merging codes. The coding team used descriptive narrative analyses to summarize the key findings present in the transcripts within the context of each interview question. To demonstrate the data-driven nature of the qualitative findings, excerpts supporting all key findings were extracted from the transcripts and are presented in the Results section.

## 5.3 Evaluation Findings

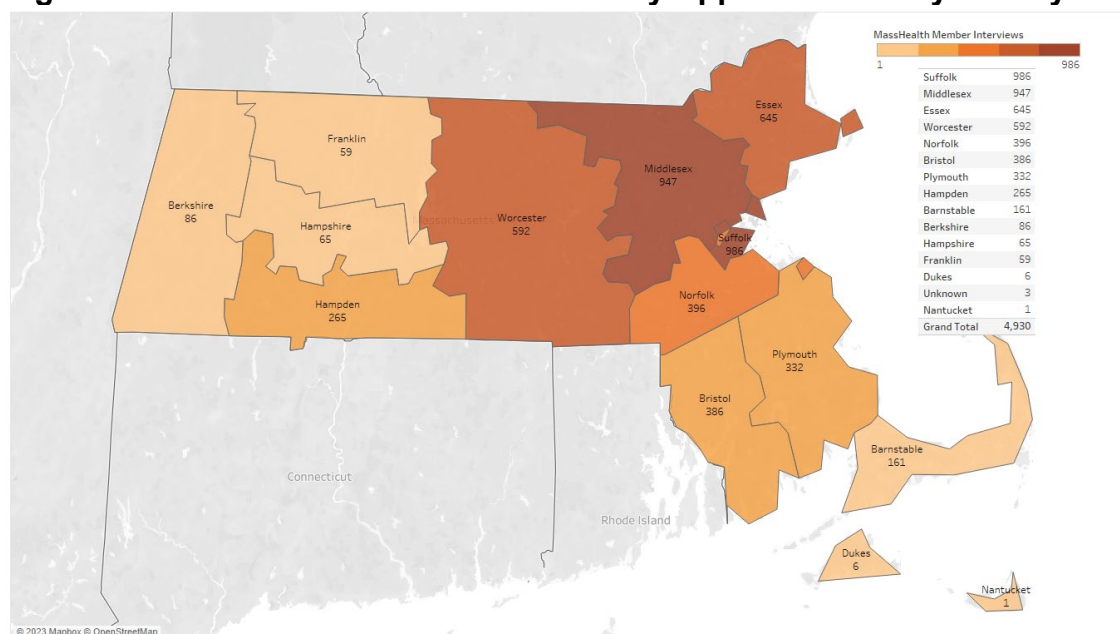
### Quantitative Findings

Below we describe and provide supporting figures for all findings within the context of each evaluation question.

**RQ1.** How many MassHealth members accessed the Buoy app over time?

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**There were 4,930 total recorded MassHealth members who completed the triage questions and accessed a TNP via the Buoy app** (see **Figure 6**). Accessing the Buoy app involved providers making recommendations about follow-up care. It is also important to note that 121,642 individuals used the triage tool without providing any insurance information in their interview. Out of the 14 Massachusetts counties involved, MassHealth members located in Suffolk County recorded the largest number of interviews (986), while MassHealth members located in Nantucket recorded the lowest number of interviews (1) (see **Figure 6**).

**Figure 6: Sum of MassHealth Member Buoy App Interviews by County**

**RQ2.** How many MassHealth members completed the triage interviews in the Buoy app?

**4,813 MassHealth members completed the triage interview to receive one of the five triage levels** (see **Table 3**). The triage levels include 1. self-isolation, 2. self-isolation and recommended evaluation for testing, 3. same-day care, 4. emergency room care, and 5. contacting 911. 117 MassHealth members did not receive a COVID-19 triage level (see **Table 3**). The triage level received by the most MassHealth members was the triage level 2: “self-isolation and recommend evaluation for testing” (2,437) (see **Table 3**). The lowest number of MassHealth members received the triage level 5: 911 (31) (see **Table 3**).

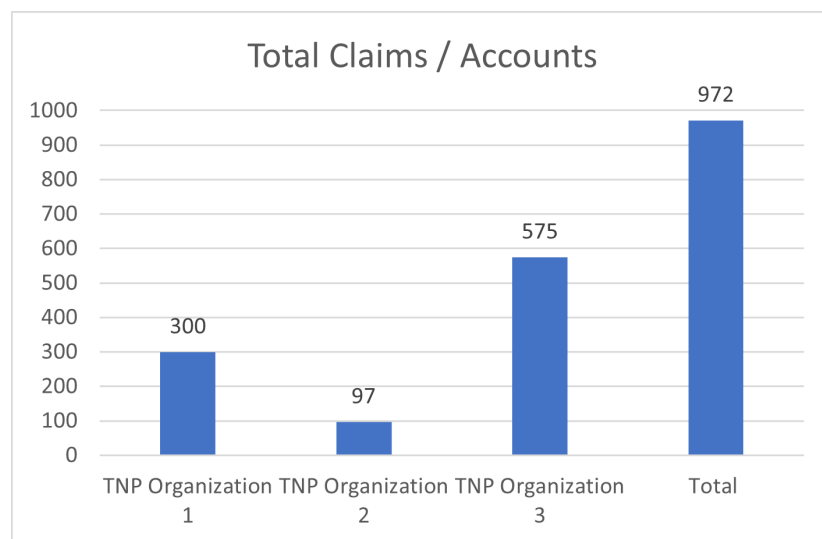
**Table 3: Levels of Triage Interview Completed by MassHealth Members**

Level of Triage	Number of MassHealth Members
1. Self-isolation	143
2. Self-isolation and recommended evaluation for testing	2,437
3. Same-day care	1,520
4. Emergency room care	682
5. 911	31
No COVID-19 Triage Level	117
Grand Total	4,930

**RQ3a.** 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?

Between March 2020 to Sept. 2020, a total of 972 encounters were reported to MassHealth as a result of interactions with the Buoy app and subsequent referrals to TNP vendors (see Figure 7). Specific TNP information for each individual member was unavailable at the time of analysis although TNP Provider 1 was the most utilized vendor. The number of encounters varied by TNP vendor, as TNP Provider 1 reported a total of 575 claims, TNP Provider 2 reported a total of 300 claims, and TNP Provider 3 reported a total of 97 claims (see Figure 7).

**Figure 7: Total Claims/Accounts**



**RQ3b.** 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?

**The types of follow-up care that were recommended during the Buoy app's triage process included self-isolation, self-isolation and recommended evaluation for testing, same-day care, emergency room care, calling 911, and no COVID-19 triage level.** There were 163,746 total recorded interviews via the Buoy app that involved providers making recommendations about follow-up care (see Table 4). The type of follow-up care that was most recommended to members was to self-isolate and recommend evaluation for testing (69,088), and the type of follow-up care that was least recommended to members was to call 911 (1,769) (see Table 4).

**Table 4: Overall Types of Follow-up Care**

Types of Follow-up Care	Sum of Interviews
1. Self-isolation	34,619
2. Self-isolation and recommended evaluation for testing	69,088
3. Same-day care	28,960
4. Emergency room care	9,042
5. 911	1,769
No COVID-19 Triage Level	20,268



Types of Follow-up Care	Sum of Interviews
Grand Total	163,746

**RQ4.** What was the cost to MassHealth of administering the TNP Program?

**The cost to MassHealth of administering the TNP Program was \$32,760** (see **Table 5**). The cost analysis was conducted on claims dated between March 2020 and Sept. 2020. The TNP vendor Organization 1 reported 300 claims, billing a total of \$15,405(see **Table 5**). The TNP vendor Organization 2 reported 97 claims, billing a total of \$3,185(see **Table 5**). Lastly, the TNP vendor Organization 3 reported 575 total claims billing a total of \$14,170 (see **Table 5**).

In the TNP contract, the rate of the claim is listed as \$65/claim. Based on the table below, the average cost per claim is about \$33.70/claim ( $=\$32,760/972$ ). This number is a weighted average of the number of claims paid at \$65 and the number of claims paid at \$0. The first claims were billed at a rate of \$65, and the second claims were billed at a rate of \$0. There was a total of 504 claims billed at \$65/claim and 468 claims billed at \$0/claim. This explains the difference in billing and payment for the first and second claims.

MassHealth did not incur administrative costs (e.g., personnel to oversee the program, Buoy app costs), as no additional resources were hired, and all the work was performed by existing FTEs.

**Table 5: Total Billed per Vendor**

Vendor	Total Claims	Billed
TNP Organization 1	300	\$ 15,405
TNP Organization 2	97	\$ 3,185
TNP Organization 3	575	\$ 14,170
Total	972	\$ 32,760

**RQ5.** What are the lessons learned about establishing, maintaining, and using TNP?

We conducted seven interviews with participants (23% of our target sample size) (see **Table 6** below for a breakdown of the sample size). We were unable to reach 100% of our target sample size due to non-response or declined participation as the program was over a while back. We interviewed three stakeholders from one TNP organization, as our attempts to establish contact with the other two TNP organizations were unsuccessful (one organization declined participation and the other did not respond to interview requests). We established contact with 26 MassHealth members, 20 of whom declined participation, and three others did not respond to follow-up requests to confirm their interview availability, leaving us with only three members who participated in an interview. We also established contact with one MassHealth TNP Program Manager and one TNP Program Manager, who participated in an interview, respectively.

**Table 6.** Final Sample of Congregate Facility Site Administrators & Program Managers

<b>TNP Organization 1</b>	<b>Target N = 5</b>	<b>Actual N = 3</b>
TNP Providers	4	2
TNP Administrator	1	1
<b>TNP Organization 2</b>	<b>Target N = 5</b>	<b>Actual N = 0</b>
TNP Providers	4	0
TNP Administrator	1	0
<b>TNP Organization 3</b>	<b>Target N = 5</b>	<b>Actual N = 0</b>
TNP Providers	4	0
TNP Administrator	1	0
<b>MassHealth</b>	<b>Target N = 16</b>	<b>Actual N = 4</b>
Members	15	3
TNP Program Manager	1	1
<b>Total</b>	<b>31</b>	<b>7</b>

Below we provide interview summaries and supporting excerpts within the context of each interview question.

**RQ5a.** What were the logistics of implementing the TNP Program?

The purpose of the TNP Program was to ensure that residents of the Commonwealth had access to telehealth services to “assess their COVID-19 symptoms and help to triage COVID-19-related care.” During the beginning of the pandemic, MassHealth did not have a technology platform that could directly connect MassHealth members to telehealth services. To remedy this, MassHealth executed an emergency procurement to contract three TNP organizations to provide “COVID-19 related evaluation services via telehealth,” as noted in the Introduction section. **TNP providers were created as a temporary and new provider type, designed to supplement the care members were receiving through their established primary care provider (PCP) for their routine medical needs.** By limiting the scope of services that could be performed by TNP providers, MassHealth ensured that TNP providers would not function as replacements for the existing network of MassHealth PCPs.

- *So, for the MassHealth population, we currently did not have a technology platform that could directly connect our MassHealth members to telehealth services. [...] So, we did an emergency procurement to identify the three telehealth network providers to bring them on board and contracted with them as a temporary new provider type. [...] We did not want to supplant our existing network, but more so wanted to supplement the providers that were out there, and so wanted to be very clear and*

*distinct in drafting this telehealth network provider type as to what their role was, and kind of what the parameters were, [...] so as to ensure that members were receiving care through their established PCPs, particularly those who have established relationships with their PCPs, and [ensure] that [TNP providers] were only used for COVID-19 triage services, and not other routine medical needs. [...] –MassHealth TNP Program Manager*

Members accessed TNP services through the Buoy Health app that connected them directly to TNP providers. Access to providers at the three TNP organizations was embedded in the Buoy App's triage system. An individual experiencing COVID-19 symptoms would open the Buoy App, answer questions about their symptoms, and then be connected to a provider. Regarding the billing logistics of the TNP Program, TNP providers and administrators noted that they were not involved in the billing process. Instead of direct entry of International Classification of Diseases, Ninth Revision (ICD-9) codes into an MMIS, **TNP providers were paid per member encounter based on records kept in a member encounter log.**

- *"These three telehealth network providers were embedded within our Buoy triage system. So, the way that would work is an individual who is experiencing symptoms would go to the Buoy triage system, go through a user flow to assess their symptoms, and then pick their healthcare coverage. For MassHealth members, they would get directed to one of these three telehealth network providers if they so choose, but prior to us providing an option for the uninsured, the uninsured did not have a direct option to be able to speak to a provider free of cost on their end. So, I think that was a really great win." –MassHealth TNP Program Manager*
- *"I have no role whatsoever with billing. And frankly, I don't even know how they do it. We do a free text note, [...] we don't have an EMR, and as a physician, I don't enter ICD9 codes. I just submit a free text box with a summary of the encounter, and I don't know what happens to it after that." –TNP Provider 1*
- *"[The billing process] was directly through [our organization]. I was just paid per member or patient that I saw." –TNP Provider 2*

**RQ5b.** What were the facilitators and successes of the TNP Program from the TNPs' perspective?

**TNP providers applauded the TNP Program for facilitating telehealth services for such a large member population.** One provider noted that through the TNP Program, members were "pretty guaranteed to get same-day care in a safe way." Another provider commented that the TNP Program was an "outstanding initiative" that helped "hundreds of families" navigate COVID-19 symptoms and keep them out of the emergency room. The Buoy App was described as member-centered, allowing members to "book an appointment within an hour with a provider licensed in their state." The TNP Program Manager described MassHealth's ability to "provide that direct linkage to telehealth services, to our MassHealth members, in a time where folks were very unsure about COVID-19 symptoms as a "big win."

- *"We were able to reach so many members and really offer on-demand care to people who really needed it during such a crazy time. We had really strong supply,*

*meaning hours set by our provider, so people were pretty guaranteed to get same-day care in a safe way.” –TNP Administrator*

- *“I think it was an outstanding initiative; it was very well executed. [...] I do feel as though we helped hundreds of families, particularly with young children, either navigate actual COVID-19 symptoms and keep them out of an emergency room or appropriately refer for a higher level of care when necessary. Or provided counseling and education, surrounding exposures, what to do if you have symptoms, encouraging vaccinations, and providing updated information as we learn more about that over the last few years. So, I think reaching the population was very significant.” –TNP Provider 1*
- *“The goal of [our platform] is when members need to book, they can book an appointment within an hour with a provider licensed in their state, so it was really easy for them to provide guidance. [...] They can message us really anytime, and most of us during working hours respond within one to two hours, so it’s easy for them.” –TNP Provider 2*
- *“The fact that we were able to provide that direct linkage to telehealth services, to our MassHealth members, in a time where folks were very unsure about COVID-19 symptoms, how to respond, when to seek in-person care, was a big win, and being able to reach some of our populations that might not have an established PCP who they would feel comfortable reaching out to via phone, etc., to be able to assess their symptoms, I think that accessibility, and expansion accessibility, was really great.” – MassHealth TNP Program Manager*

TNP providers and administrators described having limited communication with MassHealth directly. They primarily communicated with the MA Board of Registration and Medicine (BORIM) for onboarding and logistical support with processing temporary telehealth licenses. **The TNP administrator described their relationship with MA BORIM as a "strong partnership" and noted that the staff at MA BORIM were "great to work with."** Additionally, one provider shared their experience receiving emails from MassHealth and MA BORIM regarding the status of their license, which they described as "very straightforward."

**Providers were also very pleased with the speed at which their temporary telehealth licenses were granted.** The process was described as being "significantly more streamlined" than other states. Obtaining temporary licensure had a processing time of about two weeks, as providers with licensing in good standing in other states were able to take advantage of an expedited enrollment process. One TNP provider described the licensing process as "seamless" and "much easier than any other state license." This provider also noted that licensing approval had taken between two to nine months in the other states in which they were licensed.

- *“We had email correspondence with BORIM to track licenses. It was a very strong partnership, and that was my main contact, and it was a strong working relationship. I didn’t communicate with MassHealth directly. From my perspective, it was pretty smooth. BORIM was great to work with.” –TNP Administrator*

- *“I did have communications via email from the licensing board as far as the status of my license, and then the expiration date has been extended a couple of times, and I always heard directly from MassHealth with the information on my particular license number and my particular expiration date. But aside from that, I’ve had no need to interact. [It was all] very straightforward. [...] It was significantly more streamlined, (laughs) and I am very appreciative of that fact. I want to say it was like a two-page PDF document, because I did already have two licenses in good standing in other states and an NPI number. [...] It was very straightforward.” –TNP Provider 1*
- *“The [licensing process] was so seamless. [...] It was much easier than any other state license in the pandemic that I was able to get. [...] I think I’m currently licensed in like 15 to 18 states now, and even the telemedicine licenses are challenging at best. Like, the shortest state license, telemedicine still takes like one to two months, and the longest has taken six to nine months. And that’s being fully licensed with no restrictions at all, and I think Massachusetts took like one to two weeks, if I remember correctly, and the paperwork was like one to two pages. [...] But if you don’t have any restrictions on your license, and if you’re licensed in multiple other states, it should be seamless, right? You should just be able to show that you’re licensed in good standing—especially in a health crisis; it should not take that long.” –TNP Provider 2*

**RQ5c.** What were the barriers and challenges of the TNP Program from the TNPs' perspective?

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**Some of the participating TNP organizations expressed their desire for MassHealth to increase the volume of member encounters through promotion and advertising.** This challenge was described as a "tension point," as these TNP platforms were accustomed to seeing higher volumes of encounters from their contracts with other clients. However, MassHealth's position was for TNP providers to be utilized only for COVID-19 screening, which ensured members' continuity of care with their PCP. The messaging communicated to members by MassHealth was to use the TNP platform for COVID-19 screening only if they were not able to contact their PCP or if they did not have a PCP.

- *“We had very intentional messaging that the first course of action was to always contact your PCP, because we wanted to promote and ensure continuity of care. But if you were not able to contact your PCP [then a TNP provider was] available to you; and/or if there were long wait times at your established provider, this was also an option to you as a MassHealth member. I think with the TNPs, they were used to [...] higher volume with some of their other contracts. And so, I think that one of their [points of feedback] was wanting us to kind of promote their platforms more, but [...] we have the goal of ensuring continuity, cognizant of the fact that going to an established provider is better for care quality. And so that was sometimes a tension point in terms of kind of their business model of wanting to promote additional outreach and promotion across the commonwealth of these, while we wanted to be more intentional about how we were utilizing these providers and for a very specific use case.” –MassHealth TNP Program Manager*

**Developing a protocol to reimburse TNP providers outside of MassHealth’s MMIS that providers are accustomed to was also noted as a challenge.** The normal reimbursement process for MassHealth providers is to submit claims through the MMIS. However, TNP providers were not considered MassHealth providers due to their



temporary provider status. Thus, they did not have access to MassHealth's MMIS. To reimburse TNP providers, MassHealth required TNP organizations to track their encounters using an encounter file which they sent to MassHealth for reimbursement.

- *"[The biggest challenge] on our end operationally was figuring out the payment process. We ended up having them record encounters via their own reporting mechanism, and then sending us the file of encounters, and then we would reimburse them based on that, which is different than our normal claims process, where you submit a claim through MMIS, and it is paid through our established system. So given the fact that they were not enrolled in MMIS in that way [...] we had to be innovative in figuring that out. [...] I remember that was a big challenge, trying to figure all of that out."* –MassHealth TNP Program Manager

**RQ5d.** What made MassHealth members choose TNP providers versus their own primary care providers?

**Members described multiple reasons for opting for a telehealth visit with a TNP provider as opposed to an in-person visit with their PCP.** One member commented on how difficult it was to schedule a visit with their PCP "because everyone was so afraid of COVID, or because their PCP was "too busy," while also noting that a visit with a TNP provider "felt easier and didn't subject me to so many germs." Another member shared that their reasoning for seeing a TNP provider was due to transportation barriers or them not having a PCP.

- *"I was Googling [for providers in] the state of Massachusetts, and [the TNP Program] happened to pop up. At that time, it was so hard to get into your regular provider because everyone was so afraid of COVID, or they were too busy from COVID, so you couldn't get in to see them. [...] [Telehealth visits felt] easier and didn't subject me to so many germs because I was obviously afraid of getting COVID-19 even though I didn't have it in a provider's office."* –MassHealth Member 2
- *"I first became aware of [the TNP Program] in March of 2020 when the pandemic was starting to kick in. [...] I started to show symptoms of having COVID-19 [...] and [I was] able to get a telehealth appointment. [...] I didn't currently have a primary at the time, so I had to go through the process, and they had connected me with a doctor in the MassHealth program, and he was only able to do telehealth at that time, and that's how I was able to use [the TNP platform]."* –MassHealth Member 1

**RQ5e.** What were MassHealth members' overall experiences with TNP providers?

**Members' feedback about their TNP provider experience was generally positive.** One member shared that they did not have "any negative issues" with their provider and noted that their provider was attentive and able to properly diagnose their presenting symptoms. Another member shared that their provider was "very good" and a "great provider" and viewed telehealth as "a great way to keep people from cross-contamination in and out of doctor's offices." However, **this member also expressed concerns about the ability of providers to thoroughly diagnose remotely** and expressed how they viewed telehealth as "an easy way out for doctors." Another member expressed similar sentiments, noting how difficult it was for their provider to diagnose their symptoms over the Internet. This member also shared their feelings about the TNP program being a "great idea" but "just not practical."

- *“They were able to answer [my questions] as best as they could at that current time, what they knew about the situation, and how to treat COVID. I mean, [I] didn’t really have any negative issues with it. They seemed to give me the attention that -- and the diagnosis that I would need in that situation, listen to -- they listened to all the symptoms and issues I was currently going through with that, and then they were able to properly diagnose and recommend actions for me to take at the time.” –Member 1*
- *“The provider was very good. [...] At that time, I thought [telehealth visits were] a great way to keep people from cross-contamination, in and out of doctor’s offices. [...] I do agree that that was probably [the best course of action because] nobody knew much about this virus, what it was capable of, how we could spread it. But my thought on this now is you cannot thoroughly assess any patient or their symptoms through a telephone. I think it’s an easy way out for doctors, like that’s their thing right now.” –Member 2*
- *“In theory [telehealth is a] great idea for a lot of things, but for some things, it’s just not practical. I would say that I was like pretty satisfied for the most part. I think it was difficult for [my provider] to diagnose me over the internet, obviously. [My provider] ultimately prescribed me like six different things for different things that she thought it could be. I was just like, “I don’t think it’s all of those.” –Member 3*

However, one member shared the challenges they had during the initial setup of the Buoy app, referring to the process as “a little confusing” initially and taking some time to “learn how to use.” Similarly, one provider described their experience with members having technological difficulties during encounters.

- *“The first time, it was a little confusing, but once we understood it, it was fairly easy to use any sort of telehealth appointment with the various doctors. It was a relatively new experience for me and my wife to learn how to use, basically understanding ‘Okay, we’ve got to do this, we’ve got to do this, we got to click on this link’ type thing, so. But besides that, we didn’t have any difficulties. Besides the initial learning how to do it [...] there weren’t any problems besides that, so.” –Member 1*
- *“But we tend to find that Medicaid and Medicare members sometimes had difficulty, like, with Wi-Fi access, so if a member can’t connect via Wi-Fi for a video appointment, then we just call them on their cellphone.” –TNP Provider 2*

**RQ5f.** What are the lessons learned from the TNP Program that will help inform future policy if a similar emergency condition occurs?

In the event of a future pandemic, based on the success of the TNP program, **facilitating access to on-demand telehealth services for MassHealth members should be maintained. Being “very intentional” about the use of TNP providers while “continuing to encourage in-person care” was noted by MassHealth’s TNP Program Manager as an important strategy for encouraging members to maintain continuity of care with their PCPs.** One member also expressed the importance of future initiatives being equity-centered and staffed with persons who can communicate with limited English proficient individuals.

- *“I think that the biggest takeaway is that telehealth is an incredible platform and mechanism to reach folks broadly across the commonwealth. [...] I’m very pleased with*



*the fact that we were very intentional about the use cases here, and ensuring that this was for symptom checks only, and evaluation, and continuing to encourage in-person care. But I think in future pandemics, ensuring that individuals, particularly the MassHealth population, as well as those who are uninsured, have that access to physicians like, on-demand via telehealth, is really important, and it gives people kind of ease of mind [...] that they know that they have somewhere to go free of charge via telehealth.” –MassHealth TNP Program Manager*

- *“I would just say the biggest thing is you want to make sure you’re getting a provider that is actually going to listen to the patient, not rush them off of the phone, really listen to what they have to say, really listen to their symptoms. That’s really big. And make sure you do have somebody that’s bilingual. [...] imagine being sick and then having somebody kind of look at you funny or treat you different because you can’t speak English.” –Member 2*

Additionally, **one provider expressed how MassHealth's TNP Program was a pioneering example of innovative partnerships between a state health system and a telehealth services company.** The provider further described the program as a "great opportunity to provide care in needed areas for patients that just can get instant access and decrease the burden on ERs and clinics." This provider also noted that, to their knowledge, Massachusetts was the only state that their TNP provider organization partnered with during the pandemic, and that their organization is "still trying to roll out to other states."

- *“I think partnering with state organizations I think is key. This was the first, to my knowledge, state that [my organization] partnered with during the pandemic, and we’re still trying to roll out to other states; and I think that it’s a great opportunity to provide care in needed areas for patients that just can get instant access and decrease the burden on ERs and clinics, and we can prescribe COVID-19 medications and triage them to decrease burden on the ERs and urgent cares. I think more states need to follow suit.” –TNP Provider 2*

## 5.4 Conclusions, Policy Implications, and Limitations

### Conclusions

The TNP program was a new service model rapidly deployed by MassHealth to support their members with COVID-19 symptoms. Stakeholders considered the program to have been implemented smoothly and successfully.

Almost 164,000 MassHealth members inquired through the Buoy app’s triage process, with 28,960 recommended for same-day care and 9,042 for emergency room care. Between March 2020 to Sept. 2020, a total of 972 encounters were reported to MassHealth because of interactions with the Buoy app and subsequent referrals to TNP vendors. The cost to MassHealth of administering the TNP Program was \$32,760, a small cost relative to the number of MassHealth member encounters to get timely access to telehealth for their COVID-19 symptoms or conditions. MassHealth did not report incurring any administrative costs borne by EHS related to this project. All work was performed by existing FTEs and no additional resources were hired.

Based on the qualitative interviews with TNP providers and MassHealth staff, although limited in numbers, TNP providers applauded the TNP program for facilitating telehealth services for such a large member population with same-day care. Providers also noted that this program implemented a safe way of allowing members to inquire with providers while keeping hundreds of individuals out of the emergency room. They also described the strong partnership with the Massachusetts Board of Registration and Medicine (BORIM) and the very straightforward and efficient licensing process from MassHealth and BORIM.

Members' feedback about their TNP provider experience was generally positive. They expressed ease of access to tele-providers while their own PCPs were unavailable (i.e., too busy during the PHE). The TNP program was also noted as beneficial for members who reported having transportation barriers or no PCP at all. Members appear to be pleased with the quality of the TNPs.

Members also noted areas of concern and improvements. Some members questioned the ability of providers to thoroughly diagnose remotely. Others also found it would be beneficial if the providers could have more inclusive language capabilities. Stakeholders expressed the desire for MassHealth to increase the volume of member encounters through promotion and advertising. Lastly, one provider described the challenge in dealing with a new billing process outside of MMIS.

### **Policy Implications**

As an innovative and unique model during the early phase of the pandemic in Massachusetts, the TNP program demonstrated the success of a pioneering partnership between state health systems and telehealth companies. Based on the success of the Massachusetts TNP program, facilitating access to on-demand telehealth services for MassHealth members should be considered for future pandemic or epidemic public health situations. TNPs could also be considered as alternatives to address in-state workforce barriers if designed and implemented internationally to use TNP providers while encouraging in-person care.

### **Limitations**

#### **Quantitative Limitations**

It is important to note that 121,642 individuals used the triage tool without providing any insurance information in their interview, therefore, there may be MassHealth members who used the triage tool whose data were not collected. This limits the ability to ensure accuracy when reporting for RQ1. RQ4 also could not completely be addressed based on the quantitative data we received. The only information received regarding members' encounters with TNP services was the number of claims and the amount that was billed from the three TNP organizations. Buoy Health data were 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. These factors can impact the accuracy of results. Additionally, we are unable to report user demographic data, as demographic

data on MassHealth members using the Buoy App, were not included in the raw data generated from the Buoy App.

### Qualitative Limitations

We received a small sample size of qualitative interviews resulting from no and/or declined responses from prospective provider and member interviewees. For example, some members declined participation due to their inability to recall their encounter with their TNP provider. We also encountered challenges with MassHealth member outreach, including undeliverable mailing addresses and disconnected and/or incorrect telephone numbers. Our outreach to providers and members yielded few interviews due to loss to follow-up.

While our interview findings provide enlightening indicators of program effectiveness, we acknowledge that these findings are not generalizable to the broader target population due to our small sample size of seven interviewees. Given this limited sample size, we did not use the thematic analysis methodology to summarize our interview findings. Qualitative studies using thematic analysis require a minimum sample size of 12 to reach thematic saturation<sup>3</sup>, as thematic saturation is achieved when additional interviews reveal no new themes or insights<sup>4</sup>. Thus, instead of conducting thematic analyses of the TNP interview transcripts to present overarching themes, we conducted descriptive narrative analyses to summarize interview findings without generalizing them as themes.

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<sup>3</sup> Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage

<sup>4</sup> Green J, Thorogood N. Analyzing qualitative data. In: D Silverman (ed.). *Qualitative Methods for Health Research* (1st edn). London: Sage Publications, 2004; 173– 200.

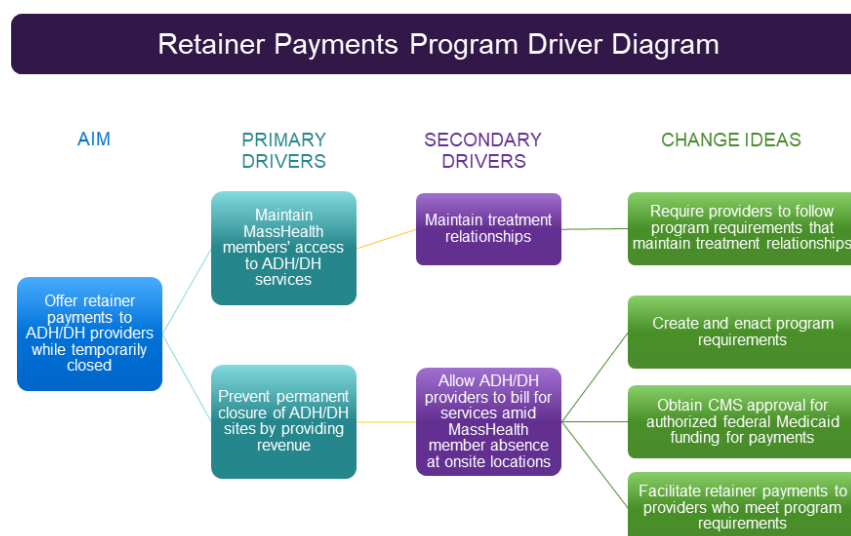
## 6. Retainer Payments for Adult Day Health and Day Habilitation Providers

### 6.1 Introduction, Policy Goal, and Objectives

MassHealth implemented the Retainer Payment Program 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. To help prevent the permanent closure of ADH and DH sites and maintain MassHealth members' access to these services after sites could reopen, MassHealth made retainer payments to ADH and DH providers from April through July 2020. The retainer payments could only be paid to providers with treatment relationships to members that existed at the time the PHE was declared. To receive retainer payments, providers were required to develop or amend individual care plans to meet the members' needs while they remained at home through remote or residential care plans.

### 6.2 Evaluation Questions, Data Sources, and Methods

To evaluate the implementation and outcomes of the Retainer Payment Program, evaluators at ForHealth Consulting of UMass Chan conducted a mixed methods evaluation. We constructed the driver diagram on the following page to understand the program and guide development of the evaluation questions and methods. The primary drivers of the program were to maintain members' service access and to avoid permanent closure of facilities. Thus, providers needed to maintain treatment relationships with members while they were at home and allow providers to bill for services while members were not receiving services onsite. The evaluation focused on the change ideas regarding program implementation.



**Research Questions (RQs).** The evaluation research questions include the following:

RQ1. Did caseloads and expenditures during and after the retainer payment period remain consistent with prior caseload trends?

RQ1a. What were the monthly caseloads of ADH and DH providers before COVID-19, during the CARES Act-funded<sup>5</sup> retainer payment period, during the Emergency Waiver Demonstration authorization payment period, and after?

RQ1b. 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?

RQ2. How did the retainer payments enable ADH and DH providers' ability to maintain needed ongoing telehealth services for Medicaid members to ensure health and safety?

RQ2a. Did ADH and DH providers develop or amend individual care plans for MassHealth members as required? If so, how?

RQ2b. 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?

<sup>5</sup> See <https://www.congress.gov/bill/116th-congress/senate-bill/3548/text> for more information about this funding

RQ3. What were the lessons learned from administering the retainer payment Demonstration? The detailed interview questions include the following:

RQa. What were the successes and facilitators of the Retainer Payment Program?

RQ3b. What were the barriers and challenges of the Retainer Payment Program?

RQ3c. What are the lessons learned that will help inform future policy related to sustaining ADH and DH providers with retainer payments if a similar emergency condition occurs?

## Data Sources

**Data:** The data used include quantitative and qualitative data sources listed below:

1. **Medicaid Emergency Waiver Demonstration program administrative data:** This data includes the counts of ADH and DH providers before, during, and after the retainer payment period. This data is used to track provider status change and determine the administrative costs/outlays to providers through the retainer payment period.

Caseload and expenditure data was also used, including prior to, during, and after the onset of the COVID-19 pandemic. The expenditure data and caseload data had drastic differences in the amount they dropped, which could be due to the expenditure data possibly demonstrating a processing lag compared to caseload data.

2. **Qualitative interview data:** Qualitative data collected from interviews with ADH and DH Providers and MassHealth Retainer Payment Program Managers.

## Methods

### Quantitative Methods

The evaluation of the Emergency Waiver Demonstration Retainer Payment Program aims to describe the implementation of the initiative by using descriptive analyses. MassHealth made retainer payments to ADH and DH providers from April through July 2020, although the data collected from the Retainer Payment Program was from July 2018 to January 2022. The measures used in the analysis include both healthcare expenditures and caseloads of MassHealth members, presented by time periods. Site administrators at ADH and DH sites received referrals directly from MassHealth.

### Qualitative Methods

We received a list of contact information from MassHealth for site administrators at ADH and DH provider sites and Retainer Payment Program Managers to interview for this evaluation. These interviews allowed us to better understand the impacts of the retainer payment policy on ADH and DH providers' ability to maintain MassHealth members' access to ADH and DH services. Referrals to ADH and DH providers were based on the

selected list of ADH and DH provider sites that we generated using the inclusion criteria below.

### Inclusion Criteria

We received a MassHealth database of 365 MassHealth-enrolled ADH and DH providers sites from which to select an interview sample. MassHealth assigned each provider site to one of the following categories based on their operating status: Open/Enrolled, Temporarily Closed, Temporarily Closed but Reopened, or Permanently Closed. The Open/Enrolled lists of ADH and DH provider sites had 143 and 162 locations, respectively.

Open/Enrolled ADH provider sites had representation in nine counties across the state. Open/Enrolled DH provider sites had representation in 12 counties across the state. The three remaining categories of ADH and DH providers sites had five and 32 locations, respectively. These categories did not have the geographic representation of counties as the Open/Enrolled category due to having fewer locations.

### Sample Size

A sample of 33 ADH and DH provider sites was selected using the inclusion criteria above. To create the target sample of prospective interviewees, we selected one provider site for each county represented on the list of Open/Enrolled ADH and DH provider sites. For the remaining categories (Temporarily Closed, Temporarily Closed but Reopened, and Permanently Closed), a random sample of two ADH provider sites and two DH provider sites per category was selected.

### Recruitment

Site administrators from each provider site were invited to be interviewed (N=33). A Retainer Payment Program Manager from MassHealth was also invited to be interviewed (N=1). We initiated contact with prospective interviewees up to five times (three attempts by email and two attempts by phone). If contact was not successfully established by the fifth attempt, the prospective interviewee was removed from the contact list. The removed contact was only replaced with a new contact if there was an eligible candidate in the database with matching inclusion criteria (i.e., same provider type, and county if possible).

### Data Collection

We conducted web-based interviews with ADH and DH provider site administrators and Retainer Payment MassHealth Program Managers. Researchers developed semi-structured facilitator guides tailored for interviews with each audience. Each guide (see **Appendices 8.2.8 – 8.2.9**) included questions designed to elicit detailed feedback about the experiences of administering or implementing the Retainer Payment Program, according to the interview questions, per the evaluation design.

### Thematic Analysis

Audio-recordings were professionally transcribed prior to analysis. To organize the information received during the interviews, coders conducted qualitative analyses of the interview transcripts in an electronic qualitative data management software using a coding manual. Coders used thematic analysis to identify key findings present in the



transcripts, which were defined in a coding manual. Coders met to compare excerpts and themes present in the data for trustworthiness and concordance among the team. Coding discrepancies were resolved using consensus and by an iterative process of refining and merging codes. To demonstrate the data-driven nature of the qualitative findings, excerpts/quotes supporting each theme were extracted from the transcripts and are presented in the Results section.

## 6.3 Evaluation Findings

Below we describe and provide supporting figures for all findings within the context of each evaluation question.

**RQ1a.** Did caseloads and expenditures during and after the retainer payment period remain consistent with prior caseload trends? What were the monthly caseloads of ADH and DH providers before COVID-19, during the CARES Act-funded retainer payment period, during the Emergency Waiver Demonstration authorization payment period, and after?

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**The caseloads and expenditures for both ADH and DH providers during and after the retainer payment period did not remain consistent compared to pre-COVID-19 caseload and expenditure trends.**

The average number of monthly caseloads for ADH providers prior to the COVID-19 pandemic was about 6,000 cases. Amid the onset of the COVID-19 pandemic (March 2020 – April 2020), ADH caseloads dropped from about 6,000 cases to about 4,900 cases (about an 18% drop) (see **Figure 8**). The ADH and DH sites were required to close during the onset of the COVID-19 pandemic, impacting caseload data. The average number of monthly expenditures for ADH providers prior to the COVID-19 pandemic (from July 2018 – February 2020) was about \$8.6 million per month. Amid the onset of the COVID-19 pandemic (February to March 2020), ADH average expenditures dropped from about \$8 million to \$4.5 million (a 43.2% drop), then, in April 2020, rose from 4.5 million to 6.5 million (see **Figure 9**). Although there remains uncertainty about why the expenditure data and caseload data had drastic differences in the percentage they dropped, one explanation could be that the expenditure data possibly demonstrates a processing lag compared to caseload data. This can also explain the inconsistent periods of available caseload data (i.e., March to April 2020) and expenditure data (i.e., February to March 2020).

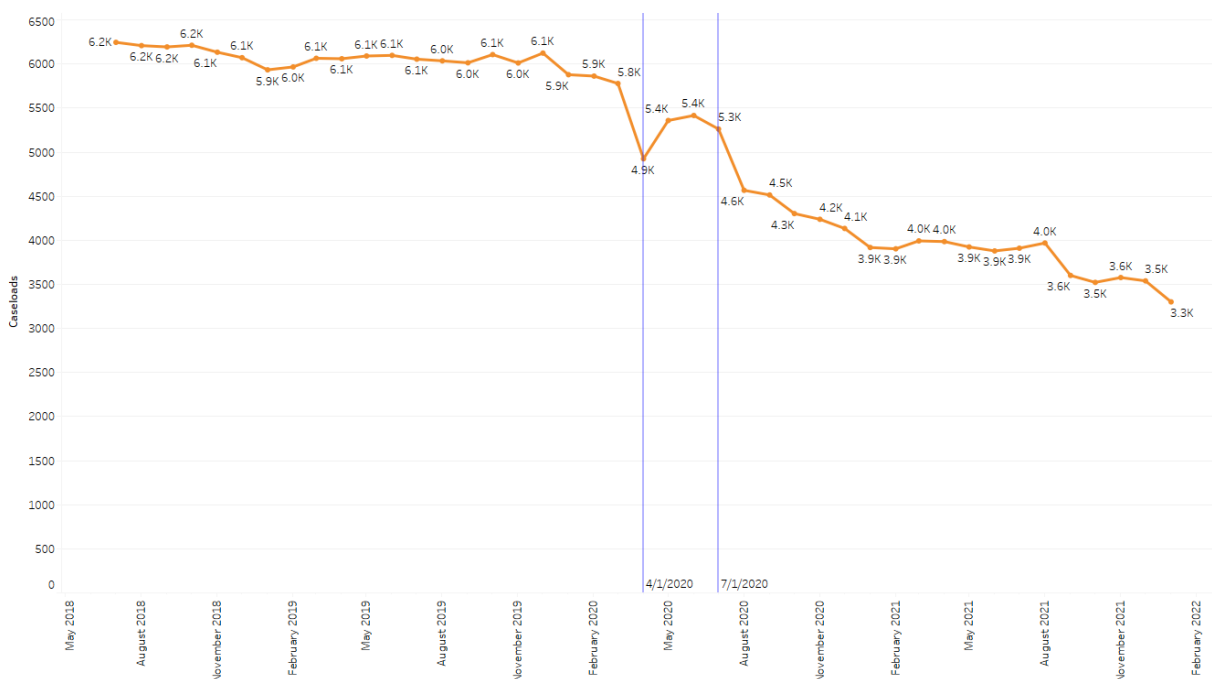
DHs reported a percentage drop similar to ADHs (i.e., 18% vs 21% in caseloads, and 43.2% vs 44% in expenditures). The average number of monthly caseloads for DH providers prior to the COVID-19 pandemic was about 9,600 cases. Amid the onset of the COVID-19 pandemic (March 2020), DH caseloads dropped from about 9,600 cases to about 7,600 cases (about a 21% drop) (see **Figure 10**). The average number of monthly expenditures for DH providers prior to the COVID-19 pandemic (July 2018 - Feb. 2020) was about \$14.5 million per month. Between the months of February to March 2020, DH expenditures dropped from about \$13.2 million to \$7.4 million (a 44% drop), then rose to \$13.6 million in April 2020 (see **Figure 11**).

During the retainer payment period, the monthly average number of caseloads for both ADH and DH providers both slightly decreased. ADH providers had an average monthly

case load of about 5,300 cases by the end of the Retainer Payment Program in July 2020 (see **Figure 8**). DH providers had an average monthly case load of about 8,900 cases by the end of the Retainer Payment Program in July 2020 (see **Figure 10**). After the retainer payment ended, the average monthly caseloads for both ADH and DH providers continued to decrease.

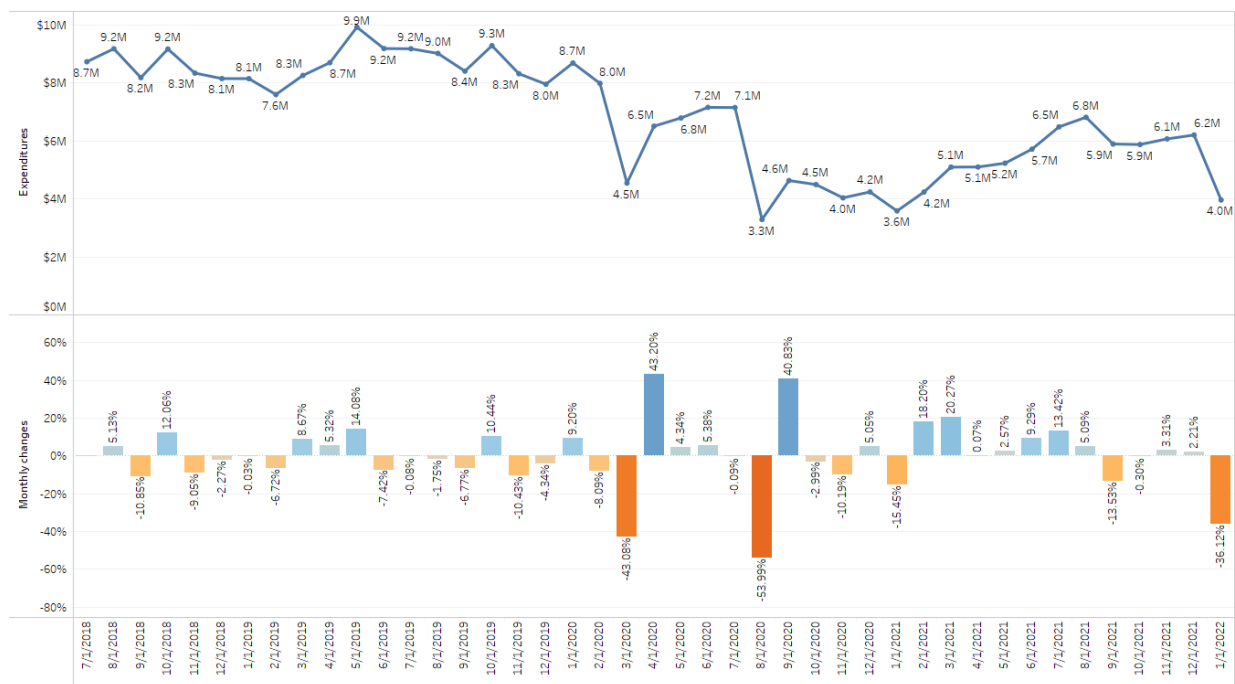
During the retainer payment period, the average expenditure from ADH providers was about \$6.9 million per month (see **Figure 9**), and the average expenditure from DH providers was about \$15.5 million per month (see **Figure 11**). Although the monthly caseloads for both ADH and DH continued to decline, the expenditures fluctuated during the retainer payment period and after the retainer payment ended (see **Figures 9 & 11**).

**Figure 8: ADH Caseloads**



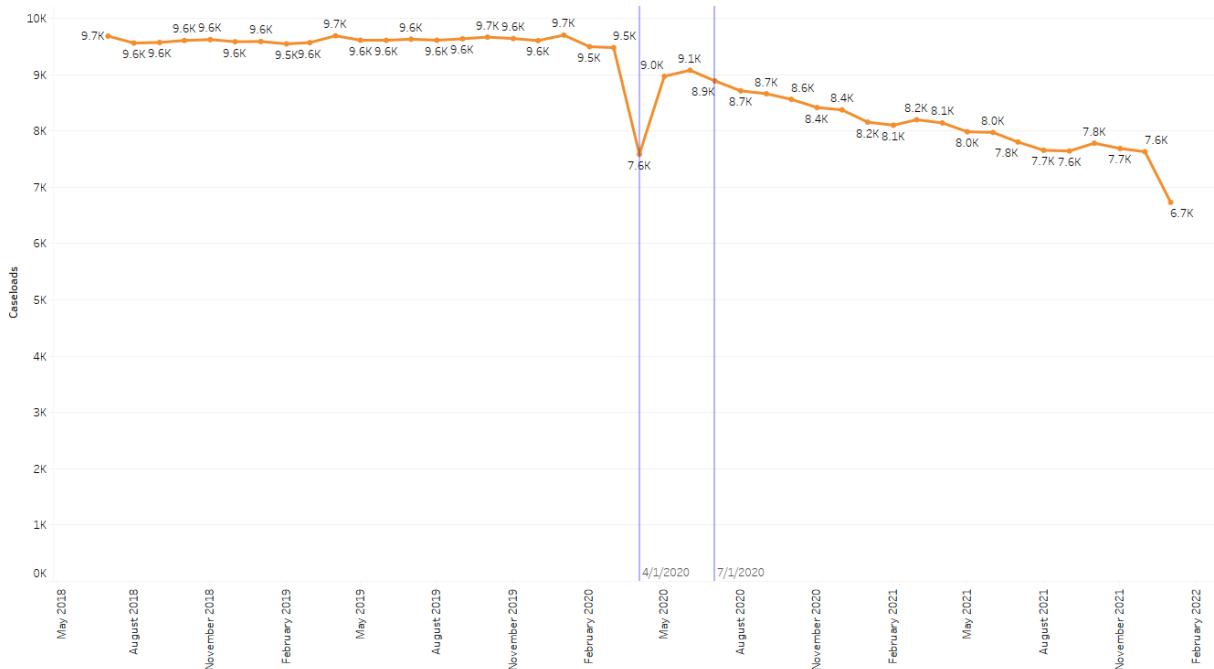
*\*Note: The Blue Lines on the Figure Above Indicate Retainer Payment Period (4/1/2020 – 7/1/2020)*

Figure 9: ADH Expenditures and Change in Expenditures

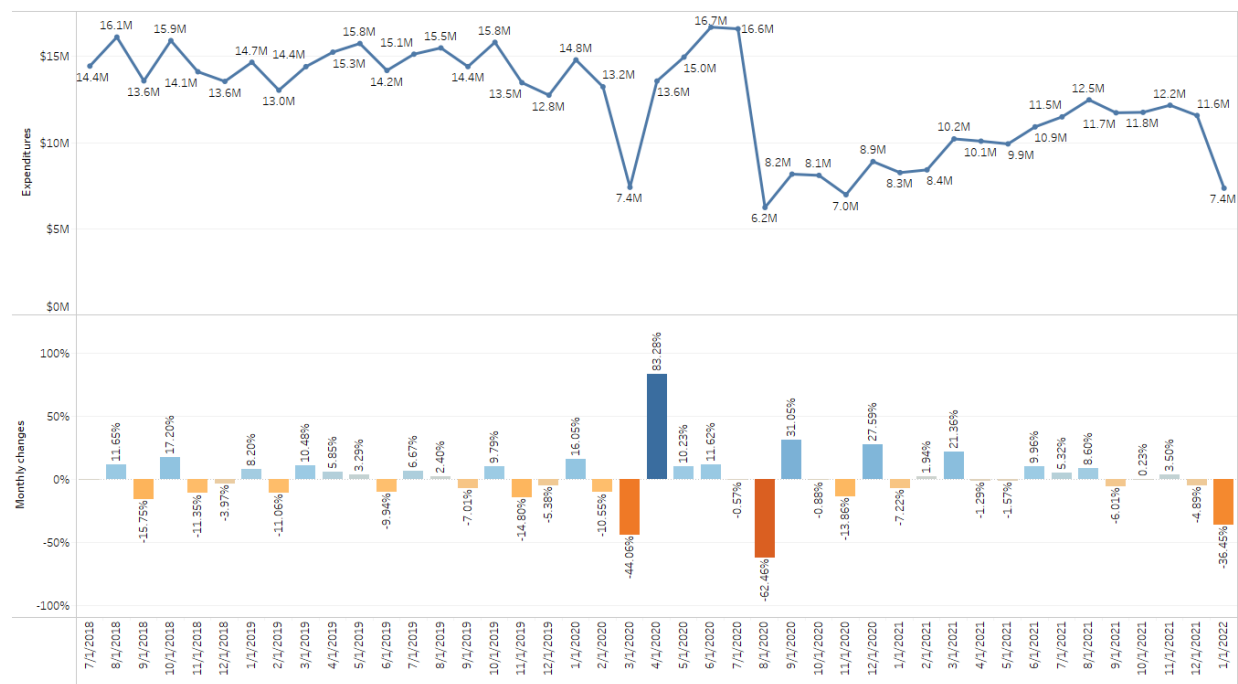


\*Note: The Blue Lines on the Figure Above Indicate Retainer Payment Period (4/1/2020 – 7/1/2020)

Figure 10: DH Caseloads



\*Note: The Blue Lines on the Figure Above Indicate Retainer Payment Period (4/1/2020 – 7/1/2020)

**Figure 11: DH Expenditures and Change in Expenditures**

\*Note: The Blue Lines on the Figure Above Indicate Retainer Payment Period (4/1/2020 – 7/1/2020)

**The monthly caseloads in ADH and DH providers declined throughout the COVID-19 pandemic amid the Retainer Payment Program.** The monthly caseloads in ADH providers before the COVID-19 pandemic averaged to be about 6,000 cases (see **Figure 8**). During the retainer payment period, ADH caseloads declined from about 6,000 cases to about 4,000 cases (see **Figure 8**). The 6-month period after the Retainer Payment Program averaged a monthly case load of about 3,900 cases per month (see **Figure 8**).

The monthly caseloads for DH providers prior to the COVID-19 pandemic were about 9,600 cases (see **Figure 10**). During the Retainer Payment Program period, DH provider caseloads declined from about 9,600 cases to about 7,800 cases (see **Figure 10**). The 6-month period after the Retainer Payment Program averaged a monthly case load of about 7,520 cases per month (see **Figure 10**).

**RQ1b.** 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?

**The business status (i.e., open/closed) of the sites who participated in the Retainer Payment Program varied.** Out of the 145 ADH programs that were enrolled in the Retainer Payment Program, 11 sites temporarily closed amid the COVID-19 pandemic, and 32 sites permanently closed (see **Table 7**). Therefore, about 22% of the participating ADH programs reported permanent closures. Out of the 162 DH programs that were enrolled in the Retainer Payment Program, five sites temporarily closed amid

the COVID-19 pandemic, and 14 sites permanently closed (see **Table 7**). Therefore, about 8.6% of the participating DH programs reported permanent closures.

**Table 7.** Business Statuses of Providers Who Received Retainer Payments

Enrolled ADH Programs	145
ADH Temporary Closures	11
ADH Permanent Closures	32
Enrolled DH Programs	162
DH Temporary Closures	5
DH Permanent Closures	14

### Qualitative Findings

All interviewees (excluding the MassHealth Program Managers) were with administrative staff at ADH and DH facilities that received retainer payments from MassHealth. These facilities provide ADH and DH services to seniors with intellectual and physical disabilities such as dementia, developmental delays, memory loss due to Parkinson's or a stroke, or behavior health disorders. Researchers conducted interviews with 17 participants (50% of the initial recruitment goal) (see **Table 8** below). Researchers were unable to reach 100% of the recruitment goal due to non-response or declined participation among the sample of prospective participants. See Appendix 8.4 for the de-identified list of provider sites interviewed for this evaluation.

**Table 8.** Sample of ADH and DH Providers & Program Managers

ADH Provider Types		Target N = 15	Actual N = 6
	Open/Enrolled	9	5
	Temporarily Closed	2	0
	Temporarily Closed but Reopened	2	0
	Permanently Closed	2	1
DH Provider Types		Target N = 18	Actual N = 10
	Open/Enrolled	12	6
	Temporarily Closed	2	2
	Temporarily Closed but Reopened	2	2
	Permanently Closed	2	0
MassHealth		Target N = 1	Actual N = 1
	MassHealth Retainer Payment Program Manager	1	1
Total		34	17

We analyzed individual transcripts from interviews with site administrators and Program Managers. Thematic analyses of interview data generated the following eight themes.

1. MassHealth's Retainer Payment Program was implemented to help providers sustain operations while keeping members safe at home during the mandated closures of ADH and DH facilities.
2. Providers adapted to virtual care plans for members but faced challenges with uptake among members with limited digital literacy or behavioral health conditions.
3. Retainer payments helped provider organizations maintain operations in the early days of the PHE.
4. Providers applauded the smooth implementation of the Retainer Payment Program and the availability of MassHealth staff to respond to their questions and concerns.
5. Official communications with MassHealth via bulletins and meetings were valued information sources for providers to receive important news and updates.
6. Some providers struggled with implementing the administrative protocols and procedures required by MassHealth.
7. Providers face financial constraints and challenges with member attrition and employee retention, which limits their ability to provide care at pre-pandemic levels.
8. Providers noted that faster turnaround times in official communication and investments made to improve reimbursement rates and hourly wages would improve future programming in a similar emergency condition.

Below we describe and provide supporting excerpts for each theme within the context of each interview question.

**RQ2a.** Did ADH and DH providers develop or amend individual care plans for MassHealth members as required? If so, how?

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**Providers adapted to virtual care plans for members but faced challenges with uptake among members with limited digital literacy or behavioral health conditions.** During the mandated closures of ADH and DH facilities, providers spoke positively about their experiences communicating tailored programming and curricula to members via Zoom, WhatsApp, and Facebook Messenger. One provider site described using Google Classroom to post assignments and worksheets to keep their members intellectually stimulated and engaged. The adaptation of virtual platforms was not without challenges. Providers shared their experiences of having to make significant financial investments in purchasing tablets and Chromebooks for members who did not have access to computers. Some providers also experienced challenges with members not being able to adapt to virtual care plans due to digital literacy limitations or behavioral health conditions which prevented their remote interactions. Once ADH and DH facilities began their phased reopening at limited capacity, providers offered hybrid in-person and virtual services for the members who remained at home.



- *“We were lucky, because we were working before the pandemic came to educate seniors in technology, smartphones, and the tablets. So, the seniors really were connected to WhatsApp. Because for our community, where we are, the majority of the seniors, they have 90 percent of their family outside the country, [and they use WhatsApp to communicate with their family.] [...] We used every channel possible, from WhatsApp, Facebook, conference calls, Zoom, and also regular calls.”*—ADH Provider Site Administrator 6 (Open/Enrolled)
- *“We were able to do some in-home services, which we didn’t do a lot of, but we did a lot of virtual services. We all learned to use Zoom really well. But what was difficult was creating whole infrastructure around remote services, which we had never done before. [...] A lot of people that had no access to computers. [It made] sense to send out a bunch of Chromebooks, and we did that. [...] And we started getting great participation, I mean there are times where we’re getting 25 people onto Zoom, which was great.”*—DH Provider Site Administrator 1 (Open/Enrolled)
- *“[...] It was an opportunity for us to kind of think outside the box and come up with alternative ways of providing services. [...] Zoom was really good for a few things, but Google Classroom afforded us the opportunity to be able to post documents, to be able to do videos more easily, and have breakout groups. And if an individual was high functioning enough, and they wanted to access something in off hours that would be comforting for them to do, like maybe a worksheet or something they needed to keep themselves busy. There were [members] we brought back, and at the same time we ran virtual programming as well because we couldn’t bring everybody back due to the limitations of whatever that square footage was. [...] We had to do kind of a hybrid.”*—DH Provider Site Administrator 2 (Temporarily Closed but Reopened)
- *“I think the challenge was some older parents who aren’t so experienced with computer technologies, is really for us, talking them through how to log on, and what to click on, and we would do that via phone while they were on their computers, so I mean, there were some problems there.”*—DH Provider Site Administrator 6 (Temporarily Closed)
- *“We tried to advocate for people to get more technology so that they could participate more. But there was also the challenge of the willingness of staff or family members to assist the [member] in participating. [Some of our members] just a small handful, just didn’t want to participate, or because of their disabilities, couldn’t interact over like a Zoom or a telephone.”*—DH Provider Site Administrator 7 (Open/Enrolled)

**RQ2b.** 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?

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**MassHealth's Retainer Payment Program helped sites sustain operations while keeping members safe at home during the mandated closures of ADH and DH facilities.** Providers worked diligently to help members maintain access to their ADH

and DH services through coordinated remote and residential support services, including phone visits, virtual visits, in-home visits, and doorstep visits. Providers spoke of contacting members sometimes multiple times daily to monitor COVID-19 symptoms, ensure medication adherence, provide nutritional services, and assist with other activities of daily living as needed. Providers stressed the importance of ensuring that members were still able to receive their ADH/DH services as they would under normal conditions. The model of the Retainer Payment Program was described by MassHealth as being adapted from what had been done previously in nursing facilities, where payments had been disbursed based on member attendance to "hold spots" during a closure period.

- *"[The Retainer Payment Program] allowed and afforded us to be able to meet the people in the community. We were serving over 3,000 seniors in Massachusetts, and none of them would have any services at all. [...] So, it was very important for us to have those retainer payments to be able to continue to see people in their homes. We sent nurses to homes. We did meal delivery. We did telephonic and virtual health connections, doorstep visits, all kinds of things, just to make sure the people that generally got our services in-house as they would in their Adult Day Health program, [...] and make sure the health needs were met [and checking for COVID-19 symptoms to] see how they are doing."*—ADH Provider Site Administrator 4 (Open/Enrolled)
- *"So, if they had COVID, we put in place like a few -- and instead of three visits, it was five visits during that week. So, we can monitor the symptoms. [...] If the patient developed new symptoms, we had to send a nurse twice, one early in the morning, and then by the end of the day. Three o'clock is the latest that we close the program, but we were working until like five, because some of them had medications that they need to take at night."*—ADH Provider Site Administrator 5 (Open/Enrolled)
- *"Our remote services involved a large number of phone calls. And then also we were dropping off supplies and activities based on the DH support plan's requirements to the residential programs. And sometimes to families. And then making that contact. And then ensuring that we contacted people about the activity."*—DH Provider Site Administrator 3 (Temporarily Closed)
- *"We knew that we needed to be able to ensure that our members were safe while being at home. [...] We had discussions about how the providers would need to outreach to the members to ensure that they were safe at home and did not have symptoms of COVID. [...] We needed a way to help providers to be sustainable while the DPH had ordered the closure of the programs. [...] We ended up looking at retainer payments which is what was done usually in nursing facilities [...] it's like holding a spot. [...] The retainer payments [were issued] to hold spots in the program through that closure period."*—MassHealth Retainer Payment Program Manager

### **RQ3a. What were the facilitators and successes of the Retainer Payment Program?**

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**Retainer payments helped provider organizations maintain operations in the early days of the PHE.** Providers repeatedly expressed their gratitude for the Retainer Payment Program in helping their organizations stay open to continue to serve their

members. Retainer payments were delivered to providers through an enhanced reimbursement rate that was 25% higher than the pre-pandemic MassHealth standard reimbursement rate. Providers described retainer payments as economic relief they “would not have been able to survive” without. Many providers also noted how important retainer payments were in helping temporarily closed sites reopen and preventing permanent closures. Some providers spoke of receiving economic relief from several sources in addition to retainer payments, including direct loans from the Small Business Administration, Paycheck Protection Program loans, and other payments through the CARES Act. ADH provider sites were noted as having other business ventures (e.g., residential programs) that helped to sustain their financial operations, whereas most DH provider sites did not and relied more heavily on support from the Retainer Payment Program.

- *“And so I wanted to be one of the first and biggest mouths to thank the state and MassHealth for creating a program that actually allowed us to survive, to continue services to people who were depending on us, and to do it in a way that was doable, that it didn’t have endless hoops to jump through when we were scrambling in every other direction, so I can’t imagine it being done in an easier way.”* –DH Provider Site Administrator 10 (Open/Enrolled)
- *“I mean, we simply wouldn’t have survived, simply, as simple as that, without the retainer payments, there’s no way we would have made it. Our attendance, not only retainer payments, retainer procedures along this remote and stuff like that. But the retainer payments at 125% of the normal rates were really the minimum we needed to stay open.”* –DH Provider Site Administrator 1 (Open/Enrolled)
- *“Without the retainer payments we most likely would have remained closed longer or potentially completely shuttered at least one of our sites.”* –DH Provider Site Administrator 4 (Open/Enrolled)
- *“We needed that funding; if we didn’t get the retainer payments [...] we would have went out of business. So, if it wasn’t for like the direct SBA, PBP, federal funding programs, the CARES Act relief program funding that we got, as well as these enhanced rates with our state funding agencies, we just would not have been able to survive, we would have completely went out of business.”* –DH Provider Site Administrator 5 (Open/Enrolled)
- *“I don’t know how many sites we would have had at this point if the retainer payments didn’t happen. So, I think it saved a lot of them. Especially ADHs. Day Habs tend to have more, like, other business ventures, like residential programs that they run, but ADH doesn’t really have that same kind of branching. I think it really did save many, many providers from closing.”* –MassHealth Retainer Payment Program Manager

**Providers applauded the smooth implementation of the Retainer Payment Program and the availability of MassHealth staff to respond to their questions and concerns.** Providers spoke positively of how MassHealth implemented the Retainer Payment Program quickly and as “easy as possible” for participating providers. Other providers commented that the program was “amazing,” “wasn’t hard at all to get into,” and that there was nothing bad they could say about how MassHealth managed the

program. One provider also noted how thankful they were to their MassHealth Program Managers for being very communicative and responsive to any questions they had.

- *“When [MassHealth] came up with this program, we were like, ‘Oh we’re safe,’ because by that time, every door was closed, and that was the only hope there for us to continue operating. [...] The participation was pretty smooth and getting into it, MassHealth made it quickly and easy as possible. [...] It’s nothing bad we can say about how they managed the pandemic.”* –ADH Provider Site Administrator 5 (Open/Enrolled)
- *“I think the process overall was pretty smooth. We appreciate MassHealth actually understanding that we needed to be able to provide services and get reimbursed for them, so that was pretty good. MassHealth was thankfully very communicative during the process, if we had questions, [they] were great at getting back to me or our billing specialist if needed.”* –DH Provider Site Administrator 4 (Open/Enrolled)
- *“MassHealth presented the program pretty smoothly. Applying was based on capacity, and it was based on having the license operation update. [...] I think the idea of having it open for everyone that [had] the license working by that time was amazing, so. It wasn’t hard at all to get into the program.”* –ADH Provider Site Administrator 5 (Temporarily Closed but Reopened)

**Official communications with MassHealth via bulletins and meetings were valued information sources for providers to receive important news and updates.**

MassHealth communicated updates to administrative and billing protocols through monthly meetings and weekly bulletins. One provider spoke of the constant influx of new bulletins being issued during the early days of the PHE and remarked that the bulletins were “very clear” and “helpful.” Providers relied on these bulletins to receive notices about changes to reimbursement rates, reporting and vaccine requirements, and other administrative modifications. Another provider expressed their gratitude for the monthly meetings and noted how important it was to have “that connection immediately and quickly, but also regularly.”

- *“I feel like MassHealth did a really nice job trying to keep us updated on a weekly basis. They had weekly calls. I think they did the best they could trying to keep integrity in the industry, given the immaturity of the industry.”* –ADH Provider Site Administrator 4 (Open/Enrolled)
- *“The bulletins were very clear. Every bulletin was reviewed weekly so as a new bulletin came out [our MassHealth Program Managers] overviewed each one in detail. If there were any questions that any of us, I had it was just an e-mail to clarify any of those issues. But I think there were 25 bulletins issued over that period of time. Typically, we might see one in a year.”* –DH Provider Site Administrator 3 (Temporarily Closed)
- *“At that point, we were having almost weekly meetings [...] And they were great, I mean, they did a great job. [The staff at MassHealth] just worked so hard to try to come up with different ways to keep us alive.”* –DH Provider Site Administrator 1 (Open/Enrolled)

- *“MassHealth gave us all the updates, and gave us all the guidance, gave us all the bulletins to read, and gave us enhanced rates. MassHealth was very generous if you ask me.”* –DH Provider Site Administrator 5 (Open/Enrolled)
- *“I believe that by having very frequent meetings with MassHealth, even though, they’re the middlemen, so to speak. They’re the messengers, right? But having that connection immediately and quickly, but also regularly, that was huge. [...] It has made for such a better connection with the providers and the state.”* –DH Provider Site Administrator 8 (Open/Enrolled)

### **RQ3b. What were the barriers and challenges of the Retainer Payment Program?**

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**Some providers experienced challenges with implementing the administrative protocols and procedures required by MassHealth.** Providers were required to adapt to new billing and administrative guidelines to receive reimbursement at the enhanced retainer payment rate. Some sites noted that the procedures required to submit claims and receive reimbursements were challenging for some sites due to the frequent changes in rate enhancement percentages and related procedures. Some providers also described feeling overwhelmed by the new COVID-19 safety protocols for in-person care, such as pre-check-ins, testing, and temperature checks. Providers also noted the strict and “prescriptive guidance” regarding MassHealth’s billing requirements for remote care, which they described as difficult and time-consuming. For example, care plans were required to be updated every time there was a change in members’ COVID-19 status. This was especially challenging for organizations that lacked the staff needed to handle the additional administrative load. One provider noted how executive team members pitched in to help their administrative staff complete paperwork due to being short-staffed.

- *“All of the pre-check-ins, doing all the tests, the temperature checking, making sure we were dealing with all the COVID-19 protocols, or verifying daily screening tools, then pivoting each day as someone got, tested positive, the notifications, the reporting, all of that, this was just yet another administrative burden. [...] To do a remote telehealth visit, you [needed] to document the date, you need to document these particular questions relative to health concerns. [...] There was very prescriptive guidance as to how they would accept the billing for those services.”* – DH Provider Site Administrator 9 (Temporarily Closed by Reopened)
- *“I think maybe the Zoom meetings were really difficult and the requirements around them. When we first started, I needed to do a spreadsheet for every Zoom meeting and kind of click every box where we were meeting a member’s goal, so that was really difficult and very time-consuming. It seemed like one summer I was a data entry clerk.”* –DH Provider Site Administrator 6 (Temporarily Closed)
- *“Paperwork was definitely a challenge because we did lose a lot of staff in this process. So, there were a lot fewer hands to handle the various paperwork updates that had to occur. A lot of that fell on our program directors who did yeoman’s work throughout this process.”* –DH Provider Site Administrator 10 (Open/Enrolled)



- “[...] If someone would [test positive for COVID] you have to re-do that care plan immediately to put in place the new operation [...] and then after COVID-19 you will have to redo that plan again and put in place another step. [...] During that period, I reviewed hundreds and hundreds of care plans. [...] It was so many, it was crazy. But the only way of [MassHealth] knowing what you’re doing [for your members] was based on the care plan. Like how many calls a patient is getting a week.” –ADH Provider Site Administrator 5 (Open/Enrolled)

**Providers face financial constraints and challenges with member attrition and employee retention, which limits their ability to provide care at pre-pandemic levels.**

Attendance-based retainer payments made it difficult for provider sites to meet fixed costs (e.g., vehicle costs, insurance, vendor costs) because, despite census loss, sites still depended on MassHealth reimbursement to cover their fixed expenses. Providers spoke of steady declines in member attendance due to concerns of COVID-19 exposure, which sequentially impacted their reimbursement levels and ability to sustain operations. One provider expressed the desire for MassHealth to have provided blanket funding, as opposed to attendance-based payments, which would have accounted for fixed expenses that are irrespective of attendance. Providers also noted having difficulty recruiting and retaining staff due to staffing shortages and competition for staff with industries paying higher hourly wages. Without adequate staffing levels, providers expressed their struggle to provide care to the same number of members as they did pre-pandemic.

- “...the 20% increase we saw this year is awesome, but it still doesn’t really cover the expenses associated with the program. We’ve seen increased demand in nurse [salaries] and general pay across the board. So that really hurts our ability to obtain new employees, and retain new employees.” –DH Provider Site Administrator 4 (Open/Enrolled)
- “The retainer payments at 125% of the normal rates were really the minimum we needed to stay open. [...] Everything they have is attendance-based, if someone comes, we can bill; if they don’t, we can’t. Or if we had interaction remotely, we can bill. But so, if those types of things didn’t occur, we weren’t able to bill.” –DH Provider Site Administrator 1 (Open/Enrolled)
- “Really, the best approach would have been to just maintain blanket funding. Give us the full funding towards maintaining operations and let us pivot in ways that we could. Staffing was certainly one of our biggest costs, but there were a variety of other fixed costs. [...] We also had to provide incentives for staff to come to work. Because people didn’t want to work.” –DH Provider Site Administrator 9 (Temporarily Closed by Reopened)
- “We haven’t had a challenge with keeping the program open, per se; we’ve had challenges with trying to bring people back. [...] We have a ton of referrals that we have not been able to even look at [because] we’re trying to bring our own people back first [...] but we have to have the staff to do it, then we can bring everybody back and start the referral process.” –DH Provider Site Administrator 2 (Temporarily Closed by Reopened)



- *“There is a staffing shortage crisis across the nation, and employers are competing for talents to recruit. [...] I had to take a deep cut for my own income so that I can retain some of my staff”*—ADH Provider Site Administrator 1 (Open/Enrolled)

**RQ3c.** What are the lessons learned that will help inform future policy related to sustaining ADH and DH providers with retainer payments if a similar emergency condition occurs?

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**Providers noted that faster turnaround times in official communication and investments made to improve reimbursement rates and hourly wages would improve future programming in a similar emergency condition.** Despite their gratitude for the weekly MassHealth bulletins, some providers expressed frustration at times with the slow turnaround times of bulletin updates. For example, one provider mentioned receiving administrative updates verbally during meetings but having to wait for weeks to receive the official guidance and update in writing via bulletins, which caused confusion. At times, this impacted billing timelines and resulted in retroactive billing. Providers noted that faster turnarounds in communication would have been helpful and would have made their participation easier. Providers also expressed their desire for higher reimbursement rates and hourly wages to attract and retain new staff. There was specific mention of how reimbursement rates have not increased proportionally with industry-wide salary demands and cost of living expenses, which has led to employee attrition. Improvements in reimbursement rates would allow providers to pay higher hourly wages, which could improve employee retention and limit staff shortages in the event of a future public health emergency.

- *“I think the way some of the information was disseminated was a little challenging, because we’d have the meetings, and there’d be discussion about such and such bulletin is coming out, and this is going to be on that bulletin, but we wouldn’t then see the bulletin for a number of weeks. [...] We’d have to wait and potentially not bill, and then try and bill retroactively. So, I think that was always a bit of a frustrating piece, like bulletins aren’t prepared, you’re presenting the information on some of the bulletins, but we don’t have anything to reference.”*—DH Provider Site Administrator 4 (Open/Enrolled)
- *“I think MassHealth is better prepared to respond more quickly. I think that [the] first time around, it took some length of time to try and make those decisions. But now they probably have the template in place should this happen again that we have to do some of that.”*—DH Provider Site Administrator 3 (Open/Enrolled)
- *“[...] it’s at a point now where I sort of dread Monday morning. I never felt that way before. It’s just, the staffing is horrific to try to get staff. People come and go like the wind. It’s trying times, trying times for everybody in the organization. [...] But now, I don’t see how we can pay less than \$20 an hour if we’re planning on getting any people to work with our clients. And so, one of the biggest challenges we have now is getting staff [...] and one way we can do that is to make salaries reasonable.”*—DH Provider Site Administrator 1 (Open/Enrolled)

- *“I think where the rates are concerned [...] we need to be able to pay people more. And I know there’s just so much that can be done about the finance with being able to attract people into these jobs; that’s where the real critical need is. Because if we were more well-staffed, we would be in a much better place.”* –DH Provider Site Administrator 2 (Temporarily Closed but Reopened)

## 6.4 Conclusions, Policy Implications, and Limitations

### Conclusions

MassHealth's Retainer Payment program was implemented to help providers sustain operations while keeping members safe at home during the mandated closures of ADH and DH facilities. The results about program effectiveness were mixed.

Providers applauded the smooth implementation of the Retainer Payment Program and the availability of MassHealth staff to respond to their questions and concerns. Official communications with MassHealth via bulletins and meetings were valued information sources for providers to receive important news and updates regarding the Retainer Payment Program.

Retainer payments helped some provider organizations sustain operations while keeping members safe at home during the early days of the PHE when closures of ADH and DH facilities were mandated. Retainer payments served as “economic relief” with a higher than pre-pandemic reimbursement rate. Providers spoke positively about their experiences communicating tailored programming and curricula to members via Zoom, WhatsApp, and Facebook Messenger.

Aside from the benefits that the Retainer Payment Program brought to sites, some providers reported challenges in implementing the administrative protocols and procedures required by MassHealth (this was also a common challenge of other Emergency Waiver Demonstration programs launched in such a short time period). Some providers reported that, even with the financial support of retainer payments, they still faced financial constraints and challenges due to high fixed costs and staffing shortages, which ultimately continues to limit ADHs and DHs ability to provide care similar to pre-pandemic levels.

The caseloads and expenditures for both ADH and DH providers during and after the retainer payment period did not remain consistent compared to pre-COVID-19 caseload and expenditure trends. Caseloads and expenditures after the Retainer Payment Program ended were lower than prior to the onset of the COVID-19 pandemic. The monthly caseloads among both ADH and DH providers declined throughout the COVID-19 pandemic despite the implementation of the Retainer Payment Program. The business status (i.e., open/closed) of the sites who participated in the Retainer Payment Program varied. About 8.6% of the participating DH programs reported permanent closures.

### Policy Implications

Economic relief of ADH and DH providers through the implementation of retainment payments has significantly helped many providers to sustain business operations, but

the level of payment may not be adequate to support all providers coping with fluctuating caseloads, maintaining staff, and sustaining their business. Public payers may consider implementing higher rates and extending the time of financial support(s) to sustain ADH and DH providers and operations, especially in the era of a health provider workforce shortage. Communicating in a timelier manner by producing quicker turnaround times in official communications, as well as investing to raise reimbursement rates and hourly wages, would improve future programming in a similar emergency condition.

## **Limitations**

### Quantitative Limitations

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. There were also inconsistencies in the retainer payment expenditure and caseload data dates, and an explanation could be that there is a lag in receiving expenditure data compared to our receipt of caseload data. This can explain the inconsistent periods of caseload data (i.e., March to April 2020) and expenditure data (i.e., February to March 2020). Also, in addressing RQ3, the data collected reflects the enrolled numbers for ADH/DH programs and the numbers for temporary/permanent closures. Data was not received that would allow for an in-depth understanding of the time of the closures.

### Qualitative Limitations

We received a small sample size for qualitative interviews due to non- and/or declined response from prospective interviewees. As a result of incomplete sampling, the findings from the interview sample are not generalizable to the broader target populations. There are many additional retainer payment stakeholders in this state that were not represented in this sample.

## 7. Cost Sharing Exemption for Referred Eligibility Group

### 7.1 Introduction, Policy Goal, and Objectives

MassHealth implemented the cost-sharing Demonstration policy for the purpose of relieving financial burdens on Medicaid members with extreme economic hardship. Members who cannot afford copayments may be less compliant with filling their prescriptions, which may lead to deteriorating health status for members with chronic medical conditions. Through this policy, the most economically disadvantaged Medicaid members are more likely to access care (i.e., filling drugs as prescribed) without incurring financial burdens.

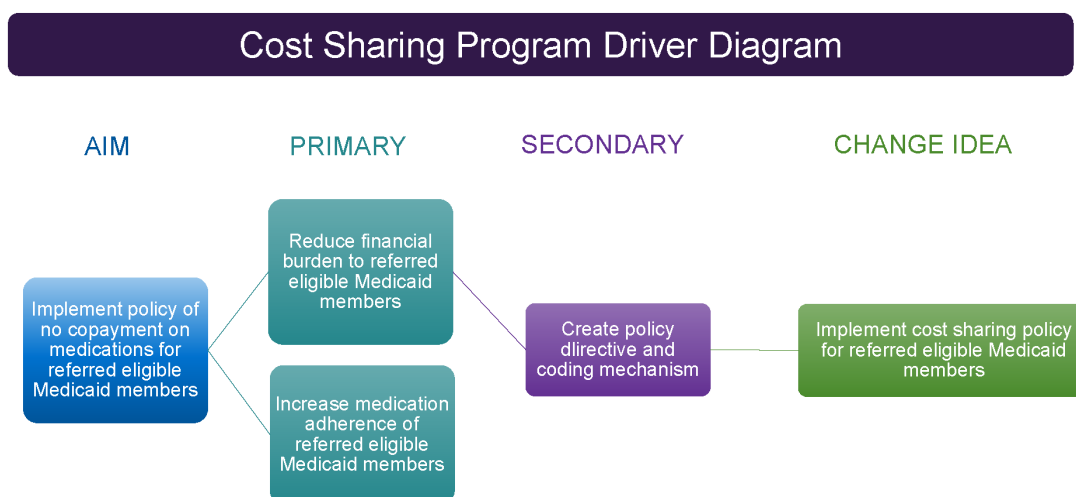
Effective July 1, 2020, MassHealth eliminated copayments for members with income below 50% of the federal poverty level (FPL). The Demonstration provided \$0 medication copayments for MassHealth members belonging to a “referred eligible” group as it authorized MassHealth to consider their income to be 0% FPL. Referred eligibility members are those who are categorically eligible for MassHealth because they are receiving other public assistance including, but not limited to: Supplemental Security Income (SSI) benefits; Transitional Aid to Families with Dependent Children (TAFDC) (i.e. Temporary Assistance for Needy Families) cash assistance; and MassHealth Standard members waiting for redetermination.<sup>6</sup> MassHealth does not receive income data for referred eligible members and was therefore unable to determine which of them had incomes <50% of the FPL. To ensure copays were eliminated for the most economically disadvantaged referred eligible members, MassHealth requested and received approval for an emergency Demonstration waiver to consider referred eligible members to have 0% FPL income. This cost-sharing Demonstration policy was effective from July 1, 2020, through July 12, 2023.

### 7.2 Evaluation Questions, Data Sources, and Methods

We constructed the driver diagram below to understand the program and guide development of the evaluation questions and methods. The primary drivers of the program were to reduce the financial burden to and increase medication adherence of eligible MassHealth members.

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<sup>6</sup> MassHealth Cost Sharing Policy Update Call June 02, 2020.  
[https://www.masshealthmtf.org/sites/default/files/MH%20Cost%20Sharing%20Call%20Transcript%206.18.20Final\\_0.pdf](https://www.masshealthmtf.org/sites/default/files/MH%20Cost%20Sharing%20Call%20Transcript%206.18.20Final_0.pdf)



To evaluate the implementation and outcomes of the cost-sharing Demonstration policy, evaluators at ForHealth Consulting of UMass Chan conducted a mixed methods evaluation.

**Research Questions (RQs).** The evaluation research questions include the following:

RQ1. How many MassHealth referred eligible members have benefited from having zero copayments for medication annually since the Demonstration program was implemented?

RQ2. How has the cost-sharing Demonstration policy been implemented and supported MassHealth's goal?

RQ3. What are the savings of medication copayment expenses for MassHealth referred eligible members before and during the Demonstration?

RQ4. How does having zero copayment impact MassHealth referred eligible members' medication adherence behaviors, especially those who are elderly?

## Data Sources

**Data:** The data used include quantitative and qualitative data sources listed below:

- **Quantitative data:** Medicaid administrative data, including enrollment, eligibility, claims, and encounter files. This data was used to identify referred eligibility members and to calculate their medication adherence rates by analyzing their copayments before and after the Demonstration policy started.
- **Qualitative interview data:** Qualitative data collected from interviews with referred eligibility members and MassHealth Cost Sharing Program Managers who administered the Demonstration policy.

## Quantitative Methods

The evaluation of the cost-sharing Demonstration policy aims to describe changes in medication compliance behaviors of referred eligible MassHealth members through descriptive analyses of administrative data before and after the Demonstration policy started. The measures used in these analyses are based on MassHealth referred eligible members' claims data, encounter, and eligibility data from the five study periods noted below. Income data for referred eligible members was coded as FPL=0% by default.

Pre-Demonstration policy implementation periods:

- July 2018 - June 2019 (SFY19) and
- July 2019 - June 2020 (SFY20)

Post-Demonstration policy implementation periods:

- July 2020 - June 2021 (SFY21),
- July 2021 - June 2022 (SFY22), and
- July 2022 - June 2023 (SFY23)

### Quantitative Measures

To assess medication adherence and calculate the financial impact of the Demonstration policy on referred eligibility members, analyses of the following four measures were conducted:

1. Total number of referred eligibility members.
2. Average cost savings from zero copayments per member per year (PMPY), adjusted by members' length of enrollment.
3. Member medication adherence rates for three chronic conditions (hypertension, diabetes, and hyperlipidemia), expressed as a proportion of days covered (PDC) (i.e., days with medication/days in the program.<sup>7</sup>
  - The PDC analysis was only conducted for members who had at least two fills of hypertension/diabetes/hyperlipidemia medication(s) on unique dates of service during the measurement period and were enrolled in MassHealth for at least 320 days in each study period.
4. Medication compliance was measured as the proportion of days a medication was supplied over a one-year period.
  - Adherent patients were identified as those reaching a threshold of 80% compliance.

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<sup>7</sup> The denominator should be the number of days enrolled in MassHealth among members with at least two fills of the chronic disease medication. However, we do not have the data on how many days of medication a member must have. We assume the medication for chronic diseases is needed for any day during a member's Medicaid enrollment, so the enrollment days are a proxy for the number of days a member needs medication.



## Qualitative Methods

### Inclusion Criteria

We received a MassHealth database of members who were eligible for the cost-sharing Demonstration policy. A sample of 30 referred eligibility members was selected as an interviewee candidate pool based on meeting the following two criteria: 1) having at least one pharmacy claim in each of the four study years (SFY2019-SFY2023); and 2) having the highest pharmacy copayments of the referred eligible study group in SFY2020 but no pharmacy copayments between SFY2021 and SFY2023. These criteria aimed to ensure that our interviewee pool consisted of members who experienced the greatest cost savings from the cost sharing exemption.

### Outreach

We conducted four rounds of telephone and email outreach to members who met the inclusion criteria and invited the respondents to be interviewed for this evaluation. We also invited a group of MassHealth Program Managers familiar with the cost-sharing policy to participate in a small group interview.

### Data Collection

We conducted telephone and web-based interviews with referred eligibility group members who expressed interest in participating and MassHealth Cost Sharing Program Managers. We developed semi-structured interview guides tailored for each type of audience. Each interview guide (see **Appendices 8.2.9 – 8.2.10**) included questions designed to elicit detailed feedback about the experiences of administering or participating in the cost-sharing Demonstration policy, per the evaluation design. The purpose of these interviews was to understand how the Demonstration was implemented, how it impacted members' access to services, and how it supported MassHealth's goal of relieving financial burdens on members with extreme economic hardship.

### Narrative Analyses

Interviews were recorded and transcribed verbatim prior to analysis. Due to the small interview sample, transcripts were manually analyzed using descriptive narrative analysis, as thematic analysis requires a minimum sample size of 12 to achieve thematic saturation.<sup>8</sup> Coders met to summarize key findings present in the transcripts within the context of each interview question. To demonstrate the data-driven nature of the qualitative findings, excerpts supporting all key findings were extracted from the transcripts and are presented in the Results section.

## 7.3 Evaluation Findings

### Quantitative Findings

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<sup>8</sup> Ando, H., Cousins, R., & Young, C. (2014). Achieving Saturation in Thematic Analysis: Development and Refinement of a Codebook. *Comprehensive Psychology*, 3. <https://doi.org/10.2466/03.CP.3.4>

Below, we describe and provide supporting figures for all quantitative findings within the context of RQ1, RQ3, and RQ4. Please note the findings for RQ2 are reported in the subsequent Qualitative Findings section.

**RQ1.** How many referred eligibility members have benefited from the zero copayments for medication annually since the Demonstration program was implemented?

There were more than 325,000 referred eligible members considered to have income less than 50% of the FPL in each study period (see **Table 9**). More than 70% of those members had at least one prescription. Before the Demonstration began, between 72-75% of members had zero prescription copayments. The percentage of members who had zero copayments increased to 95-97% after the Demonstration policy was implemented. This demonstrates how the implementation of the Demonstration policy increased the percentage of referred eligibility members who received zero copayments by at least 23 percentage points across all study periods.

**Table 9.** Number of Referred Eligibility Members' Prescription and Copayment Status between SFY19 and SFY23

Year	Total (N)	With $\geq 1RX$ (n, %)		Without Rx Copay (n, %)	
SFY19	362,366	274,124	75.65	205,187	74.85
SFY20	350,005	259,128	74.04	187,529	72.37
SFY21	330,792	239,373	72.36	227,955	95.23
SFY22	350,949	256,074	72.97	245,874	96.02
SFY23	373,605	267,396	71.57	259,198	96.93

Data: MassHealth claims/encounter

**RQ3.** What are the savings of medication copayment expenses for referred eligibility Medicaid members before and during the Demonstration?

The cost sharing Demonstration resulted in annual savings of over \$5 million in medication copayments for all referred eligible Medicaid members considered to have income less than 50% of the FPL, in each year of the Demonstration period (see **Table 10**). In the table, the difference is between the total copay of other years with the total in SFY20 – the year mostly - the period before implementation of the Demonstration policy. Members' total copayments per year exceeded \$5.6 million during SFY20 when copayments were the highest. Total copayments decreased to between \$160,000 and \$447,000 during the SFY21-SFY23 (the periods after implementation of the Demonstration policy).

**Table 10.** Differences in Medication Copayment Before and During the Demonstration Implementation

Year	Total Copay Per Year (\$)	Per Member Per Year (\$/PMPY)
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	All plans	Difference btw Years	FFS/PCC	MCO	All plans	Difference btw Years	FFS/PCC	MCO
SFY19	4,219,307	(1,401,979)	687,448	3,531,859	11.70	(4.61)	1.99	11.70
SFY20	5,621,286	Ref Year*	518,627	5,102,659	16.31	Ref Year*	1.55	16.31
SFY21	446,980	(-5,174,306)	23,980	423,000	1.38	(14.93)	0.08	1.38
SFY22	374,137	(-5,247,149)	27,983	346,154	1.09	(15.22)	0.08	1.09
SFY23	160,082	(-5,461,204)	21,979	138,102	0.44	(15.87)	0.06	0.44

Data source: MassHealth claims/encounter

\*The reference year is SFY20, with cost compared with other years' cost.

During the pre-Demonstration period of SFY20, the average medication copayment was \$16.31 PMPY. Copayments were reduced to a combined average of \$1.38 PMPY right after implementation of the Demonstration policy and further reduced to less than \$0.5 during the last year of the Demonstration policy, for a combined average savings of around \$15 PMPY. Specifically, average member copayments were reduced to \$0.06 from \$1.55, and to \$0.44 from \$16.31 for members enrolled in Primary Care Clinician (PCC)/Fee-For-Service (FFS) and managed care organizations (MCOs), respectively (**see Table 10** above). Note the distribution was highly skewed; more than 75% of members had zero medication copayments before the Demonstration implementation, so the cost was driven by some outliers. Also, the member may not be in the referral eligibility aid category for an entire year and may not be fully subject to the zero-copay policy. After implementation of the Demonstration policy, the percentage of members with zero copayments increased to more than 95% (**see Table 11**).

**Table. 11** Distribution of Medication Copays Before and During the Demonstration

	Year	Total (N)	Mean	STD	25th Pctl	50th Pctl	75th Pctl	95th Pctl	99th Pctl
<b>All plans</b>	SFY19	362,366	11.70	195.10	0	0	0	111.20	231.16
	SFY20	350,005	16.31	49.53	0	0	0	127.22	232.59
	SFY21	330,792	1.38	15.57	0	0	0	0.00	46.13
	SFY22	350,949	1.09	10.21	0	0	0	0.00	38.70
	SFY23	373,605	0.44	6.10	0	0	0	0.00	13.35
<b>FFS/PCC</b>	SFY19	362,366	1.99	16.45	0	0	0	0.00	64.44
	SFY20	350,005	1.55	14.43	0	0	0	0.00	47.32
	SFY21	330,792	0.08	2.41	0	0	0	0.00	0.00
	SFY22	350,949	0.08	2.08	0	0	0	0.00	0.00
	SFY23	373,605	0.06	1.71	0	0	0	0.00	0.00
<b>MCOs</b>	SFY19	362,366	9.71	194.46	0	0	0	99.54	216.20
	SFY20	350,005	14.76	47.68	0	0	0	123.76	226.24
	SFY21	330,792	1.31	15.38	0	0	0	0.00	43.56

	Year	Total (N)	Mean	STD	25th Pctl	50th Pctl	75th Pctl	95th Pctl	99th Pctl
	SFY22	350,949	1.01	10.00	0	0	0	0.00	36.02
	SFY23	373,605	0.38	5.85	0	0	0	0.00	10.70

Data source: MassHealth claims/encounter

**RQ4.** How does zero copayment impact MassHealth referred eligibility group members' medication adherence behaviors, especially those who are elderly?

When analyzing members' overall medication adherence, compared to the pre-Demonstration period of July 2019- June 2020, compliance rates increased about 2 percentage points during the first year of the Demonstration for members taking medications for diabetes, hyperlipidemia, or hypertension (See **Table 12**). And in the second year of the Demonstration, compared to the pre-demonstration period, compliance rates further increased roughly by about 4percentage points for all three selected chronic conditions. During the third year and final year of the Demonstration, compliance rates showed a downward trend back toward pre-demonstration rates.

**Table 12.** Medication Adherence: Compliance Rates Before and During Demonstration

Year	Diabetes (%)	Hyperlipidemia (%)	Hypertension (%)
SFY19	57.17% (=21,559/37,711)	53.87% (=32,436/60,217)	56.98% (=56,842/99,754)
SFY20	59.60% (=21,791/36,562)	55.85% (=32,256/57,757)	58.62% (=55,986/95,507)
SFY21	61.86% (=22,337/36,108)	57.45% (=32,292/56,212)	61.50% (=56,503/91,872)
SFY22	63.25% (=23,844/37,701)	59.77% (=34,239/57,286)	63.02% (=57,982/92,013)
SFY23	58.94% (=23,941/40,618)	56.39% (=33,059/58,628)	60.18% (=56,444/93,794)

Data source: MassHealth claims/encounter

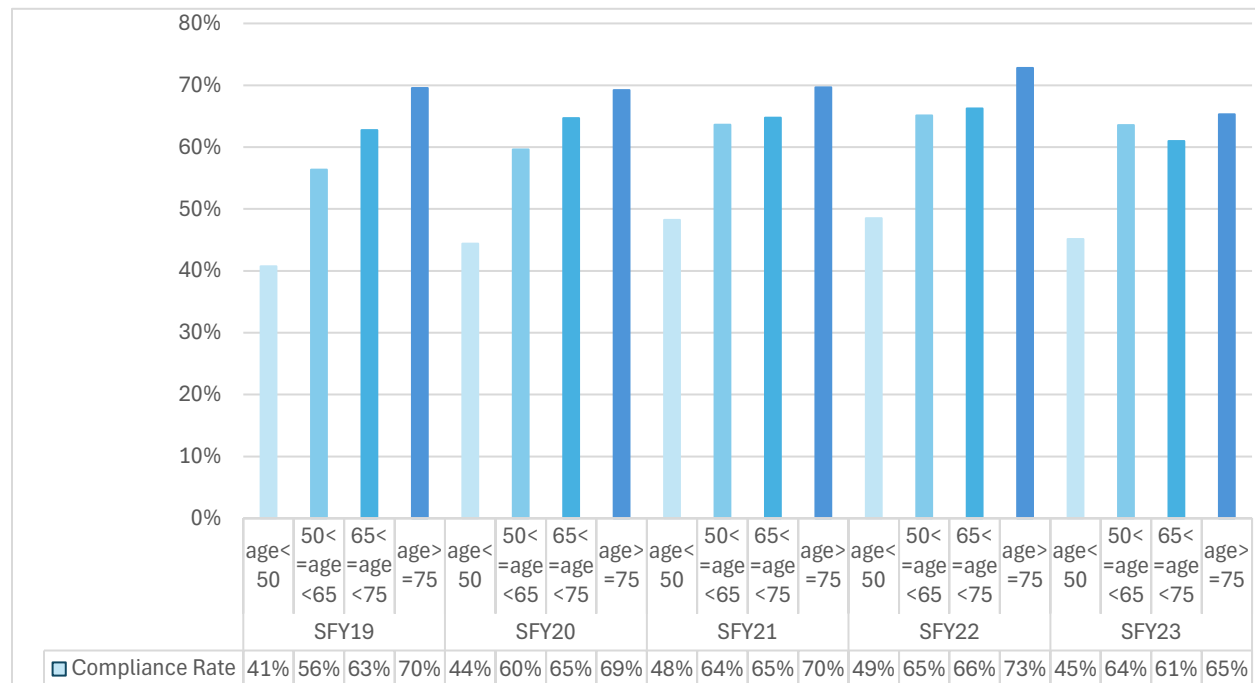
When examining medication adherence for these three chronic conditions using the proportion of days covered (PDC) method, more than 50% of the members had an average PDC score above 80% before and during the Demonstration (See **Table 13**). PDC is a measure of medication adherence based on members who had at least two refills of medication(s) on unique dates of service during the measurement period while being enrolled in MassHealth for at least 320 days in each study period (i.e., days with medication/days in the program). Based on the PDC average, the cost sharing Demonstration appeared to help members maintain their medication adherence during the Demonstration period, which supports MassHealth's goal of promoting adherence among members enrolled in this Demonstration.

**Table 13.** Medication adherence: Distribution of Proportion of Days Covered (PDC)

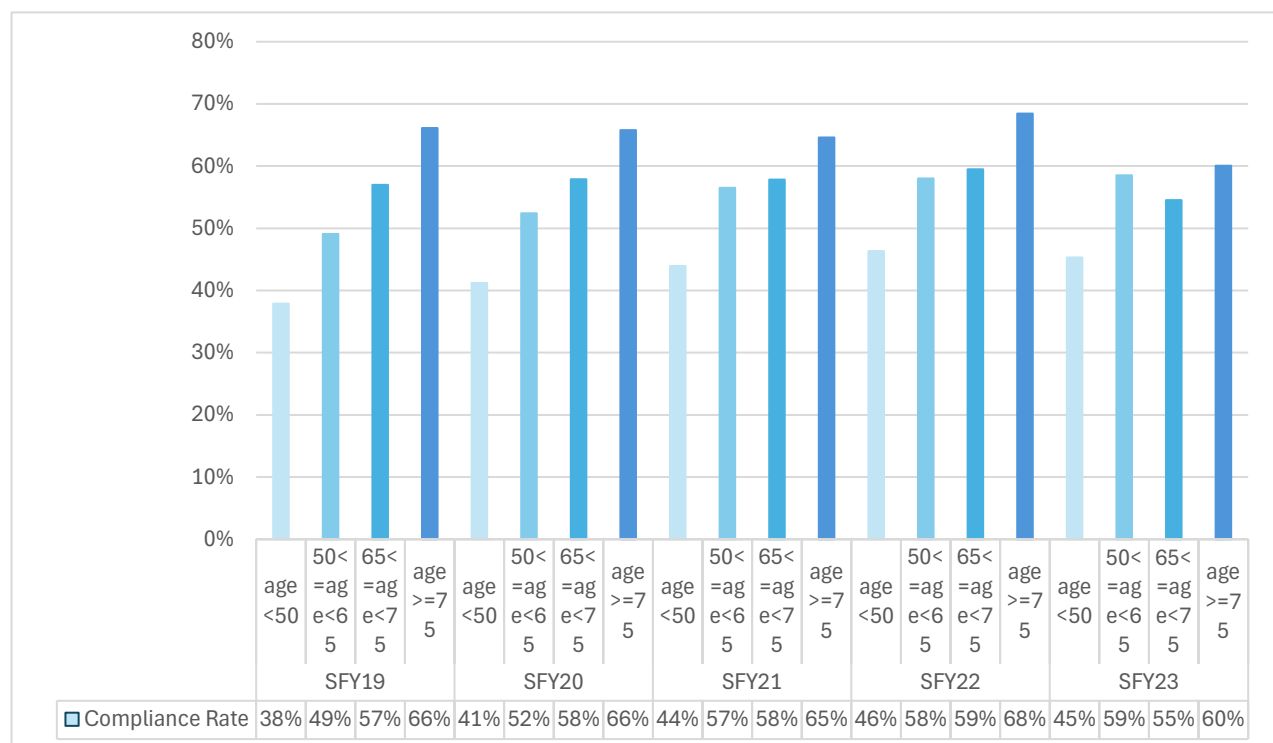
	Period	Total (N)	Mean	Std	25th Pctl	50th Pctl	75th Pctl	95th Pctl	99th Pctl
<b>Diabetes</b>	SFY19	37,711	0.75	0.27	0.56	0.86	0.98	1.00	1.00
	SFY20	36,562	0.77	0.26	0.59	0.89	0.99	1.00	1.00
	SFY21	36,108	0.78	0.26	0.62	0.90	0.99	1.00	1.00
	SFY22	37,701	0.78	0.26	0.63	0.92	0.99	1.00	1.00
	SFY23	40,618	0.76	0.27	0.57	0.88	0.99	1.00	1.00
<b>Hyperlipidemia</b>	SFY19	60,217	0.73	0.27	0.53	0.83	0.96	1.00	1.00
	SFY20	57,757	0.75	0.26	0.56	0.85	0.97	1.00	1.00
	SFY21	56,212	0.76	0.25	0.59	0.86	0.97	1.00	1.00
	SFY22	57,286	0.77	0.25	0.61	0.88	0.98	1.00	1.00
	SFY23	58,628	0.76	0.25	0.58	0.86	0.97	1.00	1.00
<b>Hypertension</b>	SFY19	99,754	0.74	0.29	0.52	0.87	0.98	1.00	1.00
	SFY20	95,507	0.75	0.28	0.54	0.89	0.99	1.00	1.00
	SFY21	91,872	0.77	0.28	0.59	0.90	0.99	1.00	1.00
	SFY22	92,013	0.78	0.27	0.61	0.92	0.99	1.00	1.00
	SFY23	93,794	0.76	0.28	0.57	0.90	0.99	1.00	1.00

When analyzing medication compliance for diabetes, hyperlipidemia, or hypertension prescriptions across age groups, members aged 75 years and older showed the highest compliance rates (66-75%) before the Demonstration (July 2018 – June 2020) (see **Figures 12-14**). This same age group showed an increase in compliance rates (68-78%) during the second year of the Demonstration. Members aged 49 years and younger had the lowest compliance rates before the demonstration (37-44%); however, these rates increased to 44-49% during the first and second years of the Demonstration. Members between ages 65 and 74 years maintained similar medication compliance rates before and during the Demonstration for diabetic and hyperlipidemia prescriptions, at 65% and 58%, respectively. For hypertension medication adherence, these members had a compliance rate of 67% before the Demonstration, which increased slightly to 69% during the second year of the Demonstration.

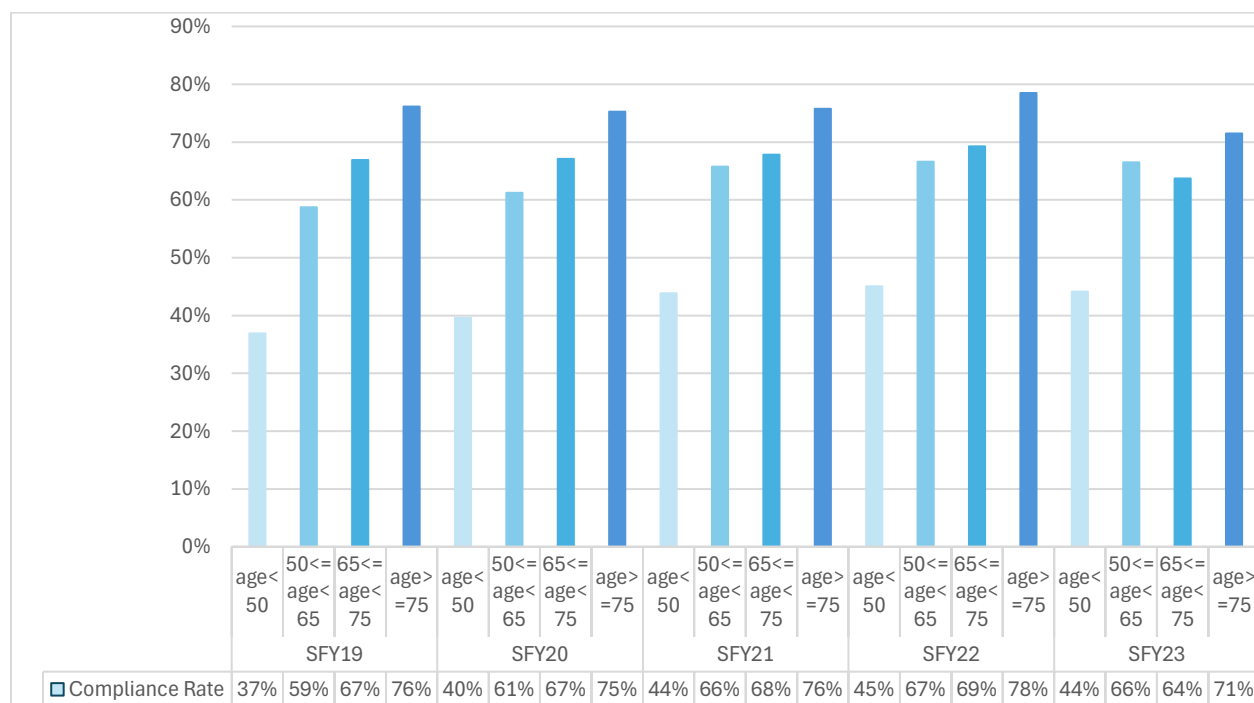
**Figure 12.** Diabetic Medication Adherence: Compliance Rates Before and After Demonstration by Age Group



**Figure 13.** Hyperlipidemia Medication Adherence: Compliance Rates Before and During Demonstration by Age Group





**Figure 14.** Hypertension Medication Adherence Compliance Rates Before and During Demonstration by Age Group

Overall, medication compliance increased across prescription areas and age groups in the baseline period and during the first two years of the Demonstration policy before falling in the third Demonstration year. Members aged 75 and older had the highest compliance rates before and during the demonstration across all prescription areas. However, compliance across the three prescription areas for this age group increased 3-4 percentage points in the first two years of the Demonstration before decreasing 7-8 percentage points from year two to year three. Members aged 50 to 64 years showed the largest changes in medication compliance rates across all age groups, increasing eight to nine percentage points from the baseline to the demonstration period across the three prescription areas. For hypertension medication adherence, this age group showed the greatest increase (10 percentage points) in compliance, from 49% in the first baseline year to 59% in the third year. This member group also increased its diabetes medication compliance by 9 percentage points, from 56% in the first baseline year to 65% in year two of the Demonstration. Members under age 50 had the lowest overall compliance across the three prescription areas, with no baseline or Demonstration year higher than 49%. Their adherence increased by 8 percentage points from year one of baseline to Demonstration year two for each of the three medications.

### Qualitative Findings

We conducted three interviews with referred eligible members (20% of our target sample size of 15). We were unable to reach 100% of our target sample size due to non-response or declined participation. We also conducted one small group interview

with three MassHealth Cost Sharing Program Managers who administered the Demonstration policy.

We analyzed individual transcripts from all interviews. Narrative analyses of interview data generated the following key findings:

1. MassHealth's cost-sharing policy aimed to improve medication adherence among members considered to have incomes  $\leq 50\%$  FPL.
2. Zero copayments helped members maintain medication adherence without affordability concerns, particularly for members taking multiple prescriptions.
3. Copayment savings helped members cover transportation costs, personal hygiene items, and household expenses.
4. Members were unaware of the zero-copayment policy until picking up their prescriptions, where they were not charged.

We describe and provide supporting excerpts for each key finding in RQ2 below.

**RQ2.** How has the cost-sharing Demonstration policy been implemented and supported MassHealth's goal?

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**MassHealth's cost-sharing policy under the Demonstration aimed to improve medication adherence for referred eligible members who were considered to have incomes  $\leq 50\%$  FPL.** Recognizing improved medication adherence with no copayments, MassHealth decided to request authority to consider referred eligible members to have 0% FPL so that they would have \$0 copayments. Copayments were waived using a no copayment code, which ensured members paid no copayments when filling prescriptions. MassHealth Cost Sharing Program Managers found the Demonstration successful and without glitches or challenges. They noted that, due to lacking income data for referred eligible members, the demonstration policy potentially included those with incomes over 50% FPL. However, they expressed gratitude for this assumption of a 0% FPL, as it guaranteed zero copayments for referred eligibility members with incomes under 50% FPL.

- *"Once the policy decision was made, we needed to consider these referred eligibility members to be 0% FPL, because we don't know their income. Even though some of them might be over 50%, we didn't want those of them that were under 50% to lose out on this new policy. [...] We were lucky that there was an authority vehicle we could use to get permission to consider these folks to have 0% income."* – MassHealth Cost Sharing Program Manager Interview

**Zero copayments helped members maintain medication adherence without affordability concerns, particularly for members taking multiple prescriptions.**

Members discussed the ease with which they can fill their prescriptions because they don't have to worry or stress over being able to afford their copayments. These members expressed how the cost sharing program made prescriptions more accessible to them. One member specifically described how not being able to afford and access behavioral health medications would make their overall health worse. All members expressed how zero copayments are especially helpful for individuals with fixed incomes. Two members expressed concerns about the financial impact of returning to

out-of-pocket copayments, particularly heightened for those taking multiple or expensive medications

Before the cost sharing Demonstration, members unable to afford copayments sought alternatives like asking family members to pay or requesting pharmacists for in-kind prescriptions. None of the members interviewed had ever asked their provider for assistance with getting prescriptions if they could not afford the copayments. One member expressed how they would not ask their provider for assistance, as they felt it would be embarrassing.

- *“I know that I don’t have to worry about paying for my medication. I feel less stressed because it’s one less thing on my back. I know I can get my meds without having to scramble around. I’m on disability and it’s really expensive to live in Massachusetts. Having no co-pays definitely helps. I’m on a lot of medications right now, I would say almost 15 different medications. Having to pay copays for all of them would really hit me in the bank. [If I had to return to out-of-pocket copayments] I’d have to budget differently. I think I’d be able to afford it, but I’d need advance notice. [...] [If I couldn’t afford my copayment] I’d ask the pharmacist if they write off the copay charge, which didn’t always work, so I’d have to borrow money from my family to pay for it. [I’ve never asked my doctor’s office for help with my copayments] but my doctors are very nice so I’m sure they’d make something happen.”*—Referred Eligibility Member 1
- *“I’m on disability, so I only get money at the beginning of the month. [Having no copayments makes getting my medication] so much easier. I don’t have to worry if it’s at the end of the month and I don’t have the money. I have 14 prescriptions. [One of my prescriptions] I wouldn’t even be able to afford it if I had to pay my co-pays, because that thing is \$30. There’s no way I could do it. That’s a lot of money. [If I couldn’t afford my copayment] I’d call my father. He’d either transfer the money into my bank account, or Western Union the money to me. [...] [I’ve never asked my doctor’s office for help with my copayments] because that would be embarrassing for me.”*—Referred Eligibility Member 2
- *“[Not being able to afford medications is] extremely stressful, considering some of the medications for BH medication are extremely expensive. And, going without them, some of the medicines that I do take, if you miss a dose, you become very sick. And it’s a really bad reaction. So, it was very stressful having to wait and then having to wait for prior authorization to go through, and you’re not in your right frame of mind because you’re not having your medication. Now, being in the program, it’s kind of very easy for me. [...] Financially, I would be in big trouble if I wasn’t in this program. I am on Social Security, disability. I only get 700 dollars a month to live on [...] if I had to actually pay for medications or actually pay a co-pay, I couldn’t do it [...] the medications would have to go. So yes, I’m extremely grateful that that’s one less thing that is on my shoulders to worry about.”*—Referred Eligibility Member 3

**Copayment savings helped members cover transportation costs, personal hygiene items, and household expenses.** Members discussed using the savings to cover the cost of rides, and the purchase of household and personal hygiene items like laundry detergent, deodorant, and shampoo. They also mentioned using the savings to pay bills such as their cell phone and electricity bills. Overall, the copayment savings help members manage their daily living costs and ease pressure on fixed expenses.

- *“[I use the copayment savings to] get me a ride somewhere, put a little cushion in the bank, or pay my phone bill.”* –Referred Eligibility Member 1
- *“It affords me to be able to get other things into that might need it. Things like buying shampoo, deodorant, hygiene items, laundry detergent, just things like that. [...] I live with my mom and she’s on a fixed income. [The copayment savings allow me] to pay towards the electric bill. [...] Not having to pay the copay is great. Because having to do so would really put an impact on the things that I could get for my house.”* – Referred Eligibility Member 2

**Members were unaware of the zero-copayment policy until picking up their prescriptions, where they were not charged.** Members discussed noticing the elimination of copayments around one to two years ago but did not recall receiving any formal notice from MassHealth explaining the change. One member noted how they first assumed the zero-copayment policy was only for the COVID-19 public health emergency. Members shared how they would have liked to be informed about this program through receiving a notice in the mail. One member suggested having MassHealth sister agencies help advertise these types of programs would have been helpful for members.

- *“I haven’t had co-pays for about a year now. I’m not sure if I received any notice from MassHealth explaining why I don’t have a co-pay. But they just don’t charge me when I get my meds. [In the future, I would like to hear about similar programs] by mail would be best.”* –Referred Eligibility Member 1
- *“It happened all of sudden, about a couple of years ago, and I thought it was part of COVID. Okay. But I always meet a max, and it came around the same time of the year that I meet my max on co-pays, so I thought it was part of COVID-19 and then they just never came back. [I would like to have about this program through the mail] because I need to be able to read something, and then read it again [...] I like things in print.”* –Referred Eligibility Member 2
- *“[To make members more aware about their enrollment in the cost-sharing program] I would’ve said in the mail, but a lot of people discard mail without opening them [...] I would say either a phone call or, maybe, through agencies like DTA [Department of Transitional Assistance]. They know members are on MassHealth, they could say ‘listen there’s this program....’”* –Referred Eligibility Member 3

## 7.4 Conclusions, Policy Implications, and Limitations

### Conclusions

Overall, the Cost Sharing Demonstration Policy to consider referred eligible members to have 0% FPL and therefore not subject to copayments supported MassHealth’s goal of promoting medication adherence among economically disadvantaged members. During most years of the Demonstration, medication adherence increased for all the selected chronic disease prescriptions, as well as for all age groups. Average PDC scores >80% before and during the Demonstration further demonstrated MassHealth’s success in helping members maintain medication adherence. Qualitative findings also supported this success. Members shared how the zero copayments helped them to maintain medication adherence without affordability concerns. The copayment savings were also

helpful to members in covering transportation costs and purchasing personal hygiene items and household expenses. Members mentioned they were unaware of the zero-copayment policy until picking up their prescriptions, where they found they were not charged. They expressed sincere gratitude for being part of the program.

## Policy Implications

The zero-copayment for referred eligible members under the demonstration relieved the financial burdens on those mostly economically disadvantaged. It also increased medication adherence rates. Recent literature (including a systematic review) shows that a higher medication adherence rate is associated with modest to significant health outcomes and healthcare cost.<sup>9,10</sup> States could consider continuing \$0 copayment policies after the PHE ends. The policy could also be relaxed to extend to a population with higher FPL if a cost effectiveness analysis is performed to confirm the effectiveness of the policy.

## Limitations

### Quantitative Limitations

The MassHealth data used in our quantitative analyses were from time periods ranging between SFY19 and SFY20 (before the Demonstration); and SFY21-SFY23 (during the Demonstration). Our analyses did not include data from time periods after the Demonstration ended. The findings from our descriptive analyses are limited to the changes that occurred during the Demonstration compared to the pre-Demonstration baseline period.

### Qualitative Limitations

We were only able to interview 20% of our target sample of referred eligibility members. Such a small sample size limits the generalizability of our findings; therefore, our findings may not be applicable to the larger population of members. We were also unable to identify Cost Sharing Program Managers from other states, as we did not find another state Medicaid program that implemented a similar Demonstration policy. As of April 1, 2024, MassHealth eliminated medication copayments for all members. Our member interviews took place after this universal policy was implemented, potentially causing member confusion about earlier experiences with zero copayments under the cost sharing demonstration policy. Members with tiered drug copayments were not included in our interview sample, which prevented comparative analyses using feedback from referred eligibility members who had zero copayments.

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<sup>9</sup> Conn VS, Ruppert TM, Enriquez M, Cooper PS. Patient-Centered Outcomes of Medication Adherence Interventions: Systematic Review and Meta-Analysis. *Value Health*. 2016 Mar-Apr;19(2):277-85. doi: 10.1016/j.jval.2015.12.001. Epub 2016 Jan 14. PMID: 27021763; PMCID: PMC4812829.

<sup>10</sup> Axon, DR, Vaffis, S, Chinthammit, C, Lott, BE, Taylor, AM, Pickering, M, Black, H, Warholak, T, Campbell, PJ. Assessing the association between medication adherence, as defined in quality measures, and disease-state control, health care utilization, and costs in a retrospective database analysis of Medicare supplemental beneficiaries using statin medications. *Journal of Managed Care & Specialty Pharmacy*. 2020 Nov; Vol 26(12). <https://doi.org/10.18553/jmcp.2020.26.12.152>





## 8. Appendices

### 8.1 Evaluation Design

#### 8.1.1 General Demonstration Background

The first case of COVID-19 in Massachusetts was diagnosed in late Jan. 2020, and by March 3, 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 10, 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 Section 1135 Emergency Waiver Demonstration requests, Disaster SPA requests, Appendix K requests, and, as described below, an Emergency 1115 Demonstration request, all to CMS. The flexibility approved by CMS under these authorities has 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 flexibility to assist with the state's response to the COVID-19 pandemic. On Dec. 30, 2020, CMS approved Emergency Waiver Demonstrations 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 ADH and DH 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 it has not designed an evaluation for this item.

The commonwealth understands that EOHHS is required to monitor and evaluate the Emergency Waiver Demonstrations and expenditures authorized under this Emergency

Waiver Demonstration, 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 Emergency Waiver Demonstration and expenditure authorities under this Emergency Waiver Demonstration expire.

The Commonwealth appreciates that, given the time-limited nature of the Emergency Waiver Demonstrations, CMS does not expect states to develop an extensive set of monitoring metrics and evaluation hypotheses for such Emergency Waiver Demonstrations but has striven to design an evaluation that will assist future policymakers in responding to crises such as the COVID-19 pandemic.

## **8.1.2 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 to address this policy goal. CMS supported this effort through the approval of Emergency Waiver Demonstrations 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 Oct. 31, 2020, with MassHealth payment for this service in place from April 4, 2020, through Aug. 31, 2020. While the ambulance providers performed mobile testing for everyone at the 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<sup>11</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, and 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 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 to October 2020<sup>12</sup>. 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. Researchers will perform a thematic analysis of qualitative data from interviews. Data

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<sup>11</sup> Two ambulance providers were contracted by MassHealth but only one performed mobile testing.

<sup>12</sup> MassHealth payment is only through August 2020.

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 and congregate site administrators?	Experiences	Qualitative interview data	Thematic analysis

## 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.

## 8.1.3 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 an Emergency Waiver Demonstration 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 Sept.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 allows?
  - 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 because 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 the 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 captures the daily number of interviews (i.e., interactions with the 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.** This data contains 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 to Sept. 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 the 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 their contact information in the data or their unwillingness to participate.
- **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 the results.

## **8.1.4 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 close temporarily between March 23 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 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 Emergency Waiver Demonstration 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 changes 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>13</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 expenditures, number of providers, and caseloads of members, will be presented by time periods. Monthly trends will be presented if data permits. The service utilization will be based on various categories of ADH and DH services if data permits.

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.

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<sup>13</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
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.

### 8.1.5 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>14</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>15</sup>. Even nominal copayments significantly reduced clinically important drug use by fee-for-service Medicaid populations<sup>16</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>17</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>14</sup> Approval of COVID19 Demonstration Amendment, May 8, 2023

<sup>15</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>16</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>17</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>18</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 copayment 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.

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

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<sup>18</sup> The savings for Medicaid members are presented as expenses for Medicaid (as a payer).

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.

## **8.1.6 Reporting**

### **6.1. Annual Reporting**

The duration of the Demonstration is contingent on the duration of the COVID-19 Emergency Waiver Demonstration authority, which is currently unknown. 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 and interpretation, and lessons learned from the Demonstration, per the approved evaluation design. The state will track all expenditures associated with the Demonstration separately, 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.

## **8.2 Interview Guides**

### **Appendix 8.2.1 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration Mobile Testing Congregative Facility Program Manager Interview Guide**

Thank you for agreeing to participate in this interview regarding MassHealth's implementation of mobile testing for COVID-19 under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we'd like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including mobile testing. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, Executive Office of

Health and Human Services (EOHHS) agency administrators, and mobile testing site administrators to understand the benefits of the program, challenges, and implications for future testing initiatives.

We are speaking with you to understand your organization's role in implementing mobile testing for COVID-19, along with any challenges and successes you have identified for the mobile testing program. Findings from all interviews, along with analyses of MassHealth mobile testing data, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration for MassHealth and the Centers for Medicare & Medicaid Services.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation. You will be mailed a \$25 Bank of America debit card as a token of appreciation for your participation. We will collect your mailing address from you at the end of the interview.

We would like to record this interview via Zoom and transcribe it to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

With your permission, I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

## **Background**

I am going to begin by asking about your role at [name of group home/nursing home etc.] and the decision to implement mobile testing.

Please tell us a little about your role at [name of group home/nursing home etc.] during the beginning of the pandemic when mobile testing was planned and started.

How long have you worked in that role?

Who are the primary populations served by [name of group home/nursing home etc.]?

## **Mobile Testing Implementation**

Next, I will be asking about how testing went at [name of group home/nursing home, etc.].

Please tell us about your experience preparing for mobile testing at [name of group home/nursing home etc.].

What challenges, if any, did you encounter with getting mobile testing up and running at your organization?

What resources were needed to help sites become operational in such a short time frame?  
What worked well and what did not?

Did you experience any hesitancy in your client/patient population's willingness to get tested?

What were the facilitators of getting testing up and running at your organization?

[Probe] What made the process easier?

[Probe] What processes and procedures worked well?

What was your process for scheduling testing with the mobile testing vendor?

What worked well?

What glitches, if any, occurred?

How did you resolve them?

How often did you communicate with the mobile testing vendor during program implementation?

[Probe] What were the major themes of the issues discussed during those communications?  
(Problems and how to address them? Reporting? Staffing?)

What were the facilitators of successful collaboration between your organization and the mobile testing vendor?

[Probe] What processes and procedures worked well?

How often did you communicate with the state agency administrator/liaison of your testing site?

[Probe] What were the major themes of the issues discussed during those communications?  
(Problems and how to address them? Reporting? Staffing?)

## **Outcomes**

Next, I will ask about the outcomes of mobile testing.

What worked well with the mobile testing program?

Were there any opportunities for improvement in the mobile testing processes? If so, what were those opportunities?

[Probe] How could those improvements take place?

How successful was your organization's mobile testing program in reaching the targeted populations?



[Probe] What other populations benefited from the mobile testing program?

From your perspective, what were the biggest successes of the mobile testing program at your organization?

### **In Closing**

Just two more questions...

From your experience with mobile testing, what would be useful to share with others who might want to implement a mobile testing program in the future?

What else would you like to share about the mobile testing program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you'd like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off]

## **Appendix 8.2.2 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration Mobile Testing EOHHS Agency Program Manager Interview Guide**

Thank you for agreeing to participate in this interview regarding MassHealth's implementation of mobile testing for COVID-19 under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including mobile testing. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, Executive Office of Health and Human Services (EOHHS) agency administrators, and mobile testing site administrators to understand the benefits of the program, challenges, and implications for future testing initiatives.

We are speaking with you to understand your agency's role in implementing mobile testing for COVID-19, along with any challenges and successes you have identified for the mobile testing program. Findings from all interviews, along with analyses of MassHealth mobile testing data, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration for MassHealth and the Centers for Medicare & Medicaid Services.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation.

We would like to record this interview via Zoom and transcribe it to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

With your permission, I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### **Background**

I am going to begin by asking about your role at your agency and the decision to implement mobile testing.

Please tell us a little about your role at [name of agency] during the beginning of the pandemic when mobile testing was planned and started.

What informed [name of agency]'s decision to implement mobile testing?

What factors went into that decision?

## **Mobile Testing Implementation**

Next, I will be asking about the implementation of the mobile testing program.

How did you prioritize or choose sites for mobile testing?

What populations did [name of agency] make the most effort to reach through mobile testing?  
[Probes: older adult population, people with chronic conditions, etc.]

How was test scheduling handled?

What worked well about the processes?

What glitches, if any, occurred?

How did you resolve them?

How often, if at all, did you communicate with the testing vendor during program implementation?

[Probe] What were the major themes of the issues discussed during those communications?  
(Problems and how to address them? Reporting? Staffing?)

How often did you communicate with mobile testing sites' administrators during program implementation?

[Probe] What were the major themes of the issues discussed during those communications?  
(Problems and how to address them? Reporting? Staffing?)

What were the facilitators of successful collaboration between mobile-testing sites' administrators and the testing vendor?

[Probe] What processes and procedures worked well?

What challenges, if any, did mobile testing sites' administrators have in collaborating with the testing vendor?

[Probe] How did you attempt to address these challenges, if at all?

[Probe] What strategies would you suggest to help navigate these challenges for any future mobile testing?

## **Outcomes**

Next, I will ask about the outcomes of mobile testing.

What worked well with the mobile testing program?

Were there any opportunities for improvement in the mobile testing process that could improve the success of future mobile testing programs? If so, what were those opportunities?

[Probe] If the improvements took place, how did they do?

*(If target populations were identified in question 3)* How successful were the mobile-testing vendor and site administrators in reaching the targeted populations?

[Probe] What other populations benefited from the mobile testing program?

Overall, how effective was mobile testing in congregant settings in helping to respond to the COVID-19 public health emergency?

From your perspective, what were the biggest successes of the mobile testing program?

### **In Closing**

Just two more questions...

From your experience with mobile testing, what would be useful to share with others who might want to create a mobile testing program in the future?

What else would you like to share about the mobile testing program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you'd like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

### **Appendix 8.2.3 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration Mobile Testing MassHealth Program Manager Interview Guide**

Thank you for agreeing to participate in this interview regarding MassHealth's implementation of mobile testing for COVID-19 under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we'd like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including mobile testing. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, Executive Office of Health and Human Services (EOHHS) agency administrators, and mobile testing site administrators to understand the benefits of the program, challenges, and implications for future testing initiatives.

We are speaking with you to understand how MassHealth implemented mobile testing for COVID-19, along with any challenges and successes you have identified for the mobile testing program. Findings from all interviews, along with analyses of MassHealth mobile testing data, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration for MassHealth and the Centers for Medicare & Medicaid Services.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation.

We would like to record this interview via Zoom and transcribe it to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

With your permission, I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

#### **Background**

I am going to begin by asking about your role at MassHealth and the decision to implement mobile testing.

Please tell us a little about your role at MassHealth during the beginning of the pandemic when mobile testing was planned and started.

What informed MassHealth's decision to implement mobile testing?

What factors went into that decision?

## **Mobile Testing Implementation**

Next, I will be asking about the implementation of the mobile testing program.

What was the process of prioritizing or choosing sites for mobile testing?

Please tell me about your experiences with the procurement process of identifying mobile testing vendors.

[Probing Qs]

How did you go about selecting the mobile testing vendor?

What capacity were you looking for in vendors?

What challenges did you experience in executing the vendor contract, if any?

How long did vendor selection take?

We heard a vendor opted out after being selected. Why was that?

What other challenges and successes did you experience with selecting a vendor?

What lessons have you learned related to vendor selection that might be applicable to future public health emergencies?

How was test scheduling handled?

[Probe] Are you aware of any glitches that occurred?

If so, how were these glitches resolved?

How often, if at all, did you communicate with the testing vendor during program implementation?

[Probe] What were the major themes of the issues discussed during those communications? (Problems and how to address them? Reporting? Staffing?)

What challenges and successes, if any, did you have helping each EOHHS ‘sister agency’ administrator get their respective mobile testing sites up and running?

What resources were needed to help sites become operational in such a short timeframe? What worked well and what did not?

How often did you communicate with “sister agency” administrators during program implementation?

[Probe] What were the major themes of the issues discussed during those communications? (Problems and how to address them? Reporting? Staffing?)

What challenges, if any, did the EOHHS sister agencies face in reporting data to MassHealth?

[Probe] How did you attempt to address data reporting challenges, if any?



[Probe] What strategies would you suggest to help support data reporting for any future mobile testing?

## **Outcomes**

Next, I will ask about the outcomes of mobile testing.

What worked well with the COVID-19 mobile testing program?

Were there any opportunities for improvement in the mobile testing process that could contribute to the success of future mobile testing programs? If so, what were those opportunities?

[Probe] If those improvements have taken place, how did they do?

How successful were the EOHHS sister agencies in reaching the targeted populations?

[Probe] What other populations benefited from the mobile testing program?

Overall, how effective was mobile testing in congregant settings in helping to respond to the COVID-19 public health emergency?

From your perspective, what were the biggest successes of the mobile testing program?

## **In Closing**

Just two more questions...

From your experience with mobile testing, what would be useful to share with others who might want to create a mobile testing program in the future?

What else would you like to share about the mobile testing program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you'd like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

## **Appendix 8.2.4 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration TNP Provider Interview Guide**

Thank you for taking the time to participate in this interview regarding MassHealth implementation of the Telehealth Network Provider (TNP) program under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including the TNP program. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, TNPs, and MassHealth members to understand the benefits of the program, challenges, and implications for initiatives in the case of future public health emergencies.

We are speaking with you to understand how MassHealth implemented the TNP program, along with any challenges and successes you have identified. Findings from all the interviews, along with MassHealth data analysis on the TNP program, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation.

We would like to record and transcribe the interviews to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting.

With your permission, we would like to audio-record the interview through Zoom and transcribe it to ensure that we accurately capture the information you provide. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### **Background**

Please briefly tell me a little about yourself.

Next, I am going to ask you about your participation as a TNP.

How did you hear about the TNP program?

What informed your decision to participate as a TNP?

### **Experience as a TNP**

Now I am going to ask you about your experience providing services as a TNP.

What was your experience providing services as a TNP?

How smoothly did communications with MassHealth go?

How easy was the billing process for TNP services?

### **Successes**

Next, I am going to ask about any successes you experienced as a TNP.

What successes did you experience in your work as a TNP?

How did you see the program benefiting MassHealth members?

### **Challenges**

The next few questions cover any challenges you may have experienced as a telehealth network provider.

What challenges did you face providing TNP services?

What challenges did you face in billing?

What worked well?

Did you use the Buoy app?

If so, what challenges did you face using the app?

What other challenges, if any, did you face?

### **Lessons Learned**

What have you learned by providing services as a TNP that would help MassHealth respond to future public health emergencies?

From your experience as a TNP, what would you want MassHealth to do differently in case of a future public health emergency?

What, if anything, would you do differently if you were to participate in a TNP-like program in the future?

### **In Closing**

Just one more question...

What else would you like to share about your experience participating in the TNP program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you would like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

## **Appendix 8.2.5 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration TNP Administrator Interview Guide**

Thank you for taking the time to participate in this interview regarding MassHealth implementation of the Telehealth Network Provider (TNP) program under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including the TNP program. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, TNPs, and MassHealth members to understand the benefits of the program, challenges, and implications for initiatives in the case of future public health emergencies.

We are speaking with you to understand how MassHealth implemented the TNP program, along with any challenges and successes you have identified. Findings from all the interviews, along with MassHealth data analysis on the TNP program, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation.

We would like to record and transcribe the interviews to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting.

With your permission, we would like to audio-record the interview through Zoom and transcribe it to ensure that we accurately capture the information you provide. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### **Background**

Please briefly tell me a little about your role at [name of TNP provider].

Next, I am going to ask you about your organization's participation in the TNP program.

How did you first hear of the opportunity to participate in the TNP program?

What informed your organization's decision to participate in the TNP program?

### **Experience with the TNP Program**

Now I am going to ask you about your experience implementing the TNP Program at [name of TNP provider organization].

What was your overall experience implementing the TNP program?

How did provider enrollment go?

What specific barriers, if any, did providers face as they tried to enroll in the TNP program?

How smoothly did communications with MassHealth go? Providers?

How easy was the billing process for TNP services?

What issues did providers face with billing?

What challenges, if any, did your organization or MassHealth face in implementing the program?

What things would you change about the program design, if anything?

### **Successes**

Next, I am going to ask about any successes you experienced implementing the TNP program.

In your opinion, what were the biggest successes of the TNP program?

Were your organization's goals for participating in the TNP program met?

If not, what specific goals were met/not met?

In your opinion, how did the program benefit MassHealth members?

What feedback did you receive from your providers about the TNP program?

### **Lessons Learned**

In hindsight, what would you have wanted to know before implementing the TNP program at your organization?

What lessons have you learned from the implementation of the TNP program that will be useful in future public health emergencies?

### **In Closing**

Just one more question...

What else would you like to share about your experience implementing the TNP program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you would like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]



## Appendix 8.2.6 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration TNP MassHealth Member Interview Guide

Thank you for taking the time to participate in this interview regarding MassHealth implementation of the Telehealth Network Provider (TNP) program under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the COVID-19 Telehealth Network Provider program. *Telehealth Network Providers are medical professionals who helped members during the COVID-19 crisis decide about the need for isolation as well as testing and treatment options.* As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth members like yourself to understand the benefits of the program, challenges, and implications for initiatives in the case of future public health emergencies.

We are speaking with you to understand how helpful the Telehealth Network provider you saw was to you and any challenges and successes you have identified. Findings from all the interviews, along with other information on the use of the program, will be included in our final evaluation report.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation. You will be mailed a \$50 Bank of America debit card as a token of appreciation for your participation. We will collect your mailing address from you at the end of the interview.

We would like to record and transcribe the interviews to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting.

With your permission, we would like to audio-record the interview through Zoom and transcribe it to ensure that we accurately capture the information you provide. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### Background

How do you self-identify?

Next, I am going to ask you about your use of a TNP.

How did you learn about the possibility of using a Telehealth Network Provider to talk about your questions and concerns about COVID-19?

Why did you choose to use a Telehealth Network Provider instead of contacting your regular healthcare provider about your questions?

### **Experience with using a TNP**

Now I am going to ask you about your experience using a TNP.

How easy was it to connect with a TNP provider?

Did you use the Buoy app (cell phone application)?

If yes, how easy was the app to use?

What challenges did you have using the Buoy app?

What challenges did you have, if any, reaching the Telehealth Network Provider?

### **Satisfaction**

Next, I am going to ask about your satisfaction with the TNP.

How satisfied were you with the services provided by the Telehealth Network Provider?

How well did they listen to your concerns?

How well did they answer whatever questions you had?

What questions, if any, were unanswered after your interaction/tele-visit?

Overall, how helpful was the Telehealth Network Provider?

### **Outcomes**

What follow-up recommendations did the TNP provider make?

How easy were the recommendations to understand?

How easy were the recommendations to follow?

Did someone check back to see if you connected to any recommended treatment? (Testing, isolation)

If so, how did they follow up on recommended treatment? Testing? Isolation?

### **In Closing**

Just one more question...

What else would you like to share about your experience using a TNP?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you would like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

## **Appendix 8.2.7 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration MassHealth TNP Program Manager Interview Guide**

Thank you for taking the time to participate in this interview regarding MassHealth implementation of the Telehealth Network Provider (TNP) program under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including the TNP program. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, TNPs, and MassHealth members to understand the benefits of the program, challenges, and implications for initiatives in the case of future public health emergencies.

We are speaking with you to understand how MassHealth implemented the TNP program, along with any challenges and successes you have identified. Findings from all the interviews, along with MassHealth data analysis on the TNP program, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We will keep to that time unless you let us know that you would like to continue our conversation.

We would like to record and transcribe the interviews to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting.

With your permission, we would like to audio-record the interview through Zoom and transcribe it to ensure that we accurately capture the information you provide. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### **Background**

Please briefly tell me a little about your role at MassHealth.

Next, I am going to ask you about your participation as a TNP.

What informed MassHealth's decision to implement the TNP program?

What were MassHealth's goals for TNP program outcomes?

## **Experience with the TNP Program**

Now I am going to ask you about your experience implementing the TNP Program.

What was your overall experience implementing the TNP program?

How did provider enrollment go?

What specific barriers did providers face as they tried to enroll in the TNP program?

How smoothly did communications with TNPs go?

How easy was the billing process for TNP services?

What issues did providers face with billing?

What challenges, if any, did you or MassHealth as a whole face implementing the program?

If you had a chance to do it over again, what things would you change about the program design?

Implementation?

## **Successes**

Next, I am going to ask about any successes you experienced implementing the TNP program.

In your opinion, what were the biggest successes of the TNP program?

Were MassHealth's goals for the TNP program met?

If not, what specific goals were met/not met?

In your opinion, how did the program benefit MassHealth members?

What feedback did you receive from TNPs about the program?

## **Lessons Learned**

In hindsight, what would you have wanted to know before implementing the TNP program?

What lessons have you learned from the implementation of the TNP program that will be useful in future public health emergencies?

## **In Closing**

Just one more question...

What else would you like to share about your experience implementing the TNP program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you would like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

## **Appendix 8.2.8 - 1115 Emergency Waiver Demonstration COVID-19 Emergency Waiver Demonstration Retainer Payment Adult Day Health & Day Habilitation Provider Site Administrator Interview Guide**

Thank you for taking the time to participate in this interview regarding MassHealth's implementation of retainer payments for Adult Day Health and Day Habilitation providers under the 1115 COVID-19 Emergency Waiver Demonstration. Before we start, we would like to mention a few things about the evaluation project and the interview process.

ForHealth Consulting at UMass Chan Medical School has been engaged to evaluate the 1115 COVID-19 Emergency Waiver Demonstration programs, including the Retainer Payment Program. As part of the evaluation, ForHealth Consulting is conducting interviews with MassHealth, Adult Day Health, and Day Habilitation program administrators to understand the benefits of the program, challenges, and implications for initiatives in the case of future public health emergencies.

We are speaking with you to understand how MassHealth implemented the Retainer Payment Program, along with any challenges and successes you have identified. Findings from all the interviews, along with MassHealth data analysis on retainer payments, will be included in the final report on the 1115 COVID-19 Emergency Waiver Demonstration.

Your participation in the interview is voluntary. The interview will take about 30 minutes.

We would like to record and transcribe the interviews to ensure that we accurately capture what you say. The information you provide will be kept confidential. Your responses will not be shared with anyone else outside the project team. You will not be identified by name or role in any of our reporting.

With your permission, we would like to audio-record the interview through Zoom and transcribe it to ensure that we accurately capture the information you provide. Audio recordings will be destroyed at the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom- Make sure your video is pinned before you press record]*

We are now recording.

### **Background**

**I am going to begin by asking about your program and your role.**

Please briefly describe your program

Where is your program located?

What is your role in the program?



What populations do you serve? (older adults, people w developmental disabilities, people with severe physical disabilities, other?)

About what percentage of people you serve are MassHealth members?

**Next, I am going to ask you about your participation in the Retainer Payment Program. For the next few sets of questions, when I say “you,” I am referring to your provider organization as a whole.**

How did you hear about the availability of retainer payments?

What informed your decision to participate in the Retainer Payment Program?

Probe: How did your participation impact your ability to sustain operations?

### **Challenges**

Now I am going to ask you about the challenges you faced participating in the Retainer Payment Program.

What challenges did you face, if any, in submitting claims for retainer payments?

What other challenges did you face during your participation in the program?

What informed your decision whether or not to open your program?

What challenges did you face amending individual care plans for members?

Probe: Did you have the required resources to adapt to remote and virtual care plans?

### **Usefulness of Retainer Payment Program**

Next, I am going to ask about how useful the retainer payments were in keeping your business open.

How useful was the retainer in helping to keep your business open during the pandemic?

In supporting members through telehealth services?

What would have made it easier for you to participate in the Retainer Payment Program?

What other support would have been helpful?

### **Post Program Operations**

The next few questions cover your experiences once the retainer program ended.

Since the retainer payment policy ended, what challenges have you faced in keeping your program open?

What would you like MassHealth to know about ways they could support your program during a pandemic so you could continue to best serve MassHealth members?

## **In Closing**

Just two more questions...

From your experience with the Retainer Payment Program, in what ways could MassHealth help programs like yours continue to serve your participants during any future public health emergencies?

What else would you like to share about the Retainer Payment program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you would like to share with us. The information you have shared will be included in our report to CMS.

[Turn recorder off.]

## Appendix 8.2.9 - 1115 Waiver COVID-19 Emergency Waiver Cost Sharing Member Focus Group Guide

Thank you for taking the time to participate in this interview regarding MassHealth's implementation of cost sharing exemptions under the 1115 COVID-19 Emergency Waiver.

[Introduction of lead interviewer/moderator]

Before I start, I'd like to mention a few things about the purpose of today's interview.

ForHealth Consulting at UMass Chan Medical School (UMass Chan), where I work, has been asked to evaluate the cost sharing exemption program. To do that, we are interviewing people like yourself who have MassHealth benefits and don't need to pay a copay for medication. I am speaking with you today to learn about your experience with this program, and how your participation in the program may have impacted your access to medications.

I want to emphasize that this is a safe space to share your feedback regarding any of the questions I ask. There are no right or wrong answers. Your participation in this interview is voluntary. This interview will take about 15-30 minutes. The information you share with me today will be shared with MassHealth in a final report. To protect your privacy, we will not identify you by name in the report. Everything you share with me will be grouped together with feedback from other participants so that it is anonymous. You will receive a \$50 gift card as a token of appreciation for your participation.

With your permission, I'd like to record the interview through Zoom. The recording will be transcribed into a written document to ensure that we accurately capture the information you provide. However, your name will not be included in the transcription. The recording will not be shared with anyone outside the project team, and it will be destroyed at the completion of the study.

As mentioned before, we will not disclose your name or any identifiable information in our reporting. Your responses will be completely anonymous to anyone outside of this space.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

I am going to begin recording now.

*[Press record on Zoom -Make sure your video is pinned before you press record.]*

We are now recording.

To start, when and how did you first hear about the cost sharing program?

If interviewee is not aware of the program, please read the following:

*Cost Sharing is a program that offers income eligible MassHealth members reduced or zero out of pocket expenses or copayments for their prescription medications. During the COVID-19 state of emergency, MassHealth implemented a Cost Sharing program from July 1, 2020, to July 12, 2023, as a relief to MassHealth members experiencing financial hardship.*

Before the cost sharing program was introduced, what did you do if you needed a prescription medication but could not afford the copayment?

Probes:

In what ways, if any, did your doctor's office help you with getting your medication if you could not afford it?

If you are a parent, what did you do if your child needed a prescription medication, but you could not afford the copayment?

During your participation in the Cost Sharing program, how did being able to afford your medication impact your ability to adhere to your medication as prescribed by your provider?

Probe:

If you have children, how did it impact their ability to adhere to their medication as prescribed by their provider?

If you yourself are a senior citizen, or if you know any senior citizens, how does being able to afford medication impact senior citizens' ability to adhere to their medication as prescribed by their provider?

How does being able to afford your medication make you feel about your overall health status?

How, if at all, did the COVID-19 pandemic impact your ability to fill your prescription medications? Please explain.

Probes:

How useful was your participation in the Cost Sharing program in helping you continue to fill your prescription medications during the pandemic?

What other support would have been helpful during that time?

How did having reduced or no copayments for your prescription medications impact your monthly budget?

Probes:

How did your participation in the Cost Sharing program impact you financially?

When you spend less on purchasing your prescription medications, how do you use the extra money?

Since the Cost Sharing program has ended, have you experienced any challenges with being able to afford your medication? Please explain.

Probe:

Can you afford to return to paying copays out-of-pocket without any financial difficulty? These copays can range anywhere between \$0 and \$60 per month, depending on your monthly copay cap calculated by MassHealth.

If a similar program were to be implemented in the future to help MassHealth members afford their medication, how would you like to hear about this program?

Probes:

From your provider? Email? Phone call? Letter in the mail?

Is there anything that we haven't already discussed that you'd like to share about your experience in the Cost Sharing program?

[Turn recorder off.]

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you'd like to share with us. As a reminder, the information you have shared will be included in our report to MassHealth, but it will be anonymous to protect your identity.

We will send you an email to collect your mailing information for the \$50 gift card. You will receive your gift card in the mail within the next few weeks. Do you have any other questions before we end?

## Appendix 8.2.10 - 1115 Waiver COVID-19 Emergency Waiver Cost Sharing MassHealth Cost Sharing Program Manager Interview Guide

Thank you for taking the time to participate in this interview regarding MassHealth's implementation of cost sharing exemptions for prescription drugs under the 1115 COVID-19 Emergency Waiver.

[Introduction of team conducting interview.]

Before we start, we'd like to mention a few things about the purpose of today's interview. ForHealth Consulting at UMass Chan Medical School (UMass Chan), has been asked to evaluate the 1115 COVID-19 Emergency Waiver programs, including the Cost Sharing Exemption Program, which offered income eligible MassHealth members reduced or zero out-of-pocket copayments for their prescription drugs. This program was implemented from July 1, 2020, to July 12, 2023, as a relief to MassHealth members experiencing financial hardship.

As part of this evaluation, we are conducting interviews with MassHealth staff members like yourself, to understand your role in implementing the Cost Sharing Exemption Program, along with any benefits, challenges, and implications for future cost sharing initiatives. Findings from all interviews (including member interviews), along with analyses of MassHealth claims/encounter data, will be included in the final evaluation report on the 1115 COVID-19 Emergency Waiver for MassHealth and the Centers for Medicare & Medicaid Services.

Your participation in the interview is voluntary. The interview will take about 30 minutes. We would like to record this interview via Zoom and transcribe it into a written document, to ensure that we accurately capture what you say. However, your name will not be included in the transcription. The recording will not be shared with anyone outside the project team, and it will be destroyed after the completion of the study.

Do you have any questions before we begin?

Is it all right to record this conversation? [wait for a reply]

With your permission, I am going to begin recording now.

***[Press record on Zoom-Make sure your video is pinned before you press record.]***

We are now recording.

### Background

I am going to begin by asking about your role at your agency, and any roles you may have had in the implementation of the Cost Sharing program.

1. Please tell us a little about your role at MassHealth during the time when the Cost Sharing program was planned and implemented.
2. What informed MassHealth's decision to implement the Cost Sharing program?
3. What involvement did you have in the planning, implementation, or reporting aspects of the Cost Sharing program, if any at all?

### Outcomes

Next, I will ask about the outcomes of Cost Sharing program.

4. How successful was MassHealth in reaching the targeted populations to notify them of their eligibility and participation in the Cost Sharing program?
5. How useful was the Cost Sharing program in supporting MassHealth's goal of relieving financial burdens for MassHealth members with extreme economic hardship?

Probe:

- a. How did the policy impact MassHealth members' access to prescription drugs?
6. What were the biggest successes of the Cost Sharing program?
7. What glitches, if any, occurred?
8. Were there any unintended outcomes or consequences of the Cost Sharing program?
9. Were there any opportunities for improvement that could improve the success of future Cost Sharing programs? If so, what were those opportunities?
10. Is there any other support that would have been helpful to MassHealth members during this time?

### **In Closing**

Just two more questions...

11. From your experience with Cost Sharing program, what would be useful to share with others who might want to create a similar program in the future?
12. Is there anything else that you would like to share about the Cost Sharing program?

Thank you for your time. Please feel free to follow up with us via email if you think of anything else you'd like to share with us. As a reminder, the information you have shared will be included in our report to MassHealth, but it will be anonymous to protect your identity.

**[Turn recorder off.]**