

Massachusetts 1115 Demonstration Extension
2022-2027

Draft Independent Evaluation Interim
Report (IEIR)

Working Draft

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Prepared by:

**UMass Chan Medical School,
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and

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About Us

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Acronym Listing

Acronym	Definition
AAP	Adults' Access to Preventive/Ambulatory Health Services
ABA	Applied Behavior Analysis
ACCS	Adult Community Clinical Services
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plans (Model A)
ACS	American Community Survey
ACSC	Ambulatory Care Sensitive Conditions
ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention-Deficit/Hyperactivity Disorder
ADL	Activities of Daily Living
AHEM	Advancing Health Equity in Massachusetts
AHRQ	Agency for Healthcare Research and Quality
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length of Stay
AOD	Alcohol or Other Drug Use
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
APTC	Advanced Premium Tax Credit
AQEIP	ACO Quality and Equity Incentive Program
ARP	American Rescue Plan
ARPA	American Rescue Plan Act
ASAM	American Society of Addiction Medicine
ASAP	Aging Services Access Points
ASC	Alternative-Specific Constants
ASL	American Sign Language
ATS	Acute Treatment Services
AUD	Alcohol Use Disorder
BCCDP	Breast and Cervical Cancer Demonstration Program
BH	Behavioral Health
BH CP	Behavioral Health Community Partner
BHHL	Behavioral Health Help Line

BH-JI	Behavioral Health Supports for Justice-Involved Individuals
BHUC	Behavioral Health Urgent Care
BMI	Body Mass Index
C&E	Coverage and Eligibility
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAT	Computerized Axial Tomography
CBAT	Community-Based Acute Treatment for Children and Adolescents
CBHC	Community Behavioral Health Center
CBHI	Children's Behavioral Health Initiative
CBO	Community-Based Organization
CCBHC	Certified Community Behavioral Health Center
CCM	Clinical Care Managers
CCS	Community Crisis Stabilization
CDC	Centers for Disease Control and Prevention
CE	Continuous Eligibility
CEO	Chief Executive Officer
CHA	Cambridge Health Alliance
CHC	Community Health Center
CHIA	Center for Health Information Analysis
CHIP	Children's Health Insurance Program
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
CI	Confidence Interval
CM	Clinical Modification
CMO	Chief Marketing Officer
CMS	Centers for Medicare & Medicaid Services
COVID	Coronavirus Disease
CP	Community Partner
CPT	Current Procedural Terminology
CQMV	Comprehensive Quality Measure Vendor
CSP	Community Support Program
CSP-HI	Community Support Program for Homeless Individuals
CSP-JI	Community Support Program for Individuals with Justice Involvement
CSP-TPP	Community Support Program for Tenancy Preservation Program
CSS	Clinical Stabilization Services
CY	Calendar Year
DCC	Disability Competent Care
DCE	Discrete Choice Experiment
DCF	Department of Children and Families

DDS	Department of Developmental Services
DiD	Difference-in-Difference
DMH	Department of Mental Health
DNP	Doctor of Nursing Practice
DO	Doctor of Osteopathic Medicine
DOV	Data-Only Variable
DPH	Department of Public Health
DSH	Disproportionate Share Hospital
DSH-like	Disproportionate Share Hospital-like
DSHP	Designated State Health Programs
DSR	Delivery System Reform
DSRIP	Delivery System Reform Incentive Payment
DxCG	Diagnostic Cost Group
DY	Demonstration Year
EA	Emergency Assistance
EAP	Employee Assistance Program
ED	Emergency Department
EDD	Evaluation Design Document
EHR	Electronic Health Record
EMH	Emergency Mental Health
EMR	Electronic Medical Record
ENS	Emergency Notification Systems
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
ESI	Employer-Sponsored Insurance
FFCRA	Families First Coronavirus Response Act
FFP	Federal Financial Participation
FFS	Fee-For-Service
FNP	Family Nurse Practitioner
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FS	Flexible Services
FSP	Flexible Service Program
FUH	Follow-up After Hospitalization After Mental Illness
FUM	Follow-Up After ED Visit for Mental Illness
FY	Fiscal Year
GEE	Generalized Estimating Equations

GPSR	Gross Patient Service Revenue
H	Hypothesis
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HEPA	High Efficiency Particulate Air
HFY	Hospital Fiscal Year
HHA	Home Health Agency
HHS	Health and Human Services / U.S. Department of Health and Human Services
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HMRS	Homeless Medical Respite Program Services
HNBC	Health-Needs-Based Criteria
HOP	Healthy Opportunities Pilots
HPSA	Health Professional Shortage Area
HQEC	Health Quality and Equity Committee
HQEI	Hospital Quality and Equity Initiative
HQEIP	Hospital Quality and Equity Incentive Programs
HR	Human Resources
HRSA	Health Resources and Services Administration
HRSN	Health-Related Social Needs
HSN	Health Safety Net
ICD	International Classification of Diseases
ICER	Incremental Cost Effectiveness Ratio
IE	Independent Evaluator
IEIR	Independent Evaluation Interim Report
IESR	Independent Evaluation Summative Report
ILC	Independent Living Center
IMD	Institutions for Mental Diseases
IOP	Intensive Outpatient Program
IRA	Inflation Reduction Act
IT	Information Technology
JOC	Joint Operating Committee
KII	Key Informant Interview
LADC	Licensed Alcohol and Drug Counselor
LANE	Low-Acuity Non-Emergent
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and more

LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTSS	Long-Term Services and Supports
LTSS CP	Long-Term Services and Supports Community Partner
LVN	Licensed Vocational Nurse
MA	Massachusetts
MAT	Medication Assisted Treatment
MBCCP	Massachusetts Breast and Cervical Cancer Program
MBHP	Massachusetts Behavioral Health Partnership
MCE	Managed Care Eligible
MCI	Mobile Crisis Intervention
MCO	Managed Care Organization
MCPAP	Massachusetts Child Psychiatry Access Program
MD	Medical Doctor
MEI	Member Experience Interview
MES	Member Experience Survey
MH	Mental Health
MHBI	MassHealth Buy-In
MHQP	Massachusetts Health Quality Partners
MLRP	Massachusetts Loan Repayment Program
MM	Member Months / MassHealth Member Months
MMIS	MassHealth Medicaid Management Information System
MOUD	Medications for Opioid Use Disorder
MPAS	Master of Physician Assistant Studies
MRI	Magnetic Resonance Imaging
MSP	Medicare Savings Program
MSW	Master of Social Work
MTM	Medically Tailored Meal
MY	Measurement Year
NACHC	National Association of Community Health Centers
NAMI	National Alliance on Mental Illness
NCQA	National Committee for Quality Assurance
NDTR	Nutrition and Dietetics Technician, Registered
NHSC	National Health Service Corps
NICU	Neonatal Intensive Care Unit
NP	Nurse Practitioner

NQF	National Quality Forum
NR	Not Reported
O:E ratio	Observed-to-Expected Ratio
OB/GYN	Obstetrics and Gynecology
OBBBA	One Big Beautiful Bill Act
OD	Overdose
OE	Open Enrollment
OR	Odds Ratio
OD	Opioid Use Disorder
PA	Physician Assistant
PAA	Potentially Avoidable Admissions
PACC	Post-Adult Community Clinical Services
PACT	Program for Assertive Community Treatment
PC	Primary Care
PCA	Personal Care Assistant
PCACO	Primary Care Accountable Care Organization (Model B)
PCC	Primary Care Clinician
PCCP	Primary Care Clinician Plan
PCE	Specific Primary Care Sub-Capitation
PCG	Public Consulting Group
PCP	Primary Care Provider
PD	Professional Development
PDT	Psychiatric Day Treatment
PFAC	Patient and Family Advisory Committee
PHE	Public Health Emergency
PHP	Partial Hospitalization Program
PHTII	Public Hospital Transformation and Incentive Initiative
PIP	Performance Improvement Projects
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMPM	Per-Member-Per-Month
PQHS	Population and Quantitative Health Sciences
PSA	Practice Site Administrator
PSH	Permanent Supportive Housing
PSLF	Public Service Loan Forgiveness
PT-1	MassHealth Provider Request for Transportation form
PTSD	Post-Traumatic Stress Disorder
PY	Performance Year
Q	Quarter
QEIP	Quality and Equity Incentive Program

QI	Quality Improvement
QMB	Qualified Medicare Beneficiaries
RAFT	Residential Assistance for Families in Transition program
RDN	Registered Dietitian Nutritionist
RE	Retroactive Eligibility
RELD SOGI	Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity
RFA	Request for Application
RN	Registered Nurse
RQ	Research Question
RRS	Relative Risk Score
RxCG	A drug based medical complexity summary score
RY	Reporting Year or Rate Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SCO	Senior Care Options
SD	Standard Deviation
SDOH	Social Determinants of Health
SE	Standard Error
SED	Serious Emotional Disturbance
SLMB/QI	Specified Low Income Medicare Beneficiaries/Qualifying Individuals
SLRP	Student Loan Repayment Programs
SME	Subject Matter Expert
SMI	Serious Mental Illness
SNAP	Supplemental Nutrition Assistance Program
SNCP	Safety Net Care Pool
SNF	Skilled Nursing Facility
SNH	Safety Net Hospital
SNP	Safety Net Provider
SNPP	Safety Net Provider Payments
SOAP	Structured Outpatient Addiction Programs
SOGI	Sexual Orientation, Gender Identity
SPA	State Plan Amendment
SQ	Status Quo
SSI	State Supplemental Income
SSO	Social Service Organization
STC	Special Terms and Conditions
STPHH	Short-Term Post Hospitalization Housing
SUD	Substance Use Disorder
SW	Social Worker
SWI	Statewide Investments

TA	Technical Assistance
TCOC	Total Cost of Care
TCU	Transitional Care Unit
THA	Temporary Housing Assistance
TIN	Taxpayer Identification Numbers
TPA	Third-Party Administrators
TPP	Tenancy Preservation Program
U.S.	United States
UC	Uncompensated Care
UCCR	Uncompensated Care Cost & Charge Report
UMass Chan	UMass Chan Medical School
USDA	United States Department of Agriculture
VA	Veterans Affairs
WCV	Child and Adolescent Well-Care Visits
WI	Workforce Initiatives
WIC	Women, Infants, and Children
WMFP	Western Mass Food Partnership
WONDER	Wide-ranging Online Data for Epidemiologic Research
YCCS	Youth Community Crisis Stabilization

Executive Summary

Purpose and Scope

This Independent Evaluation Interim Report (IEIR) is intended to inform MassHealth, the Centers for Medicare & Medicaid Services (CMS), policymakers, health system stakeholders, and the public on the progress of the Massachusetts Section 1115 Waiver Demonstration (the “Demonstration”). This executive summary of the report provides an overview of the background, interim outcomes, and impacts of the first years of the 2022-2027 Demonstration.¹ It summarizes key findings from the 2022-2024 evaluation period, recommendations, and areas for ongoing evaluation and improvement.

Background

Since its launch in 1997, Massachusetts Section 1115 Waiver Demonstrations have supported the expansion of health insurance coverage, promoted coordinated and cost-effective care, and sustained the Commonwealth’s healthcare safety net. On Sept. 28, 2022, CMS approved Massachusetts’ request to extend the Demonstration, effective Oct. 1, 2022, through Dec. 31, 2027. The 2022-2027 Demonstration builds on prior reforms by advancing accountable, value-based care, and by strengthening system-wide investments to improve access, quality, equity, and sustainability across MassHealth. Key goals for the 2022-2027 Demonstration include:

- Restructuring and strengthening accountable care organizations (ACOs) with higher standards for care improvement, cost management, and accountability.
- Investing in primary care, behavioral health, and pediatric services to expand access and reduce reliance on fee-for-service models.
- Advancing care quality and equity with targeted efforts in health-related social needs, maternal health, and support for justice-involved individuals.
- Sustaining the safety net through predictable funding for providers, linked to accountable care strategies.
- Maintaining near-universal coverage and advancing policies for coverage stability and equity.
- Addressing workforce shortages and expanding evidence-based health and substance use disorder (SUD) services, particularly for those with serious mental illness (SMI), serious emotional disturbance (SED), and opioid use disorder (OUD).

The 2022-2027 Demonstration extended many longstanding authorities and allows the Commonwealth, through various new and revised waiver and expenditure authorities, to test the efficacy of innovative programs and practices aimed at promoting consistently high-quality, equity-promoting, evidence-based, coordinated, and integrated care.

¹Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services. <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

These efforts include policies to promote insurance coverage and continuity, delivery system reforms, access to medical and behavioral health services, and programs to address health-related social needs, while sustaining safety net providers.

Evaluation Approach

This IEIR focuses on assessing implementation progress and emerging trends from the initial years of the 2022-2027 Demonstration. It reflects a mixed-methods evaluation of implementation, utilization, and outcomes across seven policy domains from 2022–2024, with some data collection extending into 2025. The Demonstration began on Oct. 1, 2022, with many policy changes enacted during 2023; for this reason, we use 2022 as a pre-implementation baseline year for most analyses. Analyses are guided by the Evaluation Design Document (EDD)² which outlines 63 research questions and corresponding hypotheses. The evaluation examines implementation activities, program outputs, service quality, member experience, healthcare utilization, and program costs. Given the early stage of Demonstration implementation³ and constraints on data availability, not all research questions are addressed in this interim report, and some are only partially addressed.

Quantitative analyses of MassHealth administrative data, surveys, and non-MassHealth datasets (e.g., Massachusetts Center for Health Information and Analysis Hospital and Health System Performance Dashboard) describe study populations and assess trends in process and outcome measures. Qualitative data, including document reviews, key informant interviews, and open-ended survey responses facilitate interpretation of quantitative trends and provide important context on implementation and stakeholder experiences. Findings are integrated across data and methods to present a comprehensive assessment of early Demonstration performance and emerging outcomes.

The Independent Evaluation Summative Report (IESR), to be submitted to CMS in July 2029, will build on the interim findings with more complete data, longer follow-up periods, and more rigorous analyses to assess the Demonstration's longer-term impacts.

² <https://www.mass.gov/doc/attachment-s-evaluation-design-document-approved-31026-0/download>

³ The following programs authorized under the April 2024 Section 1115 amendment will be examined exclusively as part of the IESR analysis: Increase the Expenditure Authority for the Health-Related Social Needs Integration Fund; Temporary Housing Assistance and Related Supports for Pregnant Members and Families; Short-Term Post-Hospitalization Housing (Homeless Medical Respite); provision of reentry MassHealth covered services to individuals in certain public institutions; and the Designated State Health Program.

Overview of the Report

Figure ES-1 provides an overview of the report's structure, summarizing the key policy areas and evaluation focus of each chapter.

Figure ES-1: Overview of IEIR Structure



Abbreviations: Independent Evaluation Interim Report (IEIR); Serious Mental Illness/Serious Emotional Disturbance (SMI/SED); Substance Use Disorder (SUD)

Key Findings and Select Recommendations

This section summarizes the principal findings and recommendations resulting from the interim evaluation of the 2022-2027 Demonstration. It highlights overarching results for each domain to date where applicable, along with policy-specific findings, implications, and recommendations (Tables ES-1 through ES-7), offering a consolidated view of progress and opportunities for improvement identified during the interim evaluation. Subsequent chapters of the report provide detailed background information on policies and programs, methods, implementation context, results, interpretation, and recommendations for each policy domain.

Coverage and Eligibility (C&E)

The C&E policies include, but are not limited to, continuous enrollment for people who are justice involved or experiencing homelessness, coverage for more populations (e.g., extended coverage for disabled adults in CommonHealth after turning 65 years of age, expansion of Medicare Savings Program), Employee Sponsored Insurance (ESI) Premium Assistance for members enrolled in certain employment-sponsored insurance, premium and cost sharing assistance for ConnectorCare, and retroactive eligibility. Collectively, the C&E policies help to maintain and broaden access to healthcare among vulnerable populations.

Table ES-1: C&E Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
Overall Coverage and Eligibility Policies	- MA continued to maintain the lowest uninsurance rate in the United States. - Medicaid enrollment increased with continuous enrollment policies during the COVID-19 PHE and started to decline with Medicaid unwinding; relatedly, churn remained low in 2022-2023. - Members generally reported stable coverage and positive experiences, but raised confusion about policies, communication gaps, and disruptions in care caused by plan changes.	- States should consider leveraging the continuation of existing policies to promote continuity of coverage while identifying and evaluating creative new policy levers to sustain and grow the impact of C&E policies in promoting access to health care among vulnerable populations. - To support members' access to care, states should consider policy options to cover those without access to insurance and provide premium assistance and cost-sharing subsidies for those with access to private insurance to ensure that it is affordable.
Continuous Enrollment	Continuous enrollment policies were successfully implemented for eligible members, with no reported effects on administrative process burden.	
Special Coverage Programs	MassHealth enrollment for special populations — those in CommonHealth, Family Assistance, BCCDP, or MSP Standard — has been maintained or expanded.	

Policy Area	Select Interim Findings	Select Implications and Recommendations
Retroactive Eligibility	Members subject to the 90-day protection of RE (e.g., pregnant women, children) have a comparable rate of continuous enrollment during the 12-month period from enrollment, compared to their counterparts who returned to 10-day protection following the end of the PHE.	
Premium Assistance and Cost-Sharing	- Enrollment in ESI Premium Assistance fluctuated but was maintained overall. - After declining during the PHE, enrollment in ConnectorCare increased substantially in 2024 with Medicaid unwinding and the waiver amendment which expanded access up to 500% FPL. - Premium and cost-sharing supports remained an important mechanism for maintaining insurance coverage in MA.	

Abbreviations: Breast and Cervical Cancer Demonstration Program (BCCDP); Coverage and Eligibility (C&E); Employer-Sponsored Insurance (ESI); Federal Poverty Level (FPL); Massachusetts (MA); Medicare Savings Program (MSP); Public Health Emergency (PHE); Retroactive Eligibility (RE)

Delivery System Reform (DSR)

The DSR policy areas, including the Accountable Care Organization (ACO) Program, Primary Care Sub-Capitation Program, enhanced care coordination, and behavioral health integration are designed to strengthen accountable care to improve access, quality, and experience for MassHealth members, while moderating healthcare cost trends. Additional reforms, such as health equity focused policies and workforce initiatives, which are further explored in later chapters, promote high-quality, coordinated care and address longstanding provider shortages across the Commonwealth.

Table ES-2: DSR Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
The ACO Program	- ACOs implemented organizational changes and strengthened relationships with hospitals, primary care practices, and clinicians to increase their capacity to deliver high-quality, equitable, and integrated care. - ACOs launched HIT and population health management initiatives including deploying dashboards, centralizing EHRs, and modifying platforms to improve care and better manage cost and quality performance.	MassHealth should continue to support ACOs with guidance and technical assistance in developing data collection, reporting, quality improvement, BH integration, and disparities reduction initiatives.

Policy Area	Select Interim Findings	Select Implications and Recommendations
	ACOs and their primary care sites reported enhancing BH service offerings and increasing integration through colocation of BH services within primary care practice sites.	
Primary Care Sub-Capitation Program	- ACOs and their primary care sites supported and responded to efforts to transition from traditional volume-based primary care payment models to a primary care sub-capitation payment arrangement. - The practices that appeared most responsive to incentives for practice reform were those with greater representation of MassHealth members among their patient panels.	MassHealth should continue to refine the Primary Care Sub-Capitation Program, enhance practice accountability, and further engage practices across all sizes and Medicaid exposure.
Enhanced Care Coordination (ACO Care Management Programs and the CP Program)	- ACOs implemented a variety of care management programs targeted for different purposes and subgroups (e.g., specific clinical conditions). - All ACOs implemented multiple care coordination programs, and most achieved contractually specified enrollment targets. - ACOs, MCOs, and CPs found that the shift to a direct contracting model improved coordination, though CPs expressed concerns regarding a perceived increased administrative burden and reduced referral volumes.	- States should carefully weigh advantages and disadvantages of direct versus state-mediated contracting between healthcare and community-based organizations. - MassHealth should collect more detailed care management program data to improve evaluation and inform best practices.
Health-Equity Focused Policies	- Enhanced expectations for quality and equity promoted ACO investment in infrastructure, processes, and partnerships to support data collection, reporting, and development of disparities reduction initiatives. - Within ACOs, more primary care practice sites reported using site-specific data to identify disparities and at more regular intervals than during the prior Demonstration period. - Most primary care practice administrators were unaware of or were not engaged as part of the ACO Health Equity Strategic planning process.	ACOs should consider taking additional steps to involve primary care practice sites in development, refinement, and implementation of the ACO's Health Equity Strategic plan.

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Community Partner (CP); Delivery System Reform (DSR); Electronic Health Records (EHRs); Health Information Technology (HIT); Managed Care Organization (MCO)

Behavioral Health (BH)

The BH policies include continuation of OUD/SUD services under the Demonstration, expansion of services for diversion or step-down from inpatient treatment for members with SMI/SED and SUD, including for children and youth, as well as Federal Financial Participation (FFP) for admissions to Institutions for Mental Diseases (IMDs) if average length of stays (ALOS) remains under 30 days.

Table ES-3: BH Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
Behavioral Health Diversionary Services (e.g., Mobile Crisis Intervention, Community Crisis Stabilization; Partial Hospitalization, Community Support Program, etc.)	• Diversionary service use within seven days of discharge from a psychiatric admission was not associated with 30-day readmission, but diversionary services were rarely used pointing to a challenge with access to diversionary services because of a lack of referrals. • Implementation of the 2022-2027 Demonstration did not appear to improve member knowledge of ways to access BH services.	The state should make information about available services, including diversionary services, accessible and widely distributed to both providers and MassHealth members to improve continuity of care through regular provider bulletins, communications, e-blasts, and social media post and outreach to first responders, schools, PCPs, and private therapists about the availability of diversionary services as alternatives to calling 911 so that diversionary services can be more frequently accessed.
SMI/SED (services in IMDs)	Implementation of 2022–2027 Demonstration services was not associated with a reduction in the number of acute psychiatric readmissions for individuals with SMI/SED diagnoses.	• The state should consider strategies for inclusion of community-based providers in pre-discharge planning. They should also encourage closed loop referrals and implement approaches to support follow-up for referrals from acute levels of care to ensure that members reach follow-up treatment post discharge. • The state should continue efforts to reduce the risk of non-fatal and fatal overdoses. • The state should continue efforts to increase access to preventative and ongoing medical care for members with SUD.
OUD/SUD services across the treatment spectrum including MAT and withdrawal management	• A temporary increase in adjusted 30-day probabilities of readmission to the same or higher level of care was seen during late CY2022 and early CY2023, followed by a return to near-CY2022 levels by the end of CY2024. • The rate of non-fatal overdoses and overdose deaths, including those involving opioids, decreased since the beginning of the 2022–2027 Demonstration. • Annual primary care visits for members with SUD increased 4% from CY2022 to CY2024. • The rate of medical hospitalizations per thousand MCE-enrolled MassHealth members with SUD increased in Q4 CY2022, possibly due to the COVID-19 pandemic, then decreased in Q1 CY2023, remaining relatively stable through Q4 CY2024.	

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Institutions for Mental Diseases (IMDs); Medication Assisted Treatment (MAT); Managed Care Eligible (MCE); Opioid Use Disorder/Substance Use Disorder (OUD/SUD); Primary Care Providers (PCPs); Quarter1 (Q1), Quarter 4 (Q4); Serious Mental Illness/Serious Emotional Disturbance (SMI/SED); Substance Use Disorder (SUD)

Safety Net Care Pool (SNCP)

The Safety Net Care Pool policies include multiple expenditure categories within the Disproportionate Share Hospital-like (DSH-like) Pool, such as Safety Net Provider Payments (SNPP), which link a portion of funding to ACO quality and Total Cost of Care (TCOC) performance, and the Uncompensated Care (UC) Pool, which supports safety net providers serving a high proportion of uninsured and underinsured patients.

Table ES-4: Safety Net Care Pool Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
DSH-like Pool SNPP Payments	- During the first three years of the Demonstration, improvements were seen in areas such as access to care measures and all-cause ED visits through SNCP. - Primary care-sensitive ED visits and behavioral health follow-up after hospitalization remained below expectations. - There appear to be remaining opportunities to align quality improvement incentives between SNHs and ACOs. SNHs utilized SNPP for ongoing operational support yet some SNHs expressed challenges with the timeframe for receiving at-risk payment.	- MassHealth and ACO leadership should strengthen SNH-ACO partnership structures, clarify shared quality goals and measures, streamline reporting, and review the design of at-risk incentives to ensure SNHs have appropriate ownership and accountability to impact performance measures and member outcomes. - State policymakers should consider easy-to-track (but low-burden) reporting for SNCP funds, such as keeping SNCP payments distinct from general revenue, to better evaluate impact while minimizing additional administrative burden on SNHs.
UC Pool	Inflation-adjusted UC costs have increased from baseline to FY2023 overall, and the costs started declining for many SNHs from FY2023 to FY2024. The changes have not accounted for patient case mix and provider rate.	State policymakers should maintain and adapt investment in SNHs, implement policies like automated coverage renewal to minimize gaps, and prioritize financial support for hospitals serving the most vulnerable populations, especially those at highest risk (e.g., rural SNHs and those with high Medicaid/uninsured mix).

Abbreviations: Accountable Care Organization (ACO); Disproportionate Share Hospital (DSH); Emergency Department (ED); Fiscal Year (FY); Safety Net Care Pool (SNCP); Safety Net Hospitals (SNHs); Safety Net Provider Payments (SNPPs); Uncompensated Care (UC)

Workforce Initiatives (WI)

Workforce Initiatives, including Student Loan Repayment Programs (SLRP) for primary care and behavioral health students and providers and the Family Nurse Practitioner

(FNP) Residency Grant Program, address provider shortages, reduce burnout, and improve recruitment and retention in community-based settings serving MassHealth members. The evaluation includes a provider preferences survey designed to assess providers' preferences for incentive options, including higher reimbursement and SLRPs, that may encourage them to work or continue working in community health settings for at least four (or four more) years. These targeted investments build on lessons learned from the 2017-2022 Waiver Demonstration, aiming to strengthen the healthcare workforce and expand access to high-quality, integrated care for MassHealth members.

Table ES-5: Workforce Initiatives Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
Primary Care (PC) and Behavioral Health (BH) SLRPs	The SLRPs increased the number of PC and BH providers retained in community-based settings across all regions of Massachusetts. These programs have also increased the number of providers retained who speak another language in addition to English.	- CMS and MassHealth should continue using SLRPs as a retention strategy, particularly for strengthening diversity, language capacity and access in community-based settings. - MassHealth should ensure early and ongoing coordination with partners, issue clear and timely guidance, and tailor workforce initiative programs to provider preferences.
Family Nurse Practitioner (FNP) Residency Grant Program	The FNP Residency Grant Program has increased the number of FNP residency slots at eight community health centers across four counties in Massachusetts.	MassHealth should continue monitoring whether expanded residency capacity leads to longer-term retention in community-based primary care settings.
Implementation of Workforce Initiative Programs	MassHealth and its vendors successfully launched the three WI programs by building upon previous experience under the DSRIP SWI portfolio from the 2017-2022 Demonstration, as well as similar programs in other states. Implementation challenges included internal alignment on procurement strategy, application design, documentation requirements, and identifying eligible organizations.	MassHealth should ensure early and ongoing coordination with partners, issue clear and timely guidance, and streamline program design and documentation requirements.
Provider Preferences Over Incentives	Across provider types and career stages, Discrete Choice Experiment (DCE) simulation analysis indicated that one-time salary increases were the most influential factor affecting retention.	CMS and MassHealth should prioritize workforce initiatives that combine moderate salary increases with SLRP, adjusting the balance based

Policy Area	Select Interim Findings	Select Implications and Recommendations
	- Although SLRPs had smaller individual effects, DCE simulation analysis indicated that they represent a viable policy option alone or in combination with salary increases. - Based on DCE simulation analysis, enhancing SLRP alone yielded modest reductions in projected attrition at a low incremental cost per provider retained, and reducing loan repayment generosity weakened the overall effectiveness and efficiency of combined compensation strategies.	on budget and targeted retention goals. CMS, MassHealth, and Community Health Centers should use flexible strategies that allow providers to select the package best suited to their needs.

Abbreviations: Behavioral Health (BH); Center for Medicare and Medicaid Services (CMS); Discrete Choice Experiment (DCE); Delivery System Reform Incentive Payment (DSRIP); Family Nurse Practitioner (FNP); Primary Care (PC); Primary Care Provider (PCP); Student Loan Repayment Program (SLRP); Statewide Investments (SWIs); Workforce Initiatives (WI)

Hospital Quality and Equity Initiative (HQEI)

The HQEI policies, including demographic and health-related social needs (HRSN) data, equitable access and quality, and capacity and collaboration are aimed at reducing disparities and improving care for MassHealth members being treated at Massachusetts hospitals. These initiatives use performance-based funding to incentivize hospitals to strengthen equity reporting, promote the delivery of integrated, high-quality care that addresses the full spectrum of members' needs, and foster collaboration across stakeholders and enhance workforce capacity.

Table ES-6: HQEI Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
Demographic and Health-Related Social Needs Data	- Statewide, hospitals achieved a 68% completion rate of self-reported race and ethnicity data in the program's second year. - Hospitals improved reporting of interpreter services provisions and disability accommodations needs. - Administrative burden from duplicate, non-aligned reporting persists. - Technical assistance and standardized templates helped hospitals meet requirements.	- MassHealth should consider simplifying and further aligning quality and equity reporting requirements with other regulatory bodies (e.g., Joint Commission) to support more efficient hospital participation. - Hospitals should refine approaches to RELDSOGI and HRSN data collection to promote patient-centricity. - MassHealth should encourage hospitals to share best practices that promote patient participation in data collection and quality and equity initiatives.

Policy Area	Select Interim Findings	Select Implications and Recommendations
Equitable Access and Quality	- Hospitals modified workflows and strengthened partnerships to identify and address HRSNs. - Care coordination and follow-up after ED/hospitalization remains uneven among racial/ethnic groups. - Hospitals and ACOs partnered to advance quality and equity improvement initiatives, often informed by community and patient input, addressing disparities in focus areas, such as care coordination, diabetes management, and perinatal health.	State and federal policymakers should consider continued investment in and further study of initiatives that integrate physical health and mental health care with social supports to improve outcomes and member experience.
Capacity and Collaboration	- Staff training in cultural competency and disability-competent care is increasing. - Financial resource and time constraints strain workforce capacity and engagement. - Hospitals report stronger quality and equity planning when patients, staff, and community members are actively involved. - Burnout and retention concerns were reported for staff working on quality and equity projects at hospitals.	- MassHealth and participating hospitals should invest in workforce development and efforts to recruit and retain quality and equity-focused staff. - Hospitals should continue to engage stakeholders in quality and equity planning processes.

Abbreviations: Accountable Care Organizations (ACOs); Emergency Department (ED); Hospital Quality and Equity Initiative (HQEI); Health-Related Social Needs (HRSNs); Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity (RELDSOGI)

Health-Related Social Needs (HRSN)

HRSN policies, including the Flexible Services Program (FSP) and Specialized Community Support Programs (CSPs) for homelessness, tenancy preservation, and justice-involved individuals seek to address HRSNs such as food and housing insecurity for MassHealth members. These initiatives promote integration between the healthcare system and community-based organizations.

Table ES-7: HRSN Domain: Select Interim Evaluation Findings, Implications, and Recommendations

Policy Area	Select Interim Findings	Select Implications and Recommendations
HRSN screening and program referrals	- HRSN screening rates were low among ACOs (14%) and MCOs (1%), and moderate (55%) among hospitals. - Referrals were affected by challenges with obtaining needed information to determine if a member met the criteria to receive an HRSN service and navigating HRSN services and programs.	MassHealth should consider providing guidance, technical assistance and streamline screening and referral pathways.

Policy Area	Select Interim Findings	Select Implications and Recommendations
Flexible Services Program	- New enrollments for the FSP increased throughout most of the 2023-2024 period, with declines in the second half of 2024 as ACOs reduced referrals in anticipation of the FSP ending in advance of the new HRSN framework implemented in 2025. - Nutrition and housing services improved food and housing security and self-reported physical and mental health. - CBOs required significant staffing and IT investments to successfully partner with health systems and receive Medicaid payments for their services. - Members reported being generally satisfied with housing and nutrition services. Some found enrollment difficult and wanted more choice in services that meet their dietary and social needs.	- Medicaid agencies should continue to invest in and scale programs that address HRSNs and improve health. - CMS and Medicaid agencies should consider flexibilities to allow participants enrolled prior to a change in criteria for receiving a service to complete their services consistent with the criteria and service plans in place at the time of their enrollment. - MassHealth and other state Medicaid agencies should prioritize making HRSN services convenient and flexible for members (e.g., offering easy enrollment, home delivered food) as these factors may help members benefit more from these programs.
Specialized CSPs	- Enrollment in the three Specialized CSPs grew throughout the Demonstration, serving over 4,000 members - Specialized CSP staff tailored support to member needs and applied their expertise in navigating community resources and health care and social service processes to connect members to services. - Housing stability and employment improved for CSP-JI members.	

Abbreviations: Accountable Care Organizations (ACOs); Community-Based Organization (CBO); Community Support Programs (CSPs); Flexible Service Program (FSP); Health-Related Social Needs (HRSNs); Information Technology (IT); Justice Involvement (JI); Managed Care Organization (MCO)

Conclusions and Next Steps

Findings from this interim evaluation indicate meaningful progress towards Demonstration goals across policy domains, alongside important opportunities for continued growth and refinement. Efforts to improve quality and equity, strengthen care integration, and promote value-based care are well underway, though they continue to evolve within the context of administrative burden, workforce constraints, and areas of system fragmentation. There are encouraging signs of increased investment in workforce development and community-based services, which provide a strong foundation for further improvement. At the same time, differences in access, quality, and outcomes persist for some populations, highlighting areas where focused attention can further enhance the impact of the Demonstration.

Ongoing efforts to streamline data collection and reporting, strengthen and sustain the workforce, and deepen coordination across physical health, behavioral health, and social services are likely to facilitate continued progress towards Demonstration goals. Strong stakeholder engagement and continued flexibility in supporting community-

based and safety net services have contributed to positive momentum toward improvement and will remain important factors moving forward. Improved data infrastructure, new and strengthened cross-sector collaborations, and stakeholder-engaged program design positions healthcare organizations and their community-based partners to build on achievements made early in this Demonstration period and ultimately improve outcomes for MassHealth members.

It is important to recognize that these findings are based on an interim assessment, reflecting a relatively short timeframe and limited data, with a focus on evaluating early implementation progress and describing quantitative trends. The results presented here should be viewed as preliminary, offering insight into implementation and emerging outcomes. Additional data and a longer evaluation period will support a more comprehensive set of analyses, conclusions, and recommendations to be included in the IESR.

1. Overview of the Massachusetts Section 1115 Medicaid Demonstration and Independent Evaluation Design

1.1. General Background Information

1.1.1. Overview of the 2022-2027 1115 Demonstration

Brief History of Massachusetts 1115 Demonstrations

MassHealth, a combination of the Massachusetts Medicaid and Children's Health Insurance Program (CHIP), served over 2.16 million Massachusetts residents as of December 2022. Massachusetts has long used a Section 1115 Demonstration Waiver (Demonstration) to pilot innovative strategies for delivering and financing healthcare for MassHealth members. Since its launch in 1997, the Demonstration has served as a vehicle to expand coverage, encourage better coordination and cost containment through managed care, and support safety net providers, among other innovations. The Demonstration played a key role in the Commonwealth of Massachusetts's 2006 healthcare reform (also known as Chapter 58 of the Acts of 2006), which made coverage more available across the income spectrum through changes to the individual marketplace and Medicaid. In 2012, the Commonwealth passed further legislation (Chapter 224 of the Acts of 2012) to address the high cost of healthcare and the need for better care integration. Chapter 224 set the healthcare cost growth benchmark for the state and created a new independent state agency, the Health Policy Commission, to monitor healthcare cost growth. The legislation also directed MassHealth to implement new payment and delivery models to promote more integrated care.

On Nov. 4, 2016, the Centers for Medicare & Medicaid Services (CMS) approved the sixth extension of the Demonstration for the period of July 1, 2017, through June 30, 2022. In this extension of the Demonstration, CMS approved the Commonwealth's plan to implement significant new components to support a value-based restructuring of MassHealth's healthcare delivery and payment system and a Delivery System Reform Incentive Payment (DSRIP) Program to transition the MassHealth delivery system into accountable care models. The extension's Safety Net Care Pool (SNCP) provisions aligned funding with MassHealth's broader accountable care strategies and expectations, establishing a more sustainable structure for the necessary and ongoing funding support to safety net providers, alongside policies and programs to maintain near-universal coverage. On June 9, 2022, CMS approved a three-month extension of the Demonstration through Sept. 30, 2022.

Key Goals of the 2022-2027 Demonstration

On Sept. 28, 2022, CMS approved Massachusetts's request to extend the Demonstration — entitled "MassHealth" (Project Number 11-W-00030/1 and 21-W00071/1) — for another five years, effective from Oct. 1, 2022, through Dec. 31, 2027, to enable the Commonwealth to achieve the following Demonstration goals:

1. Continue the path of restructuring and reaffirming accountable, value-based care — increasing expectations for how accountable care organizations (ACOs) improve care and trend management and refining the model.
2. Make reforms and investments in primary care, behavioral health (BH), and pediatric care that expand access and move the delivery system away from siloed, fee-for-service (FFS) healthcare.
3. Continue to improve access to quality and equity of care with a focus on initiatives addressing health-related social needs (HRSN) and specific improvement areas relating to health quality and equity, including maternal health care and health care for justice-involved individuals who are living in the community.
4. Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care.
5. Maintain near-universal coverage, including updates to eligibility policies to support coverage and equity.

The 2022-2027 Demonstration extended many longstanding authorities and allows the Commonwealth, through various new and revised waiver and expenditure authorities, to test the efficacy of innovative programs and practices aimed at promoting consistently high-quality, equity-promoting, evidence-based, coordinated, and integrated care.

These programs and practices are designed to address the combined goals of providing medical assistance, addressing HRSNs, and improving the health of the MassHealth population served through the Demonstration. The 2022-2027 Demonstration will also lead to additional populations being served by Medicaid and/or additional services being furnished to Medicaid members. Furthermore, the 2022-2027 Demonstration continues to address the provider workforce shortage by incentivizing providers to work at community-based settings, to maintain safety net providers' sustainability and quality of care, and to provide evidence-based behavioral health (BH) services for certain populations, such as those with serious mental illness (SMI)/serious emotional disturbance (SED), and substance use disorder (SUD)/opioid use disorder (OUD).

Demonstration Domain Descriptions

The Independent Evaluation team worked with MassHealth to crosswalk the CMS-required and recommended evaluation components with the five Demonstration goals to identify seven “policy domains” for the evaluation (see **Table 1-1**). Each policy domain is briefly described as follows, with more details in domain-specific Chapters 2 through 8.

Table 1-1: Crosswalk of Evaluation Design Document (EDD) Policy Domains, MassHealth Goals, CMS Evaluation Components, and Corresponding Special Terms and Conditions (STC)

IEIR Chapter and MassHealth Policy Domains	Demonstration Goal(s)	CMS Required and Recommended Evaluation Components	New, Revised, or Continuing 1115 Policy	Corresponding STC
2. Coverage and Eligibility	5	Waiver of Retroactive Eligibility	Revised	4.2, 4.7, 8.13
2. Coverage and Eligibility	5	Streamlined Eligibility Redetermination	Continuing	4.4
2. Coverage and Eligibility	5	Provisional Coverage for Individuals Who Self Attest to Eligibility*	Continuing	4.7
2. Coverage and Eligibility	3, 5	Continuous Eligibility	New	4.10, 4.12, 16.5.b.iv, 18.10, 18.12, 18.14, 18.15, 19.12, 23.3
2. Coverage and Eligibility	3, 5	Breast and Cervical Cancer Demonstration Program	Continuing	4.8, 5.5
2. Coverage and Eligibility	3, 5	MassHealth CommonHealth	Continuing	5.6
2. Coverage and Eligibility	3, 5	MassHealth Family Assistance	Continuing	5.7
2. Coverage and Eligibility	5	Extended Eligibility for Out-of-State Former Foster Care Youth Residing in Massachusetts*	Continuing	5.9
2. Coverage and Eligibility	1, 5	Premium Assistance for Marketplace and Employment-Sponsored Insurance	Revised	4.12, 5.7, 8.12, 8.13, 10.1.b, 16.5.b.v, 23.3
2. Coverage and Eligibility	5	Beneficiary Cost Sharing (Premiums and Copayments)	Continuing	9.1
2. Coverage and Eligibility	5	Medicare Savings Program Expansion	Revised	5.3.c, 23.3
3. Delivery System Reform	1, 2, 4	Managed Care Delivery System, including: (1) Accountable Care Partnership Plans; Primary Care Accountable Care	Continuing and Revised	8.1-8.13

IEIR Chapter and MassHealth Policy Domains	Demonstration Goal(s)	CMS Required and Recommended Evaluation Components	New, Revised, or Continuing 1115 Policy	Corresponding STC
		Organizations; Managed Care Organizations/Primary Care Clinician Plan (2) Community Partners Program; and (3) the Authority to Allow Primary Care Service Payment Rates to differ from state plan rates for Accountable Care Organization Participating Providers		
4. Behavioral Health	1, 2	Diversions Behavioral Health Services	Continuing and Revised	5.11; 17.6
4. Behavioral Health	1, 2	Opioid Use Disorder /Substance Use Disorder Programs	Continuing and Revised as of August 2022	6.1, 17.6a
4. Behavioral Health	1, 2	Serious Mental Illness/Serious Emotional Disturbance Programs	New as of August 2022	7.1, 17.6b
5. Safety Net Care Pool	4	Safety Net Care Pool	Continuing and Revised	11.1-11.6
6. Workforce Initiatives	2	Workforce Initiatives	Revised	13.1-13.8, 14.5.a, 15.17
7. Hospital Quality and Equity Incentive Program	3	Hospital Quality and Equity Incentive Program	New	14.1-14.23
8. Health-Related Social Needs	1, 3	Provision of Services to Address Health-Related Social Needs, Including Infrastructure Costs	New and Revised	15.1-15.18
8. Health-Related Social Needs	3	Increase the Expenditure Authority for the Health-Related Social Needs Integration Fund	New as of April 2024 Amendment Approval	15.18, 23.3
8. Health-Related Social Needs	3	Temporary Housing Assistance and Related Supports for Pregnant Members and Families	New as of April 2024 Amendment Approval	15.3.a.viii, 15.6.c
8. Health-Related Social Needs	3	Short-Term Post-Hospitalization Housing (also referred to herein as	New as of April 2024 Amendment Approval	15.3.a.vii, 15.4, 15.6.d, 15.6.e

IEIR Chapter and MassHealth Policy Domains	Demonstration Goal(s)	CMS Required and Recommended Evaluation Components	New, Revised, or Continuing 1115 Policy	Corresponding STC
		“Homeless Medical Respite”)		
8. Health-Related Social Needs	3, 5	Provide Reentry MassHealth Covered Services to Individuals in Certain Public Institutions	New as of April 2024 Amendment Approval	22
2. Coverage and Eligibility, and 8. Health-Related Social Needs	1-5	Designated State Health Program	New as of June 2024 Amendment Approval	23

Abbreviations: Center for Medicare and Medicaid Services (CMS); Independent Evaluation Interim Report (IEIR); Special Terms and Conditions (STC)

* These two policies were designated as optional for evaluation and are not included in the evaluation design.

Chapter 2: Coverage and Eligibility

With the 2022-2027 Demonstration, the Commonwealth seeks to continue programs begun under previous Demonstrations as well as implement new ones with the goals of (1) increasing insurance coverage and access; (2) improving health outcomes; and (3) maintaining the sustainability of Medicaid resources. This policy domain includes these key policies/programs:

1. Continuous Eligibility (CE) policies that provide coverage for a longer period (e.g., continued coverage for justice-involved population for 12 months' post-release from correctional settings and continued 24 months' coverage for qualified members experiencing homelessness),
2. Coverage for more populations through existing programs (e.g., Breast and Cervical Cancer Demonstration Program), or new initiatives (e.g., expansion of the Medicare Savings Program for Standard members through increased income limit to 225% of the federal poverty level (FPL), coverage for certain services for incarcerated individuals for up to 90 days prior to release).
3. Premium assistance and cost-sharing policies that include copay subsidies or premium assistance for low-income individuals under certain FPLs, and Marketplace premium and cost-sharing subsidies for ConnectorCare enrollees.
4. Removal of the waiver of retroactive eligibility (RE) policies that allow MassHealth members to have up to three months of RE before their enrollment date.
5. Other policies that serve the same goals (e.g., a streamlined eligibility redetermination policy).

These policies, including amendments, were implemented during the Demonstration period when there was a Public Health Emergency (PHE) period, followed by Medicaid unwinding.

Chapter 3: Delivery System Reform

The Delivery System Reform (DSR) domain of the 2022-2027 Demonstration builds on the 2017-2022 DSRIP program, which was a \$1.8 billion, five-year investment program that provided funding to Accountable Care Organizations (ACOs), Community Partners (CP), and Statewide Investments. The current DSR domain includes new and re-authorized policies and payment reforms related to the ACO Program. These include:

1. The Primary Care Sub-Capitation Program that shifts primary care from a mainly fee-for-service (FFS) payment model to an alternative payment model, while incentivizing practices to make care delivery and population health improvements by increasing payments for more integrated and enhanced primary care services.
2. Enhanced care coordination for high and rising risk members through ACO Care Management programs and the CP Program.
3. Enhanced integration and access to BH services, including among ACOs, the CP Program, and newly created Community Behavioral Health Centers (CBHCs).
4. Advancement of health equity initiatives by ACOs, including through collaborations with hospitals participating in the Hospital Quality and Equity Incentive Program (HQEIP).
5. Incentives for integration between safety net providers and ACOs by tying certain funding for safety net providers to their participation in an ACO.

Chapter 4: Behavioral Health

Behavioral Health (BH), defined here as Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and/or Substance Use Disorder (SUD)/Opioid Use Disorder (OUD), remains a top priority in the 2022-2027 Demonstration period. The BH domain has three main policy areas:

1. Diversionary BH services. Diversionary services are home- and community-based mental health and SUD services provided as a clinically appropriate alternative to, and diversion from, inpatient services. MassHealth ensures access to diversionary services to support an individual's return to the community following a 24-hour acute placement or to maintain functioning in the community.
2. A full range of SUD/OUD treatment services. The Commonwealth expanded access to evidence-based SUD/OUD treatment under previous Demonstrations. Under the 2022-2027 Demonstration, members continue to have access to high-quality services, including residential and inpatient care in Institutions for Mental Diseases (IMD). The Demonstration allows the Commonwealth to use federal Medicaid matching funds for SUD/OUD treatment in IMD settings that would otherwise be excluded.
3. Residential and psychiatric inpatient treatment for individuals with SMI or SED. MassHealth ensures access to a full range of services, including inpatient psychiatric hospitalization, Community Crisis Stabilization (CCS) for adults and youth, and Community-Based Acute Treatment (CBAT) for children and adolescents. IMDs ensure transitions to clinically appropriate levels of community

BH care, physical health care, and social services through transition planning and care coordination.

The BH policy domain includes 12 goals aligned with the three policy areas. Services under the BH domain were implemented in the context of the Massachusetts Roadmap for Behavioral Health Reform (Roadmap).⁴

Chapter 5: Safety Net Care Pool

The Safety Net Care Pool (SNCP) domain includes the continuation of longstanding authorities and programs that provide uncompensated care payments to support safety net providers (SNPs) in the Commonwealth that serve Medicaid members and low-income, uninsured individuals,⁵ while furthering efforts to increase provider accountability. A significant objective of the overall Demonstration is for the SNCP to align funding with MassHealth's accountable care strategies and expectations to create and promote a sustainable structure that allows ongoing funding to continue to support SNPs.⁶ The desired primary outcomes of the SNCP are to ensure the sustainability of various SNPs and to maintain or increase members' ability to access quality accountable care within the Commonwealth.

The SNCP funding and data sources have been adapted to better meet the Commonwealth's needs and include updated payment initiatives aligned with current policy goals.

1. The Disproportionate Share Hospital-like Pool (DSH-like Pool) will offset costs for the underinsured or uninsured. This includes Safety Net Provider Payments (SNPP) tied to ACO quality and total cost of care accountability. From October 2022 to December 2027, 20 safety net hospitals (SNH) are eligible for SNPP. During this period, 20% of the hospitals' SNPP will be risk-based.
2. Uncompensated Care Pool funding can be utilized to support uncompensated care costs in excess of the DSH-like Pool.

Chapter 6: Workforce Initiatives

The 2022-2027 Demonstration continues to make significant investments to support workforce recruitment and retention and to increase the availability of certain health care practitioners to serve MassHealth members and/or uninsured patients by implementing student loan repayment and family nurse practitioner (FNP) residency programs.⁷ In addition to investments in primary care implemented as part of MassHealth's ACO Primary Care Sub-Capitation Program, the Commonwealth is investing in three Workforce Initiative (WI) programs authorized by the Demonstration to

4 Commonwealth of Massachusetts. (2021). Roadmap for Behavioral Health Reform. Mass.gov. <https://www.mass.gov/roadmap-for-behavioral-health-reform>

5 Text imported with modifications from page 2: Centers for Medicare & Medicaid Services. (2022, September 28). *CMS Guidance, Approval Letter, Waiver Authority, Expenditure Authority, Special Terms and Conditions*. Mass.gov. <https://www.mass.gov/doc/masshealth-extension-approval/download>

6 Centers for Medicare & Medicaid Services. (2025). *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services, STC Section 2; [1115 Waiver Demonstration Special Terms and Conditions](#)

7 Health & Social Services. *MassHealth Section 1115 Demonstration Waiver*, Commonwealth of Massachusetts (2021), MA 1115 extension request updated (p. 7), <https://www.mass.gov/doc/1115-waiver-extension-request/download>

address shortages of qualified providers serving MassHealth members and/or uninsured patients.

1. Primary Care Student Loan Repayment Program (SLRP). Offers financial incentives for the primary care workforce. These incentives include up to \$100,000 for primary care physicians and up to \$50,000 for advanced practice registered nurses, pediatric clinical nurse specialists, nurse practitioners (NP), and physician assistants per practitioner, in exchange for a four-year full-time service obligation in a community-based setting serving at least 40% MassHealth and/or uninsured members.
2. BH SLRP. Offers psychiatrists and NPs with prescribing privileges up to \$300,000 per practitioner, and up to \$50,000 per practitioner for licensed BH clinicians or master's-prepared clinicians intending to obtain licensure within one year of the award, in exchange for a four-year full-time service obligation in a community-based setting serving at least 40% MassHealth and/or uninsured patients.
3. Family Nurse Practitioner (FNP) Residency Grant. This program provides up to \$131,500 per residency slot to allow community health centers, whose patient populations are made up of at least 40% MassHealth members, to support residency slots during the Demonstration period.

[Chapter 7: Hospital Quality and Equity Incentive Program](#)

The Hospital Quality and Equity Incentive Program (HQEIP) establishes a performance-based funding model to incentivize hospitals to advance healthcare quality and equity. CMS approved funding to improve the quality of care, reduce disparities, and address the needs of both Medicaid members and the uninsured. The HQEIP ties funding to demonstrated progress across three domains:

1. Improving completeness of beneficiary-reported demographic and HRSN data.
2. Enhancing equitable access and quality through reporting, stratification, intervention, and performance improvement on priority measures.
3. Strengthening hospital capacity and collaboration, including cultural competency, equity accreditation standards, and partnerships with ACOs. Hospitals are expected to build organizational and workforce capacity to deliver more equitable and culturally responsive care.

Participating hospitals are required to achieve annual milestones. Over time, performance assessments will shift from reporting and intervention development to measurable improvements in quality and equity outcomes. The goal is to strengthen data-driven disparity reduction, ensure equitable access to high-quality care, and build sustainable hospital capacity to advance health equity statewide.

[Chapter 8: Health-Related Social Needs \(HRSN\)](#)

Building on initiatives established during the previous Demonstration, MassHealth continues to refine and expand a portfolio of HRSN programs designed to address housing instability, food insecurity, justice involvement, and other social determinants

that adversely affect health outcomes under the 2022-2027 Demonstration. These initiatives complement MassHealth's broader delivery system reforms by integrating community-based supports into that system, with the objectives of advancing health equity, reducing avoidable utilization, and promoting stable community tenure. These programs include:

1. The Flexible Services Program (FSP) provides access to tenancy preservation and nutrition-sustaining supports to certain eligible MassHealth members. This program was in place from Jan. 1, 2020, to Dec. 31, 2024.
2. HRSN Services are divided into HRSN Required Services, including various Specialized Community Support Program (CSP) services, and HRSN Supplemental Services (launched on Jan. 1, 2025, following the phase-out of the FSP), which offer supplemental nutrition and housing services, each targeting specific populations and needs.
3. Short-Term Post-Hospitalization Housing (STPHH) (also referred to as the "Homeless Medical Respite Program") was initiated in January 2025 and provides eligible MassHealth members with admission to temporary settings where they can receive medically necessary pre-colonoscopy or post-hospitalization medical respite services.
4. The Reentry Demonstration Initiative provides certain pre-release Medicaid services for up to 90 days prior to the expected date of release from incarceration to qualifying MassHealth members, as well as individuals who would be eligible for CHIP if not for their incarceration status. This program was approved by CMS in an amendment to MassHealth's 1115 waiver and is expected to launch in phases, with the first phase set to launch in the second half of 2026.
5. Temporary Housing Assistance for Pregnant Members and Families provides costs for shelter, as well as supportive services to address members' health related social needs for pregnant individuals and families with children who are participating in the Massachusetts Emergency Assistance Family Shelter Program who are Medicaid-eligible and meet clinical needs-based criteria.

The HRSN Integration Fund supported community-based organizations in building their capacity to deliver the HRSN programs described and to transition to the new HRSN framework. Funding was used for technical assistance, workforce development, technology upgrades, and operational improvements to enable effective service delivery and participation in ACOs. The fund's original expenditure authority was \$8 million, which was later amended in 2024 to increase total HRSN infrastructure funding to \$25 million.

These programs reinforce MassHealth's commitment to promoting equity, preventing avoidable hospital use, and supporting community-based health and social interventions.

1.1.2. Waiver Amendments and Implications for the Evaluation

Since the Demonstration was approved on Sept. 28, 2022, CMS has approved three amendments. Certain components of the amendments are evaluated within the Independent Evaluation Interim Report (IEIR), whereas others will be evaluated exclusively in the Independent Evaluation Summative Report (IESR).

- Amendment approved April 2024: This amendment added STPHH under the HRSN authority; expanded the expenditure authority for the HRSN Integration Fund by an additional \$17 million; and extended Marketplace subsidies up to 500% of the FPL, in accordance with a state law change. The amendment also expanded Medicare cost-sharing assistance, removed the waiver of RE, and broadened CE to justice involved and additional homeless populations. Finally, the amendment authorized the Reentry Demonstration Initiative, through which MassHealth will offer limited coverage for a targeted set of services for incarcerated individuals up to 90 days prior to release.
- Amendment approved June 2024: This amendment provided expenditure authority for Designated State Health Programs to support new demonstration initiatives.
- Amendment approved December 2024: This amendment permitted the state to waive the otherwise mandatory state plan coverage requirements of a set of pre-release and post-release services for eligible juveniles and targeted low-income children under the Consolidated Appropriations Act of 2023 to permit the Commonwealth instead to cover at least the same services for the same beneficiaries under its 1115 Demonstration.

1.1.3. Environmental Implications for Implementation and Evaluation

COVID-19 Considerations

Impact on the Demonstration

With support from the federal government, the Commonwealth implemented multiple time-limited and extended policy and programmatic changes to promote continued access to health care services and health insurance coverage during the height of the COVID-19 pandemic (i.e., primarily CYs 2020 and 2021). Medicaid members across the country, including MassHealth members, maintained their benefits, and eligibility redeterminations were paused until the end of the federal COVID-19 PHE in May 2023 to facilitate continued coverage. Between April 2020 and January 2022, the Commonwealth implemented six 1915(c) Appendix K Emergency Preparedness Response and COVID-19 Addendums that provided flexibility in the operation of Home- and Community-Based Services waivers, primarily to increase funding and reimbursement for providers. Several Disaster Relief State Plan Amendments were also implemented to facilitate policies related to service rate increases, supplemental payments, payment method revisions, and access to additional resources. In addition, MassHealth received a number of Section 1135 and 1902(e)(14) waivers which provided flexibility to support members and providers during the PHE. A complete

description of pandemic-era policy changes to Demonstration programs can be found in MassHealth's Section 1115 annual report for Demonstration Year 2023.⁸

Impact on the 2022-2027 IEIR

There are two prominent impacts of the COVID-19 pandemic and associated policy responses on the 2022-2027 IEIR. First, in consideration of the timing of MassHealth's temporary COVID-19 policies and the timing of disruptions in health care delivery, we have restricted our IEIR study period to 2022 (baseline) through 2023-2024 (implementation), therein avoiding the concentrated COVID-19 disruptions during 2020-2021. This decision was further supported by the findings from our IESR for the 2017-2022 Demonstration. However, in light of delayed care during 2020-2021, we expect compensatory care-seeking behavior to still be evident during our IEIR study period, and we also recognize that certain care delivery patterns (e.g., widespread adoption of telemedicine) may have endured beyond the pandemic period. Second, the unwinding of the PHE began in April 2023 and continued through May 2024 in Massachusetts. During this time, MassHealth redetermined the eligibility of all of its members and through this process, the number of enrolled MassHealth members was reduced by approximately 363,000 (16%). This phenomenon is described in greater detail with accompanying analyses describing MassHealth and state-wide insurance coverage trends during our study period in [Chapter 2 \(Coverage and Eligibility\)](#). The PHE redeterminations may affect analyses in other domains; individuals with shorter enrollment periods are excluded from analyses requiring continuous enrollment longer than their coverage period. This impacts eligibility in 2023-2024. As a result, the 2022 baseline period contains many members who were subsequently determined to be ineligible for MassHealth (or had insufficient information for eligibility determination) during the PHE unwinding.

Massachusetts Healthcare System and Policy Changes

Roadmap for Behavioral Health Reform

In January 2023, the Commonwealth launched the Roadmap, which includes CBHCs, the BH Help Line — a 24-hour central access line and resource available via phone or text — BH Urgent Care Clinics, and other services designed to make outpatient, urgent, and crisis services more accessible for all residents, including MassHealth members, with BH conditions. In addition, the Roadmap also includes investment in a BH training clearinghouse to support use of evidence-based practices in BH. The Roadmap provides significant investments to: 1) increase front door access to the appropriate BH treatment when and where people need it; 2) significantly strengthen the delivery of outpatient, urgent and crisis services; 3) improve care for members with chronic BH conditions; and 4) improve the integration of BH care with primary care. The Roadmap intersects with the BH and DSR components of the 2022-2027 Demonstration in that it aims to increase access to all levels of BH services covered in the Demonstration while not being part of the Demonstration. Increased access to outpatient and diversionary

⁸ "MA 1115 Demonstration Q4 and Annual Report FY20 - Tables Revised.pdf | Mass.gov." *Mass.gov*, 2021, www.mass.gov/doc/section-1115-demonstration-waiver-annual-report-fy20-0/

services, as addressed in the Roadmap, may influence outcomes for accessibility of treatment, BH integration with primary care, and use of higher levels of treatment.

Provider Network Change and Hospital Closure

The national for-profit organization Steward Health Care, which owned several Massachusetts hospitals and operated a MassHealth ACO, faced significant financial distress during the second year of our IEIR study period (2024). As a result, Steward's MassHealth ACO was purchased by Rural Healthcare Group, LLC, and Steward's ACO operations transitioned on Oct. 30, 2024 to Revere Health Choice, a Rural Healthcare Group-affiliated entity, without major changes to its affiliated primary care network.⁹ Like Steward, Revere Health Choice ACO is a Primary Care ACO, meaning enrollees can access the full MassHealth provider network. Implications of the transition of the Steward MassHealth ACO to Revere Health Choice for the evaluation are expected to be modest.

Two of Steward's hospitals, Carney Hospital and Nashoba Valley Medical Center, closed in August 2024.¹⁰ Five of Steward's hospitals were sold and transitioned to new operators in October 2024, including: St. Elizabeth's Medical Center in Brighton and Good Samaritan Medical Center in Brockton, which are now part of Boston Medical Center; Saint Anne's Hospital in Fall River and Morton Hospital in Taunton, which are now part of Rhode Island-based Brown University Health (formerly Lifespan); and Holy Family Hospital (with campuses in Methuen and Haverhill), which has been integrated into Lawrence General Hospital. The closure of Carney Hospital and Nashoba Valley Medical Center may have had localized effects on access to a community hospital level of care, while the transitioning of ownership of the five other Steward hospitals may have affected their participation in the HQEI Program as described further in [Chapter 7](#). An eighth hospital, Norwood Hospital, had not been operating since 2020 and the hospital communicated to the state the intention to close permanently in October 2024.

^{11,12,13}

Federal Healthcare Policy Changes During the Interim Evaluation Period

The Inflation Reduction Act (IRA) was passed in August 2022, with implementation occurring from 2023-2026. Healthcare provisions of the IRA targeted the Medicare-enrolled population and will not directly affect Medicaid members. However, price negotiations and penalties for price increases that outpace inflation under the IRA will affect revenue for pharmaceutical manufacturers and are expected to affect manufacturer pricing practices, which may indirectly affect spending on pharmaceuticals by Medicaid programs.

⁹ "Member Support." *Reverehealthchoice.com*, 2024, www.reverehealthchoice.com/massachusetts/support

¹⁰ Massachusetts Executive Office of Health & Human Services. (2025). Steward health care transitions. <https://www.mass.gov/steward-health-care-transitions>

¹¹ "Member Support." *Reverehealthchoice.com*, 2024, www.reverehealthchoice.com/massachusetts/support

¹² Massachusetts Executive Office of Health & Human Services. (2025). Steward health care transitions. <https://www.mass.gov/steward-health-care-transitions>

¹³ Massachusetts Executive Office of Health & Human Services. (2025). Steward health care transition to the new operators. <https://www.mass.gov/info-details/steward-health-care-transition-to-the-new-operators?>

1.2. Overview of the Independent Evaluation Design

1.2.1. Evaluation Introduction

Selection of Independent Evaluator

Massachusetts has selected the UMass Chan Medical School (UMass Chan) as the Independent Evaluator (IE) for the 2022-2027 Demonstration. UMass Chan served as the IE of MassHealth's 2017-2022 1115 Demonstration and has supported MassHealth with evaluating coverage & eligibility (C&E) policies, delivery system reforms, and other related policies and programs, with findings disseminated widely at public meetings and professional conferences, and in journals. A summary of linkages between recommendations from the 2017-2022 IESR and policies that have continued during the 2022-2027 Demonstration is provided in **Appendix A-1**. The 2022-2027 Independent Evaluation will also be informed by review from external reviewers comprising nationally recognized experts in Medicaid systems transformation, program evaluation, and health services research.

Evaluation Design Development and Approval

The development of our EDD was guided by the Demonstration's STCs, and subsequent communications and guidance from CMS.^{14,15} The EDD received CMS approval on Jan. 18, 2024, for the extension of MassHealth 1115 Medicaid Demonstration program/policies originally approved on Sept. 28, 2022.¹⁶ Subsequently, the EDD was revised to account for the approved amendments as described in **Section 1.1.2** and approved by CMS March 10, 2026.

Logic Model Framework

The entire evaluation of the 2022-2027 Demonstration is guided by an evaluation logic model that illustrates the relationships between policy inputs, implementation activities, outputs, and outcomes for a specific policy domain. We recognize that seven policy domains and their overlapping components are designed to work together to achieve the overall goals of the Demonstration. As illustrated in **Table 1-1**, for example, CE, a component of the Coverage and Eligibility policy domain ([Chapter 2, Coverage and Eligibility](#)), is also key to the success of the Demonstration goals of improving access to high-quality care and improving health equity. Likewise, the DSR policies ([Chapter 3, Delivery System Reform](#)), most notably the MassHealth ACOs, are directly linked to accountability for SNHs ([Chapter 5, Safety Net Care Pool](#)) and all acute care hospitals participating in the HQEIP ([Chapter 7, Hospital Quality and Equity Incentive](#)

¹⁴ Centers for Medicare & Medicaid Services. (2022, September 28). Technical Assistance on MassHealth Section 1115 Demonstration (1115 MassHealth demonstration "waiver"). 1115 MassHealth Demonstration ("Waiver") | Mass.gov and <https://www.medicare.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>

¹⁵ Centers for Medicare & Medicaid Services. (2020). 1115 demonstration state monitoring and evaluation resources. <https://www.medicare.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>

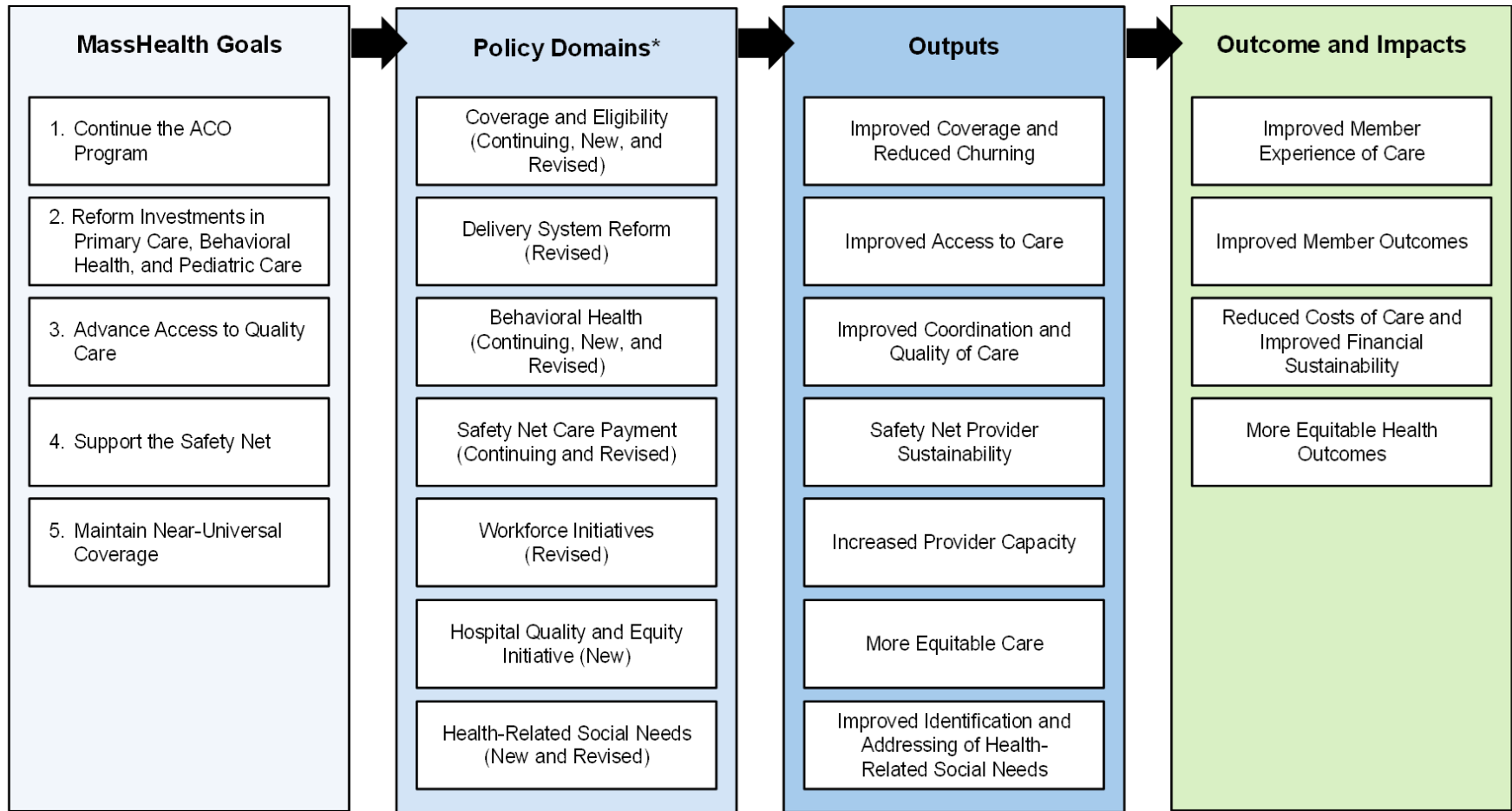
¹⁶ UMass Chan Medical School. (2023 December). Independent Evaluation Design Document. <https://www.mass.gov/doc/attachment-s-evaluation-design-document-approved-11824-0/download>

Program). The ACOs have a lead role in implementing HRSN programs ([Chapter 8, Health-Related Social Needs](#)) and are subject to the same HRSN screening and data reporting requirements as hospitals participating in the HQEIP. Policies to promote recruitment and retention of a robust community-based primary care and BH workforce ([Chapter 6, Workforce Initiatives](#)) supports community-based organizations (CBOs) (many of which are contracted with the ACOs) responsible for delivering integrated and accountable care across the continuum. The alignment and joint effects of these policies across domains will be critical to the success of the Demonstration goals related to expanding access to primary care, BH ([Chapter 4, Behavioral Health](#)), and pediatric services while supporting the Commonwealth's safety net and continuing to move the system away from a siloed FFS model.

In **Figure 1-1**, the overarching Demonstration Logic Model summarizes the process by which the Demonstration goals informed several policy initiatives designed to jointly affect a common set of outputs and outcomes.

Figure 1-1: Demonstration Logic Model

Connecting 1115 Medicaid Demonstration Waiver Policies to Demonstration Goals and Desired Outcomes



*Parentheticals indicate whether policies in each domain are continuing unchanged, revised and continuing, and/or are new since the prior 2017-2022 Demonstration period.

Research Questions and Hypotheses

Commensurate with the multidimensional Demonstration policies and programs described above, we have developed 63 research questions (RQs) and corresponding hypotheses for the entire Demonstration evaluation. Each policy domain has its respective RQs and the detailed RQ and hypothesis for each is included in the specific domain chapter. **Table 1-2** below summarizes the types of policy/program implementation activities, outputs, and outcomes examined for each domain's RQs, as guided by the logic model. While not all outputs and outcomes are applicable to every policy domain, the list below includes common outputs and outcomes across domains that collectively contribute to answering the RQs:

- Actions taken to implement policy initiatives and lessons learned (e.g., administrative process for streamlining enrollment and eligibility, and integration of care across delivery systems)
- Program/policy outputs (e.g., number of members enrolled in respective C&E policy or program; increased volume and diversity of providers in community-based clinical setting, and prevalence of HRSN screening)
- Quality of services (e.g., level of care coordination, and continuity of follow-up care post inpatient psychiatric hospital discharges)
- Member experiences (e.g., access to care, equity of care, understanding of changes in eligibility policies, and access to HRSN services)
- Member healthcare utilization (e.g., emergency department (ED) use, hospital readmission, and primary care visits)
- Financial sustainability (e.g., total cost of care (TCOC), cost effectiveness, and uncompensated care)

Table 1-2: Summary of Policy Domains, RQs, and Types of Outcomes/Outcomes

Policy Domain	# of RQs	Types of Key Outputs/Outcomes Examined by Domain-Specific RQs
C&E	7	Medicaid enrollment and enrollment continuity; Demonstration program enrollment (e.g., number of members in ConnectorCare, number of members receiving assistance with Medicare costs); level of medical debt; administrative process for enrollment & eligibility determination; members' healthcare utilization; member experiences with policies/programs
DSR	11	Change in quality, equity, and integrated care; volume and mix of clinical service delivery and changes; access to care; members outcomes and experiences; Medicaid TCOC
BH	15	Access to care; use of BH services (e.g., preventable acute psychiatric readmission; SUD services; ED use and Length of Stay); continuity of care post inpatient discharges; member outcomes (e.g., overdose death); BH TCOC
SNCP	3	Use of health care services from SNHs; quality of services; member experiences; effectiveness of supplemental payments to address uncompensated care

Policy Domain	# of RQs	Types of Key Outputs/Outcomes Examined by Domain-Specific RQs
WI	6	Implementation actions and lessons learned; volume and diversity of provider workforce in community-based settings; member access and experiences with care; provider experiences; member healthcare utilization; and sustainability
HQEIP	6	Actions taken for program implementation; completeness of member self-reported demographic and HRSN data; disparities in quality and access to care; member experiences and outcomes; sustainability
HRSN	15	Prevalence of HRSN screening; HRSN needs; member experiences receiving HRSN-related services; actions taken for HRSN initiative implementation; program eligibility identification and referral; program service utilization; healthcare utilization; member outcomes (including physical and mental); effectiveness of HRSN Integration Fund infrastructure; impact on spending on local investments; service costs

Abbreviations: Behavioral Health (BH); Coverage and Eligibility (C&E); Delivery System Reform (DSR); Emergency Department (ED); Hospital Quality and Equity Incentive Program (HQEIP); Health Related Social Needs (HRSN); Research Questions (RQs); Safety Net Care Pool (SNCP); Safety Net Hospitals (SNHs); Substance Use Disorder (SUD); Total Cost of Care (TCOC)

Not all RQs in the EDD were addressed in this IEIR, as data collection and analysis timelines were influenced by factors such as data availability and completeness, phased program implementation and maturation, and the timing of relevant reporting periods and evaluation activities. The RQs being addressed, whether fully or partially, in this report are outlined within each domain chapter, while a list of all RQs and corresponding hypotheses, as proposed in the EDD, is provided in **Appendix A-2**. Implementation actions and lessons are documented through stakeholder interviews, surveys, and program data. For quantitative output/outcome measures, measure descriptions (i.e., measure numerator, denominator, data source, and exclusion criteria) are provided in the relevant chapter appendices, with links to appendices included where measure outputs are presented.

1.2.2. Overview of Methodology

Population

This mixed-methods evaluation incorporated data obtained pertaining to various study populations of interest across policy domains for both quantitative and qualitative analyses to be included in the IEIR.

The study populations providing data for quantitative analyses included:

- Massachusetts residents (C&E)
- Primary care providers (DSR & WI)
- Primary care practice site administrators and practice site staff (DSR)
- MassHealth members receiving/eligible for various services, participating in programs, and with a range of diagnoses as relevant (all policy domains)
- Medical students/residents, including those trained for BH care (WI)
- Comparison groups as appropriate for certain policies and programs

The study populations providing data for qualitative analysis include:

- ACO/Managed Care Organization (MCO) leadership and staff (DSR, HQEIP, HRSN)
- CP leadership and staff (DSR)
- Hospital leadership and staff (DSR, HQEIP, SNCP)
- MassHealth staff (C&E, DSR, HQEIP, HRSN, SNCP, WI)
- MassHealth members receiving/eligible for various services, participating in programs, and with a range of diagnoses as relevant (BH, C&E, DSR, HQEIP, HRSN, SNCP)
- CBO leadership and staff (HRSN)
- BH service providers: Diversionary, ED and IMD providers (BH)

Specific descriptions of each study population and their relevance to the policy domain and analyses are available in the subsequent chapters.

Evaluation Approach

Our evaluation design used a mixed-methods approach to examine program implementation, utilization, outcomes, and impacts across the policy domains (see the CMS-approved EDD for all planned analyses to be included in the IEIR or IESR). For the IEIR, quantitative and qualitative data were integrated across the time period evaluated for the IEIR and domains to address RQs and hypotheses. The IEIR focused on data from the period encompassing 2022 (baseline), 2023 (first year of the Demonstration), and 2024 (second year of the Demonstration), with some primary data collection extending into 2025. This section focuses on methods used for the IEIR, for which we sought to thoroughly evaluate implementation and to describe preliminary trends during the early years of the Demonstration.

Quantitative

The Independent Evaluation team leveraged a range of quantitative data sources to examine program implementation, utilization, and outcomes. Analyses for the IEIR were primarily descriptive and model-based to characterize the population and early trends in measures. Subgroup analyses explored variations by demographic and clinical characteristics.

Data Sources

Multiple quantitative data sources were analyzed for the IEIR. Core administrative data from the Medicaid Management Information System (MMIS) and the MassHealth Data Warehouse provided comprehensive information on member eligibility, enrollment, claims, encounters, and provider characteristics, enabling analyses of service utilization, costs, and care delivery patterns. These data were supplemented with member-level programmatic and quality data, as well as program-level metrics, such as staffing, resource allocation, and service delivery characteristics to assess care processes and outcomes for key initiatives. Initiatives included, but were not limited to, workforce development, supports, housing and nutrition programs, and hospital quality and equity efforts. Publicly available and other external data sources such as the American Community Survey (ACS), uncompensated care reports, state mortality and substance use data, and the Healthcare Cost and Utilization Project provided population-level

and contextual information. Survey data collected at either individual or aggregate level from MassHealth members, providers, and other stakeholders captured experiences, perceptions, and outcomes that enhanced understanding of program implementation and complemented findings from administrative and program data. Quantitative data, such as member rosters, were used to capture enrollment in specific programs. The specific data sources used to address each RQ, and hypothesis are described within the policy domain chapters.

Descriptive Analyses

Demographic, clinical, and social characteristics of the population of interest for each analysis and relevant subpopulations were summarized by data source and Calendar Year (CY). Summaries included distributions of key demographic variables, clinical indicators, healthcare utilization, care costs, and social factors to provide a thorough description of the populations under study. Descriptive analyses included frequencies and percentages for categorical variables and measures of central tendency and dispersion (e.g., means, medians, standard deviations, interquartile ranges) for continuous variables. Where data availability permitted, process and outcome measures were calculated and tracked for each population across the IEIR period, and uncompensated care cost reports were summarized annually and presented as inflation-adjusted trends. Given the exploratory nature of descriptive analyses and the large sample size for most populations analyzed, we highlighted meaningful differences between groups or within groups across years based on absolute and standardized differences in place of p-values. In some cases, regression-adjusted means, controlling for differences in population or system characteristics, were reported to estimate Demonstration effects while accounting for potential confounding.

Survey Analyses

Data collected from MassHealth's Member Experience Survey administered by MassHealth's survey vendor for quality and accountability purposes, and from the Practice Site Administrator and WI Provider Surveys, both developed and administered by the IE for the purposes of the evaluation, were analyzed descriptively to summarize respondent characteristics and key survey measures. Weighted frequencies and percentages were calculated for categorical variables, and weighted means, medians, and associated measures of dispersion were reported for continuous variables. For the Member Experience Survey, to estimate changes in scores between 2022 and 2023, generalized linear models were fit which adjusted for member characteristics that differed significantly between respondents in each year. Sampling weights and non-response weights were applied, where available, to account for the differential probabilities of selection and nonresponse, ensuring the estimates were representative of the target populations. Winsorization¹⁷ was performed when extreme non-response weights were identified. Confidence intervals and standard errors were calculated, as appropriate, to quantify statistical precision and sampling variability of the estimates. Analyses assessed nonresponse and missing data patterns, and weighting adjustments were used to reduce potential for bias. Results were stratified, where relevant, to contextualize findings within the broader Independent Evaluation framework. These analyses provided a detailed understanding of select

¹⁷ Riffenburgh, R.H. (2012). Chapter 28 – Methods You Might Meet, But Not Every Day. *Statistics in Medicine (3rd Edition)*. <https://doi.org/10.1016/B978-0-12-384864-2.00028-7>

stakeholder's experiences and perceptions during the early Demonstration period. For the WI Provider Survey, discrete choice experiment techniques were used to elicit providers' preferences for a range of monetary and non-monetary incentives associated with working in community-based clinical settings. The analysis estimated the utilities and magnitudes of these incentives, as well as their relative importance to providers.

Observed Versus Expected Comparisons

Observed values of measures were compared to adjusted estimates of expected values within calendar years. Expected values were generated from models developed using baseline data and applied to Independent Evaluation period data, predicting outcomes based on member characteristics. Observed-to-expected (O:E) ratios provided benchmarks for assessing performance. Values above one indicated better than expected outcomes when higher values of the variable were desirable, and values below one indicated better than expected outcomes when lower values were desirable.

Throughout the report, we use color shading in tables to highlight O:E ratio changes of greater than or equal to $\pm 5\%$, to distinguish changes not explained by the modeled population characteristics. O:E ratio changes of greater than or equal to $\pm 15\%$ are indicated with darker shading to call attention to larger changes in performance relative to baseline.

Quasi-Experimental Methods

To estimate counterfactual outcomes and support causal inference, analyses accounted for differences in population and system characteristics and unrelated temporal trends across the Independent Evaluation period. Methods included propensity score approaches and weighting techniques to address confounding, and difference-in-difference analyses to adjust for secular trends. In cases where adequate data were available, interrupted time series with adjustments were employed to estimate the effects of Demonstration initiatives and programs, accounting for pre-existing trends and shifts in outcome levels over time to control for underlying temporal patterns. Mixed-effects models were applied according to outcome type, incorporating random effects to account for clustering (e.g., by ACO) and repeated measurements. Bootstrap methods were used to calculate confidence intervals that reflected the study design. Time-varying factors were incorporated where relevant, and sensitivity analyses evaluated the robustness of results under alternative model assumptions.

Qualitative

Throughout the Demonstration, qualitative data for all domains are collected over two waves, referred to as Wave 1 and Wave 2. Wave 1 analysis results are included in this IEIR. Qualitative data collected included the following elements, depending on interview type: 1) review and extraction of pertinent information from various documents (i.e., document review), 2) key informant interviews (KIIs) of individuals and groups with demographic characteristics collected from interviewees, and 3) open-ended written survey responses. Data collection processes and procedures for each type of qualitative data, as well as the overall analytic process, are described below.

Document Review

Hundreds of documents are provided to the IE throughout the Demonstration to provide context and key information regarding the design and implementation of programs for the various policy domains. Examples include ACO contracts for the DSR domain, Health Equity Strategic Plans for the HQEIP domain, and student loan documentation for the WI domain.

A standardized process was used for document review whereby a template was developed, reviewed, revised and finalized, and then used to extract relevant data for each document type. An initial template was first developed by staff assigned to the relevant policy domain and anchored in the targeted RQs and hypotheses of interest.

The template was reviewed by the full team and revised as needed until consensus was reached on the elements necessary for extraction. Document reviews were then conducted independently by team members, and data were extracted and entered in an online database (Qualtrics).¹⁸ The team met regularly throughout the process to ensure shared understanding and discuss emerging findings.

The document review process was ongoing throughout Wave 1, as new documents were made available regularly. Information extracted from documents was stored in the secure online database and downloaded as needed. For example, relevant document review data were downloaded and used to prepare for KIIs with stakeholders.

Key Informant Interviews

- Interview Guides: Semi-structured interview guides for KIIs were developed and finalized for each interview group through an iterative process. Initial interview guides were developed by staff assigned to relevant policy domains and anchored to the RQs and hypotheses of interest. Interview guides were then reviewed by the full team and revised as needed until consensus is reached. MassHealth and other relevant stakeholders (e.g., subject matter experts (SMEs)) were engaged as applicable, and guides were revised to incorporate their feedback. Interview guides were finalized prior to all interviews and sent to most interviewees in advance so they could prepare for the interview and gather relevant team members.
- Recruitment for KIIs: MassHealth provided lists of key contacts for all organizations including ACOs, CPs, MCOs, hospitals, and CBOs. Outreach was made to key contacts to inform them of the request for the upcoming interviews and arrange scheduling. For MassHealth members, organizations participating in the Demonstration assisted with nominating members according to the criteria provided. Interested members completed a nomination form which included questions about what types of services they were receiving and programs they were enrolled in. Nominated members who meet the desired criteria were then contacted to schedule interviews. MassHealth Members who participate received a \$50 gift card. Recruitment materials were translated into several languages, including Albanian, Arabic, Chinese, Haitian Creole, Portuguese, and Spanish, for those members for whom

¹⁸ Qualtrics. (2025). *Qualtrics XM Platform* [Windows]. Qualtrics. <https://www.qualtrics.com>

English was not their primary language. Key contacts and members were contacted up to three times requesting their participation in an interview.

- **Interview Procedures:** In Wave 1, the vast majority of individual or group interviews were conducted virtually, using Zoom and scheduled at the key informants' convenience. Due to technological limitations, MassHealth member interviews were sometimes conducted over the phone. Interviews ranged from 30- 90 minutes in length depending on the number of interview questions, size of group, and informants' availability. For MassHealth members who were non-English speaking, a live interpreter was provided. At least two IE staff members participated in all interviews, one as the lead interviewer asking questions, and one as the back-up interviewer/notetaker who also managed the logistics of the interview (e.g., recording of the session, managing the chat). All interviews were recorded and transcribed by a qualified vendor. Names and personal identifiers were redacted from transcripts. As interviews were conducted, the team met regularly throughout the process to share their overall impressions, address any challenges, and discuss emerging findings.
- **Demographic Characteristics:** To accurately describe the characteristics of those in our sample, informants were asked to complete a demographic survey. The survey included characteristics such as age, race/ethnicity, level of education, professional role, and years in practice/with organization. Specific characteristics were included in the survey as relevant to the informant type. Demographic data was collected anonymously, using no personal identifiers, through online software (Qualtrics). Informants were reminded up to three times to complete the survey. Demographic data was downloaded from Qualtrics and uploaded to a statistical package for descriptive analysis.

Open-ended Written Responses

In lieu of interviews with MassHealth SMEs, a survey was conducted in Wave 1 to obtain open-ended responses from MassHealth SMEs from the various policy domains. Initial survey questions were developed by UMass Chan staff assigned to relevant policy domains and anchored to the RQs and hypotheses of interest. The survey was then reviewed and iterated upon by the full UMass Chan Evaluation team. MassHealth and key stakeholders were also engaged in developing the survey, and their feedback was incorporated. MassHealth identified the appropriate SMEs to complete the survey, which was sent to MassHealth via email and completed independently by SMEs at their convenience. SMEs were also asked to complete the demographic survey. Once data collection was complete, the UMass Chan team systematically reviewed the open-ended responses and discussed overall impressions and emerging findings.

Analytic Process

Interview transcripts were reviewed for quality control by team members and uploaded to Dedoose¹⁹ for analysis. Using a framework approach²⁰ to thematic analysis, the team developed an initial set of codes for each set of KII data and open-ended written responses based on the interview guide, relevant domain key topics and themes, RQs, and hypotheses of interest. The team met several times to review the initial codebook, discuss preferred application of codes,

¹⁹ Dedoose Version 9.0.107, cloud application for managing, analyzing, and presenting qualitative and mixed method research data (2023). Los Angeles, CA: SocioCultural Research Consultants, LLC. <https://www.dedoose.com>

²⁰ Gale, N.K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodology*, 13(117). <http://dx.doi.org/10.1186/1471-2288-13-117>

and arrive at consensus. The codebook was then uploaded to Dedoose. The team met to conduct group coding initially, talk through the application of codes to excerpts of text, and ensure shared understanding. The codebook was iterated upon as needed. The team then worked in pairs to continue coding and brought questions and updates to the full team, as needed. Once consistency was reached in the application of codes, independent coding was conducted until all transcripts for each interview type are coded. For some interviews, inductive inference²¹ was used to interpret the complexities of participant experiences. Inter-coder reliability was monitored with each set of interviews, analyzed by calculating kappa coefficients using Dedoose software. When coding was complete, the team generated excerpt reports to review the code applications and discuss memos of interest. Team members then paired off to write summary memos anchored in the relevant RQs and hypotheses. Drafted memos were reviewed by a second pair of team members to ensure accuracy and consistency of findings. Sets of memos were written for each interview type to capture the domain key topics and themes, and RQs and hypotheses of interest.

Open-ended written response data were uploaded to Microsoft Excel for rapid review analysis. Staff assigned to relevant policy domains developed an initial set of codes to apply to the open-ended survey data anchored to the RQs and hypotheses of interest. The team met to review the initial codes, discuss appropriate applications, and ensure shared understanding. Once the codes were finalized and consensus was reached, staff assigned to relevant policy domains conducted rapid review coding of the open-ended survey data in Microsoft Excel.

Mixed Methods Integration

The perspectives of a diverse group of key informants were obtained in Wave 1. Using an embedded mixed methods approach, qualitative and quantitative data were integrated for the purpose of the IEIR. Qualitative data collected from interviews and other sources were used to interpret trends and outcomes in quantitative data. For example, data extracted in the document review process were integrated with findings from interviews, open-ended surveys, and quantitative data to address RQs and hypotheses. Summary memos from KII offered further explanation and a nuanced understanding of quantitative findings.

Independent Evaluation Limitations

The Independent Evaluation faces several limitations that may affect the interpretation of findings. As with any large-scale, multi-year evaluation, isolating the effects of Demonstration activities from concurrent federal and state policy changes and broader environmental and contextual factors can be challenging. Simultaneous reforms, evolving data systems and collection methods, and external factors such as food insecurity trends, healthcare workforce shortages, and recurrent virus outbreaks, may have contributed to time-varying confounding in the Independent Evaluation. Additionally, several major policy changes outside the Demonstration, including the Roadmap, and the ending of the PHE and subsequent Medicaid unwinding, were expected to influence the outcomes of interest for the IEIR. These shifts were non-random and may have affected the characteristics and care experiences of enrolled

²¹ Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, 27(2), 237-246. <https://doi.org/10.1177/1098214005283748>

members in ways that cannot be disentangled from the effects of Demonstration programs and activities.

For the IEIR, we primarily sought to characterize trends during the early Demonstration period, compared them with what might have been expected based on relationships present at baseline, and interpreted them cautiously in the context of qualitative findings, implementation progress, and contextual factors. For the IESR, we plan to apply quasi-experimental methods that seek to estimate causal effects while accounting for potential selection forces and sources of confounding.

Several data and analytical limitations must be acknowledged, including those related to data availability, completeness, and consistency. Due to factors such as lags in data availability, evolving data requirements, and variation in coding practices, data was not uniformly available across all years and populations. Surveys in general are susceptible to potential non-response biases, which we sought to address with weighting for non-response. Member surveys performed by third parties are limited for the purposes of the Independent Evaluation due to the inability to link repeated measures over time. In addition, changes in data submissions and coding practices over time can introduce artifacts that distort relationships under the Independent Evaluation. We conducted routine data quality checks, including validation against source files, consistency reviews across Independent Evaluation time periods, and assessment of outliers and missing values to ensure the robustness of our analyses.

Some of the findings were based on qualitative data collection from a sample of members that may not represent the experiences of the broader population. Members were recruited to participate in interviews through voluntary referrals, which may have resulted in a sample that was more engaged with the system or context under study. Qualitative interviews were subject to recall and reporting biases, and the timing and context of data collection may have influenced responses. Analytic approaches, including coding and thematic analyses, incorporated researchers' interpretation, and some nuances or patterns may not have been fully captured. These limitations are consistent with those generally observed in qualitative evaluations and should be considered when interpreting findings.

Model-based analyses rely on assumptions that relationships between characteristics and outcomes remain stable over time. If these relationships were to change for reasons unrelated to the Demonstration, predictive accuracy may decline. Similarly, analytic models assume that baseline conditions remain constant absent Demonstration effects, though unobserved time-varying factors may influence results. The IESR will attempt to address these challenges to estimate causal effects using quasi-experimental and comparative designs that better account for secular trends.

It is important to note some key differences between the Independent Evaluation and MassHealth's internal monitoring. The Independent Evaluation summarizes results at the program level and uses broader continuous enrollment criteria, while MassHealth typically reports median performance by individual organizations in monitoring. Variations in analytic methods, specifications, and approaches distinguish Independent Evaluation findings from administrative monitoring results. Independent Evaluation findings take longer to produce than routine monitoring data, reflecting the time required to generate robust, validated results.

2. Coverage and Eligibility

2.1. Background

Massachusetts continues to lead the nation with near-universal health insurance coverage. In 2021, before the implementation of the 2022-2027 1115 Medicaid Demonstration, only 2.5% of Commonwealth residents were uninsured, which is well below the national rate of 8.9%.²² During the COVID-19 Public Health Emergency (PHE) period, Medicaid enrollment peaked because MassHealth implemented the continuous enrollment provision of the Families First Coronavirus Response Act (FFCRA) in March 2020 to allow individuals to maintain coverage and benefits during this period except for special circumstances.²³

From February 2020 to March 2023, there was an increase of 451,842 MassHealth members.²⁴ This increase aligns with the increase in Massachusetts residency from 7 to 7.1 million during the same time period.²⁵ Subsequently, the end of Medicaid's continuous enrollment provision under the Consolidated Appropriations Act, 2023 (effective March 31, 2023) led to an estimated 666,208 MassHealth coverage terminations from April 2023 to April 2024 and contributed to a 16% reduction in MassHealth enrollment during this period.^{26,27} However, Massachusetts took proactive measures to minimize terminations for procedural reasons during the unwinding period, including renewing Medicaid eligibility for individuals with no income, allowing managed care plans to help members complete and submit renewal forms, and utilizing a variety of outreach methods to contact members about their coverage status. While these strategies were authorized under Section 1902(e)(14)(A) Waivers and the continuous enrollment "unwinding" is not directly related to the 2022–2027 1115 Demonstration Waiver authority, these events provide important context and background for this Independent Evaluation Interim Report (IEIR).²⁸

With the 2022–2027 Demonstration, the Commonwealth continued programs begun under previous Demonstrations and implemented new ones with the goals of: (1) increasing insurance coverage and access; (2) improving health outcomes; and (3) maintaining the sustainability of Medicaid resources. The coverage and eligibility (C&E) waivers are designed to cover individuals for a longer period, cover more populations, expand premium assistance and cost-sharing, and expand retroactive eligibility (RE).

²² U.S. Census Bureau (2025). *2023 American Community Survey 1-year estimates*. https://www2.census.gov/programs-surveys/demo/tables/health-insurance/2024/acs-hi/hi12_acs.xlsx

²³ Commonwealth of Massachusetts. (2020, August). *MassHealth eligibility flexibilities for COVID-19*. <https://www.mass.gov/doc/masshealth-eligibility-flexibilities-for-covid-19/download>

²⁴ Medicaid Enrollment and Unwinding Tracker. (2026). In: KFF. <https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/>

²⁵ UMass Donahue Institute. *State-level population estimates for Massachusetts*. <https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-state>

²⁶ Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Div. FF, § 5131, 136 Stat. 4459 (2022).

²⁷ Medicaid Enrollment and Unwinding Tracker. (2026). In: KFF. <https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#8815e057-6ee9-4945-8ca1-705913d143b8>

²⁸ Centers for Medicare & Medicaid Services. (2023). *COVID-19 PHE unwinding Section 1902(e)(14)(A) waiver approvals*. Medicaid.gov. <https://www.medicare.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals#MA>

C&E Waiver Provisions

Continuous Eligibility

MassHealth introduced continuous eligibility (CE) for justice-involved individuals and those experiencing homelessness to limit churn (defined as the temporary loss of coverage in which beneficiaries are disenrolled from and reenrolled in MassHealth within 12 months) and to reduce verification procedures to once every 12 or 24 months.²⁹ Beginning in April 2023, justice-involved individuals who are Medicaid eligible and under 65 years of age became eligible for continuous coverage during the 12 months following their release from correctional settings, regardless of income or other changes that would affect eligibility. This was expanded to include those over age 65 years of age starting in October 2025.

Also, beginning in December 2023, individuals who are experiencing homelessness, qualify for Medicaid, are under 65 years of age, and have a confirmed status of homelessness for at least six months are continuously eligible for coverage for 24 months, regardless of income or other changes that would affect eligibility.²⁹ Under the amendment approved on April 19, 2024, members experiencing homelessness who are age 65 years and older also began receiving 24 months of CE.

Coverage of More Populations

MassHealth continued the CommonHealth program from the previous Demonstration with two modifications in the 2022–2027 Demonstration. Qualifying non-working adults (19–64 years of age) with total and permanent disabilities are no longer required to pay a one-time deductible or work 40 hours per week. Additionally, disabled adults over 65 years of age who have had CommonHealth for 10 or more years retain coverage regardless of their work status.³⁰

MassHealth continued the Breast and Cervical Cancer Demonstration Program (BCCDP), without modification, which provides MassHealth Standard benefits to individuals under age 65 in need of treatment for breast or cervical cancer who do not otherwise qualify for MassHealth and are uninsured; individuals are determined financially eligible if they have income between 133.1% and 250% of the Federal Poverty Level (FPL).^{31,32}

The Family Assistance program for children (non-disabled children with family incomes between 150% and 300% of the FPL who are insured at application) and people with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)³³ (individuals with

²⁹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 4.10, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³⁰ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC Table 3 “CommonHealth Adults,” <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³¹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Table 3: Demonstration Expansion Populations, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³² Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 5.5, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³³ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 4.8, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

HIV not otherwise eligible with income between 133% and 200% of the FPL) continued in the 2022–2027 Demonstration without modification.³⁴

In addition, the expansion of the Medicare Savings Program (MSP) increased the income limit for MSP Specified Low Income Medicare Beneficiaries/Qualifying Individuals (SLMB/QI) benefits without an asset test to MassHealth Standard members of any age with income up to 165% of the FPL.³⁵ This policy was approved on Aug. 11, 2022, as part of the amendment to the 2017–2022 Demonstration, effective on Sept. 1, 2022, and continues through the 2022–2027 Demonstration. In a subsequent amendment to the 2022–2027 Demonstration, approved on April 19, 2024, the income threshold for MassHealth Standard members to receive Medicare Part A and Part B premium and cost-sharing assistance increased from less than or equal to 133% to less than or equal to 190% of the FPL, and the threshold for Part B premium assistance was approved from less than or equal to 165% to less than or equal to 225% of the FPL.³⁶

Table 2.1-1 explains the monthly income limits and benefits for the MSP plan types relevant to the 2022–2027 Demonstration: (1) Standard + Qualified Medicare Beneficiaries (Standard + QMB) and (2) Standard + Specified Low Income Medicare Beneficiaries/Qualifying Individuals (Standard + SLMB/QI). The waiver provisions only modify the income limits, and not the benefits, of these MSP plan types.

Table 2.1-1 Monthly Income Limits and Benefits by Standard + MSP Plan Type

MSP Plan Type	Monthly Income Limit Before the 2022–2027 Demonstration	Monthly Income Limit from September 2022 to April 2024	Monthly Income Limit as of April 2024 Amendment	Benefits
Standard + QMB	≤ 133% FPL	≤ 133% FPL	≤ 190% FPL	• Pays the person's Medicare Part A premium • Pays the person's Medicare Part B premium • Pays all costs of Medicare Part A and Part B covered services, like Medicare deductibles, coinsurance, and copays
Standard + SLMB/QI	N/A	133.1% < x ≤ 165%	190.1 < x ≤ 225% FPL	• Pays the person's Medicare Part B premium

Data Sources: Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Waiver Extension Approved*, U.S. Department of Health and Human Services (2017), <https://www.mass.gov/doc/ma-1115-waiver-extension-approved-1/download> Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Waiver and Expenditure Authorities*, U.S. Department of Health and Human Services (2024), Expenditure Authority #17, <https://www.mass.gov/doc/waiver-and-expenditure-authorities/download>. Rossi, H. (March 2024). *Eligibility Operations Memo 24-03, Medicare Savings Programs, Formerly Known as MassHealth Senior Buy-In and MassHealth Buy-In*

³⁴ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 5.7, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³⁵ Centers for Medicare & Medicaid Services. (2022, August 11). *Amendment of Massachusetts MassHealth Section 1115 demonstration special terms and conditions*. <https://www.mass.gov/doc/centers-for-medicare-medicare-services-special-terms-conditions-august-2022/download>

³⁶ The policy change was from Nov. 9, 2023, but CMS approved federal financial participation for this policy on April 19, 2024.

Programs. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid.

<https://www.mass.gov/doc/eom-24-03-medicare-savings-programs-formerly-known-as-masshealth-senior-buy-in-and-masshealth-buy-in-programs-0/download>

Abbreviations: Federal Poverty Level (FPL); Medicare Savings Program (MSP); Qualified Medicare Beneficiaries (QMB); Specified Low Income Medicare Beneficiaries/Qualifying Individuals (SLMB/QI)

Under the amendment approved on April 19, 2024, MassHealth will also provide coverage for a certain targeted set of services for incarcerated members for up to 90 days prior to the members' release. (See [Chapter 8. Health-Related Social Needs](#) for more background on the Reentry Demonstration Initiative.)

Premium Assistance and Cost-Sharing

MassHealth has demonstrated a commitment to flexible access to insurance coverage by providing premium assistance, cost-sharing, and Marketplace subsidies through the 1115 Demonstration. In both the 2017–2022 and 2022–2027 Demonstrations, all MassHealth-eligible individuals in Standard, CarePlus, Family Assistance, or CommonHealth may receive premium assistance to support enrollment in cost-effective private insurance such as employer-sponsored insurance (ESI) that meets the basic benefit level. MassHealth provides wraparound services to ensure these individuals receive no less coverage than they would otherwise have through the respective MassHealth coverage type.³⁷

Prior to eliminating copays effective April 1, 2024, under MassHealth's cost-sharing policy, specific populations, including children under 21 years of age, pregnant individuals, Native American/Alaska Native members, and individuals with income under 50% of the FPL, were not charged copays. Additionally, individuals whose gross income is less than 150% of the FPL and Native American/Alaska Native members are not charged premiums.³⁸

The Commonwealth provides Marketplace premium and cost-sharing subsidies for individuals who purchase health insurance through the Health Connector's ConnectorCare program. Eligible individuals are those who: (1) are not Medicaid or Children's Health Insurance Program (CHIP) eligible; (2) have income at or below 300% of the FPL (as originally approved); and (3) are eligible for coverage with an Advanced Premium Tax Credit. Gap coverage for ConnectorCare is supported through the state-operated Health Safety Net (HSN) program. Effective upon the amendment approval date of April 19, 2024, the income limit for the premium and cost-sharing assistance has increased from 300% of the FPL to 500%.³⁹

Retroactive Eligibility (RE)

RE provides coverage up to a set timeframe before the date of a member's application, if the member had medical expenses and would have been eligible during the retroactive period.

³⁷ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 8.12, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³⁸ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 9.1, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

³⁹ The state increased the income limit at state cost on January 1, 2024, but the federal authority for the increase is not effective until the amendment approval date.

Individuals could request up to 90-day RE during the PHE.⁴⁰ In the 2022–2027 Demonstration, MassHealth continued its waiver of RE, limiting most individuals to 10 days of RE prior to the application date. However, individuals under age 19 or who were pregnant remained eligible for up to 90 days of RE prior to the application date.⁴¹ Under the approved amendment on April 19, 2024, the Commonwealth has removed its waiver of 10 days RE for certain applicants. As a result, effective Aug. 18, 2025, all eligible Medicaid beneficiaries have up to 90 days of RE upon confirmation that the individual had medical bills at the time of application, and the individual would have been eligible at the time services were provided.⁴²

Additional CMS Evaluation Recommendations

In addition to the waiver provisions described above, the Centers for Medicare & Medicaid Services (CMS) recommends evaluating the following: (1) streamlined eligibility determination; (2) waiver of early and periodic screening, diagnostic, and treatment (EPSDT) services for children on Family Assistance; (3) provisional coverage for individuals who self-attest to eligibility; and (4) extended eligibility for out-of-state former foster care youth residing in Massachusetts. The latter two policies are ongoing and were included in the 2017–2022 Demonstration evaluation. Reevaluating them was not expected to generate substantial new information due to a lack of changes in the populations and policies, so we did not perform a reevaluation. The waiver of EPSDT services for children on MassHealth Family Assistance was not evaluated due to lack of feasibility and time constraints to determine an accurate coding logic. Results of streamlined eligibility determination are included in this IEIR.

Streamlined Eligibility Redetermination

There is a streamlined eligibility redetermination process in the 2022–2027 Demonstration whereby certain members who have not had changes in circumstances are not required to submit an annual eligibility form but instead attest to their eligibility. This policy applies to the following groups:

1. Families with children under 21 years of age whose Supplemental Nutrition Assistance Program (SNAP)-verified income is at or below 180% of the FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children under 21 years of age;
2. Childless adults whose SNAP-verified income is at or below 163% of the FPL; and

⁴⁰ Rossi, H. (December 2022). *Eligibility Operations Memo 22-18, Three-Month Retroactive Eligibility for Certain MassHealth Applicants*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. <https://www.mass.gov/doc/eom-22-18-three-month-retroactive-eligibility-for-certain-masshealth-applicants-0/download>

⁴¹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 4.2, STC 8.13, Table 9, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

⁴² Rossi, H. (August 2025). *Eligibility Operations Memo 25-14, Changes to Start Date Rules and Three-Month Retroactive Eligibility Rules*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. <https://www.mass.gov/doc/eom-25-14-changes-to-start-date-rules-and-three-month-retroactive-eligibility-rules-0/download>

3. Families with children, notwithstanding sunset dates for Express Lane eligibility applicable to the companion state plan amendments.⁴³

2.2. Study Design

Refer to [Chapter 1 Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology. The C&E evaluation estimates and describes the following outcomes: uninsurance rate, churn, enrollment continuity, special program enrollment, health care services utilization, streamlined administrative process, and member experiences. The evaluation describes the observed changes in outcomes relative to the timeline of policy implementation, while acknowledging contextual and confounding factors.

2.2.1. Research Questions, Hypotheses, and Study Design

Table 2.2-1 describes the research questions (RQs), hypotheses (Hs), data sources and evaluation period, and analytic methods. See the following appendices for other relevant methods and materials: List of Research Questions (RQs) and Hypotheses (Hs) (**Appendix A-2**), Member Nomination Form (**Appendix C-4**), and Key Informant Interview (KII) Demographics (**Appendix C-5**).

⁴³ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 4.4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

Table 2.2-1 C&E Research Questions, Hypotheses, and Study Design

Research Questions	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ1-1 Have C&E policies collectively maintained Medicaid enrollment and enrollment continuity, and maintained the number of individuals receiving Marketplace subsidies?	H1-1.1 C&E policies have collectively maintained Medicaid enrollment and reduced churning among MassHealth members.	American Community Survey (ACS) (CY2018–CY2024); Medicaid enrollment and eligibility data (CY2018–CY2024)	Descriptive statistics (frequency and percentages) (member); Subgroup analysis (member, timeline of policy effective dates)
	H1-1.2 C&E policies for justice-involved and homeless populations have increased coverage and reduced the churn of these populations.	MassHealth programmatic enrollment reports (CY2023–CY2024)	Descriptive statistics (frequency) (member)
	H1-1.3 MassHealth enrollment for special populations has been maintained or expanded.	Medicaid enrollment and eligibility data (CY2018–CY2024); MassHealth programmatic enrollment reports (CY2018–CY2024)	Descriptive statistics (frequency and percentages) (member); Subgroup analysis (member, timeline of policy effective dates)
	H1-1.5 C&E policies have maintained the number of individuals receiving Marketplace subsidies.	MassHealth programmatic enrollment reports (CY2018–CY2024)	Descriptive statistics (frequency and percentages) (member)
RQ1-2 Have premium assistance and cost-sharing programs supported continued coverage in the Demonstration?	H1-2.1 The enrollment in private health insurance through MassHealth's premium assistance and/or cost-sharing has been maintained.	MassHealth programmatic enrollment reports (CY2018–CY2025)	Descriptive statistics (frequency and percentages) (member)
RQ1-3 Has RE coverage of 90 days for children and pregnant individuals (and for all members no sooner than Jan. 1, 2026) impacted an individual's MassHealth enrollment?	H1-3.1 Increasing the RE coverage from 10 to 90 days for Medicaid members (including children and pregnant members) increased the likelihood of enrollment and enrollment continuity. ⁴⁴	MassHealth programmatic enrollment reports (CY2018–CY2024)	Descriptive statistics (frequency and percentages; interrupted time series) (member)

⁴⁴ RE bridges a temporary coverage gap.

Research Questions	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ1-4 What is the impact of the RE waiver on the level of medical bills for members subject to the RE waiver? This item will be evaluated through Dec. 31, 2026, as no members will be subject to the RE waiver as of Jan. 1, 2026, based on an amendment.	H1-4.1 Increasing the RE coverage from 10 to 90 days for Medicaid members (including children and pregnant members) will result in a lesser financial burden on those members.	Member interviews (CY2025); MassHealth program staff survey (CY2025); Document review	Thematic analysis (member, program staff)
RQ1-5 Has CE streamlined Massachusetts' administrative process for enrollment and eligibility?	H1-5.1 CE has streamlined Massachusetts's enrollment and eligibility administrative processes.	Member interviews (CY2025); MassHealth program staff survey (CY2025)	Thematic analysis (member, program staff)
RQ1-6 Did C&E policies change MassHealth members' health care utilization?	H1-6.1 MassHealth members who are subject to CE have increased preventive, primary, and medically necessary specialist care.	Medicaid administrative data (CY2018–CY2024)	Descriptive statistics (frequency and percentages)
RQ1-7 What have been members' overall experiences with the new and ongoing C&E policies/programs?	H1-7.1 The new and ongoing C&E programs/policies have improved members' experiences.	Member interviews (CY2025)	Thematic analysis (member)

Data source: 1115 Waiver Demonstration Evaluation Design Document⁴⁵

Abbreviations: American Community Survey (ACS); Continuous Eligibility (CE); Coverage and Eligibility (C&E); Calendar Year (CY); Hypothesis (H); Retroactive Eligibility (RE); Research Question (RQ)

Notes: The complete list of RQs and Hs from the Evaluation Design Document can be found in **Appendix A-2**.

⁴⁵ Centers for Medicare & Medicaid Services. MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services (2026), Attachment S Evaluation Design Document, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

2.2.2. *Methodological Limitations*

The analysis of the C&E policies in the IEIR was descriptive. The first major limitation with this descriptive approach is that non-Demonstration (exogenous) confounding factors such as COVID-19, FFCRA, and Medicaid unwinding cannot be separated from the Demonstration associated changes. For some coverage groups, the impact of the non-Demonstration factors on outcomes appears to be large relative to the waiver impacts. More rigorous analyses to differentiate the changes likely to be due to the Demonstration from confounding factors will be explored in the Independent Evaluation Summative Report (IESR). The second major limitation of the methods to evaluate C&E policies and programs pertains to the limited sample size for member interviews about their knowledge and experiences with various C&E policies and programs; the perspectives of those interviewed may not represent the perspectives of all members exposed to C&E policies.

2.3. **Interim Results and Conclusions**

2.3.1. *RQ1-1 Have C&E policies collectively maintained Medicaid enrollment and enrollment continuity, and maintained the number of individuals receiving Marketplace subsidies?*

For this section, a summary of results is provided for each RQ, followed by detailed results. A brief conclusion is provided towards the end of each RQ. The subsequent domain chapters follow the same structure of presenting results and conclusions.

2.3.1.1. **Summary of Results**

MassHealth implemented waiver provisions of the 2022–2027 Demonstration, as described previously, with the goal of maintaining or increasing insurance coverage and continuity. We examined trends in MassHealth enrollment, Massachusetts' uninsurance rate, churn, enrollment continuity, and trends related to Marketplace subsidies.

MassHealth enrollment rose during the PHE and declined in CY2024 during unwinding, but overall enrollment across all coverage sources was maintained. During the 2022–2027 Demonstration, Massachusetts still held the lowest uninsurance rate across the United States (U.S.) with a rate under 3% in each of the Demonstration years. The churn rate among all members was 3.3% in Q1 CY2018; it consistently declined and dropped to almost zero beginning in CY2021 until a rebound in Q4 CY2023 when Medicaid unwinding started taking effect. The proportion of members who were continuously enrolled in Medicaid for 12 months from their enrollment start increased slightly from almost 94% in Q1 CY2018 to 97% in Q1 CY2020, remained steady during the PHE, and reduced slightly with Medicaid unwinding; overall enrollment continuity has been maintained.

The number of members with justice involvement newly receiving 12-month CE in each quarter increased since initial implementation, ranging between 53 to 76 members from Q2 CY2024 to Q2 CY2025. The number of members verified as experiencing homelessness newly receiving 24-month CE similarly increased since the policy started, then remained steady from Q3 CY2024 to Q2 CY2025 with between 1,902 to 2,330 members newly receiving CE each quarter.

Enrollment for special populations in programs including CommonHealth, Family Assistance, BCCDP, and MSP Standard has been maintained, or in some cases increased, during the Demonstration period. The number of members in CommonHealth was steady from CY2018 to CY2022, ranging from 41,176 to 47,245 members, and then increased in CY2023 (71,272 members) and CY2024 (84,446 members). While CommonHealth enrollment among those age 65+ continued steadily increasing during the period, there was a sharp increase in enrollment among adults ages 19–64 from CY2022 to CY2024. Family Assistance enrollment declined from CY2019 to CY2022, then increased from 100,357 in CY2022 to 156,999 in CY2023 and 173,127 in CY2024. Enrollment in BCCDP has slightly increased since CY2020 through CY2024. There was also an increase in the total number of Standard members with MSP, driven by an increase in MSP Standard + QMB enrollment.

ConnectorCare enrollment declined during the PHE and then increased substantially following Medicaid unwinding and the Demonstration amendment approved in April 2024, which expanded ConnectorCare eligibility from 300% to 500% FPL. Enrollment reached a historic high of 284,376 members by December CY2024. The addition of new plan types (3C and 3D) contributed more than 54,000 new subsidized enrollees by the end of CY2024.

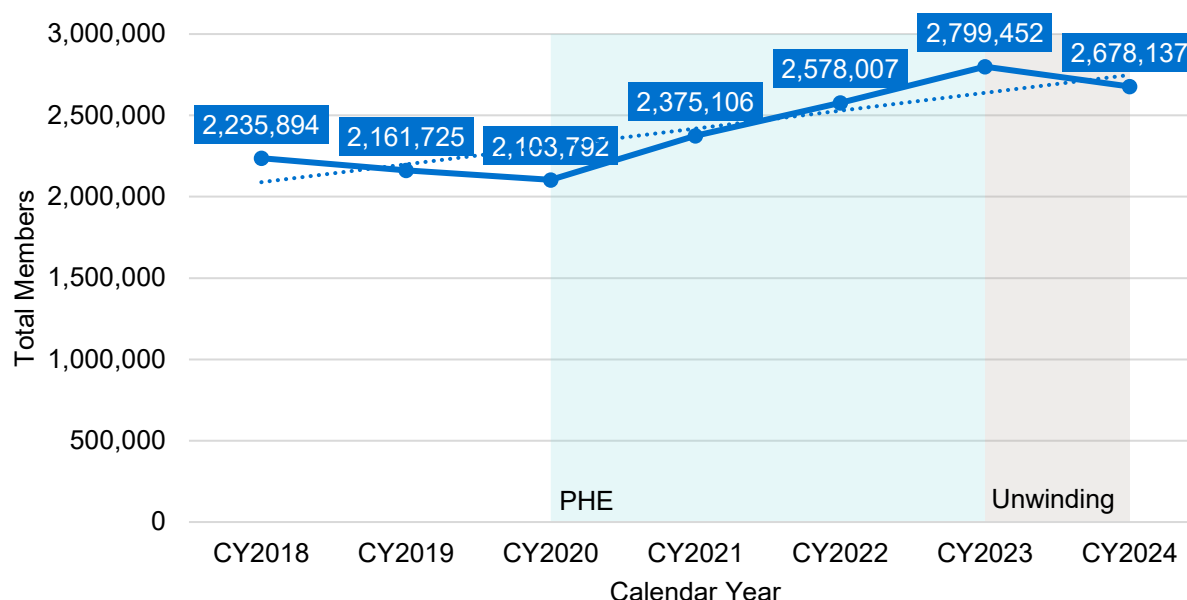
2.3.1.2. Results

H1-1.1 C&E policies have collectively maintained Medicaid enrollment and reduced churn among MassHealth members.

Medicaid Enrollment

As described in **Section 2.1**, Medicaid enrollment peaked during the PHE when MassHealth implemented the continuous enrollment provision of the FFCRA allowing individuals to maintain coverage and benefits during this period except for special circumstances. The beginning of the 2022–2027 Demonstration period coincided with the PHE and Medicaid unwinding, when eligibility redetermination restarted following the end of the PHE (effective April 1, 2023). **Figure 2.3-1** shows the change in the total number of unique members enrolled at any point and for any length of time in the year.⁴⁶ Enrollment declined in CY2024 during unwinding but, overall, there were still more members enrolled in each year during the initial period of the 2022–2027 Demonstration than in CY2018–CY2021.

⁴⁶ These estimates are higher, as expected, than MassHealth's point-in-time enrollment counts due to the inclusion of any member enrolled for any length of time in the year; however, the trend in enrollment remains comparable between these annual estimates and MassHealth's point-in-time estimates from CY2018 to CY2024 (See **Appendix B-1**).

Figure 2.3-1 Total Unique MassHealth Members Enrolled Annually, CY2018–CY2024

Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE)

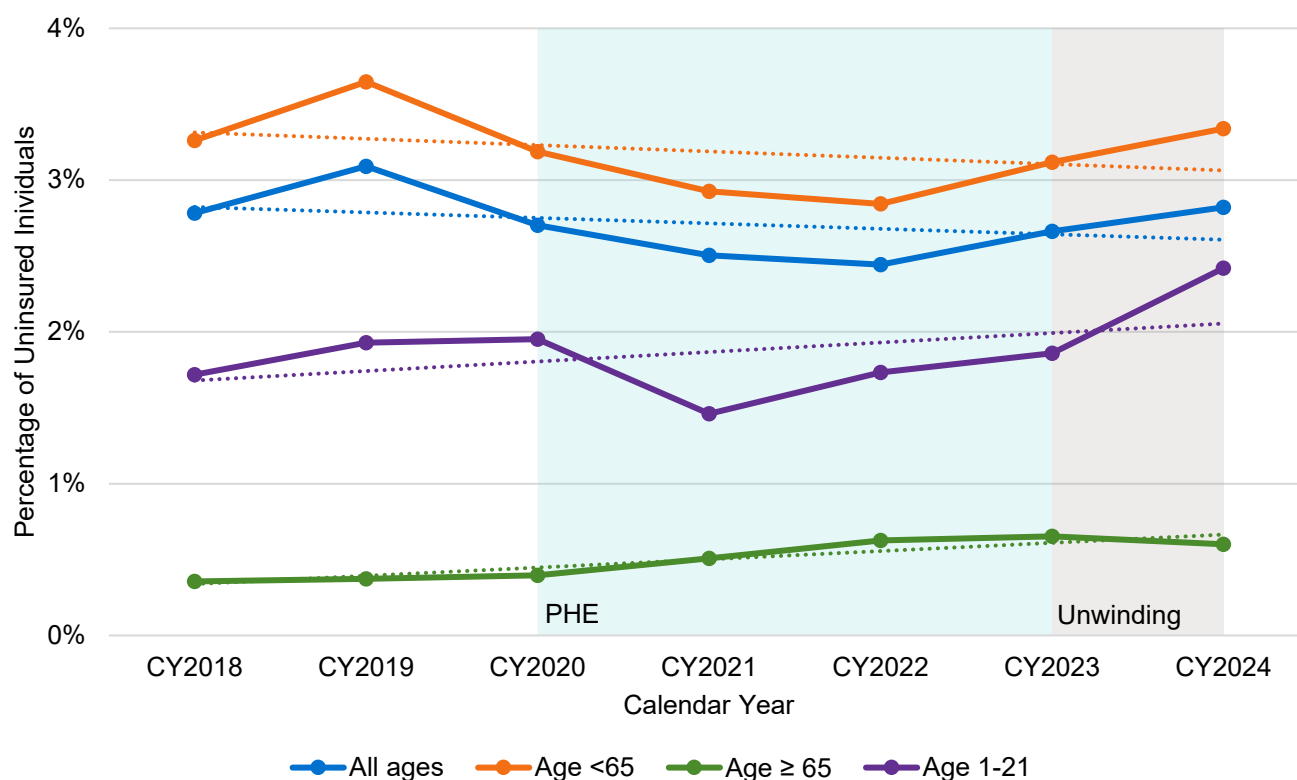
Note: The dotted line represents the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts. A sensitivity analysis was conducted of member-months of enrollment by year which showed a consistent pattern to this overall enrollment trend.

Uninsurance Rate

MassHealth plays an important role in maintaining high insurance coverage in Massachusetts. It does so by providing direct coverage to populations who do not have access to insurance, by providing premium assistance for individuals enrolled in certain employer sponsored insurance and by providing supplemental coverage and subsidies to Marketplace plans through ConnectorCare. In a report based on state fiscal year 2024 data, it was estimated that MassHealth provides access to health care for 29% of Massachusetts residents.⁴⁷

Massachusetts continued maintaining near-universal health insurance coverage during the 2022–2027 Demonstration. During the 2017–2022 Demonstration, the uninsurance rate for all residents fluctuated but overall, it trended down, especially during the COVID-19 PHE when eligibility redeterminations were paused. (See **Figure 2.3-2**). The uninsurance rate started increasing from the lowest point in CY2022 to reach almost 3.0% in CY2024. The uninsurance rate for the 65+ population was the lowest (around 0.5%) and most stable of all groups, likely due to Medicare coverage for this age group. The uninsurance rate among those <21 years old was less than 2% from CY2018 to CY2023 and rose to 2.4% in CY2024.

⁴⁷ Blue Cross Blue Shield of Massachusetts Foundation (2025, January). Policy and Research Publications: MassHealth Matters to Massachusetts. <https://www.bluecrossmafoundation.org/publication/masshealth-matters-massachusetts-updated-infographic-2025>

Figure 2.3-2 Percentage of Uninsured Individuals in Massachusetts by Age Group, CY2018–CY2024

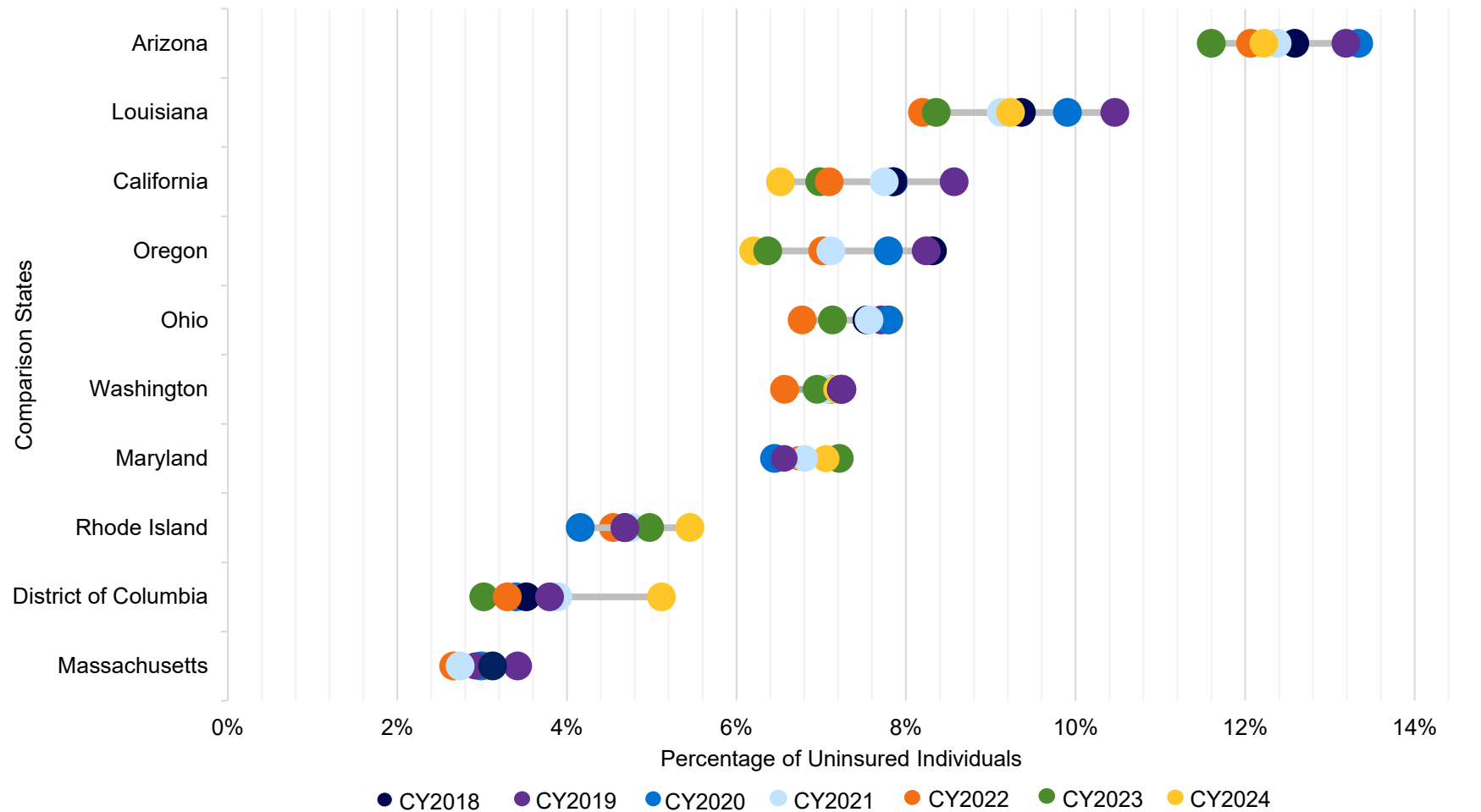
Data Source: U.S. Census Bureau, ACS 1-year estimates.

Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE); United States (U.S.)

Note: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts. See **Appendix B-2** for exact numbers and percentages of uninsured individuals in Massachusetts for each year.

As shown in **Figure 2.3-3**, in CY2022 nine comparison states (all Medicaid Expansion states; see **Appendix B-3** for additional selection criteria) had an uninsurance rate for individuals under 65 years old ranging from 3.5% in the District of Columbia to 12.9% in Arizona, all higher than Massachusetts at 2.8%. Compared to CY2022, these states’ uninsurance rates in CY2023 and CY2024 changed in both directions — some had slightly increased uninsurance rates (Louisiana, Ohio, Washington, Maryland, Rhode Island), whereas California, the District of Columbia, Oregon, and Arizona had a reduced rate from CY2022 to CY2023 or CY2024; in this context, Massachusetts’s uninsurance rate slightly increased from CY2022 to CY2023 and CY2024. However, Massachusetts still had the lowest uninsurance rate in the U.S. in any year.

Figure 2.3-3 Percentage of Uninsured Individuals Under 65 Years Old in Massachusetts and Nine Comparison States, CY2018–CY2024



Data Source: U.S. Census Bureau, ACS 1-year estimates.

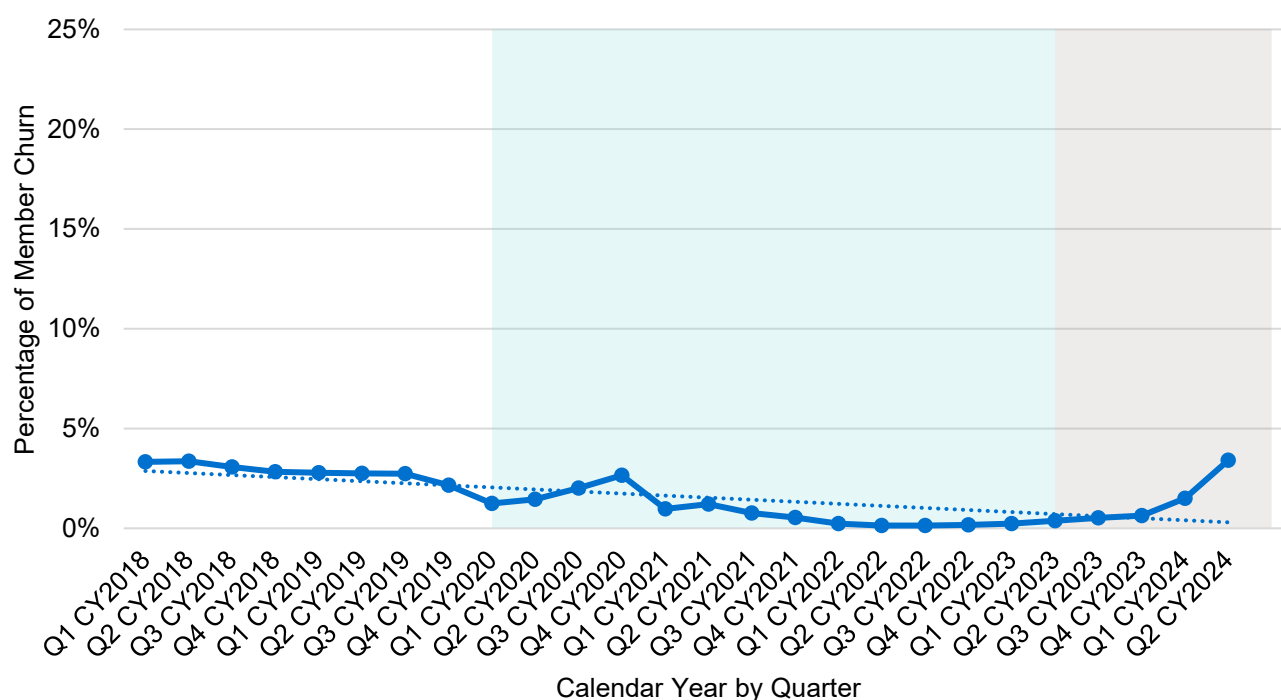
Abbreviation: Calendar Year (CY)

Note: See **Appendix B-4** for exact numbers and percentages of uninsured individuals in Massachusetts and comparison states for each year.

Churning/Coverage Gaps

Figure 2.3-4 displays the level of churning,⁴⁸ defined as a 45-day or greater coverage gap between two Medicaid enrollment periods within a year of a member's enrollment start date.⁴⁹ The churn rate among all members was 3.3% in Q1 CY2018 and declined and dropped to almost zero during 2022 until a rebound in Q4 CY2023 when Medicaid unwinding started taking effect. Overall, the churn rate is trending downward for the period of the Demonstration, despite an uptick in early 2024.

Figure 2.3-4 Percentage of Medicaid Members Who Churned Within a Year of Enrollment, Q1 CY2018–Q2 CY2024



Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Note: The dotted line represents the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts. See **Appendix B-5** for exact numbers of members churned.

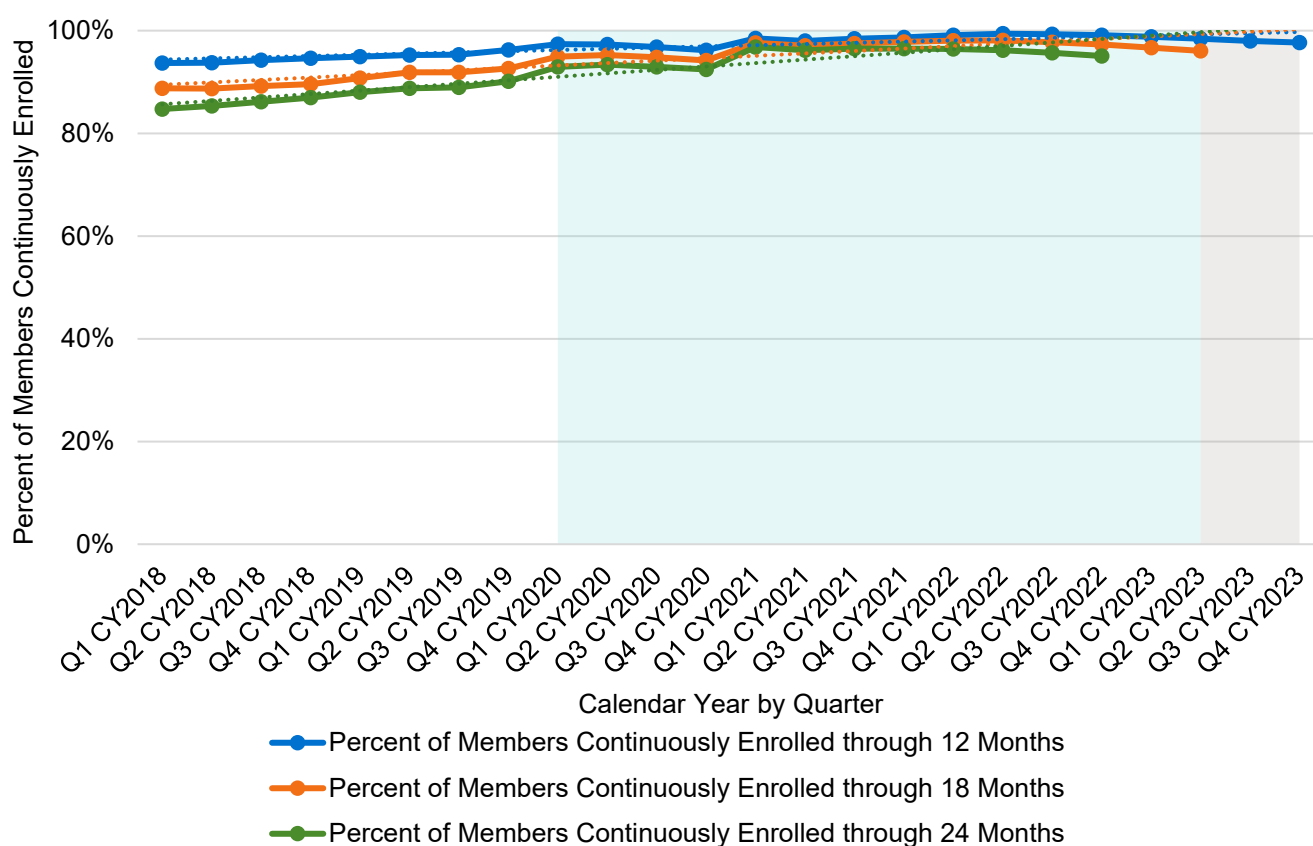
⁴⁸ The anchor date for determining the churn is the enrollment start date. For members newly enrolled in a quarter, it is the exact enrollment start date; for existing members, the start date is based on the latest enrollment period prior to the reporting quarter.

⁴⁹ Note, churn rate has been defined differently by different organizations. Some defined the churn when people lose Medicaid and then re-enroll within a short period of time ([Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing “Churn” | Center on Budget and Policy Priorities](#)), and others define churn as someone who disenrolled in one year and re-enrolled within 12 months ([An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP](#)).

Continuous Enrollment

We also examined whether members are continuously enrolled through 12, 18, and 24 months from their enrollment dates.⁵⁰ **Figure 2.3-5** shows that the percentage of members continuously enrolled through 12 months gradually increased from almost 94% in Q1 CY2018 to 97% in Q1 CY2020, then remained at that level until a slight increase to 98% in Q1 CY2021. The rate stayed relatively stable until a couple of percentage point reduction during CY2023. The trend of enrollment continuity was similar for those enrolled through 18 or 24 months. As expected, members are more likely to be continuously enrolled through 12 months than through 18 and 24 months because members' eligibility is more likely to change over a longer period.

Figure 2.3-5 Percentage of Members Who Are Continuously Enrolled During the 12-, 18-, and 24-Months, by Quarter, Since the Beginning of Enrollment, Q1 CY2018–Q4 CY2023



Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Note: The dotted line represents the linear trend. Continuous enrollment was defined as a member having no coverage gap, except for gaps less than 45 days, through 12, 18, or 24 months from their enrollment start date. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts. See **Appendix B-5** for exact numbers of members continuously enrolled through 12, 18, or 24 months.

⁵⁰ Continuous enrollment was defined as a member having no coverage gap, except for gaps less than 45 days, through 12, 18, or 24 months from their enrollment start date.

H1-1.2 C&E policies for justice-involved and homeless populations have increased coverage and reduced the churn of these populations.

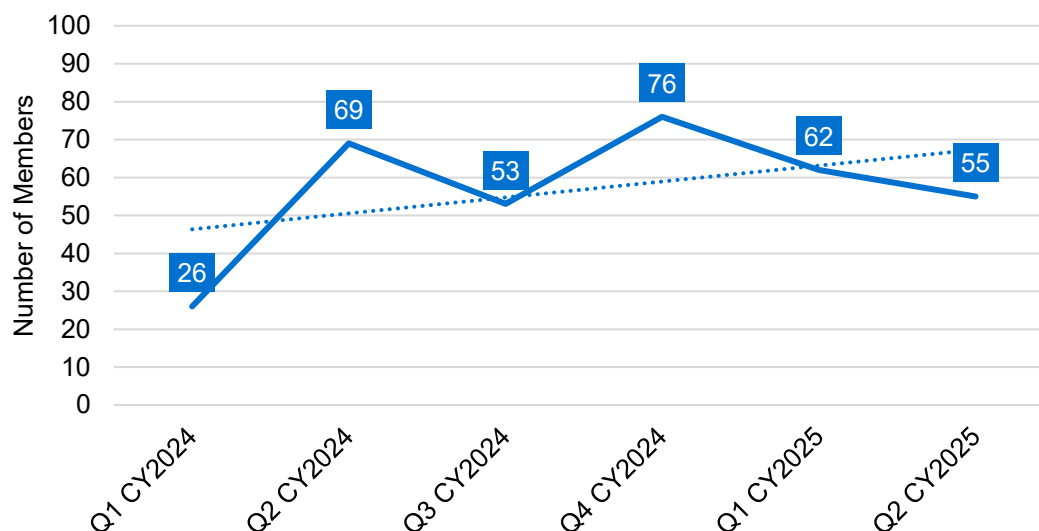
As of April CY2023, Medicaid-eligible members under 65 years of age became continuously eligible for coverage during the 12 months following their release from correctional settings. Medicaid-eligible members under 65 years of age with a confirmed status of homelessness for at least six months became continuously eligible for 24 months of coverage starting in December CY2023.⁵¹

MassHealth reported that data collection related to CE for justice-involved members was delayed until Q4 CY2023, after implementation started in Q2 CY2023. In the first quarter of data collection, less than 11 new members received CE. As shown in **Figure 2.3-6**, the numbers of these members increased to 69 in Q2 CY2024 and then ranged between 53 to 76 members newly receiving CE each quarter for the period from Q2 CY2024 to Q2 CY2025. The overall trend indicated an increasing number of justice-involved members newly receiving CE. During the period from Q4 CY2023 to Q2 CY2025, a total of 344 justice-involved members received 12-month CE. In CY2024, there were more than 20,000 individuals released to the community from the Department of Correction or House of Correction custody⁵²; while not all these individuals would be eligible for MassHealth or the CE policy, this points to a possible opportunity for improving access to CE for the justice-involved population.⁵³

⁵¹ Rossi, H. (March 2024). *Eligibility Operations Memo 24-02, Continuous Eligibility for Certain MassHealth Members*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. <https://www.mass.gov/doc/eom-24-02-continuous-eligibility-for-certain-masshealth-members-0/download>

⁵² Executive Office of Public Safety and Security (January 2026). *Cross-Tracking System: State and County Correctional Populations*. <https://www.mass.gov/info-details/cross-tracking-system-state-county-correctional-populations>.

⁵³ Per a 2021 Blue Cross Blue Shield of Massachusetts Foundation Issue Brief, one estimate for only the Department of Corrections population is that 85% are enrolled in MassHealth as a part of their release planning (<https://www.bluecrossmafoundation.org/publication/masshealth-impact-series>).

Figure 2.3-6 Number of Members Recently Released from Jail or Prison Newly Receiving CE, Q4 CY2023–Q2 CY2025

Data Source: CE data sent by MassHealth

Abbreviations: Continuous Eligibility (CE); Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

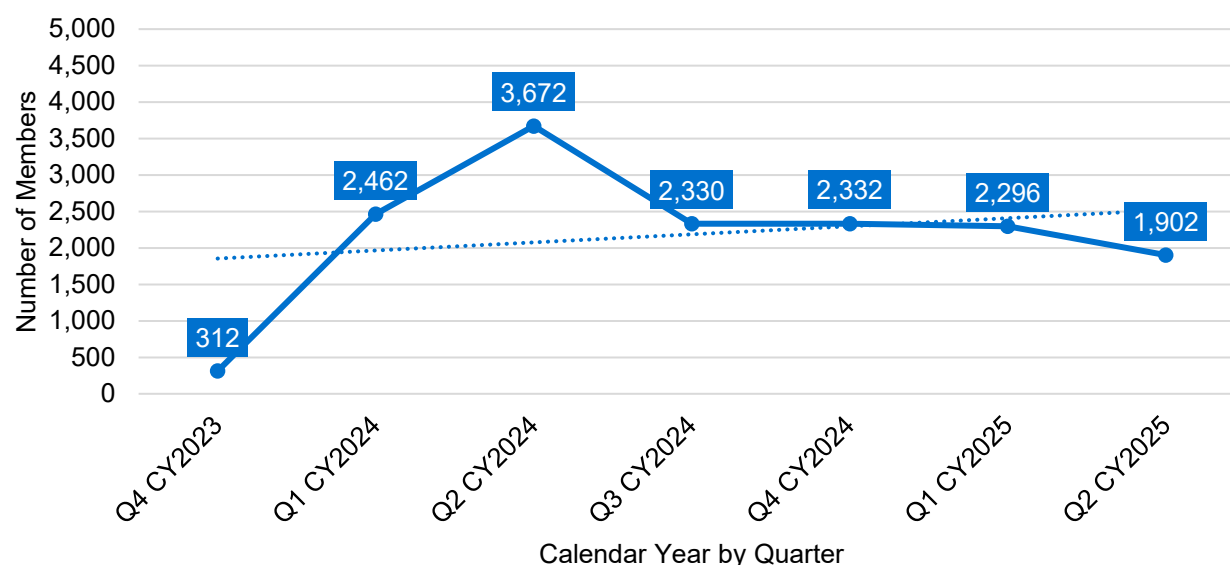
Note: The dotted line represents the linear trend

As seen in **Figure 2.3-7**, there were over 300 members experiencing homelessness who received 24-month CE when it was first implemented in December CY2023. The number of members newly receiving CE increased considerably in the following months, to 2,462 in Q1 CY2024 and then to 3,672 members in Q2 CY2024. The number of members newly receiving CE each quarter ranged from 1,902 to 2,330 from Q3 CY2024 to Q2 CY2025. During the period from Q4 CY2023 to Q2 CY2025, a total of 15,306 members experiencing homelessness received 24-month CE. For comparison, in their Demonstration extension request, MassHealth identified approximately 11,000 members experiencing homelessness in the period of CY2018–CY2021.⁵⁴ Since the number of individuals experiencing homelessness in Massachusetts increased considerably from approximately 34,000 individuals in CY2022 to approximately 57,000 in CY2024⁵⁵, the increase in members experiencing homelessness receiving CE would be expected as well. This suggests that there has been successful implementation of the 24-month CE policy for this population.

⁵⁴ Executive Office of Health and Human Services Office of Medicaid. *MassHealth Section 1115 Demonstration Extension Request* (2021). Section 5.1: Continuous Eligibility for Targeted Adult Populations. <https://www.mass.gov/info-details/1115-masshealth-demonstration-waiver-extension-request>

⁵⁵ Executive Office of Housing and Livable Communities (2025). The Rehousing Data Collective Public Dashboard. <https://www.mass.gov/info-details/the-rehousing-data-collective-public-dashboard>

Figure 2.3-7 Number of Verified Members Experiencing Homelessness Newly Receiving CE, Q4 CY2023–Q2 CY2025



Data Source: CE data sent by MassHealth

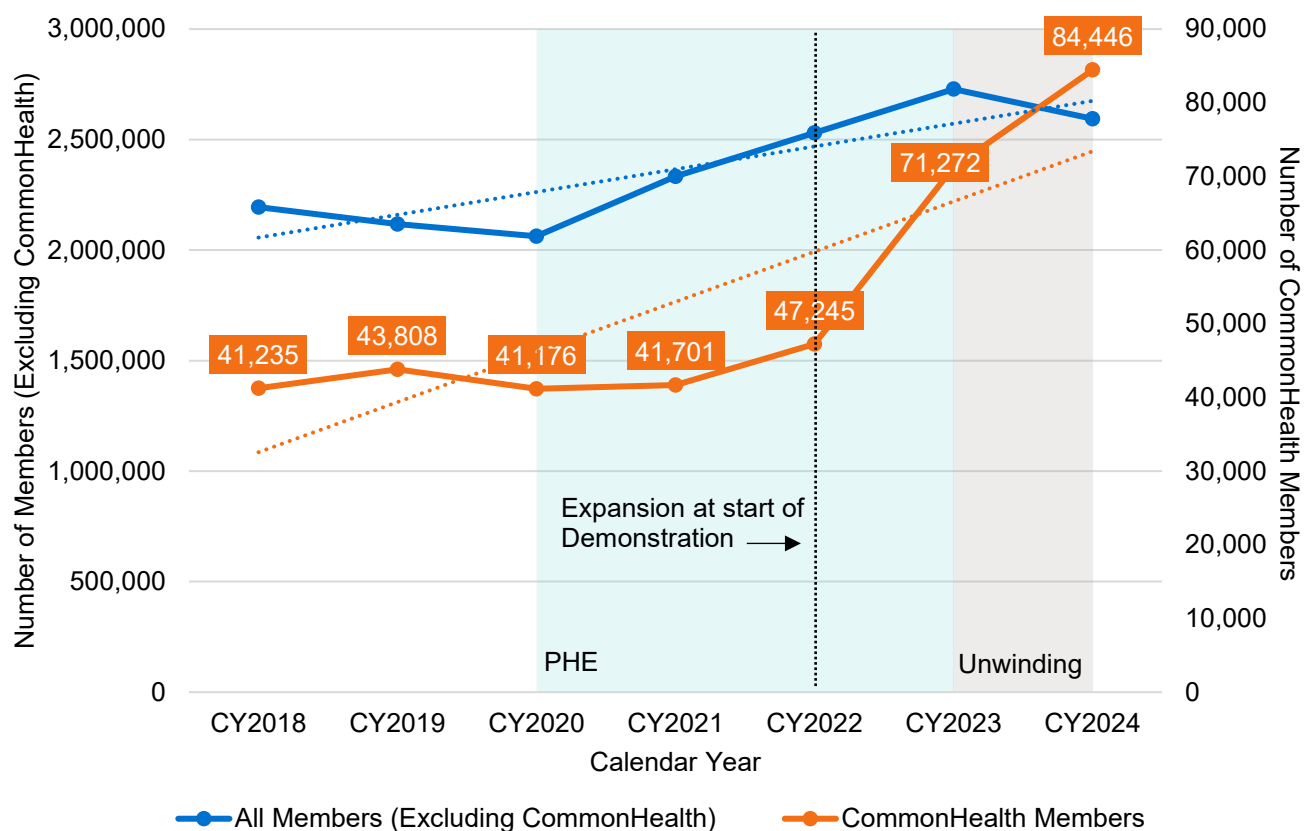
Abbreviations: Continuous Eligibility (CE); Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Note: The dotted line represents the linear trend

H1-1.3 MassHealth enrollment for special populations has been maintained or expanded.

CommonHealth

Figure 2.3-8 shows the trend in the number of MassHealth members enrolled in CommonHealth compared to all other MassHealth members. From CY2018 to CY2022, the number of CommonHealth members ranged from 41,176 to 47,245 members (around 2% of total MassHealth members). In CY2023, this number increased to 71,272 members (2.5%) and continued to rise to 84,446 members (3.2%) in CY2024. This increase in the number and percentage of CommonHealth members reflects the changes in CommonHealth eligibility under the 2022–2027 Demonstration. Consistent with **H1-1.3** and eligibility changes, the data indicate that more individuals enrolled in CommonHealth following the beginning of the Demonstration.

Figure 2.3-8 Number of CommonHealth Members, CY2018–CY2024

Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE)

Note: All Members (Excluding CommonHealth) and CommonHealth Members are mutually exclusive. The dotted lines represent the linear trend.

The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision.

Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

Figure 2.3-9 shows CommonHealth enrollment trends by age group from CY2018 to CY2024. The increase mostly occurred to non-elderly adults. Members under 19 years old enrolled in CommonHealth are not subject to Demonstration policy change, so this age group is shown for comparison purposes. The number of CommonHealth members 65 years or older steadily increased from 5,431 members in CY2018 to 11,973 in CY2024. This increase reflects the Demonstration’s new eligibility guidance for people who are age 65 and older, including allowing members who were enrolled in MassHealth CommonHealth for at least 10 years to remain on CommonHealth after turning 65 whether they work or not, and allowing members who do not meet the 10-year criteria upon turning 65 to still receive CommonHealth if they continue to work at least 40 hours per month.⁵⁶ The number of CommonHealth members 65 years or older has a similar trend to members under 19 years old enrolled in CommonHealth, with the exception that the under 19 group dips in CY2020 whereas the 65 years or older group steadily increases

⁵⁶ Rossi, H. (August 2023). *Eligibility Operations Memo 23-19, Updated: Changes to MassHealth CommonHealth Eligibility for Seniors*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. <https://www.mass.gov/doc/eom-23-19-changes-to-masshealth-commonhealth-eligibility-for-seniors/download>

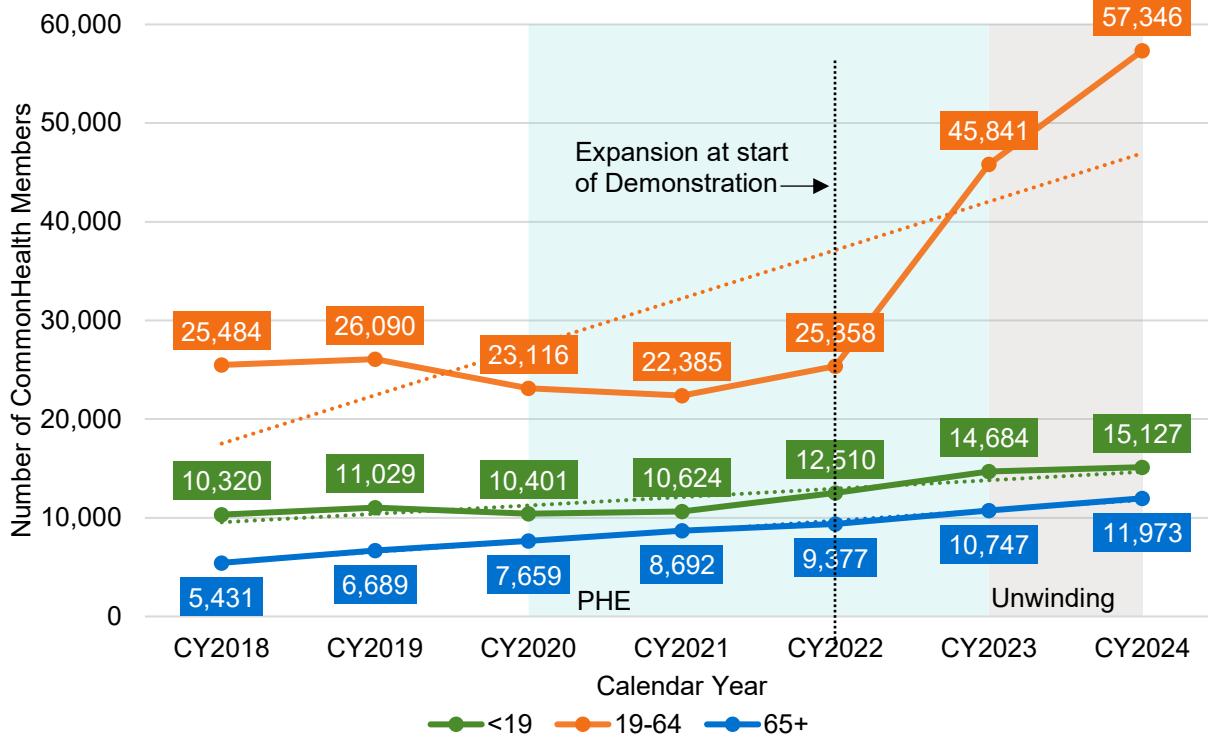
throughout the period. After the Demonstration started, both groups' enrollment in CommonHealth increased from CY2022 to CY2023, during which the PHE probably played the largest role. Since unwinding, the number for older adults continued to rise, probably benefiting from the Demonstration policy that limited the decline.

CommonHealth enrollment for members ages 19 to 64 remains relatively steady from CY2018 to CY2022, hovering around 25,000 members per year. From CY2022 to CY2024, there was a large increase in the number of members ages 19 to 64 receiving CommonHealth. This number increased from 25,358 members in CY2022 to 45,841 in CY2023 to 57,346 in CY2024. This trend reflects the CommonHealth eligibility expansion for members 19 to 64 under the 2022–2027 Demonstration. Before the Demonstration, a person applying for MassHealth who was determined to have a disability and had income above 133% of the FPL had to meet a one-time deductible (amount of deductible determined by comparing household income to CommonHealth Monthly Deductible Income Standards and multiplying the difference by six)⁵⁷ or be employed at least 40 hours per month (or have been employed at least 240 hours in the six months before the application date). The Demonstration now allows adult MassHealth members with disabilities, who have an income above 150% of the FPL and are 19–20 years old or who have an income above 133% of the FPL and are 21–64 years old, to be eligible to receive MassHealth CommonHealth benefits without having to meet this one-time deductible or be employed at least 40 hours per month.⁵⁸

⁵⁷ 130 CMR, § 506.009 - *The One-time Deductible*. (2023). <https://www.law.cornell.edu/regulations/massachusetts/130-CMR-506-009>

⁵⁸ Rossi, H. (December 2023). *Eligibility Operations Memo 23-28, Updated: Changes to Streamline MassHealth CommonHealth Eligibility for Adults*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. <https://www.mass.gov/doc/eligibility-operations-memo-23-28-updated-changes-to-streamline-masshealth-commonhealth-eligibility-for-adults-0/download>

Figure 2.3-9 CommonHealth Enrollment by Age Group, CY2018–CY2024



Data Source: Medicaid enrollment and eligibility data

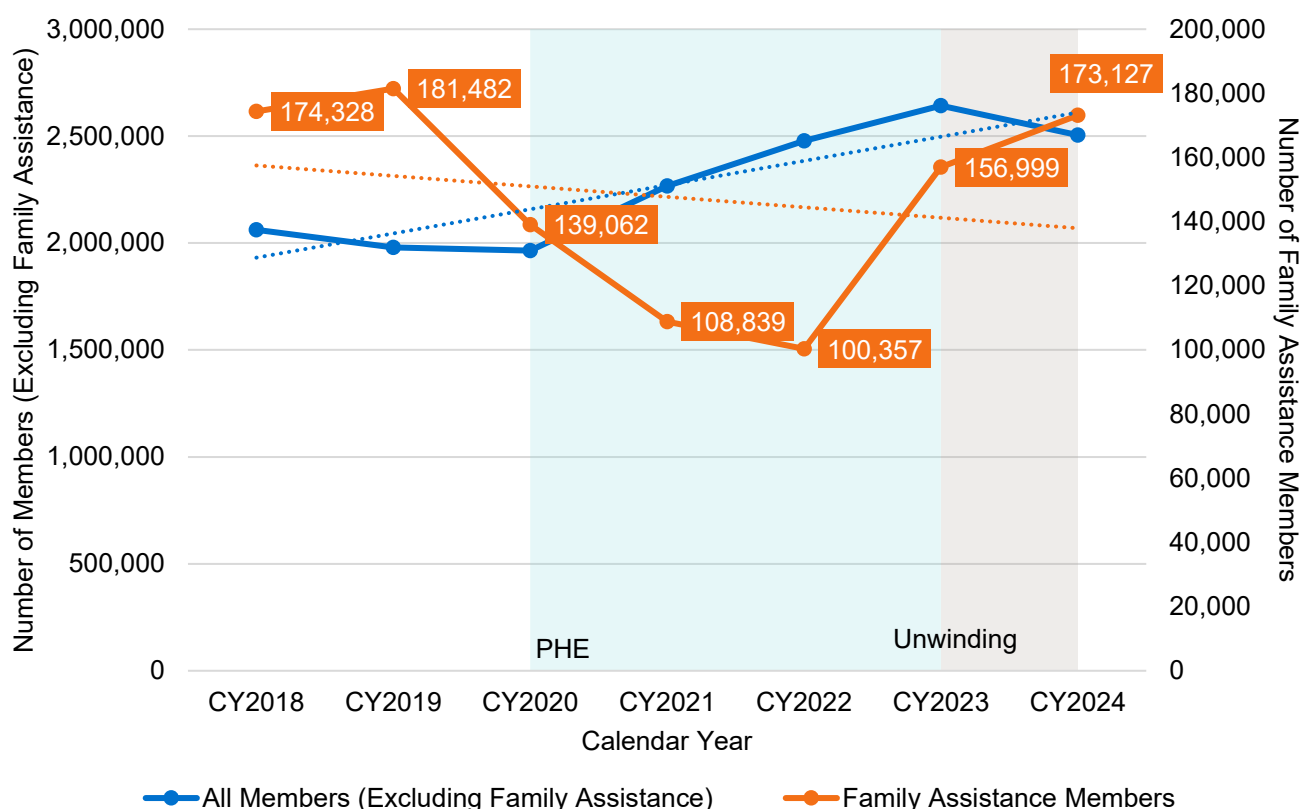
Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE)

Note: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

Family Assistance

Figure 2.3-10 shows the number of MassHealth members enrolled in Family Assistance compared to all other MassHealth members not enrolled in Family Assistance.⁵⁹ From CY2018 to CY2021, the number of Family Assistance members oscillated year-to-year, dropping from a high of 181,482 to a low of 100,357 in 2022. The number of members in Family Assistance showed an increased trend from CY2022. In CY2022, there were 100,357 members enrolled in Family Assistance (3.9% of MassHealth members). This number increased to 156,999 (5.6%) in CY2023 and 173,127 (6.5%) in CY2024, even after Medicaid unwinding.

⁵⁹ Family Assistance here refers to populations in categories of eligibility specific to the Demonstration, as outlined in Section 2.1. (Coverage of More Populations).

Figure 2.3-10 Number of Family Assistance Members, CY2018–CY2024

Data Source: Medicaid enrollment and eligibility data

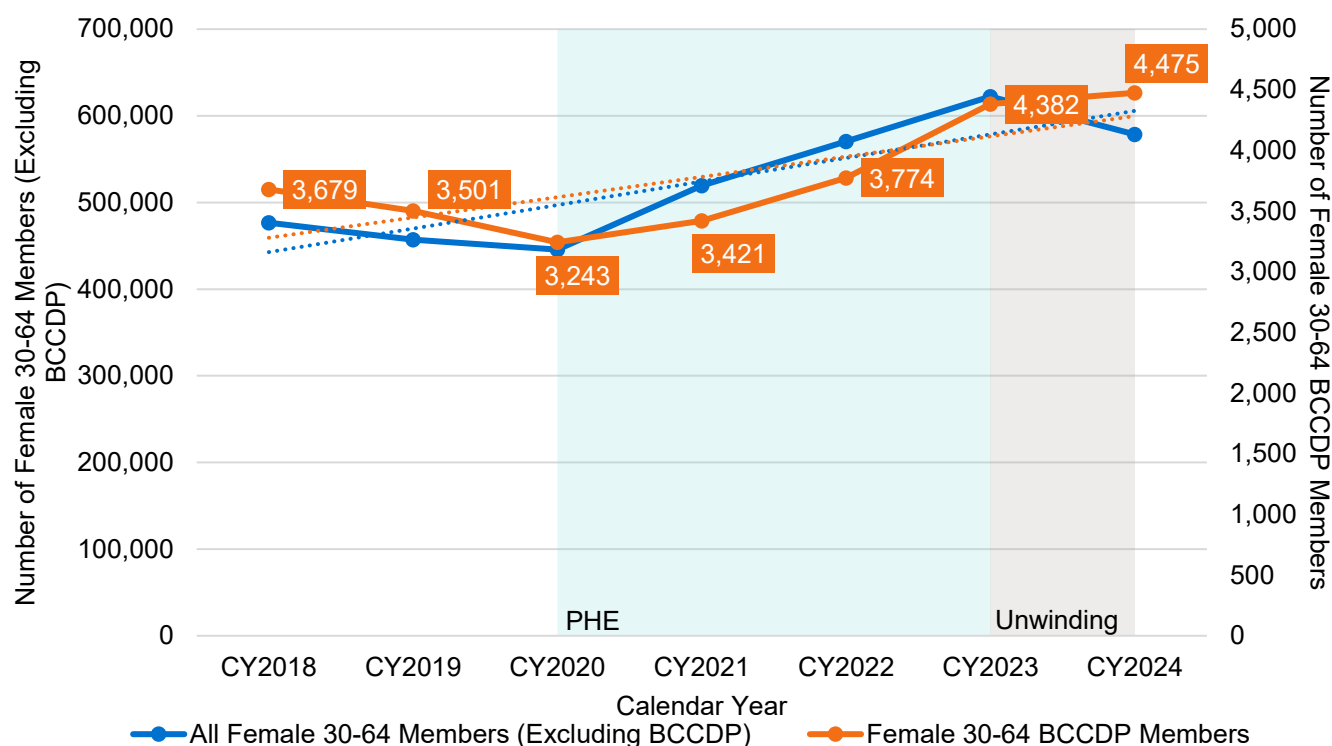
Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE)

Note: All Members (Excluding Family Assistance) and Family Assistance Members are mutually exclusive. The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

BCCDP

Figure 2.3-11 shows the number of female MassHealth members ages 30–64 enrolled in BCCDP compared to all other female MassHealth members ages 30–64 not enrolled in BCCDP. Analysis was limited to female MassHealth members ages 30–64 because BCCDP eligibility is restricted to this group.⁶⁰ From CY2018 to CY2021, the number of BCCDP members ranged from 3,679 to 3,243. The number of females ages 30–64 in BCCDP steadily increased beginning in CY2022 with 3,774 members to 4,382 in CY2023 to 4,475 in CY2024. The number of members in BCCDP continued to rise slightly even after the decline of Medicaid enrollment during the Medicaid unwinding period. BCCDP is a continuing policy; the observed trend suggests at least the program enrollment was maintained.

⁶⁰ Massachusetts Breast and Cervical Cancer Program resources for patients. Executive Office of Health and Human Services. <https://www.mass.gov/info-details/massachusetts-breast-and-cervical-cancer-program-resources-for-patients#am-i-eligible-to-receive-free-breast-and-cervical-cancer-screening>

Figure 2.3-11 Number of BCCDP Members, CY2018–CY2024

Data Source: Medicaid enrollment and eligibility data

Abbreviations: Breast and Cervical Cancer Demonstration Program (BCCDP); Calendar Year (CY); COVID-19 Public Health Emergency (PHE)

Note: All Female 30-64 Members (Excluding BCCDP) and Female 30-64 BCCDP Members are mutually exclusive. The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

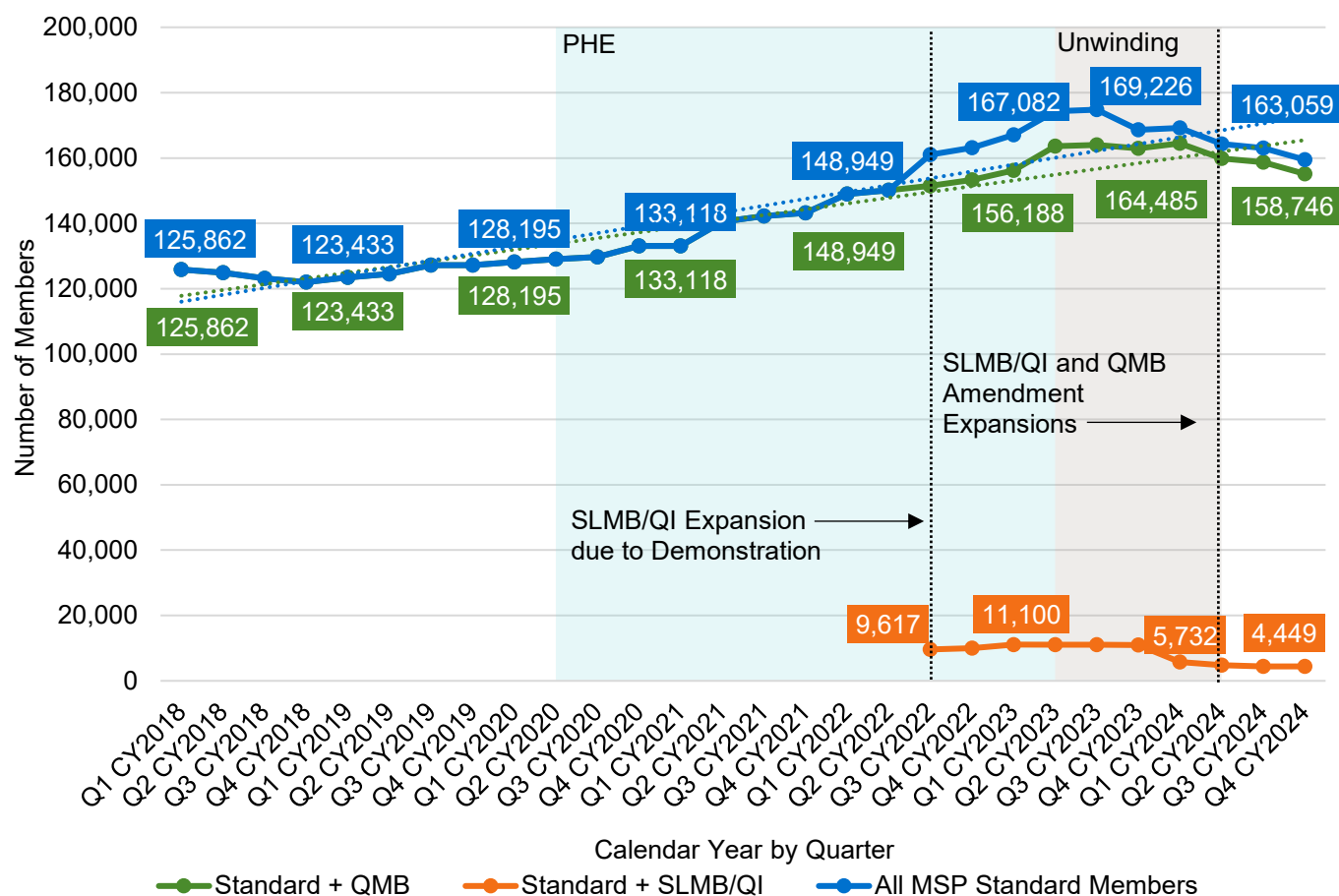
Standard + MSP

Figure 2.3-12 shows the overall trends in Standard + MSP enrollment under 1115 Waiver authority from CY2018 to CY2024, including both MSP Standard + QMB and MSP Standard + SLMB/QI. As shown in **Table 2.1-1**, the SLMB/QI income threshold was above 133% FPL and less than or equal to 165% FPL at the start of the Demonstration. From Q3 CY2022 to Q1 CY2023, SLMB/QI enrollment steadily increased and then enrollment remained relatively stable throughout CY2023. Enrollment dropped from 10,955 members in Q4 CY2023 to 5,732 in Q1 CY2024 and continued to decline modestly through the remainder of CY2024. Although the amendment to the 2022–2027 Demonstration approved in April 2024 further expanded SLMB/QI eligibility to above 190% FPL and less than or equal to 225% FPL, this decrease likely reflects shifts between MSP eligibility categories rather than reduced eligibility. Specifically, the simultaneous expansion of the QMB income threshold to less than or equal to 190% FPL may have caused some members who previously qualified for SLMB/QI to transition into the QMB category. Additionally, it is likely that the effects of Medicaid unwinding also contributed to a drop in Standard + SLMB/QI members.

Although we cannot identify Standard members who newly qualified for MSP specifically due to the 2022–2027 Demonstration, increases in the total number of Standard plus MSP members are consistent with timing of expansions in MSP eligibility criteria. MassHealth Standard + QMB

members receive both Medicare premium assistance and cost-sharing assistance for Medicare Part A and Part B services, including deductibles, coinsurance, and copays, as described in **Table 2.1-1**. **Figure 2.3-12** shows steady growth in this population over time, peaking at 164,485 members in Q1 CY2024. At Q2 CY2024, enrollment declined slightly despite the QMB amendment expansion. This decline reflects the effects of Medicaid unwinding and was likely mitigated by the April 2024 amendment for the MSP Standard SLMB/QI and QMB.

Figure 2.3-12 Standard + MSP Enrollment Under 1115 Waiver Authority by Eligibility Group, Q1 CY2018–Q4 CY2024



Data Source: Medicaid enrollment and eligibility data

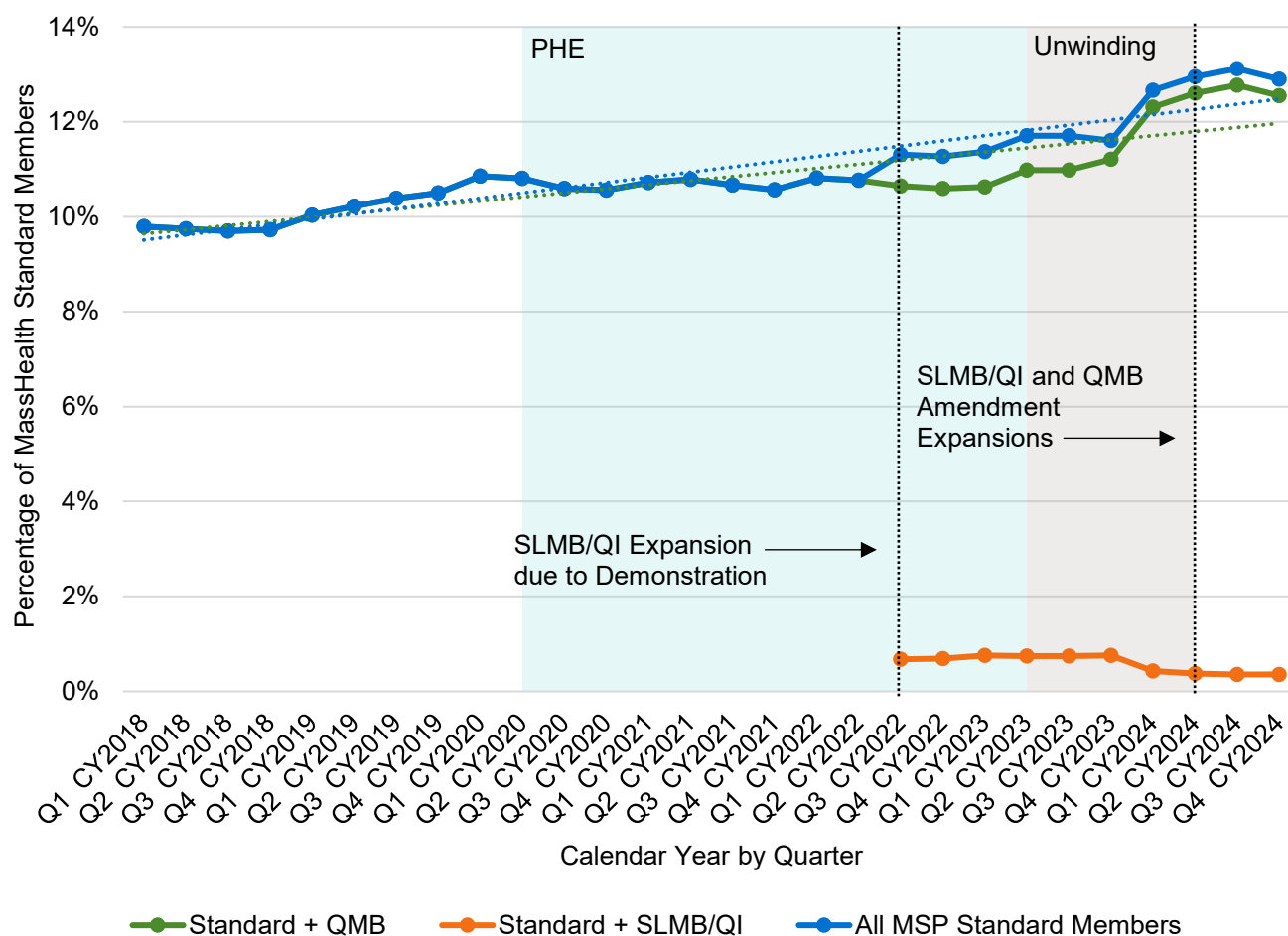
Abbreviations: Calendar Year (CY); Medicare Savings Program (MSP); COVID-19 Public Health Emergency (PHE); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4); Qualified Medicare Beneficiaries (QMB); Specified Low Income Medicare Beneficiaries/Qualifying Individuals (SLMB/QI)

Notes: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

Figure 2.3-13 shows the share of MassHealth Standard members receiving MSP relative to all MassHealth Standard members. The chart includes all members receiving MSP and breaks down the percentage by plan type, including both MSP Standard + QMB and MSP Standard + SLMB/QI. Notably, although the absolute number of Standard + QMB members and total MSP Standard members declined after Q4 CY2023 (see **Figure 2.3-12** above), their share of all MassHealth Standard members increased over the same period. This may be explained by a

reduction in the overall MassHealth Standard population during Medicaid unwinding, which appears to have caused the denominator to shrink more rapidly than the MSP-enrolled populations; this also reflects the effect of increased income threshold for MSP benefits.

Figure 2.3-13 Percentage of MassHealth Standard Members Receiving MSP Under 1115 Waiver Authority, Q1 CY2018–Q4 CY2024



Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); Medicare Savings Program (MSP); COVID-19 Public Health Emergency (PHE); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4); Qualified Medicare Beneficiaries (QMB); Specified Low Income Medicare Beneficiaries/Qualifying Individuals (SLMB/QI)

Notes: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts. See **Appendix B-6** for exact numbers of members with MassHealth Standard, total and with MSP.

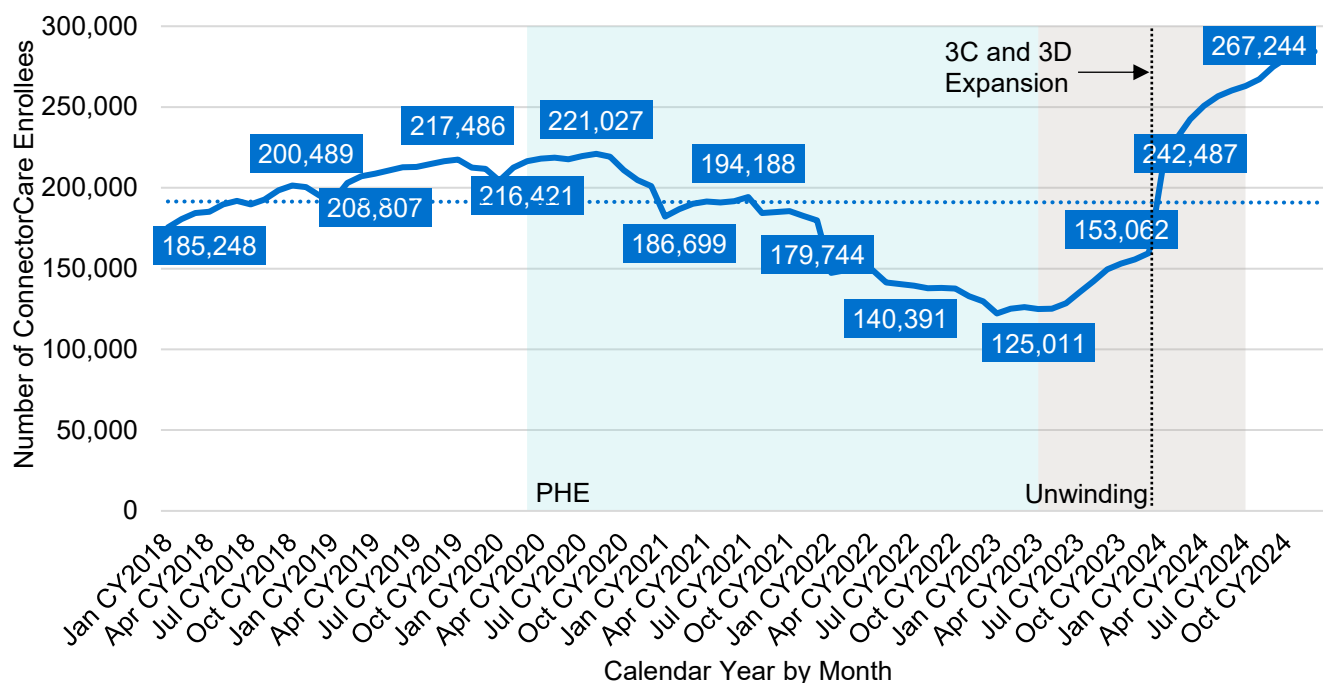
H1-1.5 C&E policies have maintained the number of individuals receiving Marketplace subsidies.

Individuals in Massachusetts receive Marketplace subsidies through the Health Connector’s ConnectorCare program. **Figure 2.3-14** presents the total number of enrollees in all ConnectorCare plan types by month for each year from CY2018 through CY2024. In both CY2018 and CY2019, before the COVID-19 pandemic, total ConnectorCare enrollment increased steadily throughout each year.

In CY2020, the FFCRA required all state Medicaid agencies to maintain continuous enrollment for all enrollees for the duration of the PHE. This included individuals who would normally lose MassHealth eligibility and transition to a Marketplace plan with ConnectorCare subsidies.⁶¹ As a result, ConnectorCare enrollment fell by approximately 26,000 individuals between March CY2020 and March CY2021, and by an additional 40,000 between March CY2021 and March CY2022. Because the PHE kept members on MassHealth who would otherwise qualify for ConnectorCare, this downward trend continued until May CY2023, when the PHE ended. After the start of the Medicaid unwinding process, many individuals lost MassHealth coverage and moved into Marketplace plans, causing ConnectorCare enrollment to rise throughout CY2023.

Figure 2.3-14 also shows a substantial increase in enrollment from December CY2023 to January CY2024 and continued growth throughout CY2024. This trend resulted from the Demonstration amendment, which took effect on Jan. 1, 2024, and increased the income limit for premium and cost-sharing assistance through ConnectorCare from 300% FPL to 500% FPL. This expansion created two new ConnectorCare plan types: 3C (300.1% to 400% FPL) and 3D (400.1% to 500% FPL).⁶² In January CY2024, more than 42,000 individuals gained Marketplace subsidies because of this eligibility change, and by the end of CY2024, more than 54,000 new individuals were receiving subsidies. As of December CY2024, ConnectorCare reached its highest program enrollment in its 10-year history, with 284,376 individuals enrolled.

Figure 2.3-14 ConnectorCare Total Enrollment by Month, CY2018–CY2024



Data Source: MassHealth programmatic enrollment reports

Abbreviations: Calendar Year (CY); COVID-19 Public Health Emergency (PHE); 3C (300.1-400% FPL); 3D (400.1-500% FPL)

⁶¹ Report to the Massachusetts Legislature: Activities and Accomplishments of the Massachusetts Marketplace, Fiscal Year 2022. (2023). <https://betterhealthconnector.com/wp-content/uploads/HealthConnectorAnnualReport2022.pdf>

⁶² ConnectorCare Expansion Pilot: Delivering affordable, accessible health care to more Massachusetts residents. (2024). <https://betterhealthconnector.com/wp-content/uploads/ConnectorCare-Pilot-Expansion-Report-082624.pdf>

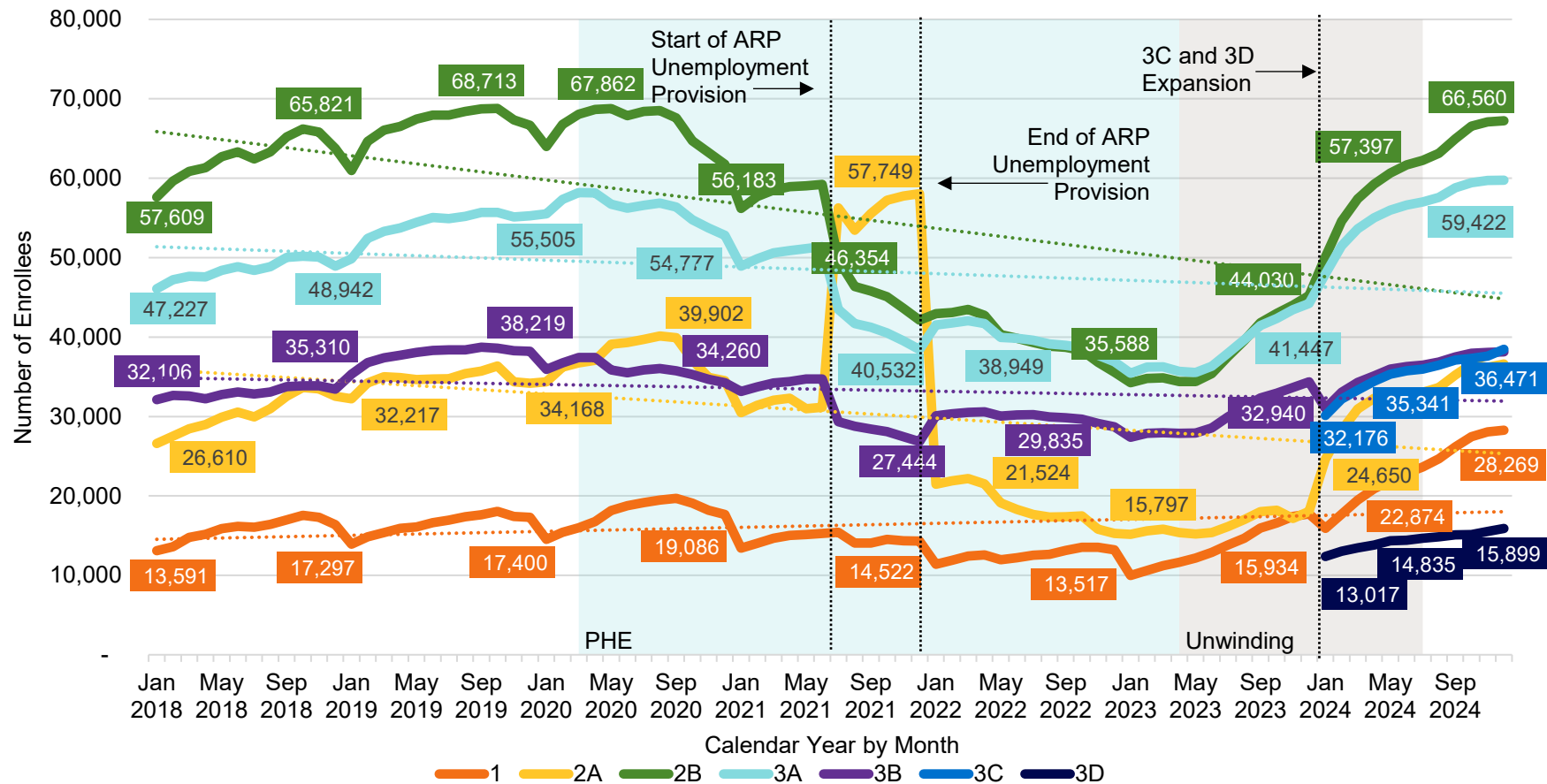
Notes: The dotted line represents the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

Figure 2.3-15 displays monthly ConnectorCare enrollment by plan type from January CY2018 through September CY2024. There are seven plan types for ConnectorCare: 1, 2A, 2B, 3A, 3B, 3C, and 3D. The original ConnectorCare eligibility groups were 1 (covered individuals with 0–100% FPL), 2A (100.1–150% FPL), 2B (150.1–200% FPL), 3A (200.1–250% FPL), 3B (25.1–300% FPL). Types 3C (300.1–400% FPL) and 3D (400.1–500% FPL) are the new groups coming out of the ConnectorCare Expansion in CY2024.⁶³ Group 1 has the lowest costs associated with it at \$0 monthly premiums and the smallest copays. With each increase in group, premiums and copays increase slightly.⁶³ Across all plan types, there is a consistent small dip followed by an increase in enrollment between November and January of each year. This pattern coincides with ConnectorCare’s annual Open Enrollment (OE) period, which typically occurs from November 1 through January 23. During OE, some members terminate coverage while new individuals enroll, resulting in the recurring dip and rise in enrollment across plan types.⁶⁴

The enrollment in each ConnectorCare plan type was relatively stable or slightly declined during the PHE period. Enrollment started increasing when Medicaid unwinding started in April 2023. Medicaid redetermination led to the loss of Medicaid coverage among some members; therefore, a portion of them could have transitioned to ConnectorCare. The Demonstration amendment’s expansion of income eligibility in CY2024 led to the creation of plan types 3C and 3D, explaining why these plan types first appeared in January CY2024 with steady increase of enrollment since then.

⁶³ *ConnectorCare: 2024 Plan Design Benefits and Copays*. (2024). <https://betterhealthconnector.com/wp-content/uploads/ConnectorCare-Pilot-Expansion-Report-082624.pdf>

⁶⁴ *Massachusetts Health Connector 2021 Open Enrollment Period: Final Enrollment Results*. (2022). <https://www.mahealthconnector.org/wp-content/uploads/Health-Connector-OE21-Brief-060122.pdf>

Figure 2.3-15 ConnectorCare Monthly Enrollment by Plan Type, January CY2018–September CY2024

Data Source: MassHealth programmatic enrollment reports

Abbreviations: American Rescue Plan (ARP); Calendar Year (CY); Federal Poverty Limit (FPL); COVID-19 Public Health Emergency (PHE); 1 (0-100% FPL); 2A (100.1-150% FPL); 2B (150.1-200% FPL); 3A (200.1-250% FPL); 3B (250.1-300% FPL); 3C (300.1-400% FPL); 3D (400.1-500% FPL)

Notes: The significant spike in enrollment for plan type 2A (100.1-150% FPL) reflects implementation of the American Rescue Plan (ARP), which was signed into law on March 11, 2021. Under the ARP, individuals who received unemployment income in 2021 were treated as having income of 133% FPL for eligibility purposes, regardless of their actual annual income. See Discussion section for additional details. The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid "unwinding" refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

2.3.1.3. Conclusions

These results partially support that the 2022–2027 Demonstration has continued to protect individuals' insurance coverage, although PHE and Medicaid unwinding have played a substantial role in enrollment patterns observed during our study period. Massachusetts maintains the lowest uninsurance rate in the United States. The churn rate remained low (at or below 1%) and enrollment continuity was maintained (above 95%) from 2021 to 2023, during the PHE. Early trends following the end of the PHE indicate that the churn rate has increased and enrollment continuity has started declining slightly, as impacted by the Medicaid unwinding; however, the levels remain comparable to those before the COVID-19 pandemic. Overall, during the current evaluation period, churn has decreased while enrollment continuity was maintained.

MassHealth enrollment for special populations — those in CommonHealth, Family Assistance, BCCDP, or MSP Standard — has been maintained or expanded. Overall, it is difficult to separate the effect of the PHE and unwinding from Demonstration policies and programs. The change of special program enrollment will need to be put in the context of the change of eligible members for each program which is not available in the existing data.

ConnectorCare enrollment declined during the PHE due to the federal continuous enrollment requirement, which kept individuals enrolled in MassHealth rather than transitioning to Marketplace coverage. Following Medicaid unwinding and especially after the Demonstration amendment expanded ConnectorCare eligibility from 300% to 500% FPL in January CY2024, enrollment increased substantially, reaching a historic high of 284,376 members by December CY2024. These findings suggest that Demonstration policies have helped maintain coverage.

2.3.2. *RQ1-2 Have premium assistance and cost-sharing programs supported continued coverage in the Demonstration?*

2.3.2.1. Summary of Results

Enrollment in MassHealth's ESI Premium Assistance program grew prior to the pandemic, stabilized during CY2020–CY2021, declined significantly during unwinding, and began to rebound in early CY2025. Enrollment trends showed continued coverage throughout the Demonstration, though with notable fluctuations tied to broader policy shifts. This may be a joint result of the premium assistance and cost-sharing programs alongside the PHE and unwinding. The section below focuses on ESI policies; the results for ConnectorCare are included in the previous section.

2.3.2.2 Results

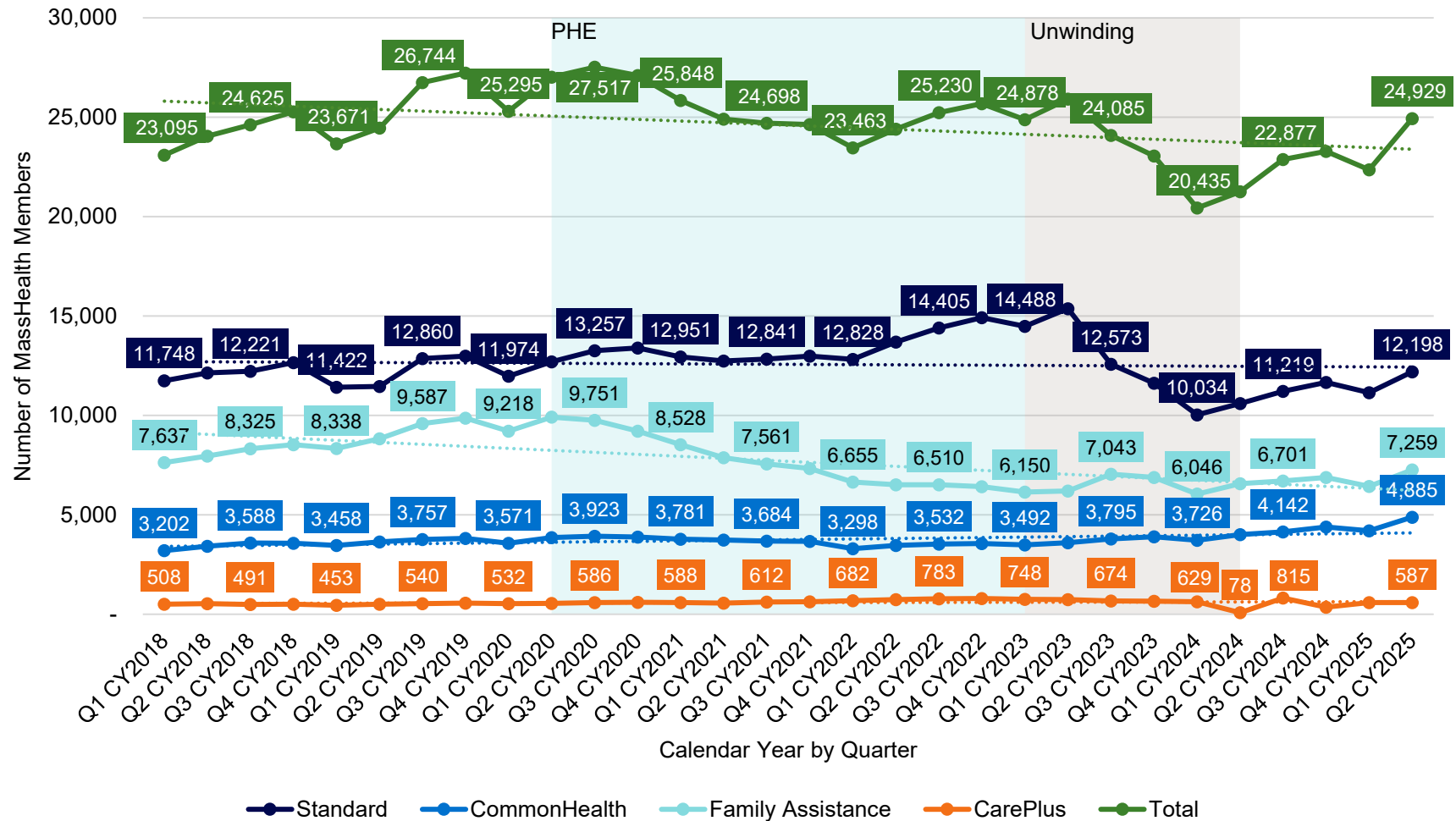
H1-2.1 The enrollment in private health insurance through MassHealth's premium assistance and/or cost-sharing has been maintained.

Figure 2.3-16 shows trends in the number and distribution of MassHealth members enrolled in ESI Premium Assistance from Q1 CY2018 through Q2 CY2025, by four coverage types:

Standard, CommonHealth, Family Assistance, and CarePlus. Total enrollment in the ESI Premium Assistance program shows noticeable variation over the CY2018 to CY2025 period. Enrollment increases steadily from 23,095 members in Q1 CY2018 to a peak of 27,225 members in Q4 CY2019, and it remains relatively high through CY2020, reaching 27,517 members at its highest point in Q3 CY2020. After this peak, enrollment begins a gradual decline throughout CY2021 and into early CY2022 before rebounding slightly through the remainder of CY2022. Beginning in mid-CY2023, enrollment experiences a more substantial decline, dropping from 25,916 in Q2 CY2023 to 23,053 in Q4 CY2023. This decline is followed by a steeper reduction during the Medicaid unwinding period. Enrollment reaches its lowest point of 20,435 members in Q1 CY2024, reflecting the eligibility redeterminations and associated MassHealth coverage loss. After this decrease, enrollment begins to recover, rising to 24,929 members by Q2 CY2025. Overall, the trend illustrates a period of growth prior to the COVID-19 pandemic, stabilization during CY2020 and CY2021, and a significant decline during unwinding, with early signs of enrollment increases in CY2025.

Across the entire period, Standard coverage consistently represents the largest share of enrollees. The number of Standard MassHealth members receiving ESI Premium Assistance fluctuates over time, with gradual increases and decreases from CY2018 to CY2022. Beginning in late CY2023, overall enrollment declines noticeably and continues to fall through 2024, which is likely due to the PHE ending in May CY2023 and subsequent Medicaid unwinding. Family Assistance is the second largest coverage group for much of the period. It peaks around CY2020 and CY2021 before gradually decreasing over the next several years. CommonHealth enrollment remains stable from CY2018 to the beginning of CY2023, and then gradually increases. CarePlus represents the smallest share of the ESI Premium Assistance population throughout the period and drops to its lowest during Q2 CY2024. According to MassHealth, this decline likely reflects significant fluctuations in member benefit plans and a large drop in the overall Third-Party Liability caseload during Medicaid unwinding following the end of the PHE.

As ConnectorCare provides cost-sharing assistance in addition to premium subsidies for all enrollees, please refer to **Figure 2.3.14** and **Figure 2.3-15** in **H1-1.5** to see the number of individuals enrolled in ConnectorCare through cost-sharing subsidies over time.

Figure 2.3-16 Number of MassHealth Members Enrolled in ESI Premium Assistance by Coverage Type, Q1 CY2018–Q2 CY2025

Data Source: MassHealth programmatic enrollment reports

Abbreviations: Calendar Year (CY); Employer-Sponsored Insurance (ESI); COVID-19 Public Health Emergency (PHE); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Notes: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid "unwinding" refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

2.3.2.3 Conclusions

Overall, the findings suggest that premium assistance and cost-sharing programs have supported continued coverage under the Demonstration, particularly through the ConnectorCare expansion. While external policy changes like the PHE continuous enrollment requirement and Medicaid unwinding affected enrollment patterns, it appears the Demonstration's eligibility expansion may have increased access to Marketplace subsidies and drove record enrollment levels. Although ESI Premium Assistance enrollment declined during unwinding, early CY2025 data indicate stabilization and recovery. Together, these results indicate that premium and cost-sharing supports remain an important mechanism for maintaining and expanding coverage, particularly during periods of policy transition.

2.3.3. RQ1-3 Has RE coverage of 90 days for children and pregnant individuals (and for all members no sooner than Jan. 1, 2026) impacted an individual's MassHealth enrollment?

2.3.3.1 Summary of Results

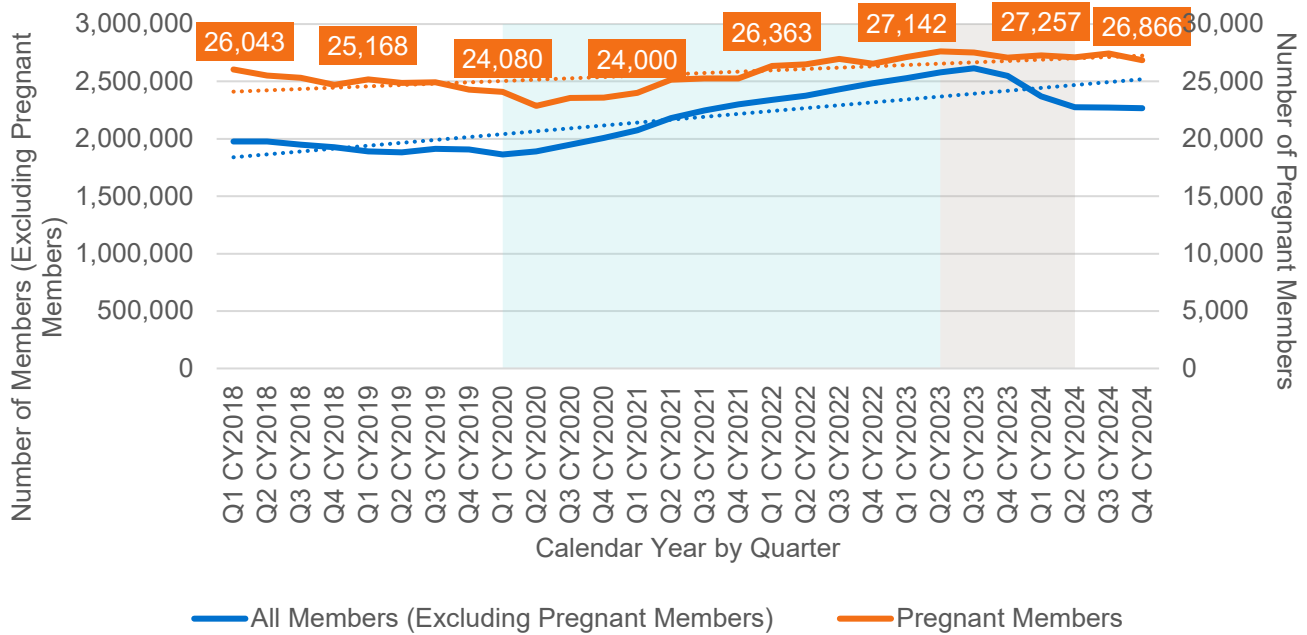
At the beginning of the 2022–2027 Demonstration, pregnant members and children under age 19 were eligible to receive 90-day RE during and after the PHE, while other groups remained at 10-day RE until an amendment in April 2024 that allows all eligible applicants to receive 90-day RE (effective January 2026). The effect of changing RE periods on enrollment and enrollment continuity was an outcome of interest per CMS recommendations, as little data had been reported on the effects of RE changes.⁶⁵ Increasing the allowable days of RE coverage would help bridge the gap of coverage due to churn from administrative errors or paperwork processing time; it also may reduce administrative errors due to less frequent eligibility redetermination. Enrollment for pregnant members was maintained from CY2018 to CY2023, while enrollment for children trended upwards during this period. As described in **H1-1.1**, the continuous enrollment rates for all members increased from CY2018 to CY2020 and then remained relatively steady through CY2023 (above 97%). These trends were similar among pregnant people and children.

2.3.3.2 Results

H1-3.1 Increasing the RE coverage from 10 to 90 days for Medicaid members (including children and pregnant members) increased the likelihood of enrollment and enrollment continuity.

Figure 2.3-17 and **Figure 2.3-18** show that enrollment among pregnant members and children was either maintained or increased from CY2018 to CY2024, similar to the trends among all members.

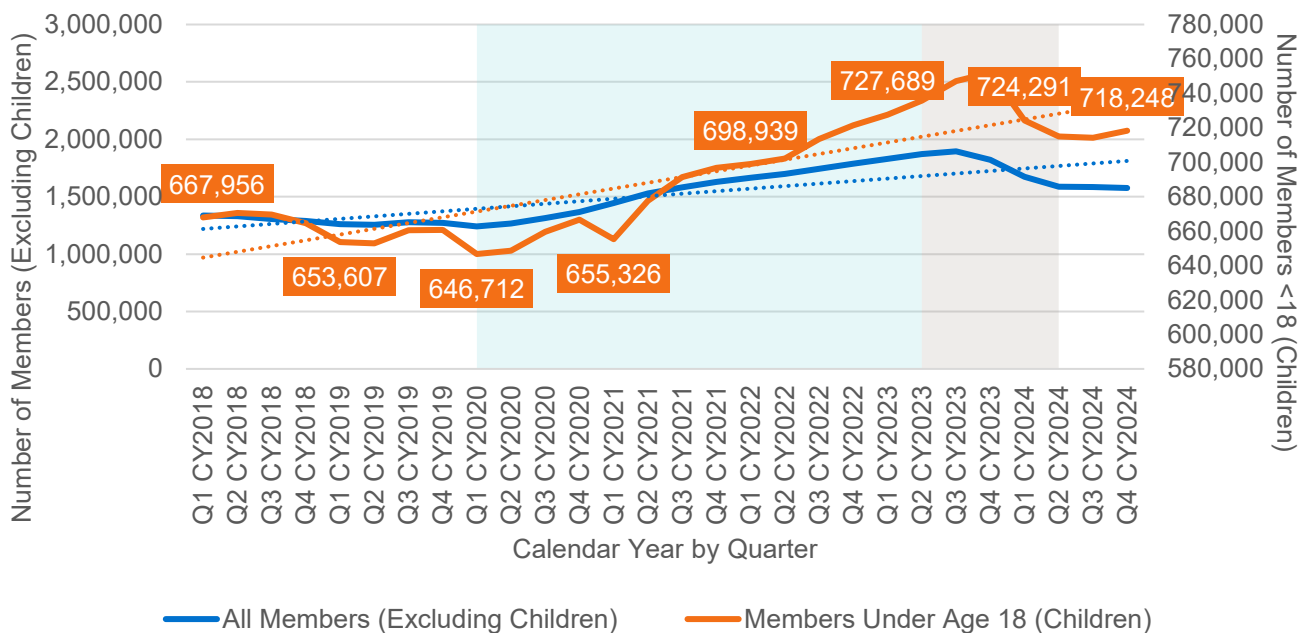
⁶⁵Medicaid and CHIP Payment and Access Commission (2019). Medicaid Retroactive Eligibility: Changes under Section 1115 Waivers. <https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf>.

Figure 2.3-17 Trends in Enrollment for Pregnant Members, CY2018–CY2024


Data Source: Medicaid enrollment and eligibility data, Medicaid claims/encounter data

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Notes: The dotted lines represent the linear trend. Pregnant members were identified using ICD-10 codes for services related to pregnancy, as recommended in NCQA's HEDIS MY2023 specifications. This method may lead to some undercounting, as members can only be identified during quarters in which they receive services. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid "unwinding" refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

Figure 2.3-18 Trends in Enrollment for Members Under Age 18 (Children), CY2018–CY2023


Data Source: Medicaid enrollment and eligibility data

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Notes: The dotted lines represent the linear trend. The PHE started in March 2020 and ended in March 2023; during this time, Massachusetts implemented the continuous enrollment provision. Medicaid “unwinding” refers to the period that eligibility redetermination restarted after the end of the PHE; this period started in April 2023 and ended in June 2024 for Massachusetts.

The rate of continuous enrollment among pregnant members during 12-, 18-, and 24-consecutive months mirrors the pattern and rates for the overall population presented earlier. The rate increased from CY2018 until it was disrupted in the beginning of CY2020, rebounded to almost 100% due to the protection of FFCRA, and then began to reduce slightly as Medicaid unwinding took effect. (See **Appendix Figure B-7.1**). From CY2018 to CY2024, the chances of being continuously enrolled for 12 months were higher than for 18 months, followed by 24 months, as expected. This trend was similar among children. (See **Appendix Figure B-7.2**). The 12-month continuous enrollment trends for pregnant and non-pregnant members were similar and were within one percentage point starting Q1 CY2021 through Q4 CY2023. (See **Appendix Figure B-7.3.3**). The rates of continuous enrollment for adults and children were also similar and within 1.5 percentage points starting Q1 CY2020. (See **Appendix Figure B-7.4**).

2.3.3.3. Conclusions

There were similar trends in enrollment and enrollment continuity among pregnant members and children as in the overall MassHealth population. Overall, pregnant members and children maintained enrollment continuity. Coverage policies for these populations may have supported this. In addition to granting the longer RE period through the Demonstration, in April 2022 the Commonwealth extended postpartum coverage from 2 to 12 months for individuals with income up to 200% of the FPL in 2022.⁶⁶ A 12-month CE policy for children went into effect after the period in this analysis (Jan. 1, 2024) and is intended to also support continuous enrollment.⁶⁷ It is difficult to separate the effect of these coverage policies from other policies, especially during the PHE.

2.3.4. RQ1-4 What is the impact of the RE waiver on the level of medical bills for members subject to the RE waiver?⁶⁷

2.3.4.1 Summary of Results

From 20 member interviews, members’ experiences with RE policy varied widely. Members tend to be unsure about their level of unpaid medical bills, and unsure of the RE policy. However, among the four interviewed members who used RE policies, the impact was perceived as meaningfully and, sometimes, substantially, reducing financial strain by eliminating significant medical debt.

⁶⁶ Rossi, H. (April 2022). *Eligibility Operations Memo 22-07, Extension of Postpartum Coverage for Eligible Individuals*. Commonwealth of Massachusetts, Executive Office of Health and Human Services, <https://www.mass.gov/doc/eom-22-07-extension-of-postpartum-coverage-for-eligible-individuals-0/download>

⁶⁷ This item will be evaluated through Dec. 31, 2025, as no members will be subject to the RE waiver as of Jan. 1, 2026, based on an amendment.

2.3.4.2 Results

H1-4.1 Increasing the RE coverage from 10 to 90 days for Medicaid members (including children and pregnant members) will result in a lesser financial burden on those members.

In MassHealth program staff survey responses (see **Appendix B-8** for MassHealth program staff survey), MassHealth noted that they do not systematically track member understanding of, or financial outcomes associated with, RE. While MassHealth reported taking formal steps to communicate the policy, including *“updat[ing] member regulations, issu[ing] sub-regulatory guidance, and communicat[ing] with external stakeholders”* (MassHealth Staff Survey Respondents, MH1 and MH10), staff indicated that they do not have data on how members experience or benefit from RE in practice. Specifically, MassHealth does not collect or verify information on unpaid medical bills reported during the application process, nor does it track the extent to which RE reduces members’ financial burden under either the 10-day or 90-day policy. As a result, MassHealth characterized the financial impact of RE, including whether certain populations are more significantly affected, as largely unknown. Given these limitations, MassHealth staff noted that member interviews are likely the primary means of assessing how the RE policy affects unpaid medical bills and financial burden.

In member interview responses (see **Appendix B-9** for member interview guide), 20 members were asked general questions about RE, including whether they were aware of it or eligible for it, and four affirmed they received 90-day RE. Members’ experiences with RE varied widely, beginning with whether they had unpaid medical bills prior to enrolling in MassHealth. Most of the 20 members reported that they did not have unpaid bills when they applied, with some stating plainly, *“I didn’t have any medical bills when I applied.”* (MassHealth member) Others were unsure whether they had outstanding bills, often because their enrollment occurred many years earlier. One member reflected that they *“probably”* had unpaid bills but could not recall the amount, noting that it *“has to be years and years old.”* (MassHealth member)

Among members who did report unpaid medical bills, the level of financial burden differed substantially. Some described relatively modest amounts, such as a bill totaling *“somewhere about \$800...\$800 to \$1000”* (MassHealth member) from copayments and blood work. Others, particularly members with more complex health needs, reported much larger debts. One member estimated owing *“probably in the thousands.”* (MassHealth member) Another member described being *“sickly”* with a chronic condition and accumulating *“thousands of bills”* (MassHealth member) prior to coverage. These accounts illustrate that while many members entered MassHealth without outstanding medical debt, those who did face unpaid bills often experienced a significant financial burden.

Awareness and understanding of the RE policy also varied. Members who knew about the policy generally found it easy to understand, often describing it as straightforward once explained. Several members emphasized their ability to navigate the policy independently. Other members explained that if something was unclear, they would *“look up what the words are”* (MassHealth member) or reach out to a knowledgeable friend. Others learned about RE through informal channels, including hospital flyers, caseworkers, and word-of-mouth from other

parents and patients. As one member explained, *“my caseworker tells me stuff and other parents...it’s a lot of word of mouth.”* (MassHealth member)

However, many members were unaware of RE altogether and expressed frustration at learning about it only later. When asked if the policy had been explained during enrollment, one member responded, *“absolutely not. I would’ve loved that. I would’ve loved to have known that.”* (MassHealth member) Another reacted with surprise upon hearing about it and expressed interest in contacting someone to learn more. These responses suggest that while the policy itself is understandable, gaps in communication or dissemination of information about RE may limit members’ ability to benefit from it.

For members who did receive 90-day RE, the impact on financial burden was substantial. Members consistently described the coverage as extremely helpful, particularly during periods of financial and emotional stress. When asked how 90-day RE helped with medical bills, one member shared, *“it paid them off, so it was great. I was a single mom at the time...I couldn’t afford that.”* (MassHealth member)

Another member recalled a similar experience when asked whether they had unpaid medical bills before being covered by MassHealth, stating,

“Member: I did have something, like some kind of ambulance bills from the past. [MassHealth] handled it and paid. They were helpful about it...they helped me rectify the situation.

Interviewer: And you would say that, overall, it was helpful to have that situation?

Member: Oh, definitely. Definitely. Nobody wants bills. They helped me take care of that.” – a MassHealth member (MEI016)

A third member described being hospitalized for a surgery that was particularly overwhelming and benefiting from 90-day RE. They noted,

“When I signed on with MassHealth, they backdated it to, I think the time I was hospitalized. So, when I went to the hospital for my surgery that was all covered...I wasn’t, like I said, in my present mind and everybody was just freaked out so yeah, they definitely covered surgery and forward.” – a MassHealth member (MEI026)

Together, these accounts demonstrate that RE is perceived among interviewees as meaningfully reducing financial strain by eliminating significant medical debt. In the anecdotes shared, RE was helpful specifically for single parents, individuals experiencing medical emergencies, and those undergoing major procedures. These findings support that increasing RE coverage from 10 to 90 days and informing members of this change have the potential to lessen the financial burden on Medicaid members, including children and pregnant members, by providing coverage during critical periods before their coverage would otherwise begin.

2.3.4.3 Conclusions

Overall, the available evidence suggests that the RE waiver’s expansion from 10 to 90 days likely reduced financial burden for members who incurred medical expenses shortly before

being determined eligible for coverage, even though administrative data are insufficient to quantify the magnitude of this effect. The absence of systematic tracking limits the ability to assess population-level impact or identify which subgroups benefited most. However, qualitative findings indicate that when RE was applied, it functioned as a financial protection during periods of need. Taken together, the results suggest that the RE policy plausibly mitigated medical debt risk for affected members, but stronger data would be needed to draw definitive conclusions about its overall impact.

2.3.5. RQ1-5 Has CE streamlined Massachusetts' administrative process for enrollment and eligibility?

2.3.5.1 Summary of Results

CE policies provide coverage to specified individuals for a set timeframe, regardless of income or other changes that would affect eligibility. MassHealth staff indicated that CE neither streamlined administrative processes nor created barriers in these processes.

2.3.5.2 Results

H1-5.1 CE has streamlined Massachusetts's enrollment and eligibility administrative processes.

The MassHealth staff who filled out open-ended surveys did not indicate that CE has streamlined enrollment and administrative processes. Across all relevant questions, staff reported no change in day-to-day administrative tasks, application processing, eligibility review workload, or oversight functions following the implementation of CE. Respondents also did not identify any specific ways in which CE either streamlined or complicated administrative processes. Taken together, these responses suggest that, from the administrative perspective captured in this survey, CE has neither meaningfully reduced administrative burden nor altered processing timelines.

2.3.5.3 Conclusions

Overall, the findings do not provide sufficient evidence that CE meaningfully streamlined Massachusetts's enrollment or eligibility administration during the Demonstration period, with very limited data gathered. Staff reported no observable changes in workload, processing timelines, or oversight responsibilities attributable to the policy. Based on available staff-reported data, the hypothesis that CE streamlined administrative processes is not supported. While CE would, by definition, reduce the number of renewals that staff have to process, staff also faced other policy changes and external factors like Medicaid unwinding that increased review of applications, so they may not perceive any difference, particularly given the relatively small proportion of members to whom CE applied. More data will be needed to further examine this hypothesis.

2.3.6. RQ1-6 Did C&E policies change MassHealth members' health care utilization?

2.3.6.1 Summary of Results

The analysis for the IEIR focuses on select members' long-term services and supports (LTSS) use, an interest expressed by CMS. The changes to CommonHealth and MSP eligibility for Standard members, which expanded access for members in these programs, may improve health care access and increase utilization for those individuals. Based on the descriptive statistics of analyzing claims/encounter data over time, MassHealth members' use of LTSS among those enrolled in CommonHealth 65+ and Standard + MSP programs has been stable overall, except for the relative decline in use of home health agency (HHA) services and "other LTSS" services, which includes prosthetics, certain equipment, and services such as non-emergency transportation and hospice.

2.3.6.2 Results

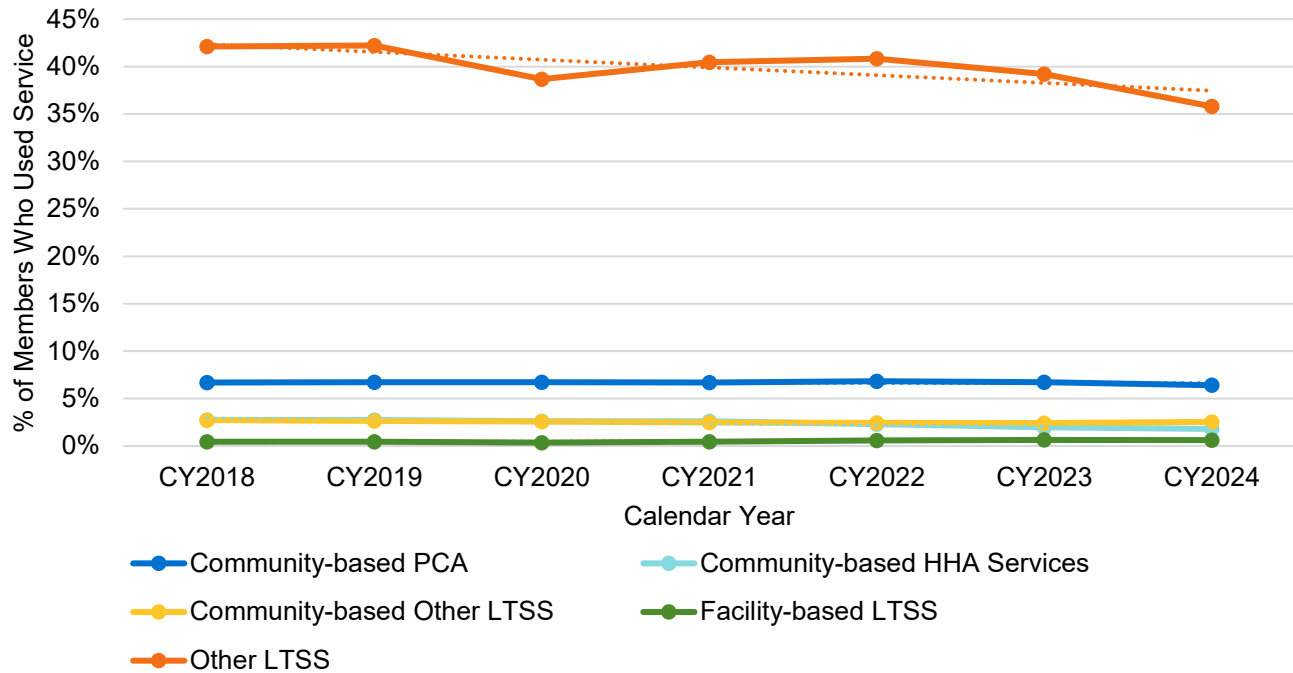
H1-6.1 MassHealth members have increased preventive, primary, and medically necessary specialist care.

Although our interim findings do not include results for preventive and primary care use, LTSS use was examined among two subgroups of MassHealth members: those enrolled in CommonHealth who are age 65 and older, and Standard members in MSP as suggested by CMS following the amendment approval of MSP eligibility expansion.⁶⁸ The services in analysis include community-based services (e.g., personal care assistant (PCA) use, HHA service use), facility-based services, and other LTSS services. PCA supports activities of daily living and HHA provides skilled nursing, physical, occupational, and speech therapy. Facility-based services include nursing facility care and specialized care for individuals with intellectual disabilities.

Figure 2.3-19 shows the overall use of LTSS services was stable, except a relative decline of HHA and other LTSS service use among CommonHealth 65+ and Standard + MSP members between CY2018 and CY2024. During this period, 6.4% to 6.8% of CommonHealth 65+ members used community-based PCA services; between 1.8% and 2.8% members used HHA services, with an overall downward trend. Between 2.4% and 2.7% of CommonHealth 65+ members used other community-based services (e.g., adult day health, adult foster care, group adult foster care, day habitation, and continuous skilled nursing). The use of facility-based LTSS was very limited among CommonHealth 65+ members ($\leq 0.6\%$ across years). Between 35.8% to 42.2% of CommonHealth 65+ members used other LTSS services, including durable medical equipment, non-emergency transportation, oxygen and respiratory therapy and equipment, orthotics, prosthetic, and hospice services; there was a dip in CY2020 during the beginning of COVID-19. A similar trend was observed among Standard + MSP members (see **Figure 2.3-13**), except that the decline of other LTSS services did not rebound from the decline after CY2020.

⁶⁸ CMS' comments in Demonstration amendment: "*The demonstration amendment increased the income threshold for MassHealth Standard members to also receive Medicare Part A and Part B premium and cost sharing assistance from 133% to 190% of the federal poverty level (FPL). In addition, the threshold to receive Medicare Part B premium assistance increased from 165% to 225% of the FPL. The state should consider exploring how these changes affect the outcomes of those who were not initially eligible for the subsidies but now are eligible under the new thresholds. The state could also consider evaluating downstream health outcomes and use of Medicaid covered home- and community-based services and other long-term supports and services.*"

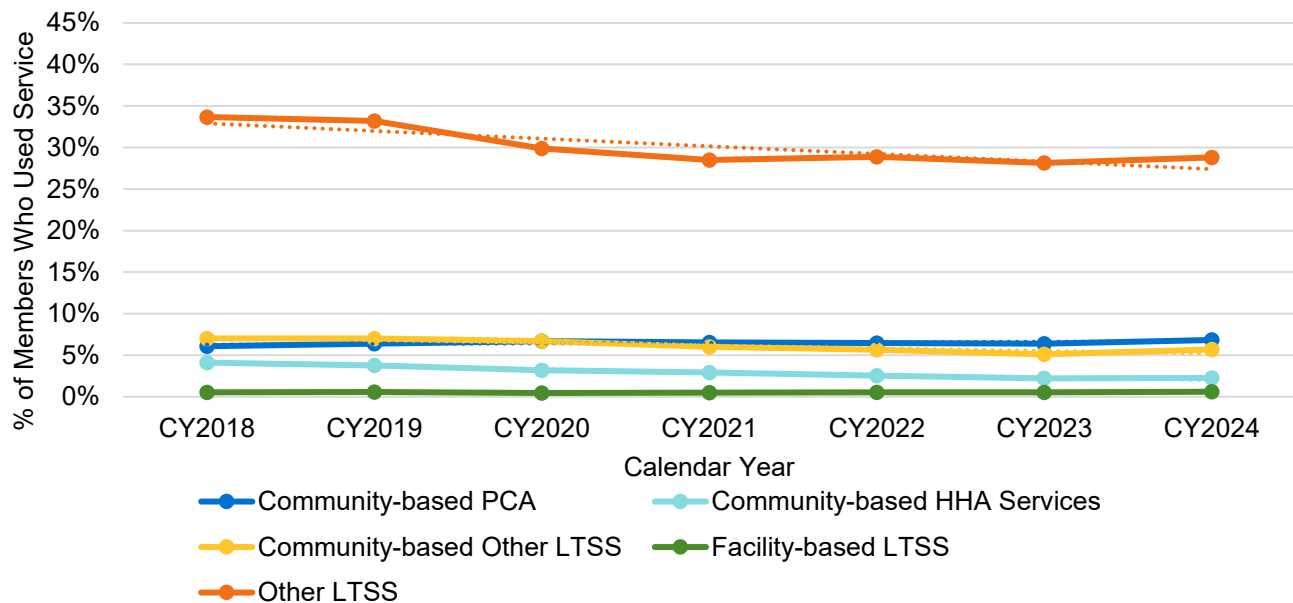
Figure 2.3-19 LTSS Use Among CommonHealth Members Age 65+, CY2018–CY2024



Data Source: Medicaid administrative data

Abbreviations: Calendar Year (CY); Home Health Agency (HHA); Long-Term Services and Supports (LTSS); Personal Care Assistant (PCA)
 Notes: The dotted lines represent the linear trend. PCA supports activities of daily living and HHA provides skilled nursing, physical, occupational, and speech therapy. Facility-based services include nursing facility care and specialized care for individuals with intellectual disabilities. Community-based Other LTSS includes adult day health, adult foster care, assisted living services, day habilitation, case management, and continuous skilled nursing. Other LTSS includes durable medical equipment, oxygen and respiratory therapy and equipment, orthotics, prosthetics, non-emergency transportation and hospice services. The number of members 65 years or older enrolled in CommonHealth steadily increases from 5,431 members in CY2018 to 11,973 in CY2024 (see Figure 2.3-9).

Figure 2.3-20 Percentage of LTSS Use Among Standard + MSP Members, CY2018–CY2024



Data Source: Medicaid administrative data

Abbreviations: Calendar Year (CY); Home Health Agency (HHA); Long-Term services and Supports (LTSS); Medicare Savings Program (MSP); Personal Care Assistant (PCA)

Notes: The dotted lines represent the linear trend. PCA supports activities of daily living and HHA provides skilled nursing, physical, occupational, and speech therapy. Facility-based services include nursing facility care and specialized care for individuals with intellectual disabilities. Community-based Other LTSS includes adult day health, adult foster care, assisted living services, day habilitation, case management, and continuous skilled nursing. Other LTSS include durable medical equipment, oxygen and respiratory therapy and equipment, orthotics, prosthetics, non-emergency transportation and hospice services. The number of members enrolled in Standard + MSP increased from 156,108 in CY2018 to 192,900 in CY2023 and then declined slightly to 189,642 with unwinding in CY2024 (see Figure 2.3-12 for quarterly trends).

2.3.6.3 Conclusions

During the 2022–2027 Demonstration, the use of most LTSS services among Medicaid members enrolled in CommonHealth 65+ and Standard + MSP programs was stable with the exception of lower use of HHA and other LTSS services.

2.3.7. RQ1-7 *What have been members' overall experience with the new and ongoing C&E policies/programs?*

2.3.7.1. Summary of Results

Based on member interviews, members' overall experiences with MassHealth were mixed, with some challenges related to understanding C&E policies and maintaining access to care. Members shared that digital communication as well as the opportunity to speak with a real person about coverage — for example, a provider or MassHealth representative — would be effective for improving awareness of C&E policies. Members also shared mixed experiences with changing coverage policies; some had no issues whereas others felt confused or concerned about losing access to services. Income or income threshold changes for coverage were not perceived as barriers to services. Members were often unsure about which special programs they were involved in but reported generally favorable experiences.

2.3.7.2. Results

H1-7.1 The new and ongoing C&E programs/policies have improved members' experiences.

In interviews, members spoke about their experiences with MassHealth, including communication about coverage, effect of income changes on coverage, and experiences of coverage and access to services. Members' overall experiences with MassHealth were mixed, with some challenges related to understanding C&E policies and maintaining access to care. When asked about how they prefer to learn about new or revised policies, several members emphasized the importance of clear, personal explanations. One member explained that *"having [C&E policies] explained to me"* (MassHealth member) by their primary care provider (PCP) was the easiest way to understand the policies and felt that, when explained in this way, the policies were easy to grasp. Others similarly expressed a preference for speaking with a real person over the phone, particularly when navigating complex situations such as long-term care applications. One member recalled how helpful it was to speak with a business manager at a long-term care facility who could walk them through the details, stating *"I think a call with an actual person would definitely be helpful."* (MassHealth member) This sentiment suggests that proactive calls from MassHealth or knowledgeable staff at their provider's office could greatly improve members' understanding of available programs.

In contrast, mailed notices were widely viewed as ineffective. Several members described feeling overwhelmed by the volume of mail they receive and admitted that MassHealth letters often go unread or are accidentally discarded. As one member put it, there is *“always something from MassHealth in the mail,”* but email would make things *“so much easier”* (MassHealth member) and more likely to be read. Others echoed this sentiment, explaining *“I think that sometimes with MassHealth the mailings aren’t eye appealing. To catch your eye to be like, ‘Oh, I should read this’”* (MassHealth member), whereas online information felt more appealing and easier to navigate. Text messages were also seen as a promising alternative, with one member noting that a text is *“more right in your face”* (MassHealth member) and, therefore, more likely to be read than mail that sits unopened for days. Across interviews, members consistently suggested that digital communication, whether by text, email, or web-based portals, would improve awareness of C&E policies and reduce confusion. Only one member suggested that mail would be their preferred form of communication.

Generally, members shared that they did not have issues with MassHealth covering their typical health care services. However, members’ experiences were not always clearly attributable to MassHealth coverage policies specifically, as some concerns appeared to relate to their managed care plans. Members who had not experienced coverage changes often expressed relief and valued being able to speak with a provider or MassHealth representative for reassurance. Other members discussed ways in which their MassHealth coverage or changes to their coverage affected their experience with accessing care. A few members described having experienced recent changes or disruptions which led to challenges with accessing needed care. One member explained that a change in insurance resulted in the loss of visiting nurse services and required them to find a new neurologist, leading to frustration and concerns about safety and continuity of care.

“Well right now I have a problem with my MassHealth...I used to have the visiting nurse...and I can’t have that service no more because MassHealth changed me, my other insurance doesn’t cover that. I have to look for another neurologist, because the one that I have in [health system] doesn’t take that insurance. I always been on Standard MassHealth that everywhere that I go, they accept me. But now with that other MassHealth, the other insurance, I’m not receiving the things that I want. And they send me a nurse company that I didn’t like it, I didn’t feel safe.” – a MassHealth member (MEI019)

Others worried preemptively about potential changes, emphasizing that they did not want their coverage altered without someone clearly explaining what services they could or could not receive. One member expressed feeling unsupported, noting that *“no one has sat down with me to tell me what I can get with it, what I can’t get with it.”* (MassHealth member)

A few members experienced challenges with finding a PCP or specialist who accepted their MassHealth plan. This was a motivator for one member to switch managed care plans, describing how they *“can’t do this anymore”* (MassHealth member) and changed insurance

because they needed to see a doctor and could no longer navigate the limitations of their existing plan.

Of the members interviewed, members reported that income changes, a key component of eligibility determination, rarely resulted in changes to members' MassHealth coverage. Most members who reported income fluctuations, such as modest annual increases in Social Security, or state supplemental income (SSI) benefits, said these changes did not affect their coverage. One member described a small yearly Social Security increase and confirmed that their MassHealth did not change as a result. Another member similarly noted that despite receiving Social Security and SSI, their coverage remained stable. Others reported income decreases after stopping work, yet their MassHealth coverage also stayed the same.

Only a small number of members experienced gaps in coverage, and these were typically attributed to administrative or timing issues rather than income changes alone.

"I went out of coverage due to making too much money and then I missed the free enrollment period so I just waited out the year which, probably not the smartest thing I could have done. But I reapplied in January and then I got the same services I had prior to not having it."
– a MassHealth member (MEI021)

Another member described a temporary gap linked to filing taxes late, noting *"as long as I file my taxes on time, there's never really a gap in coverage, but I didn't file my taxes on time one year and I did get a gap for myself."* (MassHealth member)⁶⁹ However, their children's coverage remained intact, and their own coverage was restored once the issue was resolved. These few members' accounts suggest, but cannot solely prove, that income changes at 12-month intervals rarely disrupted coverage, reinforcing continuity of coverage under current C&E policies.

Finally, while not all members were certain whether they participated in special C&E coverage programs like CommonHealth, BCCDP, Family Assistance, and Standard + MSP, those who confirmed enrollment generally reported positive experiences. Some members knew they had MassHealth or a specific managed care plan but were unsure whether that meant they were enrolled in programs such as CommonHealth or Family Assistance, with one member describing the distinction as *"a little bit tricky"* (MassHealth member) and expressing uncertainty about whether their coverage fell under a specific program category.

Among the few members who did confirm participation in these coverage programs, experiences were consistently favorable. Parents of children receiving services through these programs reported that care remained stable and that providers were supportive, with one noting that their child was *"being treated the same...her doctor has been really supportive"* (MassHealth member) and that there were no challenges to report. Others described clear improvements in their health care after enrolling in CommonHealth, often learning about the program through informal networks such as friends, and emphasized the absence of major

⁶⁹ Modified Adjusted Gross Income (MAGI) is the basis for determining Medicaid income eligibility for some members. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. If a person files their taxes late, it may result in a delay in the calculation of their MAGI.

challenges once enrolled. Together, these findings suggest that while awareness of specific C&E programs may be limited, participation itself is associated with positive member experiences and perceived improvements in care.

2.3.7.3. Conclusions

Overall, findings from the small interview sample provide mixed support for the hypothesis that new and ongoing C&E policies have improved members' experiences. While many members reported stable coverage and generally positive experiences, particularly when enrolled in special coverage programs, confusion about policy details and communication gaps limited the perceived benefits of these changes. Disruptions related to plan changes or provider access highlight that improvements in eligibility policy do not always translate into seamless care experiences. Notably, these findings should be interpreted in the context of the PHE and subsequent unwinding period, during which members received more frequent and atypical communications and were not experiencing standard renewal processes, potentially limiting the generalizability of these experiences. Taken together, C&E policies appear to support coverage continuity, but clearer, more proactive communication and attention to care transitions are critical to fully improving member experience.

2.4. Discussion

2.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

The C&E policies under the 2022–2027 Demonstration use the following levers to create new coverage or protect and enhance existing coverage: (1) covering more individuals; (2) offering continuing eligibility for special populations (e.g., individuals with justice involvement and individuals experiencing homelessness); (3) providing premium assistance and cost-sharing subsidies to support members' use of health care services; and (4) restoring RE coverage. The key outcomes of interest are: uninsurance rate, MassHealth enrollment, churn, enrollment continuity, special program enrollment, LTSS services utilization, streamlined administrative process, and member experiences.

The interim findings are based on analyses that account for some lessons learned from the 2017–2022 IESR, including gathering member experiences, examining post-PHE enrollment trends, and evaluating members' health care service utilization. Note again that the results are substantially influenced by PHE and unwinding, so observed changes presented in the IEIR do not reflect the causal impact of Demonstration policies. Our interpretation is only limited to presenting the observed changes of outcomes and do not attribute the changes solely to the Demonstration. In fact, because the C&E policies apply to specific populations, PHE and unwinding likely play a larger role in the outcomes measured among MassHealth members as a whole.

Overall, during the 2022–2027 Demonstration period, Massachusetts residents have sustained near-universal health insurance coverage, with uninsurance rates below 3% across all age groups from CY2022 to CY2024. The rates were also the lowest compared to the other nine comparison states (and across the entire United States), even amid significant policy transitions

such as the PHE and Medicaid unwinding. Multiple C&E policies and programs contribute to this high level of access for the Commonwealth's residents.

In addition to high rates of insurance coverage during the initial phase of the Demonstration, a low churn rate and high enrollment continuity rate have been maintained among MassHealth members. Overall, churn has declined and enrollment continuity increased slightly from the period before the Demonstration (CY2018–CY2021). The CE policies that allow for longer continuous enrollment for the justice-involved population and people experiencing homelessness likely contribute to the continuity, although the populations are small. Streamlined eligibility review through auto-enrollment can also reduce the churn and increase continuity, which will be evaluated in the next phase of the evaluation. Enrollment trends indicate that premium assistance and cost-sharing programs supported continued coverage. Members subject to the 90-day protection of RE (e.g., pregnant women, children) have a comparable rate of continuous enrollment during the 12-month period from enrollment, compared to their counterparts who returned to 10-day protection following the end of the PHE. Massachusetts's trends reflect this dynamic environment: overall system performance may be improving (as indicated by higher continuity rates), while federal policies and operational and economic pressures still produce variability in disenrollment and reenrollment patterns.

The simultaneous rise in continuous enrollment is an encouraging sign because research consistently shows that continuous Medicaid coverage improves access to care, continuity of clinical relationships, and health outcomes. The Commonwealth Fund reports that at least 12 months of uninterrupted Medicaid coverage reduces churn, lowers administrative burdens, and is linked to improved access and outcomes.⁷⁰ Similarly, the Office of the Assistant Secretary for Planning and Evaluation has shown that beneficiaries with longer continuous enrollment have significantly lower average monthly health care costs, due to fewer care disruptions and less pent-up demand.⁷¹

Enrollment in special programs has been stable overall and increased in some programs. For example, CommonHealth enrollment increased steadily among adults between 19 and 64 years old and those 65 years and older, echoing the changes in CommonHealth eligibility under the 2022–2027 Demonstration. Following the income threshold being increased for the Standard + MSP program, enrollment in Medicaid Standard + QMB program, which offers broader cost-sharing protections, increased during the Demonstration period and started declining after unwinding following the similar trend of the changes for the Medicaid Standard program as a whole. The Standard + SLMB/QI members appear to have shifted into the more comprehensive Standard + QMB category which offers broader cost-sharing protections, after the amendment for the Standard + QMB program took effect.

Enrollment in ConnectorCare increased during the Demonstration period as well. During periods of churn or eligibility transitions, adults frequently move between Medicaid and Marketplace

⁷⁰ Musumeci, M., Murphy, C., Leiser, E., Silverman, H., & Azimpoor, K. (2025). *Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage>

⁷¹ Sugar, S., Peters, C., De Lew, N., & Sommers, B. D. (2021). *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*. <https://aspe.hhs.gov/sites/default/files/documents/5f6e4d78d867b6691df12d1512787470/medicaid-churning-ib.pdf>

programs to prevent coverage gaps. The significant spike in enrollment for plan type 2A (100.1–150% FPL) reflects implementation of the American Rescue Plan (ARP), which was signed into law on March 11, 2021. Under the ARP, individuals who received unemployment income in 2021 were treated as having income of 133% FPL for eligibility purposes, regardless of their actual annual income.⁷² Massachusetts was the first state to implement the expanded ARP premium tax credits on March 26, 2021, and ConnectorCare incorporated this policy for July 2021 coverage. This resulted in the observed increase in plan type 2A enrollment. The provision expired at the end of CY2021, which led to the corresponding decline in plan type 2A enrollment.⁷³ The Demonstration amendment approved in April 2024, which increased the income limit for premium and cost-sharing assistance through ConnectorCare from 300% FPL to 500% FPL, also led to an increase in enrollment. As of December CY2024, ConnectorCare reached its highest program enrollment in its 10-year history.

The enrollment with ESI Premium Assistance increased through CY2019, remained stable through CY2021, declined during Medicaid unwinding, and showed early signs of recovery in CY2025. Enrollment growth through CY2019 and stability through CY2021 coincide with a period of relatively stable Medicaid operations nationwide. However, the decline during Medicaid unwinding is consistent with national evidence showing that the resumption of eligibility redeterminations led to significant disenrollment and shifts in coverage pathways across multiple programs. The early recovery observed in CY2025 shows that once states stabilize administrative processes — and especially as they improve automation and continuous-eligibility supports — affected programs begin to regain enrollment. Overall, Massachusetts's enrollment patterns across special programs demonstrate how interconnected coverage programs are, and how strongly enrollment responds to administrative rules, income eligibility adjustments, and federal policy transitions.

Findings from member interviews highlight important gaps in awareness and understanding of the RE policy, with many individuals unaware of its existence and unsure how their medical bills were being handled. Despite this low baseline awareness, the few who did use RE reported meaningful reductions in financial hardship. These experiential insights suggest that expanding the RE waiver period from 10 to 90 days is likely to alleviate financial strain for members who incur medical expenses shortly before enrolling in coverage. However, because administrative data do not adequately capture the extent of pre-enrollment medical spending or the proportion of members who benefit, the magnitude of the policy's overall impact cannot be precisely quantified at this time. Stronger, more detailed data — including claims attributable to RE, member-level financial indicators, and more robust tracking of pre-enrollment service use — would be required to draw definitive conclusions about the full effect of the expanded RE policy.

Member experiences with MassHealth were mixed, with generally favorable experiences but some challenges with understanding coverage policies. Direct communication with staff or providers was viewed as effective, while improved digital communication could enhance policy

⁷² Chu, R. C., Branham, D. K., Finegold, K., Conmy, A. B., Peters, C., De Lew, N., & Sommers, B. D. (2021). *The American Rescue Plan and the Unemployed: Making Health Coverage More Affordable After Job Loss*. <https://aspe.hhs.gov/sites/default/files/2021-07/aspe-arp-ui-ib.pdf>

⁷³ Gasteier, A. M. (2021). *American Rescue Plan Implementation Update*. https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2021/05-13-21/ARP-Update-and-Outreach-Budget-VOTE-051321.pdf

awareness. Member feedback highlights the importance of clear communication and personalized assistance in navigating coverage changes.

The service-use patterns observed among CommonHealth members 65 years of age and older — specifically, sustained use of community-based PCA services alongside reduced use of HHA and other LTSS-covered services — are consistent with broader trends in Massachusetts's LTSS landscape. Massachusetts has made substantial investments in expanding access to home- and community-based services (HCBS), which are designed to help older adults remain independent and avoid institutional settings. This emphasis aligns with statewide trends showing that the majority of LTSS users now rely primarily on HCBS rather than facility-based care. The limited use of facility-based LTSS among CommonHealth 65+ members likely reflect both the program's design and the characteristics of its enrollees. Many members continue to work, suggesting they are generally healthier and have higher functional capacity than other older adults who more frequently rely on institutional LTSS. This pattern is consistent with broader evidence that individuals with lower functional needs are more likely to rely on HCBS — particularly PCA services — while those with greater medical or custodial needs are more likely to utilize facility-based supports. Furthermore, while PCA use appears stable, reductions in HHA and other LTSS services may reflect a combination of member health status, availability of informal support, and statewide HCBS policy shifts that prioritize flexible care models like PCA over more medicalized services. Together, these findings indicate that CommonHealth 65+ members are generally maintaining independence through sustained use of community-based supports and have comparatively limited reliance on institutional LTSS, consistent with state and national trends prioritizing community living.

Overall, the findings indicate that the Demonstration has contributed to preserving coverage and financial protection, while pointing to opportunities to improve member understanding and engagement to further strengthen program effectiveness.

The evaluation of the C&E policies is subject to particular challenges. The PHE overlapped with the beginning of the Demonstration, thus, amplifying the important role of the 2022–2027 Demonstration in continuing to promote health care insurance coverage and access effectively. Similarly, Medicaid unwinding has resulted in sharp changes in the churn rate and length of churn. Disentangling the effect of C&E policies and programs from other policy impacts during the early years of the Demonstration remains a challenge. In fact, PHE and unwinding had much larger impacts on enrollment than the Demonstration programs/policies.

Changes to eligibility and enrollment policies at the federal level are anticipated to be major confounding factors in influencing future enrollment and enrollment continuity. For example, work requirements will be implemented in Massachusetts in 2027. CE policies will not be continued after the 2022–2027 Demonstration. Eligibility redeterminations will occur twice instead of once a year for some individuals, and the RE coverage period will change again. These changes are anticipated to affect enrollment outcomes and members' experiences with retaining coverage and accessing care.

2.4.2. *Lessons Learned and Recommendations*

Our evaluation of this Demonstration shows that the C&E programs and policies that MassHealth has put in place through the 2022–2027 Demonstration, including the CE policy and premium assistance or cost-sharing subsidies for Marketplace members, allow for continued access to and uptake of health insurance among Massachusetts residents and contributed to low uninsurance in the Commonwealth.

1. **Lesson Learned:** Several programs have been under Demonstration authority for many years and have remained largely unchanged. Examples of these programs are CommonHealth, Family Assistance, and BCCDP. Over the course of several previous Demonstration evaluations, these programs have been shown to be of continued value in supporting near-universal coverage for the state's residents.
 - **Recommendation:** States should consider leveraging the continuation of existing policies to promote continuity of coverage while identifying and evaluating creative new policy levers (e.g., continuous enrollment for people experiencing homelessness) to sustain and grow the impact of C&E policies in promoting access to health care among vulnerable populations.
2. **Lesson Learned:** MassHealth uses a variety of programs and policies to promote coverage, continuity, and affordability. To make the care more accessible and affordable, it requires supporting individuals with both gaining Medicaid coverage and being able to pay for services through premium assistance and cost-sharing subsidies.
 - **Recommendation:** To support members' access to care, states should consider policy options to cover those without access to insurance and provide premium assistance and cost-sharing subsidies for those with access to private insurance to ensure that it is affordable.

3. Delivery System Reform

3.1. Background

MassHealth's 2022-2027 1115 Medicaid Demonstration continues the Accountable Care Organization (ACO) Program, implemented under the 2017-2022 1115 Demonstration with the support of investments made through the Delivery System Reform Incentive Payment (DSRIP) Program⁷⁴. The Delivery System Reform (DSR) domain of this evaluation studies several new and re-authorized policies and reforms specific to the ACO Program under the 2022-2027 Demonstration. The ACO contract period for the 2022-2027 Demonstration began on April 1, 2023, and is expected to continue through the end of the Demonstration on December 31, 2027.

ACOs

The primary component of the DSR domain and vehicle for DSR is the ACO Program. ACOs are provider-led organizations that are held accountable for the cost and quality of care delivered to a population of enrollees. ACOs are held accountable for multiple quality measures per an ACO quality measure slate and are at financial risk for members' total cost of care (TCOC). Under the 2022-2027 Demonstration, there are two ACO models: the Accountable Care Partnership Plan (ACPP) and Primary Care Accountable Care Organizations (PCACOs). Of the roughly 2 million MassHealth members as of April 2024⁷⁵, approximately 68% of those eligible were enrolled in the 15 ACPPs and 24% of those eligible were enrolled in the two PCACOs procured in this Demonstration. The number of health systems in Massachusetts participating as MassHealth ACOs and accepting associated value-based payments remained consistent (n=17) from the 2017-2022 to the 2022-2027 Demonstrations. However, when accounting for the merger of two former ACOs (Beth Israel Deaconess and Lahey Health System) and the new addition of the UMass Memorial ACO during the 2022-2027 Demonstration, the overall change represents an increase in ACO participation. See **Appendix C-1** for a list of ACOs.

ACPPs

An ACPP is a partnership between a health plan and a provider-led ACO. Specifically, an ACPP is a network of primary care providers (PCPs) who have exclusively partnered with one health plan to create a full network that includes PCPs, specialists, behavioral health (BH) providers, and hospitals. Members select or are assigned a PCP affiliated with the ACPP and receive ACO-covered services from providers in the ACPP's network. ACPPs are paid through prospective risk-adjusted capitation with shared savings and losses amounts determined based on TCOC and quality performance during reconciliation with MassHealth after the end of each contract year.

PCACOs

⁷⁴ Commonwealth of Massachusetts (2026). Massachusetts Delivery System Reform Incentive Payment Program (DSRIP).

[Massachusetts Delivery System Reform Incentive Payment Program | Mass.gov](https://www.mass.gov/doc/massachusetts-delivery-system-reform-incentive-payment-program/download)

⁷⁵ Commonwealth of Massachusetts (2026). MassHealth Enrollment Summary of April 2024 Caseload. <https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-april-2024/download>

A PCACO is a provider-led entity comprising of PCPs that contract directly with MassHealth. Members enrolled in a PCACO select or are assigned a PCP affiliated with the PCACO, receive covered services through MassHealth's fee-for-service (FFS) network, and receive BH services through MassHealth's BH vendor. PCACOs are paid monthly administrative payments, and monthly capitation amounts for a defined set of primary care services. Services for members in PCACOs are paid FFS, with the exception of those covered by the primary care capitation payment and those covered by the BH vendor. The amount of shared savings and shared losses are determined based on TCOC and quality performance during reconciliation after the end of each contract year.

New and Re-Authorized DSR Policy Reforms

Primary Care Sub-Capitation Program

Primary care availability and utilization, due to lack of access, have been on the decline for more than a decade^{76,77} while the demand for primary care services remains high⁷⁸. Under the 2022-2027 Demonstration, MassHealth has committed to the advancement and support of primary care, including through an increase in funding for primary care through the Primary Care Sub-Capitation Program (Sub-Capitation Program)⁷⁹. Calculated on a per-member-per-month (PMPM) basis, Sub-Capitation Program payments to primary care practices are based on their attributed population, historical fee-for-service utilization among those attributed to the practice for a distinct set of services/codes, and their clinical tier⁸⁰. ACOs are contractually required to share gains from savings or share payment responsibility for losses such that their primary care practices are held accountable for a meaningful proportion of their Medicaid patient service revenue (sub-capitation payments plus other Medicaid payments) based on their contribution to the performance of the ACO (e.g., with respect to cost and quality). Primary care practices and PCPs are incentivized to make care delivery and population health improvements through a three-tiered payment approach. The higher the tier, the more integrated and enhanced the primary care services offered, and the larger the payment add-on. See **Table 3.1-1** for tier requirements.

⁷⁶ Jetty A, et al. An Evaluation of the Decline in Primary Care Physician Visits, 2010 to 2021. *Journal of Primary Care & Community Health*. 2025;16. doi:[10.1177/21501319251321618](https://doi.org/10.1177/21501319251321618)

⁷⁷ Hoffer E. Primary Care in the United States: Past, Present and Future. *The American Journal of Medicine*, 2024; 137, 702-705. doi:[10.1016/j.amjmed.2024.03.012](https://doi.org/10.1016/j.amjmed.2024.03.012)

⁷⁸ Milbank Memorial Fund. (2025). The Health of US Primary Care 2025 Scorecard: The Cost of Neglect. [The Health of US Primary Care 2025 Scorecard: The Cost of Neglect](#)

⁷⁹ Commonwealth of Massachusetts (2026). MassHealth Primary Care Sub-Capitation Program. [MassHealth Primary Care Sub-Capitation Program | Mass.gov](#)

⁸⁰ Commonwealth of Massachusetts (2025). MassHealth Primary Care Sub-Capitation: How Practices Get Paid. [MassHealth Primary Care Sub-Capitation: How Practices Get Paid | Mass.gov](#)

Table 3.1-1 Primary Care Sub-Capitation Program: Tier Requirements

	Care Delivery Requirements	Structure and Staffing Requirements	Population-Specific Requirements
Tier 1	- Traditional primary care - Referral to specialty care - Oral health screening and referral - BH and SUD screening - BH referral with bi-directional communication, tracking, and monitoring - BH medication management - HRSN screening - Care coordination - Clinical Advice and Support Line - Postpartum depression screening - Use of Prescription Monitoring Program - LARC provision, referral option	- Same-day urgent care capacity - Video telehealth capability - No reduction in hours - Access to translation and interpreter services	<i>Practices serving enrollees age 21 or younger:</i> - Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT - Screen for SNAP and WIC eligibility - Establish and maintain relationships with local CBHI - Coordination with MCPAP and M4M - Fluoride varnish for patients ages 6 months up to 6
Tier 2*	- Brief intervention for BH conditions - Telehealth-capable BH referral partner	- E-consults available in at least three specialties - After-hours or weekend session - Team-based staff role - Maintain a consulting independent BH clinician	<i>Practices serving enrollees age 21 or younger:</i> - On-site staff with children, youth, and family-specific expertise - Provide patients and their families who are eligible for SNAP and WIC application assistance <i>Practices serving enrollees ages 21-65:</i> - Offer at least one type of LARC - Active buprenorphine availability - AUD treatment availability
Tier 3**	<i>Fulfill at least one of three requirements:</i> - Clinical pharmacist visits - Group visits - Designated Educational Liaison for pediatric patients	- E-consults available in at least five specialties - After-hours or weekend session - Three team-based staff roles	<i>Practices serving enrollees age 21 or younger:</i> - Full-time, on-site staff with children, youth, and family-specific expertise - Offer at least one type of LARC

	Care Delivery Requirements	Structure and Staffing Requirements	Population-Specific Requirements
		Maintain a consulting independent BH clinician with prescribing capability	- Active buprenorphine availability <i>Practices serving enrollees ages 21-65:</i> - Offer multiple types of LARC - Capability for next business day MOUD induction and follow-up

Source: MassHealth Primary Care Sub-Capitation: Care Delivery Transformation⁸¹

Abbreviations: Alcohol Use Disorder (AUD); Behavioral Health (BH); Children's Behavioral Health Initiative (CBHI); Early and Periodic Screening Diagnostic, and Treatment (EPSDT); Health Related Social Need (HRSN); Long Acting Reversible Contraception (LARC); Massachusetts Child Psychiatry Access Program (MCPAP); Massachusetts Behavioral Health Partnership (M4M); Medications for Opioid Use Disorder (MOUD); Supplemental Nutrition Assistance Program (SNAP); Substance Use Disorder (SUD); Special Supplemental Nutrition Program for Women Infants and Children (WIC)

* Tier 2 Practices must meet all Tier 1 and Tier 2 requirements to achieve Tier Designation

** Tier 3 Practices must meet all Tier 1, Tier 2 and Tier 3 requirements to achieve Tier Designation

Care Coordination

ACOs are responsible for providing baseline care coordination support for all their members. Required elements of baseline care coordination are specified in the ACO contracts such as:

1. Assigning members to PCPs
2. Screening for physical health, BH, Long-Term Services and Supports (LTSS), and Health Related Social Needs (HRSNs)
3. Ensuring appropriate referrals are made
4. Ensuring appropriate and timely follow-up
5. Coordinating with service providers, community-based organizations (CBOs), and state agencies to improve integration of care

ACOs must have a methodology to predictively model, stratify, and assign their member populations into risk categories and use their risk stratification process to identify high- and rising-risk members. ACOs must then evaluate such high- and rising-risk members to determine their appropriateness for Enhanced Care Coordination which can be delivered through ACO Care Management or the Community Partner (CP) Program.

Enhanced Care Coordination includes maintaining high-functioning relationships and open communication with members' PCPs, health systems, community and specialty care team members, schools and early education programs, and other state agencies to facilitate care coordination. Additionally, all members enrolled in an Enhanced Care Coordination Program must receive a comprehensive assessment and member-centered care plan. As necessitated

⁸¹ Commonwealth of Massachusetts (2026). *MassHealth Primary Care Sub-Capitation: Care Delivery Transformation*. [MassHealth Primary Care Sub-Capitation: Care Delivery Transformation | Mass.gov](#)

by the members' needs, Enhanced Care Coordination also provides more intensive supports for transitions of care and HRSN coordination.

CP Program

CPs are community organizations that provide care coordination supports to ACO members with significant BH and LTSS needs. In 2023 and 2024, ACOs were required to enroll approximately four percent⁸² of members into the CP Program⁸³. In addition, ACOs were required to contract with at least one BH CP and one LTSS CP in each of their service areas. CPs use a person-centered approach and conduct assessments, provide care planning, and coordinate with members' care teams, as needed. CPs assist members with navigating various social and community services and focus on the overall health and wellness of their enrolled members. In the 2022-2027 Demonstration, MassHealth shifted the structure of the CP Program from state-managed to an ACO/MCO-administered program. Some CP entities provide only BH or LTSS services, whereas other entities provide both. Twenty CPs were procured in the 2022-2027 Demonstration. See **Appendix C-1** for a list of CPs.

Behavioral Health Community Partners (BH CPs)

BH CPs deliver care coordination supports to eligible adult members (18-64 years of age) with a diagnosis of or need for services to treat a serious mental illness (SMI), serious emotional disturbance (SED), or substance use disorder (SUD). ACOs were required to enroll at least three percent of their members in the program. During both the 2017-2022 Demonstration and the 2022-2027 Demonstration, BH CPs have primary responsibility for care coordination for their enrollees. In the 2022-2027 Demonstration, BH CPs are required to integrate with the newly formed Community Behavioral Health Centers (CBHCs) by having CBHCs as an Affiliated Partner or Consortium Entity as part of their organizational structure, or by having formalized agreements with CBHCs in the BH CP's service area.

Long-Term Services and Supports Community Partners (LTSS CPs)

LTSS CPs deliver care coordination supports to eligible pediatric and adult members (ages 3-64) with LTSS needs, including those with physical disabilities, traumatic brain injuries, and developmental or intellectual disabilities. ACOs were required to enroll at least one percent of their members in the program. In the 2022-2027 Demonstration, LTSS CP expectations were brought into alignment with BH CP expectations, requiring LTSS CPs to have nursing capacity and to have primary responsibility for 1) serving as the lead in care coordination supports for enrolled LTSS members; 2) conducting comprehensive assessments; and 3) managing increased expectations in technology, workforce, and overall operations. MassHealth has authority to provide up to \$20 million in add-on payments for technology, workforce, ramp-up, and operations dispersed to LTSS CPs for new activities. These activities include:

- Support of members with complex BH needs

⁸² Commonwealth of Massachusetts (2026). MassHealth Health Plan Contracts. *3rd Amended and Restated ACPP Contracts*, pg. 115, *3rd Amended and Restated PCACO Contracts*, pg. 50. [MassHealth Health Plan Contracts | Mass.gov](#)

⁸³ Commonwealth of Massachusetts (2026). MassHealth Community Partners (CP) Program. [MassHealth Community Partners \(CP\) Program: Information Overview | Mass.gov](#)

- Technological integration with BH systems including psychiatric Emergency Notification Systems (ENS)
- New organizational partnerships with Independent Living Centers (ILCs) and Aging Services Access Points (ASAPs)
- Electronic Health Record (EHR) enhancements to allow for clinical assessment
- Hiring and training staff for clinical assessment
- Clinical staffing including RNs, with minimum staff to member ratios
- New expectations for hiring, training, and supervising staff with BH expertise⁸⁴

BH Initiatives

ACOs are one of the entities responsible for ensuring member access to BH in the 2022-2027 Demonstration. This includes working with or contracting with CBHCs, which were launched in 2023 as a part of the Massachusetts Roadmap for Behavioral Health Reform (BH Roadmap),⁸⁵ an entry point for timely, flexible, person-centered, high-quality mental health and addiction treatment on an urgent and ongoing basis⁸⁶.

Implementation of Health Equity-focused Policies

ACOs have new requirements for advancing health equity⁸⁷. ACOs participate in the Quality and Equity Incentive Program (QEIP), with their performance assessed in three domains: 1) completeness of beneficiary reported demographic and HRSN data, 2) demonstrated improvements on access and quality metrics including reductions in disparities, and 3) improvement on metrics such as collaboration and capacity. ACOs must develop and maintain a Health Quality and Equity Committee (HQEC) of diverse representation from a mix of expertise (e.g., frontline staff, providers, members), as well as a Health Quality and Equity Strategic Plan, which outlines each ACO's goals for the advancement of health equity. To develop these goals, ACOs conducted community health needs assessments, and gathered information from relevant key stakeholders and input from their Health Quality and Equity Committee. Further, ACOs are encouraged to partner with affiliated hospitals to meet the goals of their Health Quality and Equity Strategic Plan. ACOs must also ensure health equity-focused training of all staff and providers and obtain accreditation from the National Committee on Quality Assurance (NCQA) Health Equity Accreditation program.

Safety Net Support Linked to Accountable Care

A key goal of the 2022-2027 Demonstration includes supporting the safety net by providing some funding to safety net providers for creating and strengthening associations with accountable care. As such, the 2022-2027 Demonstration aligns funding by conditioning certain safety net payments on partnering with an ACO. (See [Chapter 5, SNCP](#).)

⁸⁴ Centers for Medicare & Medicaid Services. (2025). *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services, STC Section 8.8, pages 68-69; [1115 Waiver Demonstration Special Terms and Conditions](#)

⁸⁵ Commonwealth of Massachusetts (2026). *Roadmap for Behavioral Health Reform*. [Roadmap for Behavioral Health Reform | Mass.gov](#)

⁸⁶ Commonwealth of Massachusetts. (2021, August 18). *1115 Waiver Demonstration Extension Request 2022-2027*, page 26. Mass.gov. [Section 1115 Demonstration Project Extension Request](#)

⁸⁷ Commonwealth of Massachusetts (2026). *MassHealth Quality and Equity Incentive Program*. [MassHealth Quality and Equity Incentive Programs | Mass.gov](#)

Workforce Initiatives (WI)

Finally, WI⁸⁸ support the Demonstration's goal of continuing to increase the availability of certain healthcare practitioners to serve MassHealth members, thereby addressing shortages in qualified providers. These programs include the Primary Care Student Loan Repayment Program (SLRP), the Behavioral Health SLRP, and the Family Nurse Practitioner (FNP) Residency Grant Program. The SLRPs offer student loan repayment in exchange for a four-year full-time service obligation in a community-based setting, serving at least 40% MassHealth and/or uninsured members. The FNP Residency Grant Program provides up to \$131,500 per residency slot to allow community health centers, whose patient populations are made up of at least 40% MassHealth members, to support FNP residency slots during the demonstration period. (See [Chapter 6, WI](#))

3.2. Study Design

See [Chapter 1, Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology. For this DSR Chapter, for quantitative data, a combination of surveys, documents (e.g., ACO reporting), and administrative data were used. Qualitative data included document review, Key Informant Interviews (KIs), and open-ended survey responses.

For quantitative surveys, the Practice Site Administrator (PSA) survey used in the 2017-2022 1115 Demonstration evaluation was modified to account for new policies, procedures, and programs in the 2022-2027 Demonstration. New questions were cognitively tested by existing PSAs (n=2), and the survey was finalized. (See **Appendix C-2**) The PSA survey was administered in CY2025 using web-based survey software. MassHealth members are surveyed using Member Experience Surveys (MESs) on an annual basis by a third-party independent vendor, Massachusetts Health Quality Partners (MHQP). MES data from two years (CY2022 and CY2023) are included in this report from five MESs: Child and Adult Primary Care, Adult BH, and Child and Adult LTSS. (See **Appendix C-3** for MESs) Color shading is used in MES tables throughout the Chapter to highlight percentage changes in performance relative to baseline. Percentage changes of less than or equal to +/-2.5% are indicated with gray shading to call attention to consistency in performance. Changes of greater than or equal to +/-2.5% to +/-5% are indicated with lighter shading (light red or light green) to call attention to moderate change in performance. Changes of greater than +/-5% are indicated with darker shading (dark red or dark green) to call attention to larger changes in performance, relative to baseline.

For administrative measures, we used multivariable modeling to examine the extent to which observed changes can be explained by changes in member characteristics between the baseline (CY2022) and subsequent years of the Demonstration (CY2023 and CY2024). We present baseline results from the Managed Care Eligible (MCE) population, and baseline and subsequent years of the Demonstration results for both the ACO population and MCO/Primary

⁸⁸ Centers for Medicare & Medicaid Services. (2025). *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services. STC Section 13, pages 99-102; [1115 Waiver Demonstration Special Terms and Conditions](#)

Care Clinician (PCC) population. Although we reserve comparative quasi-experimental designs for the 2022-2027 Independent Evaluation Summative Report (IESR), in this report, we present results for the MCO/PCC population as an early indication of changes in outcomes for members who were not directly targeted by most elements of the Demonstration. Unless otherwise specified, we report observed (i.e., unadjusted) results, expected values, and adjusted results as observed to expected (O:E) ratios for all years (2022, 2023, and 2024). With O:E ratios, the observed value for a measure is divided by the expected value predicted by a statistical model based on an individual's sociodemographic and clinical characteristics. The ratio of observed to expected values varies around 1.0; ratios <1 indicate lower than expected outcomes, while ratios >1 indicate higher than expected outcomes for the measure.

The population characteristics of the ACO and MCO/PCCs at baseline and each of the first two years of the 2022-2027 Demonstration are summarized in **Table 3.2-1**. below. Of note, our study population is limited to members enrolled for at least 320 days in a calendar year. The ACO population was its largest in 2022 ($N = 1,038,545$) with a decrease in 2023 and a rebound in 2024. The MCO/PCC population has steadily decreased over the evaluation period from $N=187,153$ in 2022 to $N=79,254$ in 2024. Across both the ACO and MCO/PCC population, of those members with available data, most members were female (50.9-53.4%), mean age ranged from 26.22 to 30.11, and a little less than half to the majority were white (34.9-52.2%).

Table 3.2-1 Characteristics of MassHealth Members Enrolled in ACOs and MCO/PCCs (CY2022-CY2024)

Population Characteristics	ACO			MCO/PCCs		
	2022 N = 1,038,545	2023 N = 800,110	2024 N = 928,939	2022 N = 187,153	2023 N = 101,820	2024 N = 79,254
Age: Mean (SD)	27.5 (17.60)	26.84 (17.46)	26.22 (17.82)	30.11 (17.41)	29.10 (17.32)	27.92 (17.72)
Age <19	419,490 (40.4%)	337,752 (42.2%)	431,757 (46.5%)	60,930 (32.6%)	35,799 (35.2%)	32,433 (40.9%)
Female	554,200 (53.4%)	423,118 (52.9%)	501,814 (54.0%)	97,624 (52.2%)	51,837 (50.9%)	40,574 (51.2%)
Race/Ethnicity: n (%)						
White	373,340 (36%)	279,136 (34.9%)	322,127 (34.7%)	97,620 (52.2%)	51,312 (50.4%)	39,091 (49.3%)
Black	144,678 (13.9%)	126,266 (15.8%)	134,911 (14.5%)	15,242 (8.1%)	8,572 (8.4%)	7,255 (9.2%)
Hispanic	82,510 (7.9%)	62,693 (7.8%)	65,205 (7.0%)	13,052 (7.0%)	6,760 (6.6%)	4,559 (5.8%)
Asian	59,048 (5.7%)	50,923 (6.4%)	47,993 (5.2%)	6,778 (3.6%)	3,803 (3.7%)	2,907 (3.7%)
Interracial	17,369 (1.7%)	14,239 (1.8%)	13,581 (1.5%)	3,531 (1.9%)	2,038 (2.0%)	1,365 (1.7%)
American Indian	3,262 (0.3%)	2,553 (0.3%)	2,837 (0.3%)	719 (0.4%)	431 (0.4%)	296 (0.4%)
Unknown	441,771 (42.5%)	343,358 (42.9%)	365,072 (39.3%)	63,489 (33.9%)	37,682 (37.0%)	25,775 (32.5%)
Risk Scores: Mean (SD)						
DXCG*	0.98 (2.11)	0.99 (2.30)	1.14 (2.48)	1.02 (2.18)	0.98 (2.30)	1.14 (2.51)
RXCG*	0.97 (2.06)	0.98 (2.14)	1.13 (2.37)	1.10 (2.16)	0.99 (2.15)	1.09 (2.33)
Other Characteristics						
Disability	100,181 (9.7%)	84,991 (10.6%)	111,547 (12.0%)	18,896 (10.1%)	10,508 (10.3%)	9,422 (11.9%)
Rural	20,967 (2.0%)	12,838 (1.6%)	18,103 (2.0%)	8,589 (4.6%)	5,648 (5.6%)	4,285 (5.4%)

Data Source: MassHealth administrative data

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Diagnostic Cost Group (DxCG); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan; Prescription Drug Cost Group (RxCG); Standard Deviation (SD)

*The DxCG and RxCG relative risk scores are summary measures of medical morbidity with the mean set to 1 in the MassHealth MCE baseline (CY2022) population.

Throughout this Chapter, we use color shading in tables to highlight O:E ratio changes in performance relative to baseline. O:E changes of less than or equal to +/-4% are indicated with gray shading to call attention to consistency in performance. Changes of greater than or equal to +/-5% to +/-14% are indicated with lighter shading (light red or light green) to call attention to moderate change in performance. Changes of greater than or equal to +/-15% are indicated with darker shading (dark red or dark green) to call attention to larger changes in performance, relative to baseline.

For qualitative data, document review and one wave of KIs, conducted between August 2024 and July 2025, are included. DSR key informants include ACO, MCO (see **Appendix C-1** for a list of MCOs), CP, CBO, and hospital leadership, MassHealth staff, as well as MassHealth members (See **Appendix B-8, B-9, and C-6** for relevant interview guides). Organizations participating in the Demonstration (e.g., ACOs and CPs) assisted with nominating members to participate in interviews. Interested members completed a nomination form (See **Appendix C-4**). See **Appendix C-5** for demographic characteristics of all key informants.

3.2.1. Research Questions, Hypotheses, and Study Design

Table 3.2-2 outlines the research questions (RQs), hypotheses, data sources and evaluation period, and analytic methods for this chapter.

Table 3.2-2 DSR Research Questions, Hypotheses, and Study Design

Research Questions	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ2-1 How did ACOs respond to enhanced expectations for quality, equity, and integrated care?	H2-1.1 ACOs will implement organizational changes to increase their capacity to deliver high-quality, equitable, and integrated care.	Document review Key Informant individual and/or group interviews and/or open-ended surveys (KII); (2024-2025)	Thematic analysis (KII Interviews)
	H2-1.2 ACOs will form and strengthen relationships with hospitals, primary care practices, and PCPs to jointly deliver high-quality, equitable, and integrated care.	Document review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025)	Thematic analysis (KII Interviews) Descriptive analyses (PSA respondents)
	H2-1.3 The number of ACO providers (health systems, practices, and individuals) accepting value-based payments and the amount of such payments will increase.	Document review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025)	Thematic analysis (KII Interviews) Descriptive analyses (PSA respondents)
RQ2-2 How did ACOs and their primary care practices respond to enhanced expectations for clinical service delivery and financial incentives for primary care reform included in MassHealth's Sub-Capitation Program?	H2-2.1 ACOs and their primary care practices will invest in staff and infrastructure to increase their clinical service delivery capacity and decrease staff burnout.	Document review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025)	Thematic analysis (KII Interviews)
	H2-2.2 ACOs and their primary care practices will implement strategies to increase access, quality, and continuity of primary care.	Document review Key Informant Individual and/or group interviews and/or open-ended surveys; (2024-2025) ACO practice site survey (2025)	Thematic analysis (KII Interviews) Descriptive analyses (PSA respondents)
	H2-2.3 ACOs and their primary care practices will implement strategies to reduce inappropriate or potentially avoidable service utilization for their members.	Document review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025)	Thematic analysis (KII Interviews) Descriptive analyses (PSA respondents)
RQ2-3 How did access to and continuity of primary care change for ACO members receiving care from primary care practice sites participating in MassHealth's Sub-Capitation Program?	H2-3.1 Access to and continuity of primary care will increase.	ACO practice site survey (2025) Member Survey (2022-2023) Administrative data (baseline 2022, post-2023-2024)	Descriptive analyses (PSA & Member respondents) Observed versus Expected Comparisons
RQ2-4 How did integration between physical, behavioral,	H2-4.1 Integration across the care continuum (e.g., physical health, BH,	Document review	Thematic analysis (KII Interviews)

social, and long-term services change over time for ACO members?	LTSS, acute care, social services) will increase.	Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025) Member Survey (2022-2023) Administrative data (baseline 2022, post-2023-2024)	Descriptive analyses (PSA & Member respondents) Observed versus Expected Comparisons
RQ2-5 To what extent did enhanced expectations for quality and equity change care for ACO members?	H2-5.1 The identification of individual members' unmet needs (including HRSNs) for ACO members will improve.	Document Review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025) Administrative data (baseline 2022, post 2023-2024)	Thematic analysis (KII Interviews) Descriptive analyses (PSA respondents)
	H2-5.2 Care processes for ACO members will improve.		Thematic analysis (KII Interviews) Observed versus Expected Comparisons
	H2-5.3 Healthcare inequities will decline in targeted measures.		Descriptive analyses (ACO Reports)
RQ2-6 How did ACOs and CPs respond to expectations for Enhanced Care Coordination Programs (CP and ACO Care Management)?	H2-6.1 Changes to the CP program will strengthen existing and new partnerships between ACOs and CPs.	Document Review Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025)	Thematic analysis (KII Interviews)
	H2-6.2 The ACOs and CPs will develop new or updated care coordination processes in alignment with enhanced CP expectations.		
	H2-6.3 LTSS CPs will use infrastructure payments to build an infrastructure and develop the workforce to support Enhanced Care Coordination and to meet higher expectations in the 2022-2027 Demonstration period.		
	H2-6.4 ACOs will implement new or refine existing care management programs to meet the needs of their enrolled population.		
RQ2-7 To what extent did access to and quality of care coordination	H2-7.1 Coordination of care will improve.		Thematic analysis (KII Interviews)

supports change for members of ACO Enhanced Care Coordination Programs (CP and ACO Care Management)?	H2-7.2 The quality-of-care coordination supports delivered by CPs and ACOs will increase.	Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) ACO practice site survey (2025) Member Survey (2022-2023) Administrative data (baseline 2022, post 2023-2024)	Thematic analysis (KII Interviews) Descriptive analyses (PSA & Member respondents) Observed versus Expected Comparisons
RQ2-8 How did the volume and mix of services change for ACO members?	H2-8.1 The volume and mix of services utilized will shift, when clinically appropriate, in the direction of lower-cost sites and types of care.	Administrative data (baseline 2022, post 2023-2024)	Observed versus Expected Comparisons
	H2-8.2 Rates of potentially avoidable emergency care and inpatient utilization will decrease.		
	H2-8.3 Utilization of outpatient LTSS, BH, and physical care services will increase or remain consistent for members.		
RQ2-9 How did member outcomes and member experience change for ACO members?	H2-9.1 Clinical outcomes will improve.	Administrative data (baseline 2022, post 2023-2024)	Observed versus Expected Comparisons
	H2-9.2 Members will report improved experiences of healthcare services and supports.	Key Informant Individual and/or group interviews and/or open-ended surveys (KII); (2024-2025) Member Survey (2022-2023)	Thematic analysis (KII interviews) Descriptive analyses (Member respondents)

Data source: 1115 Waiver Demonstration Evaluation Design Document

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Community Partner (CP); Delivery System Reform (DSR); Hypothesis (H); Key Informant Interview (KII); Long-Term Services and Support (LTSS); Practice Site Administrator (PSA); Research Question (RQ)

3.2.2. Methodological Limitations

Detailed methodological limitations were described in [Chapter 1, Overview of Methodology](#) section. As stated, quantitative and qualitative findings capture early results from the 2022-2027 Demonstration and should be interpreted cautiously. Not all research questions, hypotheses, and measures are included in this IEIR due to data availability and implementation timing. All RQs, hypotheses, and measures from the Evaluation Design Document (EDD) are planned to be reported in the 2022-2027 IESR. See **Appendix A-1** for a full listing.

3.3. Interim Results and Conclusions

3.3.1. *RQ2-1 How did ACOs respond to enhanced expectations for quality, equity, and integrated care?*

3.3.1.1 Summary of Results

One of the primary goals of the ACO program during the 2022-2027 Demonstration is to enhance quality, equity, and integrated care for members. Interviews and PSA survey results provided information regarding ACOs' responsiveness to these enhanced expectations. In the early years of this Demonstration period, ACOs implemented organizational changes, forming and enhancing partnerships, and increasing the number of providers accepting value-based payments and the amount of such payments. ACOs maintained robust governing bodies, onboarded new practices and providers, solicited and implemented member perspectives to guide operations, and prepared practice sites for the changes related to the Sub-Capitation Program. With respect to partnerships, ACOs worked closely with hospitals, primary care practices, and individual PCPs to achieve integrated care. These partnerships were enhanced by implementation of the Sub-Capitation Program and the QEIP. ACOs launched various population health management initiatives and monitored TCOC and quality performance in an effort to increase their shared savings. Overall, early findings indicate that ACOs have responded well to expectations for improvements during this Demonstration, and that the capacity for providing high-quality and integrated care has increased. Challenges persist in engaging members in governance, managing administrative burden associated with the Sub-Capitation Program, and enhancing varying relationships between ACOs, hospitals, healthcare practitioners, and practice sites.

3.3.1.2 Results

H2-1.1 ACOs will implement organizational changes to increase their capacity to deliver high-quality, equitable, and integrated care.

Each of the 17 ACOs participating in 2022-2027 Demonstration implemented organizational policies to promote provider leadership, member participation in governance, and shared oversight with MassHealth. Provider specialties represented in Governing Boards included primary care, BH, SUD, oral health, and pediatrics. Each board typically includes at least one MassHealth member (e.g. an enrollee of the ACO) or member advocate. Governing Boards meet on a monthly or quarterly basis and operate under majority voting rules. They are supported by standing committees, including the Patient and Family Advisory Committee

(PFAC), Health Equity Committee, and Quality Committee, which ensure that member perspectives and health equity priorities inform strategy and operations. Financial and compliance committees often report to a Joint Operating Committee (JOC), which serves as the central operational and strategic forum for ACO partners and reflects joint accountability between contracting entities making up the ACO. These JOCs include representation from each organization in the health plan partnership, and oversee clinical integration, financial performance, and contract compliance. Collectively, these governing bodies demonstrate robust, multi-level oversight to advance MassHealth's goal of delivering high-quality care, promoting health equity, and improving care coordination.

ACOs underwent several organizational changes to prepare for and comply with the 2022-2027 Demonstration requirements. In interviews, they noted that as new practices and providers joined their ACOs since April 2023, representatives were integrated into various committees. In interviews conducted in 2024, ACOs spoke of increased provider and hospital administration representation on boards and committees, compared to the 2017-2022 Demonstration.

"In terms of the board structure, we've made a real attempt to increase the representation on the board of a variety of providers in the network, to again be congruent with the type of care that we're planning on delivering and the needs of the Medicaid population...We have hospital representation in terms of the presidents of the hospitals, and some administrative representation...And we've likewise done the same thing with our operations committee and the other committees of the board." – an ACO participant (AP664417)

This new, robust governance structure not only facilitates communication between ACOs and external entities like hospitals, but also within ACOs' different groups and committees including the provider and health plan components of ACPPs. One ACO interviewee described the integration of teams inherent to their governance structure.

"We're a very integrated system. We are communicating consistently with one another...We have...a trustee quality committee that is representative of both sides of the house, and that also reports to our board of trustees, so we have a very robust governance structure here." – an ACO participant (AA517734)

In addition to committees focused on operations, finance, and executive leadership, PFACs played an important role in the Demonstration. PFACs serve as an opportunity for members to provide feedback and guidance to ACOs in key areas, including enhancing outreach for HRSNs, capturing marketing input, reducing screening burden, identifying clinical priorities, promoting member engagement strategies, facilitating strategic planning, and reviewing ACO contracts and other processes. One ACO interviewee described the goals of the PFAC.

"The goals of the PFAC are to provide feedback on things such as processes, patient materials, as well as some of our higher-level strategic planning, so they've reviewed things like our health equity strategic plan. And then in the future we're hoping to include them in some of our more unique programs, such as flexible services, getting

their perspective on some of the delivery mechanisms.” – an ACO participant (AA934600)

ACOs also noted the importance of allowing members to drive discussion topics and the agenda, as well as the importance of dialogue with members rather than just presenting information to them.

“I think the other piece is to really hear the voice of the member, and to really provide that as a vehicle for communication...The other thing is... how we communicate, instead of email, perhaps it’s with text, or other ways in order to... prepare for conversations, and also to really ensure that we have the right participants present during the meeting, so that there is the opportunity for members to feel that...they’re in the right place to share their feedback.” – an ACO participant (AP664417)

One ACO stated that their PFAC focuses on a project every year.

“Every year the PFAC chooses a... project they want to work on as a family voice, and that has ranged from, for example, when the BH roadmap came out a few years ago, they put together a letter to the state on not losing pediatrics in that roadmap, and we actually set up a meeting with our PFAC directly with the state.” – an ACO participant (AA673312)

Many ACOs noted the importance of recruiting diverse members to be representative of the ACO’s member demographics. One ACO noted the significance of a balance of member representation.

“We’re revisiting that now with more robust requirements around health equity, looking to ensure that our PFAC is diverse...I think PFAC is hard to recruit for; everybody has that issue. But how do we make it diverse, making sure we have well balance of male, female, other genders, other races present within that committee?” – an ACO participant (AP664417)

In terms of PFAC recruitment, ACOs used practice sites and providers, leveraged their long-standing relationships with members, posted information to their websites so that members could self-refer, created flyers for distribution, and used social media. One ACO interviewee described their strategy for leveraging long-standing relationships.

“We really value what they have to say and their experiences as...members of this community, and the challenges they’ve had to overcome, and really bringing all of that to the table in this forum and how important that is. I think because of those relationships, we were able to get folks to the table.” – an ACO participant (AA305547)

Some ACOs also offered gift cards to incentivize members to participate in PFAC.

“Any member that will attend the meetings, we will give them a \$50 gift card...We’re still having some challenges in regard to our recruiting effort...We’re relying on our providers to be able to help us, and flyers and provider offices, as well. We are right now trying to connect with the community organizations...to help us to be able to recruit for membership for the PFAC.” – an ACO participant (AA703087)

Many ACOs noted other ongoing challenges with recruiting PFAC members and having consistent involvement. This was a theme in the 2017-2022 Demonstration as well. To accommodate members, ACOs also offer translated materials and live interpreters for non-English speakers. Post COVID-19, many ACOs are still offering virtual meetings to increase attendance.

Some ACOs indicated that many governance and organizational changes were required in response to the Sub-Capitation Program payment model. ACOs expressed that preparing for the Sub-Capitation Program involved revising financial models, ensuring that administrative teams understood the complexities of payments, and establishing new communication channels. These preparatory actions were crucial in ensuring that the program could be successfully implemented and sustained.

“In regards to preparing for the [Sub-Capitation Program], we had actually stood up a steering committee, specific to the new waiver, that consisted of nine subcommittees. So, for example...we had a finance subcommittee that was specific around the [Sub-Capitation Program] changes, how to implement, which largely contained our finance folks, and we also ensured that we had provider representation or provider champions in each one of those nine subgroups.” – an ACO participant (AA702490)

Other ACOs had different types of changes in their organizational structure. One ACO changed from Model B (PCACO) to Model A (ACPP).

“So [ACO name redacted] existed in the previous waiver as a model B, and then...decided to move to a model A...So, there’s been significant change...we have stood up joint governance structures, including an executive committee, finance committee, joint operating committee, health equity committees, quality committees. We’ve done a lot of work jointly around the [Sub-Capitation Program]. The ACO still retains its ACO governing board, and that will continue, and that is still run at the ACO, not at the health plan.” – an ACO participant (AA934600)

While the majority of ACOs described that there were several organizational and governance changes required for the 2022-2027 Demonstration, some ACOs noted minimal changes, as one ACO interviewee expressed.

“As far as changes made for the new contract, they were pretty minimal for us specifically, just mainly normal network maintenance.

So, there were no large shifts in response to the new contract...outside of maybe some hiring.” – an ACO participant (AA702490)

Though some organizational changes were significant for ACOs, they described those changes as positive and led to working closer together and more efficiently.

Several ACOs noted that having their health plan partnership was also a facilitator in their overall organizational structure.

“I think we all certainly have felt that the partnership with [Health Plan name redacted], to be able to be successful under this particular waiver, it has been phenomenal. So quite frankly, I'm not sure how an ACO would be as successful without a health plan partner.” – an ACO participant (AA410937)

Despite some challenges with recruiting members to committees, organizational changes like expanding involvement with a diverse range of providers and hospital leadership, prioritizing member perspectives in operations and strategic planning, and emphasizing joint accountability among the entities composing the ACOs, have facilitated the delivery of high-quality, equitable, and integrated care.

H2-1.2 ACOs will form and strengthen relationships with hospitals, primary care practices, and PCPs to jointly deliver high-quality, equitable, and integrated care.

In the early years of the 2022-2027 Demonstration, ACOs formed and strengthened partnerships with hospitals, primary care practices, and PCPs. Delivering high-quality and equitable care was a shared goal across the entities. For some ACOs, organizational changes prompted new partnerships. New initiatives, such as the Sub-Capitation Program and QEIP, also created the opportunity for strengthening existing partnerships and creating new partnerships. Establishing and defining roles and responsibilities, avoiding duplication of services, refining information sharing strategies, and streamlining communication and workflows were key among the activities of both new and existing partnerships.

For hospital partnerships, some ACOs noted their close affiliation with hospitals due to their shared history, organizational structure, and/or geographic proximity. Some ACOs had preexisting relationships with hospital systems, which facilitated their partnerships.

“Our longstanding and largest hospital partner has been [Hospital System Redacted] for many decades...We’ve really built up some significant clinical protocols and partnership over the decades. And so that is our primary hospital partner.” – an ACO participant (AA013856)

Also fostering hospital partnerships, both hospitals and ACOs are required to jointly track and submit various deliverables under the QEIP program and are accountable to each other to meet QEIP program goals. For example, the hospital QEIP has an incentive component tied to their partner ACO’s health equity score. Another example is that ACOs have an incentive component tied to their partner hospitals’ ability to achieve external health equity standards. Some ACOs

and hospitals partnered on the preparation of Performance Improvement Plans (PIPs) and the development of Health Quality and Equity Strategic Plans.

Because hospitals and ACOs are both accountable to meet QEIP requirements and sometimes must work towards the same goals for shared patient panels, hospitals and ACOs report that they collaborate closely on these efforts. Hospitals and ACOs meet regularly and communicate often on their shared deliverables. Hospitals were interviewed in late 2024 through early 2025, and one hospital interviewee offered their perspective on shared hospital-ACO deliverables.

“I meet with the ACO pretty frequently -- members of the ACO -- and we share all of our deliverables. So, we’re kind of required to share all of our deliverables so they can make their deliverables.” – a Hospital participant (L100)

Shared EHR platforms facilitated alignment and close partnerships between hospitals and ACOs within the same system. Having a shared EHR allows common approaches to data collection and reporting. A hospital interviewee commented on the facilitators of a shared hospital-ACO EHR.

“We do share patient overlap in attribution for many of our patients...we have moved to this system-wide Epic shared EHR, which certainly has helped to drive that collaboration across both the ACO [and] with our hospitals. It really has helped to drive that shared approach with the shared data collection and reporting.” – a Hospital participant (D100)

Hospitals also reported that information and resource sharing is key, as a hospital interviewee stated.

“I think a positive is partnering with the [ACO name redacted]. They seem to have a good...amount of resources in terms of health equity...and they seem to have good access to data analysis...things that we don’t have, they might have, so that’s been a nice partnership.” – a Hospital participant (U100)

In terms of relationships with practices, some ACOs indicated that they expanded their number of practice sites including adding pediatric practices. ACOs noted that they gained and lost providers, although these were described as normal shifts and not necessarily related to the 2022-2027 Demonstration. For partnerships with primary care practice sites, many of the changes described pertain to the requirements of the Sub-Capitation Program.

“We picked up 12 new practices -- I don’t even know how many providers sit in each of those practices, but we must have picked up about 120 new primary care providers, so that was substantial...It means you have to communicate better, so it’s a communication strategy, right? You have to communicate better and across a much broader swath.” – an ACO participant (AA394666)

The ACOs indicated that their overall goal was to broaden and strengthen their provider network and to increase access for members. Many ACOs indicated that they worked to ensure that changes in the new contracting period would not disrupt access to care for members. In some cases, ACOs also worked to maintain relationships with providers that were already in-network to ensure continuity of care for members. As an ACO noted:

“One of the major focuses of our work in the run-up to the go-live was to ensure that our network included as many of the providers that members were already enrolled with and working with.” – an ACO participant (AA673312)

ACOs also noted that they contracted with new providers so that members could continue accessing care.

“We brought many of the providers that were not historically in network...into network prior to the ACO’s go live on April 1st of 2023 in order to minimize a lot of member disruption...With respect to continuities upon the advent of the ACO, we effectively were able to monitor claims within the first 90 days of members coming on to the ACO to make sure there was no disruption in care.” – an ACO participant (AA013856)

Practice Site Administrators (PSAs) from ACO practice sites across the Commonwealth were surveyed to gather data on their current processes, procedures, and feedback. The sampling frame for the ACO PSA survey included group practices, community health centers, and outpatient hospital practices participating in the ACO program at the time of the survey fielding (May-September 2025). The following sites were excluded from the survey: solo physician practices, sites that only provide acute care, practice sites located outside of Massachusetts, sites with fewer than 50 MassHealth members, and sites with an unknown number of MassHealth members. This yielded a sample of 695 unique practice sites. A total of 483 PSAs completed the survey for a response rate of 69.4%. There was good representation of PSAs across regions of the state, as well as practice size, years at practice, and percentage of MassHealth members. See **Table 3.3-1** for PSA sample characteristics.

Table 3.3-1 PSA Survey: Sample Characteristics (CY2025)

Characteristic		Percentage	n = 483*
Region	Boston/MetroWest	36%	175
	Northeast	21%	101
	Southeast	20%	97
	Central/Western	23%	110
Practice Size (all payers)	Less than 400 patients	34%	163
	400-1149 patients	33%	159
	1150 patients or more	33%	161
Years at Practice	Less than 5 years	27%	106

Characteristic		Percentage	n = 483*
	5-15 years	35%	134
	>15 years	38%	147
Percentage of MassHealth Members	Less than 20%	32%	110
	20-35%	34%	119
	35% or more	34%	120

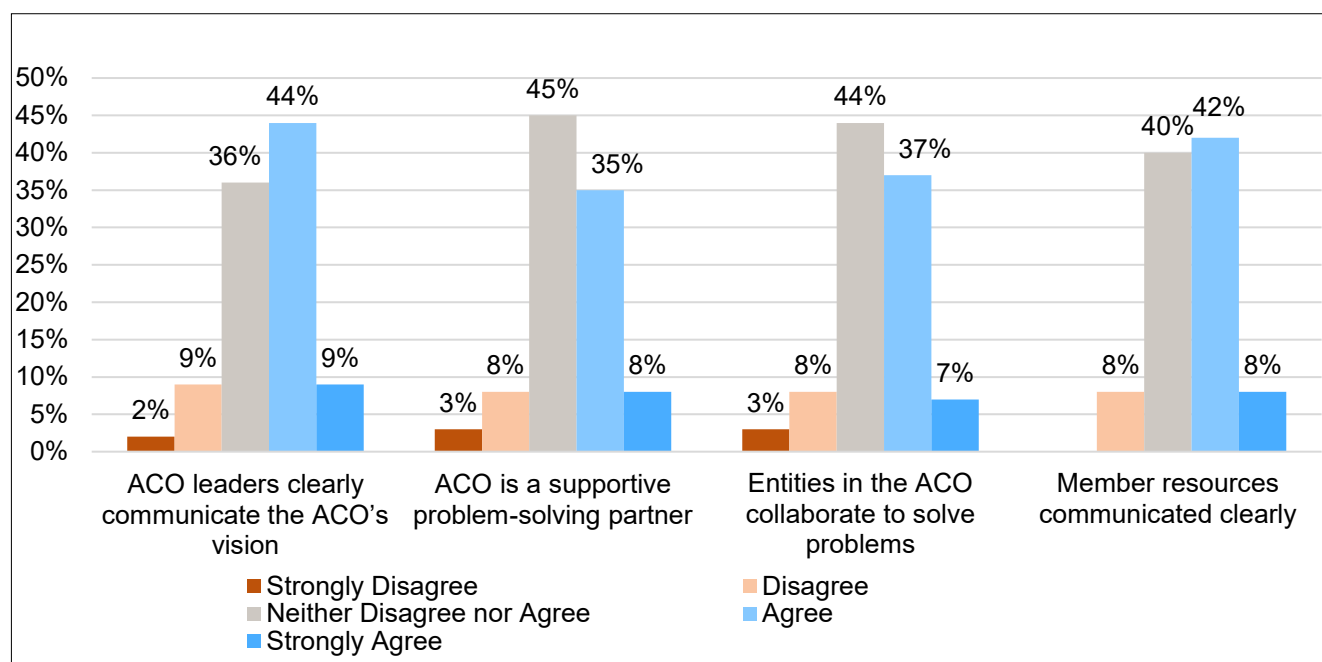
Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

*Four PSAs screened out of the survey

Approximately one-third (35%) of PSAs indicated that their practice site rarely or never had a say in important aspects of planning and decision making within the ACO. Notably, 48% of administrators employed at their site for 10 years or more reported this lack of involvement. Forty-four percent of respondents from practices with fewer than 20% of their panels comprising MassHealth members also reported lack of involvement. See **Appendix C-7** for all 2022-2027 PSA Survey data alongside Wave 2 PSA Survey data collected in the 2017-2022 Demonstration.

Over half (53%) of PSAs agreed with the statement that ACO leadership had communicated a vision for the MassHealth ACO and the care it delivers to their practice site; 43% agreed with the statement that the MassHealth ACO is a resource and partner in problem-solving for their practice site; 50% agreed that the MassHealth ACO had clearly communicated the tools and resources available for members; and 44% agreed that all entities in the MassHealth ACO work together to solve problems when needed. Notably, 59% of administrators from sites with 35% or more MassHealth members agreed that all entities in the MassHealth ACO work together to solve problems when needed. Few administrators ($\leq 11\%$) disagreed or strongly disagreed with these statements about the ACO's leadership and problem-solving. See **Figure 3.3-1**

Figure 3.3-1 PSA Survey*: ACO-Practice Site Partnerships and Collaboration (CY2025)

Data Source: PSA Survey

Abbreviation: Accountable Care Organization (ACO); Calendar Year (CY); Practice Site Administrator (PSA)

*Survey items have been paraphrased, see **Appendix C-2** for PSA Survey items

H2-1.3 The number of ACO providers (health systems, practices, and individuals) accepting value-based payments and the amount of such payments will increase.

Health Systems

Health systems participating as MassHealth ACOs and accepting value-based payments remained consistent (n=17) from the 2017-2022 to the 2022-2027 Demonstrations. However, a merger and a new ACO joining during the 2022-2027 Demonstration represents an increase in ACO participation.

As part of the ACO procurement, MassHealth requested specific information about participation in the ACO Program. In responses (i.e., bids), ACOs described in detail several initiatives they would be undertaking or continuing during this waiver period to help them succeed under value-based payment arrangements. Of note, some of these initiatives are MassHealth contract requirements whereas others are optional initiatives ACOs are taking on. Initiatives include the following:

- Care coordination and management programs: integrated primary care, medical care management, BH care management, pharmacy care management, maternal/newborn care management, chronic disease management for conditions like diabetes, hypertension, and asthma.
- Emergency department (ED) and acute care initiatives: ED admission diversion programs, reducing low-acuity ED visits, timely follow-up after inpatient discharge.
- BH and SUD programs: community-based BH care, telehealth care for SUD, shared savings programs for SUD, bundled payment models for opioid dependency treatment.

- HRSN programs: Flexible Services programs, payment incentives for more thorough HRSN diagnostic coding by providers using z-codes.
- Member engagement: post-discharge outreach and follow-up, pre-visit planning, virtual outreach campaigns, provider quality measure education, patient experience data collection and reporting.

In interviews, many ACOs recognized the shortcomings of FFS payment models for primary care and stated their preference for a value-based payment model in the form of the Sub-Capitation Program.

“I’d like to say that I think the primary care sub-cap[itation] program was an absolutely tremendous idea. I’ve long said that the only way that primary care physicians can provide the kind of value-based care that we all want to see happen for our patients is if they’re paid a capitation. The fee-for-service structure just is in no way able to appropriately finance primary care practices in a way that allows them to deliver the level of care that’s required.” – an ACO participant (AP664417)

Practices

During the 2017-2022 Demonstration, ACOs were required to hold their primary care practices accountable to some degree for their contribution to ACO performance. The 2022-2027 Demonstration added a new requirement of participation in the Sub-Capitation Program. MassHealth’s contracts with ACOs specify that: *experience a meaningful portion of their annual Medicaid patient service revenue opportunity being tied to value-based performance measures*⁸⁹. However, when surveyed, 18% of PSAs indicated that none of their practice’s total revenue was at risk based on value criteria, which suggests these administrators may not have been familiar with performance accountability arrangements with the ACO. Data was unavailable on the details of specific ACO payment arrangements with their practice sites. Data were not collected for the IEIR on value-based payment arrangements at the individual clinician level but will be collected for the IESR.

The requirement for practice site participation in the Sub-Capitation Program is responsible for a sizable increase in the amount of payments flowing through non-FFS arrangements to primary care practices in Massachusetts. Responses to our survey of MassHealth staff indicated that primary care practices saw a significant increase in value-based payments in the form of the Sub-Capitation Program’s launch.

One MassHealth staff member stated they had neither seen an increase nor decrease in other forms of value-based payments in primary care practices since the launch of the Sub-Capitation Program, noting that from their perspective practices *“layering in additional complexity on top of the [Sub-Capitation Program] would likely be more challenging than effective in most cases.”* (MassHealth staff)

⁸⁹ Commonwealth of Massachusetts (2026). *MassHealth Health Plan Contracts*. <https://www.mass.gov/masshealth-health-plan-contracts>

The PSA survey had more than half (53%) of administrators indicating that two-thirds or more of their practice's total revenue was earned through FFS. Among the subgroup of PSAs from sites with few (<20%) MassHealth members, the median response was that 83% of revenue was earned through FFS. Among practices with the most (35% or more) MassHealth members, the median response was 50% of revenue earned through FFS.

Most PSAs reported that some performance metrics are used by their ACO to determine their value-based payments:

- 64% of administrators indicated that process quality measures (e.g., screening or vaccination rates) were used.
- 60% reported outcome quality measures (e.g., blood pressure, HbA1c) were used.
- 54% reported utilization measures (e.g., ED or hospital visits) were used.

PSA survey results also showed 25% of administrators indicated that their practice site had received value-based payments from their ACO based on the practice's cost or quality performance. Notably, 62% of administrators responded "don't know" to the same question. Just 4% of administrators indicated that their practice site had made payments to their ACO or had their revenue reduced based on the practice's cost or quality performance while 62% of administrators responded "don't know" to this question.

Primary Care Providers

Some ACOs outlined their process for preparing for value-based care. One ACO interviewee mentioned the importance of leveraging their providers to understand what *"ingredients"* would need to be involved and designing their programs collaboratively with that information.

"When we've been having board retreats and conversations with them for years to say, hey, value-based care's coming... what do you guys think needs to be involved in the ingredients... So, our [practices] tell us and then we help design with them and cultivate those champions -- we don't have the answers. They do." – an ACO participant (AP884582)

An ACO interviewee recognized provider engagement tends to increase in cases where the quality performance is directly linked with provider compensation. The ACO interviewee went on to describe a recent increase in provider participation in a certain quality workgroup.

"I think one of the things we've seen from some of these value-based arrangements is provider buy-in if it's directly tied to comp[ensation]. I think we've had some quality workgroups that have been stood up recently... and the amount of engagement from providers has been encouraging." – an ACO participant (AA702490)

MassHealth staff members also stated that solo primary care practitioners have seen an increase in value-based payments after the launch of the Sub-Capitation Program. Additionally, MassHealth staff could not speak to the impact on practitioners who are employed by larger group practices because they have their compensation determined by that group practice, not by MassHealth.

3.3.1.3 Conclusions

Overall, findings in the early years of the 2022-2027 Demonstration tend to support the hypotheses that ACOs would respond favorably to enhanced expectations for quality, equity, and integrated care. Document review and qualitative data indicate that despite some challenges such as engaging members in governance, managing administrative burden associated with the Sub-Capitation Program, and enhancing varying relationships, substantial progress has been made by ACOs in enhancing their capacity for providing high-quality integrated care to MassHealth members, and in increasing both the number of providers accepting value-based payments and the dollar amount of value-based payments. However, PSA Survey findings show room for significant improvement in increasing knowledge and engagement with respect to value-based care among practice sites and individual clinicians.

3.3.2. RQ2-2 How did ACOs, and their primary care practices respond to enhanced expectations for clinical service delivery and financial incentives for primary care reform included in MassHealth's sub-capitation program?

3.3.2.1 Summary of Results

In the 2022-2027 Demonstration, ACOs and primary care practice sites are being held responsible for increased clinical service delivery and were financially incentivized for primary care reform through the Sub-Capitation Program. Interviews and PSA survey results provided context for how ACOs and their primary care practices were responding to these enhanced expectations. Investments were made in both staffing and infrastructure to meet these increased expectations. ACOs increased their capacity, made improvements in health information technology (HIT) infrastructure, offered additional training, and employed various recruitment and retention programs. ACOs and their primary care practices implemented strategies to increase the access, quality, and continuity of primary care. Through the Sub-Capitation Program tier requirements, preliminary findings indicate that primary care access and continuity increased. ACOs and practice sites invested in increasing their clinical tier and obtained associated higher capitation rates. ACOs report working to meet increased quality expectations through quality measurement tracking and new care management programs. ACOs and their primary care practices also implemented strategies to reduce or avoid unnecessary member service utilization. Despite investments made by the state, many ACOs report persistent workforce shortages and provider burnout. Although ACOs were successful in creating new systems and workflows to track quality performance, ACOs described the challenge of simultaneously improving quality across many quality measures. However, ACOs and their primary care practices perceived progress to have been made in reducing avoidable service utilization.

3.3.2.2 Results

H2-2.1 ACOs and their primary care practices will invest in staff and infrastructure to increase their clinical service delivery capacity and decrease staff burnout.

ACOs reported that they planned to focus on expanding operational capacity, strengthening training infrastructure for staff, and addressing workforce shortages. Several ACOs described large operations units that house training, workforce management, and quality assurance

functions to support staff development. Others emphasized challenges in hiring and retaining critical roles like PCPs, community health workers (CHWs), and care coordinators, and outlined strategies such as clinical education sessions, best-practice summits, and enhanced onboarding to build staff capacity.

Regarding recruitment strategies, some ACOs reported that they have been able to offer competitive wages, while other ACOs explored different strategies to recruit and retain staff, like employee assistance programs (EAPs) to support staff well-being.

Several ACOs used grants and funds (i.e., American Rescue Plan Act (ARPA), MassHire) and residency programs to support workforce initiatives.

“[We] have created pipelines for educating new medical assistants, dental techs, or pharmacy techs, providing that education free of cost, and then there's a commitment the individual makes to stay ... post-education ...in addition to a number of other initiatives through that ARPA workforce grant.” – an ACO participant (AP884582)

Still, ACOs and their primary care practices are facing challenges in the recruitment and retention of staff due to external factors. One ACO noted that part of the issue is that *“the primary care workforce is shrinking”* (ACO participant) with PCPs nearing retirement age and not enough medical students going into primary care. Geographic location also plays a role in workforce disparities, with western Massachusetts being *“a challenging area for primary care.”* (ACO participant)

ACO interviewees shared that providers and staff are experiencing burnout due to high administrative burden and time pressures. When asked whether providers found administrative processes relating to the Sub-Capitation Program difficult, an ACO interviewee provided the following example:

“We haven’t seen direct burnout. I think it’s more [that]...the number of portals that our providers need to go into and then tell us about is significant. No one has told me that...the portal we use is the straw that broke the camel’s back, but I think people are generally disappointed that they need to log into a separate portal.” – an ACO participant (AA258503)

Note that the Sub-Capitation Program did not require the creation of new provider portals

Some ACOs mentioned that COVID-19 continues to affect the workforce and, in some cases, has led to innovative approaches. For example, some staff grew comfortable working remotely, requiring ACOs to hire new staff to fill in-person roles. Some ACOs discussed innovative ways to reduce the administrative burden on providers and care teams using artificial intelligence (AI) tools and virtual scribes and incorporating advanced practitioners (APs) and medical assistants into the care team.

“Well, one of the things we did because of this significant burden, we incorporated virtual scribes, and a lot of our providers are using it. And that has made it easier, so if I’m in a room with a patient, I can

say to the scribe, 'Please code diabetes with this, that, and the other, obesity. Please order this.' And that has been a real good tool, but it comes at a fairly high price point. But it's interesting: speaking to the providers that are using it, it has typically saved them 30 minutes to an hour per day." – an ACO participant (AA517734)

ACOs also invested in the infrastructure of their primary care practices to improve clinical service delivery capacity. ACOs reported that practices are piloting new care team models and workflows, such as offering longer visits for members with complex medical conditions, conducting daily team huddles, and redesigning care pathways to ensure members see the health care provider most suited to their needs. For example, some practices have identified situations where CHWs, rather than PCPs, are best equipped to meet certain member needs. These innovations aim to move beyond the “15-minute hamster-wheel” model of primary care, as one ACO put it, and create space for providers to engage in telehealth, collaborate with BH providers, and conduct more comprehensive visits with members with complex health conditions. (ACO participant) ACOs are also convening practice staff in learning forums to share lessons learned and emerging practices in this area.

Beyond clinical innovations, ACOs and their primary care practices have made significant data- and operations-focused investments to increase service delivery capacity. Practices have strengthened their population health infrastructure by hiring data analytics managers, senior data analysts, and care coordinators dedicated to quality improvement and health equity initiatives. New roles, such as performance liaisons, have been created to help practices close care gaps, ensure necessary quality metrics are documented in member records, and proactively schedule preventive services for members. ACOs and practices have also invested substantial staff time into integrating and streamlining data systems to meet reporting requirements related to site-level and provider-level attribution, tiering, and payment accuracy.

The PSA survey asked administrators about a list of changes at their practice site in response to the Primary Care Sub-Capitation Program. See **Table 3.3-2** for results.

Table 3.3-2 PSA Survey: Changes at Practice Site in Response to Primary Care Sub-Capitation Program (CY2025)

To what extent do you agree or disagree with each of the following statements about changes at your practice site that have occurred in response to MassHealth's Primary Care Sub-Capitation Program in April 2023?					
Survey Item	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
Our practice site has added new types of clinician and staff roles	12%	25%	32%	22%	9%
We have modified our practice site's technology and software to improve care delivery	12%	32%	33%	16%	7%
Our practice site has increased resources (e.g., staff, programs, referral options) available to address patients' health-related social needs	10%	40%	34%	13%	4%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

H2-2.2 ACOs and their primary care practices will implement strategies to increase access, quality, and continuity of primary care.

ACOs initially described the ways in which they planned to increase access, quality and continuity of primary care in their population health management strategies. These included implementing contractual requirements around: launching an integrated primary care model focused on patient-centered access and BH integration; implementing new care management programs to embed care managers at primary care practices to support high-risk patients; and improving HRSN screening protocols.

ACOs planned on increasing quality of care in the following ways: employing resources to support meeting MassHealth quality measures, such as staff to follow-up with members after emergency department visits and hospitalizations for mental health or SUD; developing quality improvement projects targeted at specific quality measures such as SUD treatment and support, follow-up visits after hospitalization, and enhanced HRSN screening protocols to improve screening response rates; and improving data and analytics usage to monitor performance on quality measures.

ACOs planned to improve continuity of primary care in the following ways: focus on primary care engagement metrics such as annual primary care visit rates and transition of care measures; integrate BH care teams to support continuity of care for members with complex BH needs; and engage staff and providers in clinical education and care team meetings targeted at member engagement strategies.

MassHealth staff recognized the challenges ACOs could face in responding to the new expectations for continuity of care and service delivery, stating that *"the sub-capitation model is a significant departure from fee-for-service"* and *"required ACOs and practices to stand up new*

systems, policies, and technology infrastructure to implement it” such as “hiring additional behavioral health support, updating workflows to include new screening questions, and standing up new service offerings like Long-Acting Reversible Contraception (LARC) insertion.” (MassHealth staff). MassHealth supported ACOs in addressing these challenges in a number of ways including through providing technical assistance sessions, organizing pricing workgroups, feedback sessions, and shared learning opportunities with ACOs, continuing to measure quality performance at the ACO level, updating tier requirements, and collaborating with ACOs to define what services and associated billing codes would be included in the Sub-Capitation Program and no longer paid to primary care practices on a FFS basis. MassHealth also provides reporting to ACOs to support their practices including “*fee-for-service equivalencies*,⁹⁰ *rate build-up, payment compliance, and more.*” (MassHealth staff).

In the PSA Survey, 15% of administrators endorsed that their practice site either made “massive” or “a lot of” change to their processes since the beginning of the Sub-Capitation Program, while 41% reported some change, and 44% reported very little or no change (See **Table 3.3-3**). Additionally, 36% of administrators agreed that their practice site has adequate systems and processes to succeed under a payment model that capitates or sub-capitates primary care, while 51% neither agreed nor disagreed, and only 13% disagreed. Also, 39% of administrators agreed that their practice site’s care processes had changed in response to the Sub-Capitation Program, while 35% neither agreed nor disagreed, and 26% disagreed.

Table 3.3-3 PSA Survey: Extent of Change to Processes Since Beginning of the Sub-Capitation Program (CY2025)

Since the start of MassHealth’s Primary Care Sub-Capitation Program in April 2023, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	
	Percentage of Administrators
Massive change — completely redesigned our care model approach	2%
A lot of change	13%
Some change	41%
Very little change	19%
No change	25%

Data Source: PSA Survey
Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

During interviews, ACO interviewees outlined the ways in which the shift to the Sub-Capitation Program enabled ACOs to implement strategies to increase primary care access, quality, and continuity.

Access

ACO interviewees described the process to attain Tier 3 status as an opportunity to implement some of these strategies. Working to meet higher-tier requirements afforded ACOs the

⁹⁰ The amount MassHealth would have paid for a service if it had been paid through a fee-for-service arrangement instead of as a service included in the practice’s sub-capitation payment.

opportunity and resources to expand access to care in previously unattainable ways. Many ACOs shared that the enhanced requirements and flexible payment of the Sub-Capitation Program allowed for expanded access to care in evening and weekend hours.

PSA survey results showed that 62% of administrators reported that their practice site was able to offer appointments on weekdays before 8 a.m. and after 5 p.m., and 44% of administrators reported that their practice site was able to offer appointments on weekends. Notably, a higher percentage of administrators from large sites reported their site was able to offer these off-hours appointments than administrators from small sites. See **Table 3.3-4**.

Table 3.3-4 PSA Survey: Availability of Practice Site Services by Practice Size (CY2025)

Which of the following services does your practice site offer regularly? Please select all that apply.				
		Practice Size		
	Total	Small	Medium	Large
Appointments on weekdays before 8 a.m. or after 5 p.m.	62%	51%	60%	75%
Appointments on weekends	44%	23%	36%	71%
Home visits by practice staff or a clinician	15%	12%	16%	16%
Clinical pharmacy services at the practice site following discharge from a hospital	14%	5%	7%	31%
None of the above	25%	38%	29%	10%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

Practice size definitions: Small=Less than 400 patients; Medium=400-1149 patients; Large=1150 or more patients

Increased staffing resources also allowed ACOs to better align care delivery with the appropriate modality and member of the care team. Some ACOs also described efforts to adjust panel sizes (e.g., decreases for providers disproportionately serving patients with more complex needs and increases for providers serving less complex patients) or taking certain responsibilities off the plate of prescribers (e.g., offering a dedicated nurse advice line, so that nurses were not fielding calls in between seeing patients).

Results from the PSA survey showed that about half of administrators agreed that the amount of care delivered by clinicians and staff in existing staff roles has increased at the practice site; 67% agreed that the practice site has increased the use of electronic communication (e.g., MyChart, text messaging) with their patients; 41% agreed that the practice site has increased the use of remote visits with patients; and 33% agreed that the practice site has added clinical programs (e.g., alcohol use disorder (AUD) treatment availability, medication for opioid use

disorder (MOUD) induction and follow-up, long-acting reversible contraception (LARC) provision).

Quality

ACO interviewees described how the quality and equity incentives played a key role in improving care quality of care for members. They also described ways in which the quality measurement process could be improved. ACOs indicated that the quality and equity measures helped them identify key disparities among their population. Health Quality and Equity committees, quality teams, clinical leadership, and information technology (IT) staff used new data about health disparities to develop quality improvement initiatives to address gaps in health care for vulnerable populations.

“On the provider side what we have available is an in-real-time dashboard that looks at clinical measures internally here which we can drill down...we do a lot of examination of that performance data on a regular basis and use it to drive operational enhancements or areas that we can intervene to drive.” – an ACO participant (AA013856)

Additionally, multiple ACOs articulated that being able to stratify performance data by Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity (RELDSOGI) has helped to further target performance initiatives towards specific populations. Some ACOs shared they had *“been stratifying for a while”* (ACO participant) or had wanted to stratify quality measures by RELDSOGI prior to the MassHealth requirements but didn’t have the financial or workforce resources.

ACOs also shared that stratifying performance data by practice sites has helped to localize initiatives and heighten transparency in performance.

“Being able to stratify [internal quality measure data] to the provider level allows me...to work with my individual chiefs from each of the local sites to hold them accountable for local performance, and the chiefs are able to leverage practice pattern variation, differential performance amongst their providers, to identify best practice and really move the ball in terms of outcomes...” – an ACO participant (AA456191)

ACOs offered that another key aspect of successful quality measurement is buy-in among leadership and governing bodies. One ACO shared that they provide their board with a scorecard: *“The intent is to be able to, at a high level, have the board, which is comprised of the Chief Executive Officers (CEOs) and Chief Marketing Officers (CMOs) of all our participating [practices], be able to get a quick glance of where they are on a variety of factors.”* (ACO participant) Additionally, setting a regular meeting cadence and sharing performance updates with leadership through interactive dashboards facilitated the engagement of leadership in population health initiatives.

ACOs have extended resources towards data usage and health information technology (HIT) integration in several ways: implementing dashboards to promote data utilization; standardizing data with a centralized electronic EHR for all practices; facilitating access to the EHR for all practices and for individuals working remotely; and introducing changes to the EHR in the form of new requirements (e.g., HRSN screening questions).

ACOs rely on their data for tracking progress towards quality measures. Many ACOs described a lack of a central EHR within the ACO, presenting a challenge in tracking quality measures. One ACO stated that viewing multiple EHRs can be “*distracting*” for providers, and data tend to become “*cumbersome and redundant*.” (ACO participant) Multiple ACOs stated their desire for the Commonwealth to explore the possibility of having all providers online with a statewide, integrated EHR, to facilitate tracking quality measure progress. While the current contract does not require a single statewide EHR, it includes several provisions intended to advance interoperability and improve information sharing and quality measurement.

Many ACOs expressed that the complexity and quantity of the quality measure slate required by MassHealth was a challenge. Due to the large measure slate, ACOs said they pick specific measures to prioritize based on measurement feasibility, data availability, and relevance to their organization. ACOs described feeling that they could only make minimal improvement across all measures due to the quantity of measures.

“There’s a lot of data aspects that we don’t even have insight into to understand how we’re performing, so we’re still really breaking the measures down and trying to work with our provider partners to build up workflows so that we can start to performance-manage that program and succeed in future years when we go into pay-for-performance state.” – an ACO participant (AA394666)

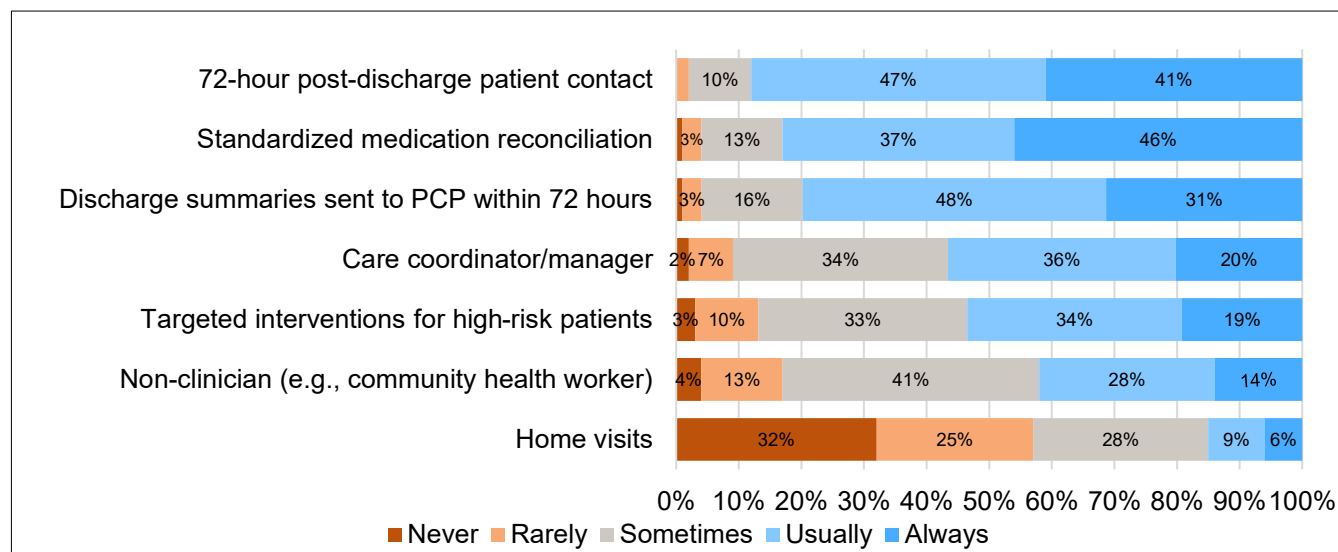
Care Coordination

A key aspect of improving continuity of primary care for members was first identifying those high-risk members who would benefit most from enhanced care coordination and other services. ACOs built their own risk-stratification algorithms, sometimes from existing commercial products. These algorithms are used to generate prioritized lists of high-risk members for care coordinators and care managers based on strata such as members who have not engaged recently, members with recent hospitalizations, or new members. The risk stratification algorithms give ACOs real-time data on member engagement and site performance and allow ACOs to respond – for example, by embedding care management resources at sites with a higher concentration of need based on their population.

The PSA survey asked about different types of care coordination and care management resources used with their members with complex care needs. Administrators widely reported that their practice site “always” or “usually” utilized some type of care coordinator or care manager, some type of non-clinician (such as a CHW), and targeted interventions for those members who have been risk stratified into a high-needs subgroup (e.g., those with repeated ED visits). Administrators also widely reported that their practice site either “always” or “usually” communicated with high-risk members within 72 hours of discharge from a hospital; that

discharge summaries were sent to PCPs within 72 hours of discharge; and that they had standardized processes to reconcile multiple medications. See **Figure 3.3-2**.

Figure 3.3-2 PSA Survey*: Frequency of Practice Resources and Processes Used to Support High Need Members (CY2025)



Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Primary Care Provider (PCP); Practice Site Administrator (PSA)

Values ≤1% are not displayed

*Survey items have been paraphrased, see **Appendix C-2** for PSA Survey items

Many ACO interviewees spoke highly of the positive impact of Enhanced Care Coordination expectations on the delivery resources to support their members.

“We had a lot of the resources potentially available, but [the Enhanced Care Coordination requirements] really forced us to organize said resources and ensure that there were referrals pathways and processes in order to quickly connect our members with those resources.” – an ACO participant (AA702490)

To facilitate care coordination, ACOs with shared EHRs across practice sites can track members’ care across multiple provider visits. When members visit the ED, those EHRs are notified. Challenges exist with ACOs who have multiple EHRs across their sites. Both ACOs and MCOs have also voiced difficulties in sharing information with CBHCs due to the lack of a shared system of communication like an EHR. MCOs were interviewed in CY2025 and an MCO stated:

“We get the mobile crisis intervention list for people who have been to a CBHC each month. That data is often missing identifying information...It just makes it difficult for us to triage them appropriately to our CP.” – an MCO participant (MC412397)

H2-2.3 ACOs and their primary care practices will implement strategies to reduce inappropriate or potentially avoidable service utilization for their members.

ACOs described their plans to implement strategies to reduce avoidable or potentially inappropriate service utilization. ACOs implemented initiatives focused on reducing members' utilization of acute care services by developing workflows for following up after hospital discharge within seven days, increasing telehealth appointments, offering after-hour appointments, and working with urgent care facilities to create member communication materials so that members were made aware of the services available through their primary care practice.

ACOs and primary care practices discussed the strategies they developed to reduce unnecessary service utilization for their members. Many of the changes that ACOs made in the 2022-2027 Demonstration were a result of the Sub-Capitation Program. The program allowed ACOs to restructure their primary care practices to offer more services for patients, increasing primary care availability.

"I think the added investment in primary care in this waiver has been very welcome for a historically underfunded specialty and provider group...it's been utilized to really support not only the resources of the practice, but the resources that are available to the members through increasing their access to things like flex[ible] services and other services within a practice. I think that's been a huge benefit." – an ACO participant (AA562141)

ACOs spoke of their efforts to enhance transitional care management efforts and divert members from excessive ED use by offering same-day visits, although challenges persist.

"We are putting a lot of work into transitional care management visits. When someone has just been discharged from a hospital or skilled nursing facility to try to get them in post-hospital management visit within seven days and 14 days, doing things of that nature. ER diversion: we've put a lot of work around making sure that patients can get in to see their provider for same-day visits." – an ACO participant (AA517734)

ACOs were able to organize their primary care practices and structures better, including enhancing pathways for referrals and access to available resources for members. Having these enhancements created more opportunities for members to receive the care they needed through primary care and not through other healthcare sites. An ACO commented, *"the philosophy behind it is many of these patients, this is the only time they come into anywhere, so try to do whatever care you can, whenever you can get them in and they're in the office. And that's a laudable goal."* (ACO participant)

Extended night and weekend hours, as required by the Sub-Capitation Program, facilitated member access to care when needed and afforded more flexibility and availability of primary care appointments.

"I can talk a little bit more about how [the Sub-Capitation Program] helped expand our access into evenings and weekends, which has certainly been welcomed with our patients' busy lives, right?...And we had that goal, but [the Sub-Capitation Program] pushed us to get

that done, and to get it done sooner and quicker to get people the right care at the right time, and again, to really decrease the need for an urgent care or an ED visit in the evening and on weekends.” – an ACO participant (AA199175)

In some cases, ACOs also noted that they were able to make appointment times longer to increase the likelihood that members’ needs will be met.

“One of the things that, for instance, I know that they did coming into this is change their appointment length time. We had been on a 30-minute physical, 15-minute urgent schedule for a long, long time. They went to 30 all across the board.” – an ACO participant (AA394666)

Promoting access to actionable data amongst care coordination staff and providers was central to ACO efforts to reduce inappropriate or potentially avoidable utilization. ACOs discussed expanding their care management and care coordination programs and ensuring their primary care practices had the HIT and support they needed to identify member needs and link members to resources to address those needs. ACOs used HIT (e.g., EHRs, population health management platforms) to share dashboards and reporting metrics with providers as part of their effort to use data to engage providers in screening and referral to services. As an ACO noted:

“I think one of the big components was identification of our ACO members, so what we had done is we had leveraged care support alerts...that way we could align what resources were available for these members, and that way our front office staff would know that this was an ACO member, and certain resources were available for them.” – an ACO participant (AA702490)

Results from the PSA survey showed most administrators widely agreed with statements regarding their practice site’s implementation of efforts to avoid unnecessary service utilization. See **Table 3.3-5** for results.

Table 3.3-5 PSA Survey: PSAs Report Their Practice Site’s Implementation of Efforts to Avoid Unnecessary Service Utilization (CY2025)

Below is a list of statements related to costs and treatment decisions. To what extent do you agree or disagree with each of the following statements?	
	Percentage of Practices Agreed
Our practice site implements processes to avoid the use of unnecessary treatments and tests	79%
Our practice site implements processes to consider the cost of a treatment or test before it is ordered	61%
Our practice site implements processes to prevent potentially avoidable emergency department and hospital stays	89%
Our practice site implements processes to reduce the occurrence of patients receiving primary care from outside our practice	80%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

3.3.2.3 Conclusions

Overall, findings moderately support the hypotheses that ACOs, and their primary care practices, would respond favorably to enhanced expectations for clinical service delivery and financial incentives for primary care reform included in the Sub-Capitation Program. ACOs and their primary care practices took steps to meet enhanced expectations for clinical service delivery and practice reform in the first phase of the 2022-2027 Demonstration. Our findings outlined the variety of investments ACOs, and primary care practices have made in staffing and infrastructure to expand their capacity to provide services. However, ACOs still describe widespread provider and staff burnout, and it is unclear to what extent the Sub-Capitation Program has affected burnout positively or negatively. ACOs reported implementing many new strategies to increase access, quality, and continuity of primary care while avoiding unnecessary service utilization. Primary care practice site administrators generally supported the notion that these strategies resulted in tangible benefits for members. These findings suggest that the large-scale, strategic, and intentional process of implementing the Sub-Capitation Program has produced at least some of the intended actions from ACOs and primary care practices. Furthermore, ACOs and their practices reported that they have already begun to perceive some of the intended benefits in the early years of implementation.

3.3.3. *RQ2-3 How did access to and continuity of primary care change for ACO members receiving care from primary care practice sites participating in MassHealth's Sub-Capitation Program?*

3.3.3.1 Summary of Results

To measure the level at which access and continuity of primary care may have increased, decreased, or stayed consistent for members, items from the PSA Survey, MES, and administrative data were assessed. The majority (>50%) of PSAs reported that members were always or usually referred to BH services when needed and more than half reported that they had counseling therapists on site. Most (>50%) PSAs also reported that new members were seen for appointments within three months or less. Composite scores calculated from MES items measuring access showed slight improvement from 2022 to 2023, indicating a moderate increase in access. Composite scores for MES items measuring continuity showed slight improvements from 2022 to 2023. More practices achieved the Sub-Capitation Program's Tier 3 designation in 2024 than in 2023, with Tier 3 offering the most expansive set of services to members, suggesting a shift toward increased access.

3.3.3.2 Results

H2-3.1 Access to and continuity of primary care will increase.

Several data sources were used to examine access to, and continuity of, primary care for ACO members in the first part of the Demonstration. This section presents results from administrative data, the PSA survey, and the MES.

The percentage of Taxpayer Identification Numbers (TINs) with practices in Tiers 1, 2, and 3 of the Sub-Capitation Program was calculated. Among all TINs in the Sub-Capitation Program during 2024, 44% exclusively had practice sites in Tier 1 (51% in 2023), 26% exclusively had practice sites in Tier 2 (25% in 2023), and 22% exclusively had practice sites in Tier 3 (17% in 2023). The percentage of MassHealth Member Months (MMs) attributed to TINs with practice sites affiliated at each Tier level during 2024 reflects these changes, as 10% of MMs were attributed to TINs exclusively with Tier 1 sites (17% in 2023), 10% were attributed to TINs with exclusively Tier 2 sites (16% in 2023), and 47% were attributed to TINs with exclusively Tier 3 sites (42% in 2023). See **Table 3.3-6**.

Table 3.3-6 Prevalence of TINs Comprised of Practices from One or More Sub-Capitation Clinical Tier (CY2023-CY2024)

Types of Practice Tier Attestations Affiliated with TINs	2023		2024		Change from 2023 to 2024	
	% TINs	% MMs	% TINs	% MMs	% TINs	% MMs
Only Tier 1 Practices in TIN	51%	17%	44%	10%	-7%	-7%
Only Tier 2 Practices in TIN	25%	16%	26%	10%	1%	-6%
Only Tier 3 Practices in TIN	17%	42%	22%	47%	5%	5%
Tier 1 and 2 Practices in TIN	2%	10%	2%	6%	0%	-4%
Tier 1 and 3 Practices in TIN	1%	8%	1%	10%	0%	2%
Tier 2 and 3 Practices in TIN	1%	2%	2%	6%	1%	4%
Tier 1, 2, and 3 Practices in TIN	1%	5%	1%	12%	0%	7%
None Listed	3%	0%	2%	0%	-1%	0%
Total, <i>n</i>	373	1,317,117	354	1,333,550	N/A	N/A

Data Source: Calculated from RY23 & RY24 Primary Care Sub-Capitation Rate Development Appendix W: PCE-Specific Primary Care Sub-Capitation

Abbreviations: Calendar Year (CY); Member Months (MM); Taxpayer Identification Numbers (TINs)

Access Measures Reported by Practice Sites

PSAs were asked how often their MassHealth members with BH conditions were referred to one of the listed entities, including prescribing clinicians, counseling therapists, and care coordinators or care managers, to address BH treatment as well as HRSNs. Most PSAs (> 50%) reported that they either “always” or “usually” referred MassHealth members with BH conditions to each of these entities. See **Table 3.3-7**. Compared to 2017-2022 Wave 2 PSA survey data, responses of “always” or “usually” increased by an average of 6% across each of these survey items.

Table 3.3-7 PSA Survey: PSAs Report of How Often MassHealth Members with BH Conditions Were Referred to Various Entities (CY2025)

In the last 12 months, how often were your MassHealth members with BH conditions referred to the following entities?					
	Always	Usually	Sometimes	Rarely	Never
Prescribing clinicians, including psychopharmacologists and psychiatrists	22%	40%	33%	3%	1%
Counseling therapists, including clinical social workers	29%	46%	22%	1%	1%
Any type of care coordinator/manager to address BH treatment, including addiction services	25%	37%	30%	7%	1%
Any type of care coordinator/manager to address HRSNs (housing, nutrition, etc.)	26%	37%	32%	5%	1%

Data Source: PSA Survey

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Health-Related Social Needs (HRSNs); Practice Site Administrator (PSA)

Compared to the second wave PSA survey in the 2017-2022 evaluation, responses indicating that there was co-location within the practice site increased by an average of 18%. Most (52%) PSAs also indicated that services from counseling therapists were located within their practice site, while for all other services asked, most administrators indicated that they were not located within their practice site. A higher percentage of PSAs from large sites reported that their site was able to offer these services at their practice site, and a smaller percentage of PSAs from small sites reported their site was able to offer these services at their site. See **Table 3.3-8**.

Table 3.3-8 PSA Survey: PSAs Report of BH Resources Within Their Practice Site and Size of Practice Site (CY2025)

For each of the entities to which you refer patients with BH conditions, please indicate if the entity is located within your practice site				
	Practice Size			
	Yes, located within practice site	Small	Medium	Large
Prescribing clinicians, including psychopharmacologists and psychiatrists	35%	21%	26%	57%

For each of the entities to which you refer patients with BH conditions, please indicate if the entity is located within your practice site				
Counseling therapists, including clinical social workers	52%	33%	44%	80%
Any type of care coordinator/manager to address BH treatment, including addiction services	41%	23%	35%	65%
Any type of care coordinator/manager to address HRSNs (housing, nutrition, etc.)	47%	26%	43%	72%

Data Source: PSA Survey

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Health-Related Social Needs (HRSNs); Practice Site Administrator (PSA)

PSAs were also asked how soon MassHealth members who were new to the practice were seen for a routine initiation of primary care. Responses varied, with 48% of PSAs indicating new members being seen in less than 1 month; 27% of PSAs indicating new members were seen between 1 month and 3 months; and 25% of PSAs indicating new members were seen in 3 months or longer. See **Table 3.3-9**.

Table 3.3-9 PSA Survey: PSAs Report of How Quickly New Patients Are Seen for Primary Care in Their Practice Site (CY2025)

For Medicaid members new to your practice who want to be seen as soon as possible for routine initiation of primary care, how soon are they usually seen?	
	Percentage of Practices
Less than 1 week	15%
One week to less than 1 month	32%
1 month to less than 3 months	27%
3 months to less than 6 months	14%
6 months or longer	12%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

Member-reported Access to Care

Member-reported access to care was assessed using the MES Survey. Respondents included: Child Primary Care (6,337 respondents), Adult Primary Care (9,626 respondents), Adult BH

(3,148 respondents), Child LTSS (805 respondents) and Adult LTSS (2,303 respondents). See **Appendix C-8** for complete demographic information for respondents of each survey.

Table 3.3-10 contains results from the Child and Adult Primary Care MES regarding access to care. The Organizational Access Composite Measure combines results from three survey questions (answered by proxies for pediatric members) that pertain to timely access to PCPs for urgent and routine care. For pediatric members, there were improvements in access to primary care. In 2023, the composite score was 79.1 compared to 76.1 in 2022. For adult members, there were also small improvements in access to primary care. In 2023, the Organizational Access composite score was 67.8 compared to 64.9 in 2022. See **Appendix C-9** and **Appendix C-10** for stratified results and stratified within-year results with p-values of this composite measure.

Table 3.3-10 Results for the Organizational Access Composite Measure from the Primary Care MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Organizational Access^a			
Child Composite Score (0-100)	76.1	79.1	3.0*
Adult Composite Score (0-100)	64.9	67.8	2.9*

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.01, ***P<0.001 a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

a Child Primary Care Organizational Access composite measure combines the following three items: 1) In the last 12 months, when you called this provider's office for an appointment for care your child needed right away, how often did you get an appointment as soon as your child needed? 2) In the last 12 months, when you made an appointment for a check-up or routine care for your child with this provider, how often did you get an appointment as soon as your child needed? 3) In the last 12 months, when you called this provider's office during regular office hours, how often did you get an answer to your medical question that same day? Adult Primary Care Organizational Access composite measure combines the following three items: 1) In the last 12 months, when you called this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed? 2) In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed? 3) In the last 12 months, when you called this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Continuity of primary care was examined through the MES. **Table 3.3-12** contains results from the Child and Adult Primary Care MES regarding continuity of care through the Knowledge of Patient composite. The Knowledge of Patient composite measure from the Primary Care MES combines results from two survey questions that pertain to a PCP's knowledge of the member as a person, indicating an ongoing, trusting relationship between member and provider. For pediatric members, there were improvements in the Knowledge of Patient composite score. In 2023, the composite score was 88.5 compared to 82.6 in 2022. For adult members, there were also improvements. In 2023, the Knowledge of Patient composite score was 77.3 compared to 70.9 in 2022. See **Appendix C-9** for stratified results with p-values of this composite measure.

Table 3.3-12 Results for the Knowledge of Patient Composite Measure from the Primary Care MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Knowledge of Patient^a			
Child Composite Score (0-100)	82.6	88.5	5.9***
Adult Composite Score (0-100)	70.9	77.3	6.4***

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a Child Primary Care Knowledge of Patient composite measure combines the following two items: 1) In the last 12 months, how often did this provider seem to know the important information about your child's medical history? 2) How would you rate this provider's knowledge about your child as a person - special abilities, concerns, fears? Adult Primary Care Knowledge of Patient composite measure combines the following two items: 1) In the last 12 months, how often did this provider seem to know the important information about your medical history? 2) How would you rate this provider's knowledge of you as a person, including values and beliefs that are important to you?

Legend

Higher is better:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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3.3.3.3 Conclusions

Early findings support the hypotheses that access to, and continuity of, primary care would change in a positive direction for ACO members receiving care from primary care practice sites participating in the Sub-Capitation Program. Access and availability of BH services within practices increased from the 2017-2022 Demonstration,⁹¹ and PSAs reported that most practices had wait times for new patients' first PCP appointments that were three months or less. Composite scores calculated from MES items measuring access and continuity both showed improvements from 2022 to 2023. MassHealth members responding to the Adult and Child Primary Care surveys reported higher rates of obtaining timely access to care (composite score of 76.1-79.1 for children and 64.9-67.8 for adults) in 2022-2023 compared with scores of 67 for children and 54 for adults among Medicaid plans nationally in 2023.⁹² A larger fraction of practice sites achieved the Sub-Capitation Program's Tier 3 designation in 2024 compared to 2023; a chi-square test of independence confirmed a statistically significant increase (p = .025).

3.3.4. RQ2-4 How did integration between physical, behavioral, social, and long-term services change over time for ACO members?

3.3.4.1 Summary of Results

Integration between physical, behavioral, social, and long-term services for ACO members was examined using interviews, MES, and administrative data during the early years of the 2022-

⁹¹ Centers for Medicare & Medicaid Services. (2026). *Independent Evaluation Summative Report Massachusetts 2017-2022 1115 Demonstration*, U.S. Department of Health and Human Services, <https://www.mass.gov/doc/independent-evaluation-summative-report-0/download>

⁹² Centers for Medicare & Medicaid Services. (2023). *Consumer Assessment of Healthcare Providers and Systems*, U.S. Department of Health and Human Services, <https://datatools.ahrq.gov/cahps?tab=cahps-health-plan-survey-database&dash=31>

2027 Demonstration. In interviews, ACOs described their efforts to integrate care across the continuum. ACOs pursued integration by increasing screening and promoting colocation of professionals and services within primary care practice sites, including an enhanced focus on BH and social services. Similarly, BH CPs reported increasing their integration efforts, in particular working closely with CBHCs. For LTSS CPs, care integration was facilitated by conducting members' comprehensive assessments, which was a new requirement for LTSS CPs in the 2022-2027 Demonstration. Members reported receiving and being satisfied with the medical care and social services they received. PSAs cited increased care coordination efforts at their practices and reported offering enhanced BH and LTSS services to members. From the MES, composite scores calculated for survey items pertaining to integration of care increased from 2022 and 2023. For integration between the inpatient and outpatient care settings, performance on most follow-up care measures declined from baseline to 2023 and 2024 among ACO enrollees, and a similar pattern was observed among MCO/PCC enrollees.

3.3.4.2 Results

H2-4.1 Integration across the care continuum (e.g., physical health, BH, LTSS, acute care, social services) will increase.

In their bids, ACOs described their efforts to integrate care across the continuum for members. This included integration of services for members' physical health, BH, LTSS, acute care, and social services (e.g., housing and nutrition supports). In documentation, ACOs described various efforts including increasing screening for services, increasing access to multiple services, developing and improving workflows, and promoting care integration across organizations. As compared to the 2017-2022 Demonstration, many ACOs described an increase in the integration of BH and social services for HRSNs for members.

From the state's perspective, the 2022-2027 Demonstration focuses on enhancing primary care through the Sub-Capitation Program, integrating care, and enhancing person-centered care, to meet the wide needs of its members.

"MassHealth has acknowledged the full potential of primary care in supporting all aspects of a person's health, inclusive of reproductive health, substance use disorders, mental health conditions, and social risk factors. The Primary Care Sub-Capitation program is designed to promote a team-based approach to addressing whole person care so that members receive optimal services while primary care providers are not burdened with additional tasks." – a MassHealth staff respondent

In January 2025, the state shifted from the pilot Flexible Services Program to HRSN Supplemental Services within the HRSN Services Framework.⁹³ Please see [Chapter 8, HRSN](#) for more information. The state described the ramp up of HRSN services in the 2022-2027

⁹³ Commonwealth of Massachusetts (2026). MassHealth Health Related Social Needs Services. <https://www.mass.gov/masshealth-health-related-social-needs-services>

Demonstration and the investments made to put new and enhanced social service structures in place.

“ACOs have made significant investments in organizational capacity and their provider networks in support of the introduction of HRSN Supplemental Services into the ACO managed care benefit as of 1/1/25. This includes work such as credentialing, contracting with, and enrolling an entirely new class of providers (i.e., HRSN Providers); modifying their claims engines and workflows to accommodate HRSN Supplemental Services claims; providing technical assistance to HRSN Providers around what it means to be a provider, given that many HRSN Providers had no experience with billing; etc.” – a MassHealth staff respondent

In interviews, ACOs described using nurse care managers, social workers, CHWs, patient navigators, and outreach specialists to facilitate care integration activities. These roles were identified as being specific to adult and pediatric populations and by specialty depending on the ACO and practice site(s). ACOs also established specialized teams, such as transitions of care teams, disease management teams, and high-risk care management, to support care integration efforts. Many ACOs placed particular emphasis on care transition teams and high-risk care management. An ACO interviewee stated:

“What changed from the last waiver to this waiver -- is the complex care management program, and that is for the highest risk patients that are the most medically complex and really need a lot of hands-on support.” – an ACO participant (AA517734)

ACOs described their use of a standardized tool to screen HRSNs, which helped streamline the screening process across different stakeholders. Some ACOs integrated HRSN screening and referrals into their EHR and care management systems, which allowed for more efficient care integration. As an ACO interviewee pointed out:

“I think that our patient population has extensive social needs and the systems in place to identify those through the screener -- so as a provider, at this point, now, many times, the community health workers [have] already been in the room and addressed that before I even make it in. So, it's been really, really helpful to have that standardized tool in place, and I definitely agree that it's a conversation-starter that's helpful. I think that's an instrumental part of our practice.” – an ACO participant (AA394666)

Many ACOs discussed their efforts to integrate BH services including offering expanded BH services within or affiliated with primary care practices, working with BH CPs, and partnering with the newly formed CBHCs. ACOs discussed their integration efforts with CBHCs, and how the existence of the CBHCs has been a benefit to members who need BH services.

“We’ve worked really, really closely with the CBHCs. We were there for tours of the facilities when they were opening, working with their leadership team...And, so, we are constantly providing updates on

what's going well, what's not going well. The CBHCs are reaching out to us to let us know when our members are there, so that we can ensure that we're following up. And it's really been a blessing for our patients, and access to care for our behavioral health members experiencing crisis has been very much a challenge. And so, it's definitely helping." – an ACO participant (AP664417)

CPs described plans to integrate care including enhancing their BH and LTSS care coordination model; expanding HRSN screening, referrals, and partnerships; and collaborating with the newly established CBHCs. CPs described the expansion of staffing for outreach and engagement efforts to include peer specialists, registered nurses (RNs), and recovery coaches. In compliance with MassHealth requirements, CPs developed relationships with CBHCs to meet members' BH needs further. In addition, LTSS CPs took on more responsibility and were the lead entity for conducting comprehensive assessments with members, moving away from comprehensive assessments being conducted by ACOs in the 2017-2022 Demonstration. Both ACOs and MCOs reflected on how this change in ownership of comprehensive assessments facilitated integration across the care continuum. As an MCO interviewee stated:

"I think the CPs conducting their own assessments too -- it really helps them really get to know the person from that beginning, again, and it's less member handoffs, so it's more like a wraparound process for the memory that doesn't feel so fragmented, so I think that's been a really good." – an MCO participant (MC412397)

The state also described the requirement that BH CPs either have a CBHC as part of their organizational structure or hold agreements with CBHCs in their service area, to further enhance integration of care for members.

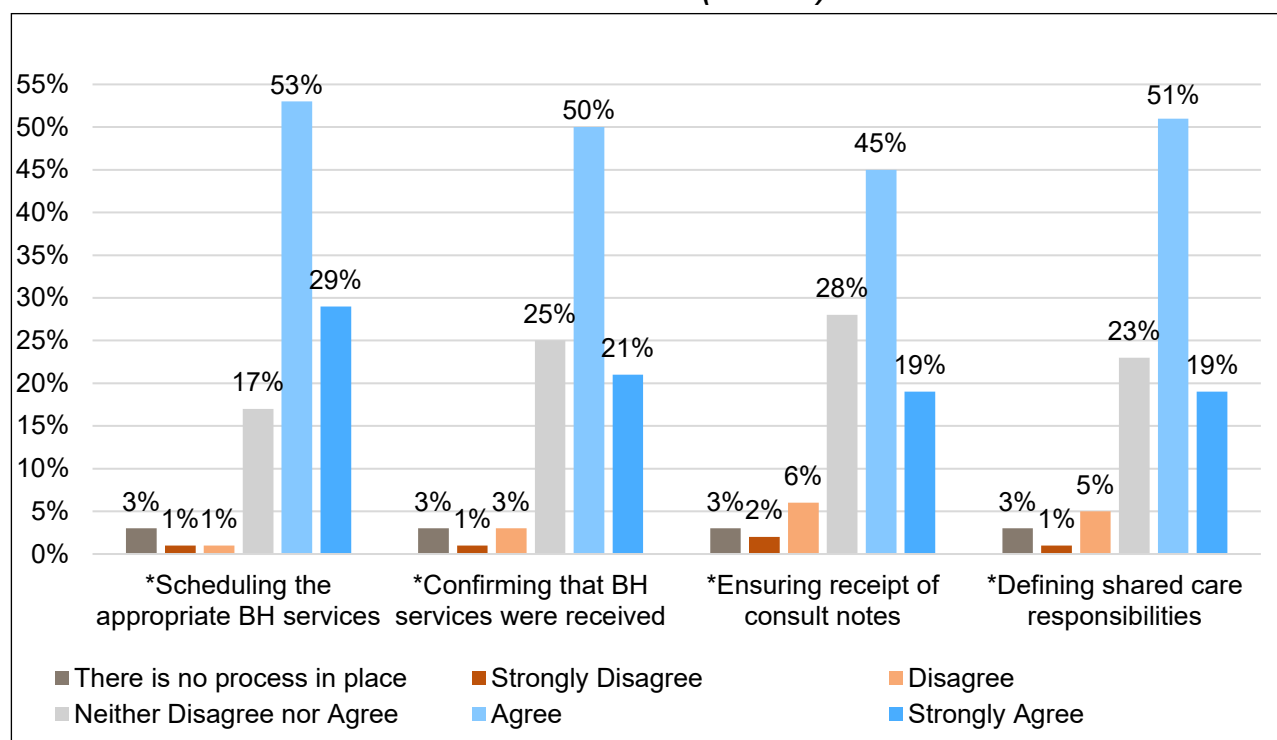
"Overall, the desire [is] to focus on reaching and engaging high need, vulnerable members, better quality outcomes, and utilize a value-based care model. In addition to the aforementioned items, MassHealth determined that, with the newly established CBHCs, it was important to have functional integration with the CPs...This relationship was intended to vastly improve the connection between the CPs and Enrollee's BH providers by requiring bi-directional communication and the sharing of information on Enrollees within predetermined time frames." – a MassHealth staff respondent

PSAs were asked how often their site's MassHealth members in BH crises were referred to CBHCs. Thirty-one percent of administrators indicated their practice site had "always" or "usually" done so, while 47% of administrators said they had "sometimes" referred members in crisis to CBHCs, and 22% "rarely" or "never" did so. Administrators who answered anything other than "never" to this question were prompted to write a brief description of their practice site's experience referring MassHealth members with acute BH needs to CBHCs. Responses were mixed, but mostly positive. Positive responses included general comments that their experience was positive for both outpatient appointments and acute care needs or crisis needs, as well as comments on the timeliness of response and appointment scheduling for their members. Negative responses mostly included experiences with delays and wait times for

appointments, as well as general perception of a lack of resources at CBHCs. Some sites indicated that they infrequently utilized CBHC services because they had their own internal BH resources to handle such situations.

PSAs were also asked to what extent they agreed that their practice site followed clear, established processes regarding BH care coordination for their MassHealth members including scheduling the appropriate BH services, confirming those services were received, ensuring their practice site received consult notes from prescribing clinicians, and establishing who is responsible for co-managing care when applicable with prescribing clinicians. Administrators widely agreed with those statements. See **Figure 3.3-3**.

Figure 3.3-3 PSA Survey: To What Extent PSAs Agreed That Their Practice Site Followed Clear, Established Processes for BH Care Coordination (CY2025)



Data Source: PSA Survey

Abbreviation: Behavioral Health (BH); Calendar Year (CY); Practice Site Administrator (PSA)

*Survey items have been paraphrased, see **Appendix C-2** for PSA Survey items

A similar domain of questions regarding care coordination for at-home care needs and LTSS provider relationships asked PSAs to what extent they agreed that their providers followed clear, established processes for a number of items including: screening members for at home service needs (82% agreed or strongly agreed); choosing particular LTSS providers (57% agreed or strongly agreed); referring patients to specific LTSS providers (52% agreed or strongly agreed); confirming that the requested supports were provided (50% agreed or strongly agreed); establishing relationships with LTSS providers (44% agreed or strongly agreed); and getting updates from the LTSS providers on the patient's conditions (48% agreed or strongly agreed). An average of 36% of respondents indicated that they neither agreed nor disagreed with statements regarding LTSS care coordination. An average of 7% of administrators indicated there was no process in place for LTSS care activities.

Primary Care: Member Integration of Care

Table 3.3-13 contains results from the Child and Adult Primary Care MES regarding integration of care. The Integration of Care composite measure from the Primary Care MES combines results from four survey questions that pertain to a PCP's level of collaboration with other providers including specialists. For pediatric members, there were improvements in integration of care. In 2023, the composite score was 83.4 compared to 76.1 in 2022. For adult members, there were notable improvements in integration of care. In 2023, the Integration of Care composite score was 86.0 compared to 64.0 in 2022, representing a 22-point improvement. See **Appendix C-9 and Appendix C-10** for stratified results and stratified within-year results with p-values of this composite measure.

Table 3.3-13 Results for the Integration of Care Composite Measure from the Primary Care MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Integration of Care^a			
Child Composite Score (0-100)	76.1	83.4	7.3***
Adult Composite Score (0-100)	64.0	86.0	22.0***

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a Child Primary Care Integration of Care composite measure includes the following four items: 1) In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care your child got from specialists? 2) In the last 12 months, when this provider ordered a blood test, x-ray, or other test for your child, how often did someone from this provider's office follow up to give you these results? 3) In the last 12 months, how often did you and someone from this provider's office talk about all the prescription medicines your child was taking? 4) In the last 12 months, did you get the help you needed from this provider's office to manage your child's care among these different providers and services? Adult Primary Care Integration of Care composite measure includes the following four items: 1) In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists? 2) In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you these results? 3) In the last 12 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking? 4) In the last 12 months, did you get the help you needed from this provider's office to manage your care among these different providers and services?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Administrative Measures

Administrative data was used to examine the rate at which integration across the care continuum (e.g., physical health, BH, LTSS, acute care, social services) decreased, increased, or remained consistent for MassHealth members in the first phase of the 2022-2027 Demonstration, including select Healthcare Effectiveness Data and Information Set (HEDIS®) measures⁹⁴. While some changes to specifications exist during the comparison period, they are seen as marginally affecting the data^{95,96}. As displayed in **Table 3.3-14**, predicted values decreased for most care integration measures in both the ACO and MCO/PCC populations in 2023 and 2024 when compared to baseline (2022), with only a few remaining consistent. See **Appendix C-11.1** for additional administrative measure data stratified by demographics.

Table 3.3-14 Observed vs. Expected Ratios of Care Integration Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Care Integration		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication on HEDIS® measure⁹⁷	Population Size, <i>N</i>	16,342	13,456	9,853	13,277	2,886	1,478	1,354
	Measure, Observed*	77.1%	77.9%	79.5%	81.4%	73.6%	75.9%	78.2%
	O:E Ratio	1.00	1.01	1.01	1.02	0.97	0.98	1.00
Physician Visit Within 30 Days of Hospital Discharge	Population Size, <i>N</i>	68,810	57,734	45,811	63,522	11,076	5,887	5,392
	Measure, Observed*	66.3%	66.9%	65.8%	66.5%	62.8%	61.1%	63.7%
	O:E Ratio	1.00	1.01	0.97	0.96	0.95	0.91	0.92
Follow-Up After ED Visit Within 7 Days for Alcohol and Other Drug Abuse or	Population Size, <i>N</i>	11,828	9,986	6,843	6,938	1,842	866	670
	Measure, Observed*	44.7%	44.2%	34.5%	35.7%	47.4%	37.0%	35.5%
	O:E Ratio	1.00	0.99	0.78	0.81	1.04	0.81	0.78

⁹⁴ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

⁹⁵ HEDIS MY 2023 Summary of Changes, <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2022/08/MY-2023-Summary-Table-of-Measures-Product-Lines-Changes.pdf>

⁹⁶ HEDIS MY 2024 Summary of Changes, <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/Summary-Table-of-Measures-Product-Lines-and-Changes.pdf>

⁹⁷ HEDIS MY2023 Bipolar Disorder Using Antipsychotic Medication

Care Integration		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Dependence HEDIS[®] measure⁹⁸								
Follow-Up After ED Visit Within 30 Days for Alcohol and Other Drug Abuse or Dependence HEDIS[®] measure⁹⁹	Population Size, <i>N</i>	11,828	9,986	6,843	6,938	1,842	866	670
	Measure, Observed*	63.2%	62.9%	54.9%	55.8%	65.2%	55.9%	54.8%
	O:E Ratio	1.00	1.00	0.86	0.88	1.02	0.86	0.85
Follow-Up After Hospital Visit for Mental Illness Within 7 Days HEDIS[®] measure¹⁰⁰	Population Size, <i>N</i>	12,780	10,674	9,256	12,710	2,106	1,276	1,277
	Measure, Observed*	49.0%	49.1%	45.4%	40.8%	48.2%	43.9%	39.9%
	O:E Ratio	1.00	1.01	0.90	0.80	0.97	0.88	0.79
Follow-Up After Hospital Visit for Mental Illness within 30 Days HEDIS[®] measure¹⁰¹	Population Size, <i>N</i>	12,780	10,674	9,256	12,710	2,106	1,276	1,277
	Measure, Observed*	76.0%	75.9%	71.6%	64.9%	76.2%	70.8%	67.1%
	O:E Ratio	1.00	1.00	0.93	0.84	1.00	0.92	0.87
Follow-Up with BH CP or Provider After ED Visit	Population Size, <i>N</i>	33,766	30,779	21,353	23,795	2,987	1,461	1,254
	Measure, Observed*	47.2%	47.4%	46.0%	48.9%	44.3%	40.7%	42.3%
	O:E Ratio	1.00	1.00	0.98	1.04	0.96	0.90	0.95
Follow-Up with LTSS CP After Acute or Post-Acute Stay**	Population Size, <i>N</i>	N/A	1,586	1,498	1,380	N/A	N/A	N/A
	Measure, Observed*	N/A	N/A	16.2%	35.7%	N/A	N/A	N/A

⁹⁸ HEDIS MY2023 Follow-Up After ED Visit Within 7 Days for Alcohol and Other Drug Abuse or Dependence⁹⁹ HEDIS MY2023 Follow-Up After ED Visit Within 30 Days for Alcohol and Other Drug Abuse or Dependence¹⁰⁰ HEDIS MY2023 Follow-Up After Hospital Visit for Mental Illness Within 7 Days¹⁰¹ HEDIS MY2023 Follow-Up After Hospital Visit for Mental Illness Within 30 Days

Care Integration		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
	O:E Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Community Partner (CP); Emergency Department (ED); Healthcare Effectiveness Data and Information Set (HEDIS); Long Term Services and Support (LTSS); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

* Yearly count per 100 members

** Coding instructions for CPs changed from 2022 to 2023 so we did not attempt to compare to data from 2022 that preceded the change. Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Higher is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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3.3.4.3 Conclusions

Early findings from the early years of the 2022-2027 Demonstration partially support the hypothesis that integration across the continuum would increase for MassHealth members, with improvements observed in the outpatient care setting and with signals of decrements in integration between the emergency/inpatient and outpatient setting. ACO, MCO, CP, and member interviewees reported stable or improved integration of care. Findings from surveys of PSAs (relative to prior surveys for the 2017-2022 Demonstration¹⁰²) and members also indicated integration was improving. The majority of follow-up after emergency and inpatient care declined among ACO and MCO/PCC enrollees from baseline (2022) to 2023 and 2024. Despite lack of improvement, when comparing to external benchmarks¹⁰³, diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic medication was comparable or slightly better than national averages for ACO members (77.9% in MA and 77% nationally in 2022, 79.5% in MA and 77.0% nationally in 2023, and 81.4% in MA and 77.8% nationally in 2024). Similarly, follow-up after hospitalization for mental illness at seven days for ACO members was approximately 10-15% higher on average across years when comparing to national benchmarks (49.1% in MA and 33.9% nationally in 2022, 45.4% in MA and 32.3% nationally in 2023, and 40.8% in MA and 32.7% nationally in 2024). Finally, follow-up after hospitalization for mental illness at 30 days for ACOs members was 20% higher in some cases when comparing to national averages (75.9% in MA and 54.5% nationally in 2022, 71.6% in MA and 53.9% nationally in 2023, and 64.9% in MA and 55.8% nationally in 2024). These results suggest that while improvements in care integration have been reported by stakeholders, such

¹⁰² Centers for Medicare & Medicaid Services. (2026). *Independent Evaluation Summative Report Massachusetts 2017-2022 1115 Demonstration*, U.S. Department of Health and Human Services, <https://www.mass.gov/doc/independent-evaluation-summative-report-0/download>

¹⁰³ Centers for Medicare & Medicaid Services. (2026). *Adult Health Quality Care Measures*. [Adult Health Care Quality Measures | Medicare.gov](https://www.medicare.gov/quality-measures/adult-health-quality-care-measures)

improvements may be concentrated in the outpatient setting and there is a particular need for quality improvement efforts focused on transitions of care and timely follow-up care.

3.3.5. RQ2-5 To what extent did enhanced expectations for quality and equity change care for ACO members?

3.3.5.1 Summary of Results

Interview, PSA Survey, and ACO reporting data were assessed to examine the extent to which enhanced expectations for quality and equity changed care for ACO members. In the early years of the 2022-2027 Demonstration, per ACO contractual requirements, ACOs reported focusing on screening and identifying members' HRSNs and connecting members to social service supports. ACOs also reported their intention to increase rates of RELDSOGI data collection. ACOs used standard tools to screen members for HRSNs and worked to standardize screening processes within their organizations. Many ACOs reported integrating HRSN screening in their EHR. Despite some progress by ACOs with HRSN screening practices, in 2025 CBOs reported receiving lower than desired referrals from ACOs through MassHealth funded HRSN programs in some cases. This was likely associated with the transition from the Flexible Services Program to HRSN Supplemental Services that occurred on Jan. 1, 2025, discussed further in the [Chapter 8, HRSN](#). ACOs reported that some providers and members experienced "screening fatigue" due to the multitude of required screeners. PSA survey results showed that a vast majority (90%) of primary care practice sites were screening members for HRSNs; however, only 45% of PSAs stated that they were able to successfully obtain members' screening results from outside organizations.

A secondary focus of enhanced quality and equity expectations was to improve care processes. ACOs and CPs reported that they were working to enhance their care management procedures, ensure adequate care coordination supports, and integrate care management processes into EHRs and workflows. ACOs and CPs strived to increase access to care management and coordination supports for members. Members reported that they appreciated that care coordinators were accessible to them via text, email, and phone when they needed support. Changes in performance on care process measures from baseline (2022) to 2023 and 2024 were consistent with such enhancements; most care process measures improved over time including topical fluoride for children at elevated caries risk, antidepressant medication management, and oral health services.

Finally, under MassHealth's ACO Quality and Equity Incentive Program (AQEIP)¹⁰⁴, beginning in Performance Year 2 (2024) of the 2022-2027 Demonstration, ACOs were responsible for reporting on several quality and equity metrics including HRSN screening rates (overall rate of 14.1% in Performance Year 2 (PY2)) and addressing language needs of members with a preferred spoken language other than English (median rate of 43% in PY2); rates varied widely across ACOs. The percentage of ACO primary care PSAs who reported using information on

¹⁰⁴ Commonwealth of Massachusetts (2026). *MassHealth ACO Quality and Equity Incentive Program (AQEIP)*. [MassHealth ACO Quality and Equity Incentive Program \(AQEIP\) | Mass.gov](#)

enrollee characteristics to identify health inequities increased since the 2017-2022 Demonstration.¹⁰⁵

3.3.5.2 Results

H2-5.1 The identification of individual members' unmet needs (including HRSNs) for ACO members will improve.

In describing their population health management strategy in their bids, many ACOs explained their focus on identifying members' HRSNs and connecting members to supports, services, and resources. In their Flexible Service Program Participation Plans, ACOs defined HRSN screening as a first step in identifying members' unmet needs. The HRSN screening was described as the beginning of the outreach process to connect members to services including Flexible Service programs. The Flexible Services Participation Plans also outlined the flow of information from ACO to CBOs and the transfer of data to MassHealth, as members are identified for services, receive outreach from ACO staff, and connect with and receive services with the appropriate CBO. Some ACOs emphasized the role of HRSN screenings in their descriptions of how they will promote health equity and specified their plans to regularly track HRSN screening rates to ensure members are being screened.

In their Health Quality and Equity Strategic Plans, many ACOs specifically outline a strategic goal for increased rates of HRSN screening and RELDSOGI data collection. Some ACOs recognize that the increased emphasis on HRSN screening and RELDSOGI data collection will afford them a better understanding of their population and its health needs, which, in turn, will allow them to serve that population better.

Responses from our MassHealth staff survey indicated that ACOs have improved internal systems to gather demographic data. MassHealth staff described how ACOs assessed their existing HRSN screening practices, selected standardized screening tools, and implemented workflow improvements and system updates to improve their capture of screening data.

ACO interviewees spoke about how standardization of screening tools across public and private payers, internal departments and sites, and health systems created more efficient communication among stakeholders. The standardization of screening tools reduced duplicative screening, thus lessening the burden on members and decreasing screening fatigue. In addition, many ACO interviewees mentioned that having the same screening tool across practices helped to identify trends in screenings and referrals and more easily identify HRSNs among members.

Integration of screening and referral processes into electronic platforms, including EHRs and care management systems, helped to facilitate care coordination efforts between ACOs, their practice sites, and CBOs. Most CBO interviewees, interviewed in CY2025, indicated that their ACO partners had a comprehensive screening and eligibility determination procedure such that members referred from the ACO to CBO services were correctly identified as eligible for CBO

¹⁰⁵ Centers for Medicare & Medicaid Services. (2026). *Independent Evaluation Summative Report Massachusetts 2017-2022 1115 Demonstration*, U.S. Department of Health and Human Services, <https://www.mass.gov/doc/independent-evaluation-summative-report-0/download>

services. Other CBO interviewees whose sites had struggles receiving referrals from their ACO partners voiced their concern for the level of administrative burden the additional screenings and eligibility assessments placed on the ACOs. In some cases, CBOs offered to assess members' eligibility themselves. In cases where members were first coming to the CBO rather than being referred by the ACO, most CBOs described the integrated processes they had built to screen and assess members' CBO service eligibility.

Many ACOs articulated that having a standard screening process integrated into their EHR systems helped to capture the HRSNs of MassHealth members in different clinical settings. One ACO mentioned that:

“The [HRSN] screening...[has] been built into the EHR as kind of a flowsheet, so it...is captured as discrete data right within the EHR. And then obviously, the referral from that would flow...” – an ACO participant (AA562141).

Still, some ACO interviewees highlighted the struggle to get accurate RELDSOGI and HRSN data in different clinical settings. ACO interviewees shared that the number of screening requirements, repetition of screening in multiple clinical settings, and limits to workforce capacity have contributed to gaps in stratified data and delays in the implementation of updated screening requirements.

ACOs highlighted various administrative barriers to complying with MassHealth's RELDSOGI reporting requirements. Many ACOs stated that the number of new RELDSOGI and HRSN data collection requirements led to significant upgrades needed for their EHR, which posed an additional challenge for ACOs with multiple EHRs in their systems. The number of upgrades led to serious workforce capacity concerns among many ACOs. For example, making these kinds of data collection and associated EHR changes typically required extensive financial and staff investments including significant staff training. One ACO alluded to the fact that the disability component of the RELDSOGI requirements in particular *“requires resources to put it into a data system, requires resources to train staff, requires resources to collect it”* and that *“some of those targets...feel a little out of reach with...where we're at and where we started.”* (ACO participant)

The implementation of new Current Procedural Terminology (CPT) codes for HRSN screening has largely been an administrative change leading to some burden. While ACOs and providers may use primary care sub-capitation, Health Quality and Equity Incentive Payment, or other dollars for HRSN screening, one ACO notes that these CPT codes are non-reimbursable, which adds to the challenge in implementing them.

“MassHealth made several changes to the CPT codes...and the whole shift to administrative coding is extremely new...The other piece of important context that I'd highlight here is that the CPT codes are non-reimbursable, so providers have to do the screenings...but there is no payment attached to them from MassHealth...Figuring out how to stand up these new administrative coding processes, as you can imagine, is quite a lift on the admin side.” – an ACO participant (AA517734)

Screening questions are designed to elicit responses that may require immediate attention (e.g., identifying situations of domestic violence or acute homelessness) and enable an ACO to address a pressing issue which otherwise would not have been known to the care team. While beneficial for members, ACO interviewees recognize that adding these screening questions potentially involves the immediate need for more resources, all of which requires larger conversations about adapting clinical workflows beyond than simply adding questions to a screening form.

“...a simple thing like adding the question about interpersonal violence -- while that’s a good question, but adding that is not a simple thing, because now all of a sudden you have to prepare for someone affirming that they’re experiencing violence in the home. It needs to be responded to in real time, and that requires a lot more forethought.” – an ACO participant (AA199175)

In some cases, members were being asked to fill out multiple screenings without their needs being addressed in a timely manner. ACOs mentioned that both providers and members have experienced “*screening fatigue*” with repeated administrations of screening questions. One ACO noted that having these repeated conversations led to a reduction in the amount of time members had with providers during appointments. ACOs indicated that a member’s discomfort answering certain RELDSOGI and HRSN questions during clinical visits was a barrier to accurate screening. Some ACO interviewees surmised reticence among members regarding what the data would be used for and how that might impact their care overall.

“We have heard that member exhaustion and, frankly, provider exhaustion as well around screenings...you’re bringing back up the same conversation over and over again and it eats up a lot of patient-provider time.” – an ACO participant (AA145082)

Results from the PSA survey showed 91% of administrators indicated that their practice site “always” or “usually” used standardized questions or screeners to identify members’ HRSNs, and 89% of administrators indicated that their practice site “always” or “usually” engaged in routine screening for HRSN, either by their practice or a partner organization (e.g., social service organization).

Notably, 45% of administrators indicated that their practice site “always” or “usually” obtained the results of members’ HRSN screenings when performed by another organization, and 27% of administrators indicated that their practice site “rarely” or “never” obtained the results of members’ HRSN screenings when performed by another organization. See **Table 3.3-15**.

Table 3.3-15 PSA Survey: PSAs Report of HRSN Screening at Their Practice Site (CY2025)

How often does your practice site engage in the following HRSN practices for your MassHealth members?					
Survey Item	Always	Usually	Sometimes	Rarely	Never
Using standardized questions or screeners to identify members' HRSNs	70%	20%	7%	1%	2%
Routine screening for HRSN either by your practice or a partner organization (e.g., social service organization)	67%	22%	9%	1%	1%
Obtaining the results of members' HRSN screenings when performed by another organization	25%	19%	28%	17%	10%
Monitoring when members you've referred to social service organizations receive services	29%	34%	28%	7%	2%
Monitoring when members you've referred to social service organizations have their needs met (e.g., they are no longer food or housing insecure)	27%	35%	28%	7%	3%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Health-Related Social Need (HRSN); Practice Site Administrator (PSA)

Results from the PSA survey also showed 60% of administrators indicated that their practice site used site-specific data (such as EHR charts or ACO reports) to identify health disparities within its served population on either a quarterly or monthly basis. Ten percent of administrators reported not having access to that type of data, and 9% reported not analyzing that type of data for health inequities. See **Table 3.3-16**.

Table 3.3-16 PSA Survey: Frequency of Use of Practice Site -Specific Data to Identify Health Disparities (CY2025)

How often does your practice site use site-specific data (such as EHR charts or ACO reports) to identify health disparities within its served population?	Percentage of Respondents
Annually	5%
Bi-annually	2%
Quarterly	26%
Monthly	34%
On an ad hoc basis	14%
We do not have access to this type of data	10%
We have access to this type of data but do not analyze it for health inequities	9%

Data Source: PSA Survey

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Electronic Health Record (EHR); Practice Site Administrator (PSA)

PSAs indicated several demographic categories that their practice site uses in their patient data to identify health disparities. See **Table 3.3-17**.

Table 3.3-17 PSA Survey: Reported Use of Patient Data to Assess Disparities Across Key Demographic Factors (CY2025)

For which of the following factors does your practice site use patient data to identify health disparities (at least annually)?	Percentage of Respondents
Age	58%
Race or ethnicity	54%
Language	46%
Cognitive, sensory, or physical disability	43%
Gender	42%
Gender identity	35%
Sexual orientation	32%
Income	25%
Education	19%
Religion	12%
None of the above	25%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

H2-5.2 Care processes for ACO members will improve.

In their bids, ACOs outlined planning to make changes to processes to make navigating care easier and more streamlined for members. Across all ACOs' population health strategies, there was a consistent emphasis on making the healthcare experience streamlined, more coordinated, and easier to navigate for members. For the 2022-2027 Demonstration, many ACOs expanded or redesigned existing care management programs, often embedding care managers in primary care practices, to help members with complex medical, behavioral, and social needs access services. Strategies like proactive outreach, remote patient monitoring, integrated BH care, and "No Wrong Door" policies further streamline access by ensuring members are pointed in the right direction to receive specific supports without needing to know initially where to look for help. Enhanced transitions of care processes, including structured follow-up after hospitalization and improved EHR workflows, help reduce gaps in care and prevent avoidable complications. ACOs also reported simplifying care processes through communications via text and email, assisting with scheduling appointments, and expanding urgent care hours. Together, these improvements create a more seamless and user-friendly experience for members.

Improvements in care processes were reflected in ACO interviews. ACOs emphasized their efforts to *“create a more transparent, more streamlined pathway to help members.”* (ACO participant) ACOs accomplished this goal using multiple methods including creating central care coordination pathways, educating providers about services available to members, and conducting timely outreach to members about changes to processes and new resources. These strategies ensured members would be quickly connected to resources.

“We have centralized services where we try to proactively identify those patients who have preventative care, or chronic care needs, and try and do that outreach to bring them in for appointments to help [...] the practices focus on the day-to-day needs, we’ve got extensive processes. We’ve made it really easy for providers to refer. We go out and we do educate the providers on the services that are available, we encourage them to build into their medical records, so that if they identify a patient, they can just click a button and send the referral over to us, so that we can outreach timely.” – an ACO participant (AP664417)

ACOs also mentioned the notion of a “No Wrong Door” policy in interviews, with one stating, *“a central referral coordination pathway was really an effort to create no wrong door to care coordination and care management.”* (ACO participant) Emphasizing to members that they can be pointed in the right direction no matter who they initially approach is key to ensuring the health care experience feels straightforward, streamlined, and simple to navigate.

CPs also explained changes to care processes to improve the member experience in their annual reports. Across the care coordination models CPs described, there is a strong emphasis on improving the member experience by making care more accessible, personalized, and responsive to individual needs. CPs outlined multiple outreach methods to streamline communication including texts, phone calls, emails, letters, and in-person visits. In addition, in their annual reports, per program requirements, CPs described how care teams monitor hospital notifications, conduct timely follow-ups, coordinate transportation, and sometimes accompany members to appointments. Regular care team meetings, increased data sharing, and collaboration across CPs and health care providers reduce fragmentation in care and simplify the experience for members.

In interviews, CPs described ways they make care processes simpler for their ACO partners and for members. Some CPs noted that they assigned staff to extract information from ACOs’ EHRs to ensure they have necessary member information to support member care in real time. Other CPs indicated that they implemented processes to ensure that members are not missing appointments. In some cases, CPs also contacted other entities who can provide services to CP enrollees.

“We’ve actually coached our RNs and our CCMs [clinical care managers] that before we’re even finalizing an assessment or a care plan, if we have EHR read-only access for that ACO, we should be checking to make sure we’re not missing anything. Are they missing appointments? Should we be including that as a goal on the care plan? Is the client calling into the PCP office for housing support

when that's something that we're supposed to be helping them on? So really making sure we're trying to close all the gaps and connect all the dots prior to that." – a CP participant (CL554196)

CPs also mentioned incorporating HRSN screening into their care coordination activities. Many of these changes aim to “close the loop” (i.e., ensuring that HRSN referrals are made so that the members received the needed services).

“We've also changed our workflows around that to make sure that we closed the loop, so that our case record review is conducted monthly, and then they identify anything that needs to be addressed...that really helps to improve the members' services, to make sure that things are not falling through the cracks kind of thing.” – a CP participant (CL371321)

Another change that improved care processes for members was no longer requiring the PCP signature on care plans, a change from the 2017-2022 Demonstration. An MCO interviewee highlighted how this change streamlines and expedites care for members.

“I think the biggest requirement change that helped all of us was not requiring the PCP signature on care plans, especially for the MCO providers, because...they're kind of all over the place, and there's not the greatest buy-in. I can remember in the first iteration of the CP program, which we always call CP 1.0, just trying to get a care plan signed by an MCO provider could sometimes take over a year. Because like the CPs would be faxing them, and then they would ask me for help expediting, and there really wasn't much that I could do on my end. So, getting rid of the actual signature component has helped the CPs get their care plans done faster with the members, and go on a faster track to engagement.” – an MCO participant (MC109077)

In interviews, members expressed that they valued technology that made communication and care coordination easier including email, patient portals like MyChart, and text or phone reminders. Members appreciated being able to email care teams directly, with one member saying, “*I love that...if we could email doctor's offices and they could email us, nobody would need a fax anymore.*” (MassHealth member) Patient portals helped members feel informed and connected, allowing providers to share updates and reducing the need to repeat their medical history, as one member explained, “*They know my story...I don't have to tell it a million times.*” (MassHealth member) Other members reported using these tools to check test results or appointment histories.

Across the interviews, members described feeling supported by their care coordinators and care teams. Many members spoke warmly about their care coordinators and social workers, describing relationships that were both practical and emotional. One member shared that they talk with their care manager often, expressing, “*I talk with them every three weeks...if there's something serious going on, we communicate more often.*” (MassHealth member) Another member explained that their social worker “*helped me out a lot...she was there for me through*

my bad times” and stayed in touch “a couple times a week.” (MassHealth member) Another member talked about how their case manager “helps me with anything I need...she’s amazing.” (MassHealth member) Altogether, members described the care coordination supports and care teams as helpful, noting that they provided support when it was needed.

Administrative Measures

Administrative measures were used to examine the rate at which care processes increased, decreased, or stayed consistent for MassHealth members in the first few years of the 2022-2027 Demonstration. Most measures assessing care processes showed an increase in predicted values from baseline (2022) to 2023 and 2024 for both the ACO and MCO/PCC populations, while metabolic monitoring for children and adolescents on antipsychotics decreased for both populations. See **Table 3.3-18**. See **Appendix C-11.2** for additional administrative measure data stratified by demographics.

Table 3.3-18 Observed vs. Expected Ratios of Care Processes Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Care Processes		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Topical Fluoride for Children at Elevated Caries Risk¹⁰⁶	Population Size, <i>N</i>	519,817	453,593	346,354	436,310	66,224	36,675	33,027
	Measure, Observed*	27.4%	27.4%	30.6%	35.0%	27.0%	29.9%	33.2%
	O:E Ratio	1.00	1.00	1.11	1.25	1.00	1.10	1.20
Metabolic Monitoring for Children and Adolescents on Antipsychotics HEDIS® measure¹⁰⁷	Population Size, <i>N</i>	4,243	3,551	2,929	4,083	692	374	364
	Measure, Observed*	38.4%	38.1%	38.6%	35.5%	40.2%	33.2%	28.3%
	O:E Ratio	1.00	1.00	0.98	0.88	1.02	0.82	0.71
Antidepressant Medication Management – Acute HEDIS® measure¹⁰⁸	Population Size, <i>N</i>	27,852	22,988	14,140	16,848	4,864	2,141	1,633
	Measure, Observed*	66.5%	66.1%	66.1%	70.8%	68.3%	68.4%	70.4%
	O:E Ratio	1.00	0.99	1.02	1.07	1.03	1.06	1.07
Antidepressant Medication Management –	Population Size, <i>N</i>	27,852	22,988	14,140	16,848	4,864	2,141	1,633
	Measure, Observed*	40.9%	40.7%	39.2%	43.5%	42.0%	40.6%	41.6%

¹⁰⁶ Topical fluoride for children at elevated caries (TFC) were calculated based on the DQA Measure Technical Specifications, which is managed by the [American Dental Association](#) on behalf of the Dental Quality Alliance (ADA/DQA).

¹⁰⁷ HEDIS MY2023 Metabolic Monitoring for Children and Adolescents on Antipsychotics

¹⁰⁸ HEDIS MY2023 Antidepressant Medication Management – Acute

Care Processes		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Chronic HEDIS® measure¹⁰⁹	O:E Ratio	1.00	0.99	0.99	1.06	1.03	1.03	1.03
Oral Evaluation, Dental Services¹¹⁰	Population Size, N	544,481	474,863	370,887	427,927	69,618	39,664	32,518
	Measure, Observed*	55.6%	55.8%	57.0%	62.1%	53.8%	55.6%	61.0%
	O:E Ratio	1.00	1.00	1.02	1.09	0.98	1.01	1.09

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Healthcare Effectiveness and Data Information Set (HEDIS);

Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

* Yearly count per 100 members

Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Higher is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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Hybrid measures from the MassHealth ACO quality performance measure slate were also used to assess the rate at which care processes increased, decreased, or remained consistent in the early phases of the 2022-2027 Demonstration. (See **Table 3.3-19.**) Results were mixed from baseline (2022) to 2023, with rates of timeliness of prenatal care improving over time, and rates of screening for depression and follow-up plan declining.

Table 3.3-19. Hybrid Measure Results of Care Processes for ACO Members (CY2022-2023)

Care Processes		2022	2023
Timeliness of Prenatal Care	Denominator Size	n = 3,785	n = 4,076
	Overall Rate	83.66%	92.38%
	Median	87.67%	93.17%
	Range	63.66-96.00%	82.73-98.15%
Timeliness of Postpartum Care	Denominator Size		n = 4,076
	Overall Rate	N/A*	86.76%
	Median		86.96%
	Range		79.40-93.43%

¹⁰⁹ HEDIS MY2023 Antidepressant Medication Management – Chronic

¹¹⁰ Oral evaluation rates for children were calculated based on the DQA Measure Technical Specifications for Oral Evaluation, Dental Services (CBE #2517), which is managed by the [American Dental Association](#) on behalf of the Dental Quality Alliance (ADA/DQA).

Care Processes		2022	2023
Screening for Depression and Follow-Up Plan	Denominator Size	$n = 6,031$	$n = 2,439$
	Overall Rate	43.73%	47.24%
	Median	42.11%	48.20%
	Range	26.83-69.98%	23.62-68.10%

Data Source: MassHealth Quality Measure Data

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY)

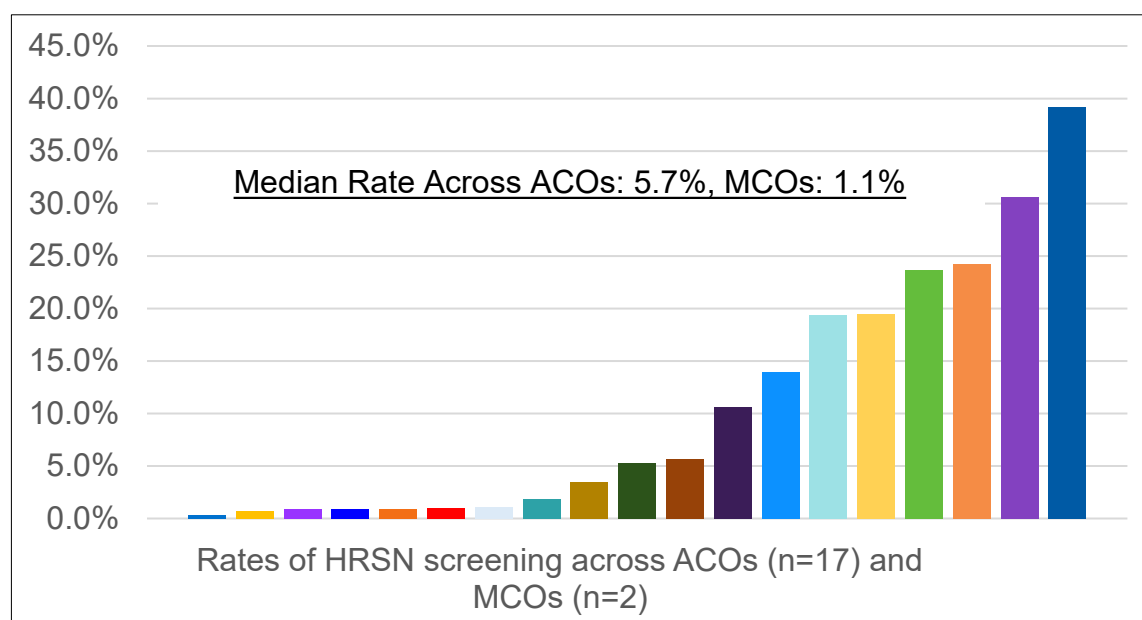
*N/A, data not available for this measure for 2022

H2-5.3 Healthcare inequities will decline in targeted measures.

Under MassHealth's AQEIP Program, ACOs were responsible for monitoring and reporting on several metrics targeting quality improvement and disparities reduction. AQEIP metrics included: HRSN screening, RELDSOGI data completeness, language access services, and providing disability competent care, among others¹¹¹. In this IEIR, we examined the AQEIP measures: *Health Related Social Needs Screening*, and *Meaningful Access to Healthcare Services for Individuals with a Preferred Language Other than English*.

Per the *Health-Related Social Needs Screening* AQEIP measure, ACOs were required to begin screening all MassHealth members on an annual basis for HRSNs starting in PY2 (2024). Using a standardized screening tool, members were screened in the following domains: food insecurity, housing instability, transportation needs, and utility difficulties. Across ACOs, an overall rate of 14.1% of members were screened for HRSNs during the measurement year, while 1% of MCO members were screened. For those ACO and MCO members who screened positive, identified needs in food insecurity were most prominent, followed by utility difficulties and housing instability, with transportation needs being least prominent. See **Figure 3.3-4** and **Table 3.3-20**.

¹¹¹ MassHealth (2025). *Technical Specifications for the MassHealth Accountable Care Organization Quality and Equity Incentive Program (AQEIP)* <https://www.mass.gov/doc/aqeip-performance-year-2-technical-specifications-updated-8252025-0/download>

Figure 3.3-4 HRSN Screening Rates Across ACOs and MCOs (CY2024)

Data Source: ACO and MCO QEIP Reporting files

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Health-Related Social Need (HRSN); Managed Care Organizations (MCOs)

Notes: The HRSN Screening Rate represents the proportion of members 0-64 years of age enrolled for at least 90 continuous days who were screened at least once during the measurement year using a standardized screening tool assessing food, housing, transportation, and utility needs. Some ACOs submitted supplemental data (n=9) while others used only administrative data (n=8). Payment for the HRSN Screening Measures in PY2 was fulfilled by reporting data (i.e. pay-for-reporting).

Table 3.3-20 Identified HRSNs Across ACOs and MCOs (CY2024)

ACO	Overall Rate (N = 169,570 members)	Average (N = 16 ACOs)	Median (Q1-Q3) (N = 16)	Range (N = 16)
Food Insecurity	11.9%	25.2%	24.7% (17.4-36.6%)	4.4-47.7%
Housing Instability	8.4%	19.4%	18.9% (11.9-24.1%)	3.9-39.6%
Transportation Needs	3.5%	3.4%	3.0% (0.2-5.7%)	0-10.1%
Utilities Difficulties	15.9%	20.8%	15.4% (9.7-30.2%)	0.4-64.8%
MCO	Overall Rate (N = 474 members)	Average (N = 2 MCOs)	Median (N = 2)	Range (N = 2)
Food Insecurity	36.1%	31.5%	31.5%	24.4-38.7%
Housing Instability	34.6%	26.1%	26.1%	12.8-39.4%
Transportation Needs	12.9%	7.9%	7.9%	0-15.7%
Utilities Difficulties	15.0%	17.7%	17.0%	13.4-22.1%

Data Source: ACO AQEIP Reporting files

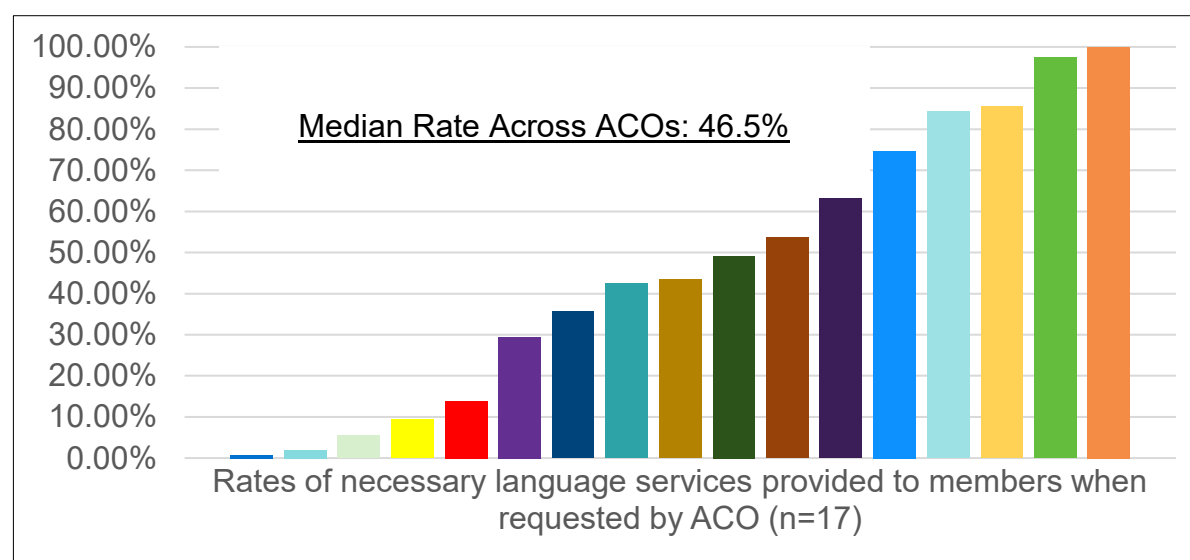
Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Health-Related Social Needs (HRSNs); Managed Care Organization (MCO); Quarter 1 (Q1); Quarter 3 (Q3)

Notes: Data from one ACO was excluded due to data quality concerns. The Food Insecurity, Housing Instability, Transportation Needs, and Utilities Difficulties percentages are calculated among ACO or MCO enrollees screened for HRSNs and reflect positive screens in each respective HRSN: food insecurity; housing instability or risk of homelessness; unmet transportation needs; and difficulty paying for or

maintaining utilities. Members may screen positive for more than one need. Some ACOs submitted supplemental data (n=8) while others used only administrative data (n=8). Payment for the HRSN Screening Measures in PY2 was fulfilled by reporting data (i.e. pay-for-reporting).

Per the *Meaningful Access to Healthcare Services for Individuals with a Preferred Language* metric, ACOs were responsible for two reporting requirements in PY2. The first was to complete the *Language Access Self-Assessment Survey*, which assessed each ACO's language service infrastructure and programming. The second was *Addressing Language Access Needs in Outpatient Settings Other than English*. The latter measure assesses the number of primary care visits where language assistance services (including sign language) were utilized for those MassHealth members with a preferred spoken language other than English. ACO reported rates of addressing language access needs, ranging from 0.73% to 85.4% with a median of 46.5%. See **Figure 3.3-5**.

Figure 3.3-5 ACO Rates of Addressing Language Access Needs when Requested in Outpatient Settings (CY2024)



Data Source: ACO QEIP Reporting files

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY)

Notes: Data from three ACOs were excluded due to data quality issues

3.3.5.3 Conclusions

Early findings tend to support the hypothesis that ACOs would respond favorably to enhanced expectations for quality and equity. Progress has been made in the systematic collection and reporting of RELDSOGI data and integrating screeners and data into EHRs. Some administrative burden with collecting RELDSOGI data and members' comfort with providing this type of data were reported. Most PSAs reported using patient characteristics to identify health disparities, an increase from the 2017-2022 Demonstration.¹¹² Members report positive experiences with enhanced care processes including ample access to care coordinators and support teams via multiple modalities (e.g., text, email). Quantitative data show that most

¹¹² Centers for Medicare & Medicaid Services. (2026). *Independent Evaluation Summative Report Massachusetts 2017-2022 1115 Demonstration*, U.S. Department of Health and Human Services, <https://www.mass.gov/doc/independent-evaluation-summative-report-0/download>

administrative care process measures improved from baseline in 2022 to 2023 and 2024. Despite lower-than-expected performance, metabolic monitoring for children and adolescents on antipsychotics was close to national averages (38.1% in MA and 35.4% nationally in 2022, 38.6% in MA and 35.1% nationally in 2023, 35.5% in MA and 37.5% nationally in 2024). Oral health evaluation rates were 10-20 percentage points higher when compared to national benchmarks (55.8% in MA and 43.4% nationally in 2022, 57% in MA and 44% nationally in 2023, 62.1% in MA and 44.9% nationally in 2024). Despite HRSN screening and language access rates being near zero for several ACOs, underscoring the opportunity for improvement in documentation and performance, early AQEIP metrics show some progress towards 2022-2027 Demonstration goals.

3.3.6. RQ2-6 How did ACOs and CPs respond to expectations for Enhanced Care Coordination Programs (CP and ACO Care Management)?

3.3.6.1 Summary of Results

Interview data were examined to assess how ACOs and CPs responded to expectations for Enhanced Care Coordination Programs. In the 2022-2027 Demonstration, the state established a core set of enhanced care coordination requirements for ACO Care Management programs and the CP Program. The goal of these programs is to deliver enhanced care coordination and care management support to ACO enrollees with complex needs. ACOs and CPs met these goals through: strengthening ACO-CP partnerships; improving coordination both within and across entities; utilizing 2022-2027 Demonstration funds (e.g., LTSS CP infrastructure payments) to improve LTSS CP infrastructure and workforce; and developing and refining ACO Care Management Programs. Findings indicated that ACOs and CPs generally responded as intended to these expectations and that the Enhanced Care Coordination expectations helped ACOs and CPs meet member needs. In the 2022-2027 Demonstration, CPs contracted directly with ACOs for the first time. Both ACOs and CPs report administrative challenges due to the lack of standardization with the new contracting structure, and continued information sharing barriers.

3.3.6.2 Results

H2-6.1 Changes to the CP program will strengthen existing and new partnerships between ACOs and CPs.

In their annual reports, CPs report extensive and structured alignment with ACOs and MCOs through regular monthly, bimonthly, and quarterly meetings focused on case conferencing, performance metrics, data exchange, and coordinated care planning. These meetings frequently include multidisciplinary reviews of high-risk or high-utilizing members, discussion of engagement challenges, and collaboration on quality measures such as Hemoglobin A1C testing, antidepressant medication adherence, hospital readmissions, and care plan timeliness. Many CPs use shared ACO and MCO EHR access, when available, and exchange supplemental reports, care plan updates, and member rosters to reduce duplication and strengthen care transitions. Several CPs reported engaging in specialized collaborations with ACOs like colocation models, high-utilizer initiatives, and targeted workgroups to support HRSNs.

Under the 2022-2027 Demonstration, ACOs are required to enroll at least seven to eight percent of members into Enhanced Care Coordination, through the CP and ACO Care Management Programs. Also in the 2022-2027 Demonstration, CPs directly contracted with ACOs for the first time (referred to by some CPs and ACOs as “CP 2.0”). Interviewees consistently reported that this shift increased touchpoints and deepened collaboration. One ACO summarized, *“We’re much more connected to the CPs...because we’re contracted with them, we can have these conversations. They’re more open to pilots, and we can really get a better sense of [their work].”* (ACO participant)

Another ACO commented that direct contracting *“further developed our relationship through new workflow development, higher meeting frequency, and closer collaboration to support new processes such as payment reconciliation and roster management.”* (ACO participant)

MCO interviewees also stated that direct contracting has facilitated their relationship with CPs and given them a better understanding of the CPs’ operations.

“I think with the change to the direct contracting...it’s allowed us to be even more cognizant of some of the other additional challenges they have, which has really helped to deepen their relationships. We’ve had to develop a lot of different new workflows around their panel management and roster management and payments. It’s definitely given us, as an MCO, a heightened line of sight into how they’re operating.” – an MCO participant (MC412397)

MassHealth conveyed similar sentiments, stating, *“In CP 2.0 [the current Waiver Demonstration], the ACOs, MCOs, and CPs are meeting more consistently and more often than in CP 1.0 [the previous Waiver Demonstration]. ACOs/MCOs and CPs are now meeting monthly, which has improved not only their relationships, but their ability to work more collaboratively.”* (MassHealth staff)

MassHealth staff explained that direct contracting intends to hold ACOs *“accountable for the enrollment, payment, and performance management of the CPs in the CP Program; this aligns with the larger MassHealth strategy of moving more towards value-based payment. MassHealth is now performance managing the ACOs/MCOs on their oversight of the CPs.”* (MassHealth staff)

Several ACOs noted that the new arrangement allowed them to enhance longstanding relationships. One explained that while their partnerships did not change in terms of which CPs they contracted with, the new structure strengthened their ability to coordinate around *“program administration, performance management, and clinical integration.”* (ACO participant)

ACO interviewees described intentionally limiting the number of CP partners to improve coordination. As one ACO put it, *“It’s easier to build a collaboration with four large BH/CP partners than eight or ten.”* (ACO participant) Another described aligning CP partnerships with physician practice locations and contract requirements, noting that this strategy improved performance management and member enrollment workflows.

ACOs also expanded CP involvement in governance. One organization highlighted adding CP representation to its joint governance committee, calling it *“a hallmark of how we’ve been able to work with them in a collaborative and productive way.”* (ACO participant)

CPs agreed that relationships with ACOs strengthened under CP 2.0, attributing much of this improvement to direct contracting. One CP stated, *“contracting directly with them has increased touchpoints...our relationships with the ACOs have always been strong, and they’ve gotten stronger.”* (CP participant)

To further foster these new and enhanced ACO-CP relationships, the state held a joint statewide meeting for ACOs and CPs in October 2024. The meeting was offered both in person and remotely to ACO and CP representatives and provided a networking opportunity for in-person attendees. The meeting covered CP Program goals and objectives for the 2022-2027 Demonstration, CP operations and reporting updates, CP performance management strategy, and joint ACO and CP presentations.

In addition to the statewide meeting, CPs described regular, constructive meetings with ACO clinical teams to jointly solve problems and prevent duplication of activities. For example, one CP interviewee expressed, *“with the ACO meeting, it’s a lot of problem-solving...we come together trying to find where the barriers are.”* (CP participant) Another CP interviewee stated, *“there’s been a more robust effort to really collaborate on duplication of services and warm handoffs.”* (CP participant)

However, CPs also emphasized the increased administrative workload associated with individualized reporting, assignment files, and reconciliation processes. The lack of standardized systems, such as *“seven different ACO referral forms”* (CP participant), created inefficiencies and strained administrative resources. One CP concluded, *“under CP 2.0, we have 13 or 14 different bosses...it becomes a very heavy administrative burden.”* (CP participant)

Despite closer relationships, CPs reported ongoing challenges with referral volume, assignment processes, and tracking metrics. Many CPs anticipated higher caseloads based on guidance during contracting, but instead experienced drops, causing staffing and workflow adjustments. MassHealth’s reduced referral caps, redetermination-related disenrollments, and transition-period disruptions contributed to these declines.

CPs also described difficulty verifying whether ACOs met referral requirements, noting *“the state decreased the requirements for ACOs...ACOs aren’t necessarily meeting that requirement. They say they are, but there’s not really a way for us to monitor.”* (CP participant) Others highlighted the instability of assignment files and the mismatch between stated and actual enrollment numbers. ACOs and CPs are working together to address these issues through regular leadership-level and staff-level communication. Yet CPs noted they have not seen an overall improvement in referral stability or the number of referrals received.

CP payment for care coordination follows a \$190 PMPM payment structure and is not tied to performance on CP quality measures, though CPs can earn an additional \$40 per month based on meeting performance targets. Most CPs compare the current PMPM payment structure to a

per member per day or a daily rate. Many CPs mentioned that the payment rate does not cover the costs of the program, leading to CPs running in a deficit. In addition, the payment decreased in the transition from CP 1.0 to CP 2.0. This has been an issue for workforce retention as wages are increasing, in some cases, while referrals are decreasing.

“As we prepared to transition to 2.0, we did staff up quite significantly given anticipated referral numbers being quite a bit higher both from direct conversations with ACOs as well as MassHealth. And then several months into the implementation of 2.0, we realized that those referral numbers were not actually going to be coming our way...we do understand that there have been some challenges with ACO cap reductions and MassHealth needs, but that was a pretty significant impact to us...where we staffed up pretty significantly and then experienced pretty significant loss because we were unable to retain and attain those referrals.” – a CP participant (CBL655744)

One CP emphasized the impact of inconsistent referrals, stating, *“we don’t have a stable number of cases that we can count on a monthly basis, where we can say that we can expect to have -- all of our budgets are based on volume. They’re based on volume with a certain amount of people that we expect. If we don’t meet that volume, then you’ve got problems with staffing that you’re paying for with no money coming in.”* (CP Participant)

The transition to CP 2.0 created some income to cost mismatches for CPs — particularly for members with partial-month enrollment. Manual reconciliation across multiple ACOs and ongoing eligibility shifts contributed to administrative burden and financial strain, especially for smaller or rural CPs.

“You could have a member that’s with you for two weeks in the month, you could provide the same level of care coordination that you would for any other member that might be there for a full month, and you only get half the payment, because it is prorated for those members that are being engaged, or assigned, I should say, during the month, and those that are disengaging.” – a CP participant (CL554196)

An add-on payment was made available for CPs serving a high percentage of members experiencing homelessness. The add-on payment could provide critical support for underserved populations. However, CPs noted this payment was often inaccessible to rural or small CPs due to stringent eligibility thresholds. Most CPs noted that they did not meet the threshold of serving a high enough percentage of members who are homeless to receive this add-on payment, nor did MassHealth share specific information on their percentage.

“Unfortunately, MassHealth said that they weren’t sharing...individual percentages with individual CPs. We weren’t looking for everyone else’s percent, just our own...We did have a little more follow-up...So, our account manager has been taking that back to the larger team. And we haven’t heard anything more about that. But that would be a recommendation.” – a CP participant (CL170142)

H2-6.2 The ACOs and CPs will develop new or updated care coordination processes in alignment with enhanced CP expectations.

MassHealth describes CP 2.0 as a significant redesign that *“align[s] the LTSS and BH care models”* (MassHealth staff), ensuring members receive a consistent level of care. A key change is that *“both LTSS and BH CPs now have RNs on staff”* (MassHealth staff), which was not always the case in CP 1.0. Under this new model, *“the CPs are the lead care coordination entity”* (MassHealth staff), giving members a clearer, reliable point of contact and strengthening accountability across the system. Both BH and LTSS CPs are also responsible for ensuring each member has a care team and for completing all required assessments, including the comprehensive assessment and the HRSN screening.

In addition, CP 2.0 improves alignment between CPs and managed care partners by ensuring that the CPs’ quality measure slates are closely aligned with that of the ACOs/MCOs.

Structural requirements were also updated, as LTSS CPs must now include an ILC and ASAP in their organizational structure, while BH CPs must hold agreements with or incorporate a CBHC. According to MassHealth, these relationships *“provide direct connections to providers”* (MassHealth staff), further strengthening integration and care coordination across the system.

The enhanced expectations introduced under the 2022-2027 Demonstration prompted both ACOs and CPs to redesign their care coordination workflows. A central change was shifting responsibility for comprehensive assessments from ACOs to LTSS CPs. ACOs consistently reported that this realignment reduced administrative burden, eliminated repetitive communication, and ultimately improved the member experience. As one ACO described, having LTSS CPs conduct assessments and HRSN screening *“helped reduce duplication of questions”* needed to develop the care plan and created a *“seamless handoff in transitioning the care of that member.”* (ACO participant) ACOs further noted that the streamlined process was *“so much more patient-centered,”* with members now able to *“tell their story to one person one time.”* (ACO participant)

Several ACOs highlighted additional improvements tied to these updated expectations. The removal of the PCP signature requirement on care plans allowed CPs to begin working with members more quickly, avoiding delays previously caused by back-and-forth messaging. One ACO noted that the previous process *“was quite an administrative lift on both the CP part and the clinician,”* and its removal made care plans *“much more efficient”* (ACO participant), enabling members to receive supports sooner. Another ACO reported that CPs expanded clinical staffing, particularly the addition of nurses for LTSS CPs to align with the staffing model of BH CPs, which enhanced their ability to manage care transitions and work with more complex members. ACOs also reported improvements to the referral process to CPs, including a greater ability to *“drive more referrals”* (ACO participant), although some noted persistent lags before members received services.

The addition of read-only access to ACO EHRs further strengthened integration with CPs, allowing CP staff to understand a member’s history before completing assessments or care plans. MassHealth staff reflect this sentiment.

“In CP 1.0, many CPs did not have access to ACOs/MCOs’ EHRs. In CP 2.0, it is now a contractual requirement for ACOs/MCOs to provide CPs with, at minimum, read-only access to their EHRs. This has significantly impacted the CPs ability to gain information about an enrollee in a faster, more efficient manner.” – a MassHealth Staff respondent

Despite these improvements, ACOs also pointed to structural barriers that limit the full benefit of redesigned care coordination processes. Several emphasized that CPs are not required to notify ACOs of care transitions in real time, creating fragmentation. As one ACO stated, *“there aren’t requirements around communication in real time, so we don’t know if they’ve seen someone during a care transition...there are all these gaps.”* (ACO participant) Others described the communication process as highly labor-intensive, expressing, *“to set up one communication touchpoint...is extraordinarily challenging”* (ACO participant) given multiple handoffs between CP care managers, practice nurses, and PCPs. ACOs noted that these challenges are exacerbated for members with complex medical needs.

CPs also redesigned internal workflows and strengthened their workforce to meet enhanced expectations. They expanded care transition teams, added clinical roles, and incorporated assessments such as HRSN screening. CPs described how these changes helped *“close all the gaps”* (CP participant) by giving care coordinators a fuller picture of a member’s needs and enabling better coordination with ACO providers. CPs acknowledged, however, that some of the enhanced expectations increased administrative work. Incorporating HRSN screening required manually entering diagnosis codes for each identified need, which CPs described as *“additional manual effort”* (CP participant) and required *“two or more external care providers”*¹¹³ (CP participant), which was challenging, especially given providers’ limited availability. One CP described persistent difficulty getting provider’s participation despite repeated outreach, calling it *“a barrier to...being able to roll out that new requirement.”* (CP participant)

For workforce sustainability, CPs described various financial incentives for providers and staff such as salary increases, sign-on bonuses, and quality-of-care incentives. Additionally, some CPs have created financial incentives by creating a bonus structure attached to quality metrics such as number of ED follow-ups conducted with members. A few CPs noted that recruiting RNs and outreach specialists has been easier than other positions.

“Since April 1 of 2023 for the starting salaries of care coordinators, we raised them a bunch. Because we really hadn’t raised starting salaries at all. People got raises if you were a continuous employee...we raised them three times actually in five months, which has helped. For nurses I think we have competitive salary, sign-on bonuses. That’s actually our easiest recruit...an RN, because they like the job...we have a hybrid work environment with telephonic nursing, so we really attract people. Outreach specialist tends to be a fairly quick recruit.” – a CP participant (CBL643399)

¹¹³ The requirement for two or more external providers did not specifically state the need for one of the providers to be a PCP or designee.

CPs incorporated training opportunities to guide staff through operational changes such as additional screening requirements and data collection. Many of the trainings conducted by CPs were required elements from their contracts. CPs also invested in educational opportunities for staff to increase their knowledge of health equity and clinical care during hiring and throughout employment. By providing training, CPs demonstrated to employees they are being invested in and reduced burnout by helping staff feel more competent in their role.

“We have done a tremendous amount of training...we have been prepping our team with all the resources and the information that they need to perform the job so that it prevents them from feeling like they are out there on their own and that they burnout from not having the capability or having the education to do the work and the support to do the work.” – a CP participant (CB144997)

Some CPs noted that they offered CHW training for all their staff as an additional way to gain training, qualification, and increased salary. In addition, some CPs indicated they partner with agencies to provide tuition reimbursement for those staff who want to continue their education, which was noted as further helping with staff retention.

“Another thing that helps with retention I think a little bit, is we do offer training so staff can become certified CHWs. That’s given to them for free. The training specialist makes that arrangement... other agencies provide some assistance with tuition if people want to get their bachelor’s degree. I have some staff who have been utilizing that. I think there’s the little things, too, that help with retention.” – a CP participant (CBL643399)

CPs described engaging staff in social activities, volunteer events, and team building to foster a positive work environment, increase retention, and reduce burnout. CPs also shared that these activities show staff that they are appreciated and recognized on an individual level.

“We make a significant investment in providing a full day of self-care and wellness to our entire staff...and we provided tools for preventing burnout, [such as] meditation, mindfulness, yoga chairs, just to not only express how important they are and how much appreciated they are, but also giving them some tools, so they can take back home.” – a CP participant (CB779109)

Overall, the enhanced CP expectations directly prompted ACOs and CPs to revise and formalize care coordination processes and to take steps to strengthen and sustain their workforce. These changes improved consistency, timeliness, and patient-centeredness, although both ACOs and CPs emphasized that persistent communication gaps, particularly during care transitions, continue to limit seamless integration.

H2-6.3 LTSS CPs will use infrastructure payments to build an infrastructure and develop the workforce to support Enhanced Care Coordination and to meet higher expectations in the 2022-2027 Demonstration period.

In CP 2.0, LTSS CPs received Infrastructure and Capacity Building Payments from the state. These payments were intended to assist LTSS CPs in building infrastructure, developing the workforce, and supporting the Enhanced Care Coordination expectations of the 2022-2027 Demonstration. Per the new Enhanced Care Coordination requirements, LTSS CPs hired RNs and CCMs. The state spoke of the importance of the infrastructure funds being available for this staffing ramp up.

“For the LTSS CPs, they did require further ramp up with hiring RNs and CCMs who do the final sign offs (while RNs were also responsible for conducting the medication review). This ramp up of RNs and CCMs was supported by MassHealth through the LTSS Infrastructure Payments which allowed LTSS CPs to utilize the funding for proportions of these staff salaries so they could more quickly hire.” – a MassHealth staff respondent

Through these payments, LTSS CPs made core investments in staff and technology. CPs noted that these funds were key to being able to maintain staffing to meet the enhanced expectations.

“Continuing the LTSS infrastructure funding has been a huge help because...it would have been very difficult for us to meet those contractual obligations without having the staffing to do it or the funding to actually hire the staff to do the job. The LTSS funding has been hugely helpful to really lay the foundation for the new structure and give us that confidence, that ability to control the process to really be the hub of care coordination for the patient population.” – a CP participant (CL486586)

Other CPs stressed the importance of these payments in making investments in HIT with one noting, *“we used every last penny of them. But part of it was definitely an investment in technologies that would help us move forward. But, also, in staff. Because it’s not possible to do this without dedicated staff to roster management.”* (CP participant)

Despite the availability of these Infrastructure payments, LTSS CPs noted that the loss of the DSRIP funding created major financial gaps. CPs shared that they faced several workforce-related challenges associated with financial investments and program changes. CPs shared that DSRIP funding was essential for staffing in the 2017-2022 Demonstration and helped to cover infrastructure changes and additional staffing. Without DSRIP dollars, CPs expressed frustration with needing to make significant technological updates and hire new staff to address updated reporting and payment requirements, but with less money. Many CPs reported operating in a negative margin, and administrative demands further stretching limited resources. CPs expressed concern about the consistency and future availability of infrastructure funding.

“The LTSS infrastructure payments...are limited to certain categories -- workforce development, infrastructure and technology...I mean, it’s good...On the other hand...dollars for reimbursing part of the nursing and part of the CCM cost...are on a decrease, so it’s 50% for a couple of years, 25%, and then it fades out...So, you give someone a leg up while you get started. But the flip side of that is then you need sustainability, and you get there through volume and

reliable level of referrals, and that's what's concerning about it.” – a CP participant (CB120429)

CPs noted that there is a need for additional investment in the CP workforce to continue to recruit and retain highly qualified staff. CPs also said that additional funding is needed to support the infrastructure changes required for the switch to the current payment model.

“With regard to the changes relative to adding a person to help with billing, that was not part of the original budget at all for this year. It became absolutely crystal clear to all of us that...the shifts in the payment systems and the methods and it being by day versus by the month, etc...the reality around that is that that played a very significant role... [one person] cannot do that themselves.” – a CP participant (CB144997)

H2-6.4 ACOs will implement new or refine existing care management programs to meet the needs of their enrolled population.

ACOs implemented and refined their care management processes to meet the needs of their enrolled members. ACO Care Management programs must provide the Enhanced Care Coordination requirements in the ACO contract. ACOs commented that these expectations were “*fundamental*” to their core functions and were not necessarily new to the 2022-2027 Demonstration.

“This is sort of the way we’re built. The infrastructure for a lot of population health-based care coordination isn’t new to this version of the ACO, or in most cases, even the previous one, sort of our leveraging of really assertive work to manage registries and close gaps in care, provide nurse case management support to patients with chronic illness, to leverage medical social workers to help patients remove barriers to work in their plan of care. I mean, that’s who we’ve been for a really long time.” – an ACO participant (AA431109)

ACO Care Management

In CY2024 reporting, ACOs described the various ACO Care Management Programs that they launched or continued from the previous reporting period. The majority of ACOs had at least three types of care management programs with some ACOs having up to six. ACO Care Management Program types included, for example:

- Complex Care Management
- Transitions of Care Management
- Behavioral Health Care Management
- Maternal Health Management

Other programs described by ACOs included those focusing on addressing members’ HRSNs, chronic illness focused programs (e.g., asthma), and primary care embedded care management

programs. ACOs described having both adult and pediatric focused programs. In reporting, ACOs described their target populations, staff roles that support each program type, and relevant metrics used to determine the effectiveness of each program. ACOs reported in CY2024 that they were enrolling on average between 3-4% of their total population in various ACO Care Management Programs. ACO's self-reported program evaluation results show positive impacts, including reduction in ED utilization, increase referrals for social services, and improved chronic illness control.

ACO interviewees commented on the breadth and depth of the various care management programs they offer. An ACO interviewee described their ACO's various care management programs.

"We offer a continuum of care management services to serve patients from low to high-risk tiers. We offer episodic telephonic care management which serves adult and pediatric populations. We also have telephonic behavioral health care management, which serves adults with moderate to severe behavioral health needs. And then we have complex care management, which is the most intensive care management program offered, and it's embedded in primary care across the PCP network. And that program serves patients with the highest risk, and addresses their goals to help mitigate any inpatient utilization." – an ACO participant (AA562141)

Another ACO interviewee described the differing levels of care management.

"We have baseline care coordination expectations across all of the primary care clinics doing a lot of initial making sure [members] are getting to appointments, following up if there's a short-term need identified, and so we do have the concept of a medical home care coordinator or an equivalent type role that's doing a lot of that in all of the primary care practices. Then if you need support sort of above and beyond what we'll call baseline care coordination, we have a few avenues in which different patient populations can get stronger support." – an ACO participant (AA673312)

ACOs report offering baseline care coordination to all members and described how members access and are referred to care management programs.

"Baseline care coordination is available to the whole population and is accessed by member services or by referral from the provider network. And it really just responds to the immediate need of whatever the patient is requesting. And then we have specific behavioral health and chronic medical care management programs that are a telephonic service... which are also accessed by request by either the patient or a provider referral." – an ACO participant (AA410937)

ACO Care Management included new or strengthened care management roles and processes. Meeting these new expectations required ACOs to reassess and refine their overall care

coordination models. ACOs used nurse care managers, social workers, CHWs, patient navigators, and outreach specialists to facilitate care coordination activities. These roles were identified as being specific to adult and pediatric populations and by specialty depending on the ACO and practice site(s).

ACO interviewees described ways in which cross-organization and within-organization communication informed ongoing work and new care coordination processes with members. The connections among team members were described by many interviewees as key to efficient, effective care coordination and meeting member needs. Implemented strategies include scheduling routine multidisciplinary rounds (e.g., monthly), embedding team members in primary care settings, centralizing work group meetings, implementing technology-based communication approaches, and monitoring care team procedures.

ACOs also discussed their ACO Care Management processes, highlighting the use of comprehensive assessments, person-centered care plans, and care trackers to support their care coordination efforts.

“The nurse is the one who completes the comprehensive assessment and the care plan with the member, in collaboration with the other disciplines, depending on the needs of the member, and then typically the care plan is implemented primarily by the CHW, under the oversight of the nurse and the social worker, as appropriate. It just depends on the complexity and the needs of that individual. But they work together in a consolidated team.” – an ACO participant (AA702490)

Some ACOs distribute high- and rising-risk member lists to care managers at practice sites to target member outreach and enrollment in ACO Care Management. The member lists are sorted by the level of need, allowing ACOs to triage their members, focusing on those who need support most. Other factors, such as members who have not engaged in services recently, members with referrals to specialists who have not yet been seen, members with recent hospitalizations, and new members, are also prioritized. In some cases, ACOs noted that members were more willing to engage in these services after an outpatient or hospital visit.

“We had one of our clinicians was reaching out for transitions of care calls, and just incidentally, one week, her transitions of care calls contained a high number of patients that were new to the plan, and sort of their feedback to her was, ‘Thank goodness you called me after this hospitalization. I don’t even know where to start...’” – an ACO participant (AA258503)

ACOs report using real-time, up-to-date data on their member engagement performance. The data helps ACOs gain insight into which practice sites might be performing better than others. The data also show ACOs which practice sites are most highly concentrated with high-risk members, allowing ACOs to consider ramping up and embedding services at these sites.

“We had a lot of the resources potentially available, but [the Care Management model] really forced us to organize said resources and ensure that there were referrals pathways and processes in order to

quickly connect our members with those resources.” – an ACO participant (AA702490)

MCOs likewise described how they identify members for their complex care management programs.

“A separate registry of all members is created every other month containing these risk scores, along with chronic conditions and other clinically relevant information for every member...to identify members for care management initiatives. Those care management initiatives do include but are not limited to our complex care management program, disease management programs, which include asthma, diabetes, and sickle cell, support for members experiencing homelessness or housing instability, supports for those who are transitioning between sites of care and are at high risk for readmission, high-risk perinatal, and support for members with special healthcare needs, for example.” – an MCO participant (MC412397)

ACOs prioritized communication with members and developed and implemented strategies particularly in connecting members with PCPs and services. These innovations have included digital navigators, referral coordinators, active outreach via text message and email, and engaging with providers to identify and make connections with high-risk members, in addition to cold calling.

“We do cold-calling, which is sort of the classic way to get patients into care coordination services, but we also leverage that [high-risk] list to better engage with providers, to say, ‘hey, were you aware that you have these five to ten or however many patients who have been identified as complex? Are there any you would like me to focus on and specifically engage with?’ It does become a nice way for us to really help our providers hone in on who may need an additional level of service, and then we work with the providers to engage those members.” – an ACO participant (AA410937)

ACOs reported investments in infrastructure (i.e., largely HIT and data analytic services) to meet the Enhanced Care Coordination expectations of the 2022-2027 Demonstration. ACOs report that the investments made in HIT facilitate communication within and across organizations about members’ needs, services provided, procedures and workflow, and the sharing of data to inform quality metrics and required reporting. These efforts have increased from the 2017-2022 Demonstration, where some connections were not as streamlined.

“A central referral coordination pathway was really an effort to create no wrong door to care coordination and care management...Some feedback that we heard about in the previous waiver from providers was they had no idea...how to get people to care management, what was available, and then what happens once the referral was made, so we were really trying to create a more transparent, more streamlined pathway to help for members. And...we’ve actually, in

this past year, integrated that into the EHR, so we're really trying to make this as easy as possible.” – an ACO participant (AA258503)

ACOs emphasized the importance of sharing and communicating data regarding members and member care to support informed decision-making, monitor member outcomes (e.g., status, visits), and fulfill MassHealth reporting requirements for quality metrics. HIT systems facilitated this communication and use of data. Communication regarding data within and across organizations contributes to the process of risk stratification, program improvements and, potentially, improved outcomes for members. ACO interviewees spoke to the value of access to and sharing of “fresh” data (i.e., not having to wait for long periods of time for data, feedback on program operations, and member status). ACO interviewees stressed that timely access to information and feedback contributes to improving quality of care.

ACOs with shared EHRs across practice sites reported being able to track members’ care across multiple provider visits. When members visit the ED, EHR systems are notified. Challenges exist with ACOs who have multiple EHRs across their practice sites. ACOs have also voiced difficulties in sharing information with CBHCs due to the lack of a shared communication system like an EHR.

“We don’t have a great access to information about how and when, ... the services are being utilized. In general, we just don’t have a lot of clarity or insight into the CBHC world. We have tried our best to partner with them and make sure that folks realize that is a resource any time we have scenarios come up where there are urgent needs around behavioral health.” – an ACO participant (AA410937)

3.3.6.3 Conclusions

Early findings suggest that ACOs and CPs generally responded to Enhanced Care Coordination expectations as hypothesized. The state’s aligned enhanced care coordination requirements sought to improve ACO-CP partnerships, improve and refine care coordination processes, and increase CP workforce and infrastructure to meet members’ complex needs. Early findings indicate that initiatives were working moderately well, partnerships were mostly strengthened, and care coordination processes implemented by entities were meeting member needs. Some administrative challenges were reported due to the lack of standardization in the new ACO-CP contracting, low referral rates for CPs, and a general concern from CPs about lack of funding sustainability. The state could continue to improve upon standardization of cross-entity processes, offer more opportunities for cross-entity collaboration, and offer more transparency in how CPs can earn infrastructure funding.

3.3.7. RQ2-7 To what extent did access to and quality of care coordination supports change for members of ACO Enhanced Care Coordination Programs (CP and ACO Care Management)?

3.3.7.1 Summary of Results

This RQ examined whether MassHealth’s ACO and CP programs achieved their intended goals of improving access to and quality of care coordination supports through activities designed to

expand care management teams, enhance collaboration between ACOs and CPs, and connect members to clinical and social services. Using multi-year data about ACO members, we analyzed trends related to care coordination across primary care, BH, and LTSS. PSA survey results provided information about the implementation of care coordination activities at the practice site level. Interviews with ACOs, CPs, and members provided context on program implementation, effectiveness of care coordination activities, and ongoing barriers to accessing services. Administrative measures were used to assess how access and quality of care coordination supports changed. Overall rates of enrollment in Enhanced Care Coordination Programs increased, while enrollment in CP programs decreased over time alongside declines in funding and enrollment targets set by MassHealth. Rates of treatment plan completion for members accessing care coordination services from BH CPs increased from baseline (2022) to 2023 and 2024 as did oral health evaluations for LTSS CPs members. However, care plan completion rates for LTSS CPs decreased. Overall, early findings indicate improvements in several aspects of care coordination, particularly in primary care and BH.

3.3.7.2 Results

H2-7.1 Coordination of care will improve.

Several ACOs highlighted the increased emphasis on BH in the 2022-2027 Demonstration and described targeted care coordination efforts for members with BH needs. These efforts included having social workers support BH service navigation and ensuring follow-up care was received. One ACO interviewee indicated the role of social workers in coordinating care for members with BH needs.

“We have a program in which we have social workers that are dedicated to doing post-discharge follow-up work after either an inpatient psych or an ED visit, and the idea is that these social workers can...ensure patients have a behavioral health provider that they’re connected to, that they’re connected to their medications, and then these social workers...can follow them for a period of a few months to ensure that they do attend those behavioral health visits.”
– an ACO participant (AA934600)

ACOs reported investments in the workforce (e.g., developing Enhanced Care Coordination teams) to improve care coordination for members. These efforts were woven into developing new or refining existing care management programs. Organizations modified existing teams (e.g., added team members and roles) and implemented new team configurations, in particular, to address the needs of high-risk, complex members and meet MassHealth contract requirements. Teams and team members were embedded in primary care practices, in many instances, to encourage connections and promote efficiencies in communication and care coordination processes.

“We talked about the additional CHWs. Obviously, our care management team, we also have extensive CHWs on that team...so we’ve kind of invested heavily across that CHW spectrum. We brought on supervisors, which are...managers for our...ACO care coordination teams, so that was an investment in this version of the

ACO, because we really felt like we needed to work on better improvement of processes, better flow, more structure...we brought on our maternity health coordinator. We brought on our new patient coordinator this go-around, which were brand-new roles for us. We brought on a flex[ible services] spend coordinator, and that's a combination flex[ible services] spend and CP coordinator.” – an ACO participant (AA394666)

Improvements in care coordination for members were also reflected in CP interviews. Several CPs reported that expanding their care transition teams (e.g., adding more nurses and full-time care coordinators) facilitated scheduling follow-up appointments and communication after discharge from inpatient and ED settings. The addition of CP staff also increased capacity to reach out to members' providers to ensure information was accurate and gather health information and context about members' histories and appointment dates. In the same vein, many CPs commented that being granted read-only access to members' EHRs from members' ACOs improved integration of care, as the CP was able to understand members' histories and situations before meeting with them.

In interviews, members discussed their experiences with ACO Care Management and how ongoing communication helped facilitate care coordination efforts by having their providers speak with one another (e.g., PCPs and specialists), accessing their health information with technology like MyChart, and communicating directly with members.

Some members felt they had to coordinate their own care, noting that providers often did not communicate directly with each other and that information was shared only through notes rather than conversations, with one member saying, *“they're not having telephone conversations. They just don't have time.”* (MassHealth member) Other members, however, described positive experiences when provider-to-provider coordination worked well, feeling reassured and supported. For example, one parent of a member shared, *“her PCP was able to get in touch with the psychiatrist at [ACO name redacted]...They were great.”* (MassHealth member)

ACO care coordinators referred members to HRSN resources such as housing assistance, nutrition and basic goods (e.g., SNAP), and benefits programs (e.g., heat assistance). As one member shared about their ACO care coordinator, *“she's been great...I had some trouble getting some supplies, and she's been really good about helping me.”* (MassHealth member) Members reported that ACO care coordinators helped with real-life needs beyond medical care including utilities, transportation, and support for children such as early intervention services. Families highlighted that accessible supports made a meaningful difference in navigating care. For example, one parent of a member said, *“I feel good because they provide an interpreter...I don't speak English.”* (MassHealth member)

Despite mostly positive reported member experiences with ACO Care Management, there were some noted barriers and suggested feedback. Across interviews, members described a health system that often feels slow, fragmented, and overburdened, characterized by long waits, missed calls, and busy providers' offices operating with heavy workload. One member said they spent two years trying to get basic medical equipment before a nurse finally told them, *“I gave up'...I have never had a doctor's office tell me they gave up.”* (MassHealth member) At the

same time, members recognized that care coordinators often could not overcome system-level problems like slow offices or insurance barriers, with one noting, *“she can’t get the doctor’s office to do anything...that’s on them.”* (MassHealth member) Some members were also unclear about what care coordination meant, with some unaware they had a coordinator or confusing the role with other support services they were receiving, which highlights both the value and the limits of these supportive relationships. Due to the complexity of the system and confusion with the various services offered, one member described how they coordinate their own care at times, stating, *“I use MyChart to coordinate anything that I have.”* (MassHealth member)

Members also discussed their care coordination experiences with the CP Program. On average, members receiving supports from a CP noted that they interacted with their CP care coordinator every few weeks to every few months. Members stated that they met with their care coordinators in person and over the phone. Members indicated that care coordinators often came to their home. Some members also noted texting with their care coordinator.

Members spoke of the specific supports provided by the CP to meet their health and social needs. In some cases, members indicated they received needed supplies and monetary support. A member spoke of receiving supplies, *“I needed hygiene stuff, and they brought me some...They help with that kind of stuff...if I needed any products or something, she can bring them out...”* (MassHealth member) A member spoke of receiving monetary support from the CP, *“she sometimes sends me cards from Amazon for my supplies, because I have a wound...so sometimes she gave me 20 dollars from Amazon...and I spoke with her a lot.”* (MassHealth member)

Members stated that, through CP care coordination supports, they were able to connect to various clinical and social services. A member stated that the CP helped get them connect to primary care: *“they started telling me that they’d help me get a primary care doctor so I could schedule an appointment sooner.”* (MassHealth member) Another member stated that their CP care coordinator assisted with gaining legal counsel: *“he does referrals as well for whatever it is that I’m looking for, any kind of help that I’m looking for, you know, lawyers and whatnot.”* (MassHealth member)

Many members indicated they received supports from CP care coordinators in addressing their HRSNs; specifically, housing and food insecurity. A member indicated they received assistance with housing: *“he’s the one that really helped find the program, helped me sign up for it...And then that was what he did, my housing, and different housing places we went to. He helped fax all my forms.”* (MassHealth member) Another member stated they received housing and food insecurity assistance and how the CP care coordinator had an important role in their life: *“she helped me do all these things like...Section 8. She helped me get SNAP. She helped me get a card from Project Bread. She’s just been amazing. I would definitely be dead without her. I would have been on the street, and it wouldn’t have been pretty.”* (MassHealth member) Another member commented on the care coordinator’s support with housing court: *“she can talk in housing court...There’s a big support there. She’s great.”* (MassHealth member)

CP enrollees commonly have clinical and social factors that make it more difficult for them to access and engage with healthcare services. Several members stated that the CP care coordinator also assisted with administrative tasks including completing medical forms,

obtaining transportation, and other services. A member said, *“they help me...with my insurances and...my up-to-date addresses and stuff. I let them know...what’s changed. So, they’re good at putting information in.”* (MassHealth member) Another member indicated, *“so we go over my PT-1s, we go over any emergency room visits I’ve had, anything else that’s going on -- she’ll do a little extra too.”* (MassHealth member) Another member stated the help they received with navigating their various needs, *“so with my paperwork and all that, if I can’t do the paperwork to send it out, she will do it for me, so I will send her everything...So, she’s done phone calls for me...if I need something, I can just call her and she’ll do it.”* (MassHealth member) Another member expressed, *“they help me with keeping my MassHealth -- my PT-1 forms going...They will put in the updates for me. They also will help me with -- say I need medical papers for utilities or anything -- like now I’m thinking about moving, they will help me coordinate that. Especially if I need any type of special things or like letters from my doctors.”* (MassHealth member)

An overwhelming majority of members receiving care coordination supports from the CP Program reported positive experiences and interactions with care coordinators. Members reported great appreciation for their CP. A member stated, *“well, my community partner is a really good worker, so I really appreciate them. And [they] would do everything.”* (MassHealth member) Another member reported this positive experience: *“she’s excellent. She’s excellent, number one...She deals with the MassHealth aspect of stuff...She’s what you call a BHCP worker.”* (MassHealth member) Another reported on their care coordinator’s effectiveness: *“the coordinator who I’ve been working with, she’s been great...I don’t know if she’s talked to my PCP, but she said...If there was anything I needed that I wasn’t getting or things were taking longer, she would follow up on it.”* (MassHealth member)

Members spoke of the competence and character of their coordinators. One member stated, *“she’s been a wonderful help. I couldn’t ask for no one else to be brought to me. She’s just been...like a breath of sunshine...and she’s always listening to you. And then she has a solution or she does it for you. So, I’m glad that I got to meet her.”* (MassHealth member) Another member indicated, *“I’m really grateful. He’s really competent. And he’s been really my saving grace.”* (MassHealth member) Another member noted, *“she is a great person. She has a lot of patience... I don’t have patience like that. I’ll ... just give up.”* (MassHealth member)

Members stated that although the CP care coordinators were helpful in making referrals and connections for them, there was a lack of available resources for social services and primary care. As one member noted, *“for the most part, I feel like any issues I have aren’t with my actual care coordinator, but more so with the places in which he’s been trying to get me services, because it’s just really hard to reach people and to obtain things of high need and things like that.”* (MassHealth member) Another member commented on the lack of social services in their region, *“I have a care manager from [CP name redacted]. She too has hit a roadblock. She’s being supportive as she’s able to, but the resources are very limited, and they don’t even actually exist.”* (MassHealth member) Another member indicated the wait lists for primary care was very long, *“most of the places that she had contacted said that they’re not seeing people until next year. That they’re, like, booked out until next year. So, it’s very difficult...and I never had a problem like this before.”* (MassHealth member)

One member commented on the duplication of services between the CP Program and other state programs. The member noted the separate care plans needed for each entity, *“two care plans, two separate care plans, a year...They’re about the same...two separate ones have to be done for some reason. I do not know that reason, though.”* (MassHealth member) Another member stated that there was a disconnect between the CP Program and other MassHealth programs, *“I don’t know if it’s relevant but the Community Partner being kind of isolated means that appointments can be affected, either because I can’t attend or because of a scheduling conflict. I’m very comfortable with MyChart because everything is unified there. But they’re disconnected from it. A good idea would be for them to also share their calendar through MyChart.”* (MassHealth member)

H2-7.2 The quality of care coordination supports delivered by CPs and ACOs will increase.

PSAs indicated care coordination and management staff resources their practice had used in the past year such as Nurse Care Managers and CHWs. Notably, 12% of all administrators indicated their practice site had not used any care coordination and management staff resources, and when stratified by practice size, results showed that 20% of administrators from small practices reported that they had not used any of these resources. Stratified results also consistently showed that a lower percentage of administrators from small practice sites indicated that these resources were available at their practice site, whereas a much higher percentage of administrators from large practice sites indicated that these resources were available at their practice site. See **Table 3.3-21** and **Table 3.3-22**.

Table 3.3-21 PSA Survey: Care Coordination and Management Resources Used by Practices in the Past 12 Months (CY2025)

Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members?	Percentage of Respondents
Nurse Care Manager/Nurse Care Coordinator	63%
CHWs	54%
Patient Navigators/Referral Navigators	49%
Social Worker (excluding those providing billable BH services)	46%
Any non-nurse Care Manager/Care Coordinator	35%
Other title - Please specify	3%
None of the above	12%

Data Source: PSA Survey

Abbreviations: Behavioral Health (BH); Community Health Worker (CHW); Calendar Year (CY); Practice Site Administrator (PSA)

Table 3.3-22 PSA Survey: Primary Service Location for Care Coordination Resources, by Practice Size (CY2025)

For each of the resources that your practice site has used for MassHealth members in the past 12 months, please indicate if the location where they primarily provide patient services was at this practice site.				
		Practice Size*		
	Total	Small	Medium	Large
Nurse Care Manager/Nurse Care Coordinator	51%	38%	38%	69%
CHWs	48%	16%	43%	70%
Patient Navigators/Referral Navigators	45%	34%	39%	58%
Social Worker (excluding those providing billable BH services)	55%	40%	49%	73%
Any non-nurse Care Manager/Care Coordinator	54%	35%	48%	68%

Data Source: PSA Survey

Abbreviations: Behavioral Health (BH); Community Health Workers (CHWs); Calendar Year (CY); Practice Site Administrator (PSA)

*Small = Less than 400 patients, Medium = 400 to 1149 patients, Large = 1150 or more patients

Additionally, administrators widely indicated that these staff resources had been “very helpful” or “helpful” in supporting the delivery of high-quality care to their members. See **Table 3.3-23**.

Table 3.3-23 PSA Survey: Helpfulness of Care Coordination Resources for MassHealth Members (CY2025)

Thinking of the past 12 months, how helpful has each of the following resources been in helping your practice deliver high-quality care to your MassHealth members?					
Survey Item	Very Helpful	Helpful	Somewhat Helpful	A Little Helpful	Not At All Helpful
CHWs	44%	38%	11%	6%	1%
Patient Navigators/Referral Navigators	40%	44%	14%	3%	0%
Nurse Care Manager/Nurse Care Coordinator	50%	34%	11%	4%	1%
Any non-nurse Care Manager/Care Coordinator	48%	34%	16%	2%	0%
Social Worker (excluding those providing billable BH services)	52%	37%	7%	2%	1%

Data Source: PSA Survey

Abbreviations: Behavioral Health (BH); Community Health Workers (CHWs); Calendar Year CY); Practice Site Administrator (PSA)

PSAs were also asked if they had any difficulty coordinating care with partnering providers or practices in a list of domains including learning the results of tests ordered, knowing if a patient followed up on a referral, learning the details of the referral, sending information to another clinician or practice, and getting in touch with another provider or practice. Most administrators

reported that they either rarely or never had any difficulty with any of those domains of coordinating care. See **Table 3.3-24**.

Table 3.3-24 PSA Survey: Frequency of Difficulty Completing Key Care Coordination Tasks for MassHealth Members (CY2025)

In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members?					
Survey Item	Never Difficult	Rarely Difficult	Sometimes Difficult	Usually Difficult	Always Difficult
Learn the result of a test your practice site ordered	38%	48%	13%	1%	1%
Know that a patient referred by your practice site was seen by the consulting clinician	18%	47%	28%	7%	1%
Learn what the consulting clinician recommended for your practice site's patient	18%	49%	27%	6%	1%
Transmit relevant information about a patient who your practice site referred to a consulting clinician	27%	50%	19%	3%	0%
Reach the consulting clinician caring for a patient when your staff needed to	17%	44%	34%	5%	1%

Data Source: PSA Survey

Abbreviations: Calendar Year (CY); Practice Site Administrator (PSA)

Primary Care Member Care Coordination

Table 3.3-25 contains scores from the Child and Adult Primary Care MES regarding care coordination. The Self-Management Support composite measure from the Primary Care MES combines results from two survey questions which pertain to care goals and managing care. For pediatric members, there were improvements in coordination of care. In 2023, the score for the Self-Management Support composite measure was 54.8 compared to 50.6 in 2022. For adult members, there were also improvements in coordination of care. In 2023, the Self-Management Support composite score was 60.1 compared to 51.0 in 2022.

The Adult Primary Care MES also contains the Adult BH composite measure which combines results from two survey questions which pertain to screening for and coordinating BH care. For adult members, there were very slight improvements in coordination of care. In 2023, the Adult BH composite score was 60.5 compared to 60.4 in 2022. See **Appendix C-9** and **Appendix C-10** for stratified results and stratified within-year results with p-values of these composite measures relating to care coordination.

Table 3.3-25 Results for Self-Management Support and Adult BH Composite Measures from the Primary Care MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Self-Management Support^a			
Child Composite Score (0-100)	50.6	54.8	4.2*
Adult Composite Score (0-100)	51.0	60.1	9.1***
Adult BH^b			
Adult BH Composite Score (0-100)	60.4	60.5	0.1

Data Source: MES (CY2022-CY2023)

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The Child Primary Care Self-Management Support composite measure combines the following two items: 1) In the last 12 months, did you and anyone in this provider's office talk about specific goals for your child's health? 2) In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your child's health? The Adult Primary Care Self-Management Support composite measure combines the following two items: 1) In the last 12 months, did you and anyone in this provider's office talk about specific goals for your health? 2) In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

^b The Primary Care Adult BH composite measure combines the following two items: 1) In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty, or depressed? 2) In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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BH Member Care Coordination

Table 3.3-26 contains scores from the BH MES regarding care coordination. The Needs Met composite measure from the Adult BH MES combines results from three survey questions that pertain to care coordination meeting the BH needs of members. For adult members, there were large improvements in coordination of BH care. In 2023, the score for the Needs Met composite measure was 83.5 compared to 66.6 in 2022.

The Member Engagement with Care Team composite measure score from the Adult BH MES combines results from two survey questions that pertain to communication with the care team. For adult members, there were improvements in coordination of BH care. In 2023, the score for the Member Engagement with Care Team composite measure was 77.9 compared to 73.0 in 2022.

The Care Plan composite measure from the Adult BH MES combines results from four survey questions that pertain to the identification of BH needs and addressing them in the care plan. For adult members, there were slight improvements in coordination of BH care. In 2023, the score for the Care Plan composite measure was 77.6 compared to 77.4 in 2022. See **Appendix C-9** and **Appendix C-10** for stratified results and stratified within-year results with p-values of these composite measures relating to care coordination.

Table 3.3-26 Results for Needs Met, Member Engagement with Care Team, and Care Plan Composite Measures from the Adult BH MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Needs Met^a			
Adult Composite Score (0-100)	66.6	83.5	16.9*
Member Engagement with Care Team^b			
Adult Composite Score (0-100)	73.0	77.9	4.9
Care Plan^c			
Adult Composite Score (0-100)	77.4	77.6	0.2

Data Source: MES (CY2022-CY2023)

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The BH Needs Met composite measure combines the following three items: 1) How well were your needs for mental health services met? 2) How well were your needs for substance use treatment services for problems with alcohol or drugs met? 3) How well were your needs for BH prescription medications met?

^b The BH Member Engagement with Care Team composite measure combines the following two items: 1) In the last 12 months, did you contact anyone from your care team about your BH services to get help or advice? 2) In the last 12 months, when you contacted someone from your care team about your BH services, how often did you get the help or advice you needed?

^c The BH Care Plan composite measure combines the following four items: 1) To what extent do you feel that your BH needs were identified and discussed during the assessment? 2) Did you have a choice of services and providers during the care planning process? 3) Did anyone in your care team explain to you who was responsible for the different parts of your care plan? 4) Do you feel that your care plan includes all of the services that you need?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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LTSS Member Care Coordination

Table 3.3-27 contains scores from the Child and Adult LTSS MES regarding care coordination. The Care Coordinator composite measure from the Child LTSS MES combines results from four survey questions which pertain to the coordination of LTSS care. For pediatric members, the Care Coordinator score decreased notably. In 2023, the score for the Care Coordinator composite measure was 65.3 compared to 81.5 in 2022.

The Needs Met LTSS Core composite measure from the Child LTSS MES combines results from three survey questions that pertain to meeting the LTSS needs of members. For pediatric members, there were large improvements. In 2023, the score for the Needs Met LTSS Core composite measure was 74.0 compared to 52.0 in 2022. The Needs Met LTSS Core composite measure from the Adult LTSS MES combines results from four survey questions that pertain to meeting the LTSS needs of members. Unlike pediatric members, the Needs Met LTSS Core score decreased for adult members. In 2023, the Needs Met LTSS Core composite score was 72.8 compared to 80.4 in 2022.

The Needs Met LTSS Non-Core composite measure from the Child LTSS MES combines results from six survey questions that pertain to care coordination meeting the LTSS needs of members. For pediatric members, there were improvements in coordination of LTSS care. In

2023, the score for the Needs Met LTSS Non-Core composite measure was 57.8 compared to 38.3 in 2022. The Needs Met LTSS Non-Core composite measure from the Adult LTSS MES combines results from ten survey questions that pertain to care coordination meeting the LTSS needs of members. For adult members, there was a slight decrease in the LTSS Non-Core composite measure. In 2023, the score for the Needs Met LTSS Non-Core composite measure was 76.5 compared to 76.7 in 2022.

The Care Plan composite measure from the LTSS MES combines results from four survey questions that pertain to the identification of LTSS needs and addressing them in the care plan. For pediatric members, the Care Plan composite measure improved. In 2023, the score for the Care Plan composite measure was 63.6 compared to 59.4 in 2022. Adult members showed a decrease in the Care Plan composite measure. In 2023, the score was 71.7 compared to 77.3 in 2022. See **Appendix C-9** and **Appendix C-10** for stratified results and stratified within-year results with p-values of these composite measures relating to care coordination.

Table 3.3-27 Results for Care Coordinator, Needs Met LTSS Core, Needs Met LTSS Non-Core, and Care Plan Composite Measures from the LTSS MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Care Coordinator^a			
Child Composite Score (0-100)	81.5	65.3	-16.2*
Needs Met LTSS Core^b			
Child Composite Score (0-100)	52.0	74.0	22.0**
Adult Composite Score (0-100)	80.4	72.8	-7.6
Needs Met LTSS Non-Core^c			
Child Composite Score (0-100)	38.3	57.8	19.5**
Adult Composite Score (0-100)	76.7	76.5	-0.2
Care Plan^d			
Child Composite Score (0-100)	59.4	63.6	4.2
Adult Composite Score (0-100)	77.3	71.7	-5.6

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Long-Term Services and Supports (LTSS); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The Child LTSS Care Coordinator composite measure combines the following four items: 1) Did your child's care coordinator help your child obtain these services in the community? 2) Did your child's care coordinator assist your child with any referrals to a specialist? 3) In the last 12 months, how often did your child's care coordinator seem to know the important information about your child's medical history? 4) How would you rate your child's care coordinator's knowledge about your child as a person, including special abilities, concerns and fears?

^b The Child Needs Met LTSS Core composite measure combines the following three items: 1) How well were your child's needs for physical, occupational or speech therapy services met? 2) How well were your child's needs for skilled nursing met? 3) How well were your child's needs for personal care or everyday tasks met? The Adult Needs Met LTSS Core composite measure combines the following four items: 1) How well were your needs for physical, occupational or speech therapy services met? 2) How well were your needs for skilled nursing met? 3) How well were your needs for personal care or everyday tasks met? 4) How well were your needs for day programs met?

^c The Child Needs Met LTSS Non-Core composite measure combines the following six items: 1) How well were your child's needs for medical equipment or medical supplies met? 2) How well were your child's needs for assistive technology met? 3) How well were your child's needs for specialty care services met? 4) How well were your child's needs for mental health services met? 5) How well were your child's needs for transportation services to get to medical appointments met? 6) How well were your child's needs for prescription medications met? The Adult

Needs Met LTSS Non-Core composite measure combines the following ten items: 1) How well were your needs for medical equipment or medical supplies met? 2) How well were your needs for special assistance or accommodations met? 3) How well were your needs for an interpreter met? 4) How well were your needs for assistive technology met? 5) How well were your needs for specialty care services met? 6) How well were your needs for mental health services met? 7) How well were your needs for substance use treatment services for problems with alcohol or drugs met? 8) How well were your needs for transportation services to get to medical appointments met? 9) How well were your needs for transportation services to get to places in the community met? 10) How well were your needs for prescription medications met?

^d The Child LTSS Care Plan composite measure combines the following four items: 1) To what extent do you feel that your child's LTSS needs were identified and discussed during the assessment? 2) Did you and/or your child have a choice of services and providers during the care planning process? 3) Did anyone in your child's care team explain to you and/or your child who was responsible for the different parts of your child's care plan? 4) Do you feel that your child's care plan includes all of the services that your child needs? The Adult LTSS Care Plan composite measure combines the following four items: 1) To what extent do you feel that your LTSS needs were identified and discussed during the assessment? 2) Did you have a choice of services and providers during the care planning process? 3) Did anyone in your care team explain to you who was responsible for the different parts of your care plan? 4) Do you feel that your care plan includes all of the services that you need?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Administrative Measures

Administrative data was used to examine the rate at which care coordination supports increased, decreased or stayed consistent for MassHealth members. Overall enrollment in programs that provide Enhanced Care Coordination increased relative to baseline. The percentage of members who were enrolled in one or both of ACO Care Management and/or the CP Program increased from baseline to the subsequent years of the 2022-2027 Demonstration, the percentage of members who were specifically and exclusively enrolled in the CP Program decreased. Of note, CP enrollment requirements specified by MassHealth decreased from 2022 to 2024. See **Table 3.3-28**.

Table 3.3-28 Enhanced Care Coordination Program Enrollment (ACO Care Management or CP Program) For MassHealth ACO Members (CY2022-CY2024)

Enhanced Care Coordination Program Enrollment***		ACO		
		2022** N = 1,019,487	2023 N = 725,830	2024 N = 862,288
ACO Care Management <u>OR</u> CP Program	Measure, Observed*	7.1%	8.8%	12.0%
ACO Care Management Only	Measure, Observed*	0.2%	3.4%	5.8%
CP Program Only	Measure, Observed*	6.8%	4.2%	4.5%
ACO Care Management <u>AND</u> CP Program	Measure, Observed*	0.2%	1.2%	1.7%

Data Source: Administrative Data

Abbreviations: Accountable Care Organization (ACO); Community Partner (CP); Calendar Year (CY)

* Yearly count per 100 members

**There was incomplete 2022 data for ACO Care Management

***Enhanced Care Coordination Program Enrollment is calculated differently by MassHealth than by the Independent Evaluators (IEs)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Treatment plan completion for BH CPs increased for the ACO population from baseline to the subsequent years of the 2022-2027 Demonstration while care plan completion for LTSS CPs decreased in both the ACO and MCO/PCC populations. Oral health evaluation for LTSS CPs stayed consistent in 2023 and increased for both ACO and MCO/PCC populations in 2024. Primary care visits for both BH CPs and LTSS CPs increased (See **Table 3.3-29**). See **Appendix C-11.3** for additional administrative measure data stratified by demographics.

Table 3.3-29. Observed vs. Expected Ratios of Care Coordination Supports Among MassHealth ACO and MCO/Members (CY2022-CY2024)

Care Coordination Supports		MCE	ACO			MCO/PCC***		
		2022	2022	2023	2024	2022	2023	2024
Treatment Plan Completion (BH CP)**	Population Size, N	19,147	17,643	12,211	14,095	1,504	568	706
	Measure, Observed*	59.2%	60.4%	69.4%	69.4%	45.6%	67.3%	57.1%
	O:E Ratio	1.00	1.02	1.17	1.16	0.79	1.15	0.98
Annual Primary Care Visit (BH CP)	Population Size, N	41,727	37,269	24,558	26,682	4,458	1,629	1,701
	Measure, Observed*	66.2%	64.6%	69.4%	81.0%	79.7%	83.5%	88.9%
	O:E Ratio	1.00	0.97	1.06	1.20	1.25	1.31	1.34
Care Plan Completion (LTSS CP)	Population Size, N	4,908	4,729	3,608	5,177	179	123	315
	Measure, Observed*	68.7%	69.0%	47.9%	62.2%	62.0%	60.2%	58.4%
	O:E Ratio	1.00	1.00	0.70	0.90	0.90	0.86	0.84
Oral Health Evaluation¹¹⁴ (LTSS CP)	Population Size, N	26,466	21,134	13,318	19,861	2,332	1,240	1,168
	Measure, Observed*	61.2%	61.3%	62.7%	67.6%	60.3%	61.0%	66.6%
	O:E Ratio	1.00	1.00	1.00	1.06	0.99	0.98	1.07
Annual Primary Care	Population Size, N	25,377	24,177	12,724	20,561	1,200	1,007	1,450
	Measure, Observed*	66.9%	65.8%	75.0%	85.5%	89.3%	95.1%	94.1%

¹¹⁴ Oral Health Evaluation were calculated based on the DQA Measure Technical Specifications, which is managed by the [American Dental Association](#) on behalf of the Dental Quality Alliance (ADA/DQA).

Care Coordination Supports		MCE	ACO			MCO/PCC***		
Visit (LTSS CP)	O:E Ratio	1.00	0.99	1.10	1.23	1.27	1.37	1.39

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Community Partner (CP); Calendar Year (CY); Long Term Services and Supports (LTSS); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

* Yearly count per 100 members

** Requirement for Primary Care Provider (PCP) signature for completed care plan was removed in 2023 and onward.

*** PCC members included here are only PCC-enrolled members also enrolled in Department of Mental Health (DMH) programs eligible for CP supports.

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Higher is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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3.3.7.3 Conclusions

Overall, findings suggest that progress was made as hypothesized. MassHealth's ACO and CP Programs contributed to improvements in care coordination through strengthening HIT infrastructure, closer collaboration between ACOs and CPs, and increased support for members with complex medical and social needs. ACOs reported investing in specialized care coordination teams and embedding staff within primary care practices, while CPs expanded staffing and improved data-sharing to better support members. Members frequently described positive relationships with care coordinators who helped them navigate health care and connect to social services such as housing, food assistance, and transportation. However, results also highlight ongoing challenges that limit the effectiveness of care coordination. Members and stakeholders noted barriers such as fragmented systems and confusion about care coordination roles. Performance varied across service areas, with more consistent improvements in primary care and BH, and more mixed results in LTSS. Overall rates of enrollment in Enhanced Care Coordination Programs increased, with some decreases in enrollment in the CP Program observed, and these changes were directionally consistent with changes in program enrollment benchmarks set by MassHealth. Treatment plan completion rates increased for BH CPs but decreased for LTSS CPs, while oral health evaluation, a quality measure for LTSS CPs only, increased. Annual primary care rates increased for both LTSS CPs and BH CPs. Together, these findings suggest that while care coordination was strengthened for ACO enrollees overall, continued efforts to improve system integration, resource availability, and role clarity will be important to ensure more consistent progress across subpopulations with varying needs, particularly those with LTSS needs.

3.3.8. RQ2-8 How did the volume and mix of services change for ACO members?

3.3.8.1 Summary of Results

Administrative data were used to assess the rate at which the volume and mix of services changed for ACO members in the first phase of the 2022-2027 Demonstration. The volume and mix of services were hypothesized to shift, when clinically appropriate, in the direction of low-cost sites and types of care. Results were positive for primary care utilization with the rate of child and adolescent well-care visits for the ACO population increasing more than 20% from baseline (2022) to 2024. Additionally, the proportion of adults with an annual primary care visit was consistently higher at baseline and during 2023-2024 for the ACO population than the MCO/PCC population. Results were mixed for potentially avoidable emergency care and inpatient utilization with performance on some measures improving (e.g., decreases in all cause ED visits), while others remained stable or deteriorated (e.g., unplanned hospital admissions). Similar patterns were observed for both the ACO and MCO/PCC populations in most cases. Finally, findings for utilization of outpatient LTSS, BH, and physical care services suggest that ambulatory care and post-acute care utilization remained stable or deteriorated in both the ACO and MCO/PCC enrollees.

3.3.8.2 Results

H2-8.1 The volume and mix of services utilized will shift, when clinically appropriate, in the direction of lower-cost sites and types of care.

Administrative Measures

Administrative data was used to examine how the volume and mix of services increased, decreased, or stayed the same when clinically appropriate, in the direction of lower-cost sites (e.g., primary care) and types of care (e.g., primary care visits) for MassHealth members. A mix of results were seen, with the child and adolescent well-care visits measure performing significantly better over time for both the ACO and MCO/PCC populations and annual primary care visits performing better for the ACO than the MCO/PCC population. See **Table 3.3-30** See **Appendix C-11.4** for additional administrative measure data stratified by demographics.

Table 3.3-30. Observed vs. Expected Ratios of Primary Care Utilization Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Primary Care Utilization		MCE	ACO				MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024	
Child and Adolescent Well-Care Visits (WCV) HEDIS® measure ¹¹⁵	Population Size, N	517,902	451,534	343,713	435,301	66,368	36,656	32,612	
	Measure, Observed	65.3%	65.2%	67.7%	70.7%	65.9%	66.7%	68.7%	

¹¹⁵ HEDIS MY2023 Child and Adolescent Well-Care Visits (WCV)

Primary Care Utilization		MCE	ACO				MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024	
	O:E Ratio	1.00	1.00	1.03	1.06	1.02	1.02	1.03	
Annual Primary Care Visit (Adult)	Population Size, <i>N</i>	745,278	619,055	462,358	497,182	126,223	66,021	46,821	
	Measure, Observed	46.1%	47.9%	47.2%	52.2%	37.4%	35.5%	39.5%	
	O:E Ratio	1.00	1.03	1.03	1.07	0.83	0.81	0.86	

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Healthcare Effectiveness Data and Information Set (HEDIS);

Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

* Yearly count per 100 members

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Higher is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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This hypothesis was also explored by examining whether post-acute care utilization performance increased, decreased, or stayed the same for MassHealth members. Post acute care utilization decreased for both ACO and MCO/PCC populations across the Demonstration period as compared to baseline. See **Table 3.3-31**. For additional administrative measure data stratified by demographics, see **Appendix C-11.4**.

Table 3.3-31. Observed vs. Expected Ratios of Post Acute Care Utilization Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Post Acute Care Utilization		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Post Acute Care Utilization – Any Service or Facility	Population Size, N	123,945	97,407	78,026	81,457	26,538	15,696	12,344
	Measure, Observed	12.7%	13.0%	11.2%	11.7%	11.7%	9.2%	8.6%
	O:E Ratio	1.00	0.99	0.93	0.95	1.02	0.93	0.89

Post Acute Care Utilization		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Post Acute Care Utilization – Home Health Service	Population Size, N	123,945	97,407	78,026	81,457	26,538	15,696	12,344
	Measure, Observed	9.4%	9.7%	8.0%	8.3%	8.2%	6.1%	5.5%
	O:E Ratio	1.00	1.00	0.91	0.93	0.98	0.88	0.81
Post Acute Care Utilization – Inpatient Rehab or Nursing Facility	Population Size, N	123,945	97,407	78,026	81,457	26,538	15,696	12,344
	Measure, Observed	3.3%	3.3%	3.2%	3.4%	3.5%	3.1%	3.1%
	O:E Ratio	1.00	0.97	0.99	1.02	1.11	1.02	1.03

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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H2-8.2 Rates of potentially avoidable emergency care and inpatient utilization will decrease.

Administrative Measures

Administrative data was used to examine the degree to which the rates of potentially avoidable emergency care and inpatient utilization decreased, increased, or stayed consistent for MassHealth members. A mix of results are seen with some measures; for example, ED visits, ED boarding, and hospital admissions for ambulatory care sensitive conditions performing consistently or better over time for both the ACO and MCO/PCC populations, and some measures performing worse such as unplanned hospital admissions for adults and children. See **Table 3.3-32**. See **Appendix C-11.4** for additional administrative measure data stratified by demographics.

Table 3.3-32. Observed vs. Expected Ratios of Potentially Avoidable, Emergency Care, and Inpatient utilization Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Potentially Avoidable, Emergency Care, and Inpatient Utilization		MCE	ACO				MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024	
All Cause ED Visits - Adult	Population Size, <i>N</i>	745,278	619,055	462,358	497,182	126,223	66,021	46,821	
	Measure, Observed*	58.9 ± 0.2	60.3 ± 0.2	59.6 ± 0.3	66.7 ± 0.3	52.1 ± 0.4	51.5 ± 0.6	57.9 ± 0.8	
	O:E Ratio	0.99	1.01	0.98	0.96	0.92	0.92	0.89	
All Cause ED Visits - Children	Population Size, <i>N</i>	480,240	419,490	337,752	431,757	60,390	35,799	32,433	
	Measure, Observed*	38.6 ± 0.1	39.0 ± 0.1	36.4 ± 0.1	37.9 ± 0.1	35.8 ± 0.4	32.1 ± 0.4	33.6 ± 0.4	
	O:E Ratio	0.98	0.99	0.92	0.93	0.92	0.81	0.83	
ED Boarding for Members with BH Conditions	Population Size, <i>N</i>	239,892	198,196	145,715	176,509	41,696	21,086	17,437	
	Measure, Observed*	73.3 ± 1.0	82.5 ± 0.6	101.6 ± 0.8	113.7 ± 0.8	72.2 ± 1.1	86.0 ± 1.9	99.0 ± 2.2	
	O:E Ratio	0.91	0.91	0.91	0.93	0.89	0.96	0.90	
Unplanned Hospital Admissions - Adult	Population Size, <i>N</i>	771,583	641,842	481,009	515,069	129,741	68,027	48,225	
	Measure, Observed*	10.7 ± 0.1	10.8 ± 0.1	12.1 ± 0.1	15.7 ± 0.1	10.5 ± 0.1	11.5 ± 0.2	14.9 ± 0.3	
	O:E Ratio	0.98	0.98	1.01	1.07	0.99	1.06	1.10	
Unplanned Hospital Admissions - Children	Population Size, <i>N</i>	418,764	365,756	295,871	404,189	53,008	31,481	30,258	
	Measure, Observed*	2.0 ± 0.0	2.0 ± 0.0	2.1 ± 0.0	2.3 ± 0.0	2.0 ± 0.1	2.1 ± 0.1	2.3 ± 0.1	
	O:E Ratio	1.00	1.00	1.05	1.06	1.02	0.97	1.02	
ED Visits for Individuals with Mental Illness, Addiction, or Co-Occurring Conditions	Population Size, <i>N</i>	178,201	146,324	110,000	130,952	31,877	16,393	13,666	
	Measure, Observed*	116.5 ± 0.7	119.5 ± 0.8	121.8 ± 1.0	126.2 ± 0.9	102.8 ± 1.4	103.9 ± 2.1	109.8 ± 2.3	
	O:E Ratio	1.00	1.01	0.97	0.92	0.96	0.93	0.87	
All Cause Readmissions –	Population Size, <i>N</i>	38,710	32,720	29,702	43,681	5,990	4,074	3,870	
	Measure, Observed*	18.1 ± 0.2	18.3 ± 0.2	20.0 ± 0.2	21.8 ± 0.2	16.7 ± 0.5	21.0 ± 0.6	21.4 ± 0.7	

Potentially Avoidable, Emergency Care, and Inpatient Utilization		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Adults HEDIS[®] measure¹¹⁶	O:E Ratio	1.00	1.01	0.93	0.97	0.95	1.01	0.94
Pediatric Asthma Admissions	Population Size, <i>N</i>	480,420	419,490	337,752	431,757	60,930	35,799	32,433
	Measure, Observed*	1.1 ± 0.1	1.2 ± 0.1	1.2 ± 0.1	1.3 ± 0.1	1.1 ± 0.1	0.5 ± 0.1	1.2 ± 0.2
	O:E Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hospital Admissions for Ambulatory Care-Sensitive Conditions – Acute	Population Size, <i>N</i>	771,292	641,533	480,673	521,943	129,759	68,031	48,789
	Measure, Observed**	0.3 ± 0.1	0.3 ± 0.1	0.2 ± 0.1	0.2 ± 0.1	0.5 ± 0.2	0.2 ± 0.2	0.4 ± 0.2
	O:E Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hospital Admissions for Ambulatory Care-Sensitive Conditions – Chronic	Population Size, <i>N</i>	771,292	641,533	480,673	521,943	129,759	68,031	48,789
	Measure, Observed**	0.8 ± 0.1	0.8 ± 0.1	0.7 ± 0.1	0.8 ± 0.1	0.8 ± 0.3	0.5 ± 0.3	0.0 ± 0.0
	O:E Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hospital Admissions for Adults with Mental Illness and/or Substance Addiction	Population Size, <i>N</i>	226,679	186,814	162,684	194,097	39,865	24,256	20,126
	Measure, Observed*	24.8 ± 0.2	25.0 ± 0.2	38.4 ± 0.3	45.1 ± 0.3	23.6 ± 0.4	36.2 ± 0.8	42.1 ± 0.8
	O:E Ratio	0.99	0.98	1.11	1.16	1.01	1.20	1.21
Use of Imaging Studies for Low Back Pain HEDIS[®] measure¹¹⁷	Population Size, <i>N</i>	15,018	12,692	10,706	25,481	2,326	1,220	2,003
	Measure, Observed***	18.9%	18.7%	19.1%	18.3%	20.2%	20.7%	17.3%
	O:E Ratio	1.00	0.99	1.01	0.87	1.06	1.09	0.81

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Calendar Year (CY); Emergency Department (ED); Healthcare Effectiveness Data and Information Set (HEDIS); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

Not Applicable (N/A) cell size was too small to support modeling

* Yearly count per 100 members

** Yearly count per 1000 members

*** This is the percentage of visits for low back pain where imaging studies were not ordered within 28 days of the diagnosis.

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce

¹¹⁶ HEDIS MY2023 All Cause Readmissions – Adults¹¹⁷ HEDIS MY2023 Imaging Studies for Low Back Pain.

expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Lower is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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H2-8.3 Utilization of outpatient LTSS, BH, and physical care services will increase or remain consistent for members.

Administrative Measures

Administrative data was used to examine whether ambulatory care utilization decreased, increased, or stayed the same for MassHealth members. Ambulatory care utilization stayed consistent for both the ACO and MCO/PCC populations across all years. See **Table 3.3-33**. See **Appendix C-11.4** for additional administrative measure data stratified by demographics.

Table 3.3-33. Observed vs. Expected Ratios of Ambulatory Care Utilization Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Ambulatory Care Utilization		MCE	ACO				MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024	
Ambulatory Care Utilization HEDIS® measure ¹¹⁸	Population Size, N	1,034,638	879,866	690,029	788,976	154,772	86,707	65,487	
	Measure, Observed*	466.9 ± 0.6	487.1 ± 0.5	490.4 ± 0.6	538.2 ± 0.6	481.7 ± 1.3	474.1 ± 1.7	506.1 ± 2.0	
	O:E Ratio	0.96	0.96	0.96	0.98	0.95	0.92	0.97	

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Healthcare Effectiveness Data and Information Set (HEDIS); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan

* Yearly count per 100 members

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Higher is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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3.3.8.3 Conclusions

Early findings show moderate support of the hypotheses that the volume and mix of services would change positively for ACO members. Based on quantitative results, results are mixed regarding the volume and service mix for ACO members. Regarding the shift of services to lower-cost sites and types of care when clinically appropriate, quantitative data show improvement from baseline to 2023 and 2024. Steady increases in rates of child and adolescent well-care visits were observed in MA between 2022 and 2024. Rates were in line with national

¹¹⁸ HEDIS MY2023 Ambulatory Care – outpatient visits (including telehealth) category.

benchmarks in 2022 (44.2% in MA and 47.6% nationally) and greater in following years (57.6% in MA and 46.0% nationally in 2023, 67.3% in MA and 49.4% nationally in 2024). Rates of annual primary care visits also improved between 2022 and 2024. Among ACO and MCO/PCC enrollees, ED utilization findings were consistent with improved performance, while inpatient utilization reflected decrements in performance. Among adults and children, all cause ED visits and ED visits for individuals with mental illness and/or substance addiction decreased between 2022 and 2024. However, adult and child rates for unplanned hospital admissions increased between 2022 and 2024. All cause readmissions in adults decreased between 2022 and 2023 for ACOs while it increased for MCO/PCCs. Rates of hospital admissions and emergency department visits for adults with mental illness and/or substance addiction increased over the measurement period. These patterns were consistent with increased medical complexity of MassHealth enrollees after redeterminations resumed following the end of the COVID-19 Public Health Emergency (PHE). Comparative quasi-experimental analyses to be conducted in the IESR will address the question of whether ACOs were more effective than MCOs and the Primary Care Clinician Plan (PCCP) in shifting care to lower-cost, higher value settings when appropriate.

3.3.9. RQ2-9 How did member outcomes and member experience change for ACO members?

3.3.9.1 Summary of Results

Using interview and administrative data, this RQ examined whether MassHealth's ACO program achieved its intended goals of improving member experience and health outcomes through program inputs and activities designed to strengthen primary care, integrate BH and LTSS, and enhance accountability for quality. Overall, member survey results indicated measurable improvements with primary care and BH services among adults, with meaningful variation across age groups and types of care provided. Member survey results relating to pediatric LTSS care and communication with LTSS providers remained relatively stable. Interviews with members provided context on program implementation, perceived effectiveness of care delivery and coordination activities, and ongoing barriers to accessing and navigating services. These results highlight opportunities for targeted policy interventions, including focused support for pediatric LTSS services, and communication infrastructure to better achieve MassHealth's objectives. Severe maternal morbidity decreased for the ACO population relative to baseline, while for the MCO population, there was decrease followed by an increase in 2024. Descriptive results for the prevalence of neonatal intensive care unit (NICU) utilization among newborn MassHealth members were consistent with a relatively stable trend among ACO enrollees, with a higher prevalence at baseline among MCO/PCC enrollees that declined and was similar to ACO enrollees in 2023-2024.

3.3.9.2 Results

H2-9.1 Clinical outcomes will improve.

Administrative Measures

Administrative data was used to examine how clinical outcomes would improve, decline, or stay consistent for ACO members. Severe maternal morbidity decreased for the ACO population

from 2022-2024 while the MCO population decreased in 2023 and then increased in 2024, relative to baseline. For NICU utilization, observed rates stayed consistent for the ACO population, while rates for the MCO/PCC population started higher at baseline, reducing to rates consistent with the ACO population by 2024. See **Table 3.3-34**. See **Appendix C-11.5** for additional administrative measure data stratified by demographics.

Table 3.3-34. Observed vs. Expected Ratios of Clinical Outcomes Among MassHealth ACO and MCO/PCC Members (CY2022-CY2024)

Clinical Outcomes		MCE	ACO			MCO/PCC		
		2022	2022	2023	2024	2022	2023	2024
Severe Maternal Morbidity	Population Size, <i>N</i>	14,105 [‡]	11,929	10,920	11,202	2,176	1,402	805
	Measure, Observed*	2.9%	3.0%	2.8%	3.2%	2.5%	1.8%	4.0%
	O:E Ratio	1.00	1.02	0.91	0.93	0.90	0.60	1.21
NICU Utilization	Population Size, <i>N</i>	25,500	22,912	24,475	25,607	2,588	1,426	1,138
	Measure, Observed*	6.8%	6.5%	6.7%	6.7%	9.5%	6.8%	6.4%
	O:E Ratio [†]	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data Source: Administrative Measures

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Managed Care Eligible (MCE); Managed Care Organization (MCO); Neonatal Intensive Care Unit (NICU); Primary Care Clinician (PCC) Plan

Not Applicable (N/A) cell size was too small to support modeling

* Yearly count per 100 members

† O:E ratios not calculated for NICU Utilization as the relevant data needed to create predicted values is from the mother prior to delivery and requires the ability to link newborns to mothers.

‡ Measure data for Severe Maternal Morbidity shows a smaller population size than for NICU Utilization as Severe Maternal Morbidity required continuous MassHealth MCE enrollment for 42 days before and after the delivery. NICU Utilization does not share the same requirement.

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values for the populations enrolled in model A and B ACOs, based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure.

Legend

Lower is better legend:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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H2-9.2 Members will report improved experiences of healthcare services and supports.

Many MassHealth members who were interviewed reported a positive experience with MassHealth services and supports. Some described their experience as “*very good*” (MassHealth member), “*pretty good...no issues*” (MassHealth member), and “*a very good experience.*” (MassHealth member) Several members expressed gratitude for the coverage, noting that without it, they would struggle to afford prescriptions. One member appreciated the care they received, crediting “*good people in the system*” (MassHealth member) for helping them maintain their health.

However, some members voiced frustrations with the outdated or complex nature of the health care system. Descriptions like *“frustrating...redundant...archaic”* and one member’s experience of it being *“easier to get brain surgery than a required MassHealth document”* (MassHealth member) reflect significant difficulties navigating the system. Others pointed out that MassHealth members *“deserve the best”* (MassHealth member), as these are individuals typically facing complex issues. One member went as far as calling their insurance *“crap.”* (MassHealth member)

A common issue for members was the difficulty in reaching someone at MassHealth or their health plan. Many experienced long waiting times to speak to someone and confusing phone systems. One member recalled waiting *“two hours”* to speak with a representative (MassHealth member), while another shared frustration with the system hanging up on them. Another recurring theme was inconsistent or unhelpful communication. Some members felt they received incorrect information or experienced rudeness from staff. One person noted that staff *“need better training”* to prevent misinformation (MassHealth member), while another mentioned being treated rudely when asking for assistance.

Many members expressed a desire for a more streamlined process of navigating MassHealth and advocated for a direct, personal point of contact. One member explained that having *“one person at MassHealth...with an email or cell phone”* (MassHealth member) would greatly simplify the process. Communication preferences varied among members. While some preferred email for its convenience, others felt that paper mail was a safer option due to concerns about email getting lost or appearing as spam. This suggests a need for flexibility in how MassHealth communicates with its members.

Several members expressed frustration with the lack of clarity around benefits and the necessary steps to access them. One member suggested that MassHealth hold seminars explaining what is covered, while another requested a step-by-step guide to navigate the system. The website was described as tricky to use, indicating a need for simpler, more user-friendly instructions.

Overall, members spoke highly of their relationships with their PCPs and specialists, but some had specific issues with individual doctors. Most members reported having long-term relationships with their PCP, that appointments were easy to access, and that they felt comfortable asking questions during appointments. Some members reported difficulty accessing appointments on an “appropriate” timeline, while otherwise being satisfied with their PCP.

Many members reported the same positive experience with their specialists; they had long-term relationships, could get appointments easily, and felt comfortable asking questions. Some members reported more negative experiences with their specialists including a difficult time getting appointments and a perception that their specialist did not listen as well as their PCP did.

“I mean, I would say the communication there [with the specialist] is average. They tend to -- they don’t listen as well as my primary care. He’s still good, but he doesn’t listen as well.” – a MassHealth member (MEI009)

Some members reported that their BH needs were being well met, while others were disappointed with their BH care. Members reported that care managers/coordinators, recovery coaches and other health care providers can be extremely helpful. They help with setting goals and day-to-day activities that help members feel better (e.g., less anxious or depressed).

“[The care managers are] remarkable because I have chronic anxiety. That’s one of my disabilities. And they help me if I’m feeling very stressed or anxiety ridden. I would call them and they would be available. Or even if they’re not, they would call me back in a day or two. And talk to me. And help me out. And I feel better talking to them. I feel reassured. They’re just amazing people.” – a MassHealth member (MEI022)

Members who received in-home supports expressed high satisfaction. One member described receiving assistance with wheelchair needs, physical therapy, occupational therapy, and home visits. Another member reported seeing workers daily and being very satisfied with “98%” (MassHealth member) of them.

Digital tools, such as the Patient Gateway for communication and scheduling, were also cited as highly beneficial. One member mentioned how useful these tools were in managing their care and appointments.

Primary Care Member Experiences and Satisfaction

Table 3.3-35 contains scores from the Primary Care MES regarding member experiences and satisfaction. The Communication composite measure combines results from four survey questions pertaining to communication with PCPs. For pediatric members, there were improvements in member experiences. In 2023, the Communication composite score was 95.4 compared to 87.6 in 2022. For adult members, there were notable improvements in member experiences. In 2023, the Communication composite score was 92.7 compared to 77.4 in 2022.

The Child Primary Care MES also contains the Child Provider Communication composite measure which combines results from three survey questions asking the parent/guardian how well the provider communicated with their child. In both years, scores were excellent: 93.3 in 2022 and 94.9 in 2023. A separate measure, the Communication composite from the Child Primary Care MES, combines results from four survey questions which pertain to the parent/guardian’s communication with PCPs. Performance on this measure improved from 87.6 to 95.4 between 2023 and 2024.

The Overall Provider Rating composite measure from the Primary Care MES pertains to satisfaction with the PCP. For pediatric members, there were improvements in member satisfaction. In 2023, the Overall Provider Rating composite score was 89.7 compared to 78.4 in 2022. For adult members, there was no change in the Overall Provider Rating score, remaining at 84.5 for 2022 and 2023.

The Willingness to Recommend composite measure from the Primary Care MES includes results from one survey question which pertains to satisfaction with the PCP. For pediatric members, there were improvements in member satisfaction. In 2023, the Willingness to

Recommend composite score was 90.3 compared to 87.1 in 2022. For adult members, there were also improvements in member satisfaction. In 2023, the Willingness to Recommend composite score was 87.2 compared to 80.1 in 2022.

The Office Staff composite measure from the Primary Care MES combines results from two survey questions which pertain to satisfaction with the PCP's office staff. For pediatric members, there were improvements in member satisfaction. In 2023, the Office Staff composite score was 93.2 compared to 81.8 in 2022. For adult members, there were sizeable improvements in member satisfaction. In 2023, the Office Staff composite score was 92.3 compared to 69.8 in 2022, representing a 22.5-point improvement.

Table 3.3-35 Results for Communication, Child Provider Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff Composite Measures from the Primary Care MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Communication^a			
Child Composite Score (0-100)	87.6	95.4	7.8***
Adult Composite Score (0-100)	77.4	92.7	15.3***
Child Provider Communication^b			
Child Composite Score (0-100)	93.3	94.9	1.6*
Overall Provider Rating^c			
Child Composite Score (0-100)	78.4	89.7	11.3***
Adult Composite Score (0-100)	84.5	84.5	0.0***
Willingness to Recommend^d			
Child Composite Score (0-100)	87.1	90.3	3.2***
Adult Composite Score (0-100)	80.1	87.2	7.1***
Office Staff^e			
Child Composite Score (0-100)	81.8	93.2	11.4***
Adult Composite Score (0-100)	83.4	85.6	2.2*

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The Child Primary Care Communication composite measure combines the following four items: 1) In the last 12 months, how often did this provider explain things about your child's health in a way that was easy to understand? 2) In the last 12 months, how often did this provider listen carefully to you? 3) In the last 12 months, how often did this provider show respect for what you had to say? 4) In the last 12 months, how often did this provider spend enough time with your child? The Adult Primary Care Communication composite measure combines the following four items: 1) In the last 12 months, how often did this provider explain things in a way that was easy to understand? 2) In the last 12 months, how often did this provider listen carefully to you? 3) In the last 12 months, how often did this provider show respect for what you had to say? 4) In the last 12 months, how often did this provider spend enough time with you?

^b The Primary Care Child Provider Communication composite measure combines the following three items: 1) In the last 12 months, how often did this provider explain things in a way that was easy for your child to understand? 2) In the last 12 months, how often did this provider listen carefully to your child? 3) Did this provider give you enough information about what you needed to do to follow up on your child's care?

^c The Child Primary Care Overall Provider Rating composite measure includes the following item: Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

^d The Primary Care Willingness to Recommend composite measure includes the following item: Would you recommend this provider to your family and friends?

^e The Primary Care Office Staff composite measure includes the following two items: 1) In the last 12 months, how often were the front office staff at this provider's office as helpful as you thought they should be? 2) In the last 12 months, how often did the front office staff at this provider's office treat you with courtesy and respect?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Table 3.3-36 shows stratified Primary Care MES findings regarding member experiences and satisfaction. Stratified analyses identified several statistically significant differences in year-over-year (YoY) changes in member experience and satisfaction. Hispanic members experienced larger improvements in Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff. Members with unknown ethnicity also had significantly smaller improvements in Communication, Child Provider Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff. By race, Black adult members experienced significantly greater gains in Communication, and Black child members showed greater improvements in Child Provider Communication. However, Black members experienced significantly smaller gains in Office Staff ratings. Members categorized as other race had significantly smaller improvements in Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff. Members with Unknown race also experienced significantly smaller gains across multiple domains including Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff.

Significant differences were also observed by age and language. Among pediatric members, children ages 6-11 and 7-12 experienced greater improvements in Communication from their providers. Children ages 7-12 also showed greater gains in Child Provider Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff. Compared to adults ages 18-29, members ages 30-44, 45-59, and 60+ experienced significantly greater improvements in Communication and Overall Provider Rating. Adults ages 45-59 and 60+ also had significantly greater gains in Willingness to Recommend and Office Staff. By language, Spanish-speaking adult members experienced greater improvements in Overall Provider Rating and Willingness to Recommend. Members who spoke languages other than English or Spanish experienced significantly smaller improvements in Communication, Child Provider Communication, Overall Provider Rating, Willingness to Recommend, and Office Staff. See **Appendix C-10** for stratified within-year results with p-values of these composite measures.

Table 3.3-36 Stratified Results for Member Experiences and Satisfaction Composite Measures from the Primary Care MES (CY2022-CY2023)

	Communication		Child Provider Communication	Overall Provider Rating		Willingness to Recommend		Office Staff	
	Child YoY	Adult YoY	Child YoY	Child YoY	Adult YoY	Child YoY	Adult YoY	Child YoY	Adult YoY
Ethnicity									
Not Hispanic	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Hispanic	0.6	2.2***	0.0	0.2	2.9***	0.7	3.9***	0.0	-1.0*
Unknown	-1.3**	-5.1***	-1.3*	-0.5	-1.3***	-0.7**	-2.0**	-1.9*	-4.6***
Race									
White	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Black	-0.2	7.3*	0.9*	-0.2	-0.1	-0.4	0.8	-1.5*	-3.7*
Other	-3.5***	2.7*	-0.5	-2.4***	-6.7***	-4.2***	-1.9	-5.5***	-1.7
Unknown	-1.2***	1.6*	-0.4	-1.3*	-4.1***	-1.6***	-3.4***	-1.7***	-1.1
Sex									
Male	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Female	0.4	0.2	0.0	-0.1	-0.9***	-0.1	0.2	0.4	-1.8***
Age, Children									
0-5	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
6-11	0.8*	N/A	0.1	0.9*	N/A	0.5	N/A	0.6	N/A
7-12	0.8*	N/A	0.8*	1.4***	N/A	0.8**	N/A	1.3*	N/A
Age, Adults									
18-29	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference

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	Communication		Child Provider Communication	Overall Provider Rating		Willingness to Recommend		Office Staff	
30-44	N/A	2.3***	N/A	N/A	1.8****	N/A	1.2*	N/A	0.6
45-59	N/A	6.9***	N/A	N/A	7.0***	N/A	7.4***	N/A	4.6***
60+	N/A	6.1***	N/A	N/A	7.1***	N/A	6.3***	N/A	6.1***
Language									
English	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
Spanish	-1.8***	-0.7	0.2	1.3	3.8***	-0.6	1.3*	-1.1**	1.1**
Other/Unknown	-2.5***	-2.1***	-1.1*	-0.2*	1.1**	-1.8***	1.8*	-2.9***	-1.1**

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Member Experience Survey (MES); Not Applicable (N/A); Year-over-Year (YoY)

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

Legend

Higher is better legend:	YoY: <-5	YoY: -5 to <-2.5	YoY: -2.5 to 2.5	YoY: >2.5 to 5	YoY: >5
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BH Member Experiences and Satisfaction

Table 3.3-37 contains scores from the BH MES regarding member experiences and satisfaction in adults. The Communication composite measure from the BH MES combines results from six survey questions which pertain to communication with BH providers. For adult members, there was a decrease in the Communication composite score. In 2023, the Communication composite score was 79.4 compared to 85.8 in 2022.

The Healthy Living in the Community composite measure from the BH MES combines results from four survey questions which pertain to being able to manage one's health and day-to-day activities. For adult members, there were improvements in member experiences. In 2023, the Healthy Living in the Community composite score was 77.2 compared to 73.4 in 2022.

The Overall Provider Rating composite measure from the BH MES combines results from one survey question which pertains to satisfaction with the BH provider. For adult members, there were improvements in member satisfaction. In 2023, the Overall Provider Rating composite score was 79.3 compared to 72.1 in 2022.

The Willingness to Recommend composite measure from the BH MES includes results from one survey question which pertains to satisfaction with the BH provider. For adult members, there were improvements in member satisfaction. In 2023, the Willingness to Recommend composite score was 83.5 compared to 76.4 in 2022.

Table 3.3-37 Results for Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend Composite Measures from the BH MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Communication^a			
Adult Composite Score (0-100)	85.8	79.4	-6.4
Healthy Living in the Community^b			
Adult Composite Score (0-100)	73.4	77.2	3.8
Overall Provider Rating^c			
Adult Composite Score (0-100)	72.1	79.3	7.2
Willingness to Recommend^d			
Adult Composite Score (0-100)	76.4	83.5	7.1

Data Source: MES (CY2022-CY2023)

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The BH Communication composite measure combines the following six items: 1) In the last 12 months, how often did your BH provider explain things in a way that was easy to understand? 2) In the last 12 months, how often did your BH provider listen carefully to you? 3) In the last 12 months, how often did your BH provider show respect for what you had to say? 4) In the last 12 months, how often did your BH provider spend enough time with you? 5) In the last 12 months, how often did your BH provider show respect for your cultural/ethnic background? 6) In the last 12 months, how often did your BH provider show respect for your sexual orientation, gender expression, and gender identity?

^b The BH Healthy Living in the Community composite measure combines the following four items: 1) My care team works with me so I am better able to manage my physical health. 2) My care team works with me so I am better able to manage my mental health. 3) My care team works

with me so I am better able to participate in activities I enjoy with friends or family. 4) My care team works with me so I am better able to take care of myself where I live.

^c The BH Overall Provider Rating composite measure includes the following item: Using any number from 0 to 10, where 0 is the worst BH services possible and 10 is the best BH services possible, what number would you use to rate your BH services in the last 12 months?

^d The BH Willingness to Recommend composite measure includes the following item: Would you recommend your BH provider(s) to your family and friends if they needed similar BH services?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Table 3.3-38 presents stratified YoY results for BH adult members. Statistically significant differences were observed across several demographic groups. By ethnicity, compared to non-Hispanic members, Hispanic members experienced significantly larger improvements in Communication, Healthy Living in the Community, as well as Willingness to Recommend. Members with unknown ethnicity also had significantly greater declines in Communication and Willingness to Recommend. By race, Black members had a significantly greater decline in Healthy Living in the Community compared to White members.

By sex, female members experienced significantly greater improvements than male members across all four measures: Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend. Significant age differences were also observed. Compared to members ages 18-29, those ages 45-59 had significantly greater improvements across all measures including Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend. Members ages 60 and older also showed significantly greater improvements in Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend. Additionally, compared to English-speaking members, Spanish-speaking members had significantly greater improvements in Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend, while members who reported another or unknown language had significantly greater improvement in Healthy Living in the Community. See **Appendix C-10** for stratified within-year results with p-values of these composite measures.

Table 3.3-38 Stratified Results for the Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend Composite Measures from the BH MES (CY2022-CY2023)

	Communication Adult YoY	Healthy Living in the Community Adult YoY	Overall Provider Rating Adult YoY	Willingness to Recommend Adult YoY
Ethnicity				
Not Hispanic	Reference	Reference	Reference	Reference
Hispanic	5.9***	4.2*	2.7	8.5***
Unknown	-0.1***	2.0	3.7	3.4*
Race				
White	Reference	Reference	Reference	Reference

	Communication Adult YoY	Healthy Living in the Community Adult YoY	Overall Provider Rating Adult YoY	Willingness to Recommend Adult YoY
Black	7.6	-4.2***	-2.7	11.4**
Other	-5.5	-2.2	1.0	-2.7
Unknown	-3.0	-4.2	-2.7	-2.6
Sex				
Male	Reference	Reference	Reference	Reference
Female	4.8***	7.4***	4.4***	2.9*
Age				
18-29	Reference	Reference	Reference	Reference
30-44	1.8	1.2	4.5*	2.5
45-59	7.3***	3.6*	9.3***	12.3***
60+	4.4	5.7*	10.1***	8.8***
Language				
English	Reference	Reference	Reference	Reference
Spanish	5.9**	7.1***	13.5***	5.6*
Other/Unknown	-7.4	12.8***	4.6	-10.8**

Data Source: MES (CY2022-CY2023)

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Member Experience Survey (MES); Year-over-Year (YoY)

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

Legend

Higher is better legend:	YoY: <-5	YoY: -5 to <-2.5	YoY: -2.5 to 2.5	YoY: >2.5 to 5	YoY: >5
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LTSS Member Experiences and Satisfaction

Table 3.3-39 contains scores from the LTSS MES regarding member experience and satisfaction. The Communication composite measure from the Child LTSS MES combines results from six survey questions which pertain to communication with LTSS providers. For pediatric members, the Communication composite score increased slightly. In 2023, the Communication composite score was 90.6 compared to 83.6 in 2022. For adult members, there was a decrease in the Communication composite score. In 2023, the Communication composite score was 83.9 compared to 89.6 in 2022.

The Healthy Living in the Community composite measure from the LTSS MES combines results from four survey questions which pertain to being able to manage one's health and day-to-day activities. For adult members, there were improvements in member experiences. In 2023, the Healthy Living in the Community composite score was 81.9 compared to 68.9 in 2022.

The Overall Provider Rating composite measure from the LTSS MES includes results from one survey question which pertains to satisfaction with the LTSS provider. For pediatric members, the Overall Provider Rating composite measure decreased slightly. In 2023, the Overall Provider Rating composite score was 82.4 compared to 84.1 in 2022. In contrast, for adult members, there were small improvements in member satisfaction. In 2023, the Overall Provider Rating composite score was 90.9 compared to 87.4 in 2022.

The Willingness to Recommend composite measure from the Child LTSS MES includes results from one survey question which pertains to satisfaction with the LTSS provider. For pediatric members, there was no change in the Willingness to Recommend composite score, which remained at 85.0 in both 2022 and 2023. In contrast, for adult members, there were improvements in member satisfaction. In 2023, the Willingness to Recommend composite score was 87.4 compared to 76.1 in 2022.

Table 3.3-39 Results for the Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend Composite Measures from the LTSS MES (CY2022-CY2023)

	2022	2023	Difference vs. 2022
Communication^a			
Child Composite Score (0-100)	86.3	90.6	4.3
Adult Composite Score (0-100)	89.6	83.9	-5.7
Healthy Living in the Community^b			
Adult Composite Score (0-100)	68.9	81.9	13.0*
Overall Provider Rating^c			
Child Composite Score (0-100)	84.1	82.4	-1.7
Adult Composite Score (0-100)	87.4	90.9	3.5
Willingness to Recommend^d			
Child Composite Score (0-100)	85.0	85.0	0.0
Adult Composite Score (0-100)	76.1	87.4	11.3

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Long-Term Services and Supports (LTSS); Member Experience Survey (MES)

Composite Score ranges are from 0-100 with higher scores being better

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

^a The Child LTSS Communication composite measure combines the following six items: 1) In the last 12 months, how often did your child's LTSS provider explain things in a way that was easy to understand? 2) In the last 12 months, how often did your child's LTSS provider listen carefully to you and/or your child? 3) In the last 12 months, how often did your child's LTSS provider show respect for what you and/or your child had to say? 4) In the last 12 months, how often did your child's LTSS provider spend enough time with your child? 5) In the last 12 months, how often did your child's LTSS provider show respect for your child's cultural/ethnic background? 6) In the last 12 months, how often did your child's LTSS provider show respect for your child's sexual orientation, gender expression, and gender identity? The Adult LTSS Communication composite measure combines the following six items: 1) In the last 12 months, how often did your LTSS provider explain things in a way that was easy to understand? 2) In the last 12 months, how often did your LTSS provider listen carefully to you? 3) In the last 12 months, how often did your LTSS provider show respect for what you had to say? 4) In the last 12 months, how often did your LTSS provider spend enough time with you? 5) In the last 12 months, how often did your LTSS provider spend enough time with you? 6) In the last 12 months, how often did your LTSS provider show respect for your sexual orientation, gender expression, and gender identity?

^b The Child LTSS Healthy Living in the Community composite measure includes the following four items: 1) My child's care team works with me and my child so we can better manage my child's physical health. 2) My child's care team works with me and my child so we can better manage my child's mental health. 3) My child's care team works with me and my child so that my child is better able to participate in activities

my child enjoys with friends or family. 4) My child's care team works with me and my child, so I am better able to take care of my child where we live. The Adult LTSS Healthy Living in the Community composite measure includes the following four items: 1) My care team works with me so I am better able to manage my physical health. 2) My care team works with me, so I am better able to manage my mental health. 3) My care team works with me, so I am better able to participate in activities I enjoy with friends or family. 4) My care team works with me, so I am better able to take care of myself where I live.

^c The Child LTSS Overall Provider Rating composite measure includes the following item: Using any number from 0 to 10, where 0 is the worst LTSS possible and 10 is the best LTSS possible, what number would you use to rate your child's LTSS in the last 12 months? The Adult LTSS Overall Provider Rating composite measure includes the following item: Using any number from 0 to 10, where 0 is the worst LTSS possible and 10 is the best LTSS possible, what number would you use to rate your LTSS in the last 12 months?

^d The Child LTSS Willingness to Recommend composite measure includes the following item: Would you recommend your child's LTSS provider(s) to your family and friends if they needed similar LTSS? The Adult LTSS Willingness to Recommend composite measure includes the following item: Would you recommend your LTSS provider(s) to your family and friends if they needed similar LTSS?

Legend

Higher is better legend:	Difference: <-5	Difference: -5 to <-2.5	Difference: -2.5 to 2.5	Difference: >2.5 to 5	Difference: >5
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Table 3.3-40 presents stratified YoY results for the LTSS MES for both child and adult members. Among children, significant differences by language were observed for Overall Provider Rating, with children of other/unknown language experiencing a significantly greater increase compared to English-speaking children. There were no other significant differences among children surveyed for the LTSS MES.

Among adults, several significant differences were observed. Compared to non-Hispanic adults, Hispanic adults experienced a significantly greater improvement in Overall Provider Rating. By race, adults of unknown race had significantly greater improvement in Willingness to Recommend compared to White adults. By sex, female adults experienced significantly greater declines than male adults in Communication and Willingness to Recommend. Significant differences by age were also identified: compared to adults ages 18-29, adults ages 30-44 had a significantly greater increase in Willingness to Recommend but a greater decline in Overall Provider Rating; adults ages 45-59 experienced significantly greater declines in Overall Provider Rating but greater improvements in Willingness to Recommend; and adults ages 60 and older had significantly greater improvement in Willingness to Recommend. By language, compared to English-speaking adults, those reporting other or unknown language had significantly greater improvement in Overall Provider Rating and Willingness to Recommend, and both Spanish-speaking adults and adults reporting other or unknown language had significantly greater improvement in Healthy Living in the Community. See **Appendix C-9** and **Appendix C-10** for stratified within-year results with p-values of these composite measures.

Table 3.3-40 Stratified Results for the Communication, Healthy Living in the Community, Overall Provider Rating, and Willingness to Recommend Composite Measures from the LTSS MES (CY2022-CY2023)

	Communication		Healthy Living in the Community		Overall Provider Rating		Willingness to Recommend	
	Child YoY	Adult YoY	Child YoY	Adult YoY	Child YoY	Adult YoY	Child YoY	Adult YoY
Ethnicity								
Not Hispanic	Reference	Reference	N/A	Reference	Reference	Reference	Reference	Reference
Hispanic	N/A	-0.9	N/A	1.7	N/A	6.1*	N/A	2.0
Unknown	N/A	-1.4	N/A	4.6	N/A	-1.6***	N/A	-2.2
Race								
White	Reference	Reference	N/A	Reference	Reference	Reference	Reference	Reference
Black	N/A	0.9	N/A	-6.1	N/A	6.7	N/A	-13.2**
Other	N/A	-0.5	N/A	5.9	N/A	4.1	N/A	15.6
Unknown	N/A	0.9	N/A	-1.9	N/A	-0.4	N/A	14.0***
Sex								
Male	Reference	Reference	N/A	Reference	Reference	Reference	Reference	Reference
Female	0.7	-6.2***	N/A	-0.9	6.1	-2.4	-1.8	-7.4***
Age (Child)								
0-5	N/A	Reference	Reference	Reference	N/A	Reference	N/A	Reference
6-11	3.0	N/A	N/A	N/A	8.2	N/A	7.8	N/A
7-12	-0.6	N/A	N/A	N/A	6.0	N/A	-4.4	N/A
Age (Adult)								
18-29	Reference	Reference	NA	Reference	Reference	Reference	Reference	Reference
30-44	N/A	0.6	N/A	-1.6	N/A	-6.9*	N/A	16.2***

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	Communication		Healthy Living in the Community		Overall Provider Rating		Willingness to Recommend	
45-59	N/A	-0.9	N/A	-4.1	N/A	-5.6*	N/A	11.4*
60+	N/A	1.3	N/A	0.8	N/A	1.0	N/A	11.1*
Language								
English	Reference	Reference	NA	Reference	Reference	Reference	Reference	Reference
Spanish	4.5	2.0	N/A	5.9*	10.7	4.3**	7.0	-0.3
Other/unknown	-8.2	3.0	N/A	7.9***	13.7*	10.5***	2.0	8.4*

Data Source: MES (CY2022-CY2023)

Abbreviations: Calendar Year (CY); Long-Term Services and Supports (LTSS); Member Experience Survey (MES); Not Applicable (N/A); Year-over-Year (YoY)

Note: Stratified Child LTSS Survey results not available (N/A) for race and ethnicity due to large amounts of missing data. Healthy Living in the Community results are N/A because they were not included as part of the Child LTSS Survey instrument.

P-value: *P<0.05, **P<0.010, ***P<0.001; a p-value of <0.05 is considered statistically significant but may not reflect clinical or policy significance.

Legend

Higher is better legend:	YoY: <-5	YoY: -5 to <-2.5	YoY: -2.5 to 2.5	YoY: >2.5 to 5	YoY: >5
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3.3.9.3 Conclusions

Early findings support the research question and hypotheses that member outcomes and member experience changed favorably for ACO members. Results for **RQ2-9** suggest that experiences among ACO members improved in several areas, particularly in primary care, though challenges remain. Quantitative findings showed YoY gains in communication, provider ratings, and willingness to recommend in primary care—especially among pediatric members and Spanish-speaking members. MassHealth members responding to the Adult and Child Primary Care surveys rated their PCP higher (composite score of 78.4-89.7 for children and 84.5 for adults) compared with scores of 75 among children and 67 of adult survey respondents nationally in 2023.¹¹⁹ Adult BH survey respondents reported improvements in satisfaction and healthy living, despite declines in communication, while LTSS survey results were mixed, with more improvements in measures for adults and little change in measures for children. Qualitative findings mirrored these trends. Members valued their relationships with PCPs, care managers, and other supports, yet described ongoing frustration with administrative complexity, long wait times, and inconsistent communication. Overall, ACO participation was associated with meaningful improvements in member experience, particularly in primary care, but persistent system-level barriers and uneven gains across populations underscore the need for continued efforts to streamline processes and promote equitable improvements in care. The prevalence of severe maternal morbidity decreased for ACO enrollees between 2022-2024, suggesting a meaningful shift in clinical outcomes. However, the prevalence of neonatal intensive care utilization remained stable between 2022-2024 among ACO enrollees, suggesting that NICU utilization did not shift meaningfully during this time. Clinical outcome measures, including blood pressure and diabetes control, will be studied in the Summative Report.

3.4. Discussion

3.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

Consistent with our recommendation for the 2017-2022 IESR, MassHealth and its partners have continued to test and evaluate innovative programs and partnerships that promote the shift to accountable and integrated care. Findings from the IEIR support the overarching conclusion that incremental progress towards MassHealth's DSR goals was made in the early years of the 2022-2027 Demonstration implementation. ACOs implemented organizational changes, forming and strengthening relationships with hospitals, primary care practices, and PCPs to increase their capacity to deliver high-quality, equitable, and integrated care (**Hypotheses H2-1.1** and **H2-1.2**). ACOs and their primary care practices invested in staff and infrastructure, while implementing strategies to increase access, quality, and continuity of primary care (**Hypotheses H2-2.1** and **H2-2.2**). Findings generally indicated that access to primary care increased, while changes in care continuity require further study (**Hypothesis H2-3.1**). Findings were consistent with improved care integration in the ambulatory care setting, including through BH integration within primary care practices, though decrements in performance on follow-up after ED visit and hospitalization quality measures highlight transitions of care as an area in need of further

¹¹⁹ Centers for Medicare & Medicaid Services. (2023). *Consumer Assessment of Healthcare Providers and Systems*, U.S. Department of Health and Human Services, <https://datatools.ahrq.gov/cahps?tab=cahps-health-plan-survey-database&dash=31>

attention (**Hypothesis H2-4.1**). As discussed in [Chapter 7, Hospital Quality and Equity Initiative \(HQEI\)](#), improving performance on these follow-up measures is already a focus of MassHealth and part of performance improvement projects being implemented by participating hospitals with their partnering ACOs, though based on the timing of implementation the effects of these projects are unlikely to be observed prior to 2025. ACOs reported increased screening for HRSNs, though performance on the HRSN screening quality measure remained relatively stable from 2022-2024 (**Hypothesis H2-5.1**). ACOs and CPs responded to Enhanced Care Coordination expectations as hypothesized (**Hypotheses H2-6.1 to H2-6.3**), with mixed early signals of improvements in coordination of care and quality of care coordination supports (**Hypotheses H2-7.1 and H2-7.2**). Among both ACO and MCO/PCC enrollees, observed all-cause ED visit rates were consistent with expected values among adults, and modest improvement was observed among adults with SMI/SUD and among children, while hospital admission rates increased; hospital readmission rates declined in 2023 among adult ACO enrollees but not MCO/PCC enrollees (**Hypotheses H2-8.1 and H2-8.2**). We did not apply quasi-experimental methods for this interim report and interpretation of descriptive trends during our study period should consider the coinciding unwinding of the COVID-19 public health emergency (PHE) and the early stage of implementation of new and revised policies.

Primary Care

The primary care workforce is decreasing¹²⁰ particularly in Massachusetts, due to a number of factors including access issues, an aging PCP workforce, and a lack of new physicians entering primary care. To strengthen primary care, states, including Massachusetts, are adopting new payment approaches, particularly value-based payment arrangements.¹²¹ To this end, one of the most prominent new DSR policies during the 2022-2027 Demonstration was the Sub-Capitation Program. The Sub-Capitation Program aims to increase the flow of funds into primary care, closely align value-based care incentives between ACOs and their primary care practices, and engage practices in delivery system reform efforts. Stakeholders generally viewed this program favorably, and recognized advantages of breaking the linkage between volume and payment for routine primary care services delivered by a member's attributed primary care practice. At the time of implementation (2023), MassHealth based sub-capitation payments on a practice tax ID's historical FFS spending, which appears to have promoted buy-in from ACOs and practices by mitigating potential disruption associated with shifting from FFS reimbursement to capitated reimbursement. This transition could have been especially challenging for certain practices if MassHealth had instead chosen to shift immediately to a risk-adjusted market standard (i.e., MassHealth's decision to base each tax ID's capitation payments on their individual historical spending mitigated large abrupt changes in revenue). However, in doing so, MassHealth maintained a direct linkage between volume and payment, rather than paying based on a risk-adjusted market standard that consistently calibrates payments based on the needs of a practice's attributed population while relying less on past utilization patterns for each tax ID.

¹²⁰ Healthcare Policy Commission (2025). *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*. <https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and>

¹²¹ Center for Health Care Strategies (2026). *Advancing Medicaid Primary Care Population-Based Payment Models*. [Advancing Medicaid Primary Care Population-Based Payment Models](#). [Four Lessons for States](#)

In our 2017-2022 IESR, we recommended that MassHealth “continue to develop and update payment formulas for continuing and new initiatives that allocate funding based on the distribution of needs among organizations and the populations they serve.” Consistent with this recommendation, MassHealth has continued to develop and refine its risk adjustment formula for paying ACOs based on enrollee needs, and in 2025, MassHealth began to break the link to historical FFS utilization in its Sub-Capitation Program by paying primary care TINs based on a risk-adjusted¹²² rate, although rate-setting at the provider type level continued to rely at least in part on FFS utilization. In the rate development process, the newly implemented primary care risk adjustment model, the Primary Care Effort Model (PCEM)¹²³, defined the outcome to be predicted (a proxy for member need) based on the set of services included in Sub-Capitation Program.

Primary care practices were categorized into three clinical tiers (**Table 3.1-1**) based on requirements set by MassHealth with all tiers receiving add-on payments, and higher tiers receiving higher add-on payments. Shifts in tier attestations towards higher tiers between 2023 and 2024 suggest MassHealth’s clinical tiering system for primary care practices have successfully encouraged some practices to expand access and integration of care in order to qualify for a higher clinical tier and associated payment. Though these changes encouragingly coincided with improvements in member experience, their implications for health care utilization and outcomes require further study. Interim, largely descriptive findings, were not consistent with substantial favorable shifts in utilization in the early years of the 2022-2027 Demonstration. Interpretation of changes in utilization during our 2022-2024 study period must consider the concurrent COVID-19 PHE unwinding, which contributed to fewer enrollees with greater medical complexity on average during 2023-2024.

Variability in engagement and misalignment of incentives between ACOs and their primary care practices continues to be a relevant factor likely to affect Massachusetts’s ability to achieve DSR goals. Primary care PSAs reported less accountability for quality and cost performance than in the prior wave of the survey conducted in 2022 as part of the evaluation of MassHealth’s 2017-2022 1115 Demonstration. One in five PSAs indicated that none of their practice’s revenue was at-risk based on value criteria. This finding suggests this minority of administrators may not have been familiar with accountability criteria and financial risk sharing associated with their participation in an ACO. Importantly, the magnitude of change experienced by PSAs since the launch of the Sub-Capitation Program varied and was correlated with exposure to Medicaid as a payer, with 35% versus 17% of practices reporting at least some change for practices with greater than versus less than 20% Medicaid patients on their panels, respectively. This suggests larger incentives and multi-payer alignment initiatives may be needed to further engage practice sites that are less dependent on Medicaid as a revenue source. Although

¹²² Center for Health Care Strategies (2025). *Massachusetts’ Primary Care Sub-Capitation Model: Implementing Primary Care Population-Based Payment in Medicaid*. <https://www.chcs.org/resource/massachusetts-primary-care-sub-capitation-model-implementing-primary-care-population-based-payment-in-medicaid/>

¹²³ Center for Health Care Strategies (2026). *Developing a Primary Care-Specific Risk Adjustment Model: Lessons from MassHealth*. https://www.chcs.org/developing-a-primary-care-specific-risk-adjustment-model-lessons-from-masshealth/?utm_source=CHCS+Email+Updates&utm_campaign=cf0bd479b7-MassHealth+Blog+Post_6%2F2%2F2026&utm_medium=email&utm_term=0_-cf0bd479b7-157215525

Massachusetts was selected as one of eight states to participate in the Centers for Medicare & Medicaid Services (CMS)'s Making Care Primary population-based payment model and this model was intended to align with the Sub-Capitation Program in Massachusetts, ultimately only 13 Massachusetts practices were participating when the program was prematurely terminated nationwide by CMS as of June 2025. In addition to limited participation, CMS identified operational complexity, overlap, cost, and misalignment with other federal models, as reasons for the model's termination. These issues will need to be addressed in future multi-payer primary care capitation initiatives and highlight that alignment across payers and administrative simplicity are key considerations for Massachusetts as it continues to implement and expand these initiatives.

Enhanced Care Coordination

The second major set of DSR policies for the 2022-2027 Demonstration centered on enhancing expectations for care coordination and care management among ACO enrollees. This includes refining and clarifying baseline care coordination for all ACO enrollees, as well as additional expectations for enrollment of subsets of members assessed to be at high and rising risk in Enhanced Care Coordination (i.e., CP and ACO Care Management). We observed increases in enrollment in programs that provide enhanced care coordination from the start of the ACO contracting period (April 2023) through the end of 2024, consistent with continuation of the CP Program, continuation or development of new Care Management Programs by ACOs, and through improved risk stratification, outreach, and engagement strategies. Successful implementation of increased expectations for LTSS CPs supports the feasibility of designating such LTSS-focused CPs as care coordination homes for Medicaid enrollees with relevant needs. However, a decline in the care plan completion rate in 2023, before rebounding in 2024, may reflect some challenges associated with the transition of care planning responsibility for LTSS CPs. BH CPs met requirements for integration with newly launched CBHCs to promote better coordination between care delivery and management components of the members' care team. There was an increase in the percentage of BH CP enrollees with annual primary care visits, treatment plans completed, and the percentage of BH member survey respondents reporting their needs were adequately met. Longitudinal comparative analyses for the IESR will be critical for interrogating the extent to which these new expectations for enhanced care coordination affected outcomes, utilization, and cost for enrollees.

In our IESR for MassHealth's 2017-2022 Demonstration, we recommended that states implementing care coordination models that involve healthcare partnerships with CBOs should calibrate program design elements to promote participation and collaboration while achieving sustainability and effectiveness of partnerships. As an example, we observed that CP participation and sustainability were supported by MassHealth's initial requirement for ACOs and MCOs to partner with CPs in their service areas, and improved effectiveness was facilitated by MassHealth's decision to reduce the requirements related to the number of partnerships ACOs and CPs had to maintain in the previous Demonstration. In the 2022-2027 Demonstration, consistent with our recommendation, MassHealth continued this policy enabling preferred partnerships, and made a substantial modification to CP Program policy by requiring direct contracting between ACOs and CPs in place of CPs contracting with MassHealth. ACOs and CPs found direct contracting promoted stronger relationships but also introduced additional administrative burden on CPs and in some cases reduced referral volumes to CPs without

strong ACO relationships, to the point of jeopardizing sustainability for those CPs. Concerns of sustainability of the CP Program under the direct contracting model are now secondary, because in February 2026 MassHealth issued guidance to ACOs and MCOs that MassHealth would no longer oversee the CP Qualified Vendor List or require ACOs to contract with CPs as of June 30, 2026. However, there remains the option for ACOs and MCOs to continue to contract with organizations formerly operating as CPs for the purpose of meeting contractual requirements for care management services. As of this writing, there remains uncertainty regarding the extent to which this will occur. In our IESR for the 2017-2022 Demonstration, we found BH and LTSS CPs were successful in connecting enrollees with outpatient services, but the costs of the additional outpatient services and the CP Program were not offset by lower costs of acute and emergency services. Additional longitudinal analyses are planned for the 2022-2027 IESR to respond to our prior recommendation to evaluate the heterogeneity of CP program impacts on cost and utilization including by member characteristics and across varying levels of engagement.

Health Equity

Infused throughout MassHealth's 2022-2027 Demonstration is a focus on reducing disparities and improving health equity. ACOs responded to enhanced expectations for promoting health equity including through health quality and equity strategic planning processes, establishment of health quality and equity committees as part of ACO governance structures, partnering with hospitals to implement equity-focused PIPs, establishing and improving mechanisms to validly collect and report RELDSOGI and HRSN data for their enrollees, and to report stratified quality measure performance to guide initiatives aimed at reducing disparities. However, screening completion rates varied across ACOs and were low overall for HRSN, disability, and SOGI, with some concerns of screening fatigue from members, clinicians, and staff that ACOs sought to mitigate through integrated information systems to reduce unnecessary re-screening. Our stratified analyses of primary care member survey data among adults reflected reductions in age-related but not ethnicity-related disparities from 2022 to 2023, with mixed results for race-related disparities. Among respondents to the Child Primary Care member survey, disparities remained largely consistent year over year. Based on the timing of implementation of ACO quality improvement and disparities reduction initiatives, with most work occurring in 2024 and later after initial planning had been completed, effects are most likely to be observed in the latter part of the 2022-2027 Demonstration period.

3.4.2. Lessons Learned and Recommendations

1. **Lesson Learned:** ACOs and their primary care practices were supportive of and responded to efforts to transition from traditional volume-based primary care payment models to a primary care sub-capitation payment arrangement with some accountability for ACO cost and quality performance. A minority of practice site administrators reported no accountability for performance, and overall little to no change in accountability from prior to the launch of the Primary Care Sub-Capitation Program was reported. The practices that appeared most responsive to incentives for practice reform were those with greater representation of MassHealth members among their patient panels.
 - **Recommendation:** MassHealth should continue to refine and study the Primary Care Sub-Capitation Program and consider refinements that could increase the level and

visibility of practice accountability for its contribution to ACO cost and quality performance and explore financial and non-financial mechanisms to further engage and support practices in reform efforts across the range of practice size and exposure to MassHealth members.

2. **Lesson Learned:** Responsibility for contracting with CPs was successfully transitioned from MassHealth to the ACOs and MCOs. ACOs, MCOs, and CPs found that the direct contracting model improved coordination, though CPs expressed concerns regarding increased administrative burden and lower referral volumes than CPs had hoped for.
 - **Recommendation:** States implementing programs that seek to integrate care through one-to-many contractual relationships between healthcare and community-based organizations should carefully weigh the strengths and limitations associated with a direct-contracting model versus contracting with the state, while mandating standardization and performing oversight where appropriate.
3. **Lesson Learned:** ACOs implemented a variety of Care Management programs targeted for different purposes (e.g., transitional care, longitudinal primary care) and subgroups (e.g., those with specific clinical conditions). All ACOs implemented multiple programs, and most achieved contractually specified enrollment targets, though limited data were available to ascertain reasons for program referral and specific types of programs in which members were enrolled.
 - **Recommendation:** MassHealth should consider collecting data to enable attribution of members to specific types of ACO care management programs to support program evaluation and identification and sharing of best practices, with the potential for future establishment of mandatory evidence-based program design components.
4. **Lesson Learned:** Enhanced expectations for quality and equity promoted ACO investment in infrastructure, processes, and partnerships to support data collection, reporting, and development of disparities reduction initiatives. Within ACOs, a larger percentage of primary care practice sites reported using site-specific data to identify disparities and at more regular intervals than during the prior Demonstration period. However, most primary care practice sites were unaware of or were not engaged as part of the ACO Health Equity Strategic planning process.
 - **Recommendation:** MassHealth should continue to support ACOs with guidance and technical assistance in developing data collection, reporting, quality improvement, and disparities reduction initiatives.
 - **Recommendation:** ACOs should consider taking additional steps to involve primary care practice sites in development, refinement, and implementation of the ACO's Health Equity Strategic plan.

4. Behavioral Health

4.1. Background

Behavioral health (BH) conditions pose significant challenges for people and communities across the country. National survey data from 2022 estimated that 23% of adults aged 18 or older had a mental illness in the past year, and serious mental illness (SMI) affected 6% of adults. Additionally, the 2022 survey data estimated that 17% of people aged 12 or older had a substance use disorder (SUD) in the past year.¹²⁴ The National Alliance on Mental Illness (NAMI) Massachusetts reported that 20% of Massachusetts residents experience a mental illness in any given year.¹²⁵ The Massachusetts Department of Public Health (MA DPH) documented 2,314 opioid-related deaths in 2022, accounting for 3.7% of all deaths in Massachusetts, compared to 2,275 deaths in 2021, representing 3.6% of all deaths.¹²⁶ In Massachusetts, between federal fiscal years 2016 and 2019, emergency department (ED) visits for individuals with BH primary diagnoses were nearly twice as common among Medicaid patients as compared to commercially insured patients (11.3% vs. 6.6%).¹²⁷ Studies indicate that crisis and diversionary services are effective in reducing reliance on ED and inpatient care, improving BH outcomes, and increasing efficiency.^{128, 129}

To improve outcomes for MassHealth members with BH conditions, Massachusetts continues to implement two program components: diversionary BH services and opioid use disorder (OUD)/SUD programs; with a new SMI/serious emotional disturbance (SED) program. These program components are designed to expand access to BH services. Under the 2022–2027 1115 Demonstration, Massachusetts may now receive Federal Financial Participation (FFP) for Institution for Mental Disease (IMD) admissions if the average length of stay (ALOS) remains under 30 days. Youth Community Crisis Stabilization (YCCS) programs were added in CY2023 to divert youth with SED from inpatient admission and as step-down from inpatient treatment. **Table 4.2-1** outlines the BH components of the 2022–2027 Demonstration.

MassHealth covers diversionary BH services to divert individuals experiencing BH crises from acute inpatient hospitalization or to stabilize individuals after discharge. The majority of BH diversionary services listed in **Table 4.2-1** are under state plan authority rather than 1115 Demonstration authority.¹³⁰ They are included in **Table 4.2-1** as part of the larger service system related to access to treatment and diversion from inpatient services.

¹²⁴ Substance Abuse and Mental Health Services Administration. (2025). 2022 NSDUH main highlights. <https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-main-highlights.pdf>

¹²⁵ National Alliance on Mental Illness. (2021). *Mental Health in Massachusetts* [Fact sheet]. <https://www.nami.org/wp-content/uploads/2023/07/MassachusettsStateFactSheet.pdf>

¹²⁶ Massachusetts Department of Public Health. (2022). *Annual Massachusetts Death Reports*. <https://www.mass.gov/lists/annual-massachusetts-death-reports>

¹²⁷ Center for Health Information and Analysis. (n.d.). Emergency Department Database (EDD) reporting. <https://www.chiamass.gov/emergency-department-database-edd-reporting/>

¹²⁸ Burns, A., Vest, J. R., Menachemi, N., Mazurenko, O., Musey, P. I., Salyers, M. P., & Yeager, V. A. (2025). *Availability of behavioral health crisis care and associated changes in emergency department utilization*. *Health Services Research*, 60(2), e14368. <https://doi.org/10.1111/1475-6773.14368>

¹²⁹ Giannouchos, T. V., Ukert, B., & Andrews, C. (2022). *Association of Medicaid expansion with emergency department visits by medical urgency*. *JAMA Network Open*, 5(6), e2216913. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793351>

¹³⁰ Services provided under the Medicaid state plan definition may change pursuant to any state plan amendment. MCIs include those for youth and adults.

Under the OUD/SUD component, MassHealth members continue to have access to high-quality, evidence-based SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD. Key program activities include implementing tiered rates for MassHealth-enrolled SUD treatment providers to improve access to diversionary services while reducing reliance on ED settings.

Under the SMI/SED component, MassHealth continues to cover inpatient psychiatric care, adult and youth community crisis stabilization (ACCS, YCCS), and community-based acute treatment (CBAT) for children and adolescents. MassHealth has established a plan to ensure quality of care in psychiatric hospitals and residential settings; improve care coordination and transitions to community-based care; increase access to a full continuum of care — including crisis stabilization; and promote earlier identification and engagement in treatment. As part of the SMI/SED component, additional specialty inpatient psychiatric services were added to the rate year (RY) 2024 Psychiatric Hospital Request for Application (RFA), effective Oct. 1, 2023, to better serve children and adolescents with neurodevelopmental disorders and SED, and individuals with eating disorders. Enhanced pre-discharge planning requirements were added to the RY24 Psychiatric Hospital RFA, effective Oct. 1, 2023, for children and adolescents with neurodevelopmental disorders and individuals with eating disorders who receive specialty inpatient psychiatric services.

Table 4.2-1 Components of the Behavioral Health Policy Domains

Policy Domain	New, Revised, or Continuing 1115 Demonstration Policy	Programs Under the Domain
Diversionary Behavioral Health Services	Continuing from the 2017-2022 Demonstration and revised as of August 2022	a. Community Support Program (CSP)¹³¹ (non-24-hour facility) b. Transitional Care Unit Services (TCU) (24-hour facility for children) c. Program for Assertive Community Treatment (PACT) (non-24-hour facility) d. Partial Hospitalization Program (PHP)¹³² (non-24-hour facility) e. Psychiatric Day Treatment (PDT)⁹ (non-24-hour facility) f. Intensive Outpatient Program (IOP)⁹ (non-24-hour facility) g. Structured Outpatient Addiction Program (SOAP)⁹ (non-24-hour facility) h. Mobile Crisis Intervention (MCI)⁹ (non-24-hour facility) These services are defined in Appendix D-1.
OUD/SUD Program	Continuing from the 2017-2022 Demonstration and revised as of August 2022	a. American Society of Addiction Medicine (ASAM) Level 3.3 Clinically Managed Population-Specific High-Intensity (not currently implemented) b. ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services (24-hour Transitional Support Services)

¹³¹ Does not include specialized CSPs outlined in STC 15, HSRN; <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

¹³² Included in the Medicaid State Plan. <https://www.medicaid.gov/medicaid/spa/downloads/MA-24-0015.pdf>

		c. ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services (24-hour Residential Rehabilitation Services and 24-hour community-based family, transition-age youth, and youth SUD treatment services) d. Recovery support navigator services e. Recovery coach services f. ASAM Level 3.5 Clinical Stabilization Services g. ASAM Level 3.7 Acute Treatment Services h. ASAM Level 4 Inpatient Medically Managed Addiction Treatment⁹
SMI/SED Program	New as of August 2022	a. ACCS and YCCS¹³³ (24-hour facility) b. Acute psychiatric inpatient services delivered in facilities that qualify as IMDs c. CBAT¹³⁴ (24-hour facility) All CBAT and CCS programs provide residential diversionary services, while only a few are IMDs.

Abbreviations: Community-Based Acute Treatment (CBAT); Community Crisis Stabilization (CCS); Institution for Mental Diseases (IMDs); Opioid Use Disorder (OUD); Serious Mental Illness/Serious Emotional Disturbance (SMI/SED); Substance Use Disorder (SUD)

The BH policy domain focuses on 12 goals.¹³⁵ The evaluation research questions are based on these goals:

1. Strengthen the delivery of BH outpatient, urgent, and crisis care;
2. Increase rates of early identification, initiation, and engagement in BH treatment;
3. Increase access to community-based recovery support services to improve member health and increase rates of long-term BH recovery;
4. Improve access to high-quality, evidence-based BH treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD;
5. Increase adherence to, and retention in, treatment for members with SUDs;
5. Improve access to care for physical health conditions amongst members with BH conditions;
6. Improve care coordination to maintain continuity of care;
7. Reduce utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other services along the continuum of care services;
8. Improve the availability of crisis stabilization services;
9. Reduce time spent in EDs awaiting disposition to clinically appropriate placement;

¹³³ ACCS and YCCS will be available for children and adolescents enrolled in managed care. Moved under IMD authority in the prior demonstration (as of 8/1/22).

¹³⁴ CBAT are available for children and adolescents enrolled in managed care. Moved under IMD authority in the prior demonstration (as of 8/1/22).

¹³⁵ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Sections 6&7, <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

10. Reduce preventable readmissions to acute psychiatric hospitals, 24-hour SUD treatment services, and residential settings; and
11. Reduce overdose deaths, particularly those due to opioids.

Outside of the 2022–2027 Demonstration, in CY2023, Massachusetts implemented the Roadmap for Behavioral Health Reform (Roadmap), which simplified and expanded access to BH treatment. The Roadmap established Community Behavioral Health Centers (CBHCs), Behavioral Health Urgent Care (BHUC) clinics, and the Behavioral Health Help Line (BHHL) as a central access point for BH services. For MassHealth members who need inpatient BH treatment, Massachusetts also increased the number of inpatient beds and developed guidance to support transitions from inpatient care to community-based services. Finally, ED crisis evaluations were implemented and Mobile Crisis Intervention (MCI) teams were mandated to provide intervention solely in the community unless contracted by a hospital to provide ED crisis evaluations. Therefore, the Roadmap intersects with the SMI/SED and diversionary components of the Demonstration through CCS and MCI services. New YCCS programs under the SMI/SED component of the 2022–2027 Demonstration were included as part of the services available through CBHCs and their partners.

4.2. Study Design

Refer to [Chapter 1, Overview of Methodology](#) for detailed descriptions of both quantitative and qualitative methodology. Individuals included in the quantitative analyses described in this chapter are MassHealth Managed Care Eligible (MCE) members with 320 days of continuous enrollment in each CY, unless otherwise specified.

The BH domain of the Independent Evaluation Interim Report (IEIR) includes selected measures to address a subset of research questions and hypotheses for the first two years of the 2022–2027 Demonstration. Several research questions are addressed solely by qualitative data in this IEIR. Quantitative measures for those research questions, where applicable, will be addressed in the Independent Evaluation Summative Report (IESR). All research questions, hypotheses, and measures from the Evaluation Design Document (EDD) will be addressed in the IESR. See **Appendix A-2** for a full listing.

For quantitative analyses, annual and quarterly measures were calculated in accordance with measure specifications. Yearly performance was assessed using observed-to-expected (O:E) ratios, comparing observed outcomes to case-mix adjusted expected estimates. Baseline-period logistic regression models were estimated using CY2022 data, and the resulting coefficients were applied to subsequent years to generate expected values, thereby anchoring the adjusted trend analysis to CY2022 and enabling assessment of performance from CY2022 through CY2024. For the O:E tables presented in this chapter, color shading highlights changes in O:E ratios relative to the CY2022 baseline. Changes of $\pm 4\%$ or less are indicated with gray shading, reflecting relative stability in performance. Changes of $\pm 5\%$ to $\pm 14\%$ are shown with lighter shading (light red or light green) to indicate moderate changes in performance. Changes of $\pm 15\%$ or greater are shown with darker shading (dark red or dark green) to indicate larger changes in performance, relative to baseline.

Quarterly metrics were estimated using adjusted models based on generalized estimating equations (GEE) with a logit link, robust standard errors, and clustering at the individual level with an exchangeable correlation structure. The analysis was anchored in Q1 CY2022, with time (by quarter) modeled as a categorical variable to estimate adjusted quarterly rates (i.e., predicted probability) and assess trends over time, while accounting for within-person correlation and changes in case mix. Unadjusted time series models were used for overdoses and overdose deaths.

Covariates included in both the quarterly adjusted models and the O:E analyses were age, Diagnostic Cost Group (DxCG) risk score, Pharmacy Cost Group (RxCG) risk score, sex, housing instability (defined as three or more addresses within a year), homelessness, disability status, rurality, and comorbid conditions (SMI/SED diagnoses for SUD-related metrics and SUD diagnoses for SMI/SED-related metrics). Definitions of SMI and SED are provided in **Appendix D-2**.

For qualitative analyses, a sample of 30 mental health diversionary, CBHC, IMD, and ED providers were interviewed. Unlike the quantitative measures, the focus of provider interviews was the entire BH population rather than the specific services for MCE members. The provider interview guides and provider characteristics are shown in **Appendix D-3**.

In addition to providers, we interviewed 10 MassHealth members who were MCE-enrolled and were identified using nomination forms shared with them through their Behavioral Health Community Partners (BH CPs) (**see Appendix C-4** for the member nomination form and **Appendix C-5** for member demographic characteristics). Of the 10 interviewees, seven were adults whom we interviewed about their own BH care experiences, and three were MCE-enrolled members who were parents of pediatric MassHealth members whom we interviewed about their experiences seeking BH care for their children. All members interviewed had medical complexities, physical or developmental disabilities, SED, or co-occurring SUD and SMI. Due to these comorbidities, they received a wide range of services, with most receiving multiple medical, mental health, SUD, and social services. Members were interviewed about their experiences with the inpatient treatment and diversionary services they had used within the past year. Information from interviews with an additional 10 adult MassHealth MCE-enrolled members who had not received diversionary or IMD services are included in research question (RQ) 3-11 about access to services. The MassHealth member interview guide is shown in **Appendix D-4**.

4.2.1. Research Questions, Hypotheses, and Study Design

Table 4.2-2 outlines the RQs, hypotheses, data sources, evaluation period, and analytic methods for this chapter covered in the IEIR. Sample and population sizes are identified in the Interim Results and Conclusions section of this chapter.

Table 4.2-2. BH Research Questions, Hypotheses, and Study Design

Research Questions ^a	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ3-1 Do Demonstration diversionary services result in a reduction in ED use and length of stay (LOS)? ¹³⁶	H3-1.1 A reduction in ED use will be observed over time after the implementation of the Demonstration.	BH Provider Interviews (CY2025) MassHealth Member Interviews (CY2025)	Thematic Analysis
	H3-1.2 A reduction in ED LOS will be observed over time after the implementation of the Demonstration.		
RQ3-2 Do Demonstration diversionary services reduce the number of preventable acute psychiatric readmissions?	H3-2.1 Use of diversionary services will be associated with a small reduction in 30-day acute psychiatric readmissions ¹³⁷	Medicaid Administrative Data (CY2022–CY2024) BH Provider Interviews (CY2025) MassHealth Member Interviews (CY2025)	Descriptive Analyses Observed vs. Expected
RQ3-7 To what extent did the Demonstration impact readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate?	H3-7.1 The Demonstration's continuous coverage of OUD/SUD treatment services will result in fewer readmissions to the same or higher level of care.	Medicaid Administrative Data (CY2022–CY2024)	Descriptive Analyses Time Series
RQ3-8 To what extent did the Demonstration impact overdose deaths, particularly those due to opioids?	H3-8.1 The Demonstration's continuous coverage of OUD/SUD treatment services will reduce non-fatal overdoses and overdose deaths, particularly those due to opioids.	Medicaid Administrative Data (CY2022–CY2024) Massachusetts Death Records (CY2022–CY2024)	Descriptive Analyses
RQ3-9 To what extent did utilization of physical healthcare services for members with SUD improve due to the Demonstration focus on care coordination between physical and	H3-9.1 The Demonstration effort to improve care coordination for members with SUD with comorbidity will improve access to physical healthcare for comorbid physical and BH	Medicaid Administrative Data (CY2022–CY2024)	Descriptive Analyses Observed vs. Expected

¹³⁶ Only qualitative data is included for the IEIR. Quantitative data will be included in the IESR.¹³⁷ Commonwealth of Massachusetts. (2019, May). *Acute Inpatient Hospital Bulletin 169*. Mass.gov. <https://www.mass.gov/doc/acute-inpatient-hospital-bulletin-169-in-state-acute-hospital-30-day-readmissions-policy-0/download>

Research Questions ^a	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
BH for SUD members with comorbidity?	conditions among members with any SUD diagnosis, including OUD diagnoses.		
RQ3-11 What is the impact of the SMI/SED Demonstration on access to the full range of community-based BH services, including adult and youth CCS? ¹³⁸	H3-11.1 An increase in utilization of community-based services by MassHealth members will be observed following SMI/SED Demonstration implementation.	MassHealth Member Interviews (CY2025) BH Provider Interviews (CY2025)	Thematic Analysis
RQ3-13 What is the impact of SMI/SED Demonstration services on preventable readmissions to acute psychiatric inpatient and residential facilities?	H3-13.1 A reduction in preventable readmissions to acute psychiatric services will be observed following the implementation of Demonstration services.	Medicaid Administrative Data (CY2022–CY2024)	Descriptive Analyses Observed vs. Expected
RQ3-14 What is the impact of SMI/SED Demonstration services on continuity of care post discharge from acute psychiatric inpatient and residential facilities?	H3-14.1 Timely transitions of care from acute psychiatric inpatient services to community-based services will be observed following the implementation of the Demonstration.	MassHealth Member Interviews (CY2025) BH Providers (CY2025)	Thematic Analysis
	H3-14.2 Improved information sharing post-discharge will be observed following the Demonstration.		

Abbreviations: Behavioral Health (BH); Community Crisis Stabilization (CCS); Calendar Year (CY); Emergency Department (ED); Hypothesis (H); Opioid Use Disorder (OUD); Research Question (RQ); Serious Mental Illness/Serious Emotional Disturbance (SMI/SED); Substance Use Disorder (SUD)

^a Research Questions developed in response to STCs sections 5.1.1, 7.2.c.i.6, 7.2.c.ii, 17.6, 17.6b; <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

¹³⁸ Only qualitative data is included for the IEIR. Quantitative data will be included in the IESR.

4.2.2. *Methodological Limitations*

Refer to [Chapter 1, Overview of Methodology](#) for overarching methodological limitations. Beyond those limitations, the population for most BH domain measures in this chapter comprises only those with at least 320 days of continuous MCE enrollment in a calendar year. The MCE members included in our analysis have MassHealth as their primary insurer and represent only about 70% of the BH population enrolled in MassHealth. The exception is for the overdose measures, which include the entire MassHealth population, excluding MassHealth Limited. Quantitative and qualitative findings capture early results from the 2022–2027 Demonstration and should be interpreted with caution.

For interviews, ED and IMD providers were sampled until saturation of themes was achieved. Providers interviewed did not necessarily limit their responses to MassHealth members or even MCE-enrolled members. The Roadmap was implemented in January 2023 and interviews took place in early 2025. Thus, changes made as part of the Roadmap were still relatively new when interviews took place and behaviors in response to new policies take time to change.

During interviews with MassHealth members, it was, at times, difficult to identify which service(s) MassHealth members received. MassHealth members often reported use of multiple services at once or in short succession and sometimes had trouble distinguishing the services by name. Recall bias impacted MassHealth members' recollections of the details of past services, especially if they were utilized several months or more in the past. MassHealth members often did not know the name of a service or program they used; more often, they knew individual staff members' names. PHPs and MCI services were more likely to be named specifically by MassHealth members. Some MassHealth members interviewed were unsure if they or their child had received CCS, CBAT, BH CP, or peer specialist services.

We mitigated these difficulties by only attributing comments to a service if the MassHealth member identified it by name or provided enough detail for us to be reasonably sure what service they were referring to. We asked MassHealth members to confirm which services they received and when they received these services instead of relying on their responses to the recruitment questionnaire. In addition, we asked MassHealth members to name the city where they received a service so that the evaluation team could refer to services in the specific locations mentioned.

4.3. Interim Results and Conclusions

Member Characteristics

Characteristics of MCE members with BH conditions included in our analyses are described in **Table 4.3-3**. At the baseline period (CY2022), 65% of MCE members with BH conditions had an SMI or SED diagnosis as defined in **Appendix D-2**, while 50% members had a diagnosis of SUD, 32% had an OUD diagnosis, and about 67% of adults had both SMI and SUD diagnoses. Population characteristics changed over the years covered by this IEIR, in part because the evaluation period covered the COVID-19 Public Health Emergency (PHE) and, at the end of the PHE, the Medicaid eligibility redetermination that began in April 2023. Those members who

remained in CY2024 had greater medical complexity, as indicated by higher DxCG and RxCG scores and more comorbidities compared to CY2022. See other characteristics in **Table 4.3-3**.

Table 4.3-3 Characteristics of MassHealth MCE Members with BH Conditions (CY2022–CY2024)

Population Characteristics	MassHealth MCE Members with a BH Diagnosis					
	CY2022 (Baseline) N = 144,138		CY2023 N = 103,269		CY2024 N = 122,703	
	N	Mean %/±SD	N	Mean %/±SD	N	Mean %/±SD
Age (years)	144,138	35.6 (± 15.7)	103,269	35.9 (± 15.9)	122,703	35.9 (± 16.4)
Age <18 years	25,587	17.8%	18,410	17.8%	23,207	18.9%
Female	71,940	49.9%	51,513	49.9%	62,972	51.3%
Race						
Race Unknown	51,717	35.9%	37,820	36.6%	42,679	34.8%
White	77,765	54.0%	55,258	53.5%	64,712	52.7%
Black	13,695	9.5%	11,042	10.7%	12,449	10.1%
Hispanic	12,609	8.7%	9,032	8.7%	10,861	8.9%
Asian	2,258	1.6%	1,763	1.7%	2,004	1.6%
Multi-Racial	2,432	1.7%	1,793	1.7%	1,869	1.5%
Plan						
ACO	117,985	81.9%	89,602	86.8%	110,913	90.40%
MCO	13,600	9.4%	8,505	8.2%	7,333	6.0%
PCC	12,553	8.7%	5,162	5.0%	4,457	3.6%
Risk scores						
DxCG Score	144,138	2.9 (± 3.7)	103,269	3.2 (± 4.2)	122,703	3.6 (± 4.4)
RxCG Score	144,138	2.3 (± 3.1)	103,269	2.5 (± 3.4)	122,703	2.8 (± 3.7)
Diagnosis						
SMI	68,212	47.3%	50,153	48.6%	63,675	51.9%
SED	25,303	17.6%	18,170	17.6%	22,912	18.7%
SMI or SED	93,515	64.9%	68,323	66.2%	86,587	70.6%
SUD	72,654	50.4%	51,739	50.1%	56,261	45.9%
ODD	45,626	31.7%	32,232	31.2%	36,191	29.5%
Other characteristics						
Any Disability	41,314	28.7%	32,443	31.4%	42,215	34.4%
Homeless	10,256	7.1%	9,575	9.3%	12,564	10.2%
Unstable Housing	15,898	11.0%	14,002	13.6%	16,141	13.2%
Rural	4,238	2.9%	2,913	2.8%	3,450	2.8%

Data Source: MassHealth administrative data.

Abbreviations: Accountable Care Organization (ACO); Behavioral Health (BH); Calendar Year (CY); Diagnostic Cost Group (DxCG); Managed Care Eligible (MCE); Managed Care Organization (MCO); Opioid Use Disorder (OUD); Primary Care Clinician (PCC) Plan; Prescription Drug Cost Group (RxCG); Standard Deviation (SD); Serious Emotional Disturbance (SED); Serious Mental Illness (SMI); Substance Use Disorder (SUD)

Each year includes members who are MCE for at least 320 days that year. The DxCG and RxCG relative risk scores (RRS) are summary measures of medical morbidity with the mean set to 1 in the MassHealth MCE baseline (CY2022) population. Homelessness is coded by International Classification of Diseases (ICD) -10; Unstable housing only is coded as having at least 3 addresses within one calendar year. Child BH includes SED and SUD; Adult BH includes SMI and SUD

4.3.1. RQ3-1 Do Demonstration diversionary services result in a reduction in ED use and length of stay (LOS)?

4.3.1.1 Summary of Results

RQ3-1 examined whether MassHealth achieved its intended goals of reducing ED use and LOS through diversionary services intended to reduce the BH burden on EDs (including MCI services, adult and youth CSS, PHPs, and IOPs).

Interim findings for this research question are from qualitative data only. Overall, our sample of eight ED providers reported that they had not observed a reduction in ED use during the first three years of the 2022–2027 Demonstration. Continued levels of ED use were attributed to a lack of knowledge about available community-based diversionary services. ED providers did report a reduction in ED lengths of stay, attributing this to internal strategies within EDs and hospitals. Members reported that their experience of care in EDs was often negative due to what they described as inappropriate care and long wait times. To form more definitive conclusions, future analyses will use quantitative data to examine changes in ED use patterns.

4.3.1.2 Interim Results

H3-1.1 A reduction in ED use will be observed over time after the implementation of the Demonstration.

Evaluators interviewed eight ED BH providers: one urban, one rural, and six staff from the same large hospital group with hospitals spread across a third of the state, with the aim of understanding ED provider perspectives on ED use and LOS. Seven diversionary providers were also interviewed and were often part of large organizations that had CSP, CBHC, CBAT, CCS, BHUC, and IOP programs. Evaluators also interviewed 10 MassHealth members, including parents of pediatric members who had visited the ED for a BH crisis, to understand their experience of care.

ED providers from three hospital systems reported they had not observed a reduction in ED use after the implementation of the 2022–2027 Demonstration. The providers indicated that all three systems had seen the same or greater volume of BH-related ED visits. One ED provider from a hospital group reported, *“I do believe more people are being seen in the community, but the same number of patients pretty much exactly by hospital since 2022 to present every month... And that’s at nine different hospitals.”* (ED provider) An ED provider from another hospital system similarly reported a *“definite increase in our volume.”* (ED provider) Contributing factors mentioned by ED providers included the after-effects of isolation caused by the COVID-19 pandemic, and that some individuals chose the ED for BH crises: *“At the end of the day,*

behavioral health patients will go where they want to go. Some people want to go to the emergency room... (ED provider)

Providers of diversionary services (CBHCs, MCIs, and CCSs) interviewed by the evaluation team provided additional context, noting that limited awareness of local diversionary services likely contributed to ED use. They reported that some individuals, primary care providers (PCPs), schools, and other organizations still called 911 to transport individuals to the ED rather than calling for a mobile crisis evaluation. An MCI provider also noted that some EDs encouraged schools to send students experiencing BH crises directly to their ED. Three parents of pediatric MassHealth members echoed this experience, reporting that their children's schools often called 911 rather than MCIs. A parent reported that they preferred to call the MCI in cases of crisis, but police brought their child to the ED after being called by school staff. One parent recounted 10 ED visits in one year as a result of this practice and shared the following example to illustrate the negative impact of the school calling 911 instead of the MCI.

"He had an appointment yesterday, but we missed it because the school called 911. So, I spent seven hours in the emergency room just for him to be cleared by EMH [emergency mental health], so that was a total waste of my time, and then I lost that appointment." –
Parent of MassHealth pediatric member

These cases highlighted potential consequences of ED use rather than diversionary options where diversionary options may have been more clinically appropriate; they also illustrated the role of other systems, such as schools and law enforcement, in ED use.

Recognizing these challenges, community providers shared ways that they have promoted the use of their services as an alternative to the ED. For example, a CBHC provider reported, *"We've done a lot of training around 'if this is a mental health emergency please call your local crisis team.'"* (CBHC provider) An MCI provider that uses a police co-response model reported, *"We strongly discourage [police from] bringing them to the ED."* (MCI provider) Overall, clinicians and MassHealth members highlighted the importance of education and outreach to schools, law enforcement, and other systems to reduce BH ED use.

H3-1.2 A reduction in ED LOS will be observed over time after the implementation of the Demonstration.

Although the eight ED providers noted high volumes of patients using the ED for BH-related reasons, they described shorter stays in the ED for these patients. Not all hospitals hired crisis counselors for their ED. Some continued to contract with MCIs to provide ED crisis evaluations as allowed. One provider reported that their ED saw decreased LOS after the hospital opened a new psychiatric unit, adding that having social workers placed in the ED would help shorten stays even more: *"I do believe if we could have those [social work] services back into the ED, we could definitely decrease the length of stays and hopefully get them placed quicker."* (ED provider) Another ED provider reported that ED length of stays greatly reduced after their team brought crisis clinicians in-house: *"The biggest thing is length of stay has decreased two to three times. Before people were waiting eight to ten days, where now it's about a day and half."* (ED provider)

ED providers from a large hospital system that included a CBHC reported a “*significant decrease*” in ED length of stay for BH patients, credited to a number of process improvements. These ED providers reported that they prioritized building relationships with other providers, established a centralized bed-finding team, and used internal referrals.

“We found a way to remove somebody from the emergency department, get them immediately into substance use treatment and then leverage our internal systems to make sure that they get the mental health stabilization as a follow-up.” – an ED provider

ED providers reported that crisis clinicians in their EDs allowed assessments to occur more quickly. Clinicians who had previous experience working in MCIs were reported by ED providers to bring strong knowledge of community resources. As an ED provider reported, “*We have just done a really great job at moving a lot of patients in a short amount of time, really targeting appropriate facilities for them and building relationships with those folks.*” On the other hand, several community providers remarked on the lack of communication with EDs now that clinicians are in-house.

“So, when they had somebody in the emergency room, they called us in. But they took that part themselves, so we are not being called in anymore. And since that happened, it’s really hard to have meetings with them or get decent regular communication. And we have been trying on all different levels to just get that going, to work a little bit more seamlessly with people when they’re in the emergency room or when they’re being discharged. But it’s really, really hard.” – a CBHC provider

ED providers identified several factors that still lead to longer stays for some individuals including co-occurring medical conditions, developmental and other disabilities, insurance, age, and disruptive behaviors. For example, an ED provider reported that their inpatient unit delayed admission for patients who had required restraints in the ED. Another ED provider cited bed availability and patient choice, noting, “*Sometimes people don’t want to go where they are placed and are opting for another location.*” (ED provider)

MassHealth members’ experiences reflect these challenges. Two parents of pediatric MassHealth members who had frequent ED visits had both experienced long ED stays for their children. A parent of a MassHealth member noted, “*I think the ERs, it’s a terrible thing for the kids. The wait time is absolutely horrific to get a bed or day therapy.*” (Parent of MassHealth member) Another parent recommended having more staff on hand to do assessments, as well as more providers who can provide alternatives to the ED: “*I would like to see the emergency room and all the providers in there utilize more community services and partners...So, families don’t have to be sitting there for 27 hours.*” (Parent of MassHealth member)

4.3.1.3 Conclusions

With only qualitative data, we can make limited inferences regarding the hypothesis that a reduction in ED LOS will be observed over time after the implementation of the Demonstration. These interview findings highlight opportunities to improve communication across agencies,

including police departments and schools, to reduce ED utilization. There are also opportunities to promote and increase awareness of diversionary services by strengthening strategic outreach to communities, so that individuals and organizations are better informed about the services available within their communities.

4.3.2. RQ3-2 Do Demonstration diversionary services reduce the number of preventable acute psychiatric readmissions?

4.3.2.1 Summary of Results

RQ3-2 examined whether MassHealth achieved its intended goal of reducing the number of preventable acute psychiatric readmissions through increasing access to diversionary services including MCIs, adult and youth CCS, PHP, Structured Outpatient Addiction Program (SOAP), IOP and other diversionary programs. Key activities included the implementation of YCCS programs for children in January 2023.

Quantitative results showed that the use of diversionary services, conceptualized as step-down services, was not associated with a reduction in the number of acute psychiatric readmissions for individuals with BH diagnoses. However, only about 1% of those discharging from acute inpatient settings used diversionary services within seven days of discharge.

MassHealth members and several providers interviewed described several factors associated with readmissions, especially for children with complex conditions. Interviewees pointed to the possibility that providing a greater number of services may not increase community tenure, but rather the fit of services to MassHealth member need and ensuring the right level of care coordination might be more important for hospital diversion. Future analyses can explore these issues in more depth.

4.3.2.2 Results

H3-2.1 Use of diversionary services will be associated with a small reduction in 30-day acute psychiatric readmissions.

Diversionary service use within seven days of discharge from a psychiatric admission was not associated with 30-day readmission. For individuals with SUD, as with SMI, in the baseline model, use of diversionary services was not associated with a change in 30-day readmission. This finding warrants further exploration. See **Appendix D-5** for measure-specific member characteristics.

Table 4.3-4 presents the results for acute psychiatric inpatient admissions in each year, indicating whether they were followed by an unplanned acute psychiatric readmission within 30 days, stratified by receipt of diversionary services within seven days of discharge. The O:E results are shown for four groups of MCE-enrolled MassHealth members 6 to 64 years of age: (1) SUD and (2) SMI/SED for those who had diversionary services within seven days of discharge, and (3) SUD and (4) SMI/SED for those who did not have diversionary services within seven days of discharge. For this measure, an O:E ratio of less than one suggests improved performance.

For individuals with SUD, the adjusted rate of 30-day psychiatric readmissions during the baseline period was 1.6 per 100 discharges, with no difference observed between those who did and did not receive diversionary services. Psychiatric readmission rates were higher than expected for both SUD groups in CY2023 (O:E: 1.05 (with) and 1.07 (without)), and much higher than expected in CY2024 (O:E: 1.36 and 1.38, respectively). For both SMI/SED groups, the rate of psychiatric readmissions within 30 days of discharge was 14.7 per 100 member discharges. Readmission rates were consistent with expected levels in CY2023 (O:E = 0.96) and remained similar to CY2022 levels in CY2024 for both the diversionary and non-diversionary SMI/SED groups.

Fewer than 1% of members with SUD and SMI psychiatric admissions utilized diversionary services within seven days of discharge. Among both the SUD and SMI/SED groups, population acuity increased relative to the baseline period, as reflected in higher-than-expected values for both recipients and non-recipients of diversionary services. Although the models adjusted for changes in clinical characteristics of the MassHealth BH population over time, residual confounding may have contributed to these elevated values.

Table 4.3-4 Observed vs. Expected Ratio of 30-Day Acute Psychiatric Readmissions Among MCE Members with an SUD/ODU or SMI/SED Diagnosis (CY2022–CY2024)

Inpatient Psychiatric Readmissions for SUD/ODU or SMI/SED		MassHealth MCE Members with an SUD/ODU or SMI/SED Diagnosis								
		CY2022			CY2023			CY2024		
		N*	Mean	±SE	N	Mean	±SE	N	Mean	±SE
SUD – diversionary services	Observed Value	2,933	1.6	±0.2	2,897	2.1	±0.3	3,858	2.7	±0.3
	Expected Value	2,933	1.6	±0.0	2,897	2.0	±0.0	3,858	2.0	±0.0
	O:E Ratio	1.00			1.05			1.36		
SUD – no diversionary services	Observed Value	2,933	1.6	±0.2	2,897	2.1	±0.3	3,858	2.7	±0.3
	Expected Value	2,933	1.6	±0.0	2,897	1.9	±0.0	3,858	1.9	±0.0
	O:E Ratio	1.00			1.07			1.38		
SMI/SED – diversionary services	Observed Value	9,372	14.7	±0.4	7,592	16.3	±0.4	10,017	18.1	±0.4
	Expected Value	9,372	14.7	±0.1	7,592	17.0	±0.1	10,017	18.0	±0.1
	O:E Ratio	1.00			0.96			1.01		
SMI/SED – no diversionary services	Observed Value	9,372	14.7	±0.4	7,592	16.3	±0.4	10,017	18.1	±0.4
	Expected Value	9,372	14.7	±0.1	7,592	17.0	±0.1	10,017	18.0	±0.1
	O:E Ratio	1.00			0.96			1.00		

Data Source: MassHealth administrative data.

Abbreviations: Calendar Year (CY); Managed Care Eligible (MCE); Observed-to-Expected (O:E); Opioid Use Disorder (ODU); Standard Error (SE); Serious Emotional Disturbance (SED); Serious Mental Illness (SMI); Substance Use Disorder (SUD)

Each year includes members who are managed care enrolled for at least 320 days that year.

*Ns are the denominator for index admissions. Index admissions are not related to whether or not they had diversionary services.

Legend

Lower is better:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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In addition to quantitative analysis, qualitative interview findings provided examples of what may have contributed to youth psychiatric inpatient readmissions. Although the evaluation team had not planned to gather qualitative data on MassHealth member experiences with readmissions, a number of MassHealth members and several providers brought up the issue during interviews.

Members who spoke about these experiences were three parents of pediatric MassHealth members who had complex co-morbidities. All three parents interviewed reported that their children had multiple readmissions in the past year despite involvement with multiple state agencies. While three is a small number of interviews on which to base conclusions, and youth represent a small percent of inpatient stays overall, interviewees suggest they experienced some disconnects in services. Based on parent reports, there appeared to be confusion about which state agency had the primary responsibility for the child's case.

Parents also reported that they tried to avoid residential and inpatient stays for their children but struggled to find services that were effective in preventing crises, with schools often calling 911. As a parent of a pediatric MassHealth member noted, *"It feels like there's a lot of chefs in the kitchen, but we're not cooking anything. He's still ended up inpatient, he's still having crises."* Parents reported their children being hospitalized multiple times in the past year, with or without stays in residential treatment. *"Too many cooks in the kitchen"* was a theme that arose from both MassHealth member and provider interviews, especially for children with complex disorders. Parents reported general confusion about youth diversionary services. A CBAT provider also noted the parents' confusion: *"Families are getting overwhelmed because they have seven providers all working towards what is the same goal."*

4.3.2.3 Conclusions

The hypothesis that use of diversionary services will be associated with a small reduction in 30-day acute psychiatric readmissions was not supported by the preliminary findings. A very small number of MassHealth members in both the SUD and SMI/SED groups stepped down to diversionary services within the seven days after discharge. Provider and MassHealth member input shed some light on possible issues related to readmissions for those with the most complex presentations, particularly pediatric members. Further analyses can examine factors associated with the use of diversionary services and acute psychiatric readmissions in more depth.

4.3.3. RQ3-7 To what extent did the Demonstration impact readmissions to the same or higher level of care for SUD where the readmission is preventable or medically inappropriate?

4.3.3.1 Summary of Results

RQ3-7 examined to what extent the 2022–2027 Demonstration impacted readmissions to the same or higher level of care. Overall, findings indicate a temporary increase in adjusted 30-day probabilities of readmission during late CY2022 and early CY2023, followed by a return to near-CY2022 levels by the end of CY2024.

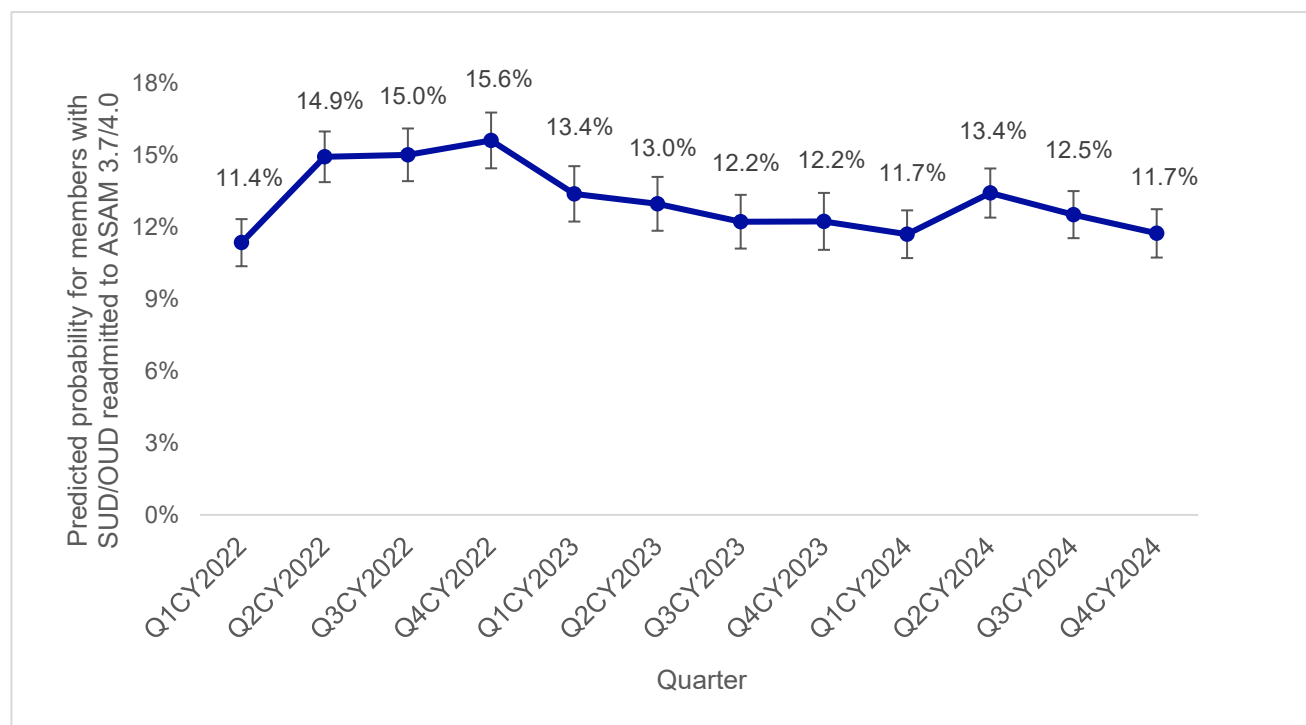
4.3.3.2 Results

H3-7.1 The Demonstration's continuous coverage of OUD/SUD treatment services resulted in fewer readmissions to the same or higher level of care.

We evaluated quarterly 30-day readmissions to the same or higher ASAM level among MCE enrollees aged 13–64 with an SUD or OUD diagnosis who had an index admission to ASAM level 3.7 or 4.0 between Q1 CY2022 and Q4 CY2024. Readmission was defined as admission to the same or higher ASAM level within 30 days of discharge. Adjusted quarterly readmission rates (predicted probabilities) were estimated, with Q1 CY2022 serving as the baseline.

Figure 4.3-1 shows that adjusted 30-day readmission probabilities increased during CY2022, peaked at the end of the year, and then declined and stabilized through CY2024. The predicted probability of readmission was 11.4% in Q1 CY2022 (95% CI: 10.4%, 12.4%) and increased to a peak of 15.6% in Q4 CY2022 (95% CI: 14.5%, 16.8%). Following this peak, adjusted probability declined, ranging from approximately 11.7% to 13.4% throughout CY2023 and CY2024. By Q4 CY2024, the adjusted probability was 11.7% (95% CI: 10.7%, 12.8%), returning to a level comparable to the baseline period. Overall, adjusted readmission probabilities increased in late CY2022 before declining and stabilizing near reference-period levels by the end of the study period, after accounting for demographic, clinical, and social risk factors.

Figure 4.3-1: Predicted Probability of MCE Members Ages 13–64 with an SUD/OUD Diagnosis Experiencing 30-day Readmission to ASAM Level 3.7 or 4.0 During the Measurement Period (CY2022–CY2024)



Data Source: MassHealth administrative data

Abbreviations: American Society of Addiction Medicine (ASAM); Calendar Year (CY); Managed Care Eligible (MCE); Opioid Use Disorder (OUD); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4); Substance Use Disorder (SUD)

4.3.3.3 Conclusions

Adjusted 30-day probabilities of readmission to ASAM level 3.7 or 4.0 increased during late CY2022 and early CY2023 but subsequently declined and stabilized, returning to near-CY2022 levels by the end of CY2024. The interim findings do not support the hypothesis that the Demonstration's continuous coverage of OUD/SUD treatment services will result in fewer readmissions to the same or higher level of care. After accounting for demographic, clinical, and social risk factors, findings indicate no downward trend in SUD/OD readmissions over the study period. However, members with frequent admissions may be inflating readmission rates. Future analyses for the IESR will examine members with frequent SUD/OD readmissions in more depth.

4.3.4. RQ3-8 *To what extent did the Demonstration impact overdose deaths, particularly those due to opioids?*

4.3.4.1 Summary of Results

RQ3-8 examined whether MassHealth's program achieved its intended goals of reducing overdose deaths. Key program activities included establishing CBHCs, which increased access to urgent and routine SUD services, and implementing tiered rates for SUD treatment providers, which incentivized treatment facilities to accept MassHealth members.

Results showed that the rate of non-fatal overdoses and overdose deaths, including those involving opioids, decreased since the beginning of the 2022–2027 Demonstration. Statewide data showed that the rate of fatal opioid overdose in the overall Massachusetts population also decreased, aligning more closely with the national average. Overall, findings indicated favorable progress toward the reduction of fatal and non-fatal overdoses.

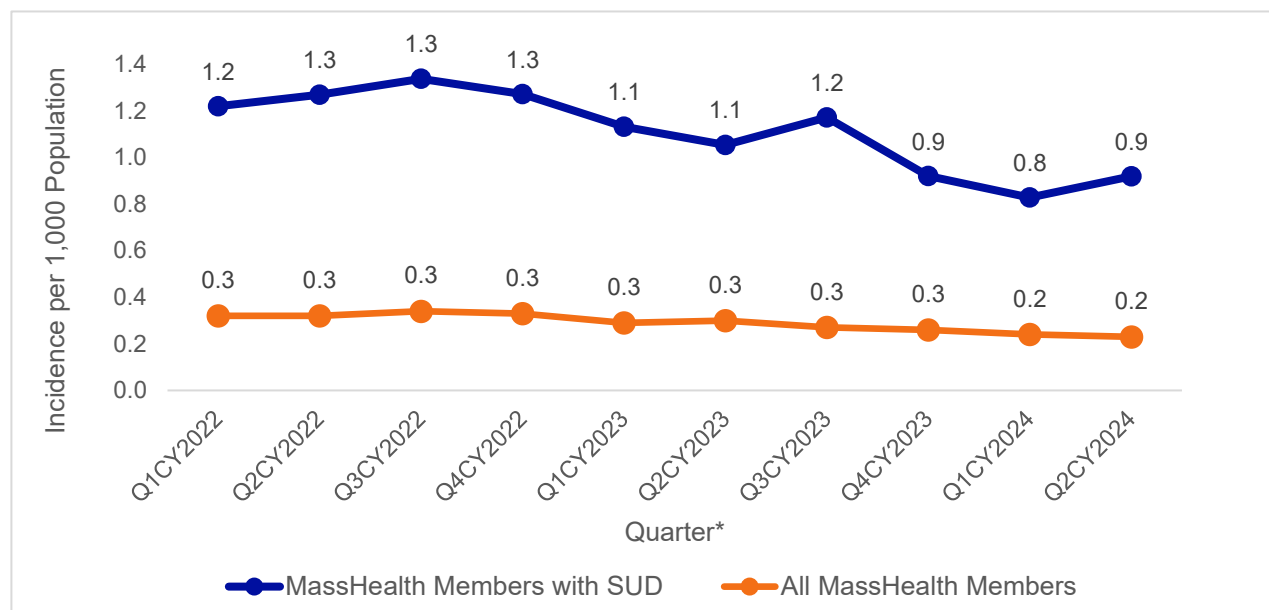
4.3.4.2 Results

H3-8.1 The Demonstration's continuous coverage of OUD/SUD treatment services reduced non-fatal overdoses and overdose deaths, particularly those due to opioids.

Between Q1 CY2022 and Q2 CY2024 the overdose death rate decreased among MassHealth members with SUDs and with all MassHealth members, as shown in **Figure 4.3-2**. There was a negligible difference (<1%) between opioid and overall overdose deaths.

This decrease aligns with national trends. According to the Centers for Disease Control and Prevention's Wide-ranging Online Data for Epidemiologic Research (WONDER) online database, the rate of fatal opioid overdoses in the 49 other states decreased by 32% (from 25.8 per 100,000 persons in CY2022 to 17.6 per 100,000 in CY2024) compared to a decrease of 43% in Massachusetts (from 33.7 per 100,000 in CY2022 to 19.1 per 100,000 in CY2024).¹³⁹

¹³⁹ Centers for Disease Control and Prevention. (2026). Provisional Mortality Statistics, 2018 through 2024. *CDC WONDER Online Database*. Retrieved February 24, 2026 from <https://wonder.cdc.gov/>

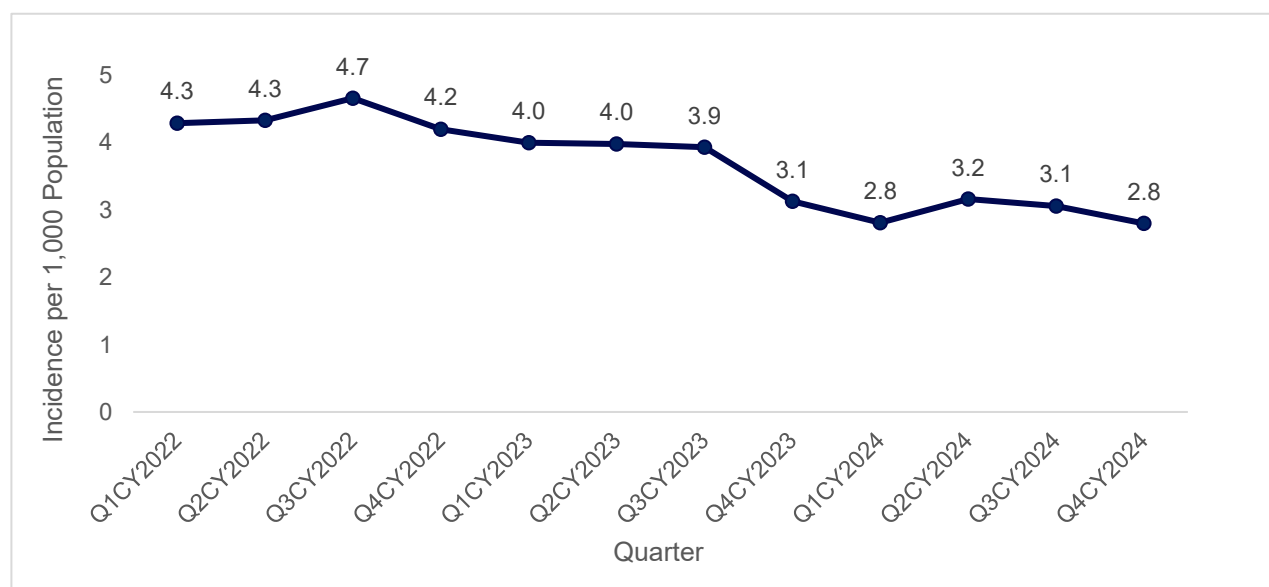
Figure 4.3-2 Rate of Overdose Deaths per 1,000 MassHealth Members, by Quarter (CY2022–CY2024)*

Data source: MassHealth administrative data and Massachusetts death records for all MassHealth members

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4); Substance Use Disorder (SUD)

*Data for Q3 and Q4 CY2024 were not shown as they were incomplete.

As shown in **Figure 4.3-3**, the trend in rates of non-fatal overdoses per 1,000 members also decreased from Q1 CY2022 to Q4 CY2024, following the trend for fatal overdoses.

Figure 4.3-3 Rate of Non-fatal Overdoses per 1,000 MassHealth Members by Quarter (CY2022–CY2024)*

Data source: MassHealth administrative data

Abbreviations: Calendar Year (CY); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

*The rate of non-fatal overdoses per 1,000 MassHealth Members includes all MassHealth members, not just MCE members

4.3.4.3 Conclusions

In line with other states across the nation, the rate of fatal and non-fatal overdoses among MCE-enrolled members decreased between CY2022 and CY2024. There are several possible reasons for the decline: the decreased strength of fentanyl¹⁴⁰ and increased access to SUD treatment.¹⁴¹ The hypothesis is supported by our preliminary findings. Future analyses can continue to explore this positive trend and factors associated with fatal and non-fatal overdoses.

4.3.5. RQ3-9 To what extent did utilization of physical healthcare services for members with SUD improve due to the Demonstration focus on care coordination between physical and BH for SUD members with comorbidity?

4.3.5.1 Summary of Results

RQ3-9 examined whether MassHealth's program achieved its intended goals of increasing utilization of physical healthcare services among members with SUD. Interventions implemented as part of the 2022–2027 Demonstration included a primary care sub-capitation program that was designed to promote physical health and BH integration, and the BH CP program. See [Chapter 3, Delivery System Reform \(DSR\)](#) for more information. The analysis aimed to assess whether annual primary care visits for MassHealth members increased over the course of the 2022–2027 Demonstration and whether medical hospitalization for MassHealth members stabilized.

Overall, findings indicated that annual primary care visits increased 4% from CY2022 to CY2024. The rate of medical hospitalizations per thousand MCE-enrolled MassHealth members with SUD increased in Q4 CY2022, possibly due to the COVID-19 pandemic, then decreased in Q1 CY2023, remaining relatively stable through Q4 CY2024.

4.3.5.2 Results

H3-9.1 The Demonstration effort to improve care coordination for members with SUD with comorbidity improved access to physical healthcare for comorbid physical and BH conditions among members with any SUD diagnosis, including OUD diagnoses.

Table 4.3-5 presents results for the Annual Primary Care Visit measure, which assesses the percentage of members aged 18–64 with an SUD diagnosis who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner in each calendar year. A higher measure value (mean) suggests more desirable performance.

In CY2022, 30% of members with an SUD diagnosis had an annual primary care visit. Rates remained consistent with the baseline period in CY2023 (O:E = 1.01) and were slightly higher than expected in CY2024 (O:E = 1.04). See **Appendix D-5** for measure-specific member

¹⁴⁰ Vangelov K, Humphreys K, Caulkins JP, Pollack H, Pardo B, Reuter P. Did the illicit fentanyl trade experience a supply shock? *Science*. 2026 Jan 8;391(6781):134-136. doi: 10.1126/science.aea6130. Epub 2026 Jan 8. PMID: 41505547. <https://pubmed.ncbi.nlm.nih.gov/41505547/>

¹⁴¹ Massachusetts Department of Public Health. (2023, December 13). *Massachusetts public health officials release latest opioid-related overdose reports* [Press Release]. <https://www.mass.gov/news/massachusetts-public-health-officials-release-latest-opioid-related-overdose-reports>

characteristics. See [Chapter 3, DSR - Table 3.3-30](#) for further discussion of primary care annual visits.

Table 4.3-5: Observed vs. Expected Ratio of Annual Primary Care Visits Among MassHealth MCE Members with an SUD Diagnosis (CY2022–CY2024)

Annual Primary Care Visit (yearly prevalence per member)	MassHealth MCE Members with an SUD Diagnosis					
	CY2022		CY2023		CY2024	
	N	Mean	N	Mean	N	Mean
Observed Value	69,841	30.0%	47,517	30.6%	53,086	32.8%
Expected Value	69,841	30.0%	47,517	30.4%	53,086	31.6%
O:E Ratio	1.00		1.01		1.04	

Data Source: MassHealth administrative data.

Abbreviations: Calendar Year (CY); Managed Care Eligible (MCE); Observed-to-Expected (O:E); Substance Use Disorder (SUD)

Each year includes members who are managed care eligible for at least 320 days that year.

Legend

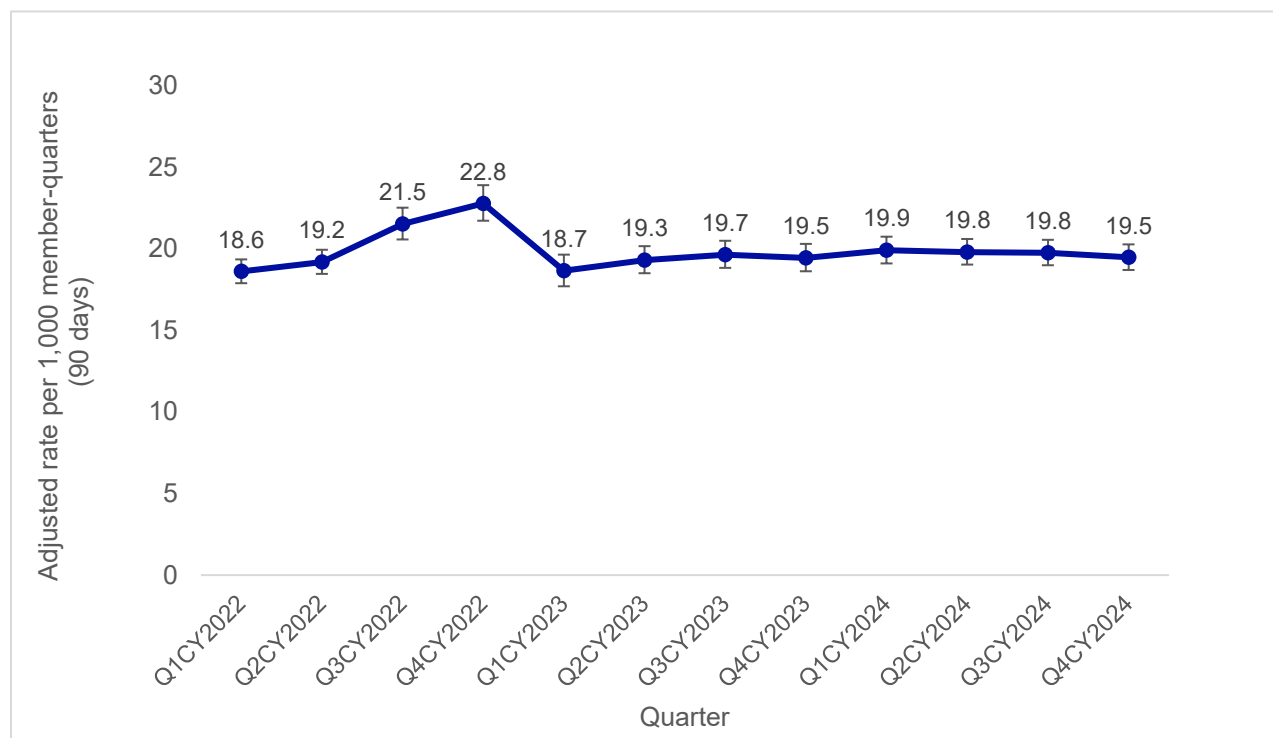
Higher is better:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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To examine trends in hospitalization rates, we analyzed quarterly rather than annual data. Annual aggregation would obscure important within-year variation and introduce bias, particularly given the improvement in rates beginning in Q1 CY2023. Using the CY2022 annual average as the baseline period would overstate the initial hospitalization rate and inherently suggest a decline in later years. By using Q1 CY2022 as the baseline period and analyzing quarterly trends, we avoid this inflationary effect and provide a more accurate representation of temporal changes in hospitalization rates.

Figure 4.3-4 shows the adjusted rate of medical hospitalizations per 1,000 MCE member quarters for individuals with SUD between CY2022 and CY2024. As shown, medical hospitalizations increased through Q4 CY2022, during the COVID-19 PHE, peaking at almost 23 per 1,000 member quarters, then decreased to baseline in Q1 CY2023. The trend for medical hospitalizations increased slightly through Q1 CY2024 but remained relatively stable. The data showed that the rate of medical hospitalization for MassHealth members with SUD remained relatively stable over time, though slightly higher than the baseline period, Q1 CY2022. These findings are consistent with other data on individuals with hospitalization rates for individuals with SUD.¹⁴²

¹⁴² Bernstein EY, Calcaterra SL, Chopra V, Edelman EJ, Kruse GR. Prevalence of Hospitalizations Among a National Sample of U.S. Adults With Substance Use Disorders. *Ann Intern Med*. 2025 Jun;178(6):900-903. doi: 10.7326/ANNALS-24-03385. Epub 2025 Apr 1. PMID: 40163870. <https://pubmed.ncbi.nlm.nih.gov/40163870/>

Figure 4.3-4 Adjusted Rate of Medical Hospitalizations per 1,000 MassHealth MCE Members with an SUD Diagnosis, by Quarter (CY2022–CY2024)



Data source: MassHealth administrative data

Abbreviations: Calendar Year (CY); Managed Care Eligible (MCE); Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4); Substance Use Disorder (SUD)

4.3.5.3 Conclusions

Only 30% of members with SUD diagnoses received a comprehensive well-care visit with a primary care practitioner in CY2022, which indicates an access gap and potential for improvement in connecting members with SUDs to primary care. The O:E ratio for primary care visits increased four percentage points from baseline, which is a positive trend, though it still indicates an area of needed improvement in BH integration. Members with SUD often have medical co-morbidities. The rate of medical hospitalization remained stable from CY2023 to CY2024, with some fluctuations during CY2022 that may reflect effects of COVID-19. Improved integration of BH and medical care could offer potential cost savings through avoided hospitalizations. Interim findings partially support the hypothesis that the Demonstration efforts would improve access to physical healthcare for comorbid physical and BH conditions among members with any SUD diagnosis, including OUD diagnoses.

4.3.6. RQ3-11 What is the impact of the SMI/SED Demonstration on access to the full range of community-based BH services, including adult and youth CCS?

4.3.6.1 Summary of Results

RQ3-11 examined whether MassHealth achieved its intended goals of increasing access to the full range of community-based BH services. Key program activities included establishing

CBHCs, which provide routine and urgent BH outpatient services, mobile crisis services, and adult and youth CCS. Interview findings suggested that the flexibility of the CBHC model has made BH services easier to access; however, some barriers to access are still present, particularly to youth services.

4.3.6.2 Results

H3-11.1 An increase in utilization of community-based services by MassHealth members will be observed following SMI/SED Demonstration implementation.

Interim findings for this research question are from qualitative data only. Several themes arose from the data. First, CBHCs appear to have improved access to both urgent care and diversionary services. However, waitlists persist for routine services for members that are not urgently in need. MassHealth members we interviewed reported receiving high quality of treatment amid access challenges. Youth face unique barriers to coordinated care and access to diversionary services. Navigating the BH system can be confusing for members and parents of members. Finally, diversionary providers identified that practices within EDs have adversely impacted referrals to CCS programs.

Easier Access Through CBHCs

According to providers and MassHealth members interviewed, CBHCs have increased access to both urgent BH outpatient services and diversionary services. Most diversionary and ED providers interviewed identified same-day walk-ins and flexibility in the CBHC model as increasing access to treatment. For example, a CBHC provider said, *“We’ve built it from the beginning to be very, very accessible and a true walk-in clinic.”* (CBHC Provider) In another example, an MCI provider described how they have assisted MassHealth members with crisis follow-up services. *“...Rather [than] in crisis, us saying, ‘Oh, well, we think you need a therapist,’ -- being able to say, ‘Allow me to walk you over to the urgent clinic, and we’ll get you in today.’”* (MCI provider)

Non-CBHC providers reported continued waitlists; however, one shared an example of how this challenge can be addressed. They described that to improve access to services for children and youth, they changed the way services were provided, introducing a brief individual treatment model with a step-down to group therapy. The change allowed the agency to reduce waitlists for children’s BH services.

Long Wait Times, Particularly for Routine Services

Interviewed MassHealth members reported that long waiting times for routine outpatient mental health services persist. Several members who had not used diversionary or acute psychiatric services, and thus may have had more stable symptoms, described waiting lists for BH treatment. Some attributed this to staff turnover. One said, *“it took me forever”* to find a counselor; the member described spending *“a year on a waiting list”* before finding one. Another MassHealth member reported on wait times.

“Everything’s been great, except for trying to get a psychiatrist appointment. I’ve been waiting years, it’s crazy. No matter who puts a consult in, no matter who refers it, I can’t get a psychiatrist.” – a MassHealth member who did not use diversionary or IMD services

High Quality of Treatment Amid Access Challenges

The majority of MassHealth members interviewed who had primary BH clinicians (such as a regular therapist, counselor, or psychiatrist) reported good relationships with those providers. One member described their long-time therapist as an important factor in keeping them stable.

“The counselor that I’m dealing with, I have a really good bond with her... Eighteen years ago, I would do something stupid, and end up in a hospital section, where now it’s like, okay, we’ll get through whatever it is, you know what I mean? I have that phone call away that I can get the help I need.” – a MassHealth member

Of the ten MassHealth members or parents interviewed, some MassHealth members reported positive experiences accessing mental health services, describing the process of finding a provider as “easy” or “good.” However, most members mentioned some barriers to access to mental health and supportive services including inaccessible treatment sites or hours, lack of transportation, lack of bilingual or multilingual staff, and lack of provider capabilities to address the needs of individuals with complex medical co-morbidities. For example, a parent of a MassHealth member reported a longstanding issue with therapy being mostly available during the school day.

“And we had tried a few therapy places, but then the time of the day has been kind of conflicting. It’s kind of like one o’clock or 12 o’clock or in the middle of the day. So that will mean that I will have to pull him out of school or things like that. So, it’s just been difficult to find things early in the morning, but not super early that he’s awake and alert. And also evening services, so I [called] a few places and that didn’t quite work out.” – a Parent of a pediatric MassHealth member

The evaluation team also heard that responsiveness of some MCIs was worse in the evenings than during regular business hours:

“The hard part is, as the day gets later, they have less and less people to help. So, if I was having a crisis later in the day, they wouldn’t have had someone to send to see me, and then you would go to the ER.” – a MassHealth member

Barriers to Accessing Youth Services

Providers reported that while access to diversionary services for children and youth has improved, some challenges persist. Several ED, IMD, CBHC, and IOP providers described barriers to accessing diversionary services for children and youth, including long wait times for local YCCS, CBAT and other step-down programs, and especially for the adolescent age group. Adolescents in inpatient treatment experienced longer LOSs because appropriate stepdown placements were unavailable or had long waitlists. Some providers reported that longer wait times were associated with acute psychiatric admissions when a YCCS or CBAT service could have potentially stabilized the child or youth. Several providers noted gaps in diversionary services for very young children and for those with complex conditions.

The three parents we interviewed reported encountering similar barriers. They expressed stress and frustration from spending a great deal of time and effort calling providers, responding to crises, and communicating with school and various service providers. As a parent of a MassHealth member reported, *“If you actually did all the small things first, then my child wouldn’t need residential.”* (Parent of MassHealth member) One parent of a child with SED also reported the need for support in the form of respite for themselves.

“What could be better is respite care and respite availability. As a single mom with a son with mental health disorders, I can’t just take respite, and I need it.” – a Parent of MassHealth member who is also a MassHealth member

Difficulty Navigating the BH Care System

A prominent barrier emerged in most member interviews: navigating the BH care system is often difficult and confusing. Healthcare systems are difficult to navigate, even for individuals with good health literacy and resources. Some MassHealth members interviewed by the evaluation team did not know who to ask for help navigating services. Many MassHealth members interviewed were unaware of what services were available through MassHealth and, in some cases, what services they had received, or how they could appeal service denials. Therefore, access to care was impacted. For example, despite the BHHL being operational at the time, some interviewees were unaware of the BHHL but were aware of the national 988 hotline.

“I knew to call like 988, but I never called it...So, it was very difficult, especially when I was going through the hardest time of my life, trying to make those phone calls was really, really difficult.” – a MassHealth member

Emergency Department Practices May Affect Access

Strategies to streamline ED crisis evaluations may have unintentionally added a barrier to CCS access. Several diversionary providers reported a decrease in referrals to CCS from EDs with the start of the Roadmap. They stated that since the local EDs started providing their own in-house crisis services, as supported under the Roadmap, the EDs stopped referring patients to CCSs. One YCCS was reportedly closed due to lack of referrals, a provider reported. Despite the CCS providers working to promote the program and educate ED providers, they still received few referrals from EDs.

“Where I used to get 30 referrals a month, I get maybe five...We do all kinds of things to solicit and market the service.” – a CCS provider

4.3.6.3 Conclusions

With only qualitative data from MassHealth members, their parents, and several providers, we can make limited inferences regarding the hypothesis that an increase in utilization of community-based services by MassHealth members will be observed following SMI/SED Demonstration implementation. However, interviewees described challenges to treatment access and barriers to service availability that highlight the need to promote and increase awareness of available services among both MassHealth members and providers, as individuals

cannot seek services they do not know exist. Implementation of the Roadmap was reported to increase access, although some members interviewed were unaware of all Roadmap services. Provider reports of lack of referrals from EDs support quantitative findings regarding the small number of members referred to diversionary services post- psychiatric hospitalization.

The example of a non-CBHC agency that reduced their youth waitlist by introducing a new service model illustrates a creative strategy that could be replicated by other non-CBHC BH providers. Data from future qualitative interviews can be used to examine ways that other non-CBHC providers have enhanced access to their services. Future analyses will also use quantitative data to examine changes in utilization of community-based services.

4.3.7. RQ3-13 What is the impact of SMI/SED Demonstration services on preventable readmissions to acute psychiatric inpatient and residential facilities?

4.3.7.1 Summary of Results

RQ3-13 examined whether MassHealth achieved its intended goal of reducing the number of unplanned readmissions to acute psychiatric and residential facilities through improved access to other SMI/SED services including care coordination and transitions to community-based care; increasing access to a full continuum of care including crisis stabilization; and promoting earlier identification and engagement in treatment. While similar to **RQ3-2**, which focuses on psychiatric readmissions to any facility and diversionary services, this RQ focuses on readmissions to acute psychiatric and residential facilities and includes all SMI/SED services. Preliminary results indicated that the implementation of 2022–2027 Demonstration was not associated with a reduction in the number of acute psychiatric readmissions for individuals with SMI/SED diagnoses.

4.3.7.2 Results

H3-13.1 A reduction in preventable readmissions to acute psychiatric services will be observed following the implementation of Demonstration services.

The 30-day psychiatric readmissions among MassHealth MCE members with an SMI/SED diagnosis for members 6–64 years of age measure assesses the number of acute psychiatric inpatient admissions during each calendar year that were followed by an unplanned acute psychiatric readmission to a psychiatric inpatient or residential facility for a primary diagnosis of SMI or SED within 30 days. Hospitals and residential facilities included in this measure include IMDs and other psychiatric inpatient facilities, not psychiatric admissions to other hospitals with acute psychiatric units. See **Appendix D-5** for measure-specific member characteristics.

Table 4.3-6 presents results for 30-day psychiatric inpatient and residential readmissions among MassHealth MCE members with an SMI/SED diagnosis for members 6–64 years of age. For this measure, an O:E ratio less than 1.00 suggests improved quality. For SMI/SED, the rate of psychiatric readmissions within 30 days of discharge was 8.3, 10.1, and 11.9 per 100 member discharges in CY2022, CY2023, and CY2024, respectively. Expected values for this measure were higher in CY2023 and CY2024, though increases in expected values were less than observed values. MassHealth members had readmission rates slightly higher than expected in CY2023 (O:E: 1.05) and much higher than expected in CY2024 (O:E: 1.17).

Table 4.3-6 Observed vs. Expected Ratio of 30-Day Psychiatric Readmissions to a Psychiatric Inpatient or Residential Facility Among MassHealth MCE Members with an SMI/SED Diagnosis (CY2022–CY2024)

Psychiatric Readmissions for SMI or SED	MassHealth MCE Members with an SMI/SED Diagnosis								
	CY2022			CY2023			CY2024		
	N	Mean	±SE / %	N	Mean	±SE / %	N	Mean	±SE / %
Observed Value	9,372	8.3	±0.3	7,525	10.1	±0.3	9,934	11.9	±0.3
Expected Value	9,372	8.3	±0.1	7,525	9.6	±0.1	9,934	10.1	±0.1
O:E Ratio	1.00			1.05			1.17		

Data Source: MassHealth administrative data.

Abbreviations: Calendar Year (CY); Managed Care Eligible (MCE); Observed-to-Expected (O:E); Standard Error (SE); Serious Emotional Disturbance (SED); Serious Mental Illness (SMI)

Each year includes members who are managed care eligible for at least 320 days that year. Only the three CCSs and one CBAT that are IMDs are included in this measure. Ns are for index admissions.

Legend

Lower is better:	OE: <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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4.3.7.3 Conclusions

The hypothesis that a reduction in preventable readmissions to acute psychiatric services will be observed following the implementation of Demonstration services was not supported by the preliminary findings. Further investigation into the increasing acuity of the SMI/SED population, the types of SMI/SED services people receive post discharge, and factors associated with use of those services are warranted.

4.3.8 RQ3-14 What is the impact of SMI/SED Demonstration services on continuity of care post-discharge from acute psychiatric inpatient and residential facilities?

4.3.8.1 Summary of Results

RQ3-14 examined whether MassHealth achieved its intended goal of enhancing continuity of care post discharge from psychiatric inpatient and residential facilities. To achieve this, in January 2023, MassHealth implemented new expectations for hospitals and residential settings to coordinate with CBHCs using specific workflows and data exchange processes to support smooth transitions from inpatient settings to the community. Additionally, MassHealth established new pre-discharge planning requirements for specific populations including youth with neurodevelopmental disorders, individuals diagnosed with eating disorders, and individuals experiencing homelessness or at risk of homelessness.

In qualitative interviews, providers reported positive experiences with discharges occurring within vertically integrated health systems but noted some ongoing challenges with the process of transitioning individuals from inpatient to community-based services. Community-based providers experienced more barriers with transitions from inpatient facilities and MassHealth

members described mixed experiences with transitioning from inpatient treatment to community-based services.

4.3.8.2 Results

H3-14.1 Timely transitions of care from acute psychiatric inpatient services to community-based services will be observed following the implementation of the Demonstration.

Interim findings for this research question are from qualitative data only. MassHealth's expectation that discharge planning begins within 24 hours of admission to acute psychiatric inpatient services remains in place and was not altered with the implementation of the 2022–2027 Demonstration. The IMD and diversionary service providers interviewed reported alignment with this standard. For example, a CBAT provider confirmed, *"We are looking at discharge when they come in for admission and at least having a projected discharge plan on our intake packet."* (CBAT provider)

IMD and diversionary providers who were part of vertically integrated health systems, including hospital systems and BH systems, reported that internal referrals and treatment transitions occur smoothly. As one IMD provider reported, *"I think, especially here at [Hospital] because we have partial programs and outpatient programs, it's been easy, because we're able to just step them down."* Diversionary providers generally agreed, as one shared.

"When they discharge from our CCS units, they have a step-down appointment already in place...if it's an internal [redacted practice site name] client, again, very easy to just kind of get them appointments." – a CCS provider

However, one IMD provider reported difficulties with discharging patients to stepdown programs, noting that community-based providers often hesitated to accept individuals with certain needs or histories.

"When we're trying to refer them to a stepdown...They don't want to take them because of the acuity and because of their history. And it's like, okay, but if they're stable now, at what point will you accept them?" – an IMD provider

CBAT providers reported that ensuring smooth treatment transitions for youth could be challenging. Providers interviewed by the evaluation team highlighted difficulties in coordinating timely and appropriate post-discharge services, especially when specialized or in-home services were required. One provider recommended that Children's Behavioral Health Initiative (CBHI) providers offer more weekend and evening availability to support children and youth who are ready to leave CBAT but need continuing in-home services. Another echoed that it was difficult to put specialized services such as in-home therapy or applied behavior analysis (ABA) in place before discharge, leading to multiple waitlists, further complicating transitions. A third provider noted that discharges were more complicated when youth are in the custody of Department of Children and Families (DCF) if they did not have a caregiver or residential placement, they can remain *"stuck in CBAT treatment."*

The three parents of children with SED and multiple disabilities and complex behavioral presentations interviewed generally echoed provider reports about service transitions. They described difficult experiences when their children were discharged from inpatient or residential treatment. All three parents interviewed reported that their children had left inpatient treatment without what parents described as meaningful support in place. In one case, the discharge process was described as “*frustrating*,” noting that the plan duplicated services that the family had already initiated and included a follow-up appointment in a city that was not local, despite the availability of local treatment options. In another example, the parent reported “*no services in place*” to support the service transition.

A few MassHealth members shared positive experiences transitioning from psychiatric inpatient treatment to community-based services. Consistent access to routine psychiatric treatment was reported as an important factor in staying stable after discharge. For example, one member preferred to “*stick with what I got*,” meaning, continue seeing their regular therapist and psychiatrist rather than trying new services after a psychiatric hospitalization. One year after their hospitalization, they had not been readmitted. Another member described using ongoing supports, including a therapist and a recovery coach, as post-discharge treatment after a psychiatric inpatient stay. They described their recovery coach as especially helpful for “*keeping me out of trouble*.”

H3-14.2 Improved information sharing post-discharge will be observed following the Demonstration.

In interviews, providers explained two factors that have led to effective information sharing post discharge. One was a policy around releases of information. A diversionary provider reported obtaining releases of information from individuals so they could follow up on referrals.

“We do ask all patients when they start treatment with us to sign a release of information with the hospital, and when they refer clients, we ask them to have a release of information in place so that we can follow up with them and tell them that the client actually took the referral and followed through or if they did not. We have the same situation with the schools...” – a CSP provider

Another factor reported to improve information sharing was the use of internal referrals. When patients were part of vertically integrated organizations that emphasize internal referrals, structured procedures allowed for communication to track and monitor referrals. One CCS provider shared, “*We work seamlessly in this building...we have both of our CCS units, mobile crisis interventions, and our urgent outpatient clinic. So sometimes it’s as easy as -- it’s a walk down the hall.*” (CCS provider) One IMD interviewee shared that with internal patients, “*We’re able to talk about the referral process, if they followed up, if they did attend their intake, if they were a no-show, and things like that.*” (IMD provider) The same IMD provider mentioned a lack of communication with providers when referrals were made outside their organization.

Community-based providers reported challenges with receiving referrals from inpatient providers. They expressed frustration with inpatient providers who did not communicate proactively when they referred individuals. Several CBHC interviewees mentioned that local inpatient providers often directed clients to walk into the CBHC as a discharge plan, rather than

involving the CBHC in the discharge planning process. They noted that the lack of proactive referrals from inpatient to community providers existed before the 2022–2027 Demonstration and has not improved. As one CBHC interviewee explained, *"From inpatient units...They might not even call us. They're just sending them to walk in, right? I would like for them to collaborate with us more."* (CBHC provider)

A lack of electronic health record (EHR) interoperability was identified as a challenge by a variety of diversionary, ED, and IMD providers; providers interviewed used a variety of EHR applications. Lack of interoperability was reported to cause extra work, lead to missed information, and prevent streamlined referrals and communication, as an ED provider reported.

"One barrier that I would say with CBHCs is also electronic health records not speaking to each other... [It's] probably a problem within the state in general, I don't think it's just us experiencing that..." – an ED provider

Communications with MassHealth members about service transitions were not always reported to be clear, and discharge criteria are not always well communicated. After being discharged from inpatient admission, one member shared, *"They didn't really set me up with any aftercare afterwards...They just sent me in a [sic] Uber and sent me home."* (MassHealth member) The information on service transitions reported by MassHealth members highlighted opportunities to improve post-discharge planning.

4.3.8.3 Conclusions

With only qualitative data, we can make limited inferences regarding the hypothesis that improved information sharing post-discharge will be observed following the Demonstration. Overall, interview findings provided direction for opportunities to improve discharge planning, information sharing, and continuity of care. Community-based providers reported challenges with receiving referrals from inpatient providers that could be improved by more standardized communication. Although CBHCs accept walk-ins, CBHC staff emphasized that formal referrals from inpatient and residential providers enable them to provide better treatment for patients transitioning to the community. Lack of EHR interoperability was also identified as a challenge. The problems that several members experienced (being discharged without a clear plan, or with duplicative services) could have been avoided if inpatient staff had more actively involved the MassHealth members (or their parents) in discharge planning. Future analyses will incorporate both qualitative and quantitative measures of access to behavioral health services.

4.4. Discussion

4.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

The period covered by the IEIR was extraordinary as it encompassed the COVID-19 PHE, MassHealth redetermination, ACO re-procurement, and implementation of the Roadmap. The service system was also impacted by the closure of two community hospitals owned by Steward Health Care and the sale of five others. One ACO changed hands as a result. The data show a MassHealth BH population in CY2024 with more medically complex conditions than in previous

years. The BH population represents individuals with more medical complexities than the overall MCE population based on DxCG and RxCG Scores (see [Chapter 3, DSR - Table 3.2-1](#)).

It is difficult, especially at this early stage in the evaluation, to untangle the effects of the Roadmap implementation and other system changes with the impacts of the Demonstration initiatives, particularly because YCCS is simultaneously part of the SMI/SED component of the 2022–2027 Demonstration, and part of the Roadmap implementation. In addition, most diversionary services are provided under the state plan, and access to BH services is also addressed through primary care sub-capitation as part of the ACO program.

Behavior change can take many years, both on the part of BH providers and for primary and specialty care providers, social services providers and the education sector. Intensive marketing to schools and other providers was implemented for the Roadmap's BHHL, though it is unclear how much of that marketing about the availability of community-based MCI services reached school personnel. It is possible that school personnel may have been in the habit of calling 911, because that is what they did in the past. The BHHL was not reported to be utilized by inpatient and ED providers interviewed when searching for discharge options. In addition, MassHealth members interviewed by the evaluation team were unaware of many available services, including services at CBHCs, BH CPs, available transportation services, language-specific services, and other options and requirements for intensive care coordination services, or how to report concerns about the quality of services. ED providers interviewed for the IEIR reported that BH patient volumes had not noticeably lowered since 2022, which is in alignment with ED utilization patterns this team has reported for 1115 SUD/SMI Monitoring.¹⁴³ More information is needed to draw conclusions about the reason for reportedly high ED volumes remaining during our study period. Increases in accessibility of outpatient and diversionary services may take time to impact provider and member behavior and thus ED and inpatient utilization. The IESR will examine any offsets in outpatient, ED, and inpatient utilization. In addition, we will examine the total cost of care (TCOC) trends over time.

Based on the first round of interviews, we conclude that MassHealth members, schools, and ED and inpatient providers need awareness of available services to ensure that members are connected to the right services in order to avoid preventable hospitalizations. The three parents interviewed discussed concerns about lack of care coordination and access to the appropriate services for their children with complex conditions. These concerns align with other evaluations this team has conducted, including the MCPAP for ASD-ID evaluation¹⁴⁴ and the BH Roadmap evaluation.¹⁴⁵ In addition, a number of adult members mentioned searching for services on their own. Additional efforts to raise public awareness about available services through widespread dissemination of accessible materials could help improve MassHealth member access to BH services, such as the BHHL, CBHCs, BHUC, IOPs, PHPs, MCIs, and CCSs. Marketing of services for providers, including PCPs, schools, EDs, hospitals, and private therapists, could increase accessibility of BH diversionary and community-based services.

¹⁴³ ForHealth Consulting at UMass Chan Medical School. (2025). *Massachusetts Medicaid 1115 Demonstration Waiver Mid-Point Assessment Report* [Report submitted for publication].

¹⁴⁴ Frazier, J. Massachusetts Child and Adolescent Psychiatry Access Program (MCPAP): ASD/Intellectual and Developmental Disabilities (ASDID) (2024). *Journal of the American Academy of Child & Adolescent Psychiatry*, 63S125. [https://www.jaacap.org/article/S0890-8567\(24\)00876-1/fulltext](https://www.jaacap.org/article/S0890-8567(24)00876-1/fulltext)

¹⁴⁵ Year 3 Rapid Cycle Evaluation Report for the BH Roadmap/CBHCs

Fatal and non-fatal overdose rates declined, in line with national trends.¹⁴⁶ Massachusetts has introduced a number of initiatives to reduce overdose deaths which are not part of the 2022–2027 Demonstration including the Massachusetts Harm Reduction Commission,¹⁴⁷ Community Naloxone Purchasing Program,¹⁴⁸ and DPH distribution of fentanyl testing kits, among other initiatives included in the State Opioid Overdose Strategy.¹⁴⁹

Individuals with SUD are at increased risk for physical health complications. Therefore, it is important to ensure that members with SUD have access to physical health care services. On the positive side, primary care visits by members with SUD increased slightly from CY2022 to CY2024. We will continue to evaluate this trend. Initial analysis of medical hospitalizations for members with SUD diagnoses were in line with national trends. Future analyses can examine factors associated with medical hospitalizations along with possible approaches to reducing preventable medical admissions.

Interim findings show that use of diversionary services was not positively associated with a decrease in acute psychiatric admissions. Possible reasons for this lack of association include the very small number of MassHealth members with BH diagnoses that were connected to diversionary services. Providers we interviewed reported that hospitals that are part of vertically integrated systems are able to make smoother transitions from inpatient to step-down diversionary and outpatient services. Even though only a small number of members were referred to diversionary services post-discharge, those referred to diversionary services might have had more severe BH conditions compared to others. Future analyses can examine characteristics of members referred and not referred to diversionary service post discharge from inpatient psychiatric services.

Trends that may be impacting readmission rates under the SMI/SED component of the 2022–2027 Demonstration include MassHealth redetermination, which began in CY2023, the increasing lack of affordable housing in the state, and the COVID-19 pandemic, whose effect is still being felt. These trends may have meant that those members with BH conditions who remain on MassHealth have more comorbidities and higher acuity than under the 2017–2022 Demonstration, with higher rates of medical comorbidities and for those without housing, less access to treatment. A further contributor to complications with our analyses is that CCS programs are diversionary yet are included under the SMI/SED component of the 2022–2027 Demonstration. Step-down to CCS from acute psychiatric inpatient services can be a positive connection to treatment and might be an indicator of increased access to treatment. We were not currently able to account for this nuance.

Future analyses will consider changes over the 2022–2027 Demonstration period, giving time to consider the impacts of the Roadmap implementation, numerous smaller policy changes that are taking place over time, and other changes in the service system landscape. Analyses will

¹⁴⁶ Ahmed, S., Javaid, S. S., Nasir, A., Manal, I., Saleem, K., Iqbal, N., ... & Arshad, A. (2026). Mortality Due to Opioid Overdose in the United States: Trends from a CDC WONDER Analysis (1999–2024). *Population Health Management*, 29(1), 1-10.; Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2025). Provisional drug overdose death counts.

¹⁴⁷ Harm Reduction Commission. <https://www.mass.gov/orgs/harm-reduction-commission>

¹⁴⁸ Community Naloxone Program (CNP). <https://www.mass.gov/info-details/community-naloxone-program-cnp>

¹⁴⁹ Department of Public Health. (2023, June 22). *Massachusetts opioid-related overdose deaths rose 2.5 percent in 2022*. [Press Release]. <https://www.mass.gov/news/massachusetts-opioid-related-overdose-deaths-rose-25-percent-in-2022>

examine the factors associated with members who frequently use intensive SUD and SMI/SED treatment services. Such analyses could assist in the development of efforts to engage them in ongoing treatment, possibly through more intensive care coordination efforts.

4.4.2. *Lessons Learned and Recommendations*

1. **Lesson Learned:** Based on the first round of interviews with providers, schools and PCPs are still sending members in crisis directly to EDs instead of requesting an MCI evaluation. The evaluation team heard that some MCI services are not as accessible as they could be, and the members we spoke with were not all clear on service availability. Given that MCI assessment and intervention in the community was recently increased with implementation of the Roadmap, it may take time for provider and school staff's behavior to change. We make the following recommendations on increasing awareness and understanding of available diversionary services.
 - **Recommendation:** The state should take the opportunity to make information about available services, including diversionary services, accessible and widely distributed to both providers and MassHealth members to improve continuity of care. Information on available services could be distributed through regular provider communications, e-blasts, and social media posts. The state should also continue to provide outreach to first responders, schools, PCPs, and private therapists about the availability of diversionary services as alternatives to calling 911 for transportation to EDs. Additional outreach to provider associations, trade groups and advocacy groups could be an efficient way to continue to spread the message to use diversionary services as a first option for hospital diversion.
2. **Lesson Learned:** Interim qualitative findings point to the need for more efficient care coordination for the members who touch multiple service systems. Parents of pediatric MassHealth members reported that care coordination could have been improved for their children.
 - **Recommendation:** The state should take steps to improve interagency coordination for members who are served by Department of Developmental Services (DDS), Department of Mental Health (DMH), or DCF, with one point of accountability for care coordination, in lieu of multiple care coordinators and duplicative services that may be expensive and ineffective.
3. **Lesson Learned:** The state is making progress in the reduction of non-fatal and fatal overdoses.
 - **Recommendation:** The state should continue efforts to reduce the risk of non-fatal and fatal overdoses.
4. **Lesson Learned:** While utilization of primary care visits by members with SUD has increased, medical hospitalizations for members with SUD have not decreased, pointing to a possible gap in preventative care.

- **Recommendation:** The state should continue efforts to increase access to preventative and ongoing medical care for members with SUD.
5. **Lesson Learned:** Preliminary data also suggests the need for improved communication and closed-loop referrals for individuals transitioning from ED, psychiatric inpatient, and ASAM 3.7 and 4.0 levels of care.
- **Recommendation:** The state should consider promulgating regulations for inclusion of community-based providers in pre-discharge planning. They should also encourage closed loop referrals and implement approaches to support follow-up for referrals from acute levels of care to ensure that members reach follow-up treatment post discharge.

5. Safety Net Care Pool

5.1. Background

Safety net hospitals (SNHs) hold a vital role in serving Medicaid members, low-income and uninsured individuals, and other populations facing access barriers by offering quality healthcare regardless of one's ability to pay.¹⁵⁰ Because SNHs provide care to individuals who are disproportionately underserved, SNHs operate with financial strain, which can impact quality of care.¹⁵¹ The Safety Net Care Pool (SNCP) policy domain of Massachusetts's 2022-2027 1115 Demonstration includes certain continuing programs from past Demonstrations that aim to provide uncompensated care (UC) payments to safety net providers, including SNHs, that disproportionately serve Medicaid members and low-income, uninsured individuals.¹⁵²

During the 2017-2022 Demonstration, the expenditure categories for the SNCP included the Disproportionate Share Hospital-like (DSH-like) Pool. The DSH-like pool consisted of the following components: The Delivery System Reform Incentive Payment (DSRIP) Program, Safety Net Provider Payments (SNPP) tied to DSRIP accountability, the UC Pool for charity care for uninsured and underinsured, Public Hospital Transformation and Incentive Initiatives (PHTII), and Designated State Health Program (DSHP)-Health Connector Subsidies.¹⁵³ In the 2017-2022 Demonstration, an increasing portion of SNPP payments, from 5% in Year 1 of the Demonstration to 20% in Year 5, were at risk and hospitals' payments were tied to the performance of partnering Accountable Care Organizations (ACOs). Each SNH was required to partner with at least one ACO.

In Massachusetts, the 2022-2027 Demonstration SNCP funding and data sources have been adapted to better fit the needs of the Commonwealth and to align with its current policy goals. The DSH-like Pool offsets Medicaid underpayment and UC and includes SNPP tied to ACO quality and Total Cost of Care (TCOC) performance. During this period, 20% of SNHs' SNPP is at-risk each Demonstration Year (DY). Of the 20%, 5% is tied to ACO TCOC and 15% is tied to ACO quality. This linkage is reinforced by the state's ACO risk-sharing methodology and the Commonwealth's broader quality and equity promoting agenda work to incentivize hospitals to engage in disparity reduction initiatives. Hospitals participating in the Hospital Quality and Equity Initiative (HQEI) program are expected to develop health equity initiatives within the following three domains: (1) attaining complete, beneficiary-reported demographic and health-related social needs (HRSN) data; (2) identifying and addressing disparities in access and quality outcomes; and (3) strengthening organizational capacity for health equity through collaboration with community and health system stakeholders, including ACOs. Funding for the HQEI is

¹⁵⁰ Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but Endangered*. National Academies Press (US). <https://doi.org/10.17226/9612>

¹⁵¹ Chatterjee, P., Qi, M., & Werner, R. M. (2021). Association of Medicaid Expansion with Quality in Safety-Net Hospitals. *JAMA internal medicine*, 181(5), 590–597. <https://doi.org/10.1001/jamainternmed.2020.9142>

¹⁵² Centers for Medicare & Medicaid Services. (2022, September 28). CMS Guidance, Approval Letter, Waiver Authority, Expenditure Authority, Special Terms and Conditions. Mass.gov. <https://www.mass.gov/doc/masshealth-extension-approval/download>

¹⁵³ Centers for Medicare & Medicaid Services. (2022). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Section 8, <https://www.mass.gov/doc/centers-for-medicare-medicaid-services-special-terms-conditions-august-2022/download>

dependent on hospitals' ability to meet performance requirements and benchmarks.¹⁵⁴ [See [Chapter 7, HQEI](#) for more information].

From October 2022 to December 2027, the 20 SNHs listed in **Table 5.1-1** are eligible for SNPP, including 13 existing and seven new SNHs. To be eligible for SNPP, SNHs must meet certain criteria, including a Medicaid and uninsured payer mix of at least 20% and a Commercial payer mix of less than 50%, as well as having demonstrated a Medicaid and underinsured financial shortfall as reported on the Uncompensated Care Cost and Charge Report (UCCR).¹⁵⁵

Table 5.1-1 20 SNHs Eligible for SNPP

SNHs	
Baystate Franklin Medical Center	Baystate Medical Center
Baystate Noble Hospital	Baystate Wing Hospital
Berkshire Medical Center	Boston Medical Center
Good Samaritan Medical Center	Heywood Hospital
Holyoke Medical Center	Lawrence General Hospital
Lowell General Hospital	Martha's Vineyard Hospital
Mercy Medical Center	MetroWest Medical Center
Morton Hospital	Salem Hospital (fka North Shore Medical Center)
Shriners Hospitals for Children Boston	Signature Healthcare Brockton Hospital
Southcoast Hospitals Group	Tufts Medical Center

Data Source: List provided by MassHealth

Abbreviations: formerly known as (fka); Safety Net Hospital (SNH); Safety Net Provider Payments (SNPP)

Notes: 1) See [Chapter 1](#) and Attachment N of the STCs for more information on hospital acquisitions and closures that impacted SNHs. 2) Southcoast Hospitals Group consists of the following hospitals: Charlton Hospital, St. Luke's Hospital, and Tobey Hospital

Like the previous Demonstration, there is access to the UC Pool in the 2022-2027 Demonstration. If the DSH-like funding is exhausted, participating SNHs and safety net providers will have access to the UC Pool to cover charity care costs, which can be utilized for specific low-income and uninsured members. Ultimately, the UC Pool payments are available to cover the cost of care provided to qualifying individuals who meet the provider's charity care policy.¹⁵⁶ The 2022-2027 Demonstration consists of the SNCP payment streams shown below and in **Figure 5.1-1**.^{157,158}

¹⁵⁴ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Attachment J, <https://www.mass.gov/doc/attachment-j-hospital-quality-and-equity-initiative-hqei-implementation-plan-performance-years-1-5-approved-11525/download>

¹⁵⁵ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Attachment N, <https://www.mass.gov/doc/attachment-n-safety-net-hospital-provider-payment-eligibility-and-allocation-protocol-approved-11525/download>

¹⁵⁶ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Section 11.3, <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

¹⁵⁷ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Attachment N, <https://www.mass.gov/doc/attachment-n-safety-net-hospital-provider-payment-eligibility-and-allocation-protocol-approved-11525/download>

¹⁵⁸ Amount does not include closeout payments for DSRIP (\$117.5 million), PHTII (\$4.8 million) and SNPP (\$47.4 million).

Disproportionate Share Hospital (DSH) Pool

The Health Safety Net Trust Fund Safety Net Care Payments for all acute hospitals and community health centers (\$1.22 billion);

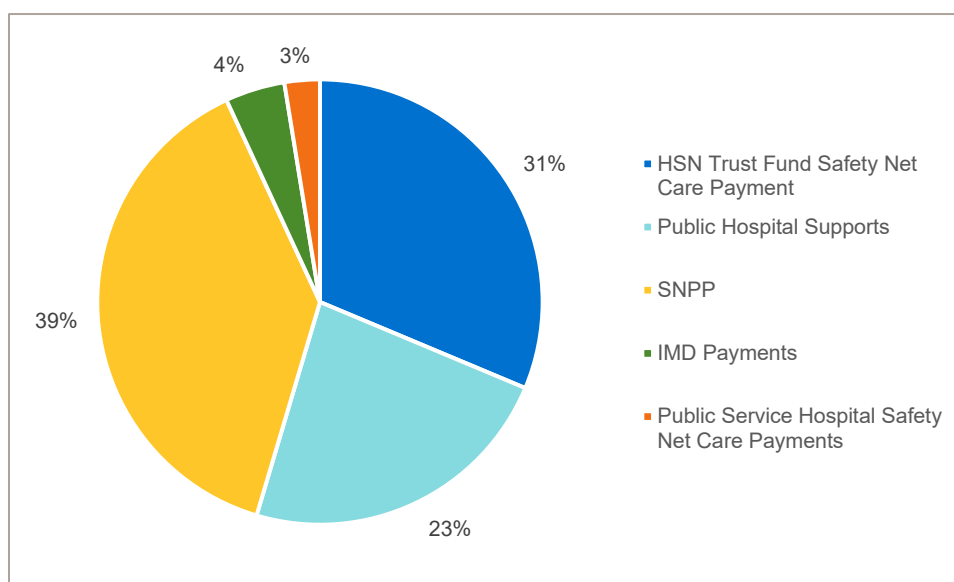
Public Hospital Supports for hospitals operated by the Department of Public Health (DPH) and the Department of Mental Health (DMH) (\$907 million);

SNPP for eligible SNHs (\$1.5 billion);

Institution for Mental Diseases (IMD) Payments for psychiatric inpatient hospitals and community-based detoxification centers (\$168.8 million); and

The Public Service Hospital Safety Net Care Payments for Boston Medical Center (\$100 million).

Figure 5.1-1 DSH Pool by SNCP Payment Stream



Data Source: STC Attachment E

Abbreviations: Disproportionate Share Hospital (DSH); Health Safety Net (HSN); Institution for Mental Diseases (IMD); Safety Net Care Pool (SNCP); Safety Net Provider Payment (SNPP)

Note: "Safety Net Provider Payments Closeout Activities" payments (\$47.4 million) were not included in this figure.

UC Pool

The Health Safety Net Trust Fund Safety Net Care Payments for all acute hospitals and community health centers (\$40 million); and

Public Hospital Supports for hospitals operated by the DPH or the DMH (\$360 million).

5.2. Study Design

Refer to [Chapter 1, Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology included in this chapter. The SNCP chapter includes preliminary analyses conducted for CY2022 (baseline) - CY2024 in the following areas: quantitative analyses on access, utilization, and behavioral health (BH) measures; qualitative analyses of key informant interviews; and descriptive analyses for the SNHs that received SNPP to examine trends in UC costs.

For the SNCP quantitative analyses, the primary study population was MassHealth Managed Care Eligible (MCE) members (i.e., those enrolled in an ACO, Managed Care Organization (MCO), or the Primary Care Clinician (PCC) Plan) with at least 320 days of MCE continuous enrollment who were served in the inpatient or outpatient setting at one of the 20 SNHs within each calendar year (CY). Each member was assigned to one SNH per CY based on where they received the most services. The unit of analysis was member level unless otherwise specified.

The changes in access, utilization and BH measures were analyzed based on the observed (i.e., unadjusted) results, expected values, and as observed to expected (O:E) ratios. We calculated O:E ratio based on member-level analysis of a specific year. For each measure, the "Observed" value equals the unadjusted quality measure result. The "Expected" value is computed from a regression model that is developed using baseline (CY2022) data to establish relationships between member characteristics (e.g., age and sex; disability; unstably housed or homeless; and medical morbidity) and the measure result, and then the model is applied to generate predicted (i.e., Expected) values for members in the denominator of the measure in each year (CY2022-CY2024). An O:E value is the ratio of "observed" to "expected" outcomes. The O:E ratios provide benchmarks for assessing performance and varies around 1.00. When higher values of a measure are desired (e.g., a higher proportion of the population screened), a ratio of observed to expected greater than 1.00 will suggest improved quality. When lower values of a measure are desired (e.g., inpatient rates), a ratio of observed to expected less than 1.00 will suggest improved quality. For the O:E tables shown in this chapter, color shading in tables are used to highlight O:E ratio changes in performance relative to baseline. O:E changes of less than or equal to +/-4% are indicated with gray shading to call attention to consistency in performance; changes of greater than or equal to +/-5% to +/-14% are indicated with lighter shading (light red or light green) to call attention to moderate change in performance; and changes of greater than or equal to +/-15% are indicated with darker shading (dark red or dark green) to call attention to larger changes in performance, relative to baseline.

For the SNCP qualitative analyses, key informant interviews were conducted with leadership and other key personnel at SNHs and also with members who self-reported as receiving services at one or more SNHs (see **Appendix C-6.4** for the hospital key informant interview guide and **Appendix B-9** for the member experience interview guide).

Organizations participating in the Demonstration (e.g., ACOs and CPs) assisted with nominating members to participate in interviews. Interested members completed a nomination form (see **Appendix C-4** for the member nomination form). See **Appendix C-5** for demographic characteristics of all key informants.

For the SNCP UC cost analyses, descriptive analyses were conducted for the SNHs that received SNPP to examine preliminary trends in UC costs and supplemental payments. The trend of inflation-adjusted changes over time was described.

5.2.1. *Research Questions, Hypotheses, and Study Design*

Table 5.2-1 outlines the research questions (RQs), hypotheses (H), data sources and evaluation period, and analytic methods for this chapter. Sample and population sizes are identified in the interim results section.

Table 5.2-1 SNCP Research Questions, Hypotheses, and Study Design

Research Questions ^a	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ4-1 What is the impact of safety net funding investments on SNHs' quality of services?	H4-1.1: The SNCP payment will result in improved care quality at SNHs.	MassHealth Administrative Data (CY2022-CY2024); Member level	Descriptive analyses (member)
RQ4-2 What were the overall experiences of members in receiving services from SNHs?	H4-2.1: Medicaid members will report better care experiences over time. ^b	MassHealth Member Interviews (CY2025); Member level	Thematic analysis (member)
RQ4-3 How effective were supplemental payments authorized through the Demonstration in supporting safety net providers?	H4-3.1: The SNCP funding will continue to maintain or improve safety net providers' capabilities to serve vulnerable individuals.	SNH Interviews (CY2024-CY2025); Hospital level	Thematic analysis (hospital)
	H4-3.2: Supplemental payments to SNHs through the DSH-like pool will reduce the total amount of UC.	UCCR (CY2017-CY2024); Hospital level	Descriptive analyses (hospital)

Abbreviations: Calendar Year (CY); Disproportionate Share Hospital (DSH); Hypothesis (H); Research Question (RQ); Safety Net Hospital (SNH); Safety Net Care Pool (SNCP); Uncompensated Care Cost and Charge Report (UCCR)

^a Research questions (RQs) developed in response to STCs sections 11.1-11.6; [1115 MassHealth Demonstration \("Waiver"\) | Mass.gov](#)

^b RQ4-2.1 language has been updated slightly to include the words 'over time'.

5.2.2. Methodological Limitations

Refer to [Chapter 1](#) for overarching methodological limitations. Beyond those limitations, there are others relevant to this chapter. Quantitative and qualitative findings capture early results from the 2022-2027 Demonstration and should be interpreted cautiously. For the qualitative analyses, the number of interviewed members receiving services in SNH settings is small; yet their comments are similar to members' perspectives on services overall (See **RQ4-2** Summary for greater detail.) Additionally, SNHs reported that SNCP was part of their general operational funding pool with no specific tracking of service impact. Therefore, it is difficult to attribute member experiences specifically to SNCP.

For the SNCP quantitative analyses, there was no comparison group as the payment was available for all SNHs. An improvement or decrement in the O:E ratio may indicate quality improvement or worsening among SNHs, but we cannot rule out the potential for bias due to confounding from changes in population characteristics over time or from other initiatives that may impact SNH performance. Comparison of the outcomes between SNHs and similar non-SNHs' patients may be conducted for the Independent Evaluation Summative Report (IESR). SNH patient's outcome analyses in the Independent Evaluation Interim Report (IEIR) included only MCE members who have MassHealth as their primary insurer. Our analysis for the IEIR was more focused on access and utilization measures than quality-of-care measures. To be

eligible for the study population, MCE members had to have one or more visits at one of the 20 SNHs within each CY. However, the access and utilization measures examined in this analysis account for services delivered at the SNHs as well as with other providers outside of the SNHs. Some data for the UC cost analyses were derived from the UCCR that were interim and not final reports. The actual dollar amounts for these SNHs at the time of our analyses may not reflect final dollar amounts. Also, the comparison of the UCs in the IEIR accounted for inflation but not changes in provider rate and patient case mix.

5.3. Interim Results and Conclusions

5.3.1. RQ4-1 What is the impact of safety net funding investments on SNHs' quality of services?

5.3.1.1 Summary of Results

RQ4-1 examined the impact of safety net funding investments on SNHs' quality of services. SNHs are intended to use SNPP for ongoing and necessary operational support, which includes workforce investments (e.g., hiring community health workers), interpreter services, and improvements to equipment. These efforts may improve member outcomes through increased access to services, improved quality of care, and increased overall satisfaction. Overall, interim findings on access, utilization and BH measures appeared to be mixed in the first few years of the 2022-2027 Demonstration, though performance improved in some areas over time. Observed performance improvement was shown for some access measures compared to their expected performance, including Annual Primary Care Visits and Child and Adolescent Well-Care Visits. All-Cause Emergency Department (ED) visits and ED visits for Individuals with Mental Illness also showed improvements in observed compared to expected performance from baseline through CY2024. Less desirable performance was seen for Primary Care Sensitive ED Visits, Follow-up After Hospitalization and Follow-up After ED Visits for Mental Illness. Adult Access to Preventive/Ambulatory Health Services and Acute Unplanned Hospital Admissions remained relatively stable over time.

5.3.1.2 Results

H4-1.1 The SNCP payment will result in improved care quality at SNHs.

Table 5.3-1 describes the population characteristics of the MCE population for the 20 SNHs over the three CYs. The SNH population was its largest in CY2022 ($N = 335,936$) with a decrease in CY2023 and a small rebound in CY2024. Population characteristics changed over the years of data included in this IEIR, in part because the evaluation period included the COVID-19 Public Health Emergency (PHE) and in part because of the Medicaid eligibility redetermination that began in April 2023 at the end of the PHE. Those members who remained in CY2024 had more medical complexities as shown by the increasing DxCG and RxCG scores, with more co-morbidities compared to CY2022. The baseline (CY2022) and Demonstration periods CY2023 and CY2024 were comprised of about 59% women in each year, with a mean age of 30 (with 32-36% below 19 years of age across years), 11-14% of members unstably housed or homeless across years, and 14-19% of members flagged as having a disability. The population had a DxCG relative risk score ranging from 1.7 to 2.1 and a RxCG relative risk score of 1.6-2.0, both of which increased over time. Approximately 85-86% of the population

were from existing SNHs, and 14-15% were from new SNHs. Other characteristics are shown in the table.

Table 5.3-1 Characteristics of MCE Members Attributed to SNHs (CY2022–CY2024)

Population Characteristics	CY2022 (Baseline) N = 335,936		CY2023 N = 223,261		CY2024 N = 251,309	
	N	Mean %/±SD	N	Mean %/±SD	N	Mean %/±SD
Age (years)	335,936	30.6 (± 18.2)	223,261	30.6 (± 18.3)	251,309	30.3 (± 18.7)
Age <19 years	110,333	32.8%	74,521	33.4%	90,423	36.0%
Female	196,887	58.6%	130,688	58.5%	148,726	59.2%
Race						
Race Unknown	149,163	44.4%	98,087	43.9%	103,276	41.1%
White	108,151	32.2%	69,306	31.0%	77,301	30.8%
Black	53,095	15.8%	41,520	18.6%	40,833	16.2%
Latino	36,884	11.0%	25,490	11.4%	25,654	10.2%
Asian	14,770	4.4%	11,186	5.0%	10,541	4.2%
Multi-Racial	4,649	1.4%	3,250	1.5%	3,057	1.2%
Plan						
ACO	290,811	86.5%	197,705	88.5%	231,509	92.1%
MCO	21,285	6.3%	12,679	5.7%	9,564	3.8%
PCC	23,840	7.1%	12,877	5.8%	10,236	4.1%
Risk Scores						
DxCG Score	335,936	1.7 (± 2.9)	223,261	1.9 (± 3.3)	251,309	2.1 (± 3.4)
RxCG Score	335,936	1.6 (± 2.7)	223,261	1.8 (± 3.0)	251,309	2.0 (± 3.1)
Other Characteristics						
New SNHs	50,418	15.0%	33,256	14.9%	34,304	13.7%
Rural	9,835	2.9%	4,432	2.0%	6,390	2.5%
Homeless	9,402	2.8%	8,526	3.8%	10,529	4.2%
Unstable Housing Only	27,279	8.1%	22,546	10.1%	24,181	9.6%
Any Disability	48,762	14.4%	38,917	17.5%	47,028	18.7%
Behavioral Health - Adult	115,982	34.5%	77,625	34.8%	91,649	36.5%
Behavioral Health - Child	48,851	14.5%	35,593	15.9%	45,041	17.9%
Opioid Use Disorder (OUD)	20,309	6.0%	14,049	6.3%	14,871	5.9%

Data Source: MassHealth administrative data

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Diagnostic Cost Group (DxCG); Managed Care Eligible (MCE); Managed Care Organization (MCO); Primary Care Clinician (PCC) Plan; Prescription Drug Cost Group (RxCG); Standard Deviation (SD); Safety Net Hospital (SNH)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year.

DxCG is diagnosis-based relative risk score of medical morbidity with values greater than 1 signifying above average comorbidity complexity.

RxCG is pharmacy drug claims-based relative risk score of medical morbidity with values greater than 1 signifying above average comorbidity complexity

Homeless is coded by International Classification of Diseases (ICD) -10; Unstable housing only is coded as having at least 3 addresses within one CY

To assess **H4-1.1**, **Tables 5.3-2 – 5.3-4** detail the "Observed" and "Expected" performance of select access and utilization measures, including select Healthcare Effectiveness Data and Information Set (HEDIS®) measures,¹⁵⁹ for the MassHealth MCE population for the 20 SNHs. See **Appendix E-1** for measure descriptions and measure-specific member characteristics.

Access to Care Measures

Table 5.3-2 presents results for select access to care measures for MCE members attributed to SNHs, where a higher measure value suggests a more desirable performance.

Annual Primary Care Visit measures the percentage of members who had at least one comprehensive well-care visit with a PCP or an Obstetrics and Gynecology (OB/GYN) practitioner in the measurement year. At baseline, 60.7% of adult members had an annual primary care visit. The percentage of members with an annual primary care visit remained consistent with baseline in CY2023 (O:E: 1.00) and in CY2024 (O:E: 1.03).

For the Adult Access to Preventive/Ambulatory Health Services HEDIS® measure¹⁶⁰, the percentage of members who had an ambulatory or preventive visit during the baseline period was 93.8%. The O:E ratios remained steady (O:E 1.00) for both CY2023 and CY2024.

The Child and Adolescent Well-Care Visit HEDIS® measure¹⁶¹ assessed the percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Approximately 72% of members had a well-care visit in the baseline year, with percentages similar to expected in CY2023 (O:E: 1.03) and higher than expected in CY2024 (O:E: 1.05), indicating improving preventive/ ambulatory service access for children and adolescents.

¹⁵⁹ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA

¹⁶⁰ HEDIS MY2023 Adult Access to Preventive/Ambulatory Health Services

¹⁶¹ HEDIS MY2023 Child and Adolescent Well-Care Visit (WCV)

Table 5.3-2 Observed vs Expected Ratios of Access to Care Measures Among MCE Members Attributed to SNHs (CY2022-CY2024)

Access to Care Measures		Managed Care Eligible (MCE) Members Attributed to SNHs					
		CY2022		CY2023		CY2024	
		N	Mean	N	Mean	N	Mean
Annual Primary Care Visit (Adults) (yearly prevalence per member)	Observed Value	225,603	60.7%	148,740	61.2%	160,886	64.4%
	Expected Value	225,603	60.7%	148,740	61.4%	160,886	62.3%
	O:E Ratio	1.00		1.00		1.03	
Adult Access to Preventive/Ambulatory Health Services (AAP) (yearly prevalence per member)	Observed Value	220,220	93.8%	144,902	94.3%	156,842	95.7%
	Expected Value	220,220	93.8%	144,902	94.4%	156,842	95.6%
	O:E Ratio	1.00		1.00		1.00	
Child and Adolescent Well-Care Visits (WCV) (ages 3-21) (yearly prevalence per member)	Observed Value	118,184	72.0%	78,099	74.7%	92,564	76.5%
	Expected Value	118,184	72.0%	78,099	72.3%	92,564	73.0%
	O:E Ratio	1.00		1.03		1.05	

Data Source: MassHealth administrative data

Abbreviations: Calendar Year (CY); Managed Care Eligible (MCE); Safety Net Hospitals (SNHs)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. Observed equals the calculated outcome for the quality measure in the specified year. Expected is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e., age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 to produce expected values for the MCE population based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure

Legend

Higher is better:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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Healthcare Utilization Measures

Table 5.3-3 presents results for hospitalization and ED measures for MCE members attributed to SNHs where performance was compared over time. For measures related to hospital admissions and ED visits, the lower the measure values, the more desirable the performance. Therefore, an O:E ratio lower than 1.00 indicates improved quality.

Overall, the Acute Unplanned Hospital Admissions rate was 17.2 admissions per 100 members per year during baseline. Rates of unplanned admissions were similar to baseline in CY2023 (O:E: 0.98) and CY2024 (O:E: 1.01). The adult population and pediatric populations followed a similar trend.

The overall All-Cause ED Visits rate was 110.8 per 100 members per year in CY2022. Compared to baseline, the ED visit rates were similar to expected in CY2023 (O:E: 0.98) but lower in CY2024 (O:E: 0.95). A similar declining pattern was seen for adults, with a lower-than-expected rate in CY2024 (O:E: 0.93); but for children, the ED rates were similar to expected in CY2023 (O:E: 1.02) and in CY2024 (O:E: 1.00) compared to baseline.

The rate of Primary Care Sensitive ED Visits was 41.2 per 100 members per year during CY2022. The rates were higher than expected in both CY2023 (O:E: 1.06) and CY2024 (O:E: 1.08). Rates for adults and children followed the same trend with children having the largest increase for both CY2023 and CY2024 (O:E: 1.09 and 1.12, respectively).

Table 5.3-3 Observed vs Expected Ratios of Inpatient Measures Among MCE Members Attributed to SNHs (CY2022-CY2024)

Acute Care Utilization		Managed Care Eligible (MCE) Members Attributed to SNHs								
		CY2022			CY2023			CY2024		
		N	Mean	±SE	N	Mean	±SE	N	Mean	±SE
Acute Unplanned Hospital Admissions (Overall) (yearly count per 100 members)	Observed Value	328,654	17.2	±0.1	219,532	19.9	±0.2	250,954	22.1	±0.2
	Expected Value	328,654	17.5	±0.1	219,532	20.3	±0.1	250,954	21.9	±0.1
	O:E Ratio	0.98			0.98			1.01		
Acute Unplanned Hospital Admissions (Adults) (yearly count per 100 members)	Observed Value	231,883	22.4	±0.2	153,015	26.3	±0.2	166,126	30.5	±0.3
	Expected Value	231,883	22.8	±0.1	153,015	26.9	±0.1	166,126	30.2	±0.2
	O:E Ratio	0.98			0.98			1.01		
Acute Unplanned Hospital Admissions (Children <19) (yearly count per 100 members)	Observed Value	96,771	4.6	±0.1	66,517	5.2	±0.1	84,828	5.6	±0.1
	Expected Value	96,771	4.7	±0.0	66,517	5.2	±0.1	84,827	5.6	±0.1
	O:E Ratio	0.98			1.00			0.99		
All-Cause ED Visits (Overall) (yearly count per 100 members)	Observed Value	335,936	110.8	±0.4	223,261	114.8	±0.5	251,309	115.6	±0.5
	Expected Value	335,936	110.9	±0.1	223,261	117.2	±0.2	251,309	121.3	±0.2
	O:E Ratio	1.00			0.98			0.95		
All-Cause ED Visits (Adults) (yearly count per 100 members)	Observed Value	225,603	119.8	±0.5	148,740	124.4	±0.7	160,886	126.4	±0.7
	Expected Value	225,603	120.0	±0.2	148,740	129.0	±0.3	160,886	135.7	±0.3
	O:E Ratio	1.00			0.96			0.93		
All-Cause ED Visits (Children <19) (yearly count per 100 members)	Observed Value	110,333	92.4	±0.4	74,521	95.8	±0.4	90,423	96.3	±0.4
	Expected Value	110,333	92.4	±0.1	74,521	94.4	±0.1	90,423	96.2	±0.1
	O:E Ratio	1.00			1.02			1.00		
Primary Care Sensitive ED Visits (Overall) (yearly count per 100 members)	Observed Value	335,936	41.2	±0.2	223,261	45.4	±0.2	251,309	47.5	±0.2
	Expected Value	335,936	41.2	±0.0	223,261	42.7	±0.1	251,309	43.9	±0.0
	O:E Ratio	1.00			1.06			1.08		

Acute Care Utilization		Managed Care Eligible (MCE) Members Attributed to SNHs								
		CY2022			CY2023			CY2024		
		N	Mean	±SE	N	Mean	±SE	N	Mean	±SE
Primary Care Sensitive ED Visits (Adults) (yearly count per 100 members)	Observed Value	225,603	42.9	±0.2	148,740	47.6	±0.3	160,886	50.0	±0.3
	Expected Value	225,603	43.0	±0.1	148,740	45.2	±0.1	160,886	47.2	±0.1
	O:E Ratio	1.00			1.05			1.06		
Primary Care Sensitive ED Visits (Children <19)	Observed Value	110,333	37.7	±0.2	74,521	41.2	±0.3	90,423	42.9	±0.2
	Expected Value	110,333	37.7	±0.0	74,521	37.9	±0.1	90,423	38.5	±0.1
	O:E Ratio	1.00			1.09			1.12		

Data Source: MassHealth administrative data

Abbreviations: Calendar Year (CY); Emergency Department (ED); Managed Care Eligible (MCE); Standard Error (SE); Safety Net Hospitals (SNHs)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. Observed equals the calculated outcome for the quality measure in the specified year. Expected is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e., age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 to produce expected values for the MCE population based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure

Legend

Lower is better:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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BH Measures

Table 5.3-4 shows results for three BH measures for MCE members attributed to SNHs between baseline and 2022-2027 Demonstration years: Follow-Up After Hospitalization for Mental Illness (7-day and 30-day); ED visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions; and Follow-Up After ED Visit for Mental Illness (7-day and 30-day). For Follow-Up After a Hospitalization and Follow-Up After an ED Visit, higher measure values indicate more desirable performance.

ED Visits for Individuals with Mental Illness, Addiction, or Co-Occurring Conditions measures the rate of ED visits for members 18-64 years of age with a diagnosis of severe mental illness (SMI) and/or substance use disorder (SUD). As with other ED visit measures, an O:E ratio lower than 1.00 suggests improved quality. The ED visit rate was 191.7 per 100 members per year in CY2022. Compared to baseline, the ED visit rates were lower than expected in CY2023 (O:E: 0.94) and even lower in CY2024 (O:E: 0.90), suggesting improved performance.

Follow-Up After Hospitalization for Mental Illness (FUH) is a HEDIS® measure¹⁶² that assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit within seven days and 30 days with a mental health provider. In CY2022, the 7-day follow-up rate for mental health hospitalizations was approximately 49.0% and the rates were lower than expected in both CY2023 (O:E: 0.93) and CY2024 (O:E: 0.84). The 30-day follow-up rate was 76.2% at baseline and also had lower than expected rates in both CY2023 (O:E: 0.95) and CY2024 (O:E: 0.88).

Follow-Up After ED Visit for Mental Illness (FUM) is a HEDIS® measure¹⁶³ that assesses the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within two time periods: seven days and 30 days. The 7-day follow-up rate for mental health ED visits at baseline was 68.3% with lower than expected in CY2023 (O:E: 0.94) and lower than expected but improving in CY2024 (O:E: 0.96). The 30-day follow-up rate for mental health ED visits at baseline increased to 73.5% at baseline and followed a similar pattern as 7-day for CY2023 and CY2024.¹⁶⁴

¹⁶² HEDIS MY2023 Follow-Up After Hospitalization for Mental Illness (FUH)

¹⁶³ HEDIS MY2023 Follow-Up After ED Visit for Mental Illness (FUM)

¹⁶⁴ As reported in the 2017-2022 IEIR, in Massachusetts, emergency service providers assess most members arriving for BH conditions on a daily basis within the ED and these visits may falsely inflate the post-discharge follow-up rates for this measure.

Table 5.3-4 Observed vs Expected Ratios of BH Measures Among MCE Members Attributed to SNHs (CY2022-CY2024)*

Access and Acute Care for BH Population		Managed Care Eligible (MCE) Attributed to SNHs								
		CY2022			CY2023			CY2024		
		N	Mean	±SE	N	Mean	±SE	N	Mean	±SE
ED Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions (Adults) (yearly count per 100 members)	Observed Value	72,509	191.7	±1.5	49,800	198.8	±1.9	55,575	199.7	±1.8
	Expected Value	72,509	191.3	±0.6	49,800	211.1	±0.8	55,575	221.4	±0.8
	O:E Ratio	1.00			0.94			0.90		
		N	Mean		N	Mean		N	Mean	
Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day (ages 6+) (yearly prevalence per member)	Observed Value	7,817	49.0%		6,301	47.6%		7,757	43.3%	
	Expected Value	7,817	49.3%		6,301	51.0%		7,757	51.7%	
	O:E Ratio	0.99			0.93			0.84		
Follow-Up After Hospitalization for Mental Illness (FUH) 30-Day (ages 6+) (yearly prevalence per member)	Observed Value	7,817	76.2%		6,301	73.9%		7,757	68.9%	
	Expected Value	7,817	76.5%		6,301	77.9%		7,757	78.4%	
	O:E Ratio	1.00			0.95			0.88		
Follow-up after ED visit for Mental Illness 7-Day (ages 6+) (yearly prevalence per member)	Observed Value	5,400	68.3%		3,718	64.6%		3,871	66.1%	
	Expected Value	5,400	69.4%		3,718	68.9%		3,871	69.1%	
	O:E Ratio	0.98			0.94			0.96		
Follow-up after ED visit for Mental Illness 30-Day (ages 6+) (yearly prevalence per member)	Observed Value	5,400	73.5%		3,718	71.3%		3,871	72.5%	
	Expected Value	5,400	74.8%		3,718	74.9%		3,871	75.2%	
	O:E Ratio	0.98			0.95			0.96		

Data Source: MassHealth administrative data

Abbreviations: Behavioral Health (BH); Calendar Year (CY); Emergency Department (ED); Managed Care Eligible (MCE); Standard Error (SE); Safety Net Hospitals (SNHs)

*Higher O:E ratio is better for Follow-up measures; Lower O:E ratio is better for ED Visit measure

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. Observed equals the calculated outcome for the quality measure in the specified year. Expected is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e., age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 to produce expected values for the MCE population based on the characteristics of members in each year and population. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure

Legend

Higher is better:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
Lower is better:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14

5.3.1.3 Conclusions

Interim findings suggest that quality performance appeared to be mixed in the first few years of the 2022-2027 Demonstration. While improvements were seen in some areas, such as access to care measures and all-cause ED visits, and remained stable for other measures, performance trends were less desirable for Primary Care Sensitive ED Visits, Follow-Up After Hospitalization for Mental Illness, and Follow-Up After ED Visits for Mental Illness. Still, some results were better on average across years than national benchmarks. For example, Follow-Up After Hospitalization for Mental Illness at seven days and 30-days for members attributed to SNHs was approximately 10-15% higher on average across years when comparing to national benchmarks.¹⁶⁵ Further investigation and ongoing analyses of MassHealth administrative data will help assess changes in these patterns over time.

5.3.2. RQ4-2 What were the overall experiences of members in receiving services from SNHs?

5.3.2.1 Summary of Results

RQ4-2 examined the overall experiences of members in receiving services from SNHs as SNPP were distributed to eligible hospitals to cover UC costs associated with the provision of care for Medicaid, low-income, and uninsured patients (See **RQ4-3**). SNPP to SNHs were provided for ongoing and necessary operational support, including staff and filling administrative and service gaps. Members receiving services at SNHs were asked about their experiences. Although members' reports of experiences were likely to have been affected by the ways in which SNHs invested SNPP funding (e.g., workforce and HQEI, equipment, etc.), members were unaware of the distribution and use of SNPP. Therefore, their reports reflect their experiences, in general, at hospitals designated as SNHs. Additional member experiences will be examined during the Wave 2 data collection of the 2022-2027 Demonstration evaluation.

5.3.2.2 Results

H4-2.1 Medicaid members will report better care experiences over time.

Members shared mixed experiences in care received at SNHs. Several members described positive experiences with specific services (e.g., receiving a magnetic resonance imaging (MRI)), and with providers (e.g., “[my doctor] was pretty attentive”). One member praised patient-centered improvements in one SNH; for example, less time waiting in the hospital for an appointment. Several members described negative experiences receiving care at SNHs, including long wait times in the ED. One member said some of the nurses did not have great “bedside manners,” but the physical therapists were “awesome” and the doctors were “fine.”

¹⁶⁵ Child and Adult Health Care Quality Measures | Medicaid. Medicaid.gov. Published 2022. <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures>

5.3.2.3 Conclusions

Members had varied experiences with access and quality of communication with providers at SNHs in the first phase of the 2022-2027 Demonstration. More qualitative data may help to draw additional insights into the member care experiences at SNHs and how the experiences have changed over time. The interviews did not ask members about their experiences over time and across hospital settings; due to members' unawareness of the hospital status and the small sample size, these experiences are anecdotal. Including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data in the future may better inform member experiences of SNHs.

5.3.3. RQ4-3 *How effective were supplemental payments authorized through the Demonstration in supporting safety net providers?*

5.3.3.1 Summary of Results

RQ4-3 explored the effectiveness of SNPP, one of the expenditure categories of the broader SNCP, in supporting safety net providers. These payments provided eligible hospitals with additional funding for UC costs associated with the provision of care for Medicaid, low-income, and uninsured patients and are intended to provide ongoing and necessary operational support.¹⁶⁶ While 20% of SNPP is at risk, 80% of SNPP is designated to support the overall operations and functions of SNHs in Massachusetts. Overall, SNHs shared that SNPP were essential to covering UC costs and providing ongoing financial support for staff. SNHs also expressed several challenges associated with the SNPP including the administrative burden required to receive the SNPP. Additionally, SNHs gave feedback on the challenges associated with the at-risk portion of the SNPP being tied to the ACO accountability score.

5.3.3.2 Results

H4-3.1 The SNCP funding will continue to maintain or improve safety net providers' capabilities to serve vulnerable individuals.

Many SNHs reported that the SNPP are an essential component of their overall operating budget. When prompted about specific initiatives the SNPP have helped support, one hospital shared that *"all of the supplemental payment dollars are part of our general operating structure"* and they could not be disaggregated from the broader budget.

"I mean obviously, it helps to fund the additional staff that are working on the equity and quality projects to be able to make sure that we are going through with all the measures that have to be met. But, yeah, otherwise, I would say it's just to help all the wheels keep moving forward." – a SNCP provider

Several SNHs shared that SNPP has been important to funding workforce investments and initiatives targeted to increase patients' access to care. Multiple SNHs described workforce

¹⁶⁶ Centers for Medicare & Medicaid Services. (2025). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Section 11, <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>

investments that included the hiring of new staff, funding staff education, and increasing salaries to retain and recruit top talent.

“I think we’re also expanding the kinds of roles that we have. We have a lot more folks doing community outreach and community health worker kinds of roles rather than strictly episodic clinical care. We have folks focused on transitional care management and trying to tuck those high-risk patients into a more cost-effective plan of care that involves bringing folks in that have different skill sets and the ability to connect them with community resources and other things that help keep them healthy and on track.” – a SNCP provider

In terms of initiatives focused on access, SNHs shared that they have used SNPP to fill service gaps in the region, provide interpreter services for patients, and invest in improvements to hospital infrastructure.

“Last year we were able to purchase a second 3D mammography machine for women, so they can get current, up-to-date care in terms of imaging services. We’ve also made improvements in our OR infrastructure space; it’s still not where we need it to be, because we still struggle on the financial side, but it does allow for a lot of basic procedures to be completed here in the community versus having to travel to some other facility outside of this community.” – a SNCP provider

Although SNHs said that the SNCP, specifically the SNPP, was helpful at supporting their operations, several SNHs shared challenges with the at-risk portion of the SNPP being tied to the ACO accountability. A few SNHs felt that the at-risk payment should be based on hospital accountability, not ACO accountability.

“I think the hospitals were a little bit interested in could MassHealth have thought about tying it to hospital-specific performance or some other type of performance. But tying it to the overall ACO did feel a little bit removed and like the hospital didn’t have much ability to really change how the ACO is going to perform substantially.” – a SNCP provider

Additionally, some SNHs expressed challenges with the timeframe for receiving the at-risk payment, which is typically 2 years after the relevant rate year due to scoring and data review processes, as the current process is designed. SNHs also discussed the administrative burden associated with the SNPP (e.g., quantity of paperwork and frequency of deadlines). SNHs conveyed that these challenges resulted in budgeting issues due to variable, subsequent cash flow and difficulty tracking hospital performance year by year. One SNH shared this in reference to the administrative burden.

“From a finance operational standpoint, we’re incurring all these costs real-time, but we don’t settle or get that money till down the road. From a cash flow perspective that’s been a little bit of a concern, is, you know, we receive a certain amount, a designated

amount by the state, but then in terms of the final settlement, that's way down the road." – a SNCP provider

H4-3.2 Supplemental payments to SNHs through the DSH-like pool will reduce the total amount of UC.

Table 5.3-5 describes the "Available Room Under Cost Limit" (i.e., the difference between Medicaid and Uninsured costs and revenue, including Medicaid shortfall) or UC costs from Schedule H or J of the UCCR reports of the existing and new SNHs that received SNPP, adjusted for inflation (CY2024 dollars). The table also shows the percentage change from baseline (fiscal year [FY]2017-FY2021) to FY2024 for existing SNHs and FY2023 to FY2024 for new SNHs. A count of hospitals with cost increases or decreases each year compared to the previous year is also provided.

The collective total inflation-adjusted UC costs for the 13 existing SNHs decreased annually from FY2022 to FY2024. There was a steeper decrease between FY2022 and FY2023 compared to FY2023 and FY2024. In terms of sustained year-to-year changes for the existing SNHs, Good Samaritan Medical Center and Signature Healthcare Brockton Hospital had consistent increases in UC costs from FY2022 to FY2024, with Signature Healthcare having the highest percentage change from baseline to FY2024 at 169%. Six SNHs had consistent decreases in UC costs from FY2022 to FY2024, and the UC costs for the remaining five SNHs varied from year to year. Holyoke Medical Center and Baystate Franklin Medical Center had the lowest percentage change at -53% and -37%, respectively, from baseline to FY2024, representing the highest decreases in UC burden.

The collective total UC costs for the five new SNHs with available UC costs data decreased from FY2023 to FY2024. Three of the new SNHs showed decreases in UC costs from FY2023 to FY2024. From FY2023 to FY2024, Martha's Vineyard Hospital showed the largest positive percentage change at 44%, while Baystate Noble Hospital showed the largest negative percentage change at -55%.

Table 5.3-5 Total UC Available Room Under Cost Limit, FY2017-FY2024 (rounded in millions)

	FY2017- FY2021 Baseline	FY2022	FY2023	FY2024	Percentage Change from Baseline to FY2024	Trend from Baseline to FY2024
Existing SNHs						
Baystate Franklin Medical Center	\$10.0	\$13.2	\$10.3	\$6.3	-37%	
Baystate Medical Center	\$75.3	\$153.0	\$115.8	\$102.4	36%	
Berkshire Medical Center	\$43.7	\$56.4	N/A	N/A	N/A	
Boston Medical Center	\$158.0	\$365.1	\$287.4	\$199.7	33%	
Good Samaritan Medical Center	\$11.5	\$16.2	\$17.4	\$30.0	161%	
Holyoke Medical Center	\$10.3	\$13.9	\$8.4	\$4.8	-53%	
Lawrence General Hospital	\$29.8	\$43.1	\$1.0	\$26.9	-10%	
Mercy Medical Center	\$34.0	\$57.9	\$63.8	\$62.0	82%	
Morton Hospital	\$6.9	\$15.1	\$11.1	\$10.4	52%	
Salem Hospital	\$48.8	\$71.9	\$43.6	\$70.0	43%	
Signature Healthcare Brockton Hospital	\$43.5	\$56.7	\$73.1	\$117.0	169%	
Southcoast Hospitals Group	\$32.8	\$15.1	\$16.8	\$27.2	-17%	
Tufts Medical Center	\$86.8	\$257.1	\$190.4	\$164.4	89%	
Total among 13 hospitals	\$591.4	\$1,134.7	\$839.1	\$821.1	41%	
Count of Hospitals with a Decrease	N/A	1	4	4		
Count of Hospitals with an Increase	N/A	12	8	8		
New SNHs						
Baystate Noble Hospital			\$8.1	\$3.6	-55%	↓
Baystate Wing Hospital			\$9.7	\$7.8	-19%	↓
Heywood Hospital			\$22.4	\$11.6	-48%	↓
Lowell General Hospital			\$25.7	\$25.8	0%	➡
Martha's Vineyard Hospital			\$5.9	\$8.5	44%	↑
Total among 5 hospitals			\$71.8	\$57.3	-20%	↓
Count of Hospitals with a Decrease			N/A	3		
Count of Hospitals with an Increase			N/A	2		

Data Source: UCCR Reports (Schedule H or Schedule J depending on hospital and year)

Abbreviations: Fiscal Year (FY); Safety Net Hospitals (SNHs); Uncompensated Care (UC)

Notes: 1) All dollar amounts have been adjusted for inflation at CY2024 dollars using United States (U.S.) Bureau of Labor Statistics data (Medical care in U.S. city average, all urban consumers, not seasonally adjusted). A limitation is that the UCCR cost data are presented in fiscal year, but the evaluation team applied the CY's inflation rate. 2) For existing SNHs, the trend line shows each individual data point from FY2017 to FY2024. The baseline is an average of UC costs from FY2017 to FY2021. 3) For existing SNHs, the percentage change is calculated from the baseline average to FY2024. For new SNHs, the percentage change is calculated from FY2023 to FY2024. 4) For existing SNHs, the count of hospitals with an increase or decrease is in comparison to the baseline average. For new SNHs, the count of hospitals with an increase or decrease is in comparison to FY2023. 5) The "Available Room under Cost Limit" is defined as the difference between Medicaid and Uninsured costs and revenue, including Medicaid shortfall. 6) Since seven hospitals became SNHs in October 2022, there was no data from FY2017 to FY2022. Five of the new SNHs had data for FY2023 and 2024 and are shown above; two had no available data (MetroWest Medical Center and Shriners Hospitals for Children Boston) and are not included in the table above.

5.3.3.3 Conclusions

Qualitative results suggest that SNHs utilized SNPP for ongoing operational support including workforce investments. SNH interviewees also suggested SNPP helped facilitate investments in health equity initiatives. SNHs faced numerous challenges in receiving SNPP including the administrative burden of SNPP requirements and difficulty with the at-risk portion of SNPP being tied to the ACO accountability score. UCCR results suggest that the UC costs may have increased from baseline to FY2023, and the costs started declining for many SNHs from FY2023 to FY2024. (See **Appendix E-2** for additional UCCR results.)

5.4. Discussion

5.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

Early results from the 2022-2027 Demonstration suggest the SNCP continues to play a stabilizing role for Massachusetts SNHs, with mixed — but directionally improving — access and utilization and declining UC burdens for many existing SNHs between FY2022 and FY2024. O:E ratio performance improved for several access measures (e.g., annual primary care visits and child/adolescent well care visits) and for all-cause ED visit rates by CY2024. However, primary care-sensitive ED visits and behavioral health follow-up after hospitalization remained below expectations — likely the result of persistent challenges to access primary and urgent care and coordination challenges for specific service categories. These results suggest there may be opportunities for continued efforts to align incentives with ACOs and anchor quality improvement actions more tightly with hospital proximally measures to maximize the return on investment.

On financial performance, though the total aggregate UC costs decreased from FY2022, many of SNHs' inflation-adjusted UC costs increased considerably from FY2023, indicating the likelihood of more financial burdens. The UC measure included in this analysis represents more factors than just the SNH payments included in the 2022-2027 Demonstration. For example, this trend has not accounted for the change in the volume of Medicaid and uninsured individuals, patient mix, or provider rate, as well as mergers/acquisitions/closures related to these hospitals. UC is sensitive to coverage churn and federal policy. While several SNHs' UC is still increasing, the decline of some SNHs' UC is encouraging. However, trends may reverse as a result of potential federal DSH allotment reductions, or more frequent eligibility redetermination anticipated from the implementation of One Big Beautiful Bill Act (OBBBA). Preparing for federal financing volatility proactively (e.g., changing policy in Marketplace subsidies, federal policies that lead to more uninsured individuals) requires continued support for SNHs to cope with anticipated care and cost burdens.

The 2022–2027 Demonstration continues to tie SNPP to SNHs with ACO performance, extending payment reform across payer/provider boundaries. One intent of this link was to incentivize hospitals to partner with ACOs. The structure of the at-risk withhold is set out in the Special Terms and Conditions (STCs), Attachment N, which conditions 15% on ACO quality and 5% on ACO TCOC — an explicit link between SNH financing and ACO program results. Notably, this linkage is reinforced by the state's ACO risk-sharing methodology and the Commonwealth's broader quality and equity agenda, which together incentivize population

health management and improved outcomes rather than increased volume. SNHs are therefore also responsible for HQEI with additional quality reporting requirements and incentives.

However, SNHs uniformly reported that SNPP are essential to ongoing operations (e.g., workforce, interpreter services, and equipment) while also pointing to administrative burden and the cashflow challenges created by the 20% at risk component tied to ACO TCOC and quality performance. In practice, several SNHs reported feeling removed from ACO-level accountability, making it difficult to predict when exactly funds would be received.

The current evaluation lacked granular data to distinguish the impact of SNCP funding from other quality improvement incentives. Some SNHs reported that they do not differentiate SNCP funding from other revenues that the hospital generates to support operations, though SNHs consistently acknowledged the importance of the SNCP funding. This indicates that SNHs have limited means to track the direct return on investment of the SNCP funding. In addition to ACO-related performance, hospitals are also subject to other hospital pay for performance programs regulated by CMS such as hospital inpatient quality reporting program, outpatient quality reporting, and hospital Value-Based Purchasing program.

The uncertainty from federal financing can add stress to SNHs. Massachusetts' Center for Health Information and Analysis' (CHIA) recent financial reports show continuing margin stress across Massachusetts hospitals into 2024-2025, with many acute hospitals operating near or below breakeven, and system pressures (labor, post-acute capacity, length of stay) still elevated relative to pre-pandemic baselines.¹⁶⁷ At the same time, federal Medicaid DSH allotment reductions — long delayed — is still a looming financial risk for SNHs, including those in Massachusetts, because the cut for FY2028 remains in statute.¹⁶⁸

Massachusetts's STCs Attachment E (SNCP Payments)¹⁶⁹ charts the Commonwealth's DSH and related SNCP streams over the 2022-2027 Demonstration period — reinforcing how state policy leverages federal authorities to sustain the safety net. The OBBBA restricts states' use of directed payments and will slash Medicaid funding substantially; this cut will potentially lead to an increase in uninsured and underinsured individuals at SNHs when SNH revenue and resources are more limited. An Urban Institute report projected the UC sought by the uninsured would increase by \$85 billion for hospital services over the next 10 years under the Reconciliation Bill.¹⁷⁰ Rural hospitals (six acute rural hospitals in Massachusetts) are especially at risk.¹⁷¹ Further, the expiration of enhanced Marketplace premium tax credits could raise uninsurance and increase UC, particularly for adults on the margin between Medicaid and ConnectorCare. These substantial funding decreases from the federal government make it more

¹⁶⁷ Center for Health Information and Analysis. (2025). Massachusetts Hospital and Health System Annual Financial Performance Report HFY 2024, <https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2024-annual-report/Hospital-Financial-Performance-2024-Report.pdf>

¹⁶⁸ American Hospital Association. (2026). Fact Sheet: Medicaid DSH Program. [Fact Sheet: Medicaid DSH Program | AHA](#)

¹⁶⁹ Centers for Medicare & Medicaid Services. (2022). MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services, Attachment E, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

¹⁷⁰ Blavin, F. and Simpson, M. (2025). State-Level Estimates of Health Care Spending and Uncompensated Care Changes under the Reconciliation Bill and Expiration of Enhanced Subsidies. <https://www.urban.org/research/publication/state-level-estimates-health-care-spending-and-uncompensated-care-changes>, last accessed April 5, 2026.

¹⁷¹ Brady M. (2025). Hospitals prepare for \$149B cut to Medicaid state-directed payments – Katz Brunner Healthcare. [katzbrunner.com](https://www.katzbrunner.com/news/hospitals-prepare-for-149b-cut-to-medicaid-state-directed-payments/). Published August 12, 2025. <https://www.katzbrunner.com/news/hospitals-prepare-for-149b-cut-to-medicaid-state-directed-payments/>, last accessed March 7, 2026.

pressing and essential to continue investing in SNHs to maintain access and improve care quality for MassHealth members, uninsured and underinsured individuals.

Finally, coverage churn from Medicaid unwinding has affected payer mix and charity care demand as uninsurance rates increase from the pandemic period, and with Medicaid enrollment falling in 2023-2024 as redeterminations resumed. These trends can raise UC and stress hospital finances as those members who remain on Medicaid and continue to use SNHs are presumed to have greater medical complexity than those who did not meet redetermination criteria, as shown by increasing DxCG and RxCG scores. Monitoring changes in population insurance coverage and preparing mitigations (such as eligibility outreach, premium assistance, health safety net (HSN) adjustments) will be important to disentangle the effect of SNPP on members outcomes. It will also be important for the sustainability of SNH finances and quality performance when provider shortages have already created ample stress to satisfy member or patient needs.

Qualitative evidence points to workforce, language access, community health workers, and equipment as SNPP-enabled upgrades. Prioritizing these investments appears consistent with quality gains in access measures and declines in ED utilization. Maintaining these high-yield, equity-oriented allocations is aligned with the 2022-2027 Demonstration's health quality and equity focus. The current limitation of assessing member experiences through qualitative interviews is that no pre-post experience was gathered to assess change over time. Insufficient data are available to compare the experiences of members receiving care from SNHs and non-SNHs. Future evaluation activities will address this limitation and consider the use of HCAHPs.

5.4.2. Lessons Learned and Recommendations

1. **Lesson Learned:** Linking SNPP at-risk funds to ACOs' quality and TCOC is designed to promote accountability for population health that may have extended beyond a hospital's traditional focus on activities occurring within its physical structure. When accountability is shared across entities, measure clarity, locus of control, strength of incentive, and reporting cadence become crucial for leading to a successful partnership and positive impact. When partnership is motivated by risk-based payment of another upstream entity's performance, the incentives may be associated with more limited impact. When dealing with high UC costs as well as competing priorities and reporting requirements, SNHs may have to prioritize their quality improvement resources on some but not all measures.
 - **Recommendation:** The state and the evaluator should continue investigating any challenges with the partnership and opportunities to enhance it, aiming to have SNHs and ACOs to strengthen the partnership structure with aligned goals, measures, and quality improvement strategies and actions to maximize system performance and support patient needs. Having direct ownership of at-risk payment would likely afford SNHs with both authority and accountability to design more targeted quality improvement strategies
2. **Lesson Learned:** While several SNHs' UC is still increasing, the decline of other existing SNHs' UC is encouraging. However, SNHs may see reversed trends of UC as a result of

implementing the OBBBA (e.g., 6-month eligibility redetermination associated with increased churn and general Medicaid funding cuts). Similar to what was recommended in Massachusetts's 2017-2022 1115 Demonstration IESR, continued investment in support of these hospitals will be helpful to relieve these hospitals' financial burdens and support their continued quality improvement efforts.

- **Recommendation:** Massachusetts and other states may consider continued investment in automated renewals for coverage determination to avoid or minimize any administrative efforts, churn, and coverage gaps that contribute to the increases in UC.
3. **Lesson Learned:** SNHs not separating SNCP funding from other general operational funds weakens the accountability of SNHs using these resources. The current evaluation cannot adequately assess use and benefit of SNPP because hospitals do not track it separately. On the other hand, SNHs are already burdened with caring for a disproportional share of uninsured and Medicaid members who tend to have greater medical complexity than populations otherwise insured, so new or complex reporting requirements will introduce additional data management and reporting burdens.
- **Recommendation:** In future demonstration terms, states should consider better upfront design to enable meaningful evaluation of funding use and success; for instance, SNH staff should consider tracking how SNH funding gets used to better understand the impact of the SNPP on SNH performance. Through this, states and SNHs can more clearly evaluate the use and value of these funds and be able to invest in areas that maximize the funding use. Use of the SNPP funding should still be more closely monitored, but the reporting requirement burdens should be minimal to not strain SNHs further.

6. Workforce Initiatives

6.1. Background

Similar to national trends, Massachusetts is experiencing a shortage of primary care providers (PCPs) that, without intervention, will continue to grow.¹⁷² Additionally, more than half (56.8%) of adults who sought treatment for behavioral health (BH) reported challenges in finding a BH provider.¹⁷³ The healthcare workforce is experiencing significant burnout, especially among PCPs. A 2023 survey of over 20,000 physicians in Massachusetts found that 55% were experiencing burnout, with 27% indicating an intention to leave the profession by 2026.¹⁷⁴ Research indicates that burnout is particularly acute in community health centers (CHCs) compared to privately-owned healthcare settings.¹⁷⁵ In 2022, the National Association of Community Health Centers (NACHC) conducted a survey that revealed that 68% of health centers have experienced a 5-25% loss of their workforce in the past six months, while 15% have seen a 25-50% reduction. Staff departures are primarily attributed to competition from other employers and the stresses of the COVID-19 pandemic, with 65% of survey respondents believing that employees left for better financial opportunities at competing healthcare organizations.¹⁷⁶ The 2025 Working Families Tax Cut Act's impacts on Medicaid and other health programs are expected to impact these challenges.

Through the 2022-2027 Demonstration, the Commonwealth is committed to making significant investments to extend and improve primary care (PC) and BH services and access to care.¹⁷⁷ In addition to the transition of PC payment in the Accountable Care Organization (ACO) program to a new sub-capitation payment model and the Commonwealth's implementation of the BH Roadmap, the Commonwealth is investing in three Workforce Initiatives (WI) programs, authorized by the Demonstration, to address shortages of qualified providers serving MassHealth members. The WIs are categorized into Student Loan Repayment Programs (SLRPs) for PC and BH providers, and the Family Nurse Practitioner (FNP) Residency Grant Program.

¹⁷² Petterson, S. M., Cai, A., Moore, M., & Bazemore, A. (2013, September). *State-level projections of primary care workforce, 2010–2030*. Graham Center. <https://www.graham-center.org/content/dam/rqc/documents/maps-data-tools/state-collections/workforce-projections/Massachusetts.pdf>

¹⁷³ Blue Cross Blue Shield Foundation of Massachusetts. (2018). *Access to care for mental health and substance use disorders is a challenge for many in Massachusetts*. https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-02/MHRS_2018_MHSUD_Summary_final.pdf

¹⁷⁴ Massachusetts Medical Society. (2023, March). *Supporting MMS physicians' well-being report: Recommendations to address the on-going crisis*. <https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Supporting-MMS-Physicians--Well-being-Report---Recommendations-to-Address-the-Ongoing-Crisis/>

¹⁷⁵ Edwards, S. T., Marino, M., Balasubramanian, B. A., Solberg, L. I., Valenzuela, S., Springer, R., Stange, K. C., Miller, W. L., Kottke, T. E., Perry, C. K., Ono, S., & Cohen, D. J. (2018). Burnout among physicians, advanced practice clinicians and staff in smaller primary care practices. *Journal of General Internal Medicine*, 33(12), 2138–2146. <https://doi.org/10.1007/s11606-018-4679-0>

¹⁷⁶ National Association of Community Health Centers. (2022). *Current state of the health center workforce: Pandemic challenges and policy solutions to strengthen the workforce of the future*. <https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf>

¹⁷⁷ Commonwealth of Massachusetts. (2021, December 27). *MA 1115 extension request updated* (p. 7). <https://www.mass.gov/doc/1115-waiver-extension-request/download>

PC SLRP

This program offers the following:

1. Up to \$100,000 for PC physicians in exchange for a four-year full-time service obligation in a community-based setting, serving at least 40% MassHealth and/or uninsured members.
2. Up to \$50,000 for advanced practice registered nurses (APRNs), including but not limited to clinical nurse specialists and nurse practitioners (NPs), and physician assistants (PAs), per practitioner, in exchange for a four-year full-time service obligation in a community-based setting serving at least 40% MassHealth and/or uninsured members.

BH SLRP

This program offers the following:

1. For psychiatrists and NPs, up to \$300,000 per practitioner in exchange for a four-year full-time service obligation in a personal practice panel or working at an organization in a community-based setting with a panel that includes at least 40% MassHealth and/or uninsured members.
2. Up to \$50,000 per practitioner for licensed master's or doctoral level BH clinicians or pre-licensed BH clinicians who have completed master's-level training but do not yet have the necessary licensure to practice independently intending to obtain BH practitioner licensure within one year of the award, in exchange for a four-year service obligation in a community-based setting serving at least 40% of MassHealth and/or uninsured members.
3. Up to \$30,000 per practitioner for licensed bachelor's level BH clinicians, in exchange for a four-year service obligation in a community-based setting serving at least 40% of MassHealth and/or uninsured members.

FNP Residency Grant Program

The Commonwealth is providing up to \$131,500 per residency slot to allow CHCs, whose patient populations are made up of at least 40% MassHealth members, to support FNP residency slots during the demonstration period.

Table 6.1-1 Workforce Expenditure Authority by Initiative (in Millions)

Initiative	Total
BH Student Loan Repayment	\$20.00M
PC Student Loan Repayment	\$18.40M
FNP Residency Grant	\$4.84M
Total	\$43.24M

Data Source: STC Table 12 page 102. <https://www.mass.gov/doc/1115-waiver-demonstration-special-terms-and-conditions-stcs-approved-8425-0/download>.

Abbreviations: Behavioral Health (BH); Family Nurse Practitioner (FNP); Million (M); Primary Care (PC)

The WI programs were informed by lessons learned from the 2017-2022 Demonstration, where the Commonwealth was able to leverage \$115 million of the \$1.8 billion in expenditure authority for the Massachusetts Delivery System Reform Incentive Payment (DSRIP) program to fund eight Statewide Investments (SWI) intended to build and strengthen healthcare infrastructure and workforce capacity across Massachusetts to support the success of ACOs and Community Partners (CPs). The SWIs from the previous Demonstration included a set of investments that supported the recruitment, retention, and training of PCPs, BH providers, and the frontline healthcare workforce in community-based settings. These investments included: the SLRP, the PC/BH Special Projects Program, Investment in Community-based Training and Recruitment, and the Workforce Development Grant Program.

Under the 2017-2022 Demonstration, DSRIP-funded SLRPs awarded PCPs and BH providers in these community-based PC and BH settings with student loan repayments of up to \$30,000 or \$50,000, depending on the provider type, in exchange for a four-year service commitment. SWIs promoted new opportunities for PC and BH providers to practice within communities, stimulated novel initiatives to coordinate and integrate care across settings, and pioneered provider strategies to manage performance and population health. These investments addressed gaps in the statewide delivery system and strengthened its capacity to deliver integrated, high-quality care for all members.¹⁷⁷

Student loan repayment is a promising tool in addressing healthcare workforce challenges, particularly for recruiting and retaining clinicians with language skills and experience providing responsive, respectful care to members with complex health and social needs.¹⁷⁸ DSRIP-funded SLRPs have shown results in achieving retention in high-Medicaid community-based settings. Preliminary results for MassHealth's SWIs in SLRPs show that 94% of PC and BH providers who received these awards in 2018 and 2019, and 98% of master's-prepared BH providers who received those awards in 2018, remained employed in community-based settings.¹⁷⁹ ACOs and CPs described the SLRPs as pivotal in the recruitment and retainment of staff at community-based settings.¹⁸⁰ In addition, DSRIP funding supported a grant program for CHCs to create or expand FNP residency programs. CHCs that implement FNP residency programs can better recruit and retain FNPs who complete the residencies.¹⁸¹ Over the first three cycles of funding, nine different CHCs utilized the DSRIP funding to support 30 FNP residency slots.

6.2. Study Design

Refer to [Chapter 1 Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology. Additional details on the WI Provider Survey methods are available in **Appendix F-1**. In brief, in response to Centers for Medicare & Medicaid Services' (CMS's)

¹⁷⁸ Garcia, A. N., Kuo, T., Arangua, L., & Pérez-Stable, E. J. (2018). Factors associated with medical school graduates' intention to work with underserved populations: Policy implications for advancing workforce diversity. *Academic Medicine*, 93(1), 82–89. <https://doi.org/10.1097/ACM.0000000000001917>

¹⁷⁹ Commonwealth of Massachusetts. (2021, December 27). *MA 1115 extension request updated* (p. 38). <https://www.mass.gov/doc/1115-waiver-extension-request/download>

¹⁸⁰ UMass Chan Medical School. (2025, September 25). Independent Evaluation Summative Report Massachusetts 2017-2022 1115 Demonstration (p. 93). <https://www.mass.gov/doc/independent-evaluation-summative-report-0/download>

¹⁸¹ Flinter, M. M., & Bamrick, K. (2017). Training the next generation: *Residency and fellowship programs for nurse practitioners in community health centers*. Community Health Center, Inc., & Weitzman Institute. <https://www.weitzmaninstitute.org/sites/default/files/NPResidencyBook/NPResidencyBook.pdf>

request to evaluate providers' preferences for higher reimbursement rates compared to SLRP, the evaluation team used a discrete choice experiment (DCE), a stated-preference method widely used in health policy analysis, to elicit providers' preferences for alternative job incentive packages.^{182, 183, 184} In each choice task, respondents selected their preferred option from two hypothetical job offers and a status quo (SQ) option representing their current job conditions. The design allows respondents to evaluate incremental changes in job attributes relative to existing conditions and reflects the trade-offs providers face when considering employment decisions in community health settings. Descriptive analyses, DCE analysis, subgroup and sensitivity analyses were conducted. To support policy interpretation and clarify the trade-off between retention gains and fiscal impact, we conducted policy scenario projections, i.e., simulations, using predicted choice probabilities derived from the estimated conditional logit model and estimated the incremental costs and benefits of each scenario relative to the SQ, projecting their annual impact under alternative policy options. Refer to **Appendix F-1** for more details on survey design and analysis, **Appendix F-2** for the survey instrument, and **Appendix F-3** for more details on the DCE design.

6.2.1. Research Questions, Hypotheses, and Study Design

The table below (**Table 6.2-1**) outlines the research questions (RQs), hypotheses (H), data sources and evaluation period, study population(s), and analytic methods for the WI Domain. See the following appendices for other relevant methods and materials: List of Research Questions (RQs) and Hypotheses (Hs) (**Appendix A-2**), MassHealth Staff Open-Ended Survey (**Appendix B-8**), and KII Demographics (**Appendix C-5**).

Table 6.2-1 WI Research Questions, Hypotheses, and Study Design

Research Questions ^a	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ5-1 What actions were taken to implement the three WIs, and what lessons were learned from the implementation?	H5-1.1 The Commonwealth will work with vendors to implement the program as intended (e.g., market the programs, release clear roles and expectations, develop policies and procedures, make payments promptly, provide operational oversight, and process applications).	Program documents (CY2025) MassHealth WI staff open-ended survey (CY2025)	Descriptive analyses (program applicants) Thematic analysis (MassHealth WI staff)
	H5-1.2 Several lessons will be learned from implementing these WI programs.	MassHealth WI staff open-ended survey (CY2025)	Thematic analysis (MassHealth WI staff)

¹⁸² Nouwens, S.P.H., Marceta, S.M., Bui, M. et al. The Evolving Landscape of Discrete Choice Experiments in Health Economics: A Systematic Review. *PharmacoEconomics* 43, 879–936 (2025). <https://doi.org/10.1007/s40273-025-01495-y>

¹⁸³ van den Broek-Altenburg, E., Atherly, A. Using discrete choice experiments to measure preferences for hard to observe choice attributes to inform health policy decisions. *Health Econ Rev* 10, 18 (2020). <https://doi.org/10.1186/s13561-020-00276-x>

¹⁸⁴ Ben-Akiva, M and Lerman. *Discrete Choice Analysis: Theory and Application to Travel Demand*. The MIT Press, Cambridge, Massachusetts.

Research Questions ^a	Hypotheses	Data Sources & Evaluation Period	Analytic Methods
RQ5-2 Did the WI programs increase the volume and diversity of the provider workforce in community-based settings?	H5-2.2 Offering BH student loan repayment will increase the volume and diversity of psychiatrists and NPs with prescribing privileges, licensed master's- or doctoral-level BH clinicians, pre-licensed master's-prepared BH clinicians, and bachelor's-level licensed BH clinicians, practicing in community-based clinical settings serving at least 40% of MassHealth members and/or uninsured patients. ^b	Program documents (CY2025)	Descriptive analyses (program applicants)
	H5-2.3 Offering PC student loan repayment will increase the volume and diversity of PC physicians, APRNs, and PAs practicing in a community-based clinical setting serving at least 40% of MassHealth members and/or uninsured patients. ^b	Program documents (CY2025)	Descriptive analyses (program applicants)
	H5-2.4 Offering an FNP residency grant program will increase the volume of FNPs in CHCs serving at least 40% of MassHealth members.	Program documents (CY2025)	Descriptive analyses (program applicants)
	H5-2.5 The WI programs will improve providers' willingness to practice in community-based settings, as compared to direct intervention, such as direct rate increase.	WI provider survey (CY2025)	Survey analysis (DCE)

Abbreviations: Advanced Practice Registered Nurse (APRN); Behavioral Health (BH); Community Health Center (CHC); Calendar Year (CY); Discrete Choice Experiment (DCE); Family Nurse Practitioner (FNP); Hypothesis (H); Nurse Practitioner (NP); Physician Assistant (PA); Primary Care (PC); Research Question (RQ); Workforce Initiative (WI)

^a Research questions (RQs) developed in response to STCs sections 13.1-13.9; [1115 MassHealth Demonstration \("Waiver"\) | Mass.gov](#)

^b H5-2.2 and H5-2.3 language have been updated to better represent eligibility requirements for the PC and BH SLRPs.

6.2.2. Methodological Limitations

Refer to [Chapter 1](#) for overarching methodological limitations relevant to this report. Beyond those general limitations, several additional limitations specific to the WI domain and the DCE methodology should be noted. First, the study may not have captured all decision-relevant attributes, including CHC-related factors beyond its objectives. Second, DCEs assume that participants act rationally and select the option with the highest perceived utility in each choice set. However, participants may deviate from this assumption due to incorporation of external information, personal experiences, fear that SLRP might be discontinued, not fully

comprehending the choice task, or bringing additional assumptions into their decisions. Fourth, the sample composition of the current WI provider survey, comprising more than 60% BH providers, may have skewed the aggregate results toward BH providers' preferences. As a result, the overall findings may not fully reflect the preferences of PCPs or the broader CHC provider population. However, in sensitivity analyses, we compared the preferences of the BH and PCP and found similar directions of effect, though with slightly different magnitudes.

6.3. Interim Results and Conclusions

6.3.1. RQ5-1 What actions were taken to implement the three WIs, and what lessons were learned from the implementation?

6.3.1.1 Summary of Results

RQ5-1 examines the actions that MassHealth and its vendors took to successfully implement the three WIs. The Massachusetts League of Community Health Centers (the Mass League) was MassHealth's vendor for the PC and BH SLRPs, and Public Consulting Group (PCG) was MassHealth's vendor for the FNP Residency Grant Program. MassHealth was responsible for policy development and oversight of the programs and worked with vendors to market the programs through social media, press releases, and partner organizations. The Mass League program staff reviewed applicants and determined eligibility for the SLRPs, while both MassHealth and PCG reviewed and scored applicants for the FNP Residency Grant Program. Several lessons were learned from the implementation of similar initiatives under the earlier DSRIP SWI portfolio from the previous 2017-2022 Demonstration, such as the importance of decreasing the number of WI programs, while increasing the investment into each one. Additionally, MassHealth learned that the award levels for the BH SLRP were likely more desirable than the award levels for the PC SLRP, which informed the levels set for the 2022-2027 Demonstration.

6.3.1.2 Results

H5-1.1 The Commonwealth will work with vendors to implement the program as intended (e.g., market the programs, release clear roles and expectations, develop policies and procedures, make payments promptly, provide operational oversight, and process applications).

SLRPs

MassHealth works with the vendor, the Mass League, to implement and manage the PC and BH SLRPs. MassHealth is responsible for policy development and oversight of the design and implementation of the programs. This includes providing the Mass League with necessary materials or information, providing guidance and input for public-facing program materials, and answering program eligibility questions. The Mass League disburses the award directly to the awardee's student loan servicer(s).

MassHealth and the Mass League outreached to relevant professional associations, medical and graduate schools, MassHealth ACOs and CPs, and legislative stakeholders to market the programs. Each SLRP had its own respective program website with all program materials made

available a week prior to the program launch on Nov. 14, 2024. To further market the programs following the launch of the programs, MassHealth, Executive Office of Health and Human Services (EOHHS), and the Mass League made announcements on social media (LinkedIn, X [formerly Twitter], and Facebook). In addition, press releases were made on Mass.gov and by news outlets.

MassHealth delayed the launch of the two SLRPs to maximize the impact of the programs by limiting the overlap with other SLRPs being implemented by the Commonwealth.¹⁸⁵ MassHealth also considered bandwidth constraints for the Mass League (e.g., implementation of other SLRPs).

Eligible applicants were awarded one priority point for each of the following: (1) being able to communicate with patients and provide care in a language other than English and that skill matching the needs of the site where the applicant works; (2) demonstrating a commitment to providing clinical care to historically underserved patients; (3) residing in an Advancing Health Equity in Massachusetts (AHEM) town¹⁸⁶; and (4) working in an AHEM town. Mass League staff scored applicants by first sorting by highest to lowest priority points and then by debt-to-income ratio from highest to lowest. As the BH SLRP received more eligible applicants than funding available, applicants were added to a waitlist and sorted by total number of priority points and then by highest debt-to-income ratio. If any awardee decided to decline the award or failed to return their awardee contract within two weeks of the send date, their award was rescinded.

Table 6.3-1 presents a snapshot of the number of applicants to each SLRP as of February 2026. The PC and BH SLRP program data have changed since the release of award announcements in April 2025, and we expect the data to continue changing. The IESR will provide the final results, including more details on implementation processes and challenges, as well as the impact of these programs. The BH SLRP received the most applicants, with 1,181 applicants, while the PC SLRP only received 134 applicants. Mass League program staff reviewed applications to determine eligibility. Most applicants for the SLRPs were deemed eligible. Applicants were deemed ineligible due to either being awarded loan repayment through a previous Loan Repayment Program for Health and Human Service Professionals (MA Repay) or working in roles or organizations that do not align with program guidelines. About one-third (31.3%) of eligible applicants for the BH SLRP were awarded. In comparison, 121 eligible applicants for the PC SLRP were awarded, with 23.2% of them subsequently being terminated (5.0%) or withdrawing from their contracts (18.2%).

FNP Residency Grant Program

MassHealth works with the vendor, PCG, to facilitate payments between the state and CHC recipients for the FNP Residency Grant Program. Additionally, MassHealth collaborates with PCG to conduct reviews and evaluations of CHC applications and awardees' quarterly and annual reports. Similar to the SLRPs, MassHealth is responsible for policy development and oversight of the design and implementation of the program. This includes providing PCG with

¹⁸⁵ The MA Repay Program implements various SLRPs to eligible professionals who commit to serving in vital roles in the Commonwealth. The Mass League administers the program in partnership with the EOHHS. The other SLRPs include but are not limited to: Behavioral Health & Primary Care (BHPC) SLRP, the Child and Adolescent Psychiatrist SLRP, and the Substance Use Treatment Provider SLRP.

¹⁸⁶ AHEM identified ten focused geographies for targeted investments based on health and social indicators. .

the necessary materials or information, providing guidance and input for public-facing program materials, and answering eligibility questions.

MassHealth directly outreached to CHCs and leveraged partner organizations' listservs to market the FNP Residency Grant Program. The program application launched on June 12, 2025. MassHealth had to delay the launch of the FNP residency grant program due to the process of procuring a vendor to administer the program.

CHCs were evaluated based on the following criteria: (1) minimum eligibility; (2) administrative information; (3) CHC experience and infrastructure; (4) proposed program, workplan, and staffing; and (5) budget request. Extra credit was given to CHCs for (1) being located in rural communities, AHEM areas, or Health Professional Shortage Areas (HPSA); and (2) demonstrating they have a vested interest in creating a positive residency experience.

Members of both MassHealth and PCG formed a review committee to evaluate CHCs. The review committee decided to maximize the number of CHCs benefiting from this grant by reducing each budget to up to \$263,000 to support two FNP residency slots.

Table 6.3-1 presents the number of CHCs that applied for the FNP Residency Grant Program. Out of 14 CHCs, eight were awarded two FNP slots each (total of 16 slots). One CHC was deemed ineligible due to a reported patient panel that was less than the required 40% MassHealth members. The remaining CHCs were deemed eligible but could not be awarded due to insufficient funding.

Table 6.3-1 Applicants by WI

	BH SLRP	PC SLRP	FNP Residency Grant
	N (%)	N (%)	N (%)
Total applicants	1,181 (100%)	134 (100%)	14 (100%)
Eligible	787 (66.7%)	121 (90.3%)	13 (92.9%)
Application Withdrawn	84 (10.7%)	22 (18.2%)	N/A
Contract Rescinded	37 (4.7%)	0 (0%)	N/A
Contract Terminated	0 (0%)	6 (5.0%)	N/A
Waitlist	420 (53.4%)	0 (0%)	5 (38.5%)
Awardee	246 (31.3%)	93 (76.9%)	8 (61.5%)
Incomplete	54 (4.6%)	3 (2.2%)	0 (0%)
Ineligible	340 (28.8%)	10 (7.5%)	1 (7.1%)

Data Source: Individual- and CHC-level program data provided by MassHealth

Abbreviations: Behavioral Health (BH); Family Nurse Practitioner (FNP); Primary Care (PC); Student Loan Repayment Program (SLRP); Workforce Initiative (WI)

Notes: 1) N for the SLRPs represents individual providers. 2) N for the FNP residency program represents CHCs. 3) Applications for the SLRPs were determined incomplete due to missing loan documents, paystubs, or degree/transcripts. Applications for the SLRPs were determined ineligible due to the following: awarded loan repayment through a previous MA Repay program, working in roles that do not align with

program guidelines, or working in organizations that do not align with program guidelines. 4) Applications for the FNP Residency Grant Program were determined ineligible due to a reported patient panel that was less than the required 40% MassHealth members. Non-awarded eligible CHCs could not be awarded due to insufficient funding. 5) The SLRPs numbers are a snapshot approximately 10 months into the programs, while FNP residency grant program numbers are at the time of award announcement in November 2025.

H5-1.2 Several lessons will be learned from implementing these WI programs.

For both programs, MassHealth drew on its experience from the previous demonstration facilitating similar initiatives under the DSRIP SWI. MassHealth WI staff explained that they reviewed which earlier efforts to recruit and retain providers had proven most effective and expanded those, focusing on long-term sustainability for the healthcare workforce. They also noted that the 2017-2022 Demonstration served as the groundwork for the 2022-2027 Demonstration. Compared to the previous Demonstration, MassHealth intentionally streamlined its approach by narrowing the number of initiatives while deepening investment in each one.

“We recognized the value of decreasing breadth while increasing depth of the state’s workforce initiatives, relative to the 2017-2022 waiver. As a result, we significantly reduced the number of workforce initiatives requested and implemented in the 2022-2027 waiver.” – a MassHealth staff respondent

SLRPs

Several lessons emerged from implementing the 2022-2027 PC and BH SLRPs. Application trends showed that the BH SLRP generated far more interest than funding could support, suggesting that the incentive levels were appealing. In contrast, the PC SLRP drew fewer applicants, which MassHealth WI staff interpreted as suggesting that its award levels may need to be increased to attract more participants.

MassHealth WI staff also identified practical challenges that should be addressed in future iterations. These include delays in finalizing application materials, technical problems with the online application platform, and difficulties compiling a comprehensive list of eligible organizations in Massachusetts. MassHealth WI staff noted that another challenge was ensuring MassHealth providers could find and provide the appropriate information needed to verify their eligibility.

MassHealth incorporated lessons from the 2017-2022 Demonstration. For instance, the agency had previously partnered with the Mass League to administer SLRPs, and continuing this partnership allowed MassHealth to rely on the Mass League’s established infrastructure and knowledge. From past implementation experience under the DSRIP SWI portfolio, MassHealth also concluded that award amounts needed to be increased to make the programs more appealing. Staff determined that psychiatrists and prescribing NPs, in particular, required substantially larger incentives. Drawing on a similar program in California, they selected a \$300,000 award level for these providers and raised award amounts for other provider types based on additional programs that MassHealth identified.

FNP Residency Grant Program

MassHealth learned lessons from challenges that arose through the implementation of the FNP Residency Program during the 2022-2027 Demonstration. MassHealth WI staff noted that

internal discussions on the procurement approach took time and delayed the launch of the FNP Residency Grant Program. The launch of the program required contracting with a vendor to manage payments between the state and the participating CHCs. Once a scope of work was added to an existing state contract, program planning and implementation proceeded smoothly. PCG supported in developing and implementing the program as well as managing contracts with the CHCs to ensure compliance. As with the SLRP, the residency program's design was influenced by similar efforts conducted during the previous Demonstration. MassHealth based the award amounts for the residency program on the earlier model and adjusted to reflect inflation.

6.3.1.3 Conclusions

Preliminary results suggest that MassHealth and its vendors successfully launched the three WI programs by building upon previous experience under the DSRIP SWI portfolio from the 2017-2022 Demonstration, as well as similar programs in other states. Additional qualitative interviews with administrators and awardees to address questions related to implementation will be conducted as part of the Independent Evaluation Summative Report (IESR) to support this conclusion.

6.3.2. RQ5-2 Did the WI programs increase the volume and diversity of the provider workforce in community-based settings?

6.3.2.1 Summary of Results

RQ5-2 examines whether the PC and BH SLRPs and the FNP Residency Grant Program increased the volume and diversity of the provider workforce in community-based settings. Early SLRP program data showed that 50.9% of awardees of the BH SLRP can provide care in another language in addition to English, while 45.2% of awardees of the PC SLRP can provide care in another language in addition to English. Program data is still changing and therefore, lessons learned from the PC and BH SLRP implementation, along with the programs' impact, will be presented in the IESR. The FNP Residency Grant Program has increased the number of FNP residency slots at eight CHCs across four counties in Massachusetts. Findings from the WI provider survey indicate that financial incentives were the primary driver of providers' stated willingness to remain in community-based settings.

The DCE found that across provider types and career stages, one-time salary increases had the greatest influence on preferences, accounting for the largest share of relative importance in the DCE and generating the strongest shifts relative to the SQ. SLRPs also had positive effects on retention preferences, though smaller in magnitude than salary increases. However, simulation results highlight their important complementary role. While enhancing SLRP alone produced more modest reductions in projected attrition, it did so at a low incremental cost per provider retained. Additionally, reducing loan repayment generosity weakened both the effectiveness and efficiency of combined incentivization strategies, suggesting that SLRP meaningfully reinforces salary-based approaches.

6.3.2.1 Results

H5-2.2 Offering BH student loan repayment will increase the volume and diversity of psychiatrists and NPs with prescribing privileges, licensed master's- or doctoral-level BH clinicians, pre-licensed master's-prepared BH clinicians, and licensed bachelor's-level BH clinicians practicing in community-based clinical settings serving at least 40% of MassHealth members and/or uninsured patients.

Table 6.3-2 shows the number of BH providers supported by the BH SLRP by provider type as of February 2026. MassHealth awarded 248 BH providers for the BH SLRP. Out of the 248 providers, 40 psychiatrists and NPs were awarded. The remaining awardees are licensed BH clinicians and master's-prepared pre-licensed clinicians. Most awardees work in a community-based organization that maintains a panel of at least 40% MassHealth members and/or uninsured patients, while the remaining awardees work in a different organization type (e.g., community hospital, personal practice) that maintains a panel of at least 40% MassHealth members and/or uninsured patients.

Table 6.3-2 Total BH Providers Supported by the BH SLRP, by Provider Type

Provider Type	Applicants (A)	Awardees (B)	Percentage Awarded by Provider Type
	N (%)	N (%)	B/A * 100%
Licensed Certified Social Worker	168 (14.2%)	32 (13.0%)	19.0%
Licensed Independent Clinical Social Worker	134 (11.4%)	24 (9.8%)	17.9%
Licensed Mental Health Counselor	140 (11.9%)	33 (13.4%)	23.6%
Master's-Prepared Pre-Licensed Professional	222 (18.8%)	52 (21.1%)	23.4%
Licensed Social Worker	44 (3.7%)	14 (5.7%)	31.8%
Psychiatric Mental Health NP	101 (8.6%)	25 (10.2%)	24.8%
Psychiatrist	45 (3.8%)	15 (6.1%)	33.3%
Psychologist	64 (5.4%)	24 (9.8%)	37.5%
Other	262 (22.2%)	27 (11.0%)	10.3%
Total	1,180 (100%)	246 (100%)	20.8%

Data Source: Individual-level program data provided by MassHealth

Abbreviations: Behavioral Health (BH); Nurse Practitioner (NP); Student Loan Repayment Program (SLRP)

Notes: Other includes Licensed Alcohol and Drug Counselor I, Registered Nurse, Board Certified Behavior Analyst, Licensed Social Work Associate, Licensed Alcohol and Drug Counselor II, Occupational Therapist, and Advanced Practice Registered Nurse

Table 6.3-3 shows the breakdown of awardees by provider’s demographic characteristics as of February 2026. The highest proportion of awardees work in Greater Boston, followed by Western Massachusetts and then Central Massachusetts. The proportion of awardees by region varied by provider type with the highest proportion of psychiatrists and NPs working in Central Massachusetts and the highest proportion of licensed and pre-licensed BH providers working in Greater Boston. Most awardees hold a master’s degree. Less than one-fifth of awardees identified themselves as Latino. Approximately one-third of awardees identified themselves as Asian or Black. An overwhelmingly high proportion of awardees identified as female. More than half of awardees speak another language in addition to English.

Table 6.3-3 BH Providers Supported by the BH SLRP by Region, Degree, Race, Ethnicity, Gender, and Languages Spoken

Characteristics	Total BH Providers N = 246
	N (%)
Region	246 (100%)
Western	59 (24.0%)
Greater Boston	73 (29.7%)
Central	58 (23.6%)
Southern	31 (12.6%)
Northern	25 (10.2%)
Degree	246 (100%)
Bachelor’s or Master’s (e.g., MSW)	210 (85.4%)
Doctoral or Medical	36 (14.6%)
Race	246 (100%)
Asian or Black	82 (33.3%)
White	122 (49.6%)
Other	42 (17.1%)
Latino	246 (100%)
Yes	37 (15.0%)
No	207 (84.1%)
Other	2 (0.8%)
Gender	246 (100%)
Female	202 (82.1%)
Male	35 (14.2%)
Other	9 (3.7%)

Characteristics	Total BH Providers N = 246
	N (%)
Languages Spoken	265 (100%)
English only	130 (49.1%)
Spanish	69 (26.0%)
Other	66 (24.9%)

Data Source: Individual-level program data provided by MassHealth

Abbreviations: Behavioral Health (BH); Master of Social Work (MSW); Student Loan Repayment Program (SLRP)

Notes: 1) Licensed BH clinicians or Master's prepared clinicians include, but are not limited to, the following provider types: Licensed Certified Social Worker, Licensed Independent Certified Social Worker, Licensed Mental Health Counselor, and Psychologist. NPs refers to Psychiatric Mental Health NPs. 2) Awardees were able to select more than one option when selecting languages spoken, gender, and race

As presented in **Table 6.3-4**, federally qualified health centers (FQHCs) with at least one SLRP awardee had higher BH provider-to-MassHealth member ratios compared to centers without awardees. Centers without an SLRP awardee had an average of 8,611 MassHealth members per BH provider, whereas centers with an SLRP awardee had 6,229 members per BH provider, an absolute difference of 2,382 additional members per BH provider, representing a 28% lower member-to-BH provider ratio.

Among MassHealth members with at least one BH visit, the ratio was 1,403 members per BH provider in centers without awardees, compared to 755 members per BH provider in centers with awardees, an absolute difference of 648 additional members per BH provider, representing a 46% lower member-to-BH provider ratio.

Table 6.3-4 presents the average ratio of BH providers to overall MassHealth members and to members with at least one BH visit, stratified by FQHC SLRP awardee status.

Table 6.3-4 Average Ratio of BH Providers to MassHealth Members

Centers by SLRP awardee status	Average ratio of all MassHealth members served to BH providers	Average ratio of MassHealth members who had at least one BH visit to BH providers
No SLRP awardee	8,611	1,403
At least one SLRP awardee	6,229	755
Differences: Members per BH providers (% of No SLRP awardee)	2,382 (28%)	648 (46%)

Data Source: MassHealth administrative data; WI Provider Survey; Individual-level program data provided by MassHealth

Abbreviations: Behavioral Health (BH); Student Loan Repayment Program (SLRP)

Notes: The average ratio of overall members was calculated by including all members who utilized the center for any services, while the average ratio of members who had at least one BH visit only include those who had a BH visit

H5-2.3 Offering PC student loan repayment will increase the volume and diversity of PC physicians, advanced practice registered nurses, clinical nurse specialists, NPs, and PAs practicing in a community-based clinical setting serving at least 40% of MassHealth members and/or uninsured patients.

Table 6.3-5 shows the number of PCPs supported by the PC SLRP by provider type as of February 2026. MassHealth awarded 93 PCPs for PC SLRP. The breakdown of PCPs is as follows: 51 APRNs, 20 PC physicians, 18 PAs, and four pediatricians. Most awardees work in a community-based organization that maintains a panel of at least 40% MassHealth members and/or uninsured patients, while the remaining awardees work in a different organization type (e.g., community hospital) that maintains a panel of at least 40% MassHealth members and/or uninsured patients.

Table 6.3-5 Total PCPs Supported by the PC SLRP, by Provider Type

Provider Type	Applicants (A)	Awardees (B)	Percentage Awarded by Provider Type
	N (%)	N (%)	B/A * 100%
APRN	78 (58.2%)	51 (54.8%)	65.4%
PA	19 (14.2%)	18 (19.4%)	94.7%
PC physician	29 (21.6%)	20 (21.5%)	69.0%
Pediatrician	5 (3.7%)	4 (4.3%)	80.0%
Other	3 (2.2%)	0 (0%)	0%
Total	134 (100%)	93 (100%)	69.4%

Data Source: Individual-level program data provided by MassHealth

Abbreviations: Advanced Practice Registered Nurse (APRN); Physician Assistant (PA); Primary Care (PC); Primary Care Provider (PCP);

Student Loan Repayment Program (SLRP)

Notes: Other includes optometrist, hospitalist, and medical assistant

Table 6.3-6 shows the breakdown of awardees by provider's demographic characteristics as of February 2026. The highest proportion of awardees work in Western Massachusetts, followed by Greater Boston. All PC physicians and pediatricians hold an MD or DO degree, while APRNs and PAs mostly hold a master's degree. Most awardees did not identify as Latino. Less than one-tenth of awardees identified themselves as Asian. About one-tenth of awardees identified themselves as Black. An overwhelmingly high proportion of awardees identified as female. Less than half of awardees speak another language in addition to English.

Table 6.3-6 PCPs Supported by the PC SLRP by Region, Degree, Race, Ethnicity, Gender, and Languages Spoken

Characteristics	Total PCPs N = 93
	N (%)
Region	93 (100%)
Central	18 (19.4%)

Characteristics	Total PCPs N = 93
	N (%)
Greater Boston	20 (21.5%)
Western	31 (33.3%)
Northern	11 (11.8%)
Southern	13 (14.0%)
Degree	93 (100%)
Master's (e.g., MPAS)	60 (64.5%)
Doctoral or Medical	33 (35.5%)
Race	93 (100%)
Asian or Black	17 (18.3%)
White	65 (69.9%)
Other	10 (10.8%)
Latino	93 (100%)
No	88 (94.6%)
Other	5 (5.4%)
Gender	93 (100%)
Female	69 (74.2%)
Male	21 (22.6%)
Other	3 (3.2%)
Languages Spoken	104 (100%)
English only	57 (54.8%)
Spanish	18 (17.3%)
Other	29 (27.9%)

Data Source: Individual-level program data provided by MassHealth

Abbreviations: Master of Physician Assistant Studies (MPAS); Primary Care (PC); Primary Care Physician (PCP); Student Loan Repayment Program (SLRP)

Notes: Awardees were able to select more than one option when selecting languages spoken, gender, and race

As presented in **Table 6.3-7**, FQHCs with at least one SLRP awardee had lower PCP-to-MassHealth member ratios compared to centers without awardees. Centers without an SLRP awardee had an average of 267 MassHealth members per PCP, whereas centers with an SLRP awardee had 207 members per PCP, an absolute difference of 60 additional members per PCP, representing a 23% lower member-to-PCP ratio.

Among MassHealth members with at least one PC visit, the ratio was 228 members per PCP in centers without awardees, compared to 174 members per PCP in centers with awardees, an

absolute difference of 54 additional members per PCP, representing a 24% lower member-to-PCP ratio.

Table 6.3-7 presents the average ratio of PCPs to overall members and to members with at least one PC visit, stratified by FQHC SLRP awardee status.

Table 6.3-7 Average Ratio of PCPs to MassHealth Members

Centers by SLRP awardee status	Average of the ratio of all MassHealth members served to PCP	Average of the ratio of MassHealth members who had at least one PC visit to PCP
No SLRP awardee	267	228
At least one SLRP awardee	207	174
Differences: Members per PCPs (% of No SLRP awardee)	60 (23%)	54 (24%)

Data Source: MassHealth administrative data, WI Provider Survey, and Individual-level program data provided by MassHealth

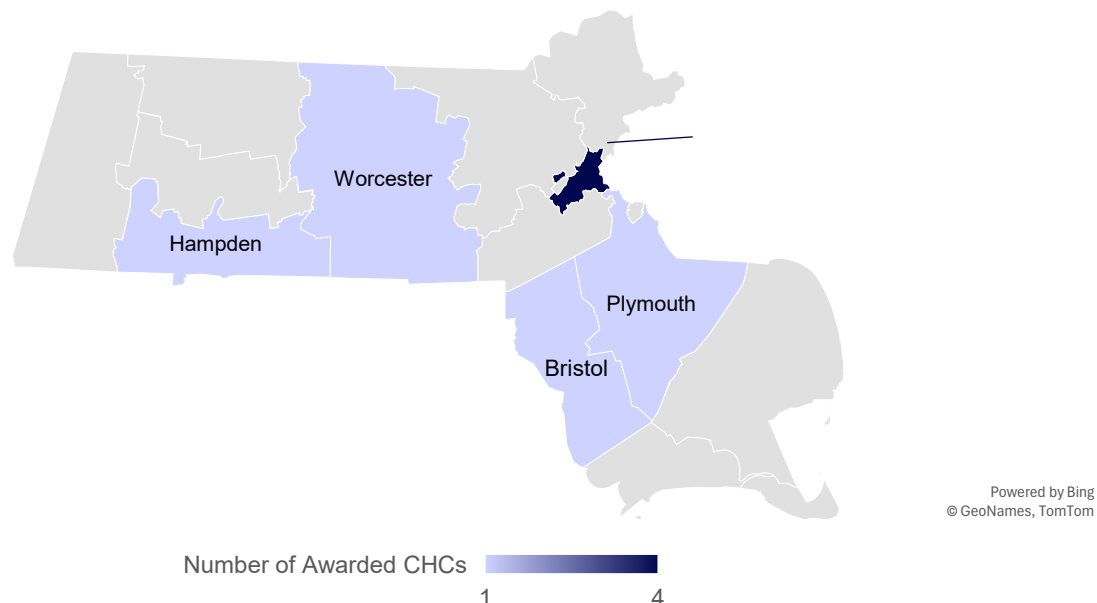
Abbreviations: Primary Care (PC); Primary Care Provider (PCP); Student Loan Repayment Program (SLRP)

Notes: The average ratio of overall members was calculated by including all members who utilized the center for any services, while the average ratio of members who had at least one PC visit only include those who had a PC visit

H5-2.4 Offering an FNP residency grant program will increase the volume of FNPs in CHCs serving at least 40% MassHealth members.

Fourteen CHCs applied to the FNP Residency Grant Program, requesting an approximate combined total of \$5.2 million in funding and a total of 40 FNP residency slots. MassHealth awarded the FNP Residency Grant to eight CHCs. Each CHC was awarded two FNP residency slots. All CHC awardees are in non-rural locations, in HPSAs, and/or are part of an AHEM community. Half of the awardees are establishing new FNP residency programs, while three of the awardees are sustaining their FNP resident slots and one awardee is expanding their number of FNP residency slots.

Figure 6.3-1 shows the number of CHC awardees by county. Half of awardees are in Boston within Suffolk County. The remaining CHC awardees are in the following counties: Bristol, Hampden, Worcester, and Plymouth.

Figure 6.3-1 Awarded CHCs by County

Data Source: CHC-level program data provided by MassHealth

Abbreviation: Community Health Centers (CHCs)

Notes: CHCs are defined as located in Massachusetts operated by an organization that is a FQHC or Rural Health Center including a hospital-licensed health center that is an FQHC, or an FQHC look-alike

H5-2.5 The WI programs will improve providers' willingness to practice in community-based settings, as compared to direct intervention, such as direct rate increase.

Of the 3,624 providers invited to participate in the WI Provider survey, 761 completed the survey, and 12 partially completed it. An additional 149 invitees were ineligible (not within the target population or retired), 121 were eligible but discontinued the survey prior to completing the DCE choice sets, and 2,581 did not respond. The overall response rate was 24.9%. Seven follow-up emails were sent to non-respondents over the course of the survey fielding period, and additional outreach was conducted through practice site administrators (PSAs) to encourage provider participation. Refer to **Appendix F-1** for more information on the population and sampling frame.

As shown in **Table 6.3-8**, 80% of respondents were female, and 37% reported speaking a language other than English fluently, indicating that they do not require an interpreter to communicate with patients in the non-English language they are proficient with. Most respondents identified as White non-Hispanic (62%), followed by Hispanic or Latino (11%) and multiracial or other race (11%). The majority of respondents (72%) were BH professionals, and 55% reported working in a community-based clinical setting for more than five years. Most respondents (70%) indicated that they were very or somewhat likely to be working in a community-based clinical setting five years from now. Approximately half of respondents reported participating in a SLRP, and among those, 41% indicated that they had completed their service obligation.

Table 6.3-8 Respondent Characteristics

Characteristic	<i>n</i>	Percentage
TOTAL	773	100%
Sex *		
Male	127	16.4%
Female	621	80.3%
Other	17	2.2%
Non-English language spoken fluently †		
Spanish	138	17.9%
Other languages	149	19.3%
Race/Ethnicity *		
White, non-Hispanic	482	62.4%
Hispanic or Latino	82	10.6%
Black, non-Hispanic	61	7.9%
Asian, non-Hispanic	45	5.8%
Multi-race or other race	95	11.1%
Provider Type		
Primary care physician (MD/DO)	95	12.3%
Primary care advanced practice provider	119	15.4%
Physician assistant	2	0.3%
Psychiatrist	27	3.5%
Mental health advanced practice provider	59	7.6%
Licensed behavioral health clinician	335	43.3%
License-eligible behavioral health provider	136	17.6%
Years working in a community-based clinical setting		
Less than 2 years	124	16.0%
2 years to less than 5 years	224	29.0%
5 years to less than 10 years	171	22.1%
10 years to less than 15 years	103	13.3%
15 years to less than 20 years	72	9.3%

Characteristic	<i>n</i>	Percentage
20 years or more	79	10.2%
Likelihood of working in a community-based clinical setting for five years *		
Very Likely	245	31.7%
Somewhat Likely	297	38.4%
Somewhat Unlikely	135	17.5%
Very Unlikely	88	11.4%
Participated in any loan repayment programs *		
Yes	385	49.8%
No	380	49.2%
Completed service obligation for the loan repayment program ‡		
Yes	158	41.0%
No	227	59.0%

Data Source: WI Provider Survey

Abbreviations: Doctor of Osteopathic Medicine (DO); Medical Doctor (MD)

Notes: † Respondents could select more than one non-English language; percentages are not mutually exclusive. ‡ Percentages calculated among respondents who participated in a loan repayment program. * Percentages do not add up to 100% due to missing responses

Policy Options for Provider Retention

Table 6.3-9 summarizes the extent to which nine potential policy options would motivate providers to continue working in a community healthcare setting, overall and by provider type. Retention bonuses were rated as the most important policy option overall (mean = 8.8, confidence interval [CI]: 8.6, 8.9 out of 10), with ratings ranging from a mean of 9.2 among mental health advanced practice providers to 7.9 among PC physicians. The second highest-rated policy was additional compensation tied to the achievement of specified performance metrics (mean = 8.0, CI: 7.8, 8.2), with average ratings ranging from 8.8 among mental health advanced practice providers to 6.5 among PC physicians. Expanding the scope of services for other members of the care team to reduce provider burnout was also rated highly (mean = 7.9, CI: 7.8, 8.1), with particularly high ratings among PAs (mean = 9.5) and lower ratings among psychiatrists (mean = 7.3).

Subsidized career advancement opportunities and support for residency or fellowship programs were rated as moderately important overall (means = 6.6, for both CI: 6.4, 6.8). Mental health advanced practice providers rated these policies more favorably (means = 7.8 and 7.2, respectively) than psychiatrists (means = 6.1 and 3.8, respectively).

Ratings varied across provider types, with the largest differences observed for loan repayment-related policies. SLRPs and extensions beyond the initial four years¹⁸⁷ were rated as moderately important overall (means = 6.3, CI: 6.0, 6.6 and 5.6, CI: 5.3, 5.9, respectively). Mental health advanced practice providers rated both SLRP (mean = 7.2) and SLRP extensions (mean = 6.4) more highly than psychiatrists, who assigned substantially lower importance (means = 3.6 and 3.3, respectively).

Support for implementing a special project was rated as modestly important overall (mean = 5.8, CI 5.6, 6.0), with substantial variation by provider type. PAs rated this policy as highly important (mean = 9.0), though this finding should be interpreted cautiously since the PA subgroup was small. Psychiatrists assigned considerably lower importance to this option (mean = 4.8).

PC and BH providers at FQHCs and CBHCs were asked to provide suggestions that would motivate them to continue working in a community-based clinical setting. Suggestions varied from MassHealth policy options, such as SLRPs, to center-level policy options, such as better benefits and a positive work culture. In terms of MassHealth policy options, out of 469 providers who made suggestions, about one-tenth felt that SLRPs were beneficial and would promote working in community-based settings; however, some felt that the time obligation should be shortened from four years to two years. In terms of center-level policy options, almost half of providers suggested that an increase in salary, including bonuses, raises, and salary differential for bilingual providers, would motivate them to continue working in a community-based clinical setting. Salary increase was suggested the most among all provider types. Other suggestions included a flexible work environment (i.e., hybrid work model), support from management and leadership, smaller patient panel sizes, and less productivity requirements. Providers also suggested policy options that could be implemented by either MassHealth or centers such as professional development and paying for protected time such as time set aside for research, patients, or teaching. About one-fourth of providers were interested in some sort of professional development, whether it be training, continuing medical education, or another opportunity.

“Paid time off along with higher wages and student loan payments. As a single parent with a mortgage and student loans, those are my two biggest concerns but also taking time off for appointments and when me or my child is sick and it has to come out of my vacation time which is really hard, especially because our paid time off is also for holidays too. There is extreme burnout in this industry but it’s a much-needed profession and we should be compensated accordingly.” – a Provider

¹⁸⁷ Extension of the SLRP beyond the initial 4 years, with \$20,000 per year for years 5 and 6 and \$10,000 per year thereafter, of continued employment in a community health setting.

Table 6.3-9 Average Importance of Policy Options for Provider Retention in Community Health Settings, Overall Rating and by Provider Type

Policy Option	n	Average Importance Rating (1-10)							
		Overall	Primary Care Physician	Primary Care Advanced Practice Provider	Physician Assistant	Psychiatrist	Mental Health Advanced Practice Provider	Licensed Behavioral Health Clinician	License-Eligible Behavioral Health Provider
Number of providers	N/A	N/A	95	119	2	27	59	335	136
Retention bonus	767	8.8	7.9	8.9	8.0	9.0	9.2	8.9	8.7
Additional compensation based on achievement of specified performance metrics	767	8.0	6.5	7.9	8.5	7.4	8.8	8.3	8.3
Expansion in the scope of service for other members of the care team to help reduce provider burnout	767	7.9	7.9	8.2	9.5	7.3	8.5	7.5	8.1
Sign-on bonus	766	6.9	6.3	7.1	4.0	6.8	8.0	6.9	6.8
Subsidized career advancement opportunities (e.g., partial funding towards a degree or certificate program)	767	6.6	6.0	6.6	6.0	6.1	7.8	6.4	7.0
SLRP	766	6.3	4.5	6.7	5.5	3.6	7.2	6.2	7.1
Residency or fellowship programs in various specialties	298	6.0	4.7	6.7	7.0	3.8	7.2	N/A	N/A
Support for the implementation of a special project of your interest (e.g., quality improvement, clinical, or research project)	767	5.7	6.5	5.9	9.0	4.8	6.8	5.3	5.7

Policy Option	<i>n</i>	Average Importance Rating (1-10)							
		Overall	Primary Care Physician	Primary Care Advanced Practice Provider	Physician Assistant	Psychiatrist	Mental Health Advanced Practice Provider	Licensed Behavioral Health Clinician	License-Eligible Behavioral Health Provider
Extension of the SLRP beyond the initial 4 years, with \$20,000 per year for years 5 and 6 and \$10,000 per year thereafter, of continued employment in a community health setting	766	5.6	4.4	6.2	5.5	3.3	6.4	5.4	5.9

Data Source: WI Provider Survey

Abbreviations: Not Applicable (N/A); Student Loan Repayment Program (SLRP)

Notes: To ensure descriptive importance ratings reflected the target distribution of provider types, we applied post-stratification non-response sampling weights based on provider position categories. Weighted means were computed for each policy rating item. N/A denotes not applicable (BH clinicians and providers were not eligible for these programs)

Discrete Choice Experiment

This section focuses on provider retention and examines the workforce strategies healthcare providers value when considering whether to remain employed in CHCs serving MassHealth members or uninsured individuals. The evaluation was designed to inform CMS questions about the relative importance of student loan repayment programs compared with increased reimbursement rates that may support higher provider salaries. To ground the analysis in the financial realities of CHCs, we used data from the 2019 Community Health Center Cost Reports to examine CHC revenue sources, expenditure patterns, and patient mix. As shown in **Appendix F-1**, third-party payers account for approximately 60% of CHC net patient service revenue, with MassHealth representing nearly half of net patient service revenue and more than one-quarter of total CHC revenue. Grants, gifts, and donations account for an additional 26% of total revenue. On the expenditure side, personnel costs, including wages, payroll taxes, and benefits, account for 66% of total CHC expenditures. These patterns highlight the potential connection between MassHealth reimbursement rates, CHC revenue structures, and CHCs' ability to support competitive provider compensation.

To assess provider preferences, we analyzed responses from a DCE survey designed to elicit provider preferences for job-related incentives intended to support retention in community health settings serving MassHealth members. Each respondent completed eight experimental choice tasks (i.e., structured scenarios in which participants were asked to choose between hypothetical policy alternatives), each presenting two hypothetical policy alternatives and a SQ option reflecting current job conditions. A ninth task served as a validity check and was excluded from the analytic sample. (See **Appendix F-1** for validity check results.) Although some DCE attributes, such as salary increases, are not directly within MassHealth's purview or included within the scope of the WIs in the 2022–2027 Demonstration, they were included because CHC financial data suggest an indirect relationship between MassHealth reimbursement rates, CHC revenues, personnel expenditures, and provider compensation. By focusing on current providers, this section informs policies aimed at improving retention, strengthening workforce stability, and supporting sustained access to care in CHCs.

Providers were categorized into four tiers according to provider type and associated student loan repayment amounts and salary increases, which varied systematically across provider categories. (See **Appendix Table F-1.1** for all job attributes and attribute levels by provider type included in the DCE survey.)

- Tier 1: BH providers, including mental health advanced practice providers, licensed BH clinicians, and license-eligible BH providers;
- Tier 2: PC advanced practice providers and PAs;
- Tier 3: PC physicians;
- Tier 4: Psychiatrists.

The initial analytic dataset included 773 provider respondents. During data cleaning, five choice tasks (corresponding to 15 alternative-level observations)¹⁸⁸ were identified in which no choice task was selected. These incomplete choice tasks occurred among psychiatrists in Tier 4 provider categories. Because discrete choice models require exactly one selected alternative per choice task, these observations were excluded from the analytic sample. The final analytic dataset, therefore, included 18,522 alternative-level observations, corresponding to 6,174 valid choice tasks.

Internal validity checks reversed the order of some of the choices to check whether the respondent's answers corrected for this. The results demonstrated high consistency across responses to repeated-choice tasks, and quality-control analyses indicated a low prevalence of potentially problematic response patterns (only 20% of 773 respondents).

Utility

Across all valid experimental choice tasks, respondents selected one of the two policy alternatives in 91% of cases. The SQ option was chosen in approximately 9% of choice tasks, indicating that most respondents were willing to consider alternative job configurations when presented with changes in incentives and job characteristics.

Table 6.3-10 presents attribute-level utility estimates from the primary conditional logit model of providers' responses in the DCE survey. Utilities represent the underlying preference value assigned to each attribute level and determine the probability that an option containing that attribute level will be chosen. Because the model uses effects coding, the utilities for the levels of each attribute are estimated relative to the attribute-specific mean, which is constrained to zero. Larger positive values indicate stronger preference relative to the average level of that attribute, while larger negative values indicate lower preference.¹⁸⁹ For example, the three levels of SLRP have utilities of -0.62, 0.08, and 0.54. Level 75% repayment has a utility of 0.54, indicating it is preferred more than the average SLRP level, whereas the level with a utility of -0.62 (25%) is preferred less than the average SLRP level. Under effects coding, utilities reflect the relative strength of provider preferences across job characteristics.

Financial incentives were the strongest drivers of provider choice. Salary increases had the largest effect on utility, with no salary increase strongly disfavored (-1.00; 95% CI: -1.11, -0.90) and modest salary increases producing the largest utility gain of any attribute level (0.90; 95% CI: 0.81, 0.99). These results indicate that increases in reimbursement that translate into salary improvements are likely the most effective lever for retaining providers in community health settings.

Student loan repayment was also an important factor influencing provider preferences. Providers strongly disliked low levels of loan repayment (repayment of 25% of student debt; -0.62; 95% CI: -0.72, -0.52), while higher repayment levels were positively valued. The most generous loan repayment option (repayment of 75% of student debt) was associated with a

¹⁸⁸ After data collection, each respondent's choice within a task is transformed into alternative-level observations for analysis. In this structure, each alternative within a choice task becomes one observation in the analytic dataset, with an indicator identifying the chosen option.

¹⁸⁹ An effects-coded model estimates how each attribute level differs from the overall average effect of that attribute, with coefficients constrained to sum to zero.

positive utility of 0.54 (95% CI: 0.44, 0.64), indicating substantial but smaller effects relative to salary increases.

Non-financial incentives played a more limited role. Special project support had modest effects on choice, with only the highest level of support (level 3: 20% effort) yielding a small positive utility (0.07; 95% CI: 0.03, 0.12), while lower levels were not meaningfully different from the attribute mean. Professional development opportunities showed clearer differentiation by type: providers strongly preferred opportunities focused on clinical skills and specialization (0.27; 95% CI: 0.22, 0.31), while technology-focused training (-0.17; 95% CI: -0.22, -0.13) and leadership or administrative development (-0.09; 95% CI: -0.14, -0.05) were both negatively valued indicating providers preferences for those options were less than the attribute's average.

Overall, the results suggest that while loan repayment programs and professional development opportunities can contribute to provider retention, salary increases are the most influential incentive, with substantially larger effects on provider choice than other policy levers examined.

Table 6.3-10 Attribute-Level Utilities from the Discrete Choice Experiment

Attribute-Level	Utility	95% CI	
Loan Repayment			
25% repayment	-0.62	-0.72	-0.52
50% repayment	0.08	0.04	0.12
75% repayment (derived)	0.54	0.44	0.64
Salary Increase			
No increase	-1.00	-1.11	-0.90
Low increase (5-15% based on tier)	0.11	0.05	0.16
Modest increase (10-30% based on tier) (derived)	0.90	0.81	0.99
Special Project Program			
5% support	-0.02	-0.07	0.03
10% support	-0.05	-0.11	0.01
20% support (derived)	0.07	0.03	0.12
Professional Development			
Technology and innovation	-0.17	-0.22	-0.13
Clinical skills and specialization	0.27	0.22	0.31
Leadership and administration roles (derived)	-0.09	-0.14	-0.05

Data Source: WI Provider Survey

Abbreviation: Confidence Interval (CI)

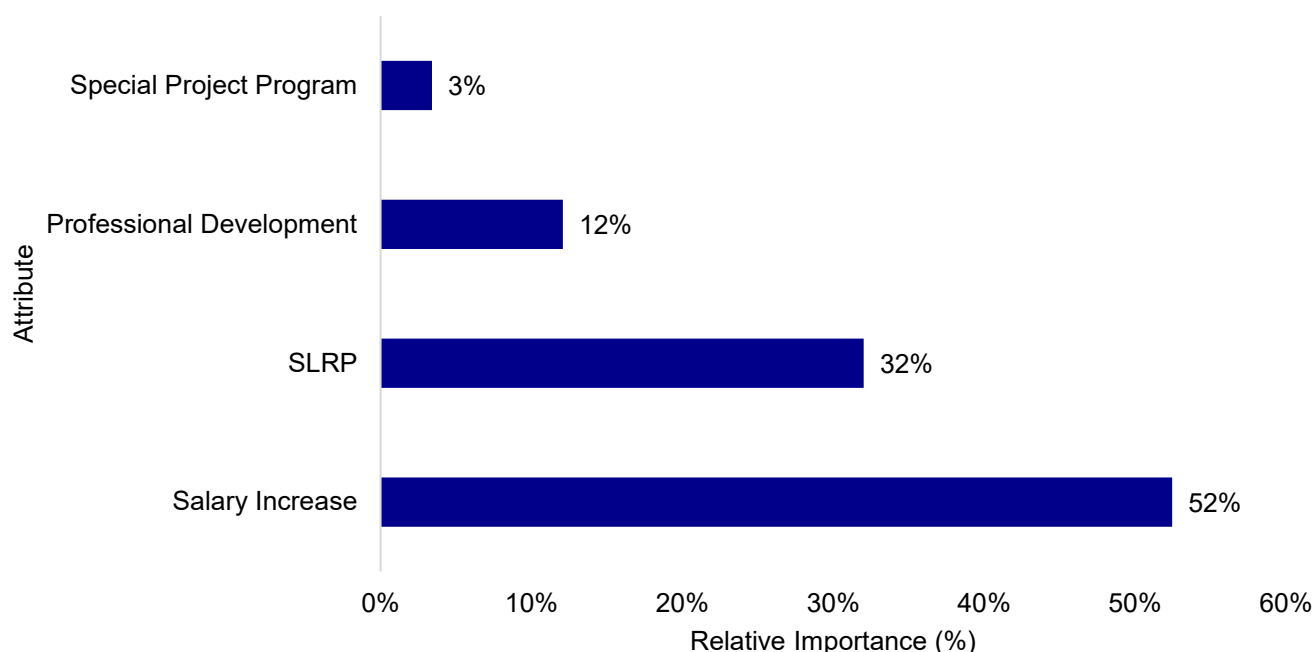
Notes: Positive utility values indicate that a job attribute level increases the likelihood that a provider would prefer a job offer relative to other levels of the same attribute. Larger differences in utility indicate stronger preferences. Relative importance reflects the share of overall decision-making attributable to each job attribute and should be interpreted comparatively rather than as absolute effects. Estimates reflect

trade-offs among four job attributes: student loan repayment, salary increases, professional development opportunities, and special project support. Robust standard errors were clustered at the respondent level to account for repeated choices. Utilities for omitted attribute levels were derived as the negative sum of estimated coefficients within each attribute. Results should be interpreted as relative preferences rather than absolute effects on observed retention behavior

Relative Importance

As presented in **Figure 6.3-2**, financial incentives overwhelmingly drove provider choice decisions. Salary increases were the most influential attribute, accounting for just over half of the total relative importance (52%) and yielding a utility range of 1.90 (i.e., -1.00 - +0.9). Student loan repayment was the second most important attribute, contributing approximately one-third of the overall relative importance (32%) and exhibiting a utility range of 1.16, about 61% of the salary utility range (i.e., $1.16/1.90 = 61\%$). Together, these financial incentives accounted for more than 80% of the total explanatory importance in provider choice.

In contrast, non-financial attributes played a substantially smaller role. Professional development opportunities contributed 12% of total relative importance (utility range = 0.44), while special project support accounted for only 3% (utility range = 0.12). Although overall ratings suggested providers had some interest in non-financial incentives, especially opportunities focused on clinical skills and specialization, the overall influence of those opportunities on choice was modest compared with financial incentives. Overall, the results indicate that while non-financial supports may complement retention strategies, salary increases and loan repayment are the primary factors driving providers' decision to continue working in community health settings.

Figure 6.3-2 Relative Importance of Financial and Non-financial Attributes

Data Source: WI Provider Survey

Abbreviation: Student Loan Repayment Program (SLRP)

Notes: Bars represent the utility range (maximum minus minimum estimated utility) for each attribute. Relative importance was calculated as the proportion of each attribute's utility range relative to the sum of utility ranges across all attributes. Utilities are effect-coded and reflect deviations from attribute-specific grand means; values for omitted levels were derived as the negative sum of estimated coefficients. Longer bars indicate attributes with greater influence on provider choice

Subgroup Analyses

Subgroup analyses indicated a high degree of consistency in provider preferences across provider type, tenure in community health settings, and participation in SLRP. Across all subgroups, salary increases were the strongest driver of provider choice, followed by student loan repayment, while professional development opportunities and special project support played more limited roles.

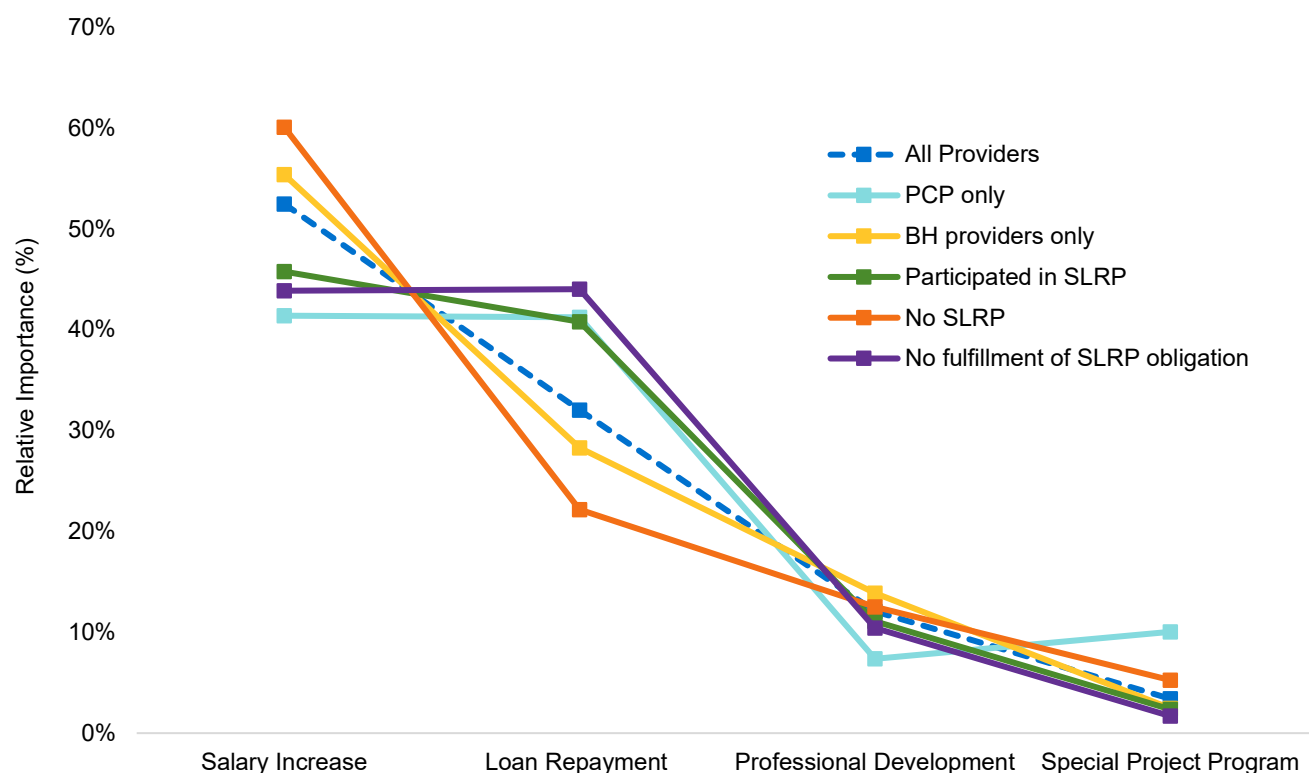
Salary increases were strongly preferred in all groups, with no increase consistently disfavored and modest increases yielding the largest utility gains. Mental health providers demonstrated greater responsiveness to salary changes than PCPs (utility range: 2.25 vs. 1.42). Providers with fewer than five years of experience in community health settings also showed greater sensitivity to salary increases than those with longer tenure (utility range: 2.26 vs. 1.65).

Student loan repayment was valued across all subgroups, although its relative importance varied. Providers who had previously participated in SLRP, particularly those who had completed their service obligation, exhibited stronger preferences for more generous repayment options. In contrast, providers without prior participation in SLRP showed smaller, though still positive, responses to higher repayment levels (utility range: 1.25 vs. 0.77).

Preferences for professional development opportunities were consistent across subgroups, with clinical skills and specialization strongly preferred relative to technology-focused or leadership-oriented training. Special project support had modest effects across all groups, with positive utility observed only at the highest level of support.

Figure 6.3-3 displays the relative importance of job attributes across selected provider subgroups. Salary increases accounted for the largest share of decision-making across all groups (41-60%), followed by student loan repayment (22-44%). Professional development and special project support contributed at substantially lower levels. Although the magnitude of preferences varied by provider type, career stage, and prior participation in SLRP, the rank ordering of attributes was consistent across subgroups, underscoring the significant role of financial incentives in provider retention decisions.

Figure 6.3-3 Relative Importance of Job Attributes Across Key Provider Subgroups



Data Source: WI Provider Survey.

Abbreviations: Behavioral Health (BH); Primary Care Provider (PCP); Student Loan Repayment Program (SLRP)

Notes: Bars represent the proportion of total utility range attributable to each attribute, calculated as the difference between the maximum and minimum estimated utility across attribute levels and normalized within each subgroup. Salary increases were the dominant driver of provider choice across all subgroups, followed by student loan repayment.

Sensitivity Analyses

Sensitivity analyses incorporating alternative samples, weighting, and model specifications supported the robustness of the primary findings. Re-estimation of the conditional logit models using survey non-response weights produced utility estimates that were closely aligned with those of the unweighted primary model, with no change in the rank ordering of attribute effects. Weighted results slightly increased the utility range and relative importance of student loan repayment (utility range: 1.24 vs. 1.16; relative importance: 34% vs. 32%), while marginally reducing the relative importance of salary increases (51% vs. 52%). These shifts were small and did not alter the substantive conclusion that salary increases and student loan repayment were the dominant drivers of provider choice.

Results were similarly stable when observations flagged for potential data quality concerns or invalid responses were excluded. Across all restricted samples, attribute-level utilities remained within the 95% confidence intervals of the full-sample estimates, and utility ranges and relative importance measures were nearly identical to those from the primary model. Salary increases consistently exhibited the largest utility range (1.86-1.93) and accounted for just over half of total relative importance (52-53%), followed by student loan repayment (utility range: 1.16-1.18; relative importance: 32%). Professional development and special project support continued to play comparatively smaller roles, together accounting for less than 15% of overall relative importance across specifications.

Findings from the mixed logit model further reinforced these conclusions while highlighting meaningful heterogeneity in provider preferences. Salary increases and student loan repayment again emerged as the most influential attributes, with substantially larger utility ranges (3.66 and 2.31, respectively) than those observed in the conditional logit models. Large standard deviations for both salary and loan repayment parameters indicate considerable variation in providers' responsiveness to financial incentives, suggesting that, while financial compensation is broadly important, its magnitude of influence differs across individuals. In contrast, non-financial incentives exhibited limited heterogeneity and remained secondary drivers of choice.

Overall, the consistency of utility estimates, utility ranges, and relative importance measures across weighted and unweighted models, restricted samples, and alternative model structures underscores the robustness of the study's results and conclusions: salary increases are the primary determinant of provider retention decisions, followed by student loan repayment, with professional development and special project support exerting modest influence. **Table 6.3-11** summarizes results from sensitivity and robustness analyses assessing the stability of attribute-level utility estimates across alternative model specifications and analytic samples.

Table 6.3-11 Sensitivity Analyses of Attribute-Level Utilities

Attribute-Level	Primary Model	Weighted	Excluding Quality Concerns	Excluding Invalid Responses	Robustness Check: Mixed Logit
	Mean	Mean	Mean	Mean	Mean
SLRP					
25% repayment	-0.62	-0.66	-0.64	-0.65	-1.23
50% repayment	0.08	0.09	0.10	0.09	0.15
75% repayment (derived)	0.54	0.57	0.54	0.51	1.08
<i>Utility Range</i>	<i>1.16</i>	<i>1.24</i>	<i>1.18</i>	<i>1.16</i>	<i>2.31</i>
<i>Relative Importance</i>	<i>32%</i>	<i>34%</i>	<i>32%</i>	<i>32%</i>	<i>33%</i>
Salary Increase					
No increase	-1.00	-0.98	-1.01	-1.02	-1.95
Low increase (5-15% based on tier)	0.11	0.10	0.09	0.10	0.25
Modest increase (10-30% based on tier) (derived)	0.90	0.88	0.92	0.90	1.70
<i>Utility Range</i>	<i>1.90</i>	<i>1.86</i>	<i>1.93</i>	<i>1.91</i>	<i>3.66</i>
<i>Relative Importance</i>	<i>52%</i>	<i>51%</i>	<i>53%</i>	<i>52%</i>	<i>53%</i>
Special Project Program					
5% Support	-0.02	-0.05	0.00	-0.03	-0.13
10% support	-0.05	-0.05	-0.07	-0.07	-0.02
20% support (derived)	0.07	0.10	0.06	0.07	0.15
<i>Utility Range</i>	<i>0.12</i>	<i>0.15</i>	<i>0.13</i>	<i>0.15</i>	<i>0.28</i>
<i>Relative Importance</i>	<i>3%</i>	<i>4%</i>	<i>4%</i>	<i>4%</i>	<i>4%</i>

Attribute-Level	Primary Model	Weighted	Excluding Quality Concerns	Excluding Invalid Responses	Robustness Check: Mixed Logit
	Mean	Mean	Mean	Mean	Mean
Professional Development					
Technology and innovation	-0.17	-0.15	-0.17	-0.16	-0.27
Clinical skills and specialization	0.27	0.26	0.26	0.28	0.43
Leadership and administration roles (derived)	-0.09	-0.12	-0.10	-0.11	-0.16
<i>Utility Range</i>	<i>0.44</i>	<i>0.41</i>	<i>0.43</i>	<i>0.44</i>	<i>0.69</i>
<i>Relative Importance</i>	<i>12%</i>	<i>11%</i>	<i>12%</i>	<i>12%</i>	<i>10%</i>

Data Source: WI Provider Survey

Abbreviation: Student Loan Repayment Program (SLRP)

Notes: Results are shown for the primary unweighted conditional logit model; a weighted model accounting for differential response rates by provider type; restricted samples excluding observations flagged for quality concerns or invalid responses; and a mixed logit specification allowing random preference heterogeneity for selected financial incentives. Utilities are effects-coded and represent deviations from attribute-specific grand means; values for omitted levels were derived as the negative sum of estimated coefficients. Utility ranges were calculated as the difference between the maximum and minimum utilities within each attribute, and relative importance was calculated as each attribute's utility range divided by the sum of utility ranges across attributes. Mixed logit results report standard deviations (SD) only for parameters specified as random

Simulation Analyses

Counterfactual policy scenarios were constructed by modifying attribute levels for the policy alternative and comparing each policy package against a provider-tier-specific SQ compensation package reflecting existing conditions (See **Appendix F-1** for more information on the five evaluated policy scenarios.) Five policy scenarios were evaluated:

1. High-salary increase scenario featuring a one-time salary increase set at the highest level by tier, with student loan repayment held at SQ levels and no non-financial incentives (i.e., High-salary and SLRP SQ)
2. An enhanced loan repayment-only scenario in which student loan repayment was set to the highest level while salary and non-financial incentives remained at SQ levels (i.e., High SLRP only)
3. A one-time salary increase set at the highest level by tier, with student loan repayment reduced to 25% of the average provider student loan per tier, and no non-financial incentives (i.e., High-salary and lower SLRP payment)
4. A balanced compensation package combining a moderate-salary increase with student loan repayment held at SQ levels by tier, and excluding any non-financial incentives (i.e., Moderate-salary and SLRP SQ)
5. Finally, we tested a scenario offering only non-financial incentives with SQ SLRP (i.e., Projects+ Professional Development + SLRP SQ).

Simulated preference probabilities under counterfactual policy scenarios confirmed that salary increases were the most influential policy lever across provider tiers. Under the high-salary increase and SLRP SQ policy option, approximately 87% of providers across provider types were predicted to prefer the policy package over their tier-specific SQ (i.e., no salary increase beyond the institute's standard annual salary adjustment, current SLRP generosity, and no additional opportunities for special projects or professional development beyond what is currently available). This strong preference was consistent across tiers, indicating that salary increases substantially outweighed differences in existing loan repayment and non-financial incentives.

The moderate-salary increase and SLRP SQ policy option was also strongly preferred, with approximately 75% of providers across tiers favoring the policy over their tier-specific SQ. Although preference levels were lower than under the highest salary increase, these results indicate that substantial preference gains can be achieved with more moderate compensation enhancements.

The high-salary increase and lower SLRP payment policy option yielded intermediate preference shifts. Approximately 77% of providers in Tiers 1-3 and 68% of Tier 4 providers preferred this package over their tier-specific SQ. These results suggest that while salary increases dominate provider preferences, reducing loan repayment generosity partially decreases the overall attractiveness of the compensation package.

In contrast, the higher SLRP-only policy option produced more modest preference shifts. Among Tiers 1-3, approximately 61% of SLRP-eligible providers preferred the enhanced loan

repayment package over their tier-specific SQ, while no preference gain was observed among Tier 4 providers, for whom baseline loan repayment was already at the maximum level. Non-financial incentives alone generated limited preference shifts and are therefore presented for context. **Table 6.3-12** shows the relative attractiveness of each policy relative to the SQ.

Table 6.3-12: Simulated Probability of Preferring Policy Package Over the Status Quo, by Provider Tier

Provider Tier	High-salary and SLRP SQ	High-salary and Lower SLRP	Moderate-salary and SLRP SQ	Higher SLRP Only	Projects + PD High (SLRP SQ)
Tiers 1-3	87%	77%	75%	61%	54%
Tier 4	87%	68%	75%	50%	54%

Data Source: WI Provider Survey

Abbreviations: Professional Development (PD); Student Loan Repayment Program (SLRP); Status Quo (SQ)

Notes: Provider tiers are defined as follows: Tier 1 includes licensed BH providers (e.g., psychologist, LADC1, LCSW, LICSW, LMHC), license-eligible BH providers, and mental health advanced practice providers (e.g., psychiatric mental health nurse practitioner [PMHNP], psychiatric clinical nurse specialist). Tier 2 includes primary care advanced practice providers (e.g., advanced practice registered nurses) and physician assistants (PAs). Tier 3 includes primary care physicians (MD/DO), such as family physicians, internists, pediatricians, geriatricians, and residents providing primary care. Tier 4 includes psychiatrists. Predicted probabilities represent the likelihood that a provider would prefer the policy package relative to the status quo when presented with these two options. For salary-inclusive scenarios, probabilities were applied to the full provider population within each tier. Simulated outcomes reflect stated preferences under hypothetical scenarios and should be interpreted as indicators of relative policy attractiveness rather than observed retention behavior. Simulated probabilities around 0.50 indicate indifference between the policy and the status quo. Simulated probabilities of 0.55-0.65 indicate a modest preference for the policy, 0.70-0.80 indicate a strong preference, and values greater than 0.85 indicate a very strong preference

Cost, Retention Implications, and Cost per Provider Retained

Under the high-salary and SLRP SQ policy option, the estimated gross costs were \$386.9 million over four years, corresponding to an expected 2,972 providers retained (See **Table 6.3-13**.) Relative to the tier-specific SQ (\$28.3 million and 1,138 providers retained), this policy has an incremental cost of \$358.6 million and an incremental retention gain of 1,834 providers, yielding an incremental cost-effectiveness ratio (ICER) of approximately \$195,570 per additional provider retained over four years or an annual cost of \$51,836 per provider retained.

Under the higher salary and lower SLRP policy option, the estimated gross costs were \$373.2 million over four years, corresponding to an expected 2,617 providers retained. Relative to the tier-specific SQ, this policy has an incremental cost of \$344.9 million and an incremental retention gain of 1,479 providers, yielding an ICER of approximately \$233,252 per additional provider retained over four years or an annual cost of \$61,824 per provider retained.

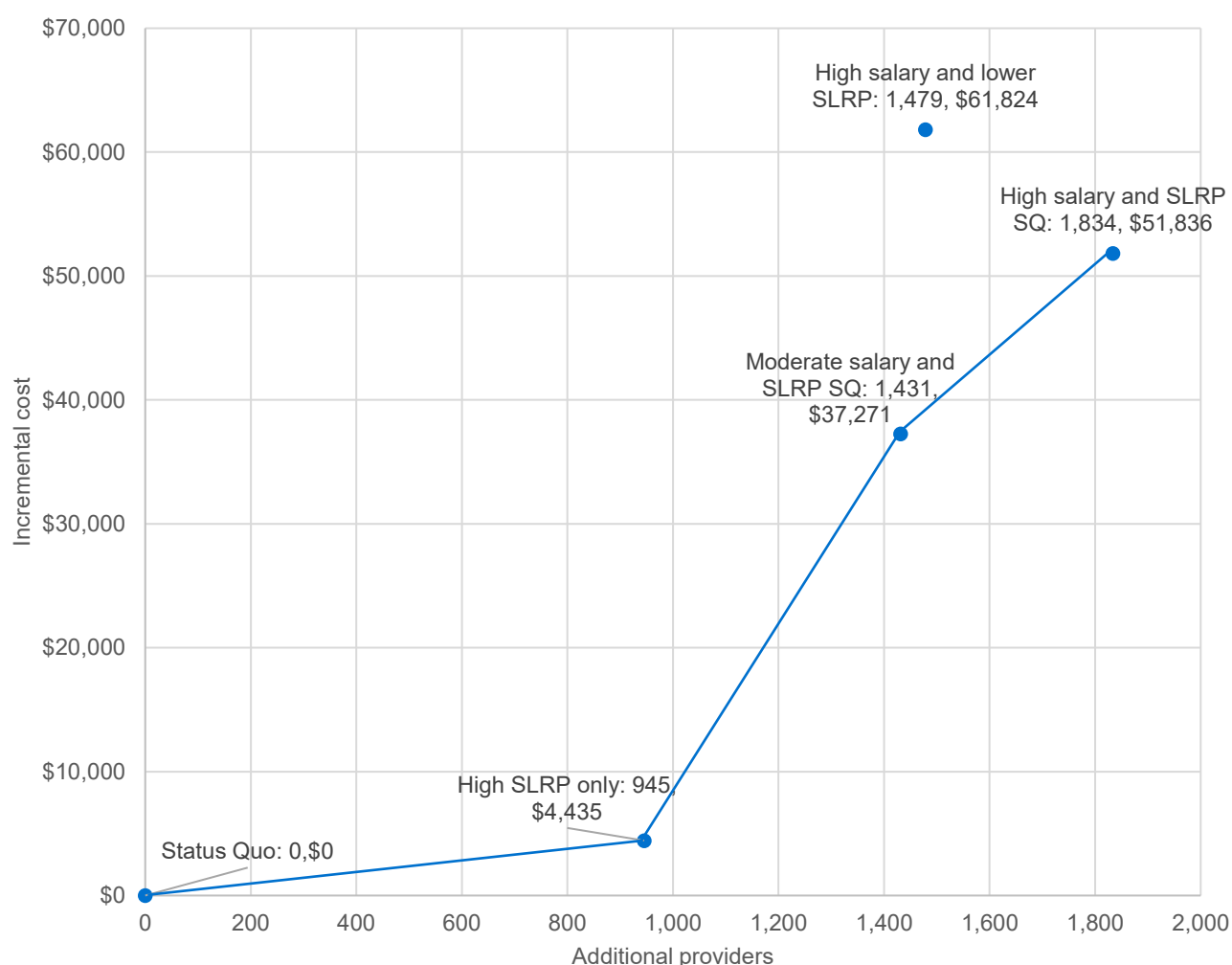
Under the moderate-salary and SLRP SQ policy option, the estimated gross costs were \$229.5 million over four years, corresponding to an expected 2,569 providers retained. Relative to the tier-specific SQ, this policy has an incremental cost of \$201.2 million and an incremental retention gain of 1,431 providers, yielding an ICER of approximately \$140,619 per additional provider retained over four years or an annual cost of \$37,271 per provider retained.

Under the higher SLRP SQ policy option, the estimated gross costs were \$44.1 million over four years, corresponding to an expected 2,084 providers retained. Relative to the tier-specific SQ,

this policy has an incremental cost of \$15.8 million and an incremental retention gain of 945 providers, yielding an ICER of approximately \$16,734 per additional provider retained over four years or an annual cost of \$4,435 per provider retained.

To synthesize these findings, **Figure 6.3-4** presents the efficiency frontier, which plots the incremental number of providers retained against the annual cost per provider. The frontier consists of four non-dominated strategies: SQ, high SLRP only, moderate-salary with SQ SLRP, and high-salary with SQ SLRP. Movement along the frontier reflects increases in retention costs, with diminishing marginal efficiency. The greatest per-dollar gain in retention occurs with the introduction of SLRP alone, while subsequent salary increases yield incremental gains at substantially higher cost per additional provider retained.

Figure 6.3-4 Cost-Effectiveness of Retention Policy Options: Efficient Frontier Analysis



Data Source: WI Provider Survey

Abbreviations: Student Loan Repayment Program (SLRP); Status Quo (SQ)

Notes: The figure plots policy options based on incremental providers retained relative to the status quo (x-axis) and annual cost per provider retained (y-axis). Policy options were evaluated for dominance using standard cost-effectiveness criteria. The status quo is normalized to (0,0). The efficient frontier (solid line) connects non-dominated policy options that provide the greatest retention gains at a given cost level.

The “High-salary and lower SLRP” option is strictly dominated, as it yields fewer retained providers at a higher cost per provider compared to the “High-salary and SLRP” option

As summarized in **Table 6.3-13**, salary-based strategies were substantially more effective in retaining providers relative to the loan repayment alone policy option. Although the high-salary scenario generated the largest absolute retention gains, the balanced compensation package achieved comparable improvements in provider participation at a lower incremental cost per additional provider retained.

Table 6.3-13 Cost and Retention Implications of Policy Scenarios (In 2025 Dollars)

Policy Option	Gross Cost	Expected Providers retained	Incremental Cost	Incremental Number of Providers Retained	Cost per Additional Provider Retained Over 4 Years	Annual Cost per Additional Provider Retained
High-salary and SLRP SQ	\$386.9M	2,972	\$358.6M	1,834	\$195,570	\$51,836
High-salary and lower SLRP payment	\$373.2M	2,617	\$344.9M	1,479	\$233,252	\$61,824
Moderate-salary and SLRP SQ	\$229.5M	2,569	\$201.2M	1,431	\$140,619	\$37,271
High SLRP only	\$44.1M	2,084	\$15.8M	945	\$16,734	\$4,435

Data Source: WI Provider Survey

Abbreviations: Million (M); Student Loan Repayment Program (SLRP); Status Quo (SQ)

Notes: Retention estimates are derived from simulated choice probabilities based on the DCE and represent the likelihood of preferring a policy package over a tier-specific status quo rather than observed behavior. Simulated probabilities were calibrated to real-world retention using a 0.89 adjustment factor based on four-year retention among participants in the prior 1115 Waiver SLRP demonstration. Adjusted probabilities were applied to the provider population within each tier to estimate the number of providers retained. The status quo retention rate was estimated separately as the discounted proportion of providers who reported they were very likely to remain at a community health center over the next 5 years, based on the provider survey. The incremental costs represent the difference between the costs under the alternative policy scenarios and the current MassHealth SLRP budget (in present value), with both estimates restricted to centers included in the survey sample frame, which represents approximately 75% of providers in eligible settings

Appendix Tables F-1.2 through F-1.5 provide the tier-level population counts, cost assumptions, and retention calculations used to derive the aggregate cost and retention estimates reported in **Table 6.3-13**.

Table 6.3-14 presents the impact of these policies on provider attrition and their decision to continue working in a community health setting for the next four years due to additional incentives. All four policy options reduced annual provider attrition compared to the SQ. The high-salary and SQ SLRP policy option demonstrated the largest reduction in annual attrition (21%), at an annual cost of \$51,836 per additional provider retained. The high-salary, lower-SLRP policy reduced annual attrition by 18% at an annual cost of \$61,824 per additional provider retained. The moderate-salary with SQ SLRP policy reduced annual attrition by 17% at an annual cost of \$37,271 per additional provider retained, suggesting a relatively favorable cost-effectiveness profile. Finally, the higher-SLRP-only policy reduced annual attrition by 12% at an annual cost of \$4,435 per additional provider retained, offering a lower-cost alternative for the state to consider given budget constraints.

Table 6.3-14 Percentage of Providers' Attrition Under Each Policy

Policy Option	Number of Current Providers	Expected Number of Providers Retained	% Retention in 4 Years	Annual % Retained	Annual Attrition	Reduction in Annual Attrition
High-salary and SLRP SQ	3,417	2,972	87%	97%	3%	21%
High-salary and lower SLRP payment	3,417	2,617	77%	94%	6%	18%
Moderate-salary and SLRP SQ	3,417	2,569	75%	93%	7%	17%
High SLRP only	3,417	2,084	61%	88%	12%	12%
SQ	3,417	1,138	33%	76%	24%	0%

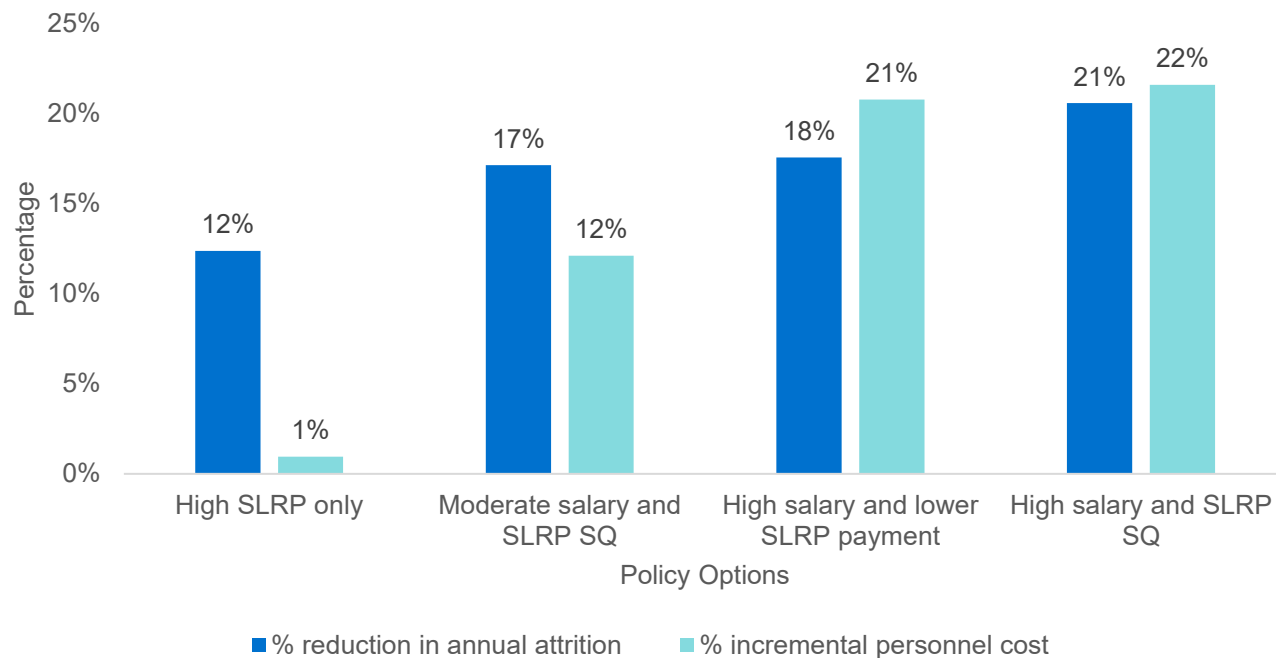
Data Source: WI Provider Survey

Abbreviations: Student Loan Repayment Program (SLRP); Status Quo (SQ)

Figure 6.3-5 illustrates the projected annual impact of alternative policy options relative to the SQ. The figure compares the percentage reduction in annual provider attrition to the percentage increase in adjusted annual personnel costs at CHCs under each policy, i.e., salaries and personnel benefits, including fringe benefits and SLRP. The high-salary with SQ SLRP option produces the largest reduction in provider attrition (21%) but also results in the highest increase in personnel costs (22%). If maximizing retention is the primary objective and sufficient budget is available, this option yields the greatest overall impact.

The high-salary with lower-SLRP policy achieves a similar reduction in attrition (18%) to the moderate-salary with the SQ SLRP option (17%), but at a substantially higher cost (21% vs. 12%). As such, it falls below the efficient frontier and would not be recommended.

The moderate-salary increase with SQ SLRP reduces providers' attrition by 17% at a 12% increase in adjusted annual personnel costs, representing a more favorable cost-effectiveness tradeoff. Finally, the high-SLRP-only policy reduces provider attrition by 12% while increasing personnel costs by 1%, demonstrating that loan repayment incentives alone can be a highly cost-efficient retention strategy under constrained budgets.

Figure 6.3-5 Projected Annual Impact of Alternative Policies Compared to the SQ

Data Source: WI Provider Survey

Abbreviations: Student Loan Repayment Program (SLRP); Status Quo (SQ)

Notes: The graph compares four policy scenarios derived from the DCE attribute levels. High-salary and SLRP SQ includes the highest modeled salary increase (10%-30% based on provider type) with student loan repayment and non-financial incentives remaining at current levels (50% of average provider debt and current professional opportunities). High SLRP only increases loan repayment to 75% of average provider debt while salary and non-financial incentives remain unchanged. High-salary and lower SLRP payment combines the highest salary increase (10%-30% based on provider type) with a reduced loan repayment benefit (25% of average provider debt), with non-financial incentives unchanged. Moderate-salary and SLRP SQ includes a moderate-salary increase (5%-10% based on provider type) while maintaining current loan repayment generosity (50% of average provider debt) and existing non-financial incentives. Personnel cost includes both the additional SLRP payments and wages, as applicable under each policy scenario, expressed as a percentage of total BH and PCP personnel costs in 2025 dollars

6.3.2.3 Conclusions

Results from program documents suggest the SLRPs have been successful in attracting providers working in community-based settings, especially providers who speak other languages in addition to English, in the first phase of the 2022-2027 Demonstration. It is too early to conclude whether SLRP awards were concentrated in centers with lower or higher member-to-PCP and member-to-BH provider ratios as program data continues to change. Overall, the WI provider survey findings suggest that financial incentives are central to strengthening provider retention in community-based settings. In the DCE, across provider types and career stages, one-time salary increases emerged as the most influential factor, reflecting the highest relative importance in the DCE and producing the largest shifts in stated preferences compared to the SQ. Although SLRPs had smaller individual effects, they represent a viable policy option alone or in combination with salary increases. Enhancing SLRP alone yielded modest reductions in projected attrition at a low incremental cost per provider retained, and reducing loan repayment generosity weakened the overall effectiveness and efficiency of combined compensation strategies. Together, these results indicate that financial incentives are the primary lever for retention, with opportunities for policymakers to balance cost and

effectiveness in terms of the number of providers retained by choosing between varying levels of salary increases and SLRP amounts — alone or in combination.

6.4. Discussion

6.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

The evaluation of the 2022-2027 Demonstration used MassHealth program documents, MassHealth Staff Survey responses, and MassHealth administrative data to determine how the WI programs were implemented and if the programs increased the volume and diversity of providers in community-based settings. The preliminary findings show that MassHealth worked with its vendors to market the programs and review applicants. Implementation of the FNP Residency Grant Program increased the number of FNP residency slots in community-based settings serving at least 40% MassHealth members, while implementation of the SLRPs has attracted many providers who speak another language in addition to English at community-based settings serving at least 40% MassHealth members and/or uninsured individuals. Promoting provider diversity is important for improving members' experience of care, particularly through culturally and linguistically concordant services, and may also reduce MassHealth's interpretation costs by decreasing reliance on interpretation services.¹⁹⁰

The difference in application volume between the PC SLRP and BH SLRP may reflect variation in the perceived net value of the programs. While award amount likely influenced providers' decisions to apply, the required service commitment also shapes the economic attractiveness of loan repayment. Providers may weigh the benefit of debt reduction against the opportunity cost of remaining in an eligible CHC, including foregone earnings. This trade-off may vary by provider type, salary level, debt burden, and outside labor market opportunities. For some lower-paid providers, loan repayment may represent a meaningful share of compensation and therefore be attractive despite a longer service obligation; for others, the same commitment may be less appealing if it limits access to higher-paying opportunities. This suggests that SLRP demand is shaped not only by award generosity, but also by how providers evaluate loan repayment relative to salary-based compensation and labor market alternatives.

The evaluation also used DCE to elicit how financial and non-financial incentives (both inclusive and exclusive of what's covered by the Demonstration) influence providers' preferences for continuing to work in community-based clinical settings serving at least 40% MassHealth members and/or uninsured individuals relative to current working incentives. The findings provide evidence relevant to CMS's interest in understanding how different macro-level workforce strategies may affect provider participation and stability within the MassHealth delivery system (e.g., direct rate vs. loan repayment). By evaluating alternative incentive packages relative to a provider type specific SQ, this novel evaluation offers comparative insights into the relative attractiveness and cost-effectiveness of policy approaches that MassHealth may consider to stabilize the CHC workforce.

¹⁹⁰ Ortega, P., Felida, N., Avila, S., Conrad, S., & Dill, M. (2023). Language Profile of the US Physician Workforce: A Descriptive Study from a National Physician Survey. *Journal of general internal medicine*, 38(4), 1098–1101. <https://doi.org/10.1007/s11606-022-07938-y>

The cost-effectiveness analysis estimates the gross and incremental costs and retention benefits associated with the selected policy options; it does not assign costs to specific payors or identify financing sources. For salary-related policy options, estimated costs reflect the additional compensation associated with each scenario, which CHCs would absorb unless separate financing mechanisms were established, such as increased reimbursement rates, supplemental payments, or state-restricted grants targeting CHC personnel. For SLRPs, continued support through the 1115 Medicaid Demonstration is appropriate given the role of CHCs in advancing MassHealth and CMS objectives; if waiver funding is not available, other options should be explored, such as state workforce funds, targeted behavioral health workforce investments, health care trust funds, or other non-waiver funding streams.

The current WI provider survey focuses on providers actively working in community-based settings to better understand factors influencing retention; findings related to recruitment will be analyzed separately and incorporated into the IESR.

Across provider types, career stages, and prior participation in loan repayment programs, financial incentives, particularly one-time salary increases, were the strongest drivers of providers' stated preferences for continuing to work in CHC settings. Salary-related attributes accounted for the largest share of decision weight in the DCE and consistently generated the largest preference shifts relative to the SQ. This pattern is expected, as salary increases affect providers' earnings on an ongoing basis, influencing not only current income but also future earnings trajectories, retirement contributions, and, where applicable, performance-based compensation. At the same time, sustaining workforce capacity may allow CHCs to maintain services for patients covered by other payers, including commercial insurance and Medicare, potentially generating additional revenue that could help offset some of these longer-term costs to CHCs.

Loan repayment programs were also associated with positive preference effects, though generally smaller in magnitude than salary increases. However, simulation results indicate that SLRP represents a cost-effective option on its own or can play an important complementary role with salary increases. While enhancing SLRP alone produced more modest reductions in projected attrition, it did so at very low incremental cost. Moreover, reducing loan repayment generosity diminished both effectiveness and efficiency in combined compensation packages, suggesting that SLRP meaningfully reinforces the impact of salary-based strategies.

These findings suggest that compensation-based policies, particularly those that include salary increases, are likely to have the greatest influence on providers' continued participation in CHCs. However, the cost-effectiveness results underscore that larger salary increases come with substantial fiscal implications. Balanced compensation strategies that combine moderate-salary increases with continued loan repayment support may offer a more efficient approach, achieving meaningful reductions in attrition at lower incremental cost.

Although MassHealth does not directly set provider salaries, payment rates and supplemental funding mechanisms influence CHCs' ability to offer competitive compensation. Because reimbursement rate increases apply broadly and are not limited to CHCs, even modest adjustments intended to support higher CHC salaries may carry significant statewide fiscal implications. Policymakers may therefore consider targeted approaches — such as conditional

grants or structured supplemental payments tied to provider compensation — that allow CHCs to raise salaries in a more focused and cost-efficient manner while preserving the retention benefits associated with financial incentives.¹⁹¹

The effectiveness of SLRPs should be interpreted within the broader context of state and federal WIs that may complement or interact with these programs. Prior evidence suggests that loan repayment incentives can meaningfully influence recruitment and retention in underserved settings. Over three-quarters of clinicians in the National Health Service Corps (NHSC) report intentions to continue practicing in underserved areas after their service obligation, and site administrators commonly report that state service programs make recruitment easier and faster and increase provider tenure, although effects on recruitment costs are more variable.^{192, 193} These patterns are consistent with the findings of this evaluation, suggesting that loan repayment improves workforce stability relative to the SQ, though not as much as salary increases. Many states, including California, Maryland, and New York, operate similar loan repayment initiatives, yet rigorous evaluations remain limited. Across Massachusetts, SLRPs also coexist with other federal workforce investments (e.g., NHSC and Health Resources and Services Administration (HRSA) grants), which may contribute to larger effects in total if individual effects from multiple programs are additive, though this remains to be studied. Considering these interactions, where more than 50% of our survey respondents indicated they participated or are participating in SLRP, it is therefore important for interpreting program impacts and for designing coordinated workforce strategies aligned with federal priorities.

As presented in **Figure 6.3-3**, SLRPs significantly influenced preferences within specific subgroups, particularly among those who did not fulfill their SLRP obligations, and PCPs. In the simulation analyses, enhancing SLRP alone reduced projected annual attrition by 12%, a smaller effect than salary-based strategies but achieved at only a 1% increase in personnel costs. This finding indicates that while loan repayment generates more modest absolute retention gains, it does so at very low incremental cost.

At the same time, cost-effectiveness results demonstrate that SLRP plays an important complementary role in broader compensation packages. Policies that maintained meaningful loan repayment support (i.e., close to 50% of the average student debt) performed more efficiently than those that reduced SLRP generosity, even when salary increases were substantial. This suggests that loan repayment enhances the overall effectiveness of salary-based strategies rather than serving solely as a standalone incentive.

Non-financial incentives, including professional development opportunities and support for special projects, were associated with positive but minor preference improvements. Although providers expressed clear preferences for certain types of professional development, particularly

¹⁹¹ Center for Health Information and Analysis (2019). Community Health Center Cost Reports. Special Data Request, October 2024.

¹⁹² Rowan, K., Shah, S. V., Knudson, A., Kolenikov, S., Satorius, J., Robbins, C., & Kepley, H. (2024). Health professional retention in underserved areas: findings from the National Health Service Corps Loan Repayment Program participants in the United States, 2019-2021. *Journal of public health policy*, 45(4), 639–653. <https://doi.org/10.1057/s41271-024-00516-y>

¹⁹³ Pathman, D. E., Sewell, R. G., Rauner, T., Overbeck, M., Fannell, J., & Resendes, J. (2022). Outcomes of States' Loan Repayment and Forgiveness Programs from the Perspective of Safety Net Practice Administrators. *Journal of the American Board of Family Medicine*, 35(5), 1015–1025. <https://doi.org/10.3122/jabfm.2022.AP.220092>

those related to clinical skills and specialization, these attributes accounted for a relatively small share of the overall decision-making process and did not offset weaker financial incentives.

Non-financial supports may enhance job quality and professional satisfaction but are unlikely to drive provider participation decisions independently. The policy option focused solely on non-financial incentives showed only a modest preference (54% probability of preferring this policy over the SQ). Such support may be most effective when implemented alongside financial incentives, reinforcing broader workforce strategies rather than substituting financial-based approaches.

Simulation results indicate salary-based strategies generate the largest retention gains, though their cost-effectiveness varies substantially. The high-salary option with SQ SLRP scenario produced the greatest reduction in annual provider attrition (21%) but also resulted in the largest increase in personnel costs (22%). This option lies on the efficient frontier and would be preferred if maximizing retention is the primary objective and sufficient fiscal capacity exists.¹⁹⁴

The moderate-salary increases, combined with SQ SLRP, reduced attrition by 17% while increasing personnel costs by 12%, resulting in a more favorable balance between cost and impact. This option also lies on the efficient frontier and may offer the most practical trade-off between effectiveness and affordability. Enhanced SLRP alone reduced attrition by 12% while increasing personnel costs by only 1%. Although the absolute retention gain is smaller, this option offers the lowest cost and may represent a highly cost-efficient strategy under tight budget constraints.

These findings highlight a clear trade-off between maximizing retention and optimizing cost-effectiveness. Larger salary increases produce the greatest reductions in attrition, but at substantially higher cost. In contrast, moderate-salary increases combined with existing loan repayment support achieve meaningful improvements in retention at a lower incremental cost.

While the relative importance of job attributes was consistent across provider subgroups, the magnitude of preferences varied meaningfully by provider type, tenure in community health settings, and prior participation in SLRP. Providers who did not participate in any SLRP and BH providers exhibited strong preferences for salary increases, suggesting heightened sensitivity to compensation levels in competitive labor markets. In contrast, student loan repayment was more influential for providers with prior exposure to SLRP, i.e., completed or currently fulfilling their program obligation, indicating that familiarity with the program and remaining debt obligations may shape responsiveness to loan repayment incentives (See **Table 6.3-8** and **Figure 6.3.3**.) These patterns suggest that extensions or enhancements to SLRP, such as higher repayment caps, or continued support beyond an initial service obligation, may be relevant policy options for retaining providers already engaged in the program.

These findings underscore the potential value of flexible, tiered workforce strategies that account for heterogeneity in provider preferences and career stages. Within the context of the

¹⁹⁴ The efficient frontier identifies the policy options that provide the greatest improvement in provider retention for a given level of spending. Policies on this frontier represent the most efficient use of resources, while policies below it achieves smaller retention gains relative to their cost.

2022-2027 Demonstration, workforce initiatives that differentiate incentives by provider type or tenure, such as combining salary-focused strategies for early-career or BH providers with extended loan repayment options for providers with prior SLRP participation, may improve the efficiency of workforce investments and better support access to care and network adequacy goals.

6.4.2. *Lessons Learned and Recommendations*

Our interim evaluation of the 2022-2027 Demonstration shows that the WI programs are addressing shortages in qualified providers serving MassHealth members by increasing the volume and diversity of providers in community-based settings. Several lessons were learned as a result of this evaluation.

1. **Lesson Learned:** Successful implementation of WI programs is facilitated by close collaboration with vendors/partners who have strong connections to the targeted provider communities, and the timely issuance of clear, consistent program guidance.
 - **Recommendation:** Policymakers considering implementation of WI programs should establish strong coordination mechanisms with vendors/partners early in the design phase and throughout implementation, and states should issue clear eligibility and operational guidance. This can help improve program uptake, ensure consistent interpretation of requirements, and strengthen overall program effectiveness.
2. **Lesson Learned:** SLRPs produce modest standalone retention gains and enhance the impact of combined compensation strategies (i.e., SLRP and salary increase) at relatively low incremental cost.
 - **Recommendation:** Policymakers considering WI programs should prioritize programs that include SLRP, salary increases, or a combination of SLRP with salary increases based on their targeted level of retention improvement and available budget. Policymakers may also work with CHCs to leverage SLRP within hiring materials to use as a recruitment tool.
3. **Lesson Learned:** Provider preferences vary by career stage, provider type, and prior SLRP participation.
 - **Recommendation:** Policymakers should consider WI programs that are aligned with the general preferences of different provider types (e.g., emphasizing salary-focused approaches for early-career or BH providers and extended loan repayment options for those with prior SLRP participation), or that grant individual participants flexibility to select programs that align with their preferences.
4. **Lesson Learned:** There is a clear trade-off between maximizing retention and fiscal sustainability.
 - **Recommendation:** Policymakers should explicitly define their targeted level of retention improvement and the available budget and select workforce strategies accordingly, prioritizing options on the efficient frontier.

7. Hospital Quality and Equity Initiative

7.1. Background

7.1.1. *Historical Overview and Current Context*

The Centers for Medicare & Medicaid Services (CMS) developed a health equity framework¹⁹⁵ to align with Healthy People 2030¹⁹⁶, a U.S. Department of Health and Human Services (HHS) initiative to set data-driven national objectives to improve the health and well-being of individuals in the United States. Healthy People 2030 and related work across HHS respond to evidence that unaddressed social determinants of health (SDOH) contribute to health care disparities and inequities.¹⁹⁷ The CMS health equity framework 2022-2032 outlines five priority areas: (1) expand the collection, reporting, and analysis of standardized data; (2) assess causes of disparities within CMS programs, and address inequities in policies and operations to close gaps; (3) build capacity of healthcare organizations to reduce health and health care disparities; (4) advance language access, health literacy, and the provision of culturally tailored services; and (5) increase all forms of accessibility to health care services and coverage. By aligning with both CMS's framework and Healthy People 2030, the Hospital Quality and Equity Initiative (HQEI) in Massachusetts provides a basis for evaluating progress towards health quality and equity and reducing disparities across the state.

Since the development of these national standards and recommendations for health equity, multiple states have leveraged Medicaid waiver authorities to launch initiatives that seek to address health disparities and inequities. As a part of their 1115 Demonstration, the New York Department of Health set health equity goals to improve workforce shortages, enhance digital health infrastructure, and strengthen housing services for homeless populations.¹⁹⁸ California's 1115 Demonstration established a Health Equity Monitoring Metrics Protocol outlining a set of metrics focused on access to, utilization of, and quality of health care and/or health outcomes for tracking progress in bridging any such inequities.¹⁹⁹ Additionally, states including Oregon, Minnesota, Ohio, and North Carolina have used Medicaid payment and purchasing strategies to advance health equity and reduce disparities in their states.²⁰⁰ Strategies included managed care contracting, payment reforms, and services to address health-related social needs (HRSNs).

¹⁹⁵ Center for Medicare and Medicaid Services. (2022). *CMS Framework for Health Equity 2022–2032*. <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>

¹⁹⁶ U.S. Department of Health and Human Services. *Healthy People 2030: Building a healthier future for all*. <https://odphp.health.gov/healthypeople>

¹⁹⁷ Green K, Zook M. When Talking About Social Determinants, Precision Matters. *Health Affairs*. Published October 29, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>

¹⁹⁸ New York State Department of Health. (2022, Sept. 2) *New York State Medicaid Redesign Team (MRT) Waiver Final Amendment Request for New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic*. https://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver/programs.htm

¹⁹⁹ California Health and Human Services Agency. (2023, Dec. 20). *Attachment M GPP Health Equity Monitoring Metrics Protocol*. <https://www.dhcs.ca.gov/Pages/CalAIM-1115-Demonstration-Amendments.aspx>

²⁰⁰ Allen, E. H., & Willis, C. (2023). Can Medicaid Payment and Purchasing Strategies Advance Health Equity? In. Urban Institute. <https://www.urban.org/research/publication/can-medicaid-payment-and-purchasing-strategies-advance-health-equity>

There are significant racial disparities in the health outcomes of communities in Massachusetts.²⁰¹ For example, the infant mortality rate for Black newborns in Massachusetts is twice that of White newborns.²⁰² These health disparities have only been exacerbated by the COVID-19 pandemic, which limited access to health care for the most vulnerable communities in Massachusetts.²⁰³ Health outcomes in Massachusetts also vary based on disability status, language use, and HRSN.²⁰⁴

7.1.2. *The Hospital Quality and Equity Initiative*

In the 2022-2027 Demonstration, MassHealth implemented an innovative HQEI²⁰⁵ to incentivize hospitals to improve health care quality and equity. CMS authorized the expenditure of up to \$400 million annually for private acute care hospitals to improve health care quality and equity within the Commonwealth and up to \$90 million annually for Cambridge Health Alliance (CHA) (the Commonwealth's only non-state-owned public hospital) to improve health care quality and equity and to develop interventions for both its Medicaid population and the uninsured individuals it serves. MassHealth designed its HQEI Program to utilize up to \$350 million of the authorized \$400 million and also designed its CHA Hospital Quality and Equity Incentive Program to utilize the full \$90 million authorized. Participating hospitals will demonstrate progress towards improving quality and equity by (1) progressing towards attaining complete, beneficiary-reported demographic and HRSN data; (2) identifying and addressing disparities in access and quality outcomes; and (3) strengthening organizational capacity for health equity through collaboration with community and health system stakeholders, including Accountable Care Organizations (ACOs). Direct funding is not being provided for implementation or to reimburse provider costs incurred for implementing the HQEI. Instead, funding is dependent on hospitals meeting performance requirements and benchmarks.

Funding for the HQEI is at risk for each performance year (PY), with state and hospital accountability. Reductions from statewide accountability will apply to the global amount of funding from which hospital payments may be made for the initiative. The accountability framework is described in the special terms and conditions²⁰⁶ and is further specified in MassHealth's HQEI Implementation Plan.²⁰⁷

²⁰¹ Radley D.C., Shah A., Collins S.R., Powe N.R., Zephyrin L.C. (2024). Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report. In: Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care>

²⁰² Massachusetts Department of Public Health. (2017). *Massachusetts State Health Assessment*. www.mass.gov/dph/2017statehealthassessment

²⁰³ Massachusetts Office of the Attorney General. (2020). *Building Toward Racial Justice and Equity in Health: A Call to Action*. <https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action>

²⁰⁴ Adverse Measures of Social Determinants of Health and Health-Related Social Needs Among Massachusetts Adults, 2022-2023: <https://www.mass.gov/doc/social-determinants-of-health-and-health-related-social-needs-among-massachusetts-adults-2022-2023/download>

²⁰⁵ The Hospital Quality and Equity Initiative includes the Hospital Quality and Equity Incentive Programs for private acute hospitals (HQEIP) and for the non-state-owned public hospital Cambridge Health Alliance (CHA-HQEIP). This evaluation includes data for CHA and private acute hospitals, therefore addressing both incentive programs.

²⁰⁶ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.9, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²⁰⁷ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 5, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

Table 7.1-1 Overview of HQEI Performance Years

HQEI Performance Year (PY)	PY1	PY2	PY3	PY4	PY5
Calendar Year (CY)	Q4 2022–2023	2024	2025	2026	2027
Demonstration Year (DY)	Q4 2027–2028	2029	2030	2031	2032
Evaluation Report Period	Interim	Interim	Summative	Summative	Summative

Data source: MassHealth HQEI Implementation Plan

Abbreviations: Hospital and Quality Equity Initiative (HQEI); Performance Year 1 (PY1); Performance Year 2 (PY2); Performance Year 3 (PY3); Performance Year 4 (PY4); Performance Year 5 (PY5); Quarter 4 (Q4)

Notes: Data for CY 2022-2024 i.e. PY1 and PY2 are included in this Independent Evaluation Interim Report. Data for PY3-5 will be included in the Independent Evaluation Summative Report (submitted to CMS in CY 2029).

HQEI Domain 1– Demographic and Health-Related Social Needs Data

MassHealth and participating hospitals are assessed on the completeness of beneficiary-reported demographic and HRSN data submitted in accordance with the CMS-approved HQEI Implementation Plan and Technical Specifications.²⁰⁸ The collection of these demographic and HRSN data is intended to support MassHealth’s goals of identifying and monitoring health disparities, increasing screening for HRSNs, and increasing the percentage of members with an identified HRSN referred to appropriate services.²⁰⁹

Demographic and HRSN screening data completeness supports enhanced transparency and increases hospitals’ ability to identify health disparities. Demographic and HRSN data include at least the following categories: race, ethnicity, preferred written language, preferred spoken language, disability status, sexual orientation, gender identity (RELD SOGI), and HRSN, and must be submitted in a consistent format across participating entities. Data completeness must be assessed separately for each data element.²¹⁰ Beneficiary reporting is voluntary; members may choose not to provide these data elements. Non-responses from members still count towards data completeness, as members are free to not answer questions for any reason (i.e. comfortability, privacy, etc.).

Through annual milestones, MassHealth and participating hospitals will be incentivized to meet an interim goal of 80% completeness for self-reported race and ethnicity data by the end of PY3. Participating entities will be incentivized through annual milestones to achieve at least 80% data completeness for additional beneficiary-reported demographic data including at least preferred written and spoken language, disability, sexual orientation, and gender identity by the end of

²⁰⁸ MassHealth HQEIP and CHA-HQEIP Technical Specifications are available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>

²⁰⁹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Figure 2, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁰ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.2, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

PY5.^{211,212} Participating entities will also be incentivized to improve rates of HRSN screening, as well as the ability to track and report on HRSNs, by the end of PY5.²¹³

HQEI Domain 2 – Equitable Access and Quality

Participating hospitals are incentivized for performance on metrics related to (1) access to care including for individuals with disability and/or language access needs and (2) quality of care including perinatal care and maternal health, care coordination, care for acute and/or chronic conditions, and patient experience.²¹⁴ MassHealth's goals for this HQEI policy domain include identifying and monitoring statewide disparities in clinical quality measures; closing gaps in specific disparities-sensitive quality measures by PY5; identifying best practices for equity improvement interventions; increasing hospital and ACO collaboration on disparities-reduction projects; improving member receipt of linguistically appropriate care; promoting high levels of provider and staff demonstrating disability competency; and improving screening for and documentation of accommodations needs.²¹⁵

Hospitals' performance expectations are specified further in the HQEI Implementation Plan and include²¹⁶:

1. Reporting on access and quality measure performance, including stratifications by demographic factors, HRSNs, and/or defined by other individual- or community-level markers or indices of social risk;
2. Developing and implementing interventions aimed at improving quality and reducing observed disparities in performance metrics to ensure that all members, regardless of their demographic characteristics, have access to covered services that are delivered in a manner that meets their unique needs; and
3. Improving quality and/or closing disparities as measured through performance on a subset of performance metrics.

For up to the first three years of the 2022-2027 Demonstration, statewide performance are being assessed based on quality measure performance reporting, improving access measures, as well as implementation of interventions to improve quality and reduce disparities. For the last two years of the Demonstration, performance will be assessed based on improving access and quality performance and closing observed disparities.

HQEI Domain 3 – Capacity and Collaboration

²¹¹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.3, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹² MassHealth. (2026). Performance Assessment Methodology Manual for the MassHealth Hospital Quality and Equity Incentive Program (HQEIP). <https://www.mass.gov/doc/py3-5-performance-assessment-methodology-pam-manual-for-hgeip-updated-242026-0>

²¹³ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.3, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁴ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁵ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Figure 3, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁶ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 3, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

MassHealth and participating hospitals are incentivized to improve provider and workforce capacity and collaboration between health system partners to improve quality and reduce health care disparities.²¹⁷ MassHealth goals for this HQEI policy domain include increasing organizational capacity, structure, and workforce for meaningful health equity work; improving MassHealth member experiences pertaining to communication, courtesy and respect; and increasing collaboration between health system partners to improve care quality and reduce disparities.²¹⁸

Participating entities are assessed on improvements in metrics such as provider communication, courtesy, and respect, achievement of externally validated equity standards, and joint accountability for ACO performance. Some assessments, detailed below, rely on surveys and standards developed by Joint Commission. This independent, not-for-profit organization offers accreditation, certification, and standard setting for the healthcare industry. For PY1 of the HQEI, participating hospitals will have their performance assessed for the Capacity and Collaboration domain based on timely submission to MassHealth of patient experience survey results for MassHealth members pertaining to communication, courtesy and respect, an attestation that the hospital has completed Joint Commission surveys for health equity accreditation standards, and the health equity performance scores of ACOs with which the hospital is partnered.²¹⁹ Achievement of at least 80% of hospitals meeting rigorous standards, as established by a national quality or accreditation organization, regarding service capacity, access, and delivery of culturally and linguistically appropriate care is expected by the end of PY3.²²⁰

7.2. Study Design

Refer to [Chapter 1 Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology. Qualitative findings draw from interviews with MassHealth members (**Appendix B-9**), interviews with hospital staff (**Appendix C-6.4**), staff surveys with MassHealth staff (**Appendix B-8**), and document reviews to provide context about changes and implementation of HQEI initiatives. Demographic information for interviewed members and hospital staff can be found in **Appendix C-5**. The quantitative analyses use data from MassHealth Managed Care Eligible (MCE) members to calculate observed-to-expected (O:E) ratios. The O:E ratio helps identify baseline gaps and disparities prior to the start of improvement projects in 2024, with “expected” outcomes calculated from a model based on 2022 member characteristics and applied to subsequent years for comparison.

²¹⁷ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.5, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁸ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Figure 4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²¹⁹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Table 4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²²⁰ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), STC 14.5, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

7.2.1. Research Questions, Hypotheses, and Study Design

Table 7.2-1 outlines the research questions (RQs), hypotheses, data sources and evaluation period, study population(s), and analytic methods for this chapter covered in the Independent Evaluation Interim Report (IEIR).

Table 7.2-1 HQEI Research Questions, Hypotheses, and Study Design

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
RQ6-1 What actions were taken by the state to support HQEI?	H6-1.1 MassHealth will distribute funding based on reporting and performance for participating hospitals to support HQEI.	Key Informant Interviews (KIIs) (CY2024-CY2025)	Open-ended written responses (MassHealth HQEI staff)
	H6-1.2 MassHealth will develop policies and procedures and provide operational oversight to support implementation.	Hospital staff	Thematic analysis (MassHealth HQEI staff and KII interviews)
	H6-1.3 MassHealth and its contractors will deliver technical assistance (TA) to support HQEI.	MassHealth HQEI staff open-ended survey (CY2025)	Descriptive analysis (MassHealth HQEI staff)
	H6-1.4 MassHealth and its contractors will provide performance monitoring to support HQEI.	Program documents	Document review
RQ6-2 What actions did participating hospitals take to implement quality and equity initiatives?	H6-2.1 Participating hospitals will perform competency and needs assessments to target quality and equity initiatives.	KIIs and/or focus groups (CY2024-CY2025)	
	H6-2.2 Participating hospitals will recruit, train, and retain providers and staff responsible for implementing quality and equity initiatives.		
	H6 -2.3 Participating hospitals will modify health information systems to ingest and use self-reported demographic and HRSN screening data.	Hospital staff	Thematic analysis (hospital staff)
	H6-2.4 Participating hospitals will train staff to systematically collect self-reported demographic and HRSN data in a culturally competent manner.	MassHealth HQEI staff open-ended survey (CY2025)	Document review
	H6-2.5 Participating hospitals will establish processes to submit self-reported demographic and HRSN data to the state.	Data submitted to MassHealth (CY2022-CY2025)	Descriptive analysis (hospital staff)
	H6-2.6. Participating hospitals will implement programs to promote access to services delivered in a culturally, linguistically, and disability-competent manner.	Documentation submitted to MassHealth (CY2022-CY2025)	

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
	H6-2.7 Participating hospitals will implement quality improvement initiatives to promote better and more equitable care quality. H6-2.8 Participating hospitals will improve and strengthen relationships with partner organizations. H6-2.9 Participating hospitals will engage MassHealth members and the community in the design and implementation of quality and equity initiatives.		
RQ6-3 Did participating hospitals improve the completeness of member self-reported demographic and HRSN data?	H6-3.1 Participating hospitals will increase the percentage of members screened for HRSN. H6-3.2 Participating hospitals will increase the percentage of members with complete data for enhanced demographic data elements. H6-3.3 Participating hospitals will increase the percentage of members with unmet needs who are linked with services and supports. H6-3.4 Participating hospitals will report performance data stratified by demographics and HRSN.	Center for Health Information Analysis (CHIA) Enhanced Demographics Data File sent to MassHealth (CY2023-CY2025) MassHealth administrative data (CY2018-CY2025) Data submitted to MassHealth (CY2023-CY2025)	Descriptive analysis (member, hospital)
RQ6-4 Did participating hospitals reduce disparities and improve care access and quality?	H6-4.1 Health care quality will improve. H6-4.3 Members will report increased access to services delivered in a manner that meets their needs.	CHIA Enhanced Demographics Data File sent to MassHealth (CY2022-CY2025) MassHealth administrative data (CY2018-CY2025) Member Experience Surveys (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)) (CY2023-CY2025)	Descriptive analysis (member, hospital) Observed vs. expected (member) Quasi-experimental methods (member) Thematic Analysis (members)

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
		KIIs (CY2024-CY2025) with MassHealth members	
RQ6-5 Did participating hospitals improve member experience and outcomes?	H6-5.1 Member experience will improve.	CHIA Enhanced Demographics Data File (CY2023-CY2025)	Thematic Analysis (members)
	H6-5.2 Disparities in member experience will decrease.	MassHealth administrative data (CY2018-CY2025)	Descriptive analysis (member)
	H6-5.3 Member health outcomes (e.g., maternal and birth outcomes) will improve.	Member Experience Surveys (HCAHPS) (CY2023-CY2025)	Observed vs. expected (member)
	H6-5.4 Members will experience a reduction in the impact of social risk factors on their health.	KIIs (CY2024-CY2025) with MassHealth members	Quasi-experimental methods (member)

Data source: 1115 Waiver Demonstration Evaluation Design Document²²¹

Abbreviations: Calendar Year (CY); Hypothesis (H); Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); Hospital and Quality Equity Initiative (HQEI); Health Related Social Needs (HRSN); Key Informant Interviews (KIIs); Research Question (RQ)

Notes: Research Questions developed based on the following STC sections²²² 14.1, 14.3, 14.4, 14.5, 14.6, 14.7, 14.9, 14.10, 14.16, and 14.17. Details are further described in section 7.4.2 "Data Sources and Collection Methods" and 1.4.1 "Summary of Data Sources" of this report. The complete list of RQs and Hs from the Evaluation Design Document can be found in **Appendix A-2**.

²²¹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2026), Attachment S Evaluation Design Document, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²²² Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

7.2.2. *Methodological Limitations*

Refer to [Chapter 1](#) for an overarching discussion of the methodological limitations pertaining to the evaluation overall. Beyond those limitations, the evaluation of the HQEI domain for the IEIR has several limitations to consider. First, the mainly descriptive analyses and absence of comparison groups limit the evaluators' abilities to attribute changes in quality, access, experience, or outcomes to the HQEI, particularly given ongoing initiatives during the evaluation period. In addition, this evaluation reflects the early stages of HQEI implementation, during which many participating hospitals were still developing infrastructure, workflows, and data systems to support quality and equity initiatives. As such, findings should be interpreted as reflecting baseline conditions and early implementation progress rather than mature program impacts, with some outcomes requiring longer follow-up to observe meaningful program effects.

Data limitations also warrant consideration. Administrative data were not always uniformly complete or consistent across years and populations because of reporting lags and changes in submission and coding practices. Although we conducted routine data validation and quality checks, measurement error may still be present. Observed increases in or completeness of demographic and HRSN data may reflect improved documentation rather than true changes. Many implementation findings rely on hospital reported documentation and interviews, which may be influenced by social desirability or reporting incentives. Participating hospitals and patient populations vary widely, and small subgroup samples limit the ability to detect meaningful changes in measurements with precision. Finally, qualitative findings may reflect recall and reporting bias, and thematic analyses involve evaluator interpretations.

7.3. **Interim Results and Conclusions**

7.3.1. *RQ6-1 What actions were taken by the state to support HQEI?*

7.3.1.1. **Summary of Results**

During the 2022-2027 Demonstration HQEI, MassHealth designed a multi-component strategy to advance hospital-based health equity initiatives. MassHealth sought to increase standardized RELDSOGI and HRSN reporting among hospitals, reduce disparities in quality performance metrics, and strengthen hospital infrastructure and workforce capacity to advance health equity initiatives. To achieve these goals, MassHealth distributed financial incentives, established required narrative and performance-based deliverables, provided ongoing oversight and technical assistance to hospitals, and monitored hospital-level performance measures. The HQEI incorporated hospital-level performance monitoring and stratified reporting requirements to increase accountability and transparency.

While hospitals generally appreciated MassHealth's responsive support and structured framework, they reported significant administrative burdens, unclear deliverables, and confusion arising from misalignment between MassHealth requirements and other accrediting bodies (e.g., Joint Commission). Performance monitoring and vendor support were valued, but the lack of standardized equity measures and ongoing revisions to measure specifications created additional strain on hospital staff. Overall, hospitals indicated that the funding did not fully cover the resources required for participation and meeting performance requirements in the HQEI and

noted opportunities for greater alignment and streamlined reporting to support sustained participation as the initiatives transition from reporting to performance.

2.3.1.2. Results

H6-1.1 MassHealth will distribute funding based on reporting and performance for participating hospitals to support HQEI.

Under the HQEI, hospitals were required and incentivized to regularly report on their progress in the three HQEI domains. One way the hospitals reported this information to MassHealth was by submitting narrative documentation.²²³ Examples of narrative documentation in PY1 included a Health Quality and Equity Strategic Plan and various self-assessments, such as a language self-assessment and a disability competent care assessment, to look at each hospital's baseline capacity to meet HQEI requirements. Hospitals also submitted performance measure data to MassHealth starting in PY2 (e.g., % of MassHealth members screened for HRSN, completeness of self-reported demographic data for MassHealth members).²²⁴ MassHealth provided financial incentives to hospitals for meeting reporting- and performance-based deliverable targets. In PY1 and PY2, MassHealth distributed four interim payments and a reconciliation payment, made in two disbursements, to participating hospitals. Hospitals had to meet key milestones, or "payment gates," to receive interim payments in PY1. MassHealth withheld 10% of each hospital's maximum annual incentive payment in PY1 and 15% in PY2 from the interim payments and paid this out according to hospital performance in the final reconciliation payment for the PY. If a hospital's performance results in them receiving less than 90% for the PY, funds would be recouped in the reconciliation payment process.²²⁵

"A dedicated Health Quality and Equity Program Management Vendor supports the review of deliverables and contributes to the development of tools and materials for entity-facing reporting. Additionally, MassHealth's payment strategy creates strong financial incentives for hospitals to meet key milestones, with missed benchmarks resulting in impacts on interim payments." – a MassHealth staff respondent

At the start of the HQEI, there were 61 participating hospitals (Appendix G-1). Four hospitals closed or transitioned to outpatient care only in 2023 or 2024. Five additional hospitals transitioned to new ownership but continued operations and participation in HQEI. All hospitals participating in the HQEI received interim payments and a reconciliation payment for both PY1 and PY2. In PY1, the average interim payment disbursement was \$1,704,544 (range: \$36,330-\$22,500,000), and the average reconciliation payment was \$737,274 (\$10,808-\$11,250,000). For PY2, the average interim payment disbursed was \$1,730,071 (range: \$38,601-\$20,025,000), and the average reconciliation payment was \$1,139,779 (range: \$27,248-

²²³ MassHealth. (2023). *Performance Year 1 Deliverables Timeline and Due Dates*. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>

²²⁴ MassHealth. (2024). *Performance Year 2 Deliverables Timeline and Due Dates*. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>

²²⁵ Centers for Medicare & Medicaid Services. MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

\$12,054,193). The full distribution of payments by hospital is in **Appendix G-2**. The total amount distributed to HQEI hospitals for PY1 was \$505,856,070 and \$419,123,362 in PY2 (**Table 7.3-1**).

Table 7.3-1 Total Payments Distributed to HQEI Hospitals in PY1 and PY2

Performance Year (PY)	Interim Payment 1	Interim Payment 2	Interim Payment 3	Interim Payment 4	Reconciliation Payment	Total
PY1	\$102,500,000	\$139,862,009	\$86,773,322	\$86,773,322	\$44,973,709	\$505,856,070
PY2	\$89,963,714	\$89,963,714	\$89,963,714	\$89,963,714	\$59,268,504	\$419,123,362

Data Source: Payment data provided by MassHealth

Abbreviations: Hospital Quality and Equity Initiative (HQEI); Performance Year 1 (PY1); Performance Year 2 (PY2)

Notes: Payments were distributed to 61 hospitals in PY1 (CY2023) (Appendix Table G-2.1) and 52 hospitals in PY2 (Appendix Table G-2.2). In PY2, payments were allocated for 60 hospitals, after one hospital transitioned to outpatient care only in CY2023. However, former Steward hospitals that closed (n=3) or transitioned operations to new ownership (n=5) have been excluded from the analysis for PY2, as payments were on hold pending legal proceedings. Hospitals had to meet key milestones, or “payment gates”, to receive interim payments in PY1. MassHealth withheld 10% of each hospital’s maximum annual incentive payment in PY1 and 15% in PY2 from the interim payments and paid this out according to hospital performance in the final reconciliation payment for the PY. If a hospital would receive less than 90% for the PY, this would be recouped in the reconciliation payment process.

Funding for HQEI is divided into three provider tiers, related to hospital safety net provider status. Briefly, safety net providers are certain acute hospitals with a Medicaid payer mix greater than 20% and Commercial payer mix less than 50%. Tier 1 hospitals are safety net providers that received delivery system transformation initiative payments in 2015-2017. Tier 2 hospitals are all remaining safety net providers not in Tier 1. Tier 3 hospitals are all other non-safety net providers. More information on these tiers and definitions can be found in the HQEI Implementation Plan.²²⁶ **Table 7.3-2** shows HQEI payments were distributed progressively across hospital tiers, with higher relative support directed to safety net providers. In PY1, Tier 1 hospitals received payments equal to 5.4% of Medicaid gross patient service revenue (GPSR), compared to 2.7% for Tier 2 and 1.4% for Tier 3 hospitals. This pattern persisted in PY2, though at slightly lower levels (4.7%, 2.4%, and 1.1%, respectively). On a per-discharge basis, Tier 1 hospitals also received substantially higher payments than other providers, reflecting their greater financial reliance on their Medicaid and safety net roles.

Cambridge Health Alliance appears as an outlier, with payments equal to 23% of Medicaid GPSR in PY1 and 14% in PY2 and substantially higher payments per discharge. However, this reflects its distinct payment structure, under which 70% of funding is tied to the same hospital-based measures as other participating hospitals and an additional 30% supporting ambulatory-based measures for served uninsured patients. **Table 7.3-2** reflects the total payment distributed to CHA.

Across both years, the overall relative distributional structure remained consistent, reinforcing the program’s emphasis on directing proportionally greater resources to hospitals serving patients with the highest needs.

²²⁶ Centers for Medicare & Medicaid Services. MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 4, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

Table 7.3-2 HQEI Payments compared to Hospital Revenue and Utilization by Safety Net Provider Designation in PY1 and PY2

PY1, CY2023				
	Safety Net Group 1 Providers (Tier 1) N=5	Safety Net Group 2 Providers (Tier 2) N=16	All Other Private Hospitals (Tier 3) N=38	Cambridge Health Alliance (CHA)
Total HQEI Payment (A)	\$136,242,147	\$109,116,075	\$136,529,966	\$123,750,000
Medicaid GPSR (B)	\$2,501,329,332	\$4,001,043,555	\$9,811,118,085	\$532,590,305
Payment as % of Medicaid GPSR (A/B)	5.4%	2.7%	1.4%	23%
Inpatient Discharges (C)	56,607	204,295	479,916	9,489
HQEI Payment per Inpatient Discharge (A/C)	\$2,407	\$534	\$285	\$13,041
PY2, CY2024				
	Safety Net Group 1 Providers (Tier 1) N=5	Safety Net Group 2 Providers (Tier 2) N=13	All Other Private Hospitals (Tier 3) N=33	CHA
Total HQEI Payment (A)	\$123,856,497	\$90,661,365	\$114,605,498	\$90,000,000
Medicaid GPSR (B)	\$2,615,125,529	\$3,706,264,778	\$10,231,799,593	\$644,749,099
Payment as % of Medicaid GPSR (A/B)	4.7%	2.4%	1.1%	14%
Inpatient Discharges (C)	55,616	175,327	472,766	10,781
HQEI Payment per Inpatient Discharge (A/C)	\$2,227	\$517	\$242	\$8,348

Data Source: Payment data provided by MassHealth, Medicaid GPSR and Inpatient Discharges from CHIA Hospital Profiles²²⁷

Abbreviations: Calendar Year (CY); Gross Patient Service Revenue (GPSR); Hospital Quality and Equity Initiative (HQEI); Performance Year 1 (PY1); Performance Year 2 (PY2)

Notes: Funding for HQEI is divided into three provider tiers, related to hospital safety net provider status. More information on these tiers and definitions can be found in the HQEI Implementation Plan.²²⁸ Payments were made to 61 hospitals in PY1 (CY2023) (Appendix Table G-2.1), however one hospital transitioned to outpatient care in 2023 and therefore did not have a CHIA Hospital Profile and was excluded here. In PY2, payments were allocated for 60 hospitals. However, former Steward hospitals that closed (n=3) or transitioned operations to new ownership (n=5) have been excluded from the analysis for PY2, as payments were on hold pending legal proceedings. Additionally, discharges were recorded by hospital fiscal year (HFY), whereas the HQEI payment is measured by CY. In addition to implementing HQEI for Medicaid members, Cambridge Health Alliance (CHA) is also implementing the program for uninsured individuals. The CHA payment model

²²⁷ Center for Health Information and Analysis (CHIA). *Massachusetts Acute Hospital Profiles: HFY 2024 Databook*.
<https://www.chiamass.gov/massachusetts-acute-hospital-profiles/>

²²⁸ Centers for Medicare & Medicaid Services. MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 4,
<https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

therefore differs from the private acute hospitals, with 70% of payment tied to the same deliverables as the private acute hospital cohort and 30% tied to ambulatory quality measures for the uninsured patients served by CHA

Throughout the HQEI, MassHealth offered hospitals ongoing guidance and recommendations to support hospitals' compliance with program deliverables. For example, one resource MassHealth suggested hospitals use to inform their Health Quality and Equity Strategic Plan was the Community Health Needs Assessment (CHNA). Most hospitals found the CHNA an effective tool for narrowing in on health equity priorities.

MassHealth staff shared that they worked with hospitals to ensure the performance metrics chosen to inform incentive payments were reflective of MassHealth priorities and hospital-specific contexts. MassHealth staff shared that they did not anticipate changes to the payment model in future years of the 2022-2027 Demonstration.

“MassHealth has worked closely with hospitals to review historical hospital performance data and other resources to inform selection of targeted measures for disparities reduction. Selected measures are intended to span MassHealth priorities while accounting for individual hospital-level differences in performance and opportunity.” – a MassHealth staff respondent

Despite MassHealth's support, hospitals reported challenges related to the administrative burden of program requirements as well as complexity of certain HQEI program deliverables. For example, two hospitals described completing nearly identical assessments for MassHealth and for the Department of Public Health (DPH). Another hospital shared unaddressed questions about the HQEI language services deliverables, including the survey assessment and the encounter-level data file, as well as the scoring approach used for these deliverables to inform payment. Completion of these deliverables affected the allocation of MassHealth funding, making uncertainty and duplication in reporting requirements particularly noteworthy.

“It was really our interpreter services that led that assessment. And I think the one observation we had about that process was that it felt a little duplicative of another assessment process that we conduct as hospitals for DPH. So DPH requires a language assessment and many of the questions were quite similar.” – a Hospital participant (Y100)

Most hospitals noted that a substantial amount of work is needed to implement the HQEI program and to perform well. Many also stated that the funding distributed does not fully cover the efforts of the hospital workforce. Hospitals stated concerns that this gap may impact the hospitals' ability to sustain participation in the program over time.

“We do think a lot about that cliff, the sustainability of these programs and what comes next. And so, our thought to MassHealth is [it would be] great to have hospital rates that are themselves sustainable and don't require the supplemental payments to make up a difference.” – a Hospital participant (M100)

Multiple hospitals also expressed concerns about the uncertainty of future Medicaid funding. Other hospitals felt that the lack of a reimbursement mechanism for certain positions such as community health workers (CHWs) inhibits the sustainability of the HQEI.

“We’re talking now about workforce development, reimbursement... We have found ways that we can address [health equity], but none of it is sustainably covered by insurance. It ends up posing some strains. And now that we know, it’s almost like we cannot look the other way. We know that community health workers work. We know that it makes [care] better. Now we cannot just say ‘oh, we’re not getting funding, our cool project is gone, bye-bye.’ We need to figure out a way to sort of like continue that work and sustain that work.” – a Hospital participant (V100)

H6-1.2 MassHealth will develop policies and procedures and provide operational oversight to support implementation.

The policies and goals of the HQEI have been shaped by national, state, and local health equity priorities. In an open-ended survey, MassHealth staff shared that a national emphasis on “*value-based care, helped to inform the HQEI goals.*” MassHealth staff also indicated that the COVID-19 pandemic exacerbated existing health inequities, thus “*reinforcing the urgency*” to address pressing health disparities in Massachusetts. Accordingly, MassHealth defined the HQEI priorities and provided ongoing operational guidance to support hospitals during program implementation.

Through the HQEI Implementation Plan, MassHealth provided a comprehensive overview of the HQEI, including its conceptual frameworks and required performance metrics and targets by performance year. MassHealth also shared guidance and other resources to support the completion of HQEI requirements (i.e., literature reviews, public meetings, and historical hospital performance data), and provided standard templates to ensure timely and complete submission of deliverables.²²⁹ In interviews, hospitals expressed satisfaction with the HQEI implementation guidance provided by MassHealth. Hospitals also shared that MassHealth had regular office hours to help answer questions about HQEI deliverables.

“MassHealth, they also have monthly meetings where[,] as things are coming up and things do, they do a deep dive and create space for folks to ask questions. And they provide lots of clarification there, so that is super helpful too.” – a Hospital participant (E100)

Additionally, Joint Commission served as an oversight body for hospitals to validate their progress and capacity for health equity initiatives. Several hospitals reported that participating in Joint Commission’s Health Care Equity Certification process provided an important opportunity to showcase and summarize the health equity initiatives they had already implemented. Numerous hospitals described the process as straightforward and highlighted the usefulness of

²²⁹ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

resources provided by Joint Commission, including checklists and other preparatory tools, which helped guide their efforts and ensure they met the standards efficiently.

“I actually have appreciated a lot of things about going through the Joint Commissions process...In some ways I think the going through the Joint Commissions like accreditation or certification is like moving us in the direction of like the real health equity strategy longer term, thoughtful work than any of the other incentive work is doing.” – a Hospital participant (Y100)

Hospitals also noted that while the process of obtaining the Health Equity Certification served as an important validation of the initiatives, the experience of going through the process was often described as stressful and demanding. Some attributed the stress to the fast timeline in which systems were required to get hospitals reviewed by Joint Commission surveyors. Others noted that the amount of preparation required a great deal of time and resources. Several hospitals also noted a lack of alignment between requirements for Joint Commission Health Equity Certification and the MassHealth HQEI. For some hospitals, this misalignment created challenges in determining how best to allocate time and resources toward meeting multiple expectations. Despite these challenges, hospitals acknowledged that the certification provided external recognition of their health equity work, even if the path to achieving it was resource-intensive and taxing.

“A message back to MassHealth is alignment of the goals that are set for an individual hospital...goals potentially set by MassHealth, Joint Commission, Medicare, individual payors. So, the more alignment that there is on those goals, then the easier it is...to have an impact actually on patient care, rather than...having to focus on specific set of criteria for one project.” – a Hospital participant (V100)

In addition to feedback on Joint Commission accreditation alignment from hospitals, MassHealth staff highlighted several HQEI implementation challenges faced by hospitals. For instance, hospitals' pace of program implementation varied by hospital size and resources. The HQEI measure slate, developed by MassHealth, required post-launch revisions to measure specifications, resulting in delays. MassHealth shared that they faced challenges in developing the measure specifications for the HQEI due to, as one MassHealth Staff described, *“the absence of widely accepted standardized equity measures at the national level”*. As a result, they shared that some measures specifications have been adjusted and refined after the launch of the program.

“This has introduced some delays in finalizing specifications and launching certain components of the program, as MassHealth works to ensure the measures are both meaningful and feasible for participating hospitals.” – a MassHealth staff respondent

Many hospital interviewees shared their satisfaction with the monitoring support of MassHealth, saying that MassHealth *“did make adjustments where they could. So that’s much appreciated.”* (Hospital participant). Another hospital said, *“the state has been responsive to questions when we pushed and we don’t understand.”* (Hospital participant) Despite this support, several hospitals shared specific feedback about the challenge of the lack of clarity on measure

specifications presented and the changing of performance measure specifications after the launch of the HQEI.

“There’s this phrase that we’re building the plane as we’re flying it; that was very true, especially in year one...more time for us to just strategize, more time sharing the requirements well in advance and the expectations and defining the specs well in advance so... as entities, as hospital systems, we’re able to be strategic in what we are doing and not just responding to requirements as they come out.”
– a Hospital participant (D100)

Hospitals also noted the high administrative burden and resources required to stand up the HQEI program. The large volume of deliverables and multiple submission dates led to hospitals feeling like the work became more about “box checking” and less about the importance of the quality and equity work. Hospitals shared that they would prefer MassHealth to streamline HQEI deliverables to ease the administrative burden on their staff and to make deliverables meaningful, resourced, and strategic. Hospital staff also talked about how they needed more time to engage stakeholders and align their efforts to wider strategic work.

“I think most of us really enjoy this work, right? But I would say if we – if MassHealth could find a way to make it feel more about the work and less about checking a box. Because there’s so many deliverables and there are periods of times when we’re thrilled and excited about the work and there’s other times when we’re like, oh my gosh, we just need to get this done by the due date.” – a Hospital participant (U100)

H6-1.3 MassHealth and its contractors will deliver technical assistance (TA) to support HQEI.

MassHealth provided TA to hospitals participating in the HQEI through multiple efforts including regular office hours focused on quality and equity initiatives, technical support provided by clinical and quality experts, assistance with data reporting and analysis, a centralized inbox to ask technical questions, and ad hoc one-on-one meetings, as needed. Several hospitals were pleased with how responsive MassHealth was to their inquiries and feedback and how they were always willing to work with hospitals to try and improve processes and systems. Hospitals also noted appreciation for the volume and timing of MassHealth communications.

“We have point people, but also, we just will send an inquiry through the general inbox, and they reach — they will then triage it to the appropriate team. And then they usually respond within 48 hours. They’ve been very responsive.” – a Hospital participant (B101)

Despite overall appreciation for MassHealth’s TA, multiple hospitals described ongoing challenges. Some hospitals shared that the information communicated in office hours was difficult to follow, and that while communications were frequent, guidance was not always clear or questions were not consistently answered.

“Office hours. Those, in my opinion, range from either very good to extremely too complex. Most of us are double-masters prepared or

doctorate prepared and we have a hard time understanding what the ask is or how billing or some other measure is derived.” – a Hospital participant (U100)

H6-1.4 MassHealth and its contractors will provide performance monitoring to support HQEI.

MassHealth contracted with numerous vendors to provide monitoring support throughout the HQEI. Performance metrics and reporting requirements are available in the HQEI Implementation Plan.²³⁰ MassHealth staff shared that their Comprehensive Quality Measure Vendor (CQMV) helped to provide *“specialized tools and resources, and expertise in using data-driven strategies to identify and address health disparities.”* (MassHealth Staff). MassHealth also worked with an external quality review organization to provide *“TA sessions on how to conduct a PIP [Performance Improvement Project], including how to do a barrier analysis, identify interventions and tracking measures.”* (MassHealth Staff).

In addition to these partnerships with vendors, MassHealth staff shared that they regularly communicated with hospitals about performance and progress through office hours, email, and OnBase, a secure document submission platform where MassHealth collects, manages, and processes hospital submissions for the HQEI.²³¹

“Hospital-specific reports, along with performance feedback, are regularly shared with participating hospitals through the OnBase platform to support transparency and continuous improvement. Additionally, aggregate performance on program measures is analyzed and shared with hospitals, when available, during office hours to support shared learning. Through this structure, MassHealth can monitor implementation, recognize progress, and intervene early when additional support is needed.” – a MassHealth staff respondent

7.3.1.3. Conclusions

Our interim findings indicate that the HQEI effectively engaged hospitals in reporting on equity-related measures and advancing health equity initiatives. This was achieved primarily through targeted financial incentives, paired with technical assistance and performance monitoring. Across participating hospitals in PY1 and PY2, MassHealth distributed both interim and reconciliation payments tied to narrative and performance-based deliverables, supporting the collection of RELDSOGI data, HRSN screening, and strategic equity planning. Hospitals generally valued the support provided, including guidance on leveraging CHNAs, standardized templates, and vendor-supported monitoring, which helped align local hospital efforts with statewide equity priorities and provided external validation of progress.

²³⁰ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²³¹ MassHealth (2026). MassHealth Hospital Quality and Equity Incentive Program (HQEIP): OnBase Reporting System. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip#onbase-reporting-system>

Hospitals consistently reported substantial administrative burdens and resource demands associated with program participation. Challenges included duplication and lack of alignment of reporting across HQEI and other accreditation requirements, evolving measure specifications, and limited national consensus on standardized equity metrics. Financial incentives were meaningful, but they typically did not fully offset operational and staffing costs that were required to implement and maintain HQEI initiatives. Hospitals emphasized the need for clearer deliverables, alignment with other reporting requirements and standards, and streamlined processes for sustained engagement without compromising the strategic goals and mission of the equity work.

These findings highlight both the promise and limitations of incentive-based programs to advance health equity, particularly for hospitals. MassHealth's approach to financial incentives, technical support, and structured monitoring demonstrated feasibility of using incentives to catalyze hospital engagement in equity efforts. Sustained impact will likely require stable measure specifications, stronger alignment across oversight entities, and streamlined reporting processes to maintain engagement while preserving the strategic intent of the initiative.

7.3.2. RQ6-2 What actions did participating hospitals take to implement quality and equity initiatives?

7.3.2.1. Summary of Results

In response to HQEI requirements, hospitals undertook organizational, technological, and workforce changes to implement quality and equity initiatives to reduce disparities among vulnerable populations. In PY1 of the HQEI, hospitals completed competency and needs assessments, developed Health Quality and Equity Strategic Plans, and strengthened internal health information technology (HIT) infrastructure to support standardized RELDSOGI and HRSN data collection. Hospitals engaged internal leaders, frontline staff, and community stakeholders, including patients, Health Quality and Equity Committees, Patient and Family Advisory Councils (PFACs), and Community-Based Organizations (CBOs), to ensure initiatives were relevant, feasible, and aligned with community priorities and operational realities. Hospitals modified electronic health records (EHRs), registration workflows, and patient-facing platforms to improve the collection of demographic and HRSN data. Hospitals developed dashboards to monitor disparities and guide quality improvement efforts. Staff received training in culturally competent, trauma-informed, and equity-focused approaches to support new data collection workflows and service delivery expectations.

Building on these early foundational efforts, hospitals implemented initiatives to improve access to culturally, linguistically, and disability-competent care including interpreter services, disability accommodations, and equity improvement projects in partnership with ACOs. Hospitals leveraged community and member input, integrated community health workers, and strengthened partnerships to improve care coordination and address HRSNs. While hospitals made meaningful progress in strengthening data collection, access initiatives, and quality and equity improvement efforts, many described the work as resource intensive and complex. Hospitals cited substantial staffing constraints, cross-departmental coordination demands, and effort required to align new data collection, reporting, and improvement activities within existing systems.

7.3.2.2. Results

H6-2.1 Participating hospitals will perform competency and needs assessments to target quality and equity initiatives.

In PY1, MassHealth incentivized hospitals to complete competency and needs assessments that would inform their quality and equity initiatives in future years. Hospitals assessed community health needs and disparities to inform their Health Quality and Equity Strategic Plans, in which they outlined their initial health equity goals and action plans. Hospitals also completed several self-assessments provided by MassHealth, for example, the Disability-Competent Care Self-Assessment Tool, which they used to guide internal improvement planning.

Needs Assessment and Strategic Planning

Hospitals included many internal and external stakeholder groups in the process of developing community-driven strategic plans for improving health equity. In interviews and reviewed documents, hospital representatives described how this work often built on existing partnerships and community or patient engagement efforts. For example, some hospitals already participated in a coalition of organizations working together to complete a CHNA every three years.²³² Hospitals also described engaging member and community representatives to inform and review their strategic plans, including groups such as their Health Quality and Equity Committee (HQEC) or PFAC. Hospital interviewees noted that this type of engagement was critical for building trust with the populations they serve. By incorporating community perspectives, hospitals were better able to design initiatives that aligned with identifiable needs, ultimately increasing the likelihood that interventions would be relevant, sustainable, and effective in reducing disparities.

“The work involve[d] a full year of conversations with community members and leaders who join the [redacted] Coalition, to get the project plan in place and do the work. It’s good public health to ensure that you get your community members on board before you roll out or implement any type of strategy that impacts their overall wellbeing. And in the end, the community decided to work on housing and homelessness...The community conversations are also used to really inform the HQEIP work as needed.” – a Hospital participant (V100)

Hospitals leveraged the findings from their most recent CHNA to inform their strategic goals. They also drew on public data sources, such as the U.S. Census, County Health Rankings and Massachusetts DPH, to better understand community health needs and disparities.²³³ Finally, some hospitals incorporated analysis of internal hospital data to identify areas for quality and equity improvement. Many hospitals included goals to improve their demographic and HRSN

²³² Community health needs assessments, 26 CFR 1.501(r)-3 (2010). [https://www.ecfr.gov/current/title-26/part-1/section-1.501\(r\)-3](https://www.ecfr.gov/current/title-26/part-1/section-1.501(r)-3)

²³³ University of Wisconsin Population Health Institute. (2026). *County Health Rankings & Roadmaps*. <https://www.countyhealthrankings.org/>

data collection so that, in future years, they could better understand and address patient needs with these data.

“Truly when we talk about this health equity work, that community health needs assessment is what drives us. It tells us what the people in the county are saying is the issue. It shows us through data what the issues are. And then it helps us to then plan on how we’re going to move forward and then strategize how we’re going to change and turn around some of these things.” – a Hospital participant (C100)

In their PY1 Health Quality and Equity Strategic Plan deliverable, hospitals summarized their findings from these various data sources and detailed their initial health equity strategic goals. Hospitals balanced several factors in their identification of these goals. They considered both the community-level concerns and disparities identified in their needs assessments as well as areas of concern and improvement within hospital processes and clinical care, often identified by internal stakeholder groups or through analysis of hospital data. Furthermore, hospitals accounted for MassHealth’s HQEI performance goals in developing their strategic plans, evidenced by goals referencing specific deliverables such as performance improvement projects with ACO partners. Hospital systems developed system-wide goals. A few also identified goals for individual hospitals, to address local community needs or hospital-specific findings.

Competency Assessments and Initiative Planning

Several of the performance requirements for PY1 focused on assessing existing practices at the hospital or within the hospital system, and planning for implementation and improvement.²³⁴ Hospital interviewees described engaging internal stakeholders to complete these assessments and, for the most part, found that the process was useful for bringing together key staff, identifying gaps, and informing improvement efforts. One example was the Disability-Competent Care Self-Assessment Tool, a CMS’ Resources for Integrated Care tool adapted by MassHealth for the hospital setting, designed to evaluate current competencies in meeting the needs of patients with disabilities and areas of opportunity in applying the Disability Competent Care (DCC) model. Hospital interviewees stated that the DCC model was new for their hospitals, and emphasized the importance of bringing multiple perspectives into the process for completing a comprehensive gap assessment and making improvement plans. They convened multidisciplinary teams to complete the Disability-Competent Care Self-Assessment Tool, including clinical staff representing different specialties, care management or social work staff, operations staff, and members of mid-level and senior leadership. Hospital interviewees described how they were able to use their assessment results to inform their staff training plans and other efforts such as improvements to physical access.

A few interviewees mentioned that the MassHealth-adapted Disability-Competent Care Self-Assessment Tool could have been improved, including components that were not directly applicable to hospitals or their patient populations. Some mentioned that the process would

²³⁴ Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

have been more beneficial if they had had more time to work on this deliverable, allowing them to engage a more diverse group of stakeholders and incorporate the findings into their organization-level planning.

Hospital interviewees shared similar feedback about the Language Services Self-Assessment. Since interpreter services were already well-established at the hospitals, the assessment was typically completed by the staff managing that workstream within the hospital or hospital system. Interviewees shared that the process was helpful for identifying areas for improvement.

“I would just add as another example the language interpreter services assessment. Again, gave us the leverage and structure to move things forward in terms of our own internal self-assessment and helping us identify where some opportunities were that maybe we didn’t recognize before. I think from that perspective, it was good.” – a Hospital participant (B101)

Additional assessments for PY1 included, but was not limited to, the RELDSOGI Assessment, HRSN Assessment, HRSN Screening Tools and Plan, and Stratified Performance Report. These tools elicited information from hospitals on their current practices for collecting and using demographic and HRSN data and prompted them on their plans for implementing changes to meet performance goals. As described further in **H6-2.3** and **H6-2.4**, hospitals completed these tools and made the necessary modifications to their health information systems and staff training. Overall, hospitals successfully completed the assessments incentivized by MassHealth within the HQEI and used the information gathered to inform their quality and equity initiatives.

H6-2.2 Participating hospitals will recruit, train, and retain providers and staff responsible for implementing quality and equity initiatives.

The healthcare workforce plays a critical role in advancing health equity initiatives. As part of the HQEI, hospitals were expected to submit narrative documents describing how providers and staff were hired and trained to support their HQEI efforts and hospitals’ health equity goals. In interviews, hospital representatives emphasized the importance of investing in staff training to sustain health equity efforts. Multiple hospitals described creating and hiring into new roles such as health equity program officers, peer navigators, CHWs, and data analysts. However, other hospitals noted financial constraints forced them to reduce their workforce and distribute responsibilities among existing employees. One hospital said, *“We haven’t really hired new people...we’ve certainly shifted a lot of work on to people...which means they’re not doing other work”* (Hospital participant) To fill some of these workforce gaps, hospitals discussed internal programs and partnerships that were developed to increase the technical capacity of their current workforce.

“And we have a robust workforce development team...we have a number of connections in with schools and with training programs [at community colleges], and a number of pipeline programs...Additionally, we have a number of programs around mentorship, partnership, and youth development, so with a variety of areas within the system, whether it be at the hospital-specific level or

it be sort of more broadly across multiple hospitals.” – a Hospital participant (D100)

Many hospitals prioritized health equity workforce training, particularly in staff orientations. Several hospitals added equity-focused workflows and learning materials to onboarding processes to help new employees understand how their roles support inclusive care.

“We make sure that we do highlight our health equity priorities and initiatives during orientation and onboarding, so that’s really key. Integrating our health equity [learnings] in their onboarding and their training. And then just partnering with local schools, mostly nursing schools and so forth, to make sure that we hire folks that reflect our community.” – a Hospital participant (U100)

To support employee retention, hospitals consistently solicited feedback from employees on areas of improvement and invested in salary increases and paid education programs. One hospital participant described how these funds enabled them to *“give a significant raise to nurses this year”* in addition to other workforce investments. (M100)

“We’re actually paying individuals while they go to school. Because what we heard loud and clear was as much as folks would like to be able to continue their education, they still need income...So we’re investing about \$6 million a year supporting the education and growth for registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, nurses’ aides, respiratory therapists, imaging.” – a Hospital participant (C100)

Though hospitals continued to invest in their workforce, many discussed how workforce shortages and the administrative demands of the HQEI created strains on both staff and providers. One hospital said: *“because of our reduction in force, we’re dealing with a tighter team. It has been quite challenging for this build.”* (Hospital participant) Multiple hospitals shared that the resources and effort needed to embed components of the HQEI into existing workflows created challenges as well.

“It’s work and effort and resources. And as we move from reporting to performance, the elements around data collection and analysis, etcetera, are [going to] only increase, especially as the volume of the activities increase.” – a Hospital participant (B101)

H6-2.3 Participating hospitals will modify health information systems to ingest and use self-reported demographic and HRSN screening data.

In the first two years of the initiative, hospitals modified their health information systems to collect and use members’ self-reported RELDSOGI and HRSN screening data according to HQEI requirements. This included modifying or creating new data collection fields, workflows, and reports or dashboards. Even when hospital systems already collected and tracked data, they often had to modify their systems to align with MassHealth expectations around standardized data collection or to improve data collection and reporting.

Hospitals described their current practices and in-progress modifications in several HQEI PY1 deliverables, including the RELDSOGI Assessment, HRSN Assessment, HRSN Screening Tools and Plan, Language Services Assessment, and Stratified Performance Report. Hospital interviewees provided updates and additional context on these topics during interviews conducted from November 2024 to April 2025. In both the reports and interviews, hospital staff provided detailed accounts of the work they undertook to modify their health information systems. They described efforts not only to meet performance benchmarks, but also to improve the experience and ease the burden of data collection for members and staff.

The integration of health information technology across a hospital system as well as features of specific platforms were identified by hospital interviewees as important factors for implementation. Some hospital systems used different EHR systems across locations. Interviewees in these settings described the need for resource investments to align data collection and reporting. Hospital systems using one EHR designed data collection and workflows to allow for data flow across locations. A few hospitals had recently transitioned or were in the process of transitioning to a different EHR vendor. This presented an opportunity on the technical side but was also described as a challenge in terms of staff effort and priorities.

Demographic Data Collection

Hospitals modified their health information systems to collect and maintain members' self-reported RELDSOGI data in alignment with MassHealth specifications.²³⁵ These modifications included creating or updating data collection fields and workflows in registration platforms and EHRs, as well as leveraging member-facing HIT, such as patient portals and self-registration platforms, to support data collection.

Prior to the HQEI, hospitals' data collection practices were informed by existing regulations, state or federal guidance, and in some cases, internal health equity initiatives. Common gaps existed, particularly in documenting members' self-reported disability, sexual orientation, and gender identity. Most hospitals needed to modify their systems to meet HQEI performance specifications.

While hospitals already collected race and ethnicity data in most clinical settings prior to HQEI, hospitals identified opportunities to improve the systematic collection of these data and to capture dates of collection and verification to comply with MassHealth's annual verification expectations for PY1-2.

“One area that we also have implemented is being able to track...not only the actual initial capture of that data but when that data is due for review. Putting a process in place so that if it had been more than 12 months since the time that it was either reviewed or updated that we would have that pop up for our registrars to be able to ask those questions again and confirm that... There was some build that was needed to change that.” – a Hospital participant (Y100)

²³⁵ MassHealth HQEIP Technical Specifications are available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>

Most hospitals already collected members' preferred language for communication about health information and services. This is done during registration or admission processes, and the information is then used to alert staff if the member needs interpreter services. Some hospitals had not previously documented patient preferences for spoken and written language separately and updated their systems to collect and report these distinct member preferences.

While hospitals collected information from members about disabilities or disability status, most needed to update their data collection and documentation to align with the HHS six-question set.²³⁶ Furthermore, many hospitals did not collect disability data with consistency across clinical settings and had difficulty reporting disability information from their EHRs. For example, some hospitals only collected this information for radiology appointments or within clinician assessments. In the PY2 RELDSOGI Data Mapping Deliverable, nearly all hospitals reported updating their health information systems to collect the six HHS disability questions. The remaining hospitals plan to make the necessary updates by 2026.

“While collecting [demographic] information has always been a feature of registration, we’ve made some changes to make sure that it’s flagging as reminders in the inpatient and the emergency department settings to collect that demographic information. For disability, there’s new questions that have been mandated by the state which is not...how [we] collected disability prior. And so, we’ve needed to add that into an [EHR] build. It was initially put into the nursing workflow. It’s now going to be moving back into the registration workflow.” – a Hospital participant (M100)

While most hospital health information systems were designed to allow sexual orientation and gender identity information to be entered, staff had not yet developed a standardized workflow to support its collection. This was reflected in lower hospital-reported data completion rates for sexual orientation and gender identity in PY1 as compared to race, ethnicity, and language data (**Table 7.3-2**) Hospital interviewees described updating their workflows, to facilitate routine data collection of RELDSOGI data fields.

Finally, hospitals invested in member-facing HIT as another mechanism for demographic data collection. This included updating fields in existing patient portal forms and setting up self-check-in kiosks. Hospital interviewees said that these investments were important to both improving privacy and reducing staff time dedicated to data collection.

“We did strive to make any collection of this if we could push that to our patient portal. If we could make it so that the patient would be able to input that information on their own. For multiple reasons — less for our hospital staff to have to do, but also that that provided a private, potentially easier to understand means for the patient to be able to actually put that data in, and in their own time frame. So that was something that we were able to do.” – a Hospital participant (Y100)

²³⁶ U.S. Centers for Disease Control and Prevention. (2025). Disability and Health Data System: Disability Datasets. <https://www.cdc.gov/dhds/datasets/index.html>

Table 7.3-3 Summary of RELDSOGI Data Collection Across Hospitals in CY2022 (Baseline)

Demographic Measures	Hospital Data Collection Rates (Inpatient Discharges)		
	Number of Hospitals Reporting	Average	Min-Max
Race	54	92%	50-100%
Ethnicity	54	92%	50-100%
Language, Written	44	87%	3-100%
Language, Spoken	52	85%	0-100%
Sexual Orientation	44	26%	0-73%
Gender Identity	47	41%	0-99%
Disability	19	56%	0-100%

Data Source: PY1 (CY 2023) RELDSOGI Assessment

Abbreviations: Calendar Year (CY); Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity (RELDSOGI)

Notes: Deliverables for 57 hospitals were provided. Of the four hospitals with missing deliverables, two were closed or transitioned to outpatient services in 2023. Three additional hospitals completed the deliverable and stated that they collected some demographic data but could not report the data for these measures. The number of hospitals reporting data varies by measure because some hospitals did not collect data or could not report the data they collected for certain measures. The percentages represent the percent of members with at least one inpatient discharge in 2022 for which there is self-reported data, for each RELDSOGI category

HRSN Data Collection

Many hospital systems were already collecting HRSN data in certain outpatient settings, such as primary care clinics, but had to modify their screening questions, information systems, and workflows to expand this into inpatient and emergency department (ED) settings. Hospitals worked to standardize data collection and ensure that screening results were available across locations, where applicable. These investments were encouraged by the alignment of performance measures for partnered ACOs and hospitals. Hospitals also described barriers to screening that were more difficult to address in acute settings, including limited staff time to collect data and respond to it, as well as patient concerns about privacy and how the data would be used. While a few hospitals reported that they were already collecting HRSN data during inpatient stays in PY1, many implemented this screening within nurse assessment workflows in PY2. A few hospitals mentioned that they were planning to provide the option for members to complete HRSN screening on a mobile device or hospital-provided device. HRSN screening rates and results are documented in **RQ6-3, Hypothesis H6-3.1**.

Using Demographic and HRSN Data

Hospitals built reports and/or dashboards to monitor collection of members' self-reported demographic and HRSN information, as well as to use that data for identifying disparities. By monitoring data completion and results, staff could identify and address technical issues early in the implementation process. This also supported ongoing monitoring and improvement efforts towards hospitals' data collection goals. Furthermore, these steps were important to ensure data

validity before hospitals stratified quality measures and other performance indicators to identify disparities in quality of care.

“We have dashboards that we’re building out [with] our metrics for each one of the requirements. And we’re sharing that with executive leadership so that they can take that back to their staff. And we’re working through rapid-cycle problem solving. We have one point in our RELDSOGI data that we’re still working through, and we know it’s a connection between our virtual check-in process and our [EHR] system.” – a Hospital participant (P100)

In the PY1 Stratified Performance Report, most hospital systems reported that they were stratifying quality measures by race and ethnicity. The few remaining hospital systems described their efforts to build capacity to be able to stratify in PY2. Nearly all hospital systems described plans to expand reporting capabilities following implementation of new or modified demographic and HRSN data collection. While some hospital systems relied on centralized analytics or quality departments to manage this reporting, others described decentralized workflows in which staff manually analyzed data and compiled reports. Challenges across hospitals included competing priorities and limited staff time to execute and improve processes for stratified quality measure reporting.

Staff also use certain data to inform their actions during the clinical care encounter. As described earlier, preferred language information is used by staff to make an appropriate connection to interpreter services. Efforts to improve tracking of interpreter service provision, as well as disability accommodations, are discussed in **H6-2.6**. Hospitals also developed or modified workflows for when members screen positive for health-related social needs. Hospital interviewees described efforts to make information about relevant resources available to members, for example, by using the after-visit summary provided to members at discharge. In some cases, a positive screen would be flagged for a case management team or social worker, who would then follow up with the member. In addition to relying on internal expertise, hospital interviewees also talked about the importance of community partnerships in being able to adequately address members’ social needs through referrals. Several hospitals reported that they were still working on a closed-loop HRSN referral system.

“We have really skilled patient navigators and social workers who work with patients and actually will sit down and help them fill out that SNAP application. So that’s an internal resource that we have...so we’re providing [members] information. We’re certainly referring them to external community partners, but also have ways of providing direct assistance ourselves because we have staff who have been doing this for some time.” – a Hospital participant (B101)

H6-2.4 Participating hospitals will train staff to systematically collect self-reported demographic and HRSN data in a culturally competent manner.

Hospitals described their plans for staff training in two PY1 deliverables, the RELDSOGI Assessment and HRSN Screening Tools and Plan. Many hospitals already required or offered staff training on cultural competency or cultural humility. Other training topics mentioned by

hospitals included trauma-informed care, health equity, and diversity and inclusion. Hospitals explained that they would incorporate training on new or modified RELDSOGI and HRSN data collection into existing staff education programs, including information on why data collection is important, how the data will be used, and how to address patient questions. Data collection training was typically already in place for new hires, with annual retraining for any staff responsible for demographic data collection. Hospitals also described their use of toolkits, scripts, or similar materials as well as management support for the rollout of new or modified data collection. For example, one hospital described their plan for “*workshops, script development, safety huddles, direct patient/staff feedback and direct instruction by [department] leadership.*”²³⁷

In interviews, hospital representatives confirmed that they had trained staff in advance of implementing health information system updates. They also emphasized the importance of building staff buy-in for RELDSOGI and HRSN data collection, as one hospital interviewee articulated.

“Particularly getting folks acquainted with why we’re doing this and [the] broader initiatives and not just having an extra thing that they’re collecting. Also, to understand all the various ways that patients might resent that and have questions on it...and there’s certainly cultural competency that’s part of that — baked into a lot of training we do.” – a Hospital participant (R100)

Hospitals continue to collect feedback from both staff and patients to improve data collection. Interviewees shared several concerns they’ve heard, including those about patient privacy, screening fatigue, and staff discomfort with asking certain questions.

“There’s also this privacy concern that’s coming up. In some cases, patients are in the waiting room or they’re in public spaces. It’s hard to ask those questions with a lot of people around and patients are not feeling comfortable...We’re getting questions in recent weeks about why we’re asking this. And so there is an opportunity to probably reeducate. And I know there’s a larger effort of how we’re communicating with our patients that it’s still safe to report this information.” – a Hospital participant (G100)

This feedback highlighted the need for ongoing staff education and support. It also underscored the role of patient education and engagement. Hospitals’ plans for patient education included information-sharing directly with patients, both at the time of data collection and through wider dissemination of educational materials. Examples included sharing brochures in waiting areas or sending a patient portal message. Hospitals also used social media or existing community outreach channels to raise awareness in the communities they serve. They engaged patient advisory groups to inform messaging. Several hospitals in Massachusetts have also adapted the “We Ask Because We Care” messaging campaign, originally designed as a part of the

²³⁷ Hospital HQEIP PY1 RELDSOGI Assessment Deliverable

Robert Wood Johnson Foundation's Aligning Forces for Quality program and now used by hospitals nationwide.²³⁸

Hospitals participating in HQEI recognized that they will need to continue their activities to promote culturally competent communication, within staff training and patient engagement efforts, beyond initial data collection implementation. Furthermore, it will be important for hospitals to continue collecting patient and staff feedback to identify and address barriers.

H6-2.5 Participating hospitals will establish processes to submit self-reported demographic and HRSN data to the state.

Hospitals established processes to submit members' demographic and HRSN data to MassHealth. A MassHealth staff member confirmed that, *"MassHealth is on track to obtain complete race and ethnicity data for 80% of members by the end of 2025."* MassHealth staff reported that hospitals continue to work towards 2027 data completeness goals for preferred spoken language, preferred written language, disability, sexual orientation, and gender identity data. In PY1, all hospitals met the minimum specifications for RELDSOGI data files, which were submitted to the CHIA for validation and processing prior to reporting to MassHealth. As described in the PY1 Technical Specifications, CHIA received demographic data from the acute hospitals on a periodic basis, conducted cross-database matching checks to support MassHealth attribution, validated submissions, and transmitted all identifiable members to MassHealth.²³⁹ Of note, while defined in the PY1 technical specifications, the cross-database matching checks were not effective until PY3.

In PY1, hospitals also made progress towards reporting HRSN data. As one MassHealth staff respondent summarized it, *"by the end of 2023, 95% [of participating hospitals] had selected a standardized HRSN screening tool, improved workflows, and made key updates to their EHR systems to prepare to report member-level HRSN data to MassHealth starting in 2024."* (MassHealth staff) In PY2, the hospitals submitted member-level HRSN data to MassHealth. Hospitals' HRSN screening rates and RELDSOGI data completeness rates for PY2 are discussed in **RQ6-3**.

Hospital interviewees explained that they had to develop processes for reporting member-level demographic and HRSN data to MassHealth separately from their internal reporting processes that support care delivery (described in **Hypothesis H6-2.3**), requiring additional hospital resources.

"There are a couple of work streams. One is building the reporting, which are the data extracts that we send to MassHealth on a quarterly basis. And so those are encounter-level or patient-level reports. But we're also building a number of dashboards, internal dashboards, where we can trend measures over time and look at the collection of the data as well as the distribution of the data in different

²³⁸ Shapiro, A., Meyer, D., Riley, L., Kurz, B., & Barchi, D. (2021). Building the Foundations for Equitable Care. Catalyst non-issue content, 2(5). <https://doi.org/doi:10.1056/CAT.21.0256>

²³⁹ MassHealth. (2023). *Technical Specifications for the MassHealth Hospital Quality and Equity Incentives Program (HQEIP): Performance Year 1*. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>

patient populations and making that available to teams across the hospital.” – a Hospital participant (B101)

H6-2.6. Participating hospitals will implement programs to promote access to services delivered in a culturally, linguistically, and disability-competent manner.

Hospitals were incentivized to meet performance benchmarks related to access to care, including for individuals with language and/or disability access needs, with the goal of providing more culturally, linguistically, and disability competent care. In PY1, hospitals completed assessments and planned improvements related to providing interpreter services, assessing disability accommodation needs, and training staff on disability-competent care topics.

In order to evaluate hospitals’ capacity to provide meaningful access to health care services for persons with a preferred language other than English, hospitals completed a Language Access Self-Assessment survey and reported on how they were collecting data related to the utilization of interpreter services. Multiple common themes were identified in the language services self-assessment completed for PY1. Hospitals indicated that information about language services and translation options for members was shared on their websites. Many hospitals shared that a patient’s language preferences are also confirmed at registration and added to their EHR. In accordance with Massachusetts statewide requirements, hospitals reported having visible interpreter services signage and various language options for the translation of patient-facing materials.²⁴⁰ Hospitals also reported on their existing infrastructure to collect self-reported preferred language information from members, discussed in more detail in **Hypothesis H6-2.3**.

Additionally, hospitals shared ways that they track access to language services. A majority of hospitals used their EHR systems to track language data collected at patient registration. They also collected feedback from those who received interpreter services. The language services metrics collected by hospitals in PY1 are summarized in **Table 7.3-3**. Given the consistency of practices across hospitals within the same hospital system, this data was analyzed and reported by hospital system.

Table 7.3-4 Language Services Metrics Collected by Hospital Systems, PY1

Language Services Metric	Percent of Hospital Systems Documenting the Metric (N=24)	Percent of Hospitals Documenting the Metric (N=60)
Number of requests received for interpreter services	95.8%	96.7%
Number of interpreter services provided	100%	100%
Specific patients to which interpreter services are provided	95.8%	98.3%
Number of interpreter services provided by type of language assistance services (e.g., in-house interpreter, telephone interpretation services, etc.)	95.8%	98.3%

²⁴⁰ Department of Public Health. (2025). 105 CMR 130.000: HOSPITAL LICENSURE. <https://www.mass.gov/regulations/105-CMR-13000-hospital-licensure>

Language Services Metric	Percent of Hospital Systems Documenting the Metric (N=24)	Percent of Hospitals Documenting the Metric (N=60)
Number of patients who were offered interpreter services but refused	62.5%	63.3%
Wait time for interpreter services after the request for services was made	75.0%	83.3%

Source: PY1 (CY2023) Language Services Self-Assessment

Abbreviation: Performance Year 1 (PY1)

Notes: Hospitals were asked to report if they documented the language services metrics listed in the table. The data was analyzed and reported by hospital system here (N=24), given the consistency of practices across hospitals within the same system, as well as by hospital (N=60).

One hospital was excluded after transitioning to outpatient care only in CY2023. The PY2 (CY2024) Language Services Self-Assessment was not yet available for all hospitals at the time this evaluation report was produced and therefore only PY1 is reported here.

Hospitals reported various methods for quality improvement that involved soliciting feedback from members who had received language services. Some hospitals spoke with their patients to collect member experiences. Some hospitals shared they had no formal method to collect member experience data and that feedback was solicited through the general grievance or complaint submissions. Other sites expressed having phone and/or email surveys specifically for members to fill out regarding their language services experience. MassHealth staff reported on how hospitals provide and evaluate language services:

“Self-assessment surveys revealed key gaps in language access, including inconsistent interpreter service tracking and unclear documentation of patients’ language needs in EHRs. In the 2024 surveys, hospitals reported significant improvements, with most having robust systems to identify language needs and allocate appropriate services. Nearly all hospitals indicated they could report key details of interpreter services — such as date, patient, interpreter, and language used — and use multiple methods to communicate the availability of free language assistance to patients and caregivers.” – a MassHealth staff respondent

In interviews with hospitals, multiple sites discussed improving their language services as a way to better address the cultural and linguistic needs of patients. One hospital highlighted having materials translated in both Brazilian Portuguese and European Portuguese.

“We found that a lot of the materials that were available to us were in Spanish, which is great. They were in Portuguese sometimes, but they were often in Brazilian Portuguese, and we have a large population of people who speak European Portuguese. And they’re different enough that that presents a challenge and certainly a barrier in terms of cultural relevance. We made a significant investment in creating new care plans that we then were able to translate.” – a Hospital participant (R100)

Another hospital shared in interviews that improving language services is an essential part of their health equity quality improvement initiatives.

“Part of our weekly meetings is this concept of continuous quality improvement. I think one of the standouts is our language interpreter services. It caused us to question some of that data and can we do it even better. And we identified a need. So, we’re great at connecting people to an interpreter once they are talking to someone but where are the trouble points to get us into the system? If they’re calling our central scheduling department and there isn’t access in the language they want. So that was a discussion point.” – a Hospital participant (C100)

To improve accessibility and the provision of disability competent services, hospitals were incentivized to (1) assess and improve practices for collecting disability accommodation needs and (2) assess competencies and train staff on focus areas within the DCC model.

At the start of the HQEI, hospitals collected patients’ disability accommodation needs using approaches similar to those described for disability status data (**H6-2.3**). In the PY1 Disability Accommodation Needs Report, few hospital systems described systematically collecting information regarding accommodation needs from patients. Many described processes where they collected information for certain visits, such as radiology appointments, or about certain needs such as mobility support or American Sign Language (ASL) interpretation. Hospital interviewees indicated that they updated when and for whom this data was collected alongside efforts to modify their processes for collecting patients’ disability status. As discussed in **H6-2.3** and **H6-2.4**, this required modifications to hospital information systems and staff training.

“We’d talk about, if you have difficulty seeing or hearing, what can we give you. But we weren’t really putting it all together as here’s a disability, here’s an accommodation, what can we do for you around that. I think was the biggest change. The staff document accommodations that the patient wants at every visit, every inpatient visit. They’ve been doing well.” – a Hospital participant (C100)

Hospitals were required to submit member-level accommodation needs screening data to MassHealth in PY2; however, these data were not available for inclusion in this report.

A few hospital interviewees suggested that the guidance on how to collect accommodation needs information could be improved. One interviewee said, *“The health-related social needs [screening] needs some standardization, and disability accommodations. Do you want us to tell you the universe of what patients want...? Help us figure out what you’re looking for and what the patient’s looking for.”* (Hospital participant) A representative of a different hospital described bringing in a local community-based organization as a partner in improving data collection.

“[At first]...we took the exact [language] on the specifications, we put it into our system, and we have our registration team asking, ‘Do you have any accessibility needs for your appointment?’...And then the feedback from our clinical areas are, ‘how come we didn’t know this patient couldn’t stand for their mammogram?’ or something like that. We had to really look at this question, and we pulled in [redacted] from [community-based organization] to say, ‘Does this make sense?’

Can you ask your community members how we can ask this and get better answers from our patients so that we can accommodate them and be prepared for them? We've gone back and forth with a few variations.” – a Hospital participant (F100)

Hospitals were also incentivized to implement education and training programs that promote competencies in providing care to members with disabilities. MassHealth adapted tools from CMS's Resources for Integrated Care to evaluate hospitals' existing competencies and opportunities for improvement framed by the DCC model.²⁴¹ The results were then used by hospitals to design training for hospital staff and inform other projects where appropriate. As described in **H6-2.1**, hospitals successfully convened multidisciplinary groups to complete the initial assessment in PY1 and used those results to inform their plans.

The DCC model comprises seven pillars:

1. Understanding the DCC model and population being served
2. Promoting participant engagement and participant-centered care
3. Helping participants access services
4. Developing and integrating responsive care
5. Identifying key care coordination needs
6. Establishing flexible long-term services and supports (LTSS)
7. Integrating behavioral health (BH) services to help participants receive integrated care

Hospitals used their assessment results to identify three focus areas for staff education (**Table 7.3-4**). Most hospital systems chose the first pillar, understanding the DCC model and population, as one of their training topics. The other most common pillar selected for training and improvement was the third pillar, helping participants access services. Within this pillar, hospitals identified opportunities to work on communications access, process modifications, physical access, and addressing bias.

Table 7.3-5 Selected Focus Areas for Disability Competent Care Training Selected by Hospitals and Hospital Systems, PY1

Disability Competent Training Pillars	Percent of Hospital Systems (N=24)	Percent of Hospitals (N=60)
1. Understanding the DCC model and population being served	83.3%	87.7%
2. Promoting participant engagement and participant-centered care	25.0%	17.5%
3. Helping participants access services	75.0%	93.0%

²⁴¹ Centers for Medicare and Medicaid Services. (2026). *Resources for Integrated Care Available for Health Plans and Providers*. <https://www.cms.gov/medicare/medicaid-coordination/about/resources-integrated-care>

Disability Competent Training Pillars	Percent of Hospital Systems (N=24)	Percent of Hospitals (N=60)
4. Developing and integrating responsive care	37.5%	52.6%
5. Identifying key care coordination needs	37.5%	24.6%
6. Establishing flexible LTSS	20.8%	42.1%
7. Integrating BH services to help participants receive integrated care	16.7%	10.5%

Data Source: PY1 (CY2023) Disability Competent Care Training Plans

Abbreviations: Behavioral Health (BH); Disability competent care (DCC); Long Term Services and Supports (LTSS); Performance Year 1 (PY1)

Notes: HQEI incentivizes participating hospitals to identify and address unmet needs for healthcare worker training to promote competencies in providing care to members with disabilities. Hospitals selected three focus areas of the seven DCC pillars for their staff education efforts. Most hospitals selected three distinct topics, and most hospital systems took a system-wide training approach. However, three hospital systems selected different sub-topics of Pillar 3 "Access" for two or three focus areas. Two hospital systems selected different topics at the hospital level and are therefore represented more than once under the number of hospital systems column. Results for all 24 hospital systems and 60 hospitals are reported, due to one hospital transitioning to outpatient care only in 2023.

A MassHealth staff respondent shared preliminary data on hospitals' training implementation.

"All 57 participating hospitals implemented online disability competency care (DCC) training for staff in 2024. Preliminary results from 36/57 hospitals DCC training reports show that 93,321 patient-facing staff were trained and demonstrated competency in key DCC pillars during July to December 2024. All hospitals surpassed the target training rate of 25% in PY2, with an average of 73% training rate." – a MassHealth staff respondent

Hospital interviewees shared that being able to work at the level of the hospital system was a facilitator to implementing DCC training. Standardization of core training elements could be ensured across hospitals in the same system, while addressing the unique needs of each hospital. Hospitals also leveraged existing learning systems and educational forums.

"Our physicians gave us great feedback after performing some of these trainings in a grand-rounds format. And I think it was nice for our providers, because they realized there's a lot of commonality in some of the issues they faced, and I think it helped kind of broaden their perspective on how best to care for these patients." – a Hospital participant (J100)

As a result of their Disability-Competent Care Self-Assessment Tool, and bringing many stakeholders together around this topic, hospitals identified ways to improve access and DCC outside of staff education. For example, a hospital interviewee shared:

"We have work to do with disability. We are doing a lot of education right now to get the staff trained but we've identified areas here that we know we have work to do to create some accessibility for patients. We just identified with our Patient Family Advisory Council, the entrances to the emergency rooms through the parking garage didn't have a handicap-accessible button to have the doors open. If

you're in a wheelchair, you couldn't even open the doors to get into the emergency center.” – a Hospital participant (L100)

H6-2.7 Participating hospitals will implement quality improvement initiatives to promote better and more equitable care quality.

In addition to their efforts to address language and disability access needs, hospitals developed and implemented projects to improve equitable quality of care. To fulfill the associated HQEI performance measure, hospitals were expected to partner with at least one ACO on performance improvement projects (PIPs).²⁴² Some hospitals were granted an exemption from partnership if they had less than 2,500 overlapping emergency department episodes, and/or less than 100 overlapping discharges with any ACO based on utilization data, and/or serve highly specialized populations that would significantly limit the impact of partnering with an ACO. Hospital system changes also resulted in some partnership exemptions. All exemptions were subject to MassHealth approval.²⁴³

For their first PIP — which was planned in 2023 and implemented from approximately 2024 to 2025 — hospitals were encouraged to focus on measures within the Care Coordination domain including follow-up care following ED visits or inpatient hospitalizations. Measures within the Care for Acute and Chronic Conditions domain were also an option of focus for PIP 1. Hospitals could also seek MassHealth’s approval for topics that fell outside the identified domains. An example of an alternate topic included language access within the pharmacy phone line.²⁴⁴ As outlined in the PIP deliverable instructions, hospitals were expected to identify a race, ethnicity, or language disparity in quality of care and specify improvement goals for the affected population.²⁴⁵ Hospitals wishing to focus on an alternate disparity group were subject to the approval of MassHealth. In their PIP 1 Baseline Reports, hospitals provided data to justify their project focus, specified their aims, and outlined their planned interventions and measures to track progress. At the time of interviews with hospital representatives, they had begun implementing PIP 1 interventions.

Of the 57 hospitals, all but three specialty hospitals partnered with an ACO. These three hospitals were also granted flexibility in PIP topic selection. The most common topic selected for PIP 1 was care coordination after an ED visit for substance use disorder (SUD), followed by comprehensive diabetes care, and care coordination after an ED visit or hospitalization for mental illness (**Table 7.3-6**)

²⁴² Centers for Medicare & Medicaid Services. MassHealth Section 1115 Demonstration Special Terms and Conditions, U.S. Department of Health and Human Services (2025), Attachment J Hospital Quality and Equity Initiative Implementation Plan Section 3, <https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver>

²⁴³ MassHealth (2023). Acute Hospital Equity-Focused Performance Improvement Projects (PIPs) Partnership Form. <https://www.mass.gov/doc/pips-equity-improvement-intervention-partnership-form-hqip-py-1-0/download>

²⁴⁴ MassHealth. (2023). Performance Year 1 Deliverables: PIPs Mid-Year Planning Report. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqip>

²⁴⁵ MassHealth. (2024). Performance Year 1 Deliverables: PIPs: Planning (Baseline) Report. <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqip>

Table 7.3-6 Performance Improvement Project (PIP) 1 Topics Selected by Hospitals

PIP Domain	Topic Area	Number of Hospitals
Care Coordination	Follow-up after ED visit for substance use disorder	18
Care for Acute and Chronic Conditions	Comprehensive diabetes care	16
Care Coordination	Follow-up after ED visit or hospitalization for mental illness	13
Care for Acute and Chronic Conditions	Controlled high blood pressure	4
Care for Acute and Chronic Conditions	SUD assessment, brief intervention, and/or treatment	3
Other	General care coordination, patient experience, and staff education	3

Data Source: Performance Improvement Project 1 Baseline Report

Abbreviations: Emergency Department (ED); Substance Use Disorder (SUD)

Notes: Hospitals were encouraged to focus on care coordination topics for PIP 1. Hospitals could also seek MassHealth's approval for topics within the Care for Acute and Chronic Conditions domain or other topics as an alternative to Care Coordination. Results for 57 hospitals are reported, due to four hospitals closing or transitioning to outpatient care only in 2023–2024.

The PIP 2 Mid-Year Planning Report was also available at the time of this report, in which hospitals shared their preferred PIP 2 topic for approval by MassHealth. Acute hospitals who do provide obstetric delivery services were required to focus on perinatal health for PIP 2. Hospitals that do not provide obstetric delivery services could select alternative domains and request exemption from ACO partnership, subject to MassHealth approval. Any other hospitals, inclusive of those that provide obstetric services, seeking partnership exemption were subject to MassHealth approval and held to exemption criteria mentioned above. At the time of interviews with hospital representatives, the hospital staff had started planning for PIP 2, with implementation scheduled to begin in 2025.

For PIP 2, 39 hospitals (68%) identified perinatal health topics to work in collaboration with an ACO partner (**Table 7.3-7**). Ten additional hospitals requested exemption from ACO partnership for PIP 2. These hospitals do not provide obstetric delivery services and, therefore, requested partnership exemption and selected alternative domains instead of perinatal health.

Table 7.3-7 Performance Improvement Project (PIP) 2 Topics Selected by Hospitals

PIP Domain	Topic Area	Number of Hospitals
Maternal Health/ Perinatal Health	Unnecessary Cesarean sections (C-sections)	13
	Gestational hypertension or pre-eclampsia	10
	Postpartum care (hemorrhage, depression, general)	6
	Severe maternal morbidity	6
	Other prenatal and postpartum care	4
Care for Acute and Chronic Conditions	Asthma management, breast cancer screening, chronic obstructive pulmonary disease, SUD readmissions	12

PIP Domain	Topic Area	Number of Hospitals
Care Coordination	Follow-up after ED visit for substance use disorder	3
Other	Unhealthy Body Mass Index (BMI); SDOH; burn prevention	3

Data Source: Performance Improvement Project 2 Mid-year Planning Report

Abbreviations: Emergency Department (ED); Social Determinants of Health (SDOH); Substance Use Disorder (SUD)

Notes: Acute hospitals with obstetric delivery services were required to focus on perinatal health for PIP 2. Hospitals that do not provide obstetric delivery services could seek MassHealth's approval for topics related to Care Coordination, Care for Acute and Chronic Conditions, or other topics. Results for 57 hospitals are reported, due to four hospitals closing or transitioning to outpatient care only in 2023–2024.

MassHealth analyzed state-level data to inform the PIP topic guidance, while allowing individual entities some flexibility in their project design. As a MassHealth staff member explained, *“selected measures are intended to span MassHealth priorities while accounting for individual hospital-level differences in performance and opportunity.”* (MassHealth staff) Per their PIP 1 Baseline Reports, hospitals and ACOs analyzed internal data to identify and demonstrate both the relevance of their PIP topic to their patient population and the presence of disparities. Furthermore, hospital systems relied on the needs assessment data described in **H6-2.1**, including CHNA and public data, to guide their project aims. For many hospital systems, there was alignment between the MassHealth guidance and their community and internal priorities. However, flexibility was still important to hospitals, as evidenced by the number that focused on comprehensive diabetes care (under the Care for Acute or Chronic Conditions Domain) rather than care coordination in PIP 1. During interviews, hospital representatives described their efforts to balance MassHealth requirements with their data findings. Some interviewees felt that the PIP requirements limited the impact of their projects. As one interviewee stated, *“[The requirements] ended up feeling super confining and narrow... They said we had to choose one of these follow-up measures but then when we actually started looking at the data, we have really small sample sizes.”* (Hospital participant) Other interviewees shared that the HQEI requirements pushed them to identify new and meaningful areas of intervention.

“Maternal health is on our health equity roadmap, but... frankly some of the things that were on the list of suggestions from MassHealth felt like they were not going to be that impactful. That was a priority for us, [and] being able to align with the ACO and have an outpatient component... We landed on c-section disparities, which is a place that we had already been working in our inpatient space in equity, and really thinking about the new doula benefit that exists on the outpatient side... It does feel like it's a creative way to bring [those] together that we probably wouldn't have done, if it were not for the HQEIP.” – a Hospital participant (M100)

As detailed in their PIP 1 Baseline Reports, all hospitals received feedback from their staff about issues or barriers impacting performance on their selected PIP aim as well as possible interventions to address these barriers. This was done through either formal data collection, such as interviews or surveys, or in facilitated discussions during staff meetings. Many hospitals incorporated feedback from patients after facilitating patient interviews or seeking input from patient representatives on existing committees. Hospitals also referred to peer-reviewed literature, guidelines from professional groups, and internal data analytics as additional sources of information to help guide this barrier analysis and intervention planning.

Interventions in the acute hospital setting included hiring new staff to engage patients in care coordination, updating educational resources for both patients and providers, and modifying workflows to improve appropriate assessments, testing, referrals, discharge planning, and follow-up. Interventions at the ACO or associated outpatient practice sites included expanding clinic hours and flexibility for walk-in and telehealth appointments, generating registries of high-risk members for care coordination teams, and creating workflows with their hospital partner(s) to ensure that the appropriate staff or provider teams are notified and receive hospital discharge summaries. Hospitals that focused on chronic health conditions for PIP 1 still aimed to improve care coordination across settings, often identifying a role for hospital, outpatient, and ACO staff. MassHealth staff reported providing feedback to hospitals about their PIP design as well as technical assistance with the External Quality Review Organization (EQRO) to support implementation. When asked about hospital progress with equity improvement interventions, MassHealth staff reported *“Foundational equity improvement work is underway, including...76 targeted equity interventions addressing maternal morbidity, care coordination, and chronic disease management.”* (MassHealth staff) Examples of PIP 1 interventions planned by partnering hospitals and ACOs are provided in **Table 7.3-8**.

Table 7.3-8 Example Performance Improvement Project (PIP) 1 Aim Statements and Interventions

PIP 1 Element	Examples
Aim Statement	• <i>“The 2023 baseline performance for the percentage of discharges for Hispanic members aged 6 to 64 with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit within 7 days of the ED visit is 58.95% for [Hospital] and 62.60% for [Hospital]...The goal of this PIP is to increase [performance levels] to the 2023 [ACO partner] average [of 66.92%].”</i> • <i>“Upon comparison of stratified [Hospital System] Diabetes Hemoglobin A1c outcomes among various race and ethnicity subgroups, Asian patients were identified as the subgroup with the lowest rate of HbA1c poor control (20.32%), while Black and Hispanic patients were identified as experiencing health disparities (33.80% and 25.29% respectively)...By the end of 2025, [Hospital] aims to reduce the disparity in Hemoglobin A1c (HbA1c) outcomes...by 50% among [ACO partner] patients with Type 1 or Type 2 diabetes diagnoses.”</i>
Interventions	Staffing: • <i>“Employ a LICSW to conduct follow-up with every eligible patient.”</i> • <i>“Introduce peer support staff to engage with eligible patients presenting to the ED with a principal diagnosis of SUD or any diagnosis of drug overdose. These individuals, with their own lived experiences, will serve as mentors and provide support to those with SUDs, thereby enhancing patient motivation and engagement in follow-up care.”</i> Education: • <i>“Develop and disseminate provider resources on how to...initiate medication-assisted treatment in the ED and...process to refer patients to follow-up care for SUD.”</i> • <i>“Standardized education to promote patient self-management for adult patients 18 or older that are discharged with a principal or secondary diagnosis of Diabetes Mellitus...Education includes basic information on the condition and how to manage it...prevention/treatment of hypoglycemia and hyperglycemia, information on appropriate diet, and written information on when to seek additional care and an overview of medication administration (injection safety)...”</i>

PIP 1 Element	Examples
	Workflow: • “Social worker at the hospital to schedule follow-up visit appointments for hospitalized patients prior to discharge. Enhance patient discharge summary documentation that is provided to the patient at the end of the hospitalization to include information regarding what to expect (follow-up phone call from [department] to coordinate plan for follow-up visit).” • “[Provide] warm hand off to treatment referral: ...If the patient agrees to outpatient treatment, the social worker will remain in the room with the patient to call the [SUD outpatient program] to help facilitate entry and provide support during intake.”

Data Source: Performance Improvement Project 1 Baseline Report

Abbreviations: Emergency department (ED); Licensed Clinical Social Worker (LICSW); Performance Improvement Project (PIP); Substance Use Disorder (SUD)

Notes: Hospitals developed and implemented projects to improve equitable quality of care. To fulfill the associated HQEI performance measure, hospitals were expected to partner with an Accountable Care Organization (ACO) on two performance improvement projects (PIP). For their first PIP — which was planned in 2023 and implemented from approximately 2024 to 2025 — hospitals were expected to focus on measures within the Care Coordination domain including follow-up care following ED visits or inpatient hospitalization. Hospitals could also seek MassHealth’s approval for topics within the Care for Acute and Chronic Conditions domain or other topics as an alternative to care coordination. In their PIP 1 Baseline Reports, hospitals provided data to justify their project focus, specified their aims, and outlined their planned interventions and measures to track progress. This table represents examples of hospital aims and interventions for PIP 1.

While many hospitals reported successfully including MassHealth member or patient perspectives in their intervention planning, some hospital interviewees pointed to challenges with this aspect of the PIP requirement. These barriers included insufficient time to carry out the work within HQEI deliverable timeframes and limited staff time and resources, generally. These challenges were also reflected in comments about the PIP reports that hospitals were required to submit to meet the deliverable requirements. One hospital interviewee shared, *“The amount of time and resources that are involved in putting these baseline reports together and putting them together in such a way that they’re going to hit each element that we’re being scored on, I think it’s an overreach for hospitals that have limited resources, don’t have all of the time.”* (Hospital participant) Interviewees were optimistic that some of these challenges were already being addressed, as the MassHealth team worked with the procured EQRO to address hospitals’ concerns about the reporting burden.

Interviewees also described positive aspects of the PIP process. Hospital interviewees described how the PIPs served as a catalyst for establishing “*successful intervention[s]*” to address health disparities in their patient populations. In addition, interviewees highlighted that the PIPs were an impetus to test creative solutions and generated heightened collaboration across the ACO, outpatient, and acute hospital teams. The flexibility in revisiting and redesigning projects was another positive aspect of the PIP process highlighted by interviewees.

“We invested in a health coach centrally on the population health team to outreach to [ACO name redacted] members that had a recent office visit with a high blood pressure. And then we teach them how to take their blood pressure at home, we send them the monitor, and we have escalation protocols in place and all of that to make sure that they get routed to the right team. That’s been a really successful intervention. We try really hard to get creative about those interventions to make sure that they’re going to close the gap and be clinically relevant.” – a Hospital participant (E100)

In PYs 3-5 (CY2025-2027), hospitals are expected to continue implementation of their initiatives. This will include tracking the results of both process and outcome measures to understand challenges and facilitators to implementation and determine the impact of their interventions.

H6-2.8 Participating hospitals will improve and strengthen relationships with partner organizations.

Hospitals and ACOs worked closely together to meet the requirements and goals of the HQEI. A shared EHR facilitated this alignment and close partnership. Having a shared EHR helped to further drive collaboration between hospitals and ACOs by supporting common approaches to data collection and reporting. One hospital system noted:

“I think a positive is partnering with the [ACO name redacted], they seem to have a good...amount of resources in terms of health equity... and they seem to have good access to data analysis. So, things that we don’t have, they might have, so that’s been a nice partnership. They’re very reliable.” – a Hospital participant (U100)

Additionally, hospitals shared that having ACO representatives embedded in their organizational structure was an asset to ongoing collaboration between the two entities. For instance, hospital representatives provided their insight on the leadership boards at ACOs of hospital-anchored ACOs, while ACO representatives worked with hospitals on HQEI deliverables. ACO representatives also participated in various organizational groups, such as Health Equity Committees, as a requirement for the HQEI. These organizational groups met often, allowing hospitals to identify needs and issues in real time and collaborate closely with ACOs.

“I think the way we are naturally organized prior to this equity incentive even coming about in 2023, it just has helped us to collaborate with the ACOs better. So, we have a population health team, and on that team are the ACO representatives across quality, ACO health equity, pharmacy, a lot of different support services. We also have, what we call, our core team who is the team that is like our ACO team. They’re the ones that actually go out to the practices and are meeting with them regularly.” – a Hospital participant (E100)

Despite strong ongoing partnerships with ACOs, many hospitals faced challenges. Hospitals reported numerous barriers including differently formatted reports from ACOs and data availability for certain sub-populations. These challenges made data less useful and meaningful for evaluation. Further, hospitals noted misalignment in the measures they are expected to report on with ACOs, such as differences in the measure development process.

“The problem that we’re running into was the ingestion of that information into the flat files that need to go to MassHealth. Because the specific way in which the files need to be set, which is using these accepted values format with ID numbers, et cetera... that’s been a challenge in terms of exchanging information.” – a Hospital participant (G100)

“I think one of the challenges in this though is difference in measures. So even though we have a common ultimate goal, any differences, even slight, in the measure development can make things really complicated.” – a Hospital participant (E100)

Hospitals also reported collaborating with local CBOs to address health inequities and HRSNs. One hospital emphasized a preference for working with local organizations to reinvest in the community and build long-term capacity, rather than relying solely on larger, external partners. These collaborations helped hospitals extend their reach and foster greater trust and credibility with patients. In some cases, partnerships were facilitated through formal networks, such as the Mayor’s Task Force or the Chamber of Commerce, which helped bring together hospitals, community organizations, and other stakeholders to coordinate resources and identify shared priorities for addressing inequities.

“There’s a large coalition of community-based organizations that are all connected with one another frequently. Whether it’s through leadership networking groups, through Chamber of Commerce stuff, [or] through formal partnerships.” – a Hospital participant (L100)

In addition to partnering with CBOs, hospitals also engaged both local and national advocacy groups to ensure that specific communities had a voice in strategic planning and service delivery. These partnerships extended beyond traditional healthcare organizations and included disability advocacy groups, organizations representing ethnic minority communities, and groups serving unhoused populations. By involving advocacy groups in decision-making processes, hospitals were able to gain deeper insight into the challenges faced by these communities and incorporate their perspectives into program design. Hospitals reported that these relationships were critical in helping them identify and prioritize needs, allocate resources more effectively, and strengthen trust with populations who have historically faced barriers to care.

“We are contracting with [organization name redacted] to help train us and to train our partners also to conduct focus groups and help us to analyze data so that we are doing everything we can to improve health equity for other populations and other languages in our area.” – a Hospital participant (J100)

Hospitals described forming a wide range of partnerships to address BH and HRSNs, with many new collaborations driven by the implementation of MassHealth’s HRSN Supplemental Services and the need to support closed-loop referrals. Partnerships commonly focused on food insecurity and housing, with hospitals working with organizations such as Project Bread, while also relying on internal staff like social workers and patient navigators to provide direct assistance. Several hospitals highlighted BH collaborations, including partnerships with community mental health organizations, harm reduction agencies, and Community Behavioral Health Centers (CBHCs). While hospitals reported strong networks in areas such as food, housing, and BH, they also identified gaps in partnerships addressing disability needs, which some are beginning to explore.

“[Community Behavioral Health Center organization name redacted] for our behavioral health is huge and helpful with our patients. We work collaboratively with them.” – a Hospital participant (P100)

Hospitals highlighted how strong partnerships and expanded care teams contributed to improved quality outcomes by ensuring better care coordination, timely follow-up, and stronger connections to primary care and community resources. CHWs were central to this work, serving as liaisons who not only connect patients to services but also accompany them to appointments, schools, and even court, building relationships that drive engagement. Hospitals described integrating CHWs into clinics, schools, and ED initiatives to address BH and social needs. Other strategies included creating a systemwide social work council to share best practices, expanding access to language interpretation services, and partnering with organizations to ensure services such as home visits and palliative care are delivered seamlessly in the community.

“We have partnership with the [Community-based organization name redacted] to put community health workers in some of our clinics. It’s more ambulatory focused. But, some of what they’re doing is impacting the hospital space as well. We had an existing partnership with the language line that has expanded since we started this, to provide remote interpreting. And I think those are the new ones.” – a Hospital participant (Y100)

H6-2.9 Participating hospitals will engage MassHealth members and the community in the design and implementation of quality and equity initiatives.

Hospitals identified multiple opportunities for member and community input throughout the HQEI. In interviews, hospitals described engaging MassHealth members and CBOs to confirm health equity priorities. MassHealth members and CBOs provided input on which SDOH should be prioritized, highlighting issues such as housing, food insecurity, and access to BH services. Hospitals noted that this type of engagement was critical for building trust with the populations they serve. By incorporating these perspectives, hospitals were better able to design initiatives that were relevant, sustainable, and effective in reducing disparities.

“So, incorporating direct input from patients, including the participation of patients, as [redacted] mentioned on the [health equity] committee, as well as community partnerships, which helped ensure that our strategic plan aligned with identified community needs.” – a Hospital participant (P100)

Hospitals also collaborated with MassHealth members to complete HQEI-required deliverables like the Health Quality and Equity Strategic Plan. Hospitals shared that MassHealth member input was essential to informing their health equity priorities.

“For the last community health needs assessment in fiscal [year] ’22, we initiated capacity-building and training for community residents to participate in as co-facilitators and focus groups. So we had lived experience as part of our focus group facilitation. And similarly, we did the same with, again, those who are historically underserved in our community, listening sessions, where those with lived experience and linguistic capacity also were trained and compensated to facilitate breakout groups. This culminates in a very comprehensive, cumbersome, data-driven both process and report that then gets

used across the system and by each hospital for a variety of mechanisms, whether it be for this effort or others around health equity.” – a Hospital participant (D100)

Many hospitals collaborated with their PFACs to help guide the development of the Health Quality and Equity Strategic Plan.

“...one of the things we do well here is PFAC including our patients in bringing these initiatives there and talking about their experiences and using that to really drive change in our program. One of the goals we have is we’re actually going to try to start bringing patients on to our health equity committee and sit on that committee as advisors similar to [hospital name redacted]. So those are our strategic goals for this year aligned with patient engagement.” – a Hospital participant (E100)

As part of the HQEI, hospitals were also required to gather patient experience data. Hospitals discussed the multitude of strategies they utilized to gather data, such as ensuring surveys are sent to patients within 24-48 hours after discharge and using algorithms to generate these surveys to send to a patient’s desired mode of contact. Some hospitals discussed using vendors to support collecting and filtering patient experience data, but multiple hospitals were dissatisfied that a vendor could not filter the data to MassHealth members only.

“For the patient experience, that was an incredible challenge, so we did have to work with our [Data vendor name redacted] to be able to collect the information. I think part of the dilemma that we had is that [Data vendor name redacted] was unable to identify the MassHealth [members].” – a Hospital participant (G100)

7.3.2.3. Conclusions

All acute-care hospitals participating in MassHealth’s HQEI took pivotal steps in pursuit of advancing health equity throughout Massachusetts. They undertook organizational and technological changes, conducted comprehensive needs assessments, and engaged a broad range of stakeholders, including internal leaders, frontline staff, patients, PFACs, and CBOs, to inform, implement, and refine health equity-focused initiatives. This inclusive approach ensured that new programs would be responsive to community priorities and the practical demands of care delivery.

Investing in the workforce was a vital part of these efforts. Hospitals recruited, trained, and retained key personnel, including health equity officers, community health workers, and data analysts, building a diverse workforce to support HQEI initiatives. Workforce constraints and rising administrative burdens posed persistent challenges, with many hospitals redistributing responsibilities to existing staff or developing innovative programs to strengthen technical capacity and reduce staff time for data collection. Hospitals recognized the importance of cultural competency, trauma-informed care, and disability competent care, and embedded these principles directly into staff onboarding and continuing education. Toolkits and opportunities for direct staff feedback helped keep training practical and relevant.

Data from the PY1 RELDSOGI Assessments showed encouraging progress, demonstrating strong uptake in standardized collection of demographic information. Most hospital systems reported collecting self-reported race and ethnicity data, with a statewide average of over 90% collected from inpatient discharges across hospital systems. Collection rates for preferred language were also consistently high, at an average of approximately 80%. However, collecting disability, sexual orientation, and gender identity data remained more challenging, with collection rates much lower at about 20%, on average. Completion rates across variables did range as low as 0%, while others reached 100% for certain fields, reflecting considerable variation and ongoing need for system modifications and workforce training. Hospitals have also expanded HRSN screening beyond outpatient settings and piloted new approaches for data collection, reporting variable progress in screening rates and responses to positive screens.

To foster access to care equitable in quality and experience, hospitals improved interpreter services, expanded screening for disability accommodations, and partnered with ACOs and community organizations. Nearly all health systems now routinely track interpreter requests and usage, with over 95% reporting detailed usage data. Many equity improvement initiatives, often informed by community and patient input, targeted disparities in care coordination, diabetes management, and perinatal health. With stratified quality reporting, hospitals can identify disparities and design solutions tailored to their unique populations. Strong partnerships and community engagement have been central drivers to HQEI progress. Hospitals leveraged shared EHR systems, formalized cross-sector collaborations, and integrated feedback from MassHealth members and advocacy groups to prioritize interventions and address program and process gaps. Expanded care teams and collaborations with CBOs have strengthened care coordination and resource navigation, especially in BH and HRSNs.

These foundational efforts have led to measurable progress toward HQEI goals, yet hospitals described the work as resource intensive and operationally complex. This feedback underscores the need for sustained investment and adaptive strategies. Continued refinement and simplification of data collection, workforce development, and partnership initiatives are critical as hospitals move from implementation to demonstrating measurable impact in reducing health disparities, a central goal of the HQEI and MassHealth's broader vision of equitable health care.

7.3.3. RQ6-3 Did participating hospitals improve the completeness of member self-reported demographic and HRSN data?

7.3.3.1. Summary of Results

One of the key domains of the HQEI was enhancing hospitals' capacity for collecting RELDSOGI and HRSN data. HRSN and RELDSOGI data completeness helps hospitals stratify performance results to identify disparities among their patient populations. Participating hospitals are working to increase the percentage of members screened for HRSNs, with screening rates averaging 54.8% across HQEI hospitals in PY2 and expected to rise as workflows are refined. Hospitals are also improving completeness of demographic data through improved workflow, staff training, and community engagement, while monitoring annual progress. Efforts are underway to link members with unmet HRSNs to appropriate social services. Finally, hospitals are reporting performance data stratified by demographics, revealing persistent disparities in care for Hispanic, African American, American Indian/Alaskan Native,

Asian, and Native Hawaiian/Pacific Islander members. The reported data demonstrate the need for targeted quality improvement.

7.3.3.2. Results

H6-3.1 Participating hospitals will increase the percentage of members screened for HRSN.

For HRSN data collection within the HQEI, participating hospitals established baseline reporting rates and are working to increase the completeness of member screening information in key domains such as food insecurity, housing instability, transportation access, and utility needs. Across Massachusetts hospitals, the median screening rate was 67% in CY2024 with wide variation across sites (1.7-100%) (**Table 7.3-9**). There was also wide variation across sites in positive screening rates for each HRSN (**Table 7.3-10**). Hospital-level screening rates are available in **Appendix G-3**.

Table 7.3-9 HRSN Screening Rates Across Hospitals in PY2

	Overall Rate N = 112,115 members	Average Rate N = 57 Hospitals	Median (Q1-Q3) N = 57	Range N = 57
HRSN Screening Rate	54.5%	65.1%	67.0% (51.1-85.6%)	1.7-100%

Data Source: Health-related social needs screening data provided by MassHealth

Abbreviations: Health-Related Social Needs (HRSN); Performance Year 2 (PY2); First Quartile (Q1); Third Quartile (Q3)

Notes: Includes data from 57 hospitals due to four hospitals closing or transitioning to outpatient care only in 2023–2024. The HRSN Screening percentage represents the proportion of inpatient and observation stay discharges where members were screened using a standardized screening tool assessing food, housing, transportation, and utility needs. The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates can be found in the Performance Year 2 Technical Specifications for the MassHealth Hospital Quality and Equity Incentive Program available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqip>.

Table 7.3-10 Identified HRSN Needs Across Hospitals in PY2

	Overall Rate N = 61,104 members	Average Rate N = 57 Hospitals	Median (Q1-Q3) N = 57	Range N = 57
Food Insecurity	14.4%	19.0%	10.3% (5.1-15.7%)	0-100%
Housing Instability	15.3%	23.3%	9.5% (5.0-15.7%)	0-100%
Transportation Needs	11.7%	19.0%	7.5% (5.1-13.8%)	0-100%
Utilities Difficulties	9.0%	15.0%	3.8% (1.6-8.8%)	0-100%

Data Source: Health-related social needs screening data provided by MassHealth

Abbreviations: Health-Related Social Needs (HRSN); Performance Year 2 (PY2); First Quartile (Q1); Third Quartile (Q3)

Notes: Includes data from 57 hospitals due to four hospitals closing or transitioning to outpatient care only in 2023–2024. The Food Insecurity, Housing Instability, Transportation Needs, and Utilities Difficulties percentages are calculated among screened members and reflect positive

screens in each respective HRSN: food insecurity; housing instability or risk of homelessness; unmet transportation needs; and difficulty paying for or maintaining utilities. Members may screen positive for more than one need. The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates can be found in the Performance Year 2 Technical Specifications for the MassHealth Hospital Quality and Equity Incentive Program available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>.

H6-3.2 Participating hospitals will increase the percentage of members with complete data for enhanced demographic data elements.

Based on PY2 data, collection of RELDSOGI data varies by element and across hospitals (**Table 7.3-11**), providing an important starting point for ongoing quality improvement. Hospital-level data collection rates are available in **Appendix G-4**.

Table 7.3-11, Summary of Member RELDSOGI Data Collection Across Hospitals in PY2

Demographic Measures	Hospital Data Collection Rates		
	Average	Median	Min-Max
Race (Age Min 0)	69.8%	87.2%	0-97.6%
Ethnicity (Age Min 0)	68.5%	85.4%	0-97.6%
Language, Written (Age Min 6)	61.8%	72.3%	0-97.8%
Language, Spoken (Age Min 6)	71.2%	89.6%	0-97.8%
Sexual Orientation (Age Min 19)	36.6%	32.4%	0-91.0%
Gender Identity (Age Min 19)	49.2%	54.9%	0-94.3%
Disability, Cognition (Age Min 6)	21.3%	9.5%	0-87.7%
Disability, Errands (Age Min 16)	21.3%	8.2%	0-87.7%
Disability, Hearing (Age Min 0)	22.6%	10.1%	0-85.1%
Disability, Mobility (Age Min 6)	22.7%	11.0%	0-87.9%
Disability, Personal Care (Age Min 6)	21.3%	9.8%	0-87.9%
Disability, Vision (Age Min 0)	22.5%	10.0%	0-85.0%

Data Source: RELDSOGI Data Completeness: Summary data provided by MassHealth

Abbreviations: Performance Year 2 (PY2); Race, Ethnicity, Language, Disability, Sexual Orientation, Gender Identity (RELDSOGI)

Notes: Hospitals (n=58) reported the number and percentage of members with acute hospital discharges within the measurement year with self-reported RELDSOGI data. All numbers represent the combined inpatient and emergency department rates. There was no data submitted for two hospitals, due to closing or transitioning to outpatient care in 2023. One additional hospital was excluded because they had n<11 eligible discharges across the demographic measures. The minimum age for data collection for each demographic measure varied across hospitals (Ranging from 0-39). Nearly all hospitals with an ED collected data on race, ethnicity, disability-hearing, and disability-vision for all patients (age min 0) in their ED (54 of 56 hospitals). Sixteen hospitals had a minimum age for data collection that was 20-39 years old in one or more settings and for one or more measures.

Recognizing the variability and room for growth, participating hospitals are committed to increasing the percentage of members with complete demographic data as required by the HQEI. Ongoing efforts include refining data collection workflows, staff training, and community engagement initiatives to close gaps in reporting. Hospitals plan to monitor their annual progress to ensure consistent improvement where needed, with targeted interventions informed by data trends and hospital-specific challenges.

H6-3.3 Participating hospitals will increase the percentage of members with unmet needs who are linked with services and supports.

HQEI hospitals are committed to increasing the percentage of members with unmet HRSNs who are linked with appropriate services and supports. As described in **H6-3.1 (Table 7.3-10 and Table 7.3-11)**, participating hospitals are identifying members with social needs to various degrees. Current available data focuses on establishing the proportion of members who screen positive for various HRSNs. Among members screened for HRSNs across hospitals, the percentage screening positive ranged from 0% to 100% for food insecurity, housing instability, transportation issues, and utilities difficulties, highlighting the variation in identified HRSNs.

These data serve as important indicators of unmet need across participating hospitals. As noted in [Chapter 8 \(Section 8.3.6\)](#), enrollment in Flexible Services and certain specialized Community Support Programs (CSPs) increased from 2023 to 2024. Hospital efforts to improve screening and referrals for HRSNs may have contributed to this increased enrollment; however, data on referrals and enrollment in social service programs (e.g., Supplemental Nutrition Assistance Program (SNAP), Flexible Services, or Specialized CSPs) are not yet consistently available, and participating hospitals are continuing to strengthen workflows and data infrastructure to better track connections to services. Over time, these efforts will support more comprehensive measurement of referrals and successful linkage to community resources for members with identified HRSNs.

H6-3.4 Participating hospitals will report performance data stratified by demographics and HRSN.

Hospitals participating in the HQEI are incentivized to stratify quality measures by social risk factors, so that they can identify and address disparities. The PY1 performance requirements included (1) reporting of member self-reported race and ethnicity data with selected chart-abstracted and EHR quality measures and (2) submission of a report describing their current practices or plans to build capacity for stratifying quality measure data, in particular claims-based measures. As described in **H6-2.3**, most hospital systems confirmed in their PY1 Stratified Performance Report that they were able to stratify quality measures by race and ethnicity. The few remaining hospital systems described their efforts to build capacity to be able to stratify in PY2. Nearly all hospital systems also described plans to expand reporting capabilities following implementation of new or modified demographic and HRSN data collection. The hospitals' PY2 Stratified Performance Report deliverables were not available for inclusion in this report.

Hospital representatives identified challenges with the stratified performance data requirements, sharing these in both their report submissions and during interviews. First, some hospitals had challenges with accessing claims data outside their systems and, therefore, reporting claims-based measures. While hospitals could use proxy measures for monitoring and improvement purposes, they described challenges with developing appropriate measures and anticipated issues with alignment between their proxy measure results and the final claims-based measure results used for HQEI performance requirements. Several hospital representatives also noted challenges with having a very small patient population for some of the MassHealth-selected

quality measures or demographic groups, limiting their ability to interpret stratified data and identify meaningful disparities for intervention.

Table 7.3-12 and **Table 7.3-13** show preliminary statewide results for quality measures stratified by ethnicity and race. The interpretation of the following data warrants several important considerations. First, this data will be updated with finalized baseline data in a future report; this data was not available at the time of this report's development. Stratified quality measure data were collected for 57 hospitals. Of these, six hospitals were missing data for measures pertinent to their respective service offerings. Furthermore, 21 hospitals did not have data for Cesarean Birth or Severe Maternal Morbidity, as they do not provide obstetric delivery services. All available data were included in the analysis, irrespective of patient volume at each hospital.

Statewide hospital rates for the Follow-up after ED Visit for Substance Use measure were substantially lower among Hispanic, African American, American Indian/Alaskan Native, Asian, and Native Hawaiian/Pacific Islander populations (**Table 7.3-12** and **Table 7.3-13**) compared with the rates observed among non-Hispanic and White patients and the overall rate reported in claims for the MCE population (See **RQ6-4**, **Table 7.3-14**). A similar pattern was observed for statewide hospital rates for the Follow-up after Hospitalization for Mental Illness measure, with notably lower rates among African American, American Indian/Alaskan Native, Asian, and Native Hawaiian/Pacific Islander, but not Hispanic, populations relative to the overall MCE rates reflected in claims data. In addition, the provision or offering of alcohol-related services—reflected in the rates of the Alcohol Use Brief Intervention Provided or Offered measure and Alcohol and Other Drug Use Disorder Treatment Provided/Offered at Discharge measure—was also markedly lower among these populations. Together, these patterns suggest consistent disparities in both post-acute follow-up and delivery of SUD-related interventions across racial and ethnic minority groups.

Table 7.3-12 Statewide Quality Measure Rates Stratified by Ethnicity, PY1

Measure	Hispanic		Non-Hispanic	
	N	%	N	%
Follow-up After ED Visit for Substance Use				
7-Day Follow-up	2,398	29.0%	7,272	37.0%
30-Day Follow-up	2,398	40.8%	7,272	50.0%
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-up	1,907	68.1%	4,849	70.0%
30-Day Follow-up	1,907	77.2%	4,849	78.1%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-up	977	31.4%	2,963	33.4%

Measure	Hispanic		Non-Hispanic	
	N	%	N	%
30-Day Follow-up	977	53.4%	2,963	54.7%
Alcohol Use Brief Intervention Provided or Offered	1,154	14.7%	5,076	29.8%
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	410	58.5%	3,066	61.1%
Cesarean Birth	1,570	23.9%	2,558	26.1%
Severe Maternal Morbidity	9,963	1.2%	10,593	1.4%

Data Source: Measures data provided by MassHealth for PY1 (CY2023)

Abbreviations: Emergency Department (ED); Performance Year 1 (PY1)

Notes: Data provided for 57 hospitals. Of these, six were missing data for measures relevant to their services provided. Sixteen hospitals did not have data for Cesarean Birth or Severe Maternal Morbidity because they do not provide obstetric delivery services. All data were included, regardless of the number of patients seen at each hospital.

Table 7.3-13 Statewide Quality Measure Rates Stratified by Race, PY1

Measure	African American		American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander		White	
	N	%	N	%	N	%
Follow-up After ED Visit for Substance Use						
7-Day Follow-up	1,422	24.9%	198	33.3%	6,427	40.6%
30-Day Follow-up	1,422	37.6%	198	25.8%	6,427	53.7%
Follow-Up After ED Visit for Mental Illness						
7-Day Follow-up	1,099	69.6%	89	47.2%	4,012	69.7%
30-Day Follow-up	1,099	77.2%	89	22.5%	4,012	78.2%
Follow-Up After Hospitalization for Mental Illness						
7-Day Follow-up	521	26.7%	180	75.6%	2,531	35.4%
30-Day Follow-up	521	49.7%	180	67.8%	2,531	57.3%
Severe Maternal Morbidity	3,318	2.3%	875	1.4%	6,228	0.9%
Alcohol Use Brief Intervention Provided or Offered	758	19.5%	196	9.2%	4,086	33.4%
Alcohol and Other Drug Use Disorder Treatment Provided/Offered at Discharge	400	57.0%	52	50.0%	2,658	62.2%

Measure	African American		American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander		White	
Cesarean Birth	687	31.1%	187	21.4%	1,622	26.5%

Data Source: Measures data provided by MassHealth for PY1 (CY2023)

Abbreviations: Emergency Department (ED); Performance Year 1 (PY1)

Notes: Data provided for 57 hospitals. Of these, six were missing data for measures relevant to their services provided. Sixteen hospitals did not report on Cesarean Birth or Severe Maternal Morbidity because they do not provide obstetric delivery services. All data were included, regardless of the number of patients seen at each hospital.

7.3.3.3. Conclusions

Participating HQEI hospitals have established a baseline understanding of the completeness of member demographic and HRSN data. Across hospitals, the median HRSN screening rate was 67%, with wide variation, and collection of RELDSOGI data elements also varied considerably, particularly for sexual orientation, gender identity, and disability measures. Using these data, hospitals stratified targeted quality measures by demographics and social risk factors, helping to identify disparities in follow-up care after ED visits for SUD and hospitalizations for mental illness, as well as the provision of brief interventions or treatment for alcohol and other drug use disorders. These early findings of lower follow-up rates and lower provision or offering of SUD interventions among several racial and ethnic minority groups is consistent with broader statewide and national findings documenting persistent disparities in BH care access and care transitions.

Massachusetts HQEI hospitals report disparities, of varying magnitudes, across measures among underserved populations including Hispanic, African American, American Indian/Alaskan Native, Asian, and Native Hawaiian/Pacific Islander members. These patterns underscore the importance of continued investment in comprehensive data collection, improved follow-up and linkages to services, and strategic equity-focused quality improvement to address disparities. Establishing this baseline provides a foundation for future longitudinal monitoring and initiatives to advance more equitable care across Massachusetts.

7.3.4. RQ6-4 Did participating hospitals reduce disparities and improve care access and quality?

7.3.4.1. Summary of Results

While the primary focus during the initial years of the 2022-2027 Demonstration was for hospitals to improve data collection in order to impact population health outcomes, hospitals soon began to leverage the collection of RELDSOGI and HRSN data to identify and address disparities within their populations. By adopting data-informed approaches, incorporating community and patient input, and forming partnerships with community resources, hospitals developed initiatives aimed at improving care access and quality for MassHealth members. During the Demonstration period and baseline years of the HQEI, analyses of administrative data revealed that, in 2023 and 2024, rates of follow-up within 7 and 30 days of an ED visit for substance use (ranging from 34.8% to 55.7%), as well as after hospitalization for mental illness

(ranging from 40.7% to 71.5%), suggested opportunities for improvement, underscoring the need to strengthen care coordination. While many members shared positive experiences, highlighting short wait times, accessible appointments, and staff responsiveness to needs, challenges such as long ED wait times were also noted.

7.3.4.2. Results

H6-4.1 Healthcare quality will improve.

Administrative data were used to assess whether health care quality improved throughout the 2022-2027 Demonstration period. By analyzing these measures of care quality, including Follow-up after ED visit for Substance Use and Follow-up after Hospitalization for Mental Illness, we aimed to determine whether key indicators of care improved during the early years of the HQEI.

Implementation of the PIP 1 and PIP 2 projects did not begin until 2024, therefore, these early quality indicators for 2023 and 2024 are unlikely to capture the impact of HQEI initiatives. The following results should be interpreted as early indicators, not definitive evidence, of program impact. Continued monitoring and targeted improvement efforts by hospitals will be essential to realize the full benefits of the HQEI and improve care quality. Furthermore, it should be noted that these findings are based on ACO and MCO administrative data and reflect MassHealth members with a recent hospitalization or ED visit; this population may differ from the members targeted by the HQEI disparities reduction requirements.

Relative to patients in 2022, administrative data analyses indicate that in 2023 and 2024, fewer patients received timely follow-up after ED visits for substance use, as well as after hospitalization for mental illness. Lower-than-expected rates indicate opportunities to strengthen care coordination and highlight areas for further improvement, such as access to care, communication, patient engagement, social needs, or the overall complexity of the health system. Full analytic results and member characteristics are available in **Appendix G-5**.

Table 7.3-14 Observed vs. Expected Ratio of HQEI Quality Measures Among MCE Members (CY2022-CY2024)

Quality Measures		Managed Care Eligible (MCE) Members					
		CY2022		CY2023		CY2024	
		N	Mean	N	Mean	N	Mean
7-Day Follow-up After ED Visit for Substance Use	Observed Value	11,828	44.7%	7,709	34.8%	7,608	35.7%
	Predicted Value	11,828	44.7%	7,709	44.6%	7,608	44.1%
	O:E Ratio	1.00		0.78		0.81	
30-Day Follow-up After ED Visit for Substance Use	Observed Value	11,828	63.2%	7,709	55.0%	7,608	55.7%
	Predicted Value	11,824	63.2%	7,700	63.7%	7,592	63.5%
	O:E Ratio	1.00		0.86		0.88	
7-Day Follow-up after Hospitalization for Mental Illness	Observed Value	12,780	49.0%	10,532	45.2%	13,987	40.7%
	Predicted Value	12,780	49.0%	10,532	50.5%	13,987	50.8%

	O:E Ratio	1.00		0.90		0.80	
30-Day Follow-up after Hospitalization for Mental Illness	Observed Value	12,780	76.0%	10,532	71.5%	13,987	65.1%
	Predicted Value	12,780	76.0%	10,532	77.2%	13,987	77.5%
	O:E Ratio	1.00		0.93		0.84	

Data Source: MassHealth administrative data, CY2022 (baseline), CY2023 (PY1), and CY2024 (PY2)

Abbreviations: Calendar Year (CY); Emergency Department (ED); Hospital Quality and Equity Initiative (HQEI); Managed Care Eligible (MCE)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure. Some of the select quality measures are derived from the Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Full analytic results and member characteristics are available in **Appendix G-5**.

Legend

Higher is better legend:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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H6-4.3 Members will report increased access to services delivered in a manner that meets their needs.

Many member interviewees reported positive care experiences at hospitals, noting that short wait times and good appointment availability contributed to their satisfaction with hospital services. One member said: *"a lot of times I have to go to emergency room, but they treat me really well. They get me...so fast a room so I can be comfortable."* (MassHealth member) However, multiple members described negative experiences related to hospital access, specifically with ED waiting times. Although most members simply said their waiting time was *"long,"* some members noted wait times ranging from 30 minutes to 12 hours.

Members also felt that hospital staff and providers met their needs by making them feel both respected and comfortable. One member said this about the doctors and nurses who took care of them: *"They apologized that I was in pain and asked if I needed a heating pad or ice or something. They were very, very attentive. They treated me like a human."* (MassHealth member) Specifically, many members expressed that doctors and nurses worked to accommodate their cultural preferences and physical needs. One member who spoke Haitian Creole noted that interpreter services were accessible, and follow-up instructions were in their preferred language. Another member provided an example of a hospital meeting their physical needs, describing their experience getting an MRI with severe claustrophobia.

"I spoke to someone at the place that did the MRI. That was very helpful on a personal level. They said that [it] would take a total of an hour, and they actually referred me to the only open body MRI, because I was claustrophobic." – a MassHealth member (MEI010)

7.3.4.3. Conclusions

Members reported positive care experiences, citing timely appointments, attentive staff, and care that felt responsive to their needs. These reported experiences suggest that hospitals' patient-centered approaches and the integration of RELDSOGI and HRSN data help staff better understand and address the diverse challenges faced by MassHealth members. According to member-reported experiences, early, community-engaged interventions may be making care accessible and personalized.

Rates of Follow-up after ED visit for Substance Use and Follow-up after Hospitalization for Mental Illness were lower than expected in MCE MassHealth members in 2023 and 2024. Although rates surpass national Medicaid benchmarks, persistent gaps in 7- and 30-day follow-up highlight ongoing challenges in care coordination and timely post-discharge engagement. Declines in performance from 2022 to 2023-2024 coincided with changes in the composition of the MassHealth member population due to the COVID-19 Public Health Emergency (PHE) unwinding. These findings reflect the need for continued focus on workflow refinement, stronger linkages to care and supports, and sustained use of member-level data to guide interventions. By building on these early findings, the HQEI hospitals are positioned to further reduce disparities and ensure that all members receive equitable, high-quality care.

7.3.5. RQ6-5 Did participating hospitals improve member experience and outcomes?

7.3.5.1. Summary of Results

The HQEI aimed to improve the hospital experience for MassHealth members, enabling them to report more positive perceptions of the quality of care received. Improvements in member experiences were expected to lead to improved member outcomes and to an overall reduction in disparities for vulnerable populations. Analysis of HCAHPs survey results and member interview data indicated that most members were satisfied with hospital care. Communication with nurses and doctors was consistently rated high, especially among Spanish-speaking and Hispanic/Latino members. Despite consistently high communication scores, overall health and overall mental or emotional health ratings were low across all groups, highlighting ongoing challenges in member care. HRSNs, including nutrition and housing supports, were generally addressed effectively, contributing to improvements in physical and mental well-being. In contrast, transportation services were identified as an area that needed further improvement. Continued monitoring and analysis in subsequent performance years will be necessary to assess the impacts of hospital actions on member experience and outcomes.

7.3.5.2. Results

H6-5.1 Member experience will improve.

Most member interviewees who reported having received care at a hospital in CY2024 were satisfied with their hospital experience. Members who shared positive care experiences during interviews were satisfied with hospital wait times, the attention they received from hospital staff and providers, and felt that their cultural and physical needs were addressed successfully. Members who shared negative care experiences said wait times were longer than they wanted and that they would prefer to go to urgent care over hospitals when possible (See **H6-4.3.**)

When asked during interviews about their experience with providing demographic information at their hospital visit, a majority of member interviewees recalled filling out a survey at registration or providing this information to hospital staff. Most members indicated that they felt comfortable providing this information to hospitals; however, several members expressed concerns with privacy. Some members also mentioned that the questions felt out of place and were irrelevant to their hospital stay.

The HCAHPS survey was used as an additional data point to determine whether member experience was improving at hospitals across Massachusetts. Developed by CMS and the Agency for Healthcare Research and Quality, HCAHPS provides consistent, publicly reported data on patients’ perspectives of hospital care. By monitoring trends in top box scores (i.e., the percentage of respondents selecting the most positive response options), hospitals track changes in areas such as communication, responsiveness, and overall hospital rating. For the HQEI, hospitals track performance on MassHealth member experience for two composite scores related to provider communication, courtesy, and respect. Comparing performance over time and across Massachusetts hospitals helped identify where member experience was improving, where gaps remained, and where targeted interventions may be needed to drive further monitoring and improvements (**Table 7.3-15**, hospital-level data in **Appendix Table G-6.2**).

Table 7.3-15 Summary of HCAHPS Top-Box Communication Composite Scores, PY1 and PY2

Indicator	PY1 Survey Data from 46 Hospitals		PY2 Survey Data from 51 Hospitals	
	Median	Range	Median	Range
Completed Surveys	37	<11 to 1,167	31	<11 to 1,898
Nurse Communication Composite	83%	56-100%	82%	67-100%
Doctor Communication Composite	84%	60-100%	83%	63-100%

Data Source: PY1 (CY2023) and PY2 (CY2024) HCAHPS survey data for MassHealth members submitted to MassHealth by HQEI hospitals
Abbreviations: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); Performance Year 1(PY1); Performance Year 2 (PY2)

Notes: The HCAHPS survey is a standardized, national, and publicly reported survey of patients’ perspectives on hospital care. A top-box rate (%) indicates the proportion of respondents who selected the most positive response for the survey question. The composite score is the average of the top-box rates for the survey questions included in the composite. The Nurse Communication Composite is comprised of three questions, as is the Doctor Communication Composite. Refer to **Appendix Table G-6.1** for information on the survey questions and top-box responses. For this analysis, data from completed surveys were included. Per CMS, surveys where 50% of questions that apply to everyone have a response other than missing. Hospitals that are exempt (n=2) or with missing/zero completed survey data (2023 n=9, 2024 n=4) are excluded here. Additionally, four hospitals that closed or transitioned to outpatient care only in 2023–2024 are excluded.

H6-5.2 Disparities in member experience will decrease.

MassHealth members reported high-quality hospital experiences, with top-box scores above 75% for nurse and doctor courtesy, communication, and listening across most groups (**Table 7.3-16**, **Table 7.3-17**). Spanish-speaking members and Hispanic/Latino members consistently reported the most positive experiences, with top-box scores reaching 90% or higher for several communication measures. Scores were slightly lower among English speakers and members reporting “other” languages. Across most groups, fewer than 30% of members reported excellent overall health or excellent mental and emotional health, highlighting ongoing challenges with patient-reported outcomes.

These data are limited. Hospital-level data were not available so we could not observe disparities across hospitals or hospital systems. As shown in **Table 7.3-15**, there was wide variation in the number of completed surveys by hospital. The ten hospitals with the highest survey count comprised more than three-quarters of the total completed surveys reported across the state. Individual-level data were also not available, so we could not observe disparities within hospitals, and adjustments for non-response bias could not be performed. These results reflect a single year of data and establish a baseline for monitoring future progress in improving hospital care experience across a diverse MassHealth member population.

Table 7.3-16 Percentage of Members Responding with the Highest Possible Score (“Top-Box Scores”) to HCAHPS Communication and Health Questions, Stratified by Member Race and Ethnicity, PY1

	Responded “Always” to the Following:						Responded “Excellent” to the Following:	
	Nurse treated you with courtesy and respect	Nurse explained things in a way you could understand	Nurse listened carefully to you	Doctor treated you with courtesy and respect	Doctor explained things in a way you could understand	Doctor listened carefully to you	Rate your overall health	Rate your overall mental or emotional health
Statewide Total	84%	78%	79%	86%	80%	83%	20%	27%
Race Stratification								
American Indian/Alaska Native	83%	80%	76%	85%	77%	81%	21%	30%
Asian	84%	76%	82%	85%	84%	87%	27%	31%
Black or African American	86%	82%	82%	88%	82%	87%	25%	28%
Native Hawaiian/Pacific Islander	88%	80%	83%	86%	81%	80%	29%	29%
White	83%	76%	77%	85%	78%	81%	17%	25%
Ethnicity Stratification								
Not Spanish/Hispanic/Latino	82%	77%	76%	84%	80%	77%	16%	22%
Spanish/Hispanic/Latino	90%	86%	85%	92%	90%	88%	28%	34%
Mexican, Mexican American, Chicano	86%	81%	73%	86%	78%	76%	11%	24%
Other	91%	88%	86%	93%	92%	89%	30%	37%
Puerto Rican	88%	80%	80%	90%	86%	84%	24%	27%

Data Source: PY1 (CY2023) HCAHPS survey data for MassHealth members submitted to MassHealth by HQEI hospitals

Abbreviation: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); Performance Year 1(PY1)

Notes: The HCAHPS survey is a standardized, national, and publicly reported survey of patients’ perspectives on hospital care. The top-box rate (%) indicates the proportion of respondents who selected the most positive response for the survey question. HCAHPS survey responses ranged from n=4,845 to n=4,975 statewide; stratification by race and ethnicity represents a subset of these totals, with sample sizes varying by question. Refer to **Appendix Table G-6.1** for information on the survey questions and top-box responses.

For this analysis, data from completed surveys were included (n). Per CMS, surveys where 50% of questions that apply to everyone have a response other than missing. Survey respondents are asked "What is your race? Please choose one or more" and "Are you of Spanish, Hispanic, or Latino origin or descent?". "Spanish/Hispanic/Latino" represents the combined results for the following responses: "Yes, Cuban", "Yes, Mexican, Mexican American, Chicano", "Yes, Puerto Rican", and "Yes, other Spanish/Hispanic/Latino". The results are suppressed when n<11 to protect the privacy of MassHealth members in accordance with CMS small cell size suppression policies.

Table 7.3-17 Percentage of Members Responding with the Highest Possible Score ("Top-Box Scores") to HCAHPS Communication and Health Questions, Stratified by Primary Language, PY1

Language	Responded "Always" to the Following:						Responded "Excellent" to the Following:	
	Nurse treated you with courtesy and respect	Nurse explained things in a way you could understand	Nurse listened carefully to you	Doctor treated you with courtesy and respect	Doctor explained things in a way you could understand	Doctor listened carefully to you	Rate your overall health	Rate your overall mental or emotional health
Statewide Total	84%	78%	79%	86%	80%	83%	20%	27%
English	83%	78%	78%	85%	81%	79%	18%	24%
Spanish	89%	85%	82%	93%	92%	88%	29%	35%
Another Language	81%	74%	75%	83%	75%	78%	16%	24%
Other	79%	71%	72%	82%	73%	76%	14%	22%
Portuguese	99%	93%	99%	94%	94%	97%	37%	46%
Russian	87%	80%	57%	93%	87%	79%	7%	7%

Data Source: CY2023 (PY1) HCAHPS survey data for MassHealth members submitted to MassHealth by HQEI hospitals

Abbreviations: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); Performance Year 1(PY1)

Notes: The HCAHPS survey is a standardized, national, and publicly reported survey of patients' perspectives on hospital care. The top-box rate (%) indicates the proportion of respondents who selected the most positive response (e.g., "Always" or "Excellent") for the survey question. HCAHPS survey responses ranged from n=4,845 to 4,975 statewide; stratification by language represents a subset of these totals, with sample sizes varying by question. Refer to **Appendix Table G-6.1** for information on the survey questions and top-box responses. For this analysis, data from completed surveys were included (n). Per CMS, surveys where 50% of questions that apply to everyone have a response other than missing. Survey respondents are asked "What language do you mainly speak at home?". "Another Language" represents the combined results for the following responses: Arabic, Chinese, German, Portuguese, Russian, Tagalog, Vietnamese, and "Some other language". The results are suppressed when n<11 to protect the privacy of MassHealth members in accordance with CMS small cell size suppression policies.

H6-5.3 Member health outcomes (e.g., maternal and birth outcomes) will improve.

The following set of measures provide early insight into member outcomes following hospital care. While some are not the standard HQEI quality measures, they were selected to capture preliminary signals of improvement in member outcomes related to the HQEI. Although early findings are encouraging, continued monitoring and analysis will be necessary to assess their sustained impact. Full analytic results and member characteristics are available in **Appendix G-7**.

Table 7.3-18 Observed vs. Expected Ratio of HQEI Outcome Measures Among MCE Members (CY2022-2024)

Outcome Measures		Managed Care Eligible (MCE) Members								
		2022			2023			2024		
		N	Mean	±SE	N	Mean	±SE	N	Mean	±SE
30-day Post-Discharge ED Visits	Observed Value	55,524	21.6	±0.3	41,561	22.4	±0.4	55,826	21.3	±0.3
	Predicted Value	55,524	21.6	±0.1	41,561	24.8	±0.1	55,826	26.2	±0.1
	O:E Ratio	1.00			0.90			0.82		
6-month Post-Discharge ED Visits	Observed Value	30,189	87.7	±1.3	21,279	87.3	±1.6	27,990	83.8	±1.3
	Predicted Value	30,189	88.0	±0.5	21,279	82.3	±0.6	27,990	95.1	±0.6
	O:E Ratio	1.00			1.06			0.88		
Readmissions (30-day)	Observed Value	38,710	18.1	±0.2	33,776	20.1	±0.2	47,551	21.8	±0.2
	Predicted Value	38,710	18.1	±0.1	33,776	21.4	±0.1	47,551	22.5	±0.1
	O:E Ratio	1.0			0.94			0.97		
Severe Maternal Morbidity During Delivery Hospitalization	Observed Value	13,977	1.4%	NR	12,136	1.4%	NR	11,861	1.4%	NR
	Predicted Value	13,977	1.4%	NR	12,136	1.5%	NR	11,861	1.8%	NR
	O:E Ratio	1.0			0.91			0.79		
Low Birth Weight Rate	Observed Value	25,569	4.1%	NR	25,969	4.3%	NR	26,843	4.1%	NR
	Predicted Value	25,569	4.2%	NR	25,969	4.7%	NR	26,843	5.1%	NR
	O:E Ratio	0.97			0.90			0.80		

Data Source: MassHealth administrative data, CY2022 (Baseline), CY2023 (PY1), and CY2024 (PY2)

Abbreviations: Calendar Year (CY); Emergency Department (ED); Hospital Quality and Equity Initiative (HQEI); Managed Care Eligible (MCE)

Notes: Each year includes members who are managed care eligible (MCE) for at least 320 days that year. "Observed" equals the calculated outcome for the quality measure in the specified year. "Expected" is from a model that was developed using 2022 data for the MCE population to quantify the relationships between the quality measure and member characteristics (i.e. age and sex; disability; medical morbidity; unstably housed or homeless; behavioral health diagnoses; and rurality). The model was then applied to 2022, 2023, and 2024 data to produce expected values. "Observed:Expected" (O:E) is the ratio of observed to expected values and varies around 1.0; O:E ratios <1 indicate lower than expected outcomes while O:E ratios >1 indicate higher than expected outcomes for the measure. Full analytic results and member characteristics are available in **Appendix G-7**.

Legend

Lower is Better:	O:E <0.86	O:E 0.86 to 0.95	O:E 0.96 to 1.04	O:E 1.05 to 1.14	O:E >1.14
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H6-5.4 Members will experience a reduction in the impact of social risk factors on their health.

Although this Chapter centers on the impact of hospital initiatives on member experiences and outcomes, the interview findings encompass perspectives from members that may or may not have had a hospital encounter. Additional details pertaining specifically to members seen at a hospital will be provided in the IESR.

Broadly, members' HRSNs were successfully identified by health care staff and providers like primary care doctors, mental health professionals, and care coordinators/managers. Social risk factors that affected members' health included housing instability, food insecurity, and a lack of transportation.

"I'd say, based on the questions they ask, they make me feel good, and they make me feel that if I put something down, there will be solutions...and there was one occasion when I asked about food services, and they gave me a list of community centers near where I live that offer food." – a MassHealth member (MEI013)

Members who received nutrition and/or housing support through MassHealth were satisfied with the services. Members noted that it was important for them to be able to select the service that could best meet their needs. For example, some members preferred receiving food they could prepare on their own while others said that they would like to receive prepared meals and packaged food. Most members receiving nutrition services expressed that it helped them with their physical and/or mental health. One member described how nutrition services helped them increase their intake of high-potassium vegetables. Another member shared that nutrition services helped to ease the financial and emotional burden on their family when they can't afford groceries. Many members told interviewers that nutrition services help them live a healthier lifestyle by increasing their access to healthy foods.

"Yes, my diet has changed, so. And you know, so yeah, it makes it lot easier. Cause I'm eating more vegetables, I'm eating more vegetables, eating more healthier." – a MassHealth member (MEI007)

For housing services, numerous members described the stressful process of finding housing to accommodate their needs. They shared that community-based organizations, care coordinators, and hospital staff helped ease the mental and emotional burden of the housing placement process (See **RQ7-3**). Regarding provider request for transportation (PT-1) services, most members reported negative experiences, citing timeliness, quality, and communication as some of the areas for improvement (See **RQ2-9** in **Section 3.3.9**).

7.3.5.3. Conclusions

Members generally described favorable hospital experiences, highlighting respectful interactions with providers, clear communication, and care that was attentive to cultural and physical needs. High communication scores across HCAHPS measures reinforce these perceptions, particularly among Spanish-speaking and Hispanic/Latino members, suggesting that hospital efforts to

deliver linguistically and culturally responsive care are reaching diverse populations. At the same time, lower ratings for overall health and mental or emotional health across all groups indicate that positive care experiences have not yet translated into stronger self-reported health outcomes, underscoring ongoing gaps in member well-being.

Early outcome measures provide a mixed but encouraging picture. Observed-to-expected ratios for readmissions, severe maternal morbidity, and low birth weight were at or below expected levels in recent years, signaling potential improvements in clinical outcomes. However, these gains should be interpreted cautiously given the preliminary nature of the data and the need for longer-term trend analysis.

Findings related to HRSNs suggest meaningful progress in identifying and addressing key drivers of health, particularly in nutrition and housing supports, which members reported as beneficial to both physical and mental well-being. In contrast, transportation services remain a persistent challenge, with members noting issues related to reliability and communication. Continued monitoring, improved data completeness, and targeted interventions, such as improvements in transportation, will be critical to advancing equitable improvements in member experience and health outcomes.

7.4. Discussion

7.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

MassHealth's approach to promoting equity-focused reporting successfully engaged hospitals through a combination of financial incentives, technical assistance, and structured monitoring activities. Hospitals reported that clear guidance, use of community needs assessments, standardized reporting templates, and vendor supported monitoring helped them meet program expectations. Performance-based deliverables further encouraged alignment with HQEI priorities, allowing hospitals to operationalize equity goals while maintaining consistency, accountability, and comparability across reporting and hospitals. These efforts reflect a broader national emphasis on standardizing equity metrics and the value of stratifying performance measurement to identify disparities and guide improvements.²⁴⁶ While MassHealth's structured reporting mirrors this emphasis on measurement, accountability, and comparability, the combination of incentives, technical assistance, and monitoring represents a distinct implementation approach that provides a model for other equity-focused initiatives.

Building on the reporting structures and aligning with broader national efforts to improve RELDSOGI data collection as a foundational step toward advancing health equity²⁴⁷, MassHealth prioritized systematic data collection and measurement to more directly monitor equity in health outcomes across hospitals. RELDSOGI and HRSN screening data collection have seen strong uptake in race, ethnicity, and language, although collection of sexual orientation, gender identity, and disability data remains limited and inconsistent. Expanding

²⁴⁶ Pillai, A., Hinton, E., Rudowitz, R., & Artiga, S. (2024, July 1). *Medicaid efforts to address racial health disparities*. KFF. <https://www.kff.org/medicaid/medicaid-efforts-to-address-racial-health-disparities/>

²⁴⁷ Gipson, L. (2024, February 13). *Medicaid and sexual orientation and gender identity data: Key factors for more equitable data collection*. Center for Health Care Strategies. <https://www.chcs.org/medicaid-and-sexual-orientation-and-gender-identity-data-key-factors-for-more-equitable-data-collection/>

these systematic data collection efforts has highlighted both progress and ongoing challenges, emphasizing the need for continued electronic system improvements, ongoing workforce training, and support for standardized workflows to ensure data are accurate, complete, and reflective of the patients being served.

Early cross-sectional 2022-2027 Demonstration data provide positive indicators of care quality across hospitals. Hospitals reported offering interpreter services and disability accommodations, enhancing care coordination, and strengthening partnerships with community organizations to address member needs. Patient feedback, including the HCAHPs surveys, reflected generally favorable experiences of care within hospitals. Yet stratified analyses suggested that follow-up care among those with SUD or mental health diagnoses after ED visits or hospitalizations remained uneven across race and ethnicity groups, highlighting the need for additional attention and targeted interventions. Importantly, the beginning of HQEI PIP implementation in 2024 was unlikely to affect these measures during the study period for this IEIR (through 2024), and this study period coincided with increasing acuity among MassHealth enrollees associated with the COVID-19 PHE unwinding. Overall, these results illustrate the promise of structured equity-focused reporting and persistent gaps in care access and delivery.

Workforce and operational capacity played a central role in outcomes. Hospitals and CBOs reported investments in staff training, such as cultural competency, trauma-informed care, and disability-competent practices, which supported more equitable service delivery. At the same time, administrative and operational burdens, including duplicate reporting, complex measure specifications, and resource constraints, continued to pose significant challenges. Financial incentives were insufficient to offset these expressed challenges, suggesting ongoing workforce support, streamlined workflows, and technical assistance continue to be critical components to sustain HQEI progress and ensure consistent uptake and performance across hospitals.

Understanding how this program functions and intersects with the broader landscape of state-level equity initiatives, such as the Advancing Health Equity in MA initiative²⁴⁸, can inform policy decisions and guide the adoption of best practices across MassHealth programs and other states. MassHealth's equity-focused reporting demonstrates clear alignment with broader statewide priorities and programs to address health disparities. The HQEI builds on existing 2022-2027 Demonstration quality measures and community health needs assessment requirements, ensuring that the hospitals' equity efforts are coordinated with local and statewide goals. Statewide equity alignment is reinforced through linkages between HQEI hospital accountability and ACO performance, and progress in addressing inequities is facilitated through support available through other initiatives including the Flexible Services Program (which transitioned into the HRSN Framework as of 2025), which provides nutrition and housing supports to members with complex needs, and Specialized CSPs, which deliver tailored services to vulnerable populations to address HRSNs. Additional efforts to integrate care for high-risk populations (e.g., Primary Care Sub-Capitation Program, enhanced care management programs) further support hospitals and providers in aligning with both local and state-level priorities and reinforces a shared commitment to improving health equity in Massachusetts.

²⁴⁸ Advancing Health Equity in MA (AHEM) [Advancing Health Equity in MA | Mass.gov](#)

The HQEI offers lessons on broader applicability beyond Massachusetts. The program offers a scalable framework for promoting health equity. By establishing baseline data on RELDSOGI and HRSN variables, the program lays the groundwork for longitudinal monitoring of performance and enables policymakers and providers to track disparities over time. It also supports evaluation of the effectiveness of targeted interventions across multiple subgroups of policy interest. Together, these features demonstrate how structured equity reporting can function as a practical implementation tool and platform for ongoing improvement in care quality and outcomes beyond the 2022-2027 Demonstration period.

The findings have several important policy implications for MassHealth and other states' equity initiatives. Sustained investment and targeted incentives can serve as a feasible mechanism to advance health equity, particularly when paired with technical assistance that offsets operational demands and reduces the burden of duplicate reporting requirements. Identifying and aligning equity-focused measures with national performance metrics (e.g., Joint Commission) and investing in systems that can support the longitudinal collection of RELDSOGI and HRSN data may enable more consistent monitoring of disparities over time. To support this alignment, MassHealth should coordinate with Joint Commission, the Massachusetts DPH, and other relevant entities regarding any planned changes to performance and equity measures. These collaborations may help ensure that updates are implemented consistently and efficiently across organizations.

Workforce development, including recruiting, training, and retaining staff with expertise in equity-focused care, remains vital to the success of these programs. Finally, stratified quality reporting, combined with cross-sector collaborations, can guide targeted interventions to reduce disparities and address social risk factors. Taken together, these efforts reinforce the role of equity-focused initiatives as both measurement and action-oriented strategies to improve health care access and care quality. In this context, HQEI demonstrates that incentive-based programs can catalyze broader hospital engagement in equity initiatives. By building on these early successes with continued investment in data infrastructure, reporting alignment, cross-sector collaboration, and workforce development, Massachusetts hospitals are positioned to advance equitable, high-quality care statewide.

7.4.2. Lessons Learned and Recommendations

The lessons learned below highlight the importance of ongoing development and refinement of data infrastructure, reporting alignment, cross-sector collaborations, and workforce development. These priorities support aligned reporting requirements, strengthen stakeholder engagement, and ensure the participating hospitals have the capacity to transition from pay-for-reporting to pay-for-performance, and, ultimately, towards measurable improvements in equitable care access, quality, and outcomes in the later years of the HQEI.

1. **Lesson Learned:** Interim findings highlight: 1) the importance of complete and accurate RELDSOGI and HRSN data for advancing equity goals, and 2) the influence of data collection protocols on the quality of data collected. Patients may be more likely to provide complete and accurate information when modes of data collection, such as patient portals and intake forms, are designed to ensure privacy, build trust, and clearly communicate how information will be used.

- **Recommendation:** Hospitals should continue to adopt and refine approaches to RELDSOGI and HRSN data collection that are patient-centered and preserve privacy, and MassHealth should encourage hospitals to share best practices that promote patient participation in data collection and quality and equity initiatives
2. **Lesson Learned:** Potential facilitators of effective implementation of equity initiatives included clear, simple, and harmonized reporting requirements, adequate funding that reflects operational and workforce costs associated with implementation expectations, and consistent technical support to help hospitals transition from reporting to performance-based accountability.
- **Recommendation:** MassHealth should consider simplifying and aligning equity reporting with other oversight entities (e.g., Joint Commission) to support more efficient hospital participation; aligning expectations with available funding levels; continuing to provide flexible, evidence-based opportunities for hospitals to align PIPs with identified needs; and providing ongoing technical assistance to HQEI hospitals.
3. **Lesson Learned:** Inclusive stakeholder engagement was essential to designing equity initiatives that were relevant and sustainable. By involving patients, staff, and community-members from diverse backgrounds, hospitals were better able to understand real needs and barriers, create responsive solutions, build trust and transparency, and foster the shared ownership needed to support and sustain equitable change over time. Additionally, meaningful engagement and effective action on community input require adequate time for hospitals to listen, interpret, and implement responsive strategies.
- **Recommendation:** MassHealth and participating hospitals should continue efforts and ensure sufficient time and resources are allocated to actively engage diverse patients, staff, and community stakeholders when planning, implementing and evaluating hospital equity initiatives.
4. **Lesson Learned:** MassHealth members receiving care at HQEI hospitals faced persistent health and mental health challenges, often compounded by HRSNs. Members who received HRSN services reported associated benefits to their health.
- **Recommendation:** State and federal policymakers should consider continued investment in and further study of initiatives that integrate physical health and mental health care with social supports to improve outcomes and member experience.

8. Health-Related Social Needs (HRSN)

8.1. Background

Building on initiatives established during the 2017–2022 Medicaid 1115 Demonstration period, in the 2022–2027 Demonstration, MassHealth continues to refine and expand a portfolio of HRSN programs designed to address housing instability, food insecurity, and other social determinants that adversely affect health outcomes. These initiatives complement MassHealth’s broader delivery system reforms by integrating community-based supports with Accountable Care Organizations (ACOs), with the objectives of advancing health equity, reducing avoidable utilization, and promoting stable community tenure. Each of these programs are described in the following subsections.

Flexible Services Program (FSP)

The FSP supported MassHealth ACO-enrolled members who met at least one health needs-based criterion (i.e., a behavioral health (BH) need, complex physical health need, activities of daily living or instrumental activities of daily living need, repeated emergency department (ED) utilization, or high-risk pregnancy) and at least one risk factor (either experiencing homelessness/at risk of homelessness or at risk for a nutritional deficiency or nutritional imbalance due to food insecurity) defined by the Commonwealth.²⁴⁹ The FSP addressed the HRSNs of eligible individuals in the areas of housing and nutrition by providing access to tenancy preservation and nutrition-sustaining supports.

- Allowable tenancy preservation supports consisted of pre-tenancy and tenancy-sustaining services, including tenant rights education and eviction prevention; housing transition navigation services; one-time transition and moving costs; and housing deposits to secure housing, including application and inspection fees and fees to obtain necessary identification. Supports also included medically necessary air conditioners, humidifiers, air filtration devices, asthma remediation, and refrigeration units as needed for medical treatment, as well as medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold or pest remediation. The supports also encompassed case management, outreach, and education, including linkages to other state and federal benefit programs, assistance with benefit program applications and application fees, and transportation to tenancy supports organizations.
- Allowable nutrition supports included nutrition counseling and education (i.e. guidance on healthy meal preparation); home delivery of up to three meals per day for up to six months (services can be renewed if the member receives a positive rescreen); additional support for households with high-risk children or pregnant individuals, as defined by program criteria; medically tailored or nutritionally appropriate food prescriptions provided through vouchers or food boxes for up to six months; cooking supplies needed for meal preparation when not available through other programs; case management, outreach,

²⁴⁹ Commonwealth of Massachusetts (2022). *Contract Year 2023 – 2024 (CY23 – CY24) Flexible Services Program (FSP) Guidance Document*
[Contract Year 2023 – 2024 \(CY23 – CY24\) Flexible Services Program \(FSP\) Guidance Document](#)

and education, including linkages to other state and federal benefit programs and assistance with benefit applications and associated fees; and transportation to nutrition supports organizations.

Of note, the FSP concluded on Dec. 31, 2024, and was replaced by HRSN Supplemental Services, which will be evaluated for the Independent Evaluation Summative Report (IESR).

Health-Related Social Needs (HRSN) Services

HRSN Services are a standardized set of supports developed by MassHealth to address social and environmental factors that influence members' health. These services are designed to integrate health care and social support for MassHealth members. HRSN Services are divided into Required Services and Supplemental Services, each targeting specific populations and needs.

HRSN Required Services focus on specialized populations with high HRSNs and include the following Specialized Community Support Programs (CSPs), implemented effective April 1, 2023:²⁵⁰

- CSP for Homeless Individuals (CSP-HI)²⁵¹ is a specialized CSP service to address the HRSNs of members who (1) are experiencing homelessness and are frequent users of acute health MassHealth services, as defined by EOHHS; or (2) are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development.²⁵²
- CSP Tenancy Preservation Program (CSP-TPP) is a specialized CSP service to address the HRSNs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.
- CSP for Individuals with Justice-Involvement (CSP-JI) is a specialized CSP service to address the HRSNs of members with justice involvement and have a barrier to accessing or consistently utilizing medical and behavioral health services, as defined by EOHHS. CSP-JI includes behavioral health and community tenure sustainment supports.

HRSN Supplemental Services began on Jan. 1, 2025, replacing the FSP, and includes two categories of Supplemental Nutrition Services and one group of Supplemental Housing Services. Program eligibility for both nutrition and housing services changed from the FSP. A detailed summary of the changes from FSP to the HRSN Supplemental Services program is in **Appendix H-1**. ACOs must offer at least one Category 1 Supplemental Nutrition and one Supplemental Housing Service to eligible members. Eligible members can only receive Category 2 nutrition services if they are also receiving a Category 1 nutrition service. Services include:

²⁵⁰ More information about CSP services can be found here: [MassHealth Community Support Program | Mass.gov](https://www.mass.gov/info-details/masshealth-community-support-program)

²⁵¹ CSP-HI will be referred to as CSP-High Intensity in future reports like the IESR because MassHealth is renaming the program.

²⁵² Hud Exchange (2015). *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Chronically Homeless Final Rule*. [Homeless Emergency Assistance and Rapid Transition to Housing \(HEARTH\): Defining Chronically Homeless Final Rule - HUD Exchange](https://www.hudexchange.info/public/chronically/homeless/final-rule)

Category 1 Supplemental Nutrition Services:

- Medically tailored home-delivered meals include fully prepared meals approved by a registered dietitian nutritionist (RDN) or a nutrition and dietetics technician, registered (NDTR), to support members experiencing very low food security with specific medical needs.²⁵³
- Nutritionally appropriate home-delivered meals include fully prepared, well-balanced meals approved by an RDN or NDTR to ensure members experiencing very low food security receive appropriate nutrition.
- Medically tailored food boxes include minimally prepared grocery items (e.g., fresh vegetables and fruits, cooked chicken breast, and cooked grains) approved by an RDN or NDTR to support members with specific medical conditions.
- Nutritionally appropriate food boxes include minimally prepared grocery items curated by an RDN or NDTR (when foods other than fresh foods are provided) to meet general nutritional standards for members experiencing very low food security.
- Medically tailored food prescriptions and vouchers include food vouchers and grocery store gift cards for purchasing items from an approved purchase list, curated by an RDN or NDTR, tailored to an enrollee's medical condition.
- Nutritionally appropriate food prescriptions and vouchers include food vouchers and grocery gift cards for items meeting nutritional standards.

Category 2 Supplemental Nutrition Services:

- Nutrition education and skills development include group or one-on-one sessions to help members understand nutritional and dietary needs.
- Nutrition counseling includes individual or group sessions with an RDN or NDTR (overseen by an RDN) to provide personalized nutritional guidance.
- Kitchen supplies include support for purchasing cooking equipment (e.g., pots, pans, utensils, refrigerators) needed for meal preparation and dietary needs, specifically to ensure members are able to utilize their Category 1 nutrition service.

Supplemental Housing Services:

- Housing search includes assistance for members age 55-64 experiencing homelessness to locate, move into, and maintain housing.
- Transitional goods include support with move-in costs (e.g., security deposits, first month's rent, movers) and furnishings to make new housing habitable.
- Housing navigation includes support for members experiencing housing instability (i.e., has received a written lease violation) in accessing benefits, negotiating with landlords, seeking legal assistance, applying for housing, and stabilizing housing situations.
- Healthy homes include the purchase of goods (e.g., HEPA vacuums, air conditioners, sharps containers, etc.) and provision of remediation services (e.g., heavy chore,

²⁵³United State Department of Agriculture (USDA). *Food Security in the U.S. - Definitions of Food Security*, USDA Economic Research Service (2026)

pest/mold remediation, etc.) that are not the responsibility of the landlord and could eliminate known housing-based health and safety risks to ensure the living environment does not adversely affect an enrollee's health and safety.

Together, both HRSN Required and Supplemental Services seek to mitigate barriers to health care, improve health outcomes, and enhance stability for high-need members by addressing the social and environmental determinants of health alongside clinical care.

Short-Term Post Hospitalization Housing (STPHH) Program

Initiated in January 2025, the STPHH Program, also referred to as Homeless Medical Respite Services (HMRS), allows the following Medicaid-eligible populations to be admitted to a temporary residential setting in order to receive certain pre-procedure and post-hospitalization services, provided that such services are medically necessary.

1. Individuals experiencing homelessness who have been scheduled for a colonoscopy with medically indicated preparation are eligible for up to 48 hours of housing and board, including the member's stay before and after the procedure; and
2. Individuals who are transitioning out of acute inpatient hospitals and are at risk of utilizing other state services are eligible for up to 183 days of post-hospitalization housing, board, and supportive services.

An individual's period of residence in the temporary residential setting, including days of medical and nonmedical-related absences, pre-procedure colonoscopy stays, and post-hospitalization stays may not exceed 183 days in a 12-month period.

Reentry Demonstration Initiative

The Reentry Demonstration Initiative provides certain targeted MassHealth pre-release services to incarcerated qualifying Medicaid and CHIP beneficiaries for up to 90 days immediately preceding their release from incarceration. Qualifying individuals include those residing in County Correctional Facilities (CCFs), state Department of Corrections (DOC) facilities, and Department of Youth Services (DYS) juvenile justice facilities. The objective of this initiative is to facilitate beneficiaries' access to health care services and case management while incarcerated, provided by Medicaid- or CHIP-participating providers, and to enable beneficiaries, while incarcerated, to establish relationships with community-based providers from whom they can receive services upon reentry into the community. This initiative aims to promote continuity of care and improve health outcomes for justice-involved individuals by bridging coverage prior to release. The Reentry Demonstration Initiative was approved by CMS in an amendment to MassHealth's 1115 Medicaid Demonstration in April 2024 and is expected to launch in phases, with the first phase aiming to launch in the second half of 2026. Because the Reentry Demonstration was not implemented at the time of writing this report, no data was available to assess the impact of any Reentry Services.

Temporary Housing Assistance (THA)

THA, effective April 2024, allows the state to claim federal financial participation for services provided to pregnant individuals and families with children enrolled in the Massachusetts

Emergency Assistance (EA) Family Shelter Program who are MassHealth-eligible and meet clinical needs-based criteria. THA covered services include up to six months of rent or temporary housing with room and board, and related supportive services.²⁵⁴

8.2. Study Design

Refer to [Chapter 1 Overview of Methodology](#) section for descriptions of both quantitative and qualitative methodology. Qualitative findings draw from interviews with MassHealth members (**Appendix B-9**), CSP, Community Based Organizations (CBOs) and ACO and MCO staff (**Appendix C-6.2 and Appendix C-6.1**), staff surveys with MassHealth staff (**Appendix B-8**), and document reviews to provide context about HRSN policies and programs. Demographic information for interviewed members and staff can be found in **Appendix C-5**.

For the FSP, we report total program expenditures, enrollment counts, and member demographics. Additionally, FSP survey data were analyzed to assess changes from baseline to program end. Changes in food and housing insecurity were analyzed using generalized estimating equation (GEE) modified Poisson regression, while changes in physical and mental health status were evaluated using ordinal logistic regression. All models accounted for missing data using weighting methods (inverse probability of censoring weights). For the FSP and Specialized CSP programs (CSP-HI, CSP-TPP, and CSP-JI), we report descriptive statistics including enrollment counts, total claims costs, and enrollee demographics. We also report an average per member per month (PMPM) cost for Specialized CSP services.

8.2.1. Research Questions, Hypotheses, and Study Design Table

Table 8.2-1 outlines the research questions (RQs), hypotheses, data sources and evaluation period, study population(s), and analytic methods for this chapter covered in the Independent Evaluation Interim Report (IEIR). The HRSN Supplemental Services, STPHH, Reentry Demonstration Initiative, and THA programs and services will be evaluated in the Independent Evaluation Summative Report (IESR), as their implementation timelines fall close to or beyond the Independent Evaluation Interim Report (IEIR) evaluation period, which ends December 2024; however, HRSN Supplemental Services may be referenced in stakeholder interview findings included in this interim report. All programs evaluated in the IEIR will also be evaluated in the IESR.

²⁵⁴Centers for Medicare & Medicaid Services. (2024). *MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 Demonstration Amendment Approval*, U.S. Department of Health and Human Services.

Table 8.2-1 HRSN Research Questions, Hypotheses, and Study Design

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
RQ7-1 What was the prevalence of HRSN screening among ACO/ Managed Care Organization (MCO) enrolled members, including ACO/MCO members, members seen in a hospital, members receiving Homeless Medical Respite, members receiving Temporary Housing Assistance, and members receiving Reentry Services over the course of the Demonstration?	H7-1.1 There was variation in the prevalence of HRSN screening associated with observable member characteristics (e.g., race, ethnicity, language, disability, social orientation, and gender identity (RELDSOGI); ACO/MCO; ACO/MCO; Temporary Housing Assistance provider; Homeless Medical Respite provider; Reentry Services; and hospital.	MassHealth administrative data: Demographics (CY2022-CY2024); Eligibility/Enrollment (CY2022- CY2024); Screened HRSN (CY2022-CY2024)	Descriptive analysis (member)
RQ7-2 What was the prevalence of HRSN needs among MassHealth members over the course of the Demonstration?	H7-2.1 MassHealth members had varying levels of HRSN needs by type (housing insecurity, food insecurity, issues with transportation, and issues obtaining utilities) and RELDSOGI demographic group.	MassHealth administrative data: Demographics (CY2022-CY2024); Eligibility/Enrollment (CY2022- CY2024); Screened HRSN (CY2022-CY2024)	Descriptive analysis (member)
	H7-2.2 The prevalence of HRSN needs decreased over time.		
RQ7-3 What were the experiences of members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services, and what was their understanding of the programs?	H7-3.1 Recipients of FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services perceived their HRSN needs as having been effectively identified.	Key Informant Interviews (KIIs) (CY2024-CY2025);	Thematic analysis (member)
	H7-3.2 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services were satisfied with their service plans.	Members	

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
	H7-3.3 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services understood the programs. H7-3.4 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services described how the services they received decreased their HRSN needs. H7-3.5 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services described how services they received improved their physical and/or mental health.		
RQ7-4 What actions did MassHealth and Key Stakeholders take to implement, operate, integrate, and coordinate HRSN initiatives and the Reentry Demonstration?	H7-4.1 MassHealth implemented or partnered with other state agencies to implement services, including FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services; released policy and procedures and provided operational oversight (monitoring protocols).	KIIs and/or focus groups (CY2024-CY2025); FSP and Specialized CSP staff	Thematic analysis (FSP and Specialized CSP staff, ACO/MCO, MassHealth HRSN staff); Document review
	H7-4.2 FSP, Specialized CSP, Temporary Housing Assistance, and Homeless Medical Respite providers provided services, and in some cases, identified eligible members.	ACO/MCO MassHealth HRSN staff open-ended survey (CY2025);	
	H7-4.3 ACOs/MCOs coordinated (identified, referred, provided care coordination) member services with FSP and specialized CSP providers.	Documentation submitted to MassHealth (CY2022-CY2025)	

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
RQ7-5 How were members identified and referred to FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services?	H7-5.1 Standardized processes and objective criteria were used by ACOs, MCOs, and partnering organizations (e.g., justice entities and housing agencies) for identifying needs, assessing eligibility, and providing referrals for each respective service.	KIIs and/or focus groups (CY2024-CY2025); ACO/MCO MassHealth HRSN staff open-ended survey (CY2025) Documentation submitted to MassHealth (CY2022-CY2025)	Thematic Analysis (ACO/MCO, MassHealth HRSN staff) Document review
RQ7-6 What were the FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services utilization and cost trends?	H7-6.1 The service utilization and cost trends vary by program type and member demographics, comorbidity, and past utilization/cost.	MassHealth administrative data: FSP CSP-JI (CY2022-CY2024); CSP-HI and CSP-TPP (CY2023-CY2024); Claims/Encounters (CY2022-CY2024)	Descriptive analysis (member)
RQ7-7 What was the effect of the FSP, Specialized CSP, Temporary Housing Assistance and Homeless Medical Respite, and Reentry Services on HRSNs?	H7-7.1 FSP nutrition supports increase food security.	MassHealth administrative data:	Descriptive analysis (member)
	H7-7.2 FSP tenancy preservation supports increases housing security.	FSP (CY2023-CY2024);	
	H7-7.4 CSP-JI and Reentry Services will increase housing security.	CSP-JI data (CY2022-CY2024)	
RQ7-9 What were the effects of FSP, specialized CSP, Temporary	H7-9.1. FSP services improved self-reported physical health.	MassHealth administrative data:	Descriptive analysis (member)

Research Questions	Hypotheses	Data Sources and Evaluation Period	Analytic Methods
Housing Assistance, Homeless Medical Respite, and Reentry Services on physical and mental health outcomes?	H7-9.2. FSP services improved self-reported mental health.	FSP (CY2023-CY2024)	
RQ7-11 Were the Health-Related Social Needs (HRSN) Integration Fund infrastructure investments effective in supporting the development and implementation of HRSN Services?	H7-11.1. The infrastructure investments supported the development and implementation of HRSN Services.	KIIs and/or focus groups (CY2024-CY2025); FSP and Specialized CSP providers Documentation submitted to MassHealth (CY2022-CY2025)	Thematic analysis (FSP and Specialized CSP) Document Review
RQ7-12 What were the impacts of FSP/Specialized CSP Medicaid spending on local investments on comparable services, for example, housing and nutrition?	H7-12.1. FSP and Specialized CSP Medicaid spending strengthened clinical-to-community linkages and non-Medicaid funding to address HRSNs among FSP and Specialized CSP providers.	KIIs and/or focus groups (CY2024-CY2025); FSP and Specialized CSP providers	Thematic analysis (FSP and Specialized CSP)
	H7-12.2. FSP and Specialized CSP providers partnered with local and state entities to identify and fill service gaps in HRSN services.	Documentation submitted to MassHealth (CY2022-CY2025)	Document Review

Data source: 1115 Waiver Demonstration Evaluation Design Document

Abbreviations: Accountable Care Organization (ACO); Community-Based Organization (CBO); Community Partner (CP); Community-Support Program (CSP); Community Support Program for Homeless Individuals (CSP-HI); Community Support Program for Individuals with Justice Involvement (CSP-JI); Community Support Program for Tenancy Preservation Program (CSP-TTP); Calendar Year (CY); Flexible Services Program (FSP); Hypothesis (H); Health-Related Social Needs (HRSN); Key Informant Interviews (KIIs); Managed Care Organization (MCO); Research Question (RQ); Special Terms and Conditions (STC)

Notes: Not all RQs are addressed in the IEIR. Please refer to **Appendix section A-2** for a list of all RQs to be addressed in the IESR. Research Questions developed based on STC 15. Health-Related Social Needs. Details are further described in section 8.4.2 "Data Sources and Collection Methods" and 1.4.1 "Summary of Data Sources" of this report.

8.2.2. *Methodological Limitations*

Please refer to [Chapter 1](#) for an overarching discussion of the methodological limitations pertaining to the overall evaluation. In addition to those considerations, the evaluation of the HRSN domain of the IEIR has several specific limitations. First, for this IEIR, most analyses were qualitative and descriptive, with a focus on program implementation. Therefore, observed changes in screening prevalence, HRSN needs, service utilization, or outcomes should not be interpreted as directly caused by HRSN programs or specific interventions. Quasi-experimental methods will be applied where feasible to estimate program impacts for the IESR. In addition, this evaluation captures an early phase of implementation, during which ACOs/MCOs, Community-Based Organizations (CBOs), and other key stakeholders were still developing workflows, partnerships, and data sharing systems. As a result, findings should be interpreted as reflecting early progress.

Several limitations are specific to the survey data collected from FSP participants. Approximately 50-65% of FSP participants completed both the baseline and endpoint FSP survey questions (response rates varied by question). Non-response has the potential to bias results if those who did not respond would have answered questions differently than those who did. Additional analyses using inverse probability of censoring weights that accounted for loss to follow-up found similar results, providing some reassurance. However, only FSP participants were surveyed, therefore, changes in outcomes cannot be compared to other Medicaid members who were not enrolled in FSP.

Interviews with CBOs were conducted in 2025, shortly after the FSP ended and HRSN Supplemental Services began. Therefore, findings reported in this IEIR reflect perspectives conveyed during a period of major program transition and may differ from perspectives on the FSP as they existed prior to this transition.

Administrative data may be incomplete or inconsistently reported across years, plans, and providers due to variation in coding practices, reporting lags, and evolving data collection requirements. As a result, observed changes in variables such as screening rates, HRSN needs, or demographic completeness may reflect improvements in documentation rather than true underlying trends. Variation across ACOs/MCOs and hospitals may also reflect differences in implementation approaches, member populations, or documentation practices. Qualitative findings from interviews and surveys may be influenced by selection, recall, and social desirability biases, and should not be interpreted as representative of all members or providers. Finally, some analyses were constrained by limited data availability for certain programs and outcomes and small subgroup sample sizes.

8.3. **Interim Results and Conclusions**

8.3.1. *RQ7-1 What was the prevalence of HRSN screening among ACO/Managed Care Organization (MCO)-enrolled members, including ACO/MCO members, members seen in a hospital, members receiving Homeless Medical Respite, members receiving*

*Temporary Housing Assistance, and members receiving Reentry Services over the course of the Demonstration?*²⁵⁵

8.3.1.1 Summary of Results

MassHealth identified HRSN screening as a key activity for improving member outcomes and advancing health equity and accordingly incorporated screening expectations into both the ACO Quality and Equity Incentive Program (AQEIP) and the Hospital Quality and Equity Incentive Program (HQEIP). In 2024, the prevalence of HRSN screening among ACO/MCO-enrolled members varied substantially across entities. ACOs generally exhibited low screening rates with wide variation, while hospitals demonstrated higher but still inconsistent screening prevalence.

8.3.1.2 Results

H7-1.1 There was variation in the prevalence of HRSN screening associated with observable member characteristics (e.g., race, ethnicity, language, disability, sexual orientation, and gender identity (RELD SOGI); ACO/MCO; Temporary Housing Assistance provider; Homeless Medical Respite provider; Reentry Services; and hospital.

Beginning in 2024, ACOs were financially incentivized to report on annual HRSN screening among members as a part of the AQEIP (also described in **H2-5.3**). ACOs used a validated screening tool to screen members in the following areas: food insecurity, housing instability, transportation needs, and utility difficulties. There was variation in the rate of HRSN screening across ACOs in 2024 (**Appendix H-2**). As shown in **Table 8.3-1**, the range of screening across all 17 ACOs was 0.7-39.2% with a median screening rate of 5.7%.

Table 8.3-1 HRSN Screening Rates Across ACOs and MCOs (CY2024)

ACO	Overall Rate N = 1,200,399 members	Average N = 17 ACOs	Median (Q1-Q3) N = 17	Range N = 17
HRSN Screening Rate	14.1%	11.8%	5.7% (1.0–19.5%)	0.7–39.2%
MCO	Overall Rate N = 46,069 members	Average N = 2 MCOs	Median N = 2	Range N = 2
HRSN Screening Rate	1.0%	1.1%	1.1%	0.3–1.8%

Data Source: ACO AQEIP Reporting files

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Health-Related Social Needs (HRSN); Managed Care Organization (MCO); First Quartile (Q1); Third Quartile (Q3)

Notes: The HRSN Screening Rate represents the proportion of members 0-64 years of age enrolled for at least 90 continuous days who were screened at least once during the measurement year using a standardized screening tool assessing food, housing, transportation, and utility needs. Some ACOs submitted supplemental data (n=9) while others used only administrative data (n=8). Payment for the HRSN Screening Measures in PY2 was fulfilled by reporting data (i.e., pay-for-reporting). The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates Measures can be found in the PY2 Technical Specifications for the MassHealth ACO Quality and Equity Incentive Program available for download from <https://www.mass.gov/doc/ageip-performance-year-2-technical-specifications-updated-8252025-0/download>

²⁵⁵The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

As described in **H6-3.1**, hospitals were also expected to begin screening certain members for HRSNs as a part of the HQEIP. Hospitals were incentivized to report screening rates for inpatient and observation stay discharges in 2024. There was significant variation in screening across the 57 hospitals reporting data in 2024, ranging from 1.7-100%. (See **Table 8.3-2**, and **Appendix Table G-3**.) The median screening rate across the hospital cohort was 67.0%.

Table 8.3-2 HRSN Screening Rates Across Hospitals (CY2024)

	Overall Rate <i>N</i> = 112,115 members	Average <i>N</i> = 57 Hospitals	Median (Q1-Q3) <i>N</i> = 57	Range <i>N</i> = 57
HRSN Screening Rate	54.5%	65.1%	67.0% (51.1–85.6%)	1.7–100%

Data Source: Health-related social needs screening data provided by MassHealth

Abbreviations: Calendar Year (CY); Health-Related Social Needs (HRSN); First Quartile (Q1); Third Quartile (Q3)

Notes: Includes data from 57 hospitals. The HRSN Screening percentage represents the proportion of inpatient and observation stay discharges where members were screened using a standardized screening tool assessing food, housing, transportation, and utility needs. The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates can be found in the PY2 Technical Specifications for the MassHealth Hospital Quality and Equity Incentive Program available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>.

8.3.1.3 Conclusions

In the first year of required reporting under the AQEIP and HQEIP, HRSN screening was implemented across ACOs and hospitals, though prevalence varied considerably across entities. ACOs generally exhibited low screening rates with wide variation, while hospitals demonstrated higher but still inconsistent screening rates. These patterns likely reflect a combination of early implementation challenges, including variation in screening practices, as well as limitations in data capture and reporting during the initial year of required reporting. ACO rates reported in 2024 were lower than those reported in the final years of the 2017–2022 Demonstration. One possible explanation for this decline is that several ACOs relied only on administrative data in 2024 rather than providing supplemental electronic health record (EHR)-based data to meet pay-for-reporting requirements. Differences in program design may also contribute to the observed variation across ACO and hospital settings. ACO screening is conducted at the member level over the course of the year, which may be difficult to operationalize across diverse outpatient settings. Hospital screening was tied to specific encounters and may be more readily embedded within standardized workflows. Taken together, these findings suggest early uptake of HRSN screening, particularly among hospitals, alongside substantial opportunity to improve consistency and support providers as implementation matures over time.

8.3.2. RQ7-2 What was the prevalence of HRSN needs among MassHealth members over the course of the Demonstration?

8.3.2.1 Summary of Results

MassHealth members who were screened for HRSN needs in 2024 demonstrated variation in HRSN prevalence across domains, including food insecurity, housing instability, transportation needs, and utilities difficulties. Substantial variation in positive HRSN screens was observed across entities, with positive screening rates differing widely among ACOs and hospitals. With only a single year of HRSN screening data available for this 2022–2027 Demonstration period, trends in HRSN needs could not yet be assessed.

8.3.2.2 Results

H7-2.1 MassHealth members had varying levels of HRSN needs by type (housing insecurity, food insecurity, issues with transportation, and issues obtaining utilities) and RELDSOGI demographic group.²⁵⁶

Among ACO members screened for HRSNs, the overall rate of utilities difficulties (15.9%) was highest, followed by food insecurity (11.9%) and housing instability (9.0%). The rate of members reporting transportation needs was lower than the other reported HRSNs (3.5%). There was large variation in positive HRSN screens reported across ACOs (See **Table 8.3-3**.)

Table 8.3-3 Identified HRSN Needs Across ACOs and MCOs (CY2024)

ACO	Overall Rate (N = 169,570 members)	Average (N = 16 ACOs)	Median (Q1-Q3) (N = 16)	Range (N = 16)
Food Insecurity	11.9%	25.2%	24.7% (17.4–36.6%)	4.4–47.7%
Housing Instability	8.4%	19.4%	18.9% (11.9–24.1%)	3.9–39.6%
Transportation Needs	3.5%	3.4%	3.0% (0.2–5.7%)	0–10.1%
Utilities Difficulties	15.9%	20.8%	15.4% (9.7–30.2%)	0.4–64.8%
MCO	Overall Rate (N = 474 members)	Average (N = 2 MCOs)	Median (N = 2)	Range (N = 2)
Food Insecurity	36.1%	31.5%	31.5%	24.4–38.7%
Housing Instability	34.6%	26.1%	26.1%	12.8–39.4%
Transportation Needs	12.9%	7.9%	7.9%	0–15.7%
Utilities Difficulties	15.0%	17.7%	17.0%	13.4–22.1%

Data Source: ACO AQEIP Reporting files

Abbreviations: Accountable Care Organization (ACO); Calendar Year (CY); Health-Related Social Needs (HRSN); Managed Care Organization (MCO); First Quartile (Q1); Third Quartile (Q3)

Notes: Data from one ACO was excluded due to data quality concerns. The Food Insecurity, Housing Instability, Transportation Needs, and Utilities Difficulties percentages are calculated among ACO or MCO members screened for HRSNs and reflect positive screens in each respective HRSN: food insecurity; housing instability or risk of homelessness; unmet transportation needs; and difficulty paying for or maintaining utilities. Members may screen positive for more than one need. Some ACOs submitted supplemental data (n=8) while others used only administrative data (n=8). Payment for the HRSN Screening Measures in PY2 was fulfilled by reporting data (i.e., pay-for-reporting). The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates Measures can be found in the PY2 Technical Specifications for the MassHealth ACO Quality and Equity Incentive Program available for download from <https://www.mass.gov/doc/aqeip-performance-year-2-technical-specifications-updated-8252025-0/download>.

Among members screened during inpatient or observation stays at hospitals, the overall rate of housing instability (15.3%) and food insecurity (14.4%) were highest, followed by transportation needs (11.7%) and utilities difficulties (9.0%). Similar to the results from ACOs, there was large variation in positive HRSNs reported across hospitals (See **Table 8.3-4**.)

²⁵⁶HRSN needs by type were not stratified by RELDSOGI demographic group in the IEIR. The HRSN needs by type analysis will include stratification by RELDSOGI in the IESR.

Table 8.3-4 Identified HRSN Needs Across Hospitals (CY2024)

	Overall Rate (N = 61,104 members)	Average (N = 57 Hospitals)	Median (Q1-Q3) (N = 57)	Range (N = 57)
Food Insecurity	14.4%	19.0%	10.3% (5.1–15.7%)	0–100%
Housing Instability	15.3%	23.3%	9.5% (5.0–15.7%)	0–100%
Transportation Needs	11.7%	19.0%	7.5% (5.1–13.8%)	0–100%
Utilities Difficulties	9.0%	15.0%	3.8% (1.6–8.8%)	0–100%

Data Source: HRSNs screening data provided by MassHealth

Abbreviations: Calendar Year (CY); Health-Related Social Needs (HRSN); First Quartile (Q1), Third Quartile (Q3)

Notes: Includes data from 57 hospitals. The Food Insecurity, Housing Instability, Transportation Needs, and Utilities Difficulties percentages are calculated among screened members and reflect positive screens in each respective HRSN: food insecurity; housing instability or risk of homelessness; unmet transportation needs; and difficulty paying for or maintaining utilities. Members may screen positive for more than one need. The full technical specifications for the HRSN Screening Rate and HRSN Screen Positive Rates can be found in the PY2 Technical Specifications for the MassHealth Hospital Quality and Equity Incentive Program available for download from <https://www.mass.gov/info-details/masshealth-hospital-quality-and-equity-incentive-program-hqeip>.

8.3.2.3 Conclusions

In 2024, MassHealth members screened for HRSNs exhibited heterogeneous needs across food, housing, transportation, and utilities domains. Food insecurity and housing instability were the most commonly identified needs in both ACO and hospital settings, while transportation needs were reported less frequently in both settings. This pattern is broadly consistent with the limited data reported on HRSN positive screen rates from the 2017–2022 Demonstration. Positive screening rates varied considerably across ACOs and hospitals, potentially reflecting differences in member populations, screening workflows, and reporting practices. Stratification of HRSN needs by RELDSOGI was not conducted for this report but is planned as screening and data completeness rates improve in future 2022–2027 Demonstration years. These findings highlight the importance of continued screening, process standardization, and provider support to ensure HRSN needs are consistently identified and addressed.

8.3.3. RQ7-3 What were the experiences of members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services, and what was their understanding of the programs?²⁵⁷

8.3.3.1 Summary of Results

We interviewed members to understand how they perceived their HRSN needs, the impact of HRSN programs²⁵⁸ on their needs, and their understanding of the FSP and Specialized CSP services they received. A majority of members that participated in interviews reported that their housing and nutrition needs were effectively screened and identified, although some indicated that screening did not capture all needs, noting that they were primarily asked about home safety.

²⁵⁷The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

²⁵⁸ Due to the timing of interviews, members could have been referring to FSP or HRSN Supplemental Services

Overall, members who self-reported receiving nutrition or housing services in the last year expressed satisfaction with the housing and nutrition services and were able to connect the services they received to improvements to their self-reported mental and physical health and reductions in their HRSNs (See **Appendix C-4**). Most members demonstrated a basic understanding of the FSP and Specialized CSPs, identifying care coordinators and community-based organizations as important for addressing their needs. However, some members had difficulty distinguishing MassHealth HRSN services from other public health benefits, such as Supplemental Nutrition Assistance Program (SNAP), and were unclear about how certain benefits, like transportation services, could be accessed to help meet their needs.

8.3.3.2 Results

H7-3.1 Recipients of FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services perceived their HRSN needs as having been effectively identified.

Most members receiving FSP and HRSN Supplemental Services endorsed speaking about their HRSNs with primary care clinicians, mental health professionals, and care coordinators/managers, or filled out HRSN screening surveys during outpatient healthcare visits or with care coordinators/managers. Some members also reported discussing HRSNs during a recent hospital visit. Many members shared that they were asked about both their housing and nutritional needs and that they were comfortable discussing these needs with providers and staff. Members felt they would be able to get information about services and programs if they needed it, and that talking to providers and staff about their HRSNs could lead to resources and solutions.

“Based on the questions they ask, they make me feel good, and they make me feel that if I put something down, there will be solutions...and there was one occasion when I asked about food services, and they gave me a list of community centers near where I live that offer food.” – a MassHealth member (MEI013)

However, several interviewees remembered only being asked about certain topics when screened at a hospital, most commonly safety at home, and not necessarily about other HRSN topics.

“They do talk to you about if you’re safe at home. And not food insecurities...that’s in the ER. I wouldn’t – there’s not been anyone that asked about food stuff or transportation in that setting.” – a MassHealth member (MEI029)

Despite the noted gaps in screening identified by some, most members felt their HRSN needs were effectively identified. Multiple members also discussed how difficult it still was to access services that addressed their HRSNs even when health care professionals were involved, citing the administrative burden put on members to navigate the process of connecting with community organizations to receive nutrition and housing supports.

“The legwork to find the services, it’s just not there. And if it is...I have to call and navigate through and figure out how to get that help

for housing or the food pantry. It's exhausting, truly." – a MassHealth member (MEI010)

H7-3.2 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services were satisfied with their service plans.

Many members who received nutrition or housing support through MassHealth were satisfied with the services they received. Members receiving nutrition services shared that the support helped them gain access to food that met their unique dietary needs. For instance, one member described needing vegetables rich in potassium: *"They did make it better. I had to increase certain vegetables — I got a low potassium as well, so they give me all the high-potassium foods to help keep my potassium level up."* (MassHealth member) Members receiving housing services expressed that CBO staff helped them navigate complex housing issues and access resources like furniture vouchers.

"I never thought I would have a problem that I'd need [this] help with, you know what I mean? But she has been very helpful. And I guess she can talk in housing court." – a MassHealth member (MEI014)

Members noted the importance of being able to select the service that could best meet their needs. For example, some members preferred receiving food they could prepare on their own, while others said that they would like to receive prepared meals and packaged food. Some members reported issues with receiving services in a timely way. For example, one member said it took over a year to begin receiving food boxes (MassHealth member). Another member described delays saying, *"It's supposed to be boxes of food delivered. But I haven't received anything yet. It's been two months. Plenty of emails. Plenty of videos and texts and Zooms. I still haven't seen the food. We'll see...."* (MassHealth member)

Multiple members shared ways in which they felt HRSN services can be improved. Some members receiving nutrition services reported that the food choices didn't always align with their preferences, while others raised concerns about the quality of food provided. For example, one member said *"I don't eat fish, and a few of them were fish. And then there were so many soups, and there's only so many soups that I can eat."* (MassHealth member)

Despite the support of MassHealth housing and nutrition services, members continued to utilize public benefits and community resources to address their HRSNs and still faced numerous systemic barriers to receiving enough food and housing assistance. Several members described how rising food costs have made it hard to obtain fruits and vegetables. They also shared those public benefits, like SNAP and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), have been decreasing, making it more difficult to afford food. One member said that their SNAP benefits decreased by *"almost a hundred dollars"* a month (MassHealth member). Members receiving housing services also shared concerns about the rising cost of utilities and rent.

"The electricity has gone up. The heating has gone up. I do get help with that. But I would prefer to find a place that includes heat...If anything happens and I have to leave this apartment, what's going to happen? Where am I going to go?" – a MassHealth member (MEI031)

Members reported numerous additional barriers to receiving HRSN services related to their individual situations and mobility. The lack of transportation was identified by many members as a key barrier to receiving or utilizing HRSN services. One member receiving grocery store gift cards shared that *“a lot of the people, they just don’t have that transportation to be able to go to the grocery store and a PT-1 isn’t going to cover that.”* (MassHealth member) Additionally, some members cited their mental or physical health as a barrier to engaging with HRSN services. A member shared that *“I’ll do like a survey, and they’ll send me like a card for food and stuff like that. But other than that, I haven’t sat down to speak to them because I really need mental health to see someone for depression....”* (MassHealth member)

Some members also shared that there is still a significant administrative burden placed on them when navigating HRSN services. Obtaining services involves individual research, multiple points of contact, and the completion of numerous forms and paperwork that can lead to delays in service delivery and frustration from members. One member said:

“You have to advocate ad nauseam constantly, never-endingly, to get basic crap that it says you’re able to get. It’s crazy. I don’t understand. I’m like, you said this is part of my membership, but now I have to fight, beg, plead.” – a MassHealth member (MEI024)

H7-3.3 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services understood the programs.

In interviews, some members demonstrated their understanding that certain nutrition and housing services were available to them as a MassHealth member. Numerous members also explained that when they were asked about their HRSNs by providers and/or staff, they could point to their care coordinator or clinician as a facilitator for connecting them to nutrition and housing support. Some members were able to identify the organization(s) providing them with supports and described the type and frequency of services they received (e.g., a food box delivered every other week).

Multiple members, however, demonstrated a lack of knowledge about some MassHealth services. Multiple members didn’t know they could obtain transportation service through the Flexible Services program. Additionally, several members expressed that they didn’t know MassHealth offered programs that could help address their HRSN needs. One shared that, *“I didn’t even know MassHealth had housing services.”* (MassHealth member) Some members said that they were unsure whether the HRSN services they were receiving were a benefit of their MassHealth enrollment or a different public or community service.

H7-3.4 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services described how the services they received decreased their HRSN needs.

Members described how services — which were confirmed by interviewers as MassHealth-funded or likely to be, based on service and service provider descriptions — helped to alleviate their nutrition and housing needs. Many members also shared positive experiences with being connected to community resources, like food pantries, which lessened the burden of food insecurity on members and their families.

Many members also acknowledged that federally and state funded nutrition and housing assistance programs helped decrease their nutrition and housing needs. Predominantly, members mentioned receiving SNAP and WIC for their nutrition needs. For housing needs, members shared that Section 8 housing vouchers and Residential Assistance for Families in Transition (RAFT) were essential to their housing placement. One member who was formally homeless shared that her daughter's primary care provider (PCP) helped her sign up for RAFT and connect with housing organizations, ultimately leading them to find a housing placement.

"My daughter's primary care office actually did help and try to help me find [housing] organizations about it...I ended up getting help with RAFT and I found a place for me and my daughter...Overall it was great. Took a little bit for all of the paperwork to go through but other than that it was smooth sailing and again I was able to find a place for me and my daughter and get furniture through them." – a MassHealth member (MEI021)

See more details about barriers to reducing members' HRSNs in **H7-3.2**.

H7-3.5 Members receiving FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services described how services they received improved their physical and/or mental health.

Preliminary findings from members who were surveyed or interviewed suggest that recipients of housing and/or nutrition supports as a part of FSP reported a positive impact of the services on their mental and physical health. (For more details, refer to **H6-5.4** and **H7-3.2** for interview findings on members receiving housing and nutrition supports, and **H7-9.1** and **H7-9.2** for survey findings on members enrolled in FSP.)

8.3.3.3 Conclusions

In interviews, members reported that FSP and Specialized CSP positively impacted their health and well-being. Members generally indicated that these MassHealth programs helped meet their HRSN needs and improve quality of life, though some continued to experience challenges accessing services due to administrative burdens, systemic barriers, or misalignment with individual needs or preferences.

Most members could distinguish FSP and Specialized CSP services from other public programs, like SNAP, and recognized the connection between services and improvements in their physical and mental health. However, some members remained unclear about specific program offerings or how to navigate HRSN services effectively. Overall, the findings suggest that FSP and Specialized CSP services likely contributed to reductions in HRSN needs and had a positive effect on members' health, while also highlighting opportunities to streamline service access and better align services with member needs and preferences.

8.3.4. RQ7-4 What actions did MassHealth and key stakeholders take to implement, operate, integrate, and coordinate HRSN initiatives and the Reentry Demonstration with other healthcare services?²⁵⁹

8.3.4.1 Summary of Results

MassHealth, ACOs and MCOs, and the organizations delivering FSP and Specialized CSP services took several actions to ensure delivery of HRSN programs and services according to STC-15. MassHealth developed and released policy and procedures to inform ACOs' individual FSP programs, as well as regulations, medical necessity guidelines, and an MCE bulletin to inform the implementation of Specialized CSPs. Additionally, MassHealth also provided technical assistance and conducted ongoing program monitoring activities to support service delivery and coordination across entities.

For FSP, the 17 MassHealth ACOs partnered with a total of 41 CBOs to deliver 113 FSP programs addressing nutrition and housing needs from 2023–2024 (**See Appendix H-4**). ACOs referred members to FSP programs and coordinated with CBOs to complete necessary eligibility assessments and service planning. CBOs delivered nutrition and housing supports to members, following established protocols to initiate and maintain services. CBOs worked to promote access to services in members' preferred languages, trained staff in culturally competent service provision, and used member feedback to improve services. ACOs and CBOs maintained consistent communication through meetings and electronic platforms to ensure service coordination. This communication supported successful member engagement and the delivery of FSP services.

For Specialized CSP, by 2024, there were 36 CSP-HI providers, five CSP-TPP providers, and 16 CSP-JI providers delivering services to eligible members in a MassHealth managed care or fee-for-service (FFS) plan across all of Massachusetts. In total, 46 CBOs provided at least one Specialized CSP service. Referrals for Specialized CSPs were not limited to ACOs/MCOs and came from several sources, most commonly other CBOs and state agencies. Once a member was enrolled, staff completed standard assessments and service plans, tailoring the type and frequency of support to member needs. Specialized CSP staff applied their expertise in navigating community resources, health care, and social service processes to improve engagement for enrolled members. They also collaborated with members to identify any long-term supports needs, making referrals or warm handoffs to appropriate service providers. Specialized CSP providers had a program contact at each ACO and MCO and maintained communication with ACO/MCO staff by phone or email regarding member cases, as needed.

²⁵⁹The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

8.3.4.2 Results

H7-4.1 MassHealth implemented or partnered with other state agencies to implement services, including FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services; released policy and procedures; and provided operational oversight (monitoring protocols).

MassHealth continued implementation of FSP from the 2017-2022 Demonstration through Dec. 31, 2024. MassHealth published a guidance document for ACO Contract Year 2023 and 2024 which outlined participation requirements, organizational roles and qualifications, administrative and service delivery workflow, and reporting requirements.²⁶⁰ ACOs used this guidance to design and implement their individual FSPs, reflected in each ACO's Flexible Services Participation Plan. MassHealth staff maintained operational oversight through ongoing communication with ACO staff and review of required semi-annual reporting. MassHealth first released service manuals for HRSN Supplemental Services in July 2024, in advance of the transition to the HRSN Supplemental Services Framework. These manuals detail the specific covered nutrition and housing services available through HRSN Supplemental Services as well as relevant member eligibility criteria and provider qualifications by service.²⁶¹

MassHealth formally implemented the three Specialized CSPs under the 1115 Demonstration Waiver on April 2023; however, CSP-JI services had already been available since Sept. 1, 2022, CSP-HI had been available through the Massachusetts Behavioral Health Partnership (MassHealth's behavioral health contractor) since 2006,²⁶² and CSP-TPP had also been available for decades in another form through a collaborative effort of MassHousing and multiple state agencies.²⁶³ MassHealth maintains program and rate regulations, as well as guidelines for medical necessity determination, a provider manual, and managed care bulletin. All resources are available online.²⁶⁴ MassHealth monitors implementation and program effectiveness by tracking several indicators, including the number of providers, referrals to services, members served, services provided, housing stabilization, and linkages to community resources. These three Specialized CSPs continued as part of "HRSN Required Services" starting Jan. 1, 2025.

To support successful implementation of these programs, MassHealth provided direct technical assistance and encouraged partnership development across stakeholders. They held regular meetings with providers of each program, facilitating information sharing across organizations. They also encouraged relationship building across health plans and providers by educating stakeholders about each other's work and making contact information available to facilitate connections. MassHealth assisted Specialized CSP providers in "*communicating, contracting, and working with ACOs, particularly if any issues arose*" such as with provider qualification

²⁶⁰Centers for Medicare & Medicaid Services. *Contract Year 2023 – 2024 (CY23 – CY24) Flexible Services Program (FSP) Guidance Document*, U.S. Department of Health and Human Services (2022).

²⁶¹Centers for Medicare & Medicaid Services. *Information for MassHealth ACOs and HRSN Providers*, U.S. Department of Health and Human Services (2026).

²⁶²Blue Cross Blue Shield of Massachusetts Foundation, *Estimating Cost Reductions from MassHealth Homeless Support Programs* <https://www.bluecrossmafoundation.org/programs/convenings-events/estimating-cost-reductions-masshealth-homeless-support-programs>

²⁶³University of Massachusetts Donahue Institute, *MassHousing Tenancy Preservation Program Evaluation Report* https://donahue.umass.edu/documents/FINAL_Report_3-30-10.pdf

²⁶⁴Centers for Medicare & Medicaid Services. *Community Support Program and Specialized Community Support Program Services*, U.S. Department of Health and Human Services (n.d.)

authorizations or other forms of technical assistance (MassHealth staff). This type of support continued with the transition to the HRSN Supplemental Services Framework in January 2025.

H7-4.2 FSP, Specialized CSP, Temporary Housing Assistance, and Homeless Medical Respite providers provided services, and in some cases, identified eligible members.

Flexible Services Program (FSP)

All 17 ACOs participated in the FSP from 2023-2024. They partnered with 41 CBOs to deliver 113 individual FSPs addressing members' nutrition and housing needs. (See **Table 8.3-5**.) Per interviews and reviewed documents, ACOs and CBOs coordinated closely — using standard workflows and regular communication — to make referrals to FSPs, confirm eligibility, initiate service planning, and coordinate service delivery. ACOs identified members for referral to FSP programs through centralized assessment processes, screening at practice sites and Community Partner (CP) sites, and sometimes through other community agencies. CBOs sometimes also identified members; for example, through outreach and programs outside of FSP. Often, an ACO staff member was responsible for verifying eligibility and completing the referral to the CBO. In most cases, the CBO staff would then attempt to contact the members to complete the service assessment and plan, verify service start with the ACO, and deliver services. At a few ACOs, their case managers were responsible for service planning with the members. ACO and CBO coordination and processes to deliver FSP and Specialized CSP services and programs are further described in **H7-4.3** and **H7-5.1**.

Table 8.3-5 Number of Flexible Services Programs, by Type, from CY2023–2024

Flexible Services Programs 2023–2024	Number of Programs	Number of ACOs with One or More Programs	Number of CBO Providers
Total Individual Programs	113		
Housing Support Programs	61	17	24
Home Modifications	51	16	21
Pre-tenancy Supports	56	15	21
Tenancy Sustaining Supports	56	16	23
Transitional Goods	53	15	21
Nutrition Support Programs	52	17	21
Food Boxes	18	11	13
Food Vouchers	23	12	11
Home Delivered or Medically Tailored Meals	21	14	8
Kitchen Supplies	26	15	13
Nutrition Education	26	16	17

Data Source: ACO 2023 and 2024 Flexible Program Participation Plans

Abbreviations: Accountable Care Organizations (ACOs); Community-based Organization (CBO); Calendar Year (CY)

Notes: ACOs managed programs addressing nutrition and tenancy needs within the FSP. The programs aligned with MassHealth guidance for FSP and were either delivered by the ACO or in partnership with a CBO.

During interviews in 2025, staff from 10 CBOs that partner with ACOs on 42 individual nutrition or housing programs described providing services as part of the FSP and/or the HRSN Supplemental Services (implemented in January 2025).

Nutrition Supports

Nutrition services in FSP included home-delivered meals, food boxes, and food vouchers. Nutrition services in FSP could be provided for up to six months, with the option to re-enroll based on the ACOs assessment. As described by CBO interviewees, CBO staff reached out to members for the initial assessment and enrollment in programs, then checked in with them during service delivery. Depending on the size of the organization and program, CBOs had an individual or team whose responsibilities include outreach and continued engagement with the members.

With an initial welcome call, staff worked to establish a relationship or line of communication with the enrolled member so that the member knows who to contact and feels more comfortable doing so if there are issues or changes affecting their services. CBO staff also used this conversation to discuss information about the program that can help the members successfully participate. This might have included reviewing the list of local stores where the voucher is accepted or asking about dietary preferences to help tailor food boxes. CBOs described a standardized approach to the initial welcome call, with three attempts to contact the member by phone.

Ongoing member engagement was more flexible and depended on the service type. Two CBOs that made home deliveries described how their drivers were an important point of contact with members and would share feedback or updates with program staff as needed. As one interviewee put it, *“Our drivers have weekly contact with folks and keep us posted. If their folks are missing consecutive deliveries, we’ll reach out. If there needs to be an address change, or they learn something on the ground, we can update that in our system.”* (CBO representative) One CBO that administers food vouchers had its outreach team conduct *“inactivity outreach”* to check in with members who did not use their voucher cards in the last month. They described this as effective for reengaging members: *“We have some data analysis...indicating that when we do make contact with a cardholder that hasn’t shopped in the previous month, that they’re 50% more likely to shop in the next month after that contact.”* (CBO representative)

CBO interviewees described ways in which they have designed their programs to best meet the needs of members. First, they try to promote access to the program by hiring bilingual staff, using phone-based interpreter services, and translating program materials. One CBO described partnering with a local grocery store for their food box service since *“they stock the things that people in the community like to eat.”* (CBO representative) In the Flexible Service Participation Plans, ACOs and CBOs also described training staff and monitoring member data and feedback to help ensure the provision of culturally appropriate and trauma-informed services.

Housing Supports

For pre-tenancy and tenancy-sustaining supports, such as housing search and navigation services, CBOs develop service plans with members and stay in regular contact with them to work towards their move-in and stabilization goals. This can include transitioning into housing after being unhoused, transitioning back into the community after release from incarceration, stabilizing housing, and care to prevent eviction. The specific activities are directed at the needs of the individual member. As one CBO interviewee explained, they often focus on the best steps to prepare someone for a new housing opportunity while being realistic and creative about finding affordable housing for the member.

“They all need affordable housing. They need it now. They need to know how to access it. And it’s not a straightforward process...We just have to offer what is there and give clients the tools to be able to navigate it on their own. Helping them sign up for lotteries...Opening up your geographic locations. Cleaning up your credit. Helping them with budgeting. Trying to prepare them for finding a unit when the time comes. Making sure they’re in the best position possible...It’s not going to be a quick turnaround, but you’re helping people get set up for success.” – a CBO representative (HP750343)

Home modifications and transitional goods services paid for certain move-in costs, items, and remediation services to help members move in or stay in their housing. CBO staff have an important role in coordinating with and on behalf of members. One CBO interviewee described their model: *“If I’m going to your house and doing your Healthy Homes assessment, I’m the one that’s going to then make sure that this happens for you and coordinates all your services for you.”* (CBO representative)

Specialized CSPs

As of 2024, there were 36 CSP-HI providers, five CSP-TPP providers, and 16 CSP-JI providers delivering services to eligible members in a MassHealth managed care plan or FFS MassHealth across all of Massachusetts. In total, there were 46 CBOs providing at least one Specialized CSP. Staff from six CBOs providing Specialized CSPs, representing 11 total programs, participated in interviews in which they described their service delivery models.

Referrals for CSPs are not limited to ACOs and can come from several sources. Interviewees described that, most commonly, external referrals for CSP-HI came from housing providers, external referrals for CSP-TPP came from housing providers or housing court, and external referrals for CSP-JI came from justice entities such as the Sheriff’s Offices or Department of Correction. CBOs also have processes in place to identify eligible members within other programs offered at their organization. For example, one CBO described that staff at their homeless shelter can identify members who might be eligible for CSP-HI and make an internal referral to the CSP-HI program director. Another CBO has a central intake team of staff who are cross trained in program eligibility criteria and work to identify the appropriate program for the member. Regardless of the referral source, interviewees explained that Specialized CSP staff are involved in confirming member eligibility. These referral and eligibility determination processes are described in more depth in **H7-4.3** and **H7-5.1**.

After a member is enrolled in a Specialized CSP, their case manager focuses on improving access to healthcare. Case managers would typically be in contact with a newly enrolled member at least several times a week during this time. This could include phone calls with the member, meeting the member at their home or in a community setting such as a shelter, or at a scheduled appointment. For example, Specialized CSP staff may accompany a member to a health care visit if the member requests it. As one CBO interviewee said, *“Somebody will help you today...tomorrow, rather than, ‘I’ll get you a referral.’ We’ll talk to your doctor, I’ll make a call or call your doctor, and I’ll check back in the next week. The CSP programs are much more hands-on and much more direct service.”* (CBO representative)

Specialized CSP case managers work with members to identify their needs and goals, overcome barriers to services, and empower members to make decisions to improve their health. Staff complete standard assessments and service plans to tailor the type and frequency of support, while factoring in the need for flexibility and quickly responding to member requests. CBO interviewees mentioned that a major part of their work is identifying a PCP for members, as well as finding BH service providers or programs that fit a member’s individual needs. They also supported members with obtaining IDs, gaining employment or starting job training programs, and navigating housing vouchers and opportunities. Specialized CSP staff applied their expertise in navigating community resources, and health care and social service processes to improve access for enrolled members. Specialized CSPs, with the exception of CSP-HI, are designed to provide short-term case management, so staff also work with members to identify any long-term supports they will need and make a referral or warm handoff to appropriate service providers.

Overall, Specialized CSP providers emphasized that the case management models they use are person-centered, designed around meeting someone “where they are.” Specialized CSP interviewees across programs also noted the voluntary nature of the programs, meaning that goal setting and activities were driven by members, and that a member could decide they no longer wanted to participate in the program. Techniques such as motivational interviewing and the Stages of Change model²⁶⁵ were used to promote engagement. One CBO interviewee described their approach; *“We call ourselves partnered with people, so we make suggestions, but we really make suggestions based on what it is they’ve told us they want.”* (CBO representative)

Each Specialized CSP is designed to serve a specific population of members. While the service delivery model was similar across programs, it was also apparent from interviews that there were nuances to each program and how they worked to meet the needs of those member populations. Organizations operating Specialized CSP programs also varied in terms of the types of services and programs offered at the organization. As described below, there were examples of coordination across teams within the same organization to facilitate member engagement and relationship-building.

²⁶⁵ Prochaska, James O.; DiClemente, Carlo C. (2005). "The transtheoretical approach". In Norcross, John C.; Goldfried, Marvin R. (eds.). *Handbook of psychotherapy integration*. Oxford series in clinical psychology (2nd ed.). Oxford; New York: Oxford University Press. pp. 147–171. ISBN 978-0-19-516579-1. OCLC 54803644.

CSP-HI is designed to support members experiencing homelessness with finding, transitioning into, and maintaining housing. The CBOs that participated in interviews offered a range of housing services in addition to CSP-HI, including homeless street outreach, shelter programs, and permanent supportive housing. Interviewees described close collaboration across these teams to both identify eligible members and keep in contact with CSP-HI participants.

“A big part of our programs is...the street outreach component...Our folks transitioning from homelessness to housing, [it] is an incredibly difficult transition. It can take many months if not years for folks to feel comfortable within their new home. We find that our folks do frequently return to wherever they came from before, whether it’s the street or it’s in and out of different facilities and things like that. Our ability to be flexible and meet those needs and find our folks where they are has been where we’ve found the most success.” – a CBO representative (HP143105)

Once housing has been obtained, another aspect of CSP-HI case management is to identify and help address any issues with a member’s housing unit. As one CBO interviewee describes it, *“part of the case management is to be the eyes on the unit, to make sure that it maintains habitability, and to kind of be that buffer between our client and the landlord...We’re in there, seeing it first, addressing it first before it becomes an issue, hopefully.”* (CBO representative)

CSP-TPP is also a housing stabilization program, but for members at risk of losing their housing as a result of behavior related to a disability. Therefore, one CBO interviewee explained that their assessment and service plans for CSP-TPP focus on addressing the lease violation and behavior associated with it: *“We have our own assessment forms that are specific to the criteria — the lease violations, impairments, and the relationship between the two. And then part of the assessment is also what would be potential interventions.”* (CBO representative)

CSP-JI supports members with justice-involvement to improve and maintain health while transitioning back to the community and to promote successful community tenure. Some CSP-JI providers also managed in-reach case management services in Massachusetts jails and prisons through the Commonwealth’s Behavioral Health Supports for Justice Involved Individuals (BH-JI) program. Members can transition from the BH-JI program to the CSP-JI program after their release from incarceration. One CBO providing both services described their use of an integrated team; meaning they try to keep the same case manager with the member regardless of service type. Another CBO talked about their efforts to ensure that the CSP-JI case manager is there to meet the member when they are released from incarceration: *“Our navigators will often pick individuals up who are releasing and help get them to their placement; that helps ensure that the connection occurs, that their basic needs are identified and met, and that there’s a rapport that develops.”* (CBO representative) Several interviewees emphasized the voluntary nature of the program and how this improves their ability to engage members. While the case manager will communicate with a parole or probation officer, the program is not a requirement.

“Let us help you from a voluntary perspective, right? Nobody’s forcing you to do this. This isn’t a condition of your release or condition of your probation or parole. We are an ally, we’re not a ‘have-to.’ And I think that really works...We’ve seen a really nice

collaboration and connection there [with the member] because it's not forced." – a CBO representative (HP088715)

H7-4.3 ACOs/MCOs coordinated (identified, referred, provided care coordination) member services with FSP and Specialized CSP providers.

Flexible Services Program (FSP)

ACOs continued to coordinate closely with contracted CBOs to deliver FSP programs to members. There were two major pathways for referral into the programs: (1) the ACO screened members routinely for HRSNs and initiated an FSP referral when appropriate and (2) in a less common pathway, CBOs would identify potentially eligible members and then confirm their eligibility for the FSP with the members' ACOs. Once eligibility was confirmed, the ACO staff would submit a formal referral to the CBO to initiate service planning and enrollment. CBO interviewees shared that frequent information sharing between ACOs and CBOs was essential to ensuring accuracy of information within FSP referral documents. They also shared that having ACOs conduct the eligibility screening prior to sending the FSP referral to the CBO was helpful in easing the administrative burden on CBOs. One CBO shared that, *"A referral will come to us, having already been fully screened for eligibility from our ACO partners, and then we pick up the process to just move forward with the nutrition assessment and enrollment."* (CBO representative)

Under the FSP framework, ACOs and CBOs communicated regularly to coordinate services. Many ACOs held regular meetings with their FSP partners, while some ACOs leveraged electronic platforms for sharing information, such as referral and service updates, between the ACO, providers, and CBOs. A few ACOs mentioned the success of having a dedicated staff person or team, such as an FSP coordinator, at the ACO to follow up on referrals and coordinate directly with partners. These strategies supported successful member engagement and delivery of FSP services. This level of partnership and coordination was also described as an important complement to care management and impactful when it comes to building trust between patients and care team members.

"We build relationships with [our Flexible Services partners]. They understand what we do to serve the patient. That level of coordination between Flex[ible Services partners] has just been transformational to how care management is able to support patients. It goes a long way in engaging trust in other maybe more intricate or complex problems to solve because we can demonstrate we're responsive. We have these resources and we're here to help you." – an ACO participant (AA145082)

CBO representatives also noted that regular meetings as well as streamlined information sharing were facilitators of HRSN service coordination. They found that it was important to identify people on each side — at the ACO and CBO — who could keep communication lines open. Overall, both ACO and CBO interviewees agreed that they had very good working relationships for the delivery of FSP.

"We had really solid relationships with ACO partners...we met all the time. We talked about clients. I mean, we'd email. It was just really

good workflows and pathways of communication that we had established with our ACO partners.” – a CBO representative (HP088715)

Specialized CSPs

Several ACO representatives said they did not regularly meet with Specialized CSP providers, unless the organization was also an FSP partner, but coordinated as needed. They attributed this to aspects of the programs’ designs. ACOs did not coordinate as much with Specialized CSPs for referrals since Specialized CSP providers often identified members for the program independently of ACOs. Unlike the FSP, members referred to Specialized CSPs did not have to be ACO members. Both ACOs and MCOs made referrals to the Specialized CSPs, but CBO representatives shared that the most common referral sources were internal referrals, and referrals from additional CBOs and state agencies (See **H7-5.1.**) ACO interviewees also noted that it would be repetitive to enroll these members in ACO care coordination given the focus of the Specialized CSPs on case management.

“[Our ACO] will be aware when services are beginning under CSP when that authorization is obtained...Providers may reach out directly to [the ACO’s] point of contact with questions and topics. But in terms of coordination and direct relationships with CSP providers, it’s really coming from the CSP providers themselves and members accessing service directly through there.” – an ACO participant (AA145082)

CBO representatives confirmed that they had a specific program representative they could contact at each ACO and MCO. This was helpful for resolving issues related to documentation and authorizations. Interviewees also indicated that they could communicate with ACO/MCO staff by phone or email about a member’s case, as needed. A few CBO staff described reviewing Specialized CSP enrollee cases during existing case management meetings with some ACO partners. Similar to ACO interviewee feedback, this model was facilitated by pre-existing practices established over the course of other programs such as FSP or the CP program. One interviewee whose organization participated in the FSP, Specialized CSP, and CP program shared, *“Because we have the relationships with the ACOs in the practice sites and the health centers and we’re in meetings as a CP with these different groups reviewing members, we’re able to bring forward or escalate things that may be getting stuck.”* (CBO representative)

8.3.4.3 Conclusions

MassHealth’s technical guidance and program monitoring enabled the implementation of HRSN services and programs. Qualitative results suggest that ACOs and CBOs worked closely together to deliver nutrition and housing supports to members, although coordination was less structured and consistent for members enrolled with Specialized CSP providers who did not have other existing relationships with ACOs through the FSP or CP programs. MCOs also made referrals to Specialized CSP providers and coordinated, as necessary.

Key aspects of the FSP design, such as ACO staff involvement in referrals and sometimes in service planning, contributed to successful coordination. Specialized CSP providers coordinated with local organizations and state entities, in addition to ACOs and MCOs, to identify eligible members and provide case management. The emphasis on person-centered case management — empowering members to set goals and decide on participation — was essential to the programs' success. The expertise of CBOs in navigating local health and social service systems also played a critical role in delivering effective HRSN services. Moving forward, it will be important to monitor coordination changes and service delivery under the new HRSN Services Framework which launched on Jan. 1, 2025.

8.3.5. RQ7-5 How were members identified and referred to FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services?²⁶⁶

8.3.5.1 Summary of Results

ACOs and MCOs used standardized processes for screening members for unmet HRSNs. ACOs also used standardized workflows for assessing eligibility and making referrals for their individual FSPs. Interviewees discussed challenges with obtaining needed eligibility information and navigating available HRSN services and programs. They also discussed successful strategies to address these challenges, including hiring a centralized HRSN coordinator, regularly educating practice site staff on available resources, and leveraging CBO staff expertise. In interviews, Specialized CSP providers described successfully partnering with other CBOs and a variety of state agencies to identify eligible members for these programs. They used standardized workflows both for receiving referrals from partner organizations and for internal teams to identify eligible members and make referrals. Some CBOs had issues with receiving inappropriate referrals, pointing to a potential need for educating referring entities on program criteria.

8.3.5.2 Results

H7-5.1 Standardized processes and objective criteria were used by ACOs, MCOs, and partnering organizations (e.g., justice entities and housing agencies) for identifying needs, assessing eligibility, and providing referrals for each respective service.

ACOs and MCOs used standardized processes and tools for screening members for unmet HRSNs upon enrollment and then annually. Screening took place either during provider visits, care management engagement, or via centralized teams at the ACO or MCO. They integrated HRSN screening and referrals into their EHR and care management systems, which allowed for more efficient care coordination and data tracking. Facilitators and challenges of ACO screening implementations were described in **H2-5.1**.

ACOs developed and used standard workflows for assessing eligibility and making referrals for their individual FS programs. These addressed the roles of both ACO and CBO staff in

²⁶⁶The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

collecting additional eligibility information, confirming service approval, and contacting the members to initiate services. ACO and MCOs did not have a similar workflow for Specialized CSP referrals. However, ACO and MCO interviewees shared that their case management staff make referrals for members with BH needs to the appropriate Specialized CSP.

ACO and MCO interviewees described a few barriers providers and partners face in successfully navigating members into appropriate services and programs to address unmet HRSNs, including eligibility information gaps and overall service complexity. For example, even when a relevant HRSN is identified in routine screening, staff may need to follow up for additional information to ensure a member meets more specific eligibility requirements for available programs like FSP or Specialized CSPs. In some cases, the healthcare entities could not confirm certain eligibility requirements on their own. A common example of this shared by interviewees was the requirement that members will be housed within 120 days of CSP-HI program enrollment.

“Generally speaking, we don’t have the same ability to refer members into CSP services largely due to the fact that, at least in my view, there’s this housing on the horizon requirement for the CSP-HI services, so the vendors can’t simply accept a referral and begin billing. They actually need to be able to attest to the fact that the member is going to be housed within 120 days.” – an ACO participant (AA013856)

There were also several successful strategies that ACOs employed to overcome these challenges. First, many ACOs had a centralized coordinator or team receiving screening results and managing referrals. These staff were positioned to identify appropriate resources and facilitate hand-off to a CBO or engage members directly in service navigation. Another key strategy was recurring education with practice site staff about available programs to help them understand what was available and make appropriate referrals. Finally, several ACOs mentioned the benefit of partnering with CBOs that offered multiple programs, including FS programs and Specialized CSPs, since these organizations could facilitate referrals and hand-offs between programs within their organization, as needed. Nine of the 41 CBOs (22%) participating in FSP from CY2023-CY2024 were also a provider of one or more Specialized CSPs (See **Appendix H-4**).

Specialized CSP providers partnered with other CBOs and a variety of state agencies to identify eligible members for these programs. The specific partners and established referral pathways were influenced by each Specialized CSP’s program design and eligibility criteria. CBO interviewees described having standardized workflows for receiving referrals from partner organizations. They also had workflows for internal teams to identify eligible members and make referrals. Some CBOs had occasional challenges with referrals, which may be related to the strict eligibility criteria or instances where referrals didn’t fully align with program requirements. These experiences suggest a potential need for educating referring entities on program criteria.

To be eligible for CSP-HI, a member must have been verified as experiencing homelessness and must have an identified permanent supportive housing opportunity they will move into within 120 days of enrollment. Members must have met BH-need criteria or, starting Jan. 1, 2025, Health Needs Based Criteria (HNBC, ACO members only), with eligibility verified through a

diagnosis or member attestation. BH-need criteria include mental health or substance use disorder (SUD) requiring support, and HNBC cover significant physical health needs, functional limitations, frequent emergency service use, or pregnancy-related risks that require support to maintain independence.²⁶⁷

In order to become a CSP-HI provider, an organization must have experience providing services to individuals with mental health or SUDs and a history of providing “pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness.”²⁶⁸ These criteria encouraged organizations to partner with housing agencies for referrals, since they can refer members with a housing voucher or other housing opportunity, allowing the CSP-HI provider to focus on supporting the member as they transition into or maintain their housing. It also meant that many organizations providing CSP-HI and other programs such as street outreach, transitional housing, and permanent supportive housing, could identify eligible members for referral to CSP-HI within these programs. As one CBO interviewee described, *“We have shelter, we have street outreach, we have a portfolio of 800 PSH [permanent supportive housing] units. CSP-HI is a way for us to help people move out and support them from the shelter setting or unsheltered setting into our PSH portfolio and then provide those ongoing services once housed.”* (CBO representative) Another CBO representative explained that when they receive a referral for one of their permanent supportive housing programs, they can check the diagnosis provided and the individual’s insurance to see if they will be eligible for CSP-HI. CBO representatives described training staff, maintaining structured workflows, and communicating regularly across program teams to facilitate their referral pathways.

Members eligible for CSP-TPP are at risk of homelessness and facing eviction as a result of behavior related to a disability. They must also meet the same clinical criteria as those described above for CSP-HI. Providers of MassHealth CSP-TPP services must already be contracting with MassHousing to provide TPP services. The CSP-TPP program is operated in partnership with the Housing Court Department, and each CSP-TPP provider’s regional Housing Court refers individuals to the program.

“[There is] a special session just for housing court. We have staff that staff those. The judge may identify, ‘There’s an eviction case, this is someone with a disability, would you please talk to them and see if they’re eligible?’ We’ll give them some advice, and then it becomes potentially a case.” – a CBO representative (HP454077)

CSP-TPP providers shared in interviews that they received referrals from many other sources outside of the housing courts, including housing agencies, health care providers, legal services providers, and from direct member outreach. For example, one CBO directed individuals calling their organization’s public housing hotline for assessment: *“They might get a call, ‘I’m not homeless yet. Can you help me? I need to pay. I’m behind on my rent,’ something like that. They’ll refer those calls to the [CSP-]TPP provider to evaluate.”* (CBO representative) Another CBO representative shared that they are *“inundated with referrals, but most of them don’t meet the eligibility.”* (CBO representative) The time spent assessing eligibility and trying to refer

²⁶⁷Eligibility criteria and the changes that went into effect January 1, 2025, are summarized in Appendix H-1

²⁶⁸Centers for Medicare & Medicaid Services. *Community Support Program Services Manual*, U.S. Department of Health and Human Services (2023)

individuals to other resources cannot be billed, and for this CBO, which meant that it was not seeking extra referrals due to a strain on its capacity.

CSP-JI services are for members with justice involvement — including individuals released from incarceration in the past year or on probation or parole — who demonstrate a need for BH diversionary services and have barriers to accessing or consistently using medical and BH services.²⁶⁹ CSP-JI providers must have a DPH license to also provide mental health and SUD services. Nine of 16 total CSP-JI providers operated the Commonwealth’s BH-JI program, which supported individuals while they were incarcerated with reentry planning and care coordination. Interviewed CSP-JI providers shared that many of their referrals come through the BH-JI program, either as internal referrals or from a BH-JI provider to a different CSP-JI provider. Providers received referrals from justice entities including the county Sheriffs’ Offices, Department of Corrections, Parole Board, and Probation Services. They also receive walk-in referrals, or self-referrals, and referrals from other CBOs that operate reentry programs. Overall, interviewees described having well-established partnerships and referral pathways. One CBO representative raised that they do still face challenges with inappropriate referrals: *“We don’t always get all the information when individuals are coming from a specific facility. And sometimes referrals are inappropriate in the amount of needs that they may have. They may need way more than what it is this service is intended to do. Which can sometimes be a challenge”* (CBO representative). MassHealth staff reported that they mitigated some of these issues by holding bimonthly statewide meetings with referring partners and require BH-JI providers to regularly coordinate with justice entities and other local referring partners (MassHealth staff).

8.3.5.3 Conclusions

ACOs described challenges with navigating available services and collecting appropriate eligibility information. ACOs mitigated these challenges using standardized workflows and successfully coordinated with CBOs to assess member eligibility and make referrals to FSPs. While Specialized CSP providers described successfully partnering with other CBOs and a variety of state agencies to identify eligible members for these programs, they also discussed challenges with receiving appropriate referrals. ACOs and MCOs were described as uncommon sources of referrals to Specialized CSP programs. These findings indicate that education and outreach efforts with referring entities may be needed to enhance access to programs and reduce the burden of inappropriate referrals on CBO capacity, in particular when there are changes to eligibility criteria and referral requirements.

²⁶⁹ Eligibility criteria are summarized in Appendix H-1

8.3.6. RQ7-6 What were the FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services utilization and cost trends?²⁷⁰

8.3.6.1 Summary of Results

Throughout the early years of the 2022–2027 Demonstration, service utilization and costs varied substantially across program types and member characteristics. In the start of the 2022-2027 Waiver period, in Q2 2023 the FSP enrolled 11,165 members; this included individuals who began receiving services during the 2017–2022 Demonstration period (2020-Q1 2023) and who were still receiving services in Q2 2023, in addition to new members beginning services in Q2 2023. Between Q3 2023 and 2024, new enrollments grew steadily, peaking at 4,182 new nutrition members and 1,599 new housing members in Q2 2024. Expenditures rose from \$26 million in CY2023 (three quarters total from March – December, annualized to ~\$35 million) to \$42 million in CY2024 (full calendar year from January – December), with the majority of spending on nutrition supports (60%) versus housing supports (40%). Enrollment and costs declined later in 2024 as the FSP approached its sunset on Dec. 31, 2024, transitioning to HRSN Supplemental Services on Jan. 1, 2025.

The CSP-HI program had rapid growth in enrollment from April 2023 to December 2024, reaching 2,187 members/month in December 2024 and \$1.4 million in monthly costs. Total program costs were \$27 million, with an average per-member-per-month (PMPM) cost of \$731. The CSP-TTP program, servicing a smaller number of MassHealth members, had gradual growth in enrollment from 21 members in 2023 to 116 members in 2024. Total costs grew from \$29,733 in 2023 to \$307,689 in 2024, with a PMPM cost of \$544. The CSP-JI program also demonstrated robust growth, with enrollment rising from 177 members in September 2022 to 686 in December 2024. The program costs for September to December 2022 were \$488,561 and rose to \$2.2 million in 2023 and \$3.4 million in 2024. Total costs for this program were \$6.1 million with a PMPM cost of \$482.

8.3.6.2 Results

H7-6.1 The service utilization and cost trends vary by program type and member demographics, comorbidity, and past utilization/cost.

Flexible Services Program (FSP)

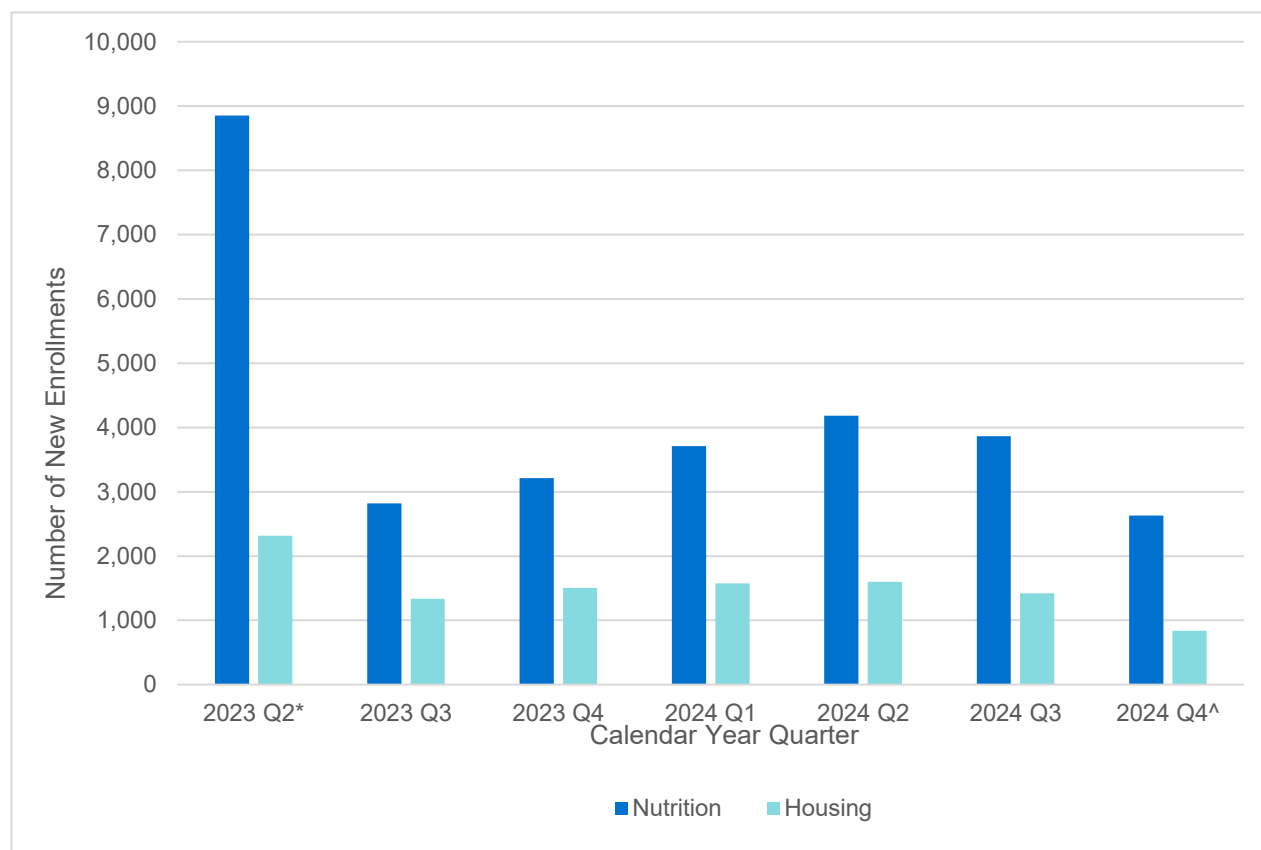
The FSP launched in January 2020 and provided nutrition and housing services to members who experienced food insecurity, homelessness or were at risk of homelessness, and had at least one qualifying HNBC including: a BH need, complex physical health need, activities of daily living need, repeated ED utilization, or high-risk pregnancy.²⁷¹ The FSP continued into the 2022–2027 Demonstration. Members who continued to receive services across Demonstration

²⁷⁰The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

²⁷¹ Centers for Medicare & Medicaid Services. (2018, October 4). MassHealth 1115 Demonstration Waiver: Flex Services Protocol Approval. U.S. Department of Health & Human Services.

periods were marked in administrative data as ending services on March 31, 2023 (last day of former contracting period) and then marked as starting new services on April 1, 2023 (first day of new contracting period). The FSP sunset on Dec. 31, 2024, and transitioned to the HRSN Supplemental Services on Jan. 1, 2025. Enrollment trends for FSP in the 2022-2027 Demonstration are in **Figure 8.3-1**.

Figure 8.3-1 New Flexible Services Program Enrollments by Calendar Year Quarter, CY2023-CY2024



Data Source: MassHealth Administrative data, second quarter of CY2023 and CY2024

Abbreviation: Calendar Year (CY), Quarter 1 (Q1); Quarter 2 (Q2); Quarter 3 (Q3); Quarter 4 (Q4)

Notes: New enrollment counts reflect individuals newly enrolled in each quarter based on available program data.

*Q2 2023 enrollment counts are artificially elevated because they include individuals who began services during the previous waiver period (2020-Q12023) and were still receiving services.

^ Enrollment in 2024 Q3 and Q4 was lower due to the impending transition to the Health-Related Social Needs Supplemental Services on Jan 1, 2025. ACOs reduced new enrollments in FSP as the program neared its sunset date.

New enrollments in Q2 2023 are artificially elevated because they include individuals who began services during the previous Demonstration period (January 2020 to March 2023) and continued receiving services in FSP beginning on April 1, 2023. Q1 is excluded because it was part of the previous ACO contracting period. Starting in Q3 2023 and in each subsequent quarter through Q2 2024, new enrollments in both nutrition and housing services increased each quarter, reaching a peak of 4,182 new nutrition enrollments and 1,599 new housing enrollments in Q2 2024. Enrollment plateaued in Q3 2024, then declined in Q4 2024. This decline was likely attributable to the sunset of the FSP on Dec. 31, 2024, and the transition to the new HRSN Supplemental Services Program. While this transition to the managed care framework created

opportunities for greater sustainability and standardization, it also introduced different criteria for service enrollment and financial constraints that may have contributed to reduced utilization during the transition period. ACOs staff also noted that they were hesitant to enroll new members in FSP at the end of 2024 because they would need to end their enrollment in FSP early, and those members may not have been eligible to continue receiving services under the new HRSN Supplemental Services Program.

Table 8.3-6 ACO Expenditures by Program Type for Flexible Services Programs, CY2023-CY2024

Flexible Services Program Types	CY2023 (Mar – Dec 2023) Expenditures, all ACOs	CY2023 (annualized) Expenditures, all ACOs	CY2024 (Jan – Dec 2024) Expenditures, all ACOs
Total	\$25,969,463	\$34,563,884	\$42,154,345
Housing Support Programs	\$10,506,657	\$13,973,350	\$16,894,333
Home Modifications	\$361,689	\$481,046	\$1,337,566
Pre-tenancy Supports	\$4,480,965	\$5,816,282	\$6,888,788
Tenancy Sustaining Supports	\$3,584,674	\$4,767,616	\$5,305,629
Transitional Goods	\$2,079,329	\$2,908,405	\$3,362,350
Nutrition Support Programs	\$15,462,806	\$20,590,536	\$25,260,011
Food Boxes	\$3,241,981	\$4,311,835	\$4,649,453
Food Vouchers	\$5,475,057	\$7,281,826	\$7,850,605
Home Delivered or Medically Tailored Meals	\$2,819,939	\$3,775,520	\$5,157,576
Kitchen Supplies	\$1,254,439	\$1,668,404	\$2,090,166
Nutrition Education	\$569,727	\$757,737	\$1,523,398
Transportation	\$430	\$572	\$1,378
Other (e.g., staff time for nutritional assessment, referrals, and coordination)	\$2,101,234	\$2,794,641	\$3,987,435

Data Source: CY2023 and CY2024 ACO Flexible Services Program Budget Reports

Abbreviations: Accountable Care Organizations (ACOs); Calendar Year (CY)

Notes: Data for CY2023 excludes Q1 CY2023, as this quarter was not included in the ACO contract period starting April 2023. Data reflect reported expenditures in the time period by program type. Differences between totals and the sum of component amounts are due to rounding.

In alignment with increasing enrollment in FSP throughout 2023-2024 Q2, overall FSP expenditures increased from \$25.9 million in 2023 (annualized to \$34.6 million since CY2023 was only three quarters from March – December) to \$42.1 million in 2024 (**Table 8.3-6**). Program categories with the lowest total spending included transportation support, nutrition education, and home modifications; categories with the greatest total spending included food vouchers, pre-tenancy supports, and medically tailored meals.

Table 8.3-7 Population Characteristics of Members Receiving Flexible Services, Housing and Nutrition Services, CY2023-CY2024

Population Characteristic	Housing				Nutrition			
	CY2023 N = 4,937		CY2024 N = 5,179		CY2023 N = 14,010		CY2024 N = 13,295	
Age at Start Date – mean, SD	37.4	17.3	36.8	17.7	32.9	19.7	33.3	19.3
DxCG – mean, SD	4.4	5.4	4.3	5.1	3.2	4.8	3.6	4.8
RxCG – mean, SD	3.5	4.6	3.6	4.6	3.0	4.4	3.4	4.6
Race/Ethnicity, n, %								
White	1,941	39.3%	1,899	36.7%	3,939	28.1%	4,078	30.7%
Black	982	19.9%	1,059	20.5%	2,774	19.8%	2,408	18.1%
Hispanic	531	10.8%	555	10.7%	1,478	10.6%	1,437	10.8%
Asian/Native American/Pacific Islander	115	2.3%	85	1.7%	332	2.4%	289	2.2%
Prefer not to say/Missing	2,131	43.2%	2,116	40.9%	6,899	49.2%	5,587	42.0%
Female, Sex, n, %	2,901	58.8%	3,083	59.5%	8,703	62.1%	8,154	61.3%
Homeless, n, %	1,097	22.4%	1,175	22.8%	1,206	8.7%	1,437	10.9%
At Risk of Homelessness, n, %	1,157	23.6%	1,203	23.3%	2,047	14.7%	2,245	17.0%
Rural, n, %	32	0.7%	32	0.6%	221	1.6%	196	1.5%

Data Source: MassHealth administrative data and MassHealth claims and encounters data, CY2023-2024

Abbreviations: Calendar Year (CY); Diagnostic Cost Group (DxCG); Prescription Drug Cost Group (RxCG); Standard Deviation (SD)

Notes: DxCG is diagnosis-based relative risk score of medical morbidity. DxCG risk scores are standardized to a mean of 1. RxCG is pharmacy drug claims-based relative risk score of medical morbidity, standardized to a mean of 1, with values greater than 1 signifying above average comorbidity complexity. At risk of homelessness is defined as having 3+ addresses within the measurement period.

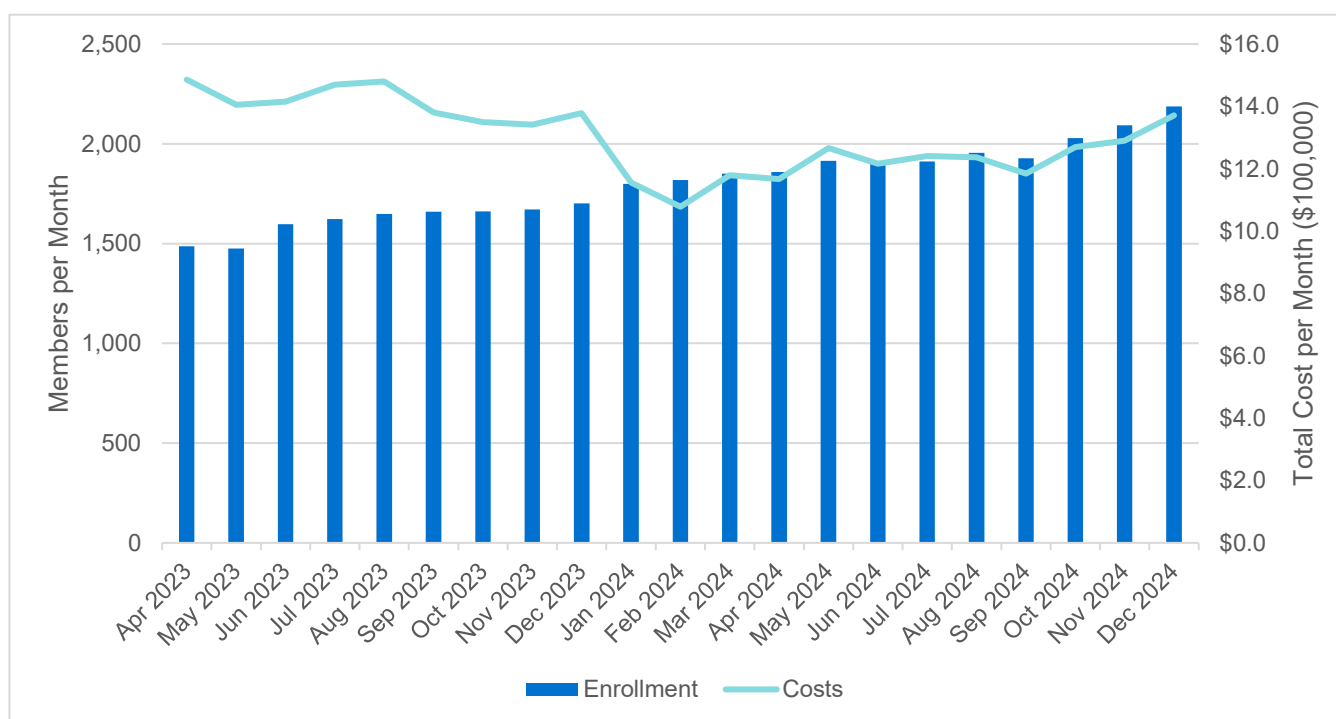
The FSP continued to enroll a high-risk member population with significant medical comorbidities. Overall, the enrolled member populations were similar in characteristics during 2023 and 2024 within service types. In 2024, the average DxCG score was 4.3 (housing) and 3.6 (nutrition), and 46.0% (housing) and 23.7% (nutrition) were experiencing homelessness or at risk of homelessness (based on 3+ address changes within the year).²⁷² The majority of FSP participants were female (~60% across nutrition and tenancy combined) and very few participants lived in rural areas (~ 1% across nutrition and housing combined). Race and ethnicity data were missing for ~45% of members. In 2024, across nutrition and housing services combined and among FSP participants with complete race and ethnicity data, 50.6% identified as non-Hispanic White, 29.4% identified as non-Hispanic Black, 16.9% identified as Hispanic, and 3.2% identified as Asian.

²⁷² DxCG is a diagnosis-based relative risk score of medical morbidity, standardized to a mean of 1, with values greater than 1 signifying above average medical morbidity.

Community Support Program for Homeless Individuals (CSP-HI)

The CSP-HI program began April 1, 2023.²⁷³ In its first month, 1,487 members used CSP-HI with an associated cost of approximately \$1.5 million (See **Figure 8.3-2**).²⁷⁴ This high utilization in the first month can be attributed to members who were previously receiving a similar service continuing their care through enrollment in CSP-HI. Utilization grew steadily and in December 2024, 2,187 members used CSP-HI services with an associated cost of about \$1.4 million. There were 3,749 individuals who used CSP-HI services from April 2023 to December 2024. The total cost for 2023–2024 was approximately \$27 million, while the average PMPM cost was \$736. As enrollment scaled, costs stabilized, reflecting program maturation and service normalization over time.

Figure 8.3-2 CSP-HI Utilization and Cost Trends for CY2023–2024



Data Source: Medicaid administrative data

Abbreviation: Community Support Program for Homeless Individuals (CSP-HI); Calendar Year (CY)

Notes: The bar chart represents utilization (members using services per month) while the line represents total cost per month (\$100,000). Costs reflect deduplication of identical positive amounts on the same date of service and top coding at \$27.72 in 2023 and \$28.35 in 2024.

During the first two years of CSP-HI (CY2023-CY2024), enrolled participants had an average age of 47.3-48.7 years and higher than average medical morbidity (DxCG 5.5-6.0 and RxCG 3.3-3.7). (See **Table 8.3-8**.) The largest reported race and ethnicity group was White (about 41.2–43.3%), followed by Black (14.4-14.9%) and Hispanic (8.5–8.9%), although a substantial proportion of the participants selected Prefer not to say/Missing regarding their race and

²⁷³ Centers for Medicare & Medicaid Services. *Community Support Program for Homeless Individuals*, U.S. Department of Health and Human Services (n.d.)

²⁷⁴ Centers for Medicare & Medicaid Services. MassHealth Managed Care Entity Bulletin 44 October 2020, U.S. Department of Health and Human Services (2020)

ethnicity (46.9-49.7%). Approximately one-third of participants were female, and a sizeable share (42.9-46.8%) had a documented disability designation, meaning the member was enrolled with the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or eligible for MassHealth due to a disability.

Table 8.3-8 Population Characteristics of Members Enrolled in the CSP-HI Program

Variable	CY2023 N = 2,309 ^a		CY2024 N = 3,194 ^a	
Age at Start Date – mean, SD*	48.7	11.5	47.3	11.8
DxCG ^a	5.5	5.7	6.0	6.0
RxCG ^b	3.3	4.1	3.7	4.8
Race/Ethnicity, n, %				
Black	333	14.4%	477	14.9%
White	952	41.2%	1,384	43.3%
Native American/Asian/Pacific Islander*	31	1.3%	46	1.4%
Hispanic	202	8.9%	270	8.5%
Prefer not to say/Missing	1,148	49.7%	1,497	46.9%
Female, Sex, n, %	697	30.2%	1,022	32.0%

Data Source: MassHealth administrative data and MassHealth claims and encounters data, CY2023-2024

Abbreviations: Community Support Program for Homeless Individuals (CSP-HI); Calendar Year (CY); Diagnostic Cost Group (DxCG); Prescription Drug Cost Group (RxCG); Standard Deviation (SD)

Notes: DxCG is diagnosis-based relative risk score of medical morbidity. DxCG risk scores are standardized to a mean of 1. RxCG is pharmacy drug claims-based relative risk score of medical morbidity, standardized to a mean of 1. At risk of homelessness is defined as having 3+ addresses within the measurement period.

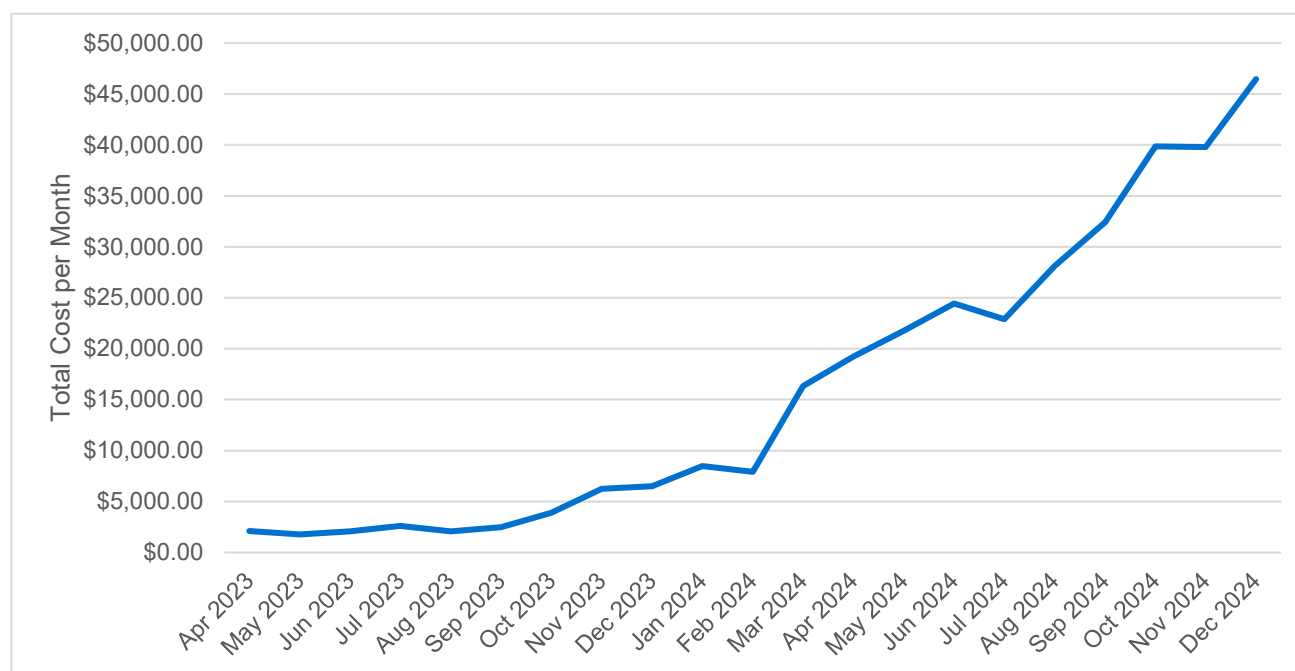
^aDxCG Missing: CY2023 n=319; CY2024 n=481

^bRxCG Missing: CY2023 n=319; CY2024 n=481

*Categories were combined because cell sizes were fewer than 11.

Community Support Program: Tenancy Preservation Program (CSP-TPP)

The CSP-TPP program began April 1, 2023. In 2023, 21 members used CSP-TPP services with an associated cost of \$29,733. (See **Figure 8.3-3.**) Utilization grew and in 2024, 116 members used CSP-TPP services with an associated cost of \$307,689. There were 128 individuals who used CSP-TPP services from April 2023 to December 2024. The total cost for 2023–2024 was \$337,422 while the average PMPM cost was \$544.

Figure 8.3-3 CSP-TPP Cost Trends for 2023-2024

Data Source: Medicaid administrative data

Abbreviation: Community Support Program Tenancy Preservation Program (CSP-TPP)

Notes: Monthly utilization (members using services per month) not included due to CMS small cell size requirements to mask values <11. The line represents total cost per month.

Across the first two years of the program, CSP-TPP participants had a mean age of 42.4 years and higher than average medical morbidity (DxCG=3.7; RxCG=2.6) (See **Table 8.3-9.**) Approximately 28.1% of participants were white, and half (50%) were female.

Table 8.3-9 Population Characteristics of Members Enrolled in the CSP-TPP Program

Variable	CY2023-CY2024 N = 128 ^a	
Age at Start Date – mean, SD*	42.4	11.5
DxCG – mean, SD^b	3.7	3.9
RxCG – mean, SD^b	2.6	3.5
Race/Ethnicity, n, %		
White	36	28.1%
Black	22	17.2%
Other/Unknown	70	54.7%
Female Sex, n, %	64	50.0%

Data Source: MassHealth administrative data and MassHealth claims and encounters data, CY2023-2024

Abbreviations: Community Support Program Tenancy Preservation Program (CSP-TPP); Calendar Year (CY); Diagnostic Cost Group (DxCG); Prescription Drug Cost Group (RxCG); Standard Deviation (SD)

Notes: DxCG is diagnosis-based relative risk score of medical morbidity. DxCG risk scores are standardized to a mean of 1. RxCG is pharmacy drug claims-based relative risk score of medical morbidity. At risk of homelessness is defined as having 3+ addresses within the measurement period.

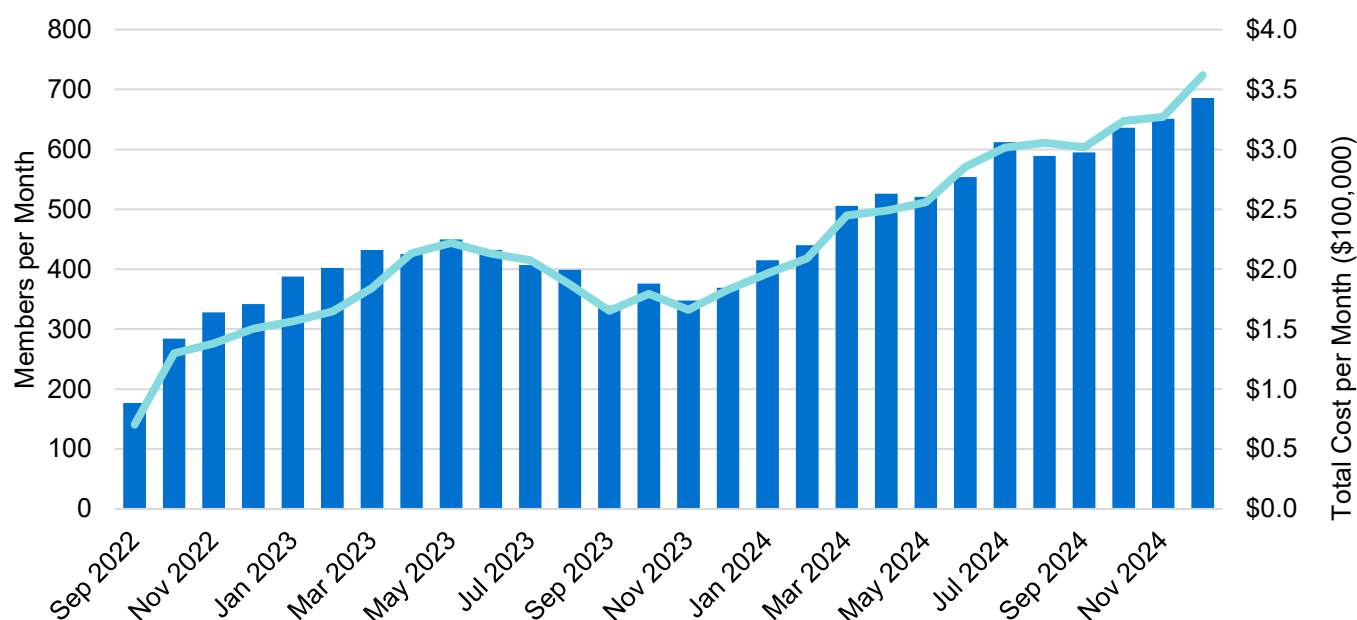
^a Missing demographic data for 23 members.

^b Categories were combined because cell sizes were fewer than 11.

Community Support Program for Individuals with Justice Involvement (CSP-JI)

The CSP-JI services began in September 2022, enrolling 3,169 unique members through the end of 2024. In the first month, 177 members utilized CSP-JI services with an associated cost of \$70,316. (See **Figure 8.3-4.**) Utilization grew steadily and in December 2024, 686 members utilized CSP-JI services with an associated cost of \$362,019. The total cost for the period was \$6,093,846 while the PMPM cost was \$482.

Figure 8.3-4 CSP-JI Utilization and Cost Trends for 2022-2024



Data Source: Medicaid administrative data

Abbreviation: Community Support Program for Individuals with Justice-Involvement (CSP-JI)

Notes: The bar chart represents utilization (members using services per month) while the line represents total cost per month (\$100,000).

From September 2022 through December 2024, CSP-JI participants had a mean age of about 40 years and higher than average medical morbidity (DxCG ~2.5; RxCG ~1.7) (see **Table 8.3-10**). A little more than half were white, with Black participants representing about 15% of program members. Less than one-fifth were females (~15%), roughly 18% had a disability designation, and roughly half were homeless or at risk of homelessness.

Table 8.3-10 Population Characteristics of Members Enrolled in the CSP-JI Program

Variable	CY2022 N = 511		CY2023 N = 1,123		CY2024 N = 1,535	
Age at Start Date – mean, SD	39.7	10.6	39.7	10.0	40.2	10
DxCG ^a – mean, SD	2.4	3.1	2.4	3.5	2.7	3.5

Variable	CY2022 N = 511		CY2023 N = 1,123		CY2024 N = 1,535	
RxCG^a – mean, SD	1.6	1.9	1.7	1.3	1.9	2.4
Race/Ethnicity, n, %						
Black ^b	73	14.3%	168	15.0%	232	15.1%
White ^b	279	54.6%	643	57.3%	755	49.2%
Native American/Asian/Pacific Islander ^b	NR	NR	23	2.0%	16	1.0%
Hispanic ^b	36	7.0%	74	6.6%	93	6.1%
Prefer not to say/Missing	212	41.5%	419	37.3%	566	36.9%
Female, Sex, n, %^b	74	14.5%	188	16.7%	219	14.3%
Homeless or at Risk of Homelessness, n, %	247	48.3%	580	51.6%	820	53.4%
Rural, n, %^c	19	3.7%	34	3.0%	51	3.3%

Data Source: MassHealth administrative data and MassHealth claims and encounters data, CY2023-2024

Abbreviations: Community Support Program for Individuals with Justice-Involvement (CSP-JI); Calendar Year (CY); Diagnostic Cost Group (DxCG); Prescription Drug Cost Group (RxCG), Standard Deviation (SD)

Notes: DxCG is diagnosis-based relative risk score of medical morbidity. DxCG risk scores are standardized to a mean of 1. RxCG is pharmacy drug claims-based relative risk score of medical morbidity. At risk of homelessness is defined as having 3+ addresses within the measurement period.

^a DxCG and RxCG Missing: only available on 507 in 2022; 1,099 in 2023; and 1,424 in 2024;

^b Race/Ethnicity Missing: only available on 4 in 2022; 24 in 2023; 113 in 2024;

^c Rural Missing: only available on 76 in 2022, 27 in 2023; and 120 in 2024

8.3.6.3 Conclusions

The FSP served 37,421 MassHealth members with significant social and medical needs from April 2023 through December 2024. FSP enrollment grew through early 2024, with expenditures increasing from \$26 million in CY2023 to \$42 million in CY2024, with a majority directed towards nutrition supports. Enrollment and spending declined in the second half of 2024 as the program transitioned to HRSN Supplemental Services, which launched on Jan. 1, 2025.

Specialized CSP programs showed varied growth and utilization patterns. CSP-HI experienced rapid uptake after launching on April 1, 2023, due to members enrolling in CSP-HI from a retired similar service, enrolling 3,749 members with total costs of approximately \$27 million through December 2024. CSP-TPP served a smaller cohort of 128 individuals, with moderate costs of \$337,422 during this timeframe. CSP-JI steadily expanded to 686 members per month by December 2024, enrolling 3,169 total members with total costs of \$6.1 million.

Across programs, participants were medically complex, with high medical morbidity scores and rates of disabilities (enrolled in DMH, DDS, or eligible for MassHealth due to a disability) and substantial social risk factors, including homelessness. These findings demonstrate the need for tailored supports and provide a benchmark for anticipating how future program changes may influence enrollment and costs.

8.3.7. RQ7-7 What was the effect of the FSP, Specialized CSP, Temporary Housing Assistance and Homeless Medical Respite, and Reentry Services on HRSNs?²⁷⁵

8.3.7.1 Summary of Results

Among 8,768 FSP nutrition support recipients who completed baseline and end of program surveys, household food insecurity declined from 92.8% at program start to 79.6% at program end, a significant 13 percentage point reduction. FSP housing supports improved housing security among 4,789 participants, with housing insecurity falling from 81.2% to 58.3%, a 23-percentage point reduction. Data were not available to assess housing outcomes for the CSP-HI and CSP-TPP programs during 2022 to 2024. CSP-JI participants achieved improvements in housing stability, with the proportion of participants in unstable housing decreasing from 18% to 14% and those owning or renting a home increasing from 11% to 16%. Employment outcomes also improved for CSP-JI participants, with the share of employed rising from 15% to 34% and those actively looking for work declining from 70% to 44%, potentially as a result of becoming employed. Overall, these results indicate that FSP and CSP-JI programs positively impacted members, particularly in food security, housing stability, and employment.

8.3.7.2 Results

H7-7.1 FSP nutrition supports increase food security.

Food insecurity was measured using surveys at FSP program start and program end for nutrition recipients using the 2-item Hunger Vital Sign. About half (49.3%) of participants did not respond to complete the final survey or declined to answer the questions on food insecurity. In total, 8,768 FSP nutrition recipients completed an initial survey at program enrollment and a final survey at the end of their services.

Table 8.3-11 Food Insecurity Rates Among FSP Nutrition Participants at Program Start and Program End

Outcome	Frequency	Percent
Food Insecurity at FSP Start	8,134	92.8%
Food Insecurity at FSP End	6,976	79.6%
Change from FSP Start to End	- 1,158	- 13.2 percentage points

Data Source: Flexible Services Administrative Data

Abbreviation: Flexible Support Program (FSP)

Notes: A total of 8,768 FSP nutrition recipients completed the initial and final surveys. Statistical significance for the change in food insecurity rates was assessed using a two-sample test of proportions ($p < 0.001$).

Among these 8,768 FSP nutrition recipients, 92.8% reported household food insecurity at the start of the program, which declined to 79.6% experiencing household food insecurity at the end of the program (**Table 8.3-11**).²⁷⁶ In other words, there was a modest but significant 13 percentage point reduction in the proportion of FSP participants experiencing food insecurity at the end of the program ($p < 0.001$). Generalized Estimating Equation (GEE) modified Poisson

²⁷⁵The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

²⁷⁶ This data is collected on the first date of service utilizing the Hunger Vital Signs. Screening for eligibility of the service may have been completed on a different date with a different screener dependent upon the ACO

models also assessed the relative change in food insecurity from baseline to program end among participants and accounted for missing data using inverse probability of censoring weights. The relative risk of experiencing food insecurity after FSP receipt was 0.85 (95%CI: 0.84, 0.86; $p < 0.001$), corresponding to a 15% decrease in food insecurity as compared to baseline, adjusted for participant characteristics that may impact missing data.

H7-7.2 FSP housing supports increases housing security.

Housing insecurity was measured using surveys at FSP program start and program end for nutrition recipients. Respondents who were experiencing homelessness and those who were worried they would lose housing were categorized jointly as housing insecure. More than one-third (37.8%) of participants did not respond to complete the final survey or declined to answer the question about housing insecurity. In total, 4,789 FSP housing recipients completed an initial survey at program enrollment and a final survey at the end of their services.

Table 8.3-12 Housing Insecurity Rates Among FSP Tenancy Service Participants at Program Start and Program End

Outcome	Frequency	Percent
Housing Insecurity at FSP Start	3,887	81.2%
Housing Insecurity at FSP End	2,791	58.3%
Change from FSP Start to End	- 1,096	- 22.9 percentage points

Data Source: Flexible Services Administrative Data

Abbreviation: Flexible Support Program (FSP)

Notes: A total of 4,789 FSP tenancy service recipients completed the initial and final surveys. Statistical significance for the change in food insecurity rates was assessed using a two-sample test of proportions ($p < 0.001$).

Among these 4,789 FSP housing recipients, 81.2% reported housing insecurity at the start of the program, which declined to 58.3% experiencing housing insecurity at the end of the program (**Table 8.3-12**).²⁷⁷ In other words, there was a significant 23 percentage point reduction in the proportion of FSP participants experiencing housing insecurity at the end of the program ($p < 0.001$). GEE modified Poisson models also assessed the relative change in housing insecurity from baseline to program end among participants and accounted for missing data using inverse probability of censoring weights. The relative risk of experiencing housing insecurity after FSP receipt was 0.72 (95%CI: 0.70, 0.74); $p < 0.001$), corresponding to a 28% decrease in housing insecurity as compared to baseline, adjusted for participant characteristics that may impact missing data.

H7-7.4 CSP-JI and Reentry Services increases housing security.²⁷⁸

CSP-JI staff assessed participants' housing status at enrollment and disenrollment. At enrollment, nearly one-third of individuals lived in sober housing. (See **Table 8.3-13**.) Nearly one-fifth (18%) of members had unstable housing (living in a shelter, couch surfing, or temporarily staying with a friend). Approximately one-fifth (18%) of members lived with a relative or guardian and only one in 10 (11%) lived in rented housing or owned a home. At

²⁷⁷ This data is collected on the first date of service utilizing the Hunger Vital Signs. Screening for eligibility of the service may have been completed on a different date with a different screener dependent upon the ACO.

²⁷⁸ The Reentry demonstration is not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate this program in later years of the demonstration based on Reentry implementation, with results reported solely in the IESR.

disenrollment, there was an increase in housing stability observed relative to enrollment with a five-percentage point increase in the percent owning or renting and a four-percentage point decrease in the percent in unstable housing. There was also some recidivism, with under 5% of members in jail or prison at the time of CSP-JI disenrollment.

Table 8.3-13 Housing Status of CSP-JI Members at Enrollment and Disenrollment

Housing Status	Percent of CSP-JI Members at Enrollment (N = 2,694)	Percent of CSP-JI Members at Disenrollment (N = 1,611)
Own/Rent	11.1%	16.0%
Relative/Guardian's Home	18.4%	18.2%
Sober Home	31.3%	23.3%
Unstable	17.9%	14.1%
Jail/Prison	--	4.8%
Other/Unknown	21.3%	23.6%

Data Source: Medicaid administrative data and CSP-JI program reports

Abbreviation: Community Support Program for Individuals with Justice-Involvement (CSP-JI)

Notes: Data was available from nine CSP-JI providers who also deliver the Commonwealth's Behavioral Health Supports for Justice Involved Individuals (BH-JI) program. There were 475 missing and 211 unknowns at enrollment; there were 1,008 missing and 258 unknowns at disenrollment. "Unstable housing" includes living in a shelter, couch surfing, and temporarily staying with a friend. The population are those individuals who have initial CSP-JI claims/encounters at some time between September 2022 through December 2024. Data is cross-sectional and there are some differences in the composition of enrollment and disenrollment groups. Enrollment spans of fewer than 30 days were not included in the disenrollment statistics.

CSP-JI staff also assessed participant's employment status at enrollment and disenrollment. At enrollment, approximately 15% of members were employed. This increased to 34% at disenrollment (see **Table 8.3-14**) and, correspondingly, the percentage of members who were not employed and looking for work decreased.

Table 8.3-14 Employment Status of CSP-JI Members at Enrollment and Disenrollment

Housing Status	Percent of CSP-JI Members at Enrollment (N = 2,695)	Percent of CSP-JI Members at Disenrollment (N = 1,600)
Employed Part-time or Full-time	14.7%	33.6%
Not Employed, Looking for Work	69.8%	43.7%
Unable to Work/Disability	6.2%	9.3%
Other/Unknown	9.4%	13.4%

Data Source: Medicaid administrative data and CSP-JI program reports

Abbreviation: Community Support Program for Individuals with Justice-Involvement (CSP-JI)

Notes: Data was available from nine CSP-JI providers who also deliver the Commonwealth's Behavioral Health Supports for Justice Involved Individuals (BH-JI) program. There were 474 missing and 81 unknowns at enrollment; there were 1,019 missing and 64 unknowns at disenrollment. The population are those individuals who have initial CSP-JI claims/encounters at some time between September 2022 through December 2024. Data is cross-sectional and there are some differences in the composition of enrollment and disenrollment groups. Enrollment spans of fewer than 30 days were not included in the disenrollment statistics.

8.3.7.3 Conclusions

Receipt of FSP nutrition and housing services was associated with significant improvements in food insecurity and housing insecurity among program participants. There was evidence that the program had a greater impact on improving self-reported housing insecurity than food insecurity, although both measures improved. Since available data could not distinguish between severity of food insecurity (i.e., very low versus low food insecurity), any partial improvements in household food insecurity status were not observable. While data were not available to assess housing outcomes for CSP-HI and CSP-TPP members during this period, CSP-JI members also showed improvements in housing stability and employment. Collectively, these findings highlight the potential for FSP and Specialized CSP programs to enhance food security, housing stability, and employment among medically and socially vulnerable populations, and offer a critical evidence base to guide future evaluation of investments in social and housing supports.

*8.3.8. RQ7-9 What were the effects of FSP, Specialized CSP, Temporary Housing Assistance, Homeless Medical Respite, and Reentry Services on physical and mental health outcomes?*²⁷⁹

8.3.8.1 Summary of Results

FSP service recipients that completed the survey at baseline and end of program enrollment had improvements in both self-reported physical and mental health. Among 15,073 participants, the proportion reporting good, very good, or excellent physical health increased from 49% at program start to 62% at program end. Similarly, among 13,486 participants, the proportion reporting good, very good, or excellent mental health increased from 47% to 58% over the course of participation. Data were not available to assess the effects of Specialized CSPs services on physical and mental health outcomes.

8.3.8.2 Results

H7-9.1. FSP services improved self-reported physical health.

Self-reported physical health was measured using surveys at FSP program start and program end for both nutrition and tenancy support recipients. Physical health was assessed using the Clinician & Group Consumer Assessment of Healthcare Providers and Systems survey. About two in five (43.8%) of participants did not respond to complete the final survey or declined to answer the question on physical health. In total, 15,073 FSP recipients completed an initial survey at program enrollment and a final survey at the end of their services.

²⁷⁹The Homeless Medical Respite Service (HMRS), Temporary Housing Assistance (THA), and Reentry program are not included in our evaluation results in the IEIR for this research question and corresponding hypotheses. We will evaluate these programs in later years of the demonstration based on their initiation dates, with results reported solely in the IESR.

Table 8.3-15 Self-Reported Physical Health Status Among FSP Participants at Program Start and Program End

Self-Reported Physical Health Status	FSP Start (N, %)	FSP End (N, %)	Percentage Point Change from FSP Start to FSP End
Poor	2,212 (14.7%)	1,457 (9.7%)	- 5.0
Fair	5,455 (36.2%)	4,331 (28.7%)	- 7.5
Good	5,146 (34.1%)	6,252 (41.5%)	+ 7.4
Very Good	1,354 (9.0%)	1,883 (12.5%)	+ 3.5
Excellent	906 (6.0%)	1,150 (7.6%)	+ 1.6

Data Source: Flexible Services Administrative Data

Abbreviation: Flexible Support Program (FSP)

Notes: 15,073 FSP participants had both a baseline and final survey response for self-reported physical health status. Statistical significance was assessed using the Wilcoxon signed rank test for comparison of ordinal variables ($p < 0.001$).

Among these 15,073 FSP recipients, 49.1% reported being in good, very good, or excellent health at the start of the program, which increased to 61.6% experiencing good, very good, or excellent health at the end of the program (**Table 8.3-15**). In other words, there was a significant 12.5 percentage point increase in the proportion of FSP participants experiencing positive physical health status at the end of the program ($p < 0.001$). Ordinal logistic regression models also assessed the relative change in physical health status from baseline to program end among participants and accounted for missing data using inverse probability of censoring weights. The odds ratio for improving one category in self-reported physical health after FSP receipt was 1.68 (95%CI: 1.60, 1.76; $p < 0.001$) as compared to baseline, corresponding to a 68% increase in the odds of experiencing improved physical health, adjusted for participant characteristics that may impact missing data.

H7-9.2. FSP services improved self-reported mental health.

Self-reported mental health was measured using surveys at FSP program start and program end for both nutrition and tenancy support recipients. Mental health was assessed using the Clinician & Group Consumer Assessment of Healthcare Providers and Systems survey. About half (50.7%) of participants did not respond to complete the final survey or declined to answer the question on mental health. In total, 13,486 FSP recipients completed an initial survey at program enrollment and a final survey at the end of their services.

Table 8.3-16 Self-Reported Mental Health Status among FSP Participants at Program Start and Program End

Self-Reported Physical Mental Status	FSP Start (N, %)	FSP End (N, %)	Percentage Point Change from FSP Start to FSP End
Poor	2,001 (14.8%)	1,307 (9.7%)	- 5.1
Fair	5,102 (37.8%)	4,389 (28.7%)	- 9.1
Good	4,489 (33.3%)	5,561 (41.2%)	+ 7.9
Very Good	1,089 (8.1%)	1,377 (10.2%)	+ 2.1
Excellent	805 (6.0%)	852 (6.3%)	+ 0.3

Data Source: Flexible Services Administrative Data

Abbreviation: Flexible Support Program (FSP)

Notes: 13,486 FSP participants had both a baseline and final survey response for self-reported mental health status. Statistical significance was assessed using the Wilcoxon signed rank test for comparison of ordinal variables ($p < 0.001$).

Among these 13,486 FSP recipients, 47.4% reported being in good, very good, or excellent health at the start of the program, which increased to 57.7% experiencing good, very good, or excellent health at the end of the program (**Table 8.3-16**). In other words, there was a significant 10.3 percentage point increase in the proportion of FSP participants experiencing positive mental health status at the end of the program ($p < 0.001$). Ordinal logistic regression models also assessed the relative change in mental health status from baseline to program end among participants and accounted for missing data using inverse probability of censoring weights. The odds ratio for improving one category in self-reported mental health after FSP receipt was 1.52 (95%CI: 1.45, 1.60; $p < 0.001$) as compared to baseline, corresponding to a 52% increase in the odds of experiencing improved mental health, adjusted for participant characteristics that may impact missing data.

8.3.8.3 Conclusions

Among FSP participants who completed both surveys, meaningful improvements were observed in both self-reported physical and mental health. These findings suggest that FSP nutrition and housing supports not only address HRSNs but may also contribute to downstream improvements in overall well-being. While data were not available to assess the effects of Specialized CSP on physical and mental health during this period, the results from surveyed FSP participants underscore the potential for integrated social services to improve self-rated health among high-risk populations. Previous research supports that more favorable self-rated health outcomes are correlated with health improvements.²⁸⁰ Collectively, these findings reinforce the importance of incorporating social supports into healthcare strategies and the value of investment in these services.

8.3.9. RQ7-11 *Were the Health-Related Social Needs (HRSN) Integration Fund infrastructure investments effective in supporting the development and implementation of HRSN Services?*

8.3.9.1 Summary of Results

CMS approved up to \$25 million in expenditure authority for HRSN infrastructure investments for the first four years of the demonstration. This funding is meant to support the development and implementation of HRSN Supplemental Services, including support for activities related to technology (e.g., case management and billing systems), operational practices, workforce development, and outreach and education.²⁸¹ In the first three years of the Demonstration, this funding has supported technical assistance for organizations interested in and already providing HRSN Supplemental Services. It also supported approximately \$9.7 million in direct grants to 35 CBOs. CBO representatives shared positive feedback about the assistance they received. Grant funds were crucial for HRSN Supplemental Services implementation. CBOs reported using the funds for updating service platform technology, paying for billing systems and vendors, and

²⁸⁰ Nehme, M., Schrepft, S., Baysson, H. et al. Associations Between Healthy Behaviors and Persistently Favorable Self-Rated Health in a Longitudinal Population-Based Study in Switzerland. *J GEN INTERN MED* 39, 1828–1838 (2024).

²⁸¹Centers for Medicare & Medicaid Services. *MassHealth Section 1115 Demonstration Special Terms and Conditions*, U.S. Department of Health and Human Services (2024)

covering staff costs during the transition from Flexible Services to HRSN Supplemental Services.

8.3.9.2 Results

H7-11.1. The HRSN Integration Fund infrastructure investments supported the development and implementation of HRSN Supplemental Services.

From 2024 to 2025, HRSN infrastructure investments (i.e., “the HRSN Integration Fund”) were used for technical assistance and direct grants to CBOs. MassHealth contracted with Health Resources in Action (HRiA) to implement these activities. HRiA also served in a similar role supporting CBOs during the 2017–2022 Demonstration. HRiA and MassHealth staff partnered to deliver seven webinars and associated resources in 2024. These were aimed at preparing CBOs for the transition from Flexible Services to the HRSN Supplemental Services model, and addressed topics such as contracting, claims, and financial management. In interviews, several CBO representatives mentioned that the technical assistance sessions were helpful for understanding the upcoming program changes. Some CBO interviewees also participated in a Social Services Integration Working Group and in office hours with MassHealth and other CBOs where they raised questions and provided feedback on program implementation.

The HRSN Integration Fund grant application process launched in August 2024. The maximum grant award was \$250,000 per applicant or \$500,000 if the applicant was applying for the purpose of establishing a “Hub” (**Table 8.3-17**). The Hub model allows for one “Parent Entity” CBO to perform administrative functions and support its “Satellite Entities” (other CBOs) in key areas such as credentialing, contracting, and claims management.²⁸² Awardees were announced in January 2025. Approximately \$9.7 million was awarded to 35 CBOs, of which seven applied for the purpose of establishing a Hub.

Table 8.3-17 HRSN Integration Fund CY2025 Grant Distribution

	Number of Awardees	Award Range	Total Amount
Individual Awardees	28	\$125,000–\$250,000	\$6,428,588
Hub Awardees	7	\$358,907–\$500,000	\$3,292,687

Data Source: HRSN Integration Fund award data provided by MassHealth

Abbreviation: Calendar Year (CY); Health-Related Social Needs (HRSN)

Notes: The HRSN Integration Fund grant application process was launched in August 2024 to support the transition to the HRSN Supplemental Services. The maximum grant award was \$250,000 per applicant or \$500,000 if the applicant was applying to establish a Hub. The Hub model allows for one “Parent Entity” to perform administrative functions and support its “Satellite Entities” in key areas such as credentialing, contracting, and claims management.

For CBO interviewees who confirmed their organization had received HRSN Integration Fund grants, these funds were crucial. They reported that their CBOs used the funds for updating service platform technology, paying for billing systems and vendors, and covering staff costs during the transition. CBOs also shared various feedback to improve future rollout of HRSN

²⁸² Centers for Medicare & Medicaid Services. *Application Procurement For MassHealth Health Related Social Needs (HRSN) Integration Fund Grant*. U.S. Department of Health and Human Services (2024)

integration fund grants. One CBO representative shared that because they were uncertain about receiving the grant until after HRSN Supplemental Services began in January 2025, they could not depend on that funding during their planning. Another CBO shared a concern about the sustainability of their program when the grant ends.

8.3.9.3 Conclusions

HRSN infrastructure investments were essential to the implementation of HRSN Supplemental Services. MassHealth successfully engaged CBOs in technical assistance to strengthen service delivery and address operational needs for the transition to HRSN Supplemental Services in 2025. Awardees used grant funding to support their workforce and technology needs during this transition, but expressed concerns that without future grant support, continuing to make necessary updates to information technology platforms would be a challenge and affect sustainability.

8.3.10. RQ7-12 What were the impacts of FSP/Specialized CSP Medicaid spending on local investments on comparable services; for example, housing and nutrition?

8.3.10.1 Summary of Results

A key goal of the FSP and Specialized CSPs was to strengthen clinical-to-community linkages to address HRSNs, and we hypothesized Medicaid spending would stimulate non-Medicaid investments to address HRSNs and partnerships between CBOs and local and state agencies to identify and fill service gaps. We found that the FSP and Specialized CSPs strengthened clinical-to-community linkages and expanded housing and nutrition service options in Massachusetts, while providing critical funding that helped organizations sustain staff and services. This support also positioned local organizations to access additional funding opportunities, reinforcing the capacity and sustainability of community-based services.

8.3.10.2 Results

H7-12.1. FSP and Specialized CSP Medicaid spending strengthened clinical-to-community linkages and non-Medicaid funding to address HRSNs among FSP and Specialized CSP providers.

CBOs partnered with a number of stakeholders in order to deliver HRSN housing and nutrition services. Their relationships with ACOs and MCOs were catalyzed by the FSP and Specialized CSPs, especially given that the majority of MassHealth members are enrolled in ACOs and MCOs. ACOs and MCOs helped provide CBOs with clinical information about MassHealth members including details on members' medical needs and MassHealth eligibility. CBOs shared that the FSP and Specialized CSPs led to a strengthening of their partnerships with ACOs and MCOs. (See **RQ7-4**).

"I think the organization has kept up with [ACO/MCO partnerships] now and diversifying who our partners are and who the funders are through the BHCP [Behavioral Health Community Program] and CBHC [Community Behavioral Health Center] and some of the other

programs that we're working directly with MassHealth and with the ACOs and MCOs." – a CBO representative (HP143105)

A few CBOs also described that the financial support of the HRSN programs has helped them expand their service populations and infrastructure, leading to access to more funding opportunities.

"MassHealth Flexible Services and now HRSN program expanded access to services and allowed us to just serve more individuals, which then had some downstream effect on research partnerships that we are able to develop, or grants associated with different populations that we're serving. And I definitely think that the relationship and the ability to serve MassHealth members through this expanded our ability to get funded in other parts of our operations for serving clients." – a CBO representative (HP173900)

Additionally, CBOs referenced the instability of financing for HRSN service providers. Despite some CBOs having more funding opportunities, multiple organizations expressed that without the HRSN programs, they would have to face difficult workforce reduction decisions. One CBO interviewee said, *"if we didn't have the CSP-HI revenue, we would have to most likely look at reducing our staffing."* (CBO representative)

H7-12.2. FSP and Specialized CSP providers partnered with local and state entities to identify and fill service gaps in HRSN services.

CBOs worked with numerous state and local entities to identify members for referral to community-based services, the FSP, and Specialized CSPs (See **RQ7-4** and **RQ7-5**). Referral sources included health centers, shelters, Department of Corrections, other CBOs, and members themselves (self-referrals). CBOs shared that "continuous communication," information sharing, and organizational structure integration, such as sitting on advisory boards with partnering agencies and other CBOs, has led to successful member interventions, even when a member's needs are outside of the service scope of the initial CBO.

"If there is an individual that's looking for things outside of nutrition or housing, even just referring them to the councils on aging — we have [a] pretty good relationship with those in all of our service area. And that is just continuous communication with them...But we do sit on a lot of different committees or advisory boards...So, I think a lot of the information can be shared through that...that puts us in a room with a lot of individuals that we can share information about what we're doing as it relates to their clients, if it could be helpful for them. And then, same thing, we hear things from them that we can connect our clients to if it's something beyond our scope." – a CBO representative (HP077632)

A lack of available services was a key barrier to addressing MassHealth member needs. CBOs shared particular concerns about the lack of available housing options in Massachusetts, saying *"there are sort of these structural problems,"* alluding to a lack of funding and a general overwhelming need for housing (CBO representative). Despite these challenges, CBOs shared

that FSP and Specialized CSPs helped fill in some of the service gaps that they face. One CBO interviewee said the CSP-HI and CSP-TPP programs have been essential for growing their tenancy support capacity.

“The launch of CSP and the kind of growth and positive changes with that over the years, it’s definitely let us grow our PSH [permanent supportive housing] portfolio, because, you know, we can get capital financing from the state or feds or municipalities, but it very rarely comes with adequate support dollars.” – a CBO representative (HP454077)

Regarding nutrition, CBOs highlighted that their partnerships with other local organizations were useful for filling service gaps for hard-to-reach populations like families who have children with food allergies, and individuals who face barriers accessing food pantries.

“There are folks that have a challenge getting to the food pantries, so something that delivers. And there’s a program called Lasagna Love or something like that, where they — if they have volunteers in the community, they will make a lasagna and bring it out to the family. And there’s usually enough to freeze later, so I’ve had two people that have accepted that.” – a CBO representative (HP953004)

8.3.10.3 Conclusions

MassHealth spending helped strengthen local HRSN infrastructure and catalyze additional investments in housing and nutrition services. CBOs reported that program funding enabled them to expand service capacity, sustain staff, and reach more individuals. The programs also reinforced partnerships with ACOs, MCOs, and other local organizations, fostering collaborations that enhanced both service delivery and organizational stability. By filling critical service gaps and supporting workforce and infrastructure development, FSP and Specialized CSPs addressed the immediate needs of members, but also helped CBOs build the foundation for longer-term sustainability with investment from local and state organizations in comparable community-based services.

8.4. Discussion

8.4.1. Interpretation, Policy Implications, and Interactions with Other State Initiatives

New enrollments for the FSP increased throughout most of the 2023-2024 period, with declines in the second half of 2024 as ACOs reduced referrals in anticipation of the FSP ending. The FSP served 37,421 MassHealth members during this evaluation period. Similarly, Specialized CSP programs, including CSP-HI, CSP-TPP, and CSP- JI, enrolled thousands of members with substantial social and medical needs, and provided tailored supports such as tenancy case management, employment assistance, and targeted service coordination. CSP-HI experienced rapid adoption in the first month of implementation, due to members enrolling in CSP-HI after the sunset of a similar service, and steady increases in enrollment thereafter, enrolling a total of 3,749 members with costs of approximately \$27 million from April 2023 through December 2024. CSP-TPP served a smaller cohort of 128 members and total program costs of

approximately \$337,422 over the evaluation period. CSP-JI steadily expanded enrollment over time, serving a total of 3,169 members. Together, FSP and Specialized CSP programs served over 40,000 MassHealth members with complex needs. Across FSP and Specialized CSP programs, participants were medically complex, with high morbidity scores, disability rates, and substantial social risk factors, including homelessness.

The FSP appeared to achieve its goal of improving members' HRSNs, with measurable improvements in self-reported food insecurity, housing insecurity, physical health status, and mental health status among those for whom we have program end data, which is only half of the program. It is possible our outcomes would be further improved if we had complete program data. The 22 percentage point reduction in housing insecurity among FSP housing participants is particularly encouraging, especially recognizing that the program did not directly provide funding for housing to participants, but rather invested in pre-tenancy, transitional supports, home modifications, and tenancy sustaining supports with case management to help members secure, maintain, and remediate housing. CSP-JI members also demonstrated improvements in housing stability, employment, and access to supportive services, reflecting positive impacts on broader social determinants of health. The convergence of multiple patient-centered outcomes improving jointly also strengthens the evidence of program impact and supports the findings from the 2017–2022 Demonstration which found beneficial effects of FSP on acute health care utilization and costs.²⁸³ In sum, the findings from the 2017–2022 Demonstration combined with data from the current 2022-2027 interim evaluation show that Medicaid nutrition and housing supports can improve members' social needs, self-reported health, and perceived overall well-being, while reducing acute health care utilization and costs.

Most FSP participants still reported nutrition and housing insecurity at the end of their FSP participation. This is consistent with findings from other state Medicaid contexts. For example, the Healthy Opportunities Pilots (HOP) in North Carolina interim evaluation found that food insecurity and housing insecurity improved among participants, but that HOP did not fully eliminate these needs.²⁸⁴ The effect sizes we observed were also consistent with other peer-reviewed studies of food and housing interventions. In a randomized trial that provided medically tailored meals to low-income patients with diabetes, food insecurity prevalence declined by 20 percentage points.²⁸⁵ FSP participation was associated with a 13 percentage point reduction in the proportion of FSP participants experiencing food insecurity. Considering that medically tailored meals (MTMs) were the most intensive FSP nutrition service (and, therefore, we would expect larger effects of MTMs on food insecurity), the observed 13 percentage point reduction in food insecurity across all types of FSP nutrition services is reasonably aligned with existing scientific literature.

²⁸³ Hager, K., Sabatino, M., Williams, J., Ash, A. S., Halasa-Rappel, Y., Flahive, J. M., Min, H. S., Sing, G., Buckler, S., Rich, A., Bowman, J., Himmelstein, J., & Alcusky, M. J. (2025). *Medicaid nutrition supports associated with reductions in hospitalizations and ED visits in Massachusetts, 2020-23*. Health Affairs, 44(4), 413-421. <https://doi.org/10.1377/hlthaff.2024.01409>

²⁸⁴ Cecil G. Sheps Center for Health Services Research. *NC Healthy Opportunities Pilots Interim Evaluation Report*, North Carolina Department of Health and Human Services – Division of Health Benefits (2024)

²⁸⁵ Berkowitz, S. A., Delahanty, L. M., Terranova, J., Steiner, B., Ruazol, M. P., Singh, R., Shahid, N. N., & Wexler, D. J. (2019). Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: a Randomized Cross-over Trial. *Journal of general internal medicine*, 34(3), 396–404. <https://doi.org/10.1007/s11606-018-4716-z>

In parallel with service delivery, early HRSN screening under AQEIP and HQEIP was implemented across ACOs and hospitals, with wide variation in prevalence and workflows. ACOs generally exhibited low screening rates at the member level, while hospitals had higher but inconsistent encounter level screening for inpatient visits and observational stays. These screening efforts were critical for identifying high-risk members for FSP and Specialized CSP enrollment, ensuring that services reached those with the greatest social and medical needs.

Findings from member interviews support the survey results showing improvements in food security, housing security, and self-reported health. Members were satisfied with FSP and Specialized CSP services they received, sharing how it positively affected their mental and physical health. Many members shared that they were asked about both their housing and nutritional needs through their clinical care and that they were comfortable discussing these needs with ACO providers and staff. Many members shared positive experiences with being connected to existing community resources and new FSP nutrition services that lessened the burden of food insecurity on members and their families. Members enrolled in Specialized CSP programs similarly reported support navigating housing challenges, employment opportunities, and other social services, highlighting the complementary role of Specialized CSP in meeting diverse member needs. Yet, members also shared challenges navigating services and that their individual preferences were not always reflected in the current service offerings, pointing to a need for ongoing education to members and to better tailor programs so they more effectively meet members' varied needs. In addition, systemic improvements such as refining referral pathways, standardizing screening and eligibility processes across ACOs and hospitals, and enhancing provider training could help reduce variability and ensure more consistent access to services.

Overall, both ACO and CBO interviewees agreed that they had strong relationships for the delivery of FSP and highlighted that clear communication was critical for successful referrals and program implementation. Service providers used member outreach, case management strategies, and frequent communication and information-sharing with ACOs and local organizations to identify, screen, and enroll members in their respective programs. ACOs used standardized workflows and successfully coordinated with CBOs to assess member eligibility and make referrals to FSP programs. Specialized CSP providers also coordinated extensively with local government and state agencies to identify eligible members, deliver person-centered services, and expand housing, employment, and other supports. Overall, interviews from both CBOs and ACOs highlight that health systems can successfully partner with CBOs at scale when supported with technical assistance and funding for investments in health information technology, as was done in Massachusetts during 2023-2024 through the HRSN Integration Fund.

Infrastructure investments (e.g., upgrading referral and data systems at CBOs) were essential to the transition of FSP to HRSN Supplemental Services. MassHealth successfully engaged CBOs in technical assistance to improve service delivery and address operational needs for the transition to HRSN Supplemental Services in 2025. Awardees used grant funding to support their workforce and technology needs during this transition and stated that FSP transition and planning for the HRSN Supplemental Services launch in 2025 would have been very challenging without these key investments.

Collectively, FSP and Specialized CSP programs addressed immediate member needs while also strengthening local HRSN infrastructure, supporting workforce sustainability, and catalyzing some additional funding investment in community-based services to address HRSNs.

8.4.2. *Lessons Learned and Recommendations*

1. **Lesson Learned:** HRSN screening and reporting practices varied across ACOs and hospitals, with low screening rates reported by many ACOs and differences in screening prevalence and workflows observed during early implementation.
 - **Recommendation:** MassHealth should consider providing continued guidance, technical assistance, and opportunities for shared learning across ACOs and hospitals to support more consistent and effective implementation of HRSN screening practices over time.
2. **Lesson Learned:** Referral pathways and eligibility processes varied across providers, and some stakeholders reported challenges navigating available services and determining appropriate referrals.
 - **Recommendation:** MassHealth should consider streamlining the referral processes, educating referring organizations on eligibility criteria, and clarifying eligibility requirements to support more consistent and timely access to HRSN services.
3. **Lesson Learned:** Medicaid-funded nutrition and housing programs can increase rates of food and housing security, as well as patient-centered health measures such as self-reported physical health and mental health.
 - **Recommendation:** Medicaid agencies should continue to invest in and scale successful programs that address member HRSNs and improve health.
4. **Lesson Learned:** Participants were generally satisfied with the FSP services and believed the program helped address their social needs and improved their health. Yet, some members faced challenges navigating services, while others wished they could have more selection in services that met their needs and preferences.
 - **Recommendation:** MassHealth and other Medicaid agencies should prioritize member access (e.g., simple enrollment, home-delivery of food, easy access to participating grocery stores) and choice (e.g., in selection of food, where to shop) to promote better member engagement with services.
5. **Lesson Learned:** CBOs require significant staffing and IT investments to successfully partner with health systems and receive Medicaid payments for their services.
 - **Recommendation:** Medicaid agencies should dedicate resources, including technical assistance and grants, to CBOs that would like to participate in HRSN services but lack the sufficient capacity to partner with health systems.
6. **Lesson Learned:** Significant program restructuring and eligibility changes in initiatives like the FSP contributed to a decline in new enrollments as ACOs cautiously approached the new program requirements. Cessation of services for all participants actively enrolled at the time the FSP was terminated on Dec. 31, 2024 (prior to completion of their service plans) may have also reduced the overall program effectiveness for those who were

forced to end their nutrition and housing services early. Our finding from the 2017–2022 Independent Evaluation Summative Report that FSP participants with <90 days of nutrition services did not achieve reductions in acute health care utilization or health care costs is consistent with this hypothesis.

- **Recommendation:** Whenever feasible, Medicaid agencies should allow participants enrolled at the time of a change in eligibility to complete their services consistent with the eligibility criteria and service plans in place at the time of their enrollment.