Commonwealth of Massachusetts

Executive Office of Health and Human Services

Medicaid Section 1115 Demonstration Project Extension Request

Posted on September 14, 2026

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I. Executive Summary

MassHealth, the Massachusetts Medicaid and Children's Health Insurance Program (CHIP), provides health coverage to nearly 1.9 million people. Since 1997, the MassHealth 1115 demonstration ("the demonstration") has been an important vehicle for advancing delivery system reform, addressing whole person health, improving quality outcomes for members, and creating accountability for costs. The demonstration has enabled the development of new and effective delivery models (including managed and accountable care), supported safety net providers, and provided critical healthcare coverage while stewarding taxpayer dollars responsibly. MassHealth is requesting an extension of its 1115 demonstration.

The current demonstration period, for the years 2022 – 2027, builds upon delivery system reform efforts from previous demonstrations, sustaining the Commonwealth's focus on value-based, accountable care with the goals of improving quality, outcomes, member experience and wellbeing, while managing costs.

MassHealth has made strong progress during this demonstration period as discussed in the attached Independent Evaluation Interim Report (IEIR). More than 90% of eligible MassHealth members are enrolled in Accountable Care Organizations (ACOs), healthcare organizations that take on accountability for improved population-level health outcomes, lower cost, and improved member experience. MassHealth has continued to empower members with substance use disorder (SUD) treatment across the Commonwealth, contributing to a meaningful decrease in opioid overdoses and setting individuals on the path to self-sufficiency. MassHealth has also continued support for critical rural and safety net providers, while linking funding to performance to improve provider accountability.

In addition, the current demonstration authorizes several targeted initiatives to advance quality, efficiency, access, and system modernization. Through the Primary Care Sub-Capitation program, MassHealth has implemented prospective, value-based payment for primary care within ACOs, supporting team–based care models, preventative care, and whole person health. The demonstration also provides authority to launch a Reentry initiative to promote continuity of coverage and care for individuals transitioning from incarceration to the community, with the goal of reducing recidivism and improving health outcomes and self-sufficiency. MassHealth has also established a new generation of evidence-based initiatives providing targeted tenancy supports and nutrition services to address the root causes of chronic disease, which have demonstrated measurable reductions in hospitalization and emergency department (ED) use, thereby improving health for members and reducing costs.[1]

[1] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29, 2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download

MassHealth has also implemented targeted pediatric initiatives in concert with the 1115 demonstration to strengthen access to high-quality, developmentally appropriate care for children and youth, including in primary care, behavioral health (BH), and care coordination. These efforts aim to support early identification and intervention, improve outcomes for children with complex needs, and promote more preventative, coordinated, family-centered care for MassHealth's pediatric population.

Currently, three years into this demonstration, our initiatives have already begun to demonstrate promising results, including more members being connected to primary, preventative care, the shift of services to lower-cost sites and types of care, a decrease in both non-fatal and fatal overdoses, improved coordination of member care, and enhanced member experience and engagement in care. Severe maternal morbidity decreased for ACO enrollees. ACOs reported that care management programs showed positive impacts, including reduction in ED utilization. These results are described further in the Introduction (see Section II).

Despite these successes, important challenges remain. Massachusetts, like states across the country, continues to grapple with rising healthcare costs driven by increasing member acuity, a growing burden of preventable chronic disease and workforce pressures, and persistent gaps in access to primary care and behavioral health services. The cost of healthcare is a growing concern for members, providers, and the Commonwealth alike.

This demonstration extension is a central vehicle for the Commonwealth's affordability strategy: by strengthening prevention, accountability, and value-based care, MassHealth can improve outcomes for members while ensuring responsible stewardship of state and federal resources. MassHealth proposes to continue certain key initiatives through renewed demonstration authorities (see Section III), while making changes to or sunsetting other initiatives as well as requesting new authorities for new initiatives. MassHealth seeks to scale and build on proven models, based on emerging evidence.

This extension of the demonstration offers a critical opportunity to maintain the gains Massachusetts has made and make further progress to drive value-based care that delivers on quality and costs. Massachusetts proposes that its next demonstration period, beginning in 2028, will focus on the following goals:

Goal 1: Continue to promote value by improving access, quality, and efficiency

MassHealth requests authority to continue the ACO program which serves as the foundation for delivering coordinated, whole-person care while creating accountability for cost and outcomes. MassHealth intends to maintain the same core pillars of the ACO program, while pushing to ensure that ACOs deliver even greater value for federal and state taxpayers. ACOs

generated over half a billion dollars in savings under MassHealth's 2017-2022 1115 demonstration, and MassHealth expects to continue to build upon these results. ACOs are held accountable to a robust quality slate, with dollars tied to health outcomes, member experience, and total cost of care. ACOs are also responsible for coordinating care for members, to reduce overall chronic disease burden.

MassHealth is also requesting authority to cover traditional healthcare services for American Indian/Alaskan Native (AI/AN) populations, who generally experience worse health outcomes compared with non-AI/AN populations, particularly in terms of diabetes, tobacco use, and cancer. AI/AN populations also face higher rates of mental health disorders, substance use disorder, and suicide. Traditional healthcare practices, also known as traditional healing or traditional medicine, are a form of culturally competent care that has been shown to improve health and wellness, especially behavioral health and chronic disease prevention. Some common forms of traditional healthcare practices include herbal medicine, sweat lodges, ceremonies, talking circles, and smudging. These practices will allow Indian Health Service (IHS) and tribal facilities to provide the traditional services they know are best for their tribal populations, resulting in improved outcomes and healthy and productive lives.

MassHealth is also proposing a Hospital Innovation and Healthy Communities Program (HIH-C Program) to create greater accountability for key cost, member experience, and quality outcomes through a Care Delivery Innovation (CDI) incentive program that will create accountability for reduced avoidable hospital utilization and enhanced coordination across the healthcare delivery system, as well as a voluntary hospital global budget arrangement. The CDI program will drive evolution towards care models that provide necessary acute care in the lowest-cost, most appropriate setting; interventions that reduce avoidable utilization; and hospital and ACO partnerships to improve transitions of care. MassHealth proposes to pair the HIH-C Program with a Medicare primary care capitation model, aligned with the CMS Innovation Center's Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.[2] This multi-pronged approach will drive state healthcare transformation and multi-payer alignment to improve the overall health of the Massachusetts population while lowering costs.

MassHealth also seeks expenditure authority to make hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin. This authority would protect access for MassHealth members while allowing MassHealth to reduce net Medicaid

[2] Centers for Medicare and Medicaid Services, AHEAD (Achieving Healthcare Efficiency Through Accountable Design) Model, https://www.cms.gov/priorities/innovation/innovation-models/ahead

prescription drug costs and fully participate in CMS Innovation Center's innovative GENEROUS Model (GENErating cost Reductions fOr U.S. Medicaid).[3]

Goal 2: Strengthen innovative care delivery for primary care, behavioral health, and pediatric care, focusing on prevention, chronic disease management, and shifting the delivery system away from siloed, fee-for-service healthcare

MassHealth is committed to advancing primary care as the foundation of the Commonwealth's delivery system to further improve the health of all residents of the Commonwealth. MassHealth requests authority to continue the primary care sub-capitation payment model, which supports and incentivizes evidence-based care while moving providers off the "fee-for-service (FFS) treadmill." This payment model aims to increase Massachusetts residents' access to high-quality, team-based integrated primary care and improve population health. At the practice level, MassHealth aims to improve both the patient's quality of care and the experience of the primary care provider.

MassHealth will also continue to invest in expanded behavioral health access and integration as part of the Commonwealth's *Roadmap for Behavioral Health Reform.*[4] To support these efforts, MassHealth requests authority to continue diversionary behavioral health services, and services for individuals with serious mental illness (SMI) and serious emotional disturbance (SED), including coverage of SUD and SMI/SED services provided in Institutions for Mental Diseases (IMD). These are all critical services in the Commonwealth. MassHealth also seeks new authority to implement contingency management as a non-24-hour diversionary service. Contingency management is an evidence-based intervention for people with Stimulant Use Disorder (StUD) that provides positive reinforcement for healthy behaviors.

The current demonstration authorizes targeted tenancy support and nutrition services to address the root causes of chronic disease and has seen meaningful impacts in healthcare utilization, outcomes, and reduced spending for members receiving these services. MassHealth seeks to continue authority for tenancy supports and nutrition services, which are evidence-based interventions for eligible members.

With the approval of the Reentry Demonstration, MassHealth began the process of supporting individuals transitioning from incarceration to independence in the community. MassHealth has initiated the implementation of policies and operational changes to support timely eligibility

[3] Centers for Medicare and Medicaid Services, GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model, https://www.cms.gov/priorities/innovation/innovation-models/generous

[4] Massachusetts Roadmap for Behavioral Health Reform, https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform

determinations, care coordination, and access to services upon release. Through this extension request, MassHealth seeks authority to continue these reentry-focused efforts, with the goals of improving access to care, supporting successful community reintegration, and reducing avoidable utilization.

Recognizing the unique needs of children, youth, and families, under the current demonstration, MassHealth has also brought enhanced clarity, expectations, and investments to care coordination for children. For example, MassHealth intends to continue the primary care sub-capitation program's focus on improving primary care for pediatric members. Additionally, MassHealth will continue our youth-focused diversionary BH services, including Community Based Acute Treatment (CBAT) and Transitional Care Unit (TCU) services.

Goal 3: Sustainably support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care

Ensuring the stability and sustainability of the Commonwealth's safety net is a core priority of the demonstration extension. Massachusetts requests authority to continue its Safety Net Care Pool (SNCP), which provides essential funding support for both safety net and public, state-owned providers through the Disproportionate Share Hospital (DSH) and Uncompensated Care (UC) Pools.

Goal 4: Maintain near-universal coverage for all eligible Commonwealth residents

To support Massachusetts' high healthcare coverage rate of nearly 98%,[5] MassHealth requests continued authority for all existing eligibility and eligibility/application processing authorities, except for those no longer allowable or that require modification due to changes in federal law or policy. MassHealth acknowledges that changes in federal law will make healthcare coverage harder to maintain, however MassHealth will continue to strive towards this goal, given the importance of healthcare coverage to resident wellbeing and economic prosperity throughout the Commonwealth.

[5] Center for Health Information and Analysis (CHIA), Massachusetts Health Insurance Survey (MHIS), https://www.chiamass.gov/insights-analysis/access/massachusetts-health-insurance-survey/

II. Introduction

Background

MassHealth is the Massachusetts Medicaid and Children's Health Insurance Program that provides health coverage to nearly 1.9 million Massachusetts residents. MassHealth is key to maintaining the Commonwealth's overall level of health insurance coverage at nearly 98%, the highest in the nation. MassHealth covers almost 700,000 children, including just under 35,000 disabled children, with children representing 36% of the MassHealth caseload. MassHealth pays for 37% of the births in the Commonwealth. Seniors represent about 14% of members, and disabled adults under 65 represent about 12% of the MassHealth caseload.

Since it was first approved in 1997, MassHealth's demonstration has been an important vehicle for healthcare innovation and delivery system reform at the state level. The demonstration has enabled Massachusetts to test and scale prevention-oriented, value-based approaches that improve outcomes while ensuring responsible stewardship of federal and state taxpayer dollars. Through the demonstration, MassHealth has established managed care, supported providers through SNCP funding, expanded coverage of behavioral health and SUD services, streamlined coverage and access, and restructured its delivery system. In recent years, the demonstration advanced delivery system reforms towards integrated, value-based care by establishing the ACO model.

On September 28, 2022, the Centers for Medicare and Medicaid Services (CMS) approved MassHealth's current demonstration, effective October 1, 2022, through December 31, 2027. This demonstration continues many of the authorities from the previous demonstration period, such as those authorizing managed care, support and accountability for safety net providers, and promotion of wellness and healthy lifestyles. It also continues and builds upon prior demonstrations' efforts to restructure both the delivery of care and payment models, with the goals of promoting integrated, value-based care, holding providers accountable for the quality and total cost of care, and improving the integration of physical, behavioral, and long-term services and supports to address the root causes of health problems and empower members to take control of their health. These efforts support self-sufficiency, healthier living, and reduced reliance on high-cost, avoidable care. CMS also approved a number of waiver amendments during the current demonstration that have enabled further progress.

Current Demonstration Period (2022-2027)

Goals

As described in MassHealth's Section 1115 Demonstration Project Amendment and Extension

Request (submitted in December 2021), and approved by CMS in September 2022, MassHealth's current demonstration aims to achieve the following goals:

1. **Continue the path of restructuring and reaffirm 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, and pediatric care** that expand access and move the delivery system away from siloed, fee-for-service healthcare
3. **Advance health equity,** with a focus on initiatives **addressing health-related social needs** and specific disparities, including **maternal health** and healthcare for **justice-involved** individuals
4. **Sustainably support the Commonwealth's safety net and maintain near-universal coverage** – including level, predictable funding for safety net providers, with a continued linkage to accountable care
5. **Maintain near-universal coverage**, with updates to eligibility policies to support coverage and equity

Progress

This extension request is being submitted along with the Independent Evaluation Interim Report (IEIR), which examines results from the first three years of the current demonstration (2022–2024). The IEIR documents strong implementation progress and promising early outcomes. In designing this extension request, MassHealth also considered the Independent Evaluation Summative Report (IESR) from the previous demonstration (2017-2022), which was approved by CMS earlier this year.[6] Building on the results of both demonstrations, MassHealth has developed this extension request to maintain and strengthen value-based care and fiscal sustainability, address areas where further progress is needed, and empower MassHealth members to improve their health and reduce burden on the Commonwealth's healthcare system.

The IESR for the 2017-2022 demonstration found that the ACO model demonstrated a high return on investment for state and federal taxpayers: MassHealth's ACO program saved $512 million over the 5-year demonstration period, with a projected 10-year savings of $962 million through 2028. Per-member per-month costs for MassHealth members enrolled in an ACO were significantly lower than they would have been without the Demonstration. Healthcare reforms shifted utilization from high-cost settings to lower-cost outpatient settings while maintaining high levels of member satisfaction in the ACO program. Among MassHealth members in ACOs,

[6] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29,2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download

there were improvements in chronic disease, including diabetes and high blood pressure management, appropriate use of EDs, and timely follow-up after ED visits.

To continue this highly successful path of restructuring and reaffirm accountable, value-based care under the current demonstration, MassHealth has refined its ACO program, building upon lessons learned, while maintaining core pillars and requirements of holding ACOs accountable for high-quality care and outcomes. ACOs are required to coordinate care for all members and have more intensive support for members with high and rising risk. MassHealth has also led the nation in innovative risk adjustment, ensuring value-based care accurately and appropriately incentivizes plans and providers to support complex patients.

Results from the 2017-2022 IESR also demonstrated improvements in successfully addressing SUD for MassHealth members, including decreases in the rates of overdoses and overdose fatalities, improvements in SUD treatment initiation and engagement, increases in the utilization of new SUD services, improvements in SUD quality of care and outcomes, and increases in the number of providers treating SUD. These successes empower members on the path to recovery and to reengage with their communities and employment.

A notable result of the 2017-2022 demonstration is that when we address the root causes of chronic disease, members have improved lifestyle and wellbeing.[7] MassHealth members who received at least 90 days of nutrition supports had a lower total cost of care (-$2,502) which offset the cost of nutrition services per member, leading to a net savings of $210 per member.[8] Hospitalization rates were 23% lower and ED visit rates were 13% lower among those receiving nutrition support services, as compared to eligible non-participants. Hospitalization rates were 18% lower and ED visit rates were 17% lower among those receiving tenancy support services, as compared to eligible non-participants. These successful programs have evolved and continued under the current demonstration, and the attached IEIR also found that nutrition and tenancy supports positively impacted members' physical and mental health and well-being.

Under this demonstration (2022 – 2027), MassHealth deepened its commitment to primary care by investing over $130 million annually between 2023 and 2025 through a new sub-capitation model that requires primary care providers to meet clear standards for access and team-based, integrated care, while giving them more flexibility in the delivery of care to meet their patients' needs. The IEIR shows promising early results for this program, including a successful transition away from claims-based payment.

[7] Ibid.
[8] Hager K., et al.; *Medicaid Nutrition Supports Associated with Reductions in Hospitalizations and ED Visits in Massachusetts, 2020-2023,* Health Affairs, April 2025, https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01409

In broader efforts to improve the health of all residents of the Commonwealth, MassHealth launched a >$2 billion initiative over five years to hold ACOs and ACO-participating hospitals accountable for reducing disparities in healthcare quality and access. Providers improved data collection and reporting on demographic and social risk factors; implemented evidence-based clinical interventions to improve quality and access; and received incentive funding for performance on improving quality and reducing disparities in health outcomes.

The Commonwealth is also committed to improving outcomes for kids and their families and has strengthened expectations for ACOs to invest in pediatric preventive care, primary care access, and care coordination, including through pediatric-focused requirements within the primary care sub-capitation model. The Commonwealth introduced a new targeted Case Management benefit, MassHealth CARES for Kids, to support children with medical complexity.[9]

Additionally, MassHealth implemented policies outside of the demonstration as part of a Maternal Health Bill signed into law in Massachusetts in 2024 to improve maternal health outcomes, including 12-month postpartum eligibility and coverage of doula services. Over 400 doulas who speak over 23 languages are currently enrolled and providing integrated, whole-person healthcare to MassHealth members and their infants. MassHealth also implemented enhanced postpartum depression screening and coverage for midwifery services.

To sustainably support the Commonwealth's safety net, the Commonwealth has invested in safety net providers, increasing Safety Net Provider Payments by $125 million per year and supporting accountable care. Additionally, the State has preserved other long-time funding for the Commonwealth's safety net (e.g., the Health Safety Net).

The Commonwealth also maintained the lowest uninsurance rate in the nation throughout this period. MassHealth made targeted updates to eligibility processes to support coverage including a simplified process for adults with disabilities to qualify for CommonHealth and expanded access to Medicare Savings Programs for members with MassHealth Standard.

Through this demonstration extension request, MassHealth seeks to build on the successes from the previous and current demonstrations, as well as make changes based on lessons learned.

Extension Proposal (2028-2032)

MassHealth proposes maintaining most of our current authorities, while making data and evidence-based changes designed to improve accountability and system efficiency, promote chronic disease prevention, ensure sustainability, and responsibly steward federal and state taxpayer dollars. The extension request aims to promote evidence-based prevention and

[9] CARES for Kids Program Services, https://www.mass.gov/cares-for-kids-program-services

empower MassHealth members to achieve their health goals, while also holding entities accountable for cost and quality of care.

Goals

MassHealth proposes its next demonstration focus upon the following four goals and strategies:

1. Continue to promote value by **improving access, quality, and efficiency**
2. **Strengthen innovative care delivery** for primary care, behavioral health, and pediatric care, focusing on prevention, chronic disease management, and shifting the delivery system away from siloed, fee-for-service healthcare
3. **Sustainably support the Commonwealth's safety net**, including through ongoing, predictable funding for safety net providers with a continued linkage to accountable care
4. **Maintain near-universal coverage** for all eligible Commonwealth residents

Stakeholder Engagement

The strategy proposed in this document is the result of a year-long process of stakeholder engagement throughout the Commonwealth. In October 2025, MassHealth released its Roadmap for its 2028-2032 1115 Demonstration Extension Request and held two public meetings in November 2025 to discuss the demonstration extension request process and the Roadmap.

MassHealth provided periodic updates regarding its planned extension request throughout 2026 and held 6 public meetings to engage with the public and key partners about proposed policies and authorities under consideration.

MassHealth also engaged with existing forums for input and feedback from key partners. MassHealth discussed the proposed 1115 Demonstration Extension Request with its Member Advisory Council, Delivery System Technical Advisory Council, Social Services Integration Working Group, Medical Director’s Forum, and Disability and Eligibility Advocates Meetings.

Public Process

On September 14, 2026 MassHealth notified tribal organizations of the upcoming submission of this demonstration proposal.

On September 14, 2026, MassHealth posted this document on a public website and between September 14, 2026 and September 17, 2026 published notice in newspapers throughout the Commonwealth. This publication marks the start of the Commonwealth’s minimum 30-day public comment period, including tribal consultation and two public hearings conducted at least 20 days before the extension request is submitted to CMS.

MassHealth is committed to continued transparency and stakeholder input throughout the further development and implementation of these reforms. Following its submission of this proposal to CMS, MassHealth will continue to seek input from stakeholders on key topics throughout the remainder of 2026 and 2027, leading up to the start of the new demonstration period.

III. Narrative

Accountable Care Organizations

A. Statement of Request

MassHealth requests the authority to continue its ACO program. The ACO program has delivered substantial value for MassHealth members, the Commonwealth, and the federal government, producing $512 million in documented savings over the 2017-2022 demonstration period, with a projected total savings of nearly a billion dollars through 2028.[10] In the next demonstration period, MassHealth will build on these successes while making evidence-based refinements designed to drive greater value for the state and for CMS. Amid a challenging healthcare cost environment, MassHealth will expect all ACOs to be accountable for measurable improvements in quality, cost management, member experience, and provider experience in order to most responsibly steward taxpayer dollars. MassHealth is in the process of sunsetting its legacy Managed Care Organization (MCO) Program but will continue the long-standing Primary Care Clinician (PCC) Plan program authorized under the 1115 demonstration. MassHealth also intends to continue contracting with a single, statewide managed care entity (MCE) to manage behavioral health services for certain populations.

B. Background and Goals

ACOs in the Current Demonstration

ACOs are provider-led organizations that are held financially accountable for the quality, coordination, and total cost of members' care. The ACO program was authorized and approved by CMS with the goal of promoting whole person health and addressing the root causes of disease while generating value for taxpayers. Members are attributed to ACOs based on primary care; members choose or are assigned their primary care provider (PCP) and are assigned to the plan in which that provider is enrolled. In the MassHealth ACO program a given PCP may only participate in one ACO (known in the program as "primary care exclusivity").

The ACO Program is a key component of MassHealth's Comprehensive Quality Strategy that creates accountability to high-quality care.[11] ACOs are assessed on performance and improvement on quality measures, which are tied to dollars. Quality performance results from

[10] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29,2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download
[11] MassHealth 2025 Comprehensive Quality Strategy, https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download

the current demonstration suggest progress in overall quality scores, especially in the area of preventative care (see Section V. Quality).

Progress To-Date

Since 2018, MassHealth has successfully implemented the ACO model. The majority of MassHealth healthcare providers now participate in an ACO, including all hospitals and community health centers, as well as a diverse range of group practices, independent practices, and community-based organizations. These providers all joined in the effort to improve cost, quality, and experience for MassHealth members. As of April 2026, of the approximately 1.1 million MassHealth members eligible for ACOs, over 1 million (over 90%) were enrolled in an ACO.[12]

The IESR for the 2017-2022 demonstration confirmed that the ACO program delivered a high return on investment, delivering value for state and federal taxpayers. This strong financial performance was achieved by holding providers accountable for outcomes, addressing the root causes of disease through prevention, leveraging clinical integration and improving clinical quality, and shifting utilization towards more appropriate, lower-cost settings, all while maintaining strong member satisfaction.

Some promising results from the ACO program include:

- The program is projected to save $962 million over ten years. Per-member per-month costs for MassHealth members enrolled in an ACO were significantly lower than they would have been without the demonstration.
- The ACO program shifted utilization to lower cost settings that better address the root causes of disease. ACO enrollees had more annual primary care visits, fewer hospitalizations, and less ED boarding, than would have been expected absent the ACO Program, and all-cause unplanned hospitalization rates declined among ACO enrollees.
- The ACO program bent the cost curve. Results of total cost of care (TCOC) analyses suggest cost growth was moderated for ACO enrollees relative to a comparison group.
- Performance on several clinical quality measures improved over time.
- ACO enrollees reported a positive experience with their providers and care. Ratings of primary care, BH, and Long Term Services and Supports (LTSS) providers were consistently positive throughout the evaluation period among respondents to the adult and child member experience surveys.

[12] In general, only members under 65 that do not have other health insurance (e.g., are not dually eligible for MassHealth and Medicare) are eligible to enroll in ACOs.

The attached IEIR for the current demonstration documents continued positive momentum, including that ACOs have strengthened members' connection to primary care and demonstrated continued progress on clinical quality measures. The IEIR found that 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. The IEIR also found that ACO-led enhanced care coordination programs have improved care coordination for members with complex needs.

C. Program Design

MassHealth requests authority to continue the ACO program, building upon successes while making targeted changes to promote the goals of this demonstration. In the next demonstration period, MassHealth will require ACOs to improve value, strengthen accountability, and ensure the responsible stewardship of federal and state taxpayer dollars. Accountable care will remain the framework for MassHealth's delivery system and will be paired with new initiatives that further these aims, including the HIH-C Program (see Section III: Hospital Innovations).

Improving value in ACO program delivery

MassHealth plans to refine the program based on lessons learned. Since the launch of the ACO program in 2018, MassHealth has operated two complementary ACO models: Accountable Care Partnership Plans (ACPPs), which are fully integrated managed care plans combining a health plan and a provider network, and Primary Care Accountable Care Organizations (PCACOs), which are provider-led organizations that contract directly with MassHealth and bear accountability for TCOC and quality without a health plan intermediary. These models have demonstrated meaningful improvements in quality and access. At the same time, experience to date indicates variation in administrative and medical cost structures across ACOs. In the current fiscal environment, MassHealth has an obligation to ensure that all models deliver measurable value and operate as efficiently as possible.

In the next demonstration period, MassHealth will take a more rigorous approach, requiring improved administrative efficiency and stronger performance on cost, quality, and experience. MassHealth will also expect measurable improvement in member and provider experience, foundations of program quality and sustainability.

To achieve greater value, and in furtherance of the Commonwealth's fiscal responsibility, MassHealth will establish and enforce expectations across accountable care organizations spanning quality, cost, and administrative performance. ACOs will be expected to demonstrate improvement across areas including but not limited to:

- Value-based payment arrangements that reward quality and outcomes, with increased expectations for the proportion of provider payments tied to performance rather than volume;
- Network management, including timely access to services, responsiveness to providers, and meaningful coordination of care that enables whole person health;
- Cost growth management, demonstrated success in moderating TCOC trend over time and promoting clinical efficiency, including in reducing avoidable admissions;
- Quality performance with benchmarks and accountability mechanisms to ensure performance and outcomes;
- Administrative efficiency, including streamlining functions and reducing unnecessary overhead to ensure optimal use of public resources;
- Use of data, tools, and technology, including remote patient monitoring and other data-driven capabilities, to improve care management and enable proactive interventions; and
- Advancing clinically integrated, whole-person care that addresses root causes of chronic disease and supports member self-sufficiency, including through appropriate supports that enable participation in the workforce.

As part of the Commonwealth's broader affordability agenda, MassHealth will continue to evaluate policy options and program design changes to improve efficiency, enhance accountability, and ensure responsible stewardship of federal and state taxpayer dollars.

To advance quality, an enhanced and modernized ACO quality program will hold ACOs accountable to:

- Improving quality in priority areas outlined in MassHealth's Comprehensive Quality Strategy:[13]
    - Preventative care for children, family and adults;
    - High impact acute and chronic disease management;
    - Coordinated and efficient care for behavioral health populations and individuals with complex care needs;
    - Member experience and engagement in their care; and
    - Timely access to, and appropriate utilization of services;

[13] MassHealth 2025 Comprehensive Quality Strategy, https://www.mass.gov/doc/2025-masshealth-comprehensive-quality-strategy-cqs-0/download

- Utilizing data-driven approaches to identify and implement targeted quality improvement interventions that improve quality and reduce variation in quality outcomes; and
- Advancing electronic clinical and quality measurement.

Traditional Healthcare Services

A. Statement of Request

MassHealth is requesting authority to pay for traditional healing services provided by a MassHealth participating Indian Health Service (IHS) Facility or a tribal health facility (collectively referred to as an "IHS Facility" for the purposes of this request). Under this new program, IHS Facilities may contract with an Urban Indian Organization (UIO) under a Care Coordination agreement or otherwise contract with a UIO to provide traditional healing services. MassHealth is seeking authority to pay for these services and claim Federal Financial Participation (FFP) when the services are provided by IHS Facilities to American Indian/Alaska Native (AI/AN) members at 100 percent Federal Medical Assistance Percentage (FMAP), pursuant to Sections 1903(a)(1) and 1905(b) of the Social Security Act.

B. Background and Goals

Traditional healthcare practices, also known as traditional healing or traditional medicine, are a form of culturally centered care practiced by many federally recognized tribes. Common forms of traditional medicine practices include, but are not limited to, herbal medicine, sweat lodges, talking circles, and smudging.[14]

AI/ANs experience significantly worse health outcomes compared to the general population, including higher incidence and prevalence of obesity, diabetes, substance use disorders, tobacco use, and cancer.[15] Various studies have shown that traditional medicine can have a positive impact on AI/AN populations, improving behavioral health outcomes and socioeconomic well-being.[16]

Medicaid is the largest source of third-party reimbursements for services billed by IHS federal facilities, accounting for nearly two-thirds of insurance payments.[17] Given the significant role of Medicaid as a payer for IHS Facility services, authorizing MassHealth payment for traditional healthcare services would improve patient access to culturally appropriate practices and support IHS Facilities in keeping traditional medicine as a viable service. Traditional healing

[14] Assistant Secretary of Planning and Evaluation (ASPE), *How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives*, 2022, https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[15] Centers for Medicare & Medicaid Services, *Tribal Technical Advisory Group strategic plan 2020-2025,* November 2020, https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[16] National Council of Urban Indian Health, *Recent Trends in Third Party Billing: Thematic analysis of Traditional Food Programs at UIOs and UIO Research on Traditional Healing,* 2024, ncuih.org/traditionalfood

[17] Assistant Secretary of Planning and Evaluation (ASPE), *How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives*, 2022, https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

interventions have been shown to have a substantial and positive impact on mental health, substance use cessation, and combined health (physical health, mental health, and substance use), with one meta-analysis estimating that traditional healing interventions are three times as effective at substance use cessation as compared to standard interventions.[18] This can have positive downstream effects, such as improving overall well-being and achieving or maintaining employment.[19] As such, supporting the unique cultural practices of tribes also aligns with CMS's Framework for Healthy Communities' goal of providing person-centered services.[20]

Massachusetts has two federally recognized tribes: Mashpee Wampanoag Tribe in Mashpee and Wampanoag Tribe of Gay Head (Aquinnah). The former has an IHS Facility, and the latter has a tribal health facility. Native American Lifelines is Massachusetts's only UIO. The Facilities managed by the above tribes are currently enrolled as MassHealth providers.

C. Program Design

Approval of this request will authorize coverage of traditional healing services provided to MassHealth-eligible AI/AN individuals at enrolled IHS Facilities, or at an UIO contracted with a Facility to provide traditional healing services.

The IHS Facility will determine the appropriate traditional healing services to provide for their populations. Examples of services that may be provided by the Facility include, but are not limited to:

- Traditional Sweat House Ceremony (Sweat Lodge Ceremony)
- Spiritual counseling
- Smudging and purification
- Talking Circle facilitation

Training and qualifications of traditional healing providers can vary by tribe. As such, the scope of practice provided by traditional healers must reflect the established and accepted traditional healing practices of the identified Facility and the member's tribe. The Facility will also be responsible for the vetting process for traditional healing practitioners, including educational or cultural competencies requirements.

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[18] National Council of Urban Indian Health, *Recent Trends in Third-Party Billing at Urban Indian Organizations: Thematic Analysis of Traditional Healing Programs at Urban Indian Organizations and Meta-Analysis of Health Outcomes,* 2023, https://ncuih.org/research/third-party-billing

[19] US Bureau of Labor Statistics, *American Indians and Alaska Natives in the U.S. labor force,* 2019, https://www.bls.gov/opub/mlr/2019/article/american-indians-and-alaska-natives-in-the-u-s-labor-force.htm

[20] Centers for Medicare & Medicaid, *CMS Framework for Healthy Communities,* 2026, https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

The IHS Facility rendering traditional healing services will be paid for each traditional health service at the federally determined IHS All-Inclusive-Rate (AIR) applicable for any IHS Facility billed service. MassHealth will implement appropriate requirements to ensure that services are rendered by qualified providers, and to ensure a high level of program integrity.

Hospital Innovations

A. Statement of Request

As part of MassHealth's goal of promoting value by improving access, quality, and efficiency, Massachusetts requests authority for a Hospital Innovation and Healthy Communities Program (HIH-C Program). The HIH-C Program will include two components: 1) a Care Delivery Innovation (CDI) incentive program that will create accountability for more efficient acute care delivery, reduced avoidable utilization, and enhanced health system coordination, and 2) a voluntary hospital global budget arrangement.

MassHealth also seeks expenditure authority to make 340B hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin. This authority will produce savings for both MassHealth and the federal government, enable full participation in the GENEROUS model and other pharmacy rebating initiatives, while preserving access to critical hospital services. This authority would mitigate revenue losses due to the elimination of 340B retail pharmacy margin at critical service providers, including hospitals with a high public payer mix, and ensure ongoing access to services for all MassHealth members.

B. Background and Goals

MassHealth's ACOs have been successful in bending the cost curve while improving quality and maintaining a strong member experience.[21] However, healthcare spending in Massachusetts continues to rise faster than the state benchmark for sustainable growth. While Massachusetts continues to perform well overall on many rankings of health system performance, the Commonwealth has substantial opportunity to improve on measures of potentially avoidable care such as readmissions, avoidable ED visits, and preventable hospitalizations.[22] Avoidable utilization among MassHealth members aligns with overall state trends despite ongoing efforts from ACOs to meet members' needs in lower-cost, appropriate settings.

Acute hospital providers are foundational to the Commonwealth's healthcare system but largely rely on FFS reimbursement models that reinforce volume over value. Hospitals are accountable to high standards of quality; however, incentives to date have predominantly focused on inpatient structures, processes, and outcomes and less frequently on population

[21] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29, 2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download

[22] Radley D.C., Kolb K, and Collins S.R.; *2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities;* Commonwealth Fund, June 2025, https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance

health interventions, transitions of care, or reductions in avoidable utilization. Fragmented coordination between hospitals and ACOs continues to contribute to inefficient care, and FFS payment constrains the ability to invest in upstream interventions to improve health and prevent acute care utilization.

Massachusetts sees opportunity to achieve better value in acute care by promoting expansion of community-based care models, adoption of innovations to reduce avoidable utilization, and deployment of transitional care interventions. For example, "hospital-at-home" models that provide acute care in the home setting have been shown to offer safety comparable or superior to brick-and-mortar inpatient care, lower costs, and equal or reduced readmissions;[23] evidence from a Massachusetts Medicaid population receiving acute hospital care at home similarly demonstrated low rates of care escalation, readmission, and discharge to skilled nursing facilities.[24] Emerging evidence for mobile integrated health/community paramedicine models suggest they may hold promise for reducing emergency department visits and hospitalizations.[25] Telemonitoring may improve chronic disease outcomes[26] and reduce hospitalizations.[27] Case management programs addressing upstream drivers of health contribute to reducing all-cause and avoidable admissions,[28] and recuperative care can significantly lower readmission rates.[29] Further, transitional care interventions have been

[23] Levine DM, Ouchi K, Blanchfield B, Saenz A, Burke K, Paz M, Diamond K, Pu CT, Schnipper JL. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77-85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232.

[24] Chin M, Fondurulia J, Michaelidis CI, Soni A, Dave J, Pu CT, Levine DM. Acute Hospital Care at Home in Massachusetts Medicaid. J Am Geriatr Soc. 2026 May 4. doi: 10.1111/jgs.70469. Epub ahead of print. PMID: 42081830.

[25] Lurie T, Adibhatla S, Betz G, Palmer J, Raffman A, Andhavarapu S, Harris A, Tran QK, Gingold DB. Mobile integrated health-community paramedicine programs' effect on emergency department visits: An exploratory meta-analysis. Am J Emerg Med. 2023 Apr;66:1-10. doi: 10.1016/j.ajem.2022.12.041. Epub 2022 Dec 29. PMID: 36640693.

[26] Leo DG, Buckley BJR, Chowdhury M, Harrison SL, Isanejad M, Lip GYH, Wright DJ, Lane DA; TAILOR investigators. Interactive Remote Patient Monitoring Devices for Managing Chronic Health Conditions: Systematic Review and Meta-analysis. J Med Internet Res. 2022 Nov 3;24(11):e35508. doi: 10.2196/35508. PMID: 36326818; PMCID: PMC9673001.

[27] Smedslund G, Østerås N, Hestevik CH. Effects of Remote Patient Monitoring on Health Care Utilization in Patients With Noncommunicable Diseases: Systematic Review and Meta-Analysis. JMIR Mhealth Uhealth. 2025 Oct 1;13:e68464. doi: 10.2196/68464. PMID: 41032865; PMCID: PMC12530163.

[28] Brown DM, Hernandez EA, Levin S, De Vaan M, Kim MO, Lynch C, Roth A, Brewster AL. Effect of Social Needs Case Management on Hospital Use Among Adult Medicaid Beneficiaries : A Randomized Study. Ann Intern Med. 2022 Aug;175(8):1109-1117. doi: 10.7326/M22-0074. Epub 2022 Jul 5. PMID: 35785543.

[29] Jachimiak JF, Arda Y, Amon CC, et al. The Experience of Readmission After Trauma Among the Unhoused. *JAMA Surg.* 2026;161(2):132‑140. doi:10.1001/jamasurg.2025.5282

shown to reduce healthcare utilization for patients transitioning from acute care settings to the community.[30]

MassHealth aims to promote more efficient, innovative hospital care delivery through deployment of a value-based payment model for acute hospital care, specifically a hospital global budget model, in the upcoming waiver period. Hospital global budgets offer predictable funding that enables hospitals to focus less on "filling a bed" and more on efficient care delivery, and evidence suggests their use can reduce hospital service expenditures and admissions.[31] A shift to this payment model for acute hospitals is aligned with the goals of the CMS Innovation Center's AHEAD Model and would support the Commonwealth's goals to improve population health while delivering care more efficiently.[32]

Additionally, hospitals currently retain 340B retail pharmacy margin when they are paid through MassHealth managed care, as they are reimbursed at a higher price than the 340B ingredient cost. This structure reinforces a focus that isn't directly advancing care delivery, while also reducing the supplemental rebates available to the state and CMS. This dynamic is exacerbated as additional rebates are made available, such as through the GENEROUS model, in which MassHealth intends to participate. At the same time, 340B margin is critical for safety net providers who reinvest these resources to maintain access and offset costs not fully reimbursed by payors. In this next waiver, MassHealth seeks to enable hospitals to stop relying on 340B retail pharmacy margin while preserving critical access and simultaneously generating additional rebates and reducing net pharmacy spend.

C. Program Design

MassHealth proposes establishing the HIH-C Program to strengthen hospital accountability for cost and quality. The HIH-C Program will have two primary components, 1) a CDI program, and 2) a hospital global budget payment model that hospitals can participate in electively. MassHealth also requests authority to make 340B hospital access stabilization payments, described below, to support hospitals maintaining access for MassHealth members while reducing net prescription drug costs.

[30] Tyler N, Hodkinson A, Planner C, et al. Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis. *JAMA Netw Open.* 2023;6(11):e2344825. doi:10.1001/jamanetworkopen.2023.44825

[31] Beil H, Haber SG, Giuriceo K, Amico P, Morrison M, Beadles C, Berzin O, Cole-Beebe M, Greenwald L, Jiang L, Perry R, Wright A. Maryland's Global Hospital Budgets: Impacts on Medicare Cost and Utilization for the First 3 Years. Med Care. 2019 Jun;57(6):417-424. doi: 10.1097/MLR.0000000000001118. PMID: 30994523.

Care Delivery Innovation (CDI)

MassHealth proposes to implement a care delivery innovation program that incentivizes hospitals to deliver necessary acute care efficiently, reduce avoidable utilization, and strengthen transitions of care, including by leveraging technology and empowering individuals to take control of their health.

The CDI program will incentivize performance in three domains: Efficient Acute Care, Reducing Avoidable Utilization, and Health System Coordination.

a. **Efficient Acute Care**

The Efficient Acute Care domain will incentivize hospitals to improve value and patient outcomes by diverting necessary acute care utilization to appropriate, lower-cost settings. Incentivized interventions may include care models that substitute traditional ED and inpatient care with equivalent services delivered in lower cost, non-facility settings, such as Hospital at Home, Mobile Integrated Health models, and recuperative care models. Entity performance in this domain would be determined by improvement towards and/or achievement of ambitious performance targets related to substitutive care programs, such as visits diverted, patient safety, care escalation, and post-acute utilization.

b. **Reducing Avoidable Utilization**

The Reducing Avoidable Utilization domain will incentivize hospitals to reduce avoidable acute care utilization. Hospitals would be incentivized to employ technology-enabled solutions that empower patients to improve chronic disease outcomes and reduce unnecessary acute care utilization, such as remote patient monitoring, wearable technologies, digital health applications to support self-management and patient engagement, home-based interventions that empower patients to manage chronic disease, and AI-enabled tools for clinical documentation, risk stratification, and care gap identification. Entity performance in this domain would be determined by improvement and/or achievement on metrics related to, for example, reducing unplanned readmissions, avoidable admissions, and ED utilization. Entities may also be rewarded for addressing access barriers and addressing root causes of chronic disease.

c. **Health System Coordination**

The Health System Coordination domain will incentivize hospitals to partner closely with ACOs and community-based providers to streamline and improve transitions of care from and to acute care settings in order to reduce avoidable utilization. Incentivized interventions could include implementation of technology-supported transitions of care (e.g., virtual follow-ups, automated outreach); integrated care models linking hospitals, primary care, and specialty

providers, and other interventions that support more efficient acute care delivery and reductions in avoidable utilization. Entity performance in this domain would be determined by assessment of design and implementation of robust, ACO-partnered interventions around transitions of care.

Hospital Global Budgets

MassHealth intends to implement voluntary global budgets for acute hospitals, across inpatient and outpatient services at a minimum, for both FFS and managed care enrollees. A baseline budget will be set prospectively, with trend applied each year to allow for inflation. Adjustments will be made to reflect care delivery changes, such as service line expansions or reductions; hospitals' payments will not be reconciled to costs. MassHealth intends to offer this approach voluntarily to hospitals. Hospitals participating in global budgets will be held accountable to improve performance on quality and efficiency metrics, leveraging the same measure slates in MassHealth's existing Clinical Quality Incentive (authorized under non-1115 authorities) and proposed CDI programs.

MassHealth anticipates applying for the CMS Innovation Center's AHEAD Model. Regardless of selection, MassHealth intends to generally align its global budget methodology with AHEAD requirements, to the extent possible and appropriate, such as:

- Specifying guidelines for hospital participation in global budgets (e.g., any criteria related to specialty hospital designation or geographic location)
- Describing the methodology for constructing the baseline hospital global budget (e.g., number of years and associated weighting of historical data, which services to include, frequency of payment distribution)
- Proposing the methodology to determine budget updates and adjustments (e.g., to account for inflation, population growth, demographic changes, market shifts, service line changes)
- Proposing a population health improvement strategy with a focus on preventative care (e.g., hospital-specific population health strategies)

Additionally, to align maximally with AHEAD, MassHealth encourages CMS to consider allowing Medicare FFS to offer both a global budget payment option to Massachusetts hospitals and a primary care capitation payment option for MassHealth-participating Massachusetts primary care practices (see Section III: Primary Care Sub-Capitation Payment Model on multi-payer alignment). By combining a hospital global budget model with incentives to transform care delivery, the HIH-C Program will allow participating hospitals to benefit from stable, predictable funding and the opportunity to invest in transformative, innovative care models that reduce avoidable utilization, improve health outcomes, and lower cost growth.

340B Hospital Access Stabilization Payments

MassHealth is seeking authority to make 340B hospital access stabilization payments to eligible hospitals, if MassHealth removes 340B retail pharmacy margin from its managed care payment structure.

Methodologically, MassHealth will develop eligibility criteria for hospitals receiving payments under this authority. These criteria may include participation in the 340B drug pricing program, a demonstrated volume of 340B managed care pharmacy claims, and service to a significant MassHealth population. MassHealth would determine payment amounts using a CMS-approved methodology. These 340B stabilization payments would be made directly by MassHealth to eligible hospitals and would not be made through managed care. MassHealth would also establish documentation and reporting requirements sufficient to support appropriate payments to hospitals.

This authority would allow MassHealth to protect access for MassHealth members by preserving support for hospitals affected by the loss of 340B retail pharmacy margin. At the same time, it would allow MassHealth to implement pharmacy reforms that reduce net Medicaid prescription drug costs, support full participation in the GENEROUS model, and allow the Commonwealth and CMS to obtain the value of lower net Medicaid prices available through rebate arrangements not available for drugs purchased through the 340B drug pricing program.

Primary Care Sub-Capitation Payment Model

A. Statement of Request

MassHealth seeks authority to continue its primary care sub-capitation payment model for primary care practices participating in the ACO program. This program shifts primary care away from volume-based, FFS payment toward a value-based, population-focused paradigm. By sustaining this model, MassHealth aims to build upon and expand the program's successful implementation and initial performance, support practice transformation, and advance improved access, quality, and health outcomes for MassHealth members. Strong primary care is the basis of a high-functioning health system and ultimately reduces the burden of chronic disease.

Specifically, MassHealth requests continued authority to:

1) Require ACOs to make payments to primary care providers using actuarially developed rates calculated to account for enhanced clinical expectations and anticipated utilization, instead of at State Plan rates and without regard to applicable payment limits; and
2) Allow ACOs to make sub-capitation payments without conducting a reconciliation of prospective payments to cost or utilization (except where such calculations are necessary to determine required prospective payment system (PPS) wrap payments for participating Federally Qualified Health Centers (FQHCs)).

B. Background and Goals

Primary Care Context in Massachusetts

MassHealth's primary care sub-capitation model, which launched in April 2023 with authority from the current 1115 demonstration, represents a successful example of state and federal partnership to advance innovative primary care payment reform. Through CMS's flexible demonstration authority, Massachusetts was able to implement a population-based primary care payment model at scale, aligned with CMS-developed innovation models, including the AHEAD Model's focus on strengthening primary care through population-based payment and multi-payer alignment. Early implementation data demonstrate that this model is feasible, sustainable, and effective in strengthening primary care delivery.

Under the model, ACOs make prospective, population-based sub-capitation payments to participating primary care practices in lieu of traditional FFS reimbursement for a defined set of services. Payments are risk-adjusted and tiered based on patient panel characteristics and practice capabilities, providing predictable monthly revenue and flexibility to deliver care outside of traditional, in-person visits. Participating practices are assigned to tiers based on

their capacity to deliver whole-person health – such as through care management, behavioral health integration, virtual care, and expanded access – with higher tiers tied to higher payment rates and more advanced expectations. This approach aligns with CMS-led primary care initiatives that promote prospective, efficient, population-based payment and reflects broader federal priorities to strengthen primary care through value-based models.

Early results indicate that this model is driving meaningful changes in care delivery. Since implementation, 37% of participating practices have added new clinician and staff roles, 44% have enhanced technology and software, and co-location of behavioral health services has increased by 18%.

These positive results are particularly important in the context of broader challenges facing primary care in Massachusetts and nationally. These challenges include high levels of provider burnout and administrative burden, persistent workforce shortages, and access challenges that lead patients to forgo preventative care.[33] These pressures contribute to reduced access to preventive services and growing strain on the healthcare system.

In January 2025, the Commonwealth established a Primary Care Task Force to address these challenges and provide recommendations for improving access, care delivery, and financial sustainability statewide. Building on early evidence from MassHealth's sub-capitation model, the Task Force identified this approach as an effective and scalable solution.[34] Their recommendations underscore that Massachusetts now views the sub-capitation model not only as a successful demonstration, but as a foundation for broader, statewide primary care transformation across payers.

Program Goals

The primary care sub-capitation payment model advances the objectives of the demonstration by strengthening primary care as the foundation of the delivery system and enabling more integrated, accessible, and comprehensive care. By shifting from FFS to prospective, population-based payments, the model supports improved care coordination, including integration of behavioral health, and expanded capacity for preventive and chronic disease care.

Together, these features support core Medicaid and CHIP objectives of improving health outcomes and experience while enhancing cost efficiency. They also reinforce broader

[33] Massachusetts Health Policy Commission, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts—and What Can Be Done,* July 2024, https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and

[34] Massachusetts Health Policy Commission**,** *State Task Force Recommends Rebalancing Health Care Spending to Support Primary Care*, December 2024, https://masshpc.gov/news/press-release/state-task-force-recommends-rebalancing-health-care-spending-support-primary

Commonwealth efforts to strengthen primary care sustainability by promoting prevention, fostering innovation in care delivery, and empowering members to take control of their health.

Program Performance to Date

Since its launch in 2023, the program has achieved near-universal participation across the MassHealth delivery system, with approximately 850 primary care practices participating and 94% of managed-care eligible MassHealth members attributed to participating providers. Participation includes all major health systems and FQHCs, reflecting system-wide support for the program.

The program has delivered on its goal of improving payment stability for primary care providers – sub-capitation payments have been reliable and accurate, with most participating practices experiencing stable or increased revenue under the model. MassHealth has invested over $130 million annually in primary care under this initiative, over and above historical primary care payment levels, enabling providers to move away from visit-based billing and toward value-based care delivery.

Early indicators demonstrate practices are adapting their care models in line with program goals. Under the model's tiered structure, participating primary care practices are assigned to levels based on their capacity to deliver enhanced services, such as care management, behavioral health integration, and expanded access. Higher tiers reflect more advanced capabilities and expectations, and receive higher payment. Of practices that continued in the program from 2023 to 2025, 20% increased their tier designation, reflecting greater care delivery capacity and expanded service offerings as defined under the program's tiered framework. This means that more than 200 practices have expanded capabilities such as after-hours access, behavioral health integration, and enhanced care management. These changes are important indicators of improved access, quality, and coordination, and are expected to translate into better outcomes and more efficient utilization over time. MassHealth continues to audit practices to ensure program integrity and adherence to the requirements of the model.

The IEIR highlights several positive early outcomes of this program, including the addition of new staff roles and care models to address chronic disease, improved systems for tracking quality, and reductions in avoidable utilization. Member experience has also improved, with survey scores reflecting improvements in communication, provider ratings, access to behavioral health services, and wait times. Survey data show improved access and continuity for both adult and pediatric populations, along with stronger care integration.

C. Program Design

MassHealth's sub-capitation program operates within the ACO framework, extending value-based payment to the practice level. ACOs that are ACPPs receive capitated payments for total

cost of care and are required to make prospective, population-based payments to participating primary care providers for a defined set of primary care services – hence, a "sub-capitation". Currently, in the ACPP program, MassHealth directs ACPPs (which are MCOs under 42 CFR Part 438) to make prospective sub-capitation payments to their participating primary care providers, in line with MassHealth's prescribed model. This arrangement is an approved value-based State Directed Payment.

For the PCACO program, which is a Primary Care Case Management (PCCM) construct in which the ACO is the PCCM entity, MassHealth makes capitation payments for certain primary care services to the ACO (i.e., the PCCM entity), which is then required to make prospective sub-capitation payments to their participating primary care providers, replacing FFS payments for a defined set of primary care services.

Participation in the sub-capitation payment model is a requirement of ACO-participating primary care practices.

This structure aligns financial incentives across the system. ACOs retain accountability for total cost of care and quality performance, and the sub-capitation model extends value-based purchasing down to the level of the provider. ACOs continue to hold primary care providers financially accountable for the ACO's performance and for the primary care provider's contribution to performance. This value-based payment structure includes FQHCs, while still ensuring that they are paid no less than PPS, as required under the federal Benefits Improvement and Protection Act of 2000 (BIPA).

The design of the primary care sub-capitation model reflects widely recognized best practices in primary care payment reform, including frameworks advanced by the Health Care Payment Learning & Action Network (HCP-LAN) and other national stakeholders, which emphasize prospective, population-based, prevention-focused payments to support comprehensive, team-based care.[35,36,37,38]

Clinical Model and Expectations

The model includes three tiers of participation, each with increasing expectations for care delivery and corresponding payment levels. Tier 1 establishes a baseline for high-quality

[35] Berenson R., Delbanco S., Upadhyay D., Murray R., *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care;* Urban Institute, December 5, 2020, https://www.urban.org/policy-centers/healthpolicy-center/projects/payment-methods-and-benefit-designs

[36] Basu S., Phillips RS., Song Z., Bitton A., Landon BE.; *High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care.* Health Affairs, September 2017, https://doi.org/10.1377/hlthaff.2017.0367

[37] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, May 2021, https://doi.org/10.17226/25983

[38] Centers for Medicare & Medicaid Services, *Innovation Center Strategy Refresh*. November 2021, https://innovation.cms.gov/strategic-direction-whitepaper

primary care and broad participation. Tiers 2 and 3 require more advanced capabilities, including expanded staffing, integrated services, and enhanced access. Care delivery expectations include:

- **Behavioral Health Integration:** All practices must provide behavioral health screening, with higher tiers requiring integrated staffing, on-site services, and expanded treatment capabilities.
- **Care Coordination and Root Causes of Chronic Disease**: Practices are expected to screen for and address medical, behavioral, and oral health needs, as well as identify the root causes of disease. Higher tiers require dedicated staff (e.g., community health workers) and enhanced support services.
- **Pediatric Care:** The primary care sub-capitation program gives practices tools and supports to further tailor care to meet the unique needs of children and their families. Higher tiers require specialized staff and services tailored to children and families, including pediatric-focused care coordination, behavioral health integration, preventive oral health services, and staff with pediatric expertise and training.
- **Expanded Access:** All practices must use care models and technology to empower individuals to engage in their care. Higher-tier practices must offer expanded hours, and leverage tools like telehealth and e-consults, to create flexibility in how and when members receive care.

Payment

Payments are made on a per member per month basis, risk-adjusted and tiered according to practice capabilities. Rates reflect the clinical capabilities of practices, with higher rates for higher-tier practices. The current demonstration has confirmed MassHealth's expectations that the tier structure incentivizes providers and ACOs to make practice improvements in order to qualify for higher payments. To reinforce the shift away from FFS, the model does not include retrospective reconciliation to utilization, except to the extent required to calculate and ensure appropriate PPS payment for FQHCs. Instead, providers and ACOs remain accountable for quality and total cost of care, with risk mitigation mechanisms in place to address unexpected utilization changes. This is a critical element of the model, for both ACPP and PCACO participating PCPs, which the Commonwealth seeks to maintain in the next demonstration.

Multi-Payer Alignment

The Commonwealth also seeks to partner with CMS to implement population-based primary care capitation in Medicare, aligned with the AHEAD Model. Consistent with the multi-payer alignment principles underlying the AHEAD Model, Massachusetts believes Medicare participation in primary care is essential to achieving sufficient scale for practices to make

meaningful improvements to their care models.[39,40,41] Primary care practices face significant constraints in redesigning staffing models, integrating behavioral health, expanding preventive and community-based services, and adopting technology-enabled approaches to chronic disease management when a substantial share of their patient panel remains tied to FFS reimbursement. Evidence suggests practices require suggests practices require payments under prospective, population-based payment arrangements to justify and sustain operational and clinical transformation.[42,43,44,45] Massachusetts has already made strides towards multi-payer participation in value-based care, the Commonwealth's Primary Care Task Force has issued recommendations around an aligned capitation model across public and private payers. Absent Medicare alignment, providers will continue to face fragmented and conflicting incentives that undermine quality, equity, and cost-containment goals.

[39] Centers for Medicare & Medicaid Services, States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, https://www.cms.gov/priorities/innovation/innovation-models/ahead
[40] Centers for Medicare & Medicaid Services, AHEAD Model Primary Care Fact Sheet, https://www.cms.gov/files/document/ahead-primarycare-fs.pdf
[41] Centers for Medicare & Medicaid Services, AHEAD Model Frequently Asked Questions, https://www.cms.gov/priorities/innovation/ahead/faqs
[42] Basu S, Phillips RS, Song Z, Bitton A, Landon BE.; *High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care*, Health Affairs, 2017, https://pubmed.ncbi.nlm.nih.gov/28874487/
[43] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, Washington, DC: The National Academies Press, 2021, https://pubmed.ncbi.nlm.nih.gov/34251766/
[44] Centers for Medicare & Medicaid Services, Comprehensive Primary Care Plus (CPC+), https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus
[45] Centers for Medicare & Medicaid Services, Independent Evaluation of Comprehensive Primary Care Plus (CPC+) Fifth Year Findings at a Glance, https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-anniv-report-ataglance

Root Cause Interventions

A. Statement of Request

Addressing the root causes of chronic disease and other poor health outcomes can reduce costs while empowering members to take control of their health. Evidence from MassHealth's current programs in nutrition and tenancy shows that these interventions are effective. To refine and build upon these successes, MassHealth seeks authority to:

1. Continue currently authorized nutrition services, food-based interventions, and tenancy support services;
2. Continue recuperative care for eligible individuals; and
3. Continue supportive services for clinically eligible members participating in the Massachusetts Emergency Assistance Program (EA program).

B. Background and Goals

The root causes of chronic disease include factors such as access to nutritious foods and a stable home – and account for up to 80 percent of a person's health outcomes.[46] These root causes of chronic disease significantly impact the health outcomes of MassHealth enrollees in Massachusetts and across the United States. In 2024, over 1 in 3 households in Massachusetts were experiencing a lack of nutritious food access,[47] and, in 2025, approximately 220,000 households struggled with stable tenancy.[48,49] Interventions that address these root causes can make the population healthier by reducing avoidable healthcare utilization, preventing and managing chronic diseases, and improve overall health outcomes.[50]

MassHealth has offered nutrition services, food-based interventions, and tenancy support services as a component of the Commonwealth's broader delivery system reform efforts. These services have specific evidence-based criteria and are designed to reduce the burden of chronic disease, hospitalizations, ED utilization, and total cost of care. These services ultimately

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[46] Hood CM., Gennuso KP., Swain GR., Catlin BB.; *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes*, American Journal of Preventative Medicine, February 2016, https://pubmed.ncbi.nlm.nih.gov/26526164/

[47] Greater Boston Food Bank**,** *Food Access Report*, 2025, https://www.gbfb.org/wp-content/uploads/2025/06/GBFB_Food-Access-Report_2025_final.pdf

[48] Massachusetts Executive Office of Housing and Livable Communities**,** *Rehousing Data Collective Public Dashboard*. https://www.mass.gov/info-details/the-rehousing-data-collective-public-dashboard

[49] National Low Income Housing Coalition**,** *State Housing Profile: Massachusetts*., https://nlihc.org/sites/default/files/SHP_MA.pdf

[50] Tsega M., Lewis C., McCarthy D., Shah T., Coutts K.; *Review of Evidence on the Health Care Impacts of Interventions to Address the Social Determinants of Health (Combined ROI Evidence Review)*, The Commonwealth Fund, July 2019, https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf

empower MassHealth members to become more self-sufficient, living healthy lives in their communities and enabling members to maintain or return to work.

Nutrition and tenancy support services

Beginning in 2020, MassHealth has offered certain nutrition and tenancy supports to members through its 1115 demonstration. The program has evolved over time; it was initially operating as a grant-based pilot program called Flexible Services, approved by the Trump Administration in late 2018 and aligned with the priorities outlined in State Health Official Letter #21-001. It has since evolved into a more streamlined, clinically integrated set of services available to ACO-enrolled members who meet certain clinical and needs-based criteria. These services do not include rent.

The data and evidence show that these services have significant positive outcomes, both clinically and in cost reduction:

- For members who received tenancy supports, there was an 18% lower hospitalization rate and 17% lower ED visit rate as compared to members who were eligible but did not receive these services.[51]
- For members who received nutrition support services, there was a 23% lower hospitalization rate and 13% lower ED visit rate as compared to members who were eligible but did not receive nutrition services.[52]
- Statistically significant reductions in TCOC were observed in both tenancy support (-$3,047) and nutrition (-$1,721) services for members that received services after the height of the COVID-19 pandemic.[53]
- Adults who received nutrition services for at least 90 days had a statistically significant reduction in TCOC (-$2,502) that more than offset the average cost of nutrition services per member ($2,292) leading to net savings of $210 per member.[54]
- Adult members with behavioral health conditions receiving tenancy support services showed statistically significant reduction in TCOC at 6 months (-$2,117) and at 12 months (-$3,260) with an estimated cost of tenancy services at $3,129, suggesting these services offset some, if not all, costs of the tenancy services.[55]

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[51] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29,2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download
[52] Ibid.
[53] Ibid.
[54] Hager K., et al.; *Medicaid Nutrition Supports Associated with Reductions in Hospitalizations and ED Visits in Massachusetts, 2020-2023,* Health Affairs, April 2025, https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01409
[55] Sabatino M.; *Massachusetts Medicaid Housing Supports Reduced Health Care Costs Among Adults with Behavioral Health Conditions,* Health Affairs, April 2026, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2025.00916

- The receipt of Medically Tailored Meals (MTM) was associated with a 31% fewer hospitalizations, 20% fewer ED visits, and $3,433 lower TCOC.[56]
- Members with certain chronic conditions receiving MTM had significant reductions in utilization and TCOC including those with chronic kidney disease (-$12,312), cardiovascular disease (-$10,450), depression and anxiety disorders (-$5,597), and diabetes (-$4,123). For these specific conditions, reductions in TCOC both offset the costs of MTM and resulted in net savings.[57]
- Members receiving tenancy support or nutrition support services reported improvements in both physical and mental health.[58]

Recuperative Care

Healthcare systems face persistent challenges when coordinating to find appropriate placements for patients discharging from an acute hospital stay who lack a safe and appropriate place to recover. For individuals with no community tenancy options, this often results in longer inpatient stays as providers work to ensure appropriate discharge. It can also result in discharge to an inappropriate situation, leading to high risk for individuals returning to the ED or being readmitted to hospitals.[59] These dynamics create strain on health system capacity, contribute to inefficient use of high-cost inpatient resources, and complicate care transitions. A 2020 study evaluating hospital readmission rates among people without community tenancy options compared to people who had stable tenancies in Florida, Massachusetts, and New York, found that people without community tenancy options across states had an overall 30-day hospital readmission rate of 17.3% compared to 14% in those who had stable community tenancy.[60]

Recuperative care addresses this gap by providing a step-down setting for patients who no longer require hospital-level care but are not yet able to recover independently. These programs create a clinically appropriate discharge option that allows hospitals to transition patients out of inpatient beds while maintaining support for individuals to recuperate appropriately. National evidence shows that recuperative care programs fill a critical gap in the

[56] Hager, K., Alcusky, M., Zhang, F.F. et al.; *Medically tailored meals receipt and healthcare utilization and costs in Massachusetts' Medicaid demonstration*, Nat Med, 2026, https://www.nature.com/articles/s41591-026-04407-5
[57] Ibid.
[58] Independent Evaluation Summative Report, Massachusetts 2017-2022 1115 Demonstration, approved January 29,2026, https://www.mass.gov/doc/independent-evaluation-summative-report-0/download
[59] Garcia C., Doran K., Kushel M.; *Homelessness and Health: Factors, Evidence, Innovations That Work, and Policy Recommendations*, February 2024, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.01049
[60] Khatana SAM., Wadhera RK., Choi E., et al.; *Association of Homelessness with Hospital Readmissions—An Analysis of Three Large States*, Journal of General Internal Medicine, September 2020, https://pubmed.ncbi.nlm.nih.gov/32556872/

care continuum, and reduce hospital length of stay, ED use, and readmissions.[61] In addition to supporting recovery following hospital discharge, recuperative care can also help certain members safely access medically necessary procedures that require advance preparation and recovery support, such as for colonoscopies. Members without stable community tenancy options may face significant barriers to completing bowel preparation requirements and other pre-procedure instructions, which can lead to cancelled or delayed procedures and worsening health conditions.

MassHealth has a recuperative care service that shows strong evidence of impact and success:[62]

- 73% of participants did not return to the street or shelter upon discharge from the program.
- Program participants had statistically significantly fewer behavioral health-related inpatient admissions and 30-day hospital readmissions.
- In addition to securing community tenancy, many program participants were discharged with greater self-sufficiency, including reunifying with family members, maintaining sobriety, securing employment, and/or returning to school, while also gaining better control of their health conditions.
- Results demonstrate a reduction in acute care utilization and an improvement in community engagement.
- Participants showed increased use of outpatient and pharmacy services, indicating improved follow-up care and engagement with ongoing treatment. This pattern reflects a transition away from episodic, acute care toward more routine and preventive services—an outcome that supports both better health management and more efficient use of healthcare resources.

Supportive Services for Emergency Assistance Program Participants

MassHealth provides specialized supportive services to clinically eligible families and pregnant members in the state's EA program who do not have stable tenancy. These services – which include case management, employment resources, and tenancy supports - have a stabilizing effect on the health of families and pregnant individuals by helping facilitate connections to needed healthcare, community tenancy, employment opportunities, and education.

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[61] National Institute for Medical Respite Care, *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care*, March 2021, https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

[62] Results from the Evaluation of the Pilot Medical Respite Program. ForHealth Consulting at UMass Chan Medical School, *Evaluation of the Medical Respite Pilot Program – Final Report*, December 30, 2025, https://forhealthconsulting.umassmed.edu/siteassets/pdfs/medical-respite-pilot-evaluation-abbreviated_05132025.pdf

C. Program Design

MassHealth seeks to continue to provide these services, building upon the successes of the current and previous demonstrations.

MassHealth requests to continue the following services:

- Tenancy Search
- Transitional Goods
- Tenancy Navigation
- Healthy Homes for Chronic Disease Prevention
- Medically Tailored and Nutritionally Appropriate Meals
- Medically Tailored and Nutritionally Appropriate Food Boxes
- Medically Tailored Food and Nutritionally Appropriate Prescriptions and Vouchers
- Nutrition Counseling
- Nutrition Education Classes and Skills Development
- Kitchen Supplies
- Recuperative Care Services
- Supportive Services for Individuals in the EA program

MassHealth is requesting a minor change to expand the pre-procedure component beyond colonoscopies to include any procedure that would require bowel preparation.

MassHealth aims to continue to refine these services to improve health outcomes, reduce healthcare utilization, improve self-sufficiency for members, and reduce TCOC. These services help members gain better control of their health by preventing, managing, and treating chronic diseases. Evidence has demonstrated that these services have led to fewer inpatient hospital readmissions and ED visits, and more stable tenancy so that members can regain employment and attain independence.

Behavioral Health

A. Statement of Request

MassHealth requests (1) authority for the renewal of diversionary behavioral health services, substance use disorder (SUD) services, and services for individuals with serious mental illness (SMI) and serious emotional disturbance (SED), as described in the current demonstration's Special Terms and Conditions (STC), including coverage of SUD and SMI/SED services provided in IMDs, and (2) new authority to implement contingency management as a non-24-hour diversionary service.

B. Background and Goals

Access to quality behavioral health services grounded in evidence-based practices remains a long-standing priority for MassHealth. In 2023 the Commonwealth began implementation of a new phase of its behavioral health work, the *Roadmap for Behavioral Health Reform* (the Roadmap). The Roadmap was informed by listening sessions with approximately 700 members, providers, and other collaborators. One of the key themes was the need to expand access to BH treatment, leading the Commonwealth to launch community behavioral health centers (CBHCs) and behavioral health urgent care (BHUCs). CBHCs and BHUCs bolster access to, and quality of, outpatient assessment and treatment through urgent behavioral health access, coordination with primary care, and the addition of community-based alternatives to the ED for individuals seeking crisis intervention services.

Diversionary behavioral health services are mental health and SUD services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and SUD services. Diversionary services are a critical component of the behavioral health system, providing timely, evidence-based care in less restrictive settings to prevent unnecessary utilization of acute levels of care. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement, or to provide intensive support to maintain functioning in the community. Currently, the 1115 demonstration provides authority for two categories of diversionary services (1) those provided in a 24-hour facility, and (2) those provided on an outpatient basis in a non-24-hour setting or facility.

Specialized Community Support Program (CSP) services provide case management services and focus on members with unique needs related to justice involvement (JI) and tenancy instability. Specialized CSP services are provided by community-based, multi-disciplinary teams of professionals and paraprofessionals to members whose conditions impact their ability to access essential medical services in a way that may prevent them from remaining stable in the community. These services empower members to take control of their health, address root

causes of chronic disease, divert and prevent institutionalization, support tenancy stabilization, and promote successful reintegration into the workforce and community.

The current 1115 demonstration authorizes key 24- and non-24-hour diversionary and SUD services that, together with MassHealth's state plan services, create a holistic behavioral health system that supports comprehensive, high-quality care. The evidence shows progress towards achieving the Commonwealth's aims in its behavioral health system. Overdose deaths, ED utilization for SUD, and use of opioids at high dosage in persons without cancer have sharply decreased across the current demonstration period. Since MassHealth introduced a series of reforms in the *Roadmap* in 2023, the number of MassHealth members waiting an extended time in EDs for disposition to inpatient psychiatric care has decreased by 75%. This reduction is in part due to mobile crisis intervention and other outpatient SUD, SMI, and SED services supporting members in the community, which ultimately led to avoiding unnecessary and costly levels of care. Targeted investments in public health, primary prevention, and SUD services have helped Massachusetts achieve a ten percent decrease in opioid-related overdose deaths from 2022 to 2023.[63]

The IEIR for the current demonstration identified promising findings related to non-24-hour diversionary services. Members and providers reported that the flexibility of the CBHC model has made behavioral health services more accessible overall under the demonstration, and emphasized the importance of same-day walk-ins, urgent outpatient services, mobile crisis follow-up, and the ability to connect members directly to community-based care. The CBHC model was also associated with reductions in ED lengths of stay. Organizations that are part of systems that include medical, BH, and SUD care described successful experiences with discharge planning and continuity of care, demonstrating the potential effectiveness of the diversionary service model when properly implemented. These services continue to evolve as important alternatives to hospitalizations, and the IEIR recommends strategies for increasing awareness of the availability of these services.

Specialized CSP services are highly effective, as demonstrated by a study of MassHealth managed care members that found that engaging with a Specialized CSP diversionary behavioral health service was associated with up to an $11,914 reduction in annual per-person healthcare costs.[64] Members receiving Specialized CSP services reported that these programs positively impacted physical and mental health and enhanced wellness. Data from the current demonstration also indicate that Specialized CSP services are associated with improvements in

[63] Massachusetts Department of Public Health, *Substance Use and Overdose Data*, https://www.mass.gov/lists/substance-use-and-overdose-data

[64] Byrne et al.; *Estimating Cost Reductions Associated with the Community Support Program for People Experiencing Chronic Homelessness,* 2017, https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-10/CSPECH_Report_Mar17_FINAL.pdf

tenancy stability and employment outcomes, and are effective at helping members be active and stable members of the community. For example, 90% of members who engaged with a Community Support Program – Tenancy Preservation Program (CSP-TPP) provider in 2025 were able to regain control of their tenancy and avoid homelessness, and they were connected to appropriate outpatient health and behavioral healthcare as well as employment, vocational rehabilitation, and educational opportunities, as needed. Among Community Support Program for Individuals with Justice Involvement (CSP-JI) participants, the share of members who were employed increased from 15% at enrollment to 34% at disenrollment. These programs have demonstrated their effectiveness in addressing complex needs through multi-disciplinary, community-based teams that help members overcome barriers to accessing essential medical services and other basic needs critical for community stability.

Additionally, MassHealth continues to invest in recovery support services as effective ways to engage members and enable them to achieve and maintain recovery. Peer recovery coaching is associated with reduced hospitalizations and hospital length of stay as well as increases in treatment adherence.[65] Recovery support navigation services help facilitate connections to care and other ancillary services. There has been steady growth in peer recovery coaching and recovery support navigation since the initial authority to include as benefits was granted in 2017. In 2023, the Massachusetts Department of Public Health identified a specific goal of creating perinatal recovery support services as part of a larger effort to improve severe maternal mortality rates. In 2025, MassHealth launched perinatal peer recovery coaching and recovery support navigation services to meet the needs of this population. Differentiated rates for these services were developed to support specialized peer recovery coaching and recovery support navigation for members with a SUD who are pregnant and postpartum.

The Commonwealth has continued to expand access to SUD services and infrastructure during the current demonstration period. For example, MassHealth implemented a new tiered rate structure in October 2023 for Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS) that has increased access for MassHealth members. Additionally, from January 1, 2023 through June 30, 2024, MassHealth's network providers added 85 Co-Occurring Enhanced ASAM 3.1 treatment beds to support members with co-occurring SUD and mental health conditions.

Additionally, MassHealth members' average length of stay in IMDs has remained well under the demonstration targets.

The IEIR shows encouraging early outcomes for SUD and SMI/SED services. Fatal and non-fatal overdose rates decreased over the demonstration period. There was a modest improvement in

[65] Byrne T., et al.; *Inpatient Link to Peer Recovery Coaching: Results from a Pilot Randomized Control Trial*, Drug and Alcohol Dependence, October 2020, https://www.sciencedirect.com/science/article/abs/pii/S0376871620303999

utilization of physical healthcare services for members with SUD, particularly in annual primary care provider visits suggesting incremental progress in connecting members with SUD to primary care and advancing integration of physical and behavioral health services. The SMI/SED demonstration has also had a positive impact on access to community-based behavioral health services, including adult and youth Community Crisis Stabilization (CCS) services.

Overall, we are seeing continued trend from the prior waiver period: increased utilization of SUD, SMI, and SED services has smoothed transitions between levels of care and suggests improved outcomes for members.

Contingency Management for Stimulant Use Disorders

Approximately 38,000 MassHealth members have a diagnosed Stimulant Use Disorder (StUD). Deaths involving stimulants increased nearly 300% in Massachusetts between 2013 and 2021.[66] In 2024, of all opioid-involved overdose decedents that received a toxicology screen during their autopsy, 56% were positive for cocaine and 11% were positive for amphetamine.[67] The total cost of care for MassHealth members with a diagnosed StUD is over four times higher than members without a StUD.

While there are FDA-approved medications as the standard of care to treat alcohol and opioid use disorders, the same is not true for StUD. Contingency management (CM) is an evidence-based intervention for people with StUD that provides positive reinforcement for healthy behaviors, such as abstinence of illicit drug use, and empowers members to take an active role in managing their health and recovery. By improving stability and treatment engagement, CM is also expected to support members' ability to participate in and retain employment. CM is recognized as the Standard of Care by the American Academy of Addiction Psychiatry (AAAP) and the American Society of Addiction Medicine (ASAM) for people living with a StUD.[68] Five meta-analyses to date have investigated the efficacy of CM among adults with StUD, and all five found that CM increases abstinence rates and length of abstinence compared to treatment as

[66] Massachusetts Department of Public Health, *Data Brief: Stimulant-Related Data among Massachusetts Residents*, July 2023, https://www.mass.gov/doc/stimulant-report/download

[67] *Massachusetts 2024 Opioid-Involved Overdoes Report*, Massachusetts Department of Public Health, March 2026, https://www.mass.gov/doc/massachusetts-2024-opioid-involved-overdose-report-0/downloadhttps://www.mass.gov/doc/massachusetts-2024-opioid-involved-overdose-report-0/download

[68] The American Society of Addiction Medicine and the American Academy of Addiction Psychiatry (ASAM/AAAP), *The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder*, May 2024, https://journals.lww.com/journaladdictionmedicine/fulltext/2024/05001/the_asam_aaap_clinical_practice_guideline_on_the.1.aspx

usual.[69,70,71,72,73] Multiple meta-analyses also report that CM substantially improves treatment retention compared to control conditions.[74,75,76,77]

In a randomized control trial of CM for StUD treatment among patients with SMI, those who received three months of CM were one-fifth as likely to be admitted for psychiatric hospitalization compared to the control group, demonstrating that CM has the potential to reduce costly inpatient care in addition to improving health outcomes for members.[78]

Introducing CM as a MassHealth covered benefit will empower members with StUD to improve their mental and physical health through access to evidence-based care while tackling a key goal shared by Massachusetts, CMS, and the Office of National Drug Control Policy of reducing overdose fatalities.

C. Program Design

Through this extension request, MassHealth seeks to further support members in accessing evidence-based care in the least costly setting by renewing and expanding the following behavioral health services that empower members to achieve their health goals and advances whole-person health through coordinated physical, behavioral, and social supports that promote resilience, well-being, and long-term community stability.

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[69] Minozzi S., Saulle R., Amato L., Traccis F., Agabio R.; *Psychosocial Interventions for Stimulant Use Disorder*, Cochrane Database of Systemic Reviews, 2024, https://pubmed.ncbi.nlm.nih.gov/38357958/
[70] Ginley MK., Pfund RA., Rash CJ., Zajac K.; *Long-Term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence From Illicit Substance Use Up to 1 Year Following Treatment: A Meta-Analysis*, Journal of Consulting and Clinical Psychology, 2021, https://pubmed.ncbi.nlm.nih.gov/33507776/
[71] Pfund RA., Ginley MK., Boness CL., et al.; *Contingency Management for Drug Use Disorders: Meta-Analysis and Application of Tolin's Criteria*, 2024, https://pubmed.ncbi.nlm.nih.gov/38863566/
[66] Ronsley C., Nolan S., Knight R., et al.; *Treatment of Stimulant Use Disorder: A Systematic Review of Reviews*, PLoS One, 2020, https://pmc.ncbi.nlm.nih.gov/articles/PMC7302911/
[73] Bolívar HA., Klemperer EM., Coleman SRM., et al.; *Contingency Management for Patients Receiving Medication for Opioid Use Disorder: A Systematic Review and Meta-analysis*, JAMA Psychiatry, 2021, https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2782768
[74] Ronsley C., Nolan S., Knight R., et al.; *Treatment of Stimulant Use Disorder: A Systematic Review of Reviews*, PLoS One, 2020, https://pmc.ncbi.nlm.nih.gov/articles/PMC7302911
[75] Bolívar HA., Klemperer EM., Coleman SRM., et al.; *Contingency Management for Patients Receiving Medication for Opioid Use Disorder: A Systematic Review and Meta-analysis*, JAMA Psychiatry, 2021, https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2782768
[76] De Crescenzo F, Ciabattini M, D'Alò GL, et al.; *Comparative Efficacy and Acceptability of Psychosocial Interventions for Individuals With Cocaine and Amphetamine Addiction: A Systematic Review and Network Meta-Analysis*, PLoS Medicine, 2018, https://pubmed.ncbi.nlm.nih.gov/30586362/
[77] Minozzi S., Saulle R., Amato L., Traccis F., Agabio R.; *Psychosocial Interventions for Stimulant Use Disorder*, Cochrane Database of Systemic Reviews, 2024, https://pubmed.ncbi.nlm.nih.gov/38357958
[78] McDonell MG., Srebik D., Angelo F., et al.; *Randomized Controlled Trial of Contingency Management for Stimulant Use in Community Mental Health Patients with Serious Mental Illness*, January 2013, https://pubmed.ncbi.nlm.nih.gov/23138961/

IMDs

MassHealth seeks to renew its existing authority for SUD, SMI, and SED services including coverage of SUD, SMI, and SED services when delivered in IMDs.[79,80] MassHealth seeks to remove the 90-day length of stay limitation for members receiving ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment- Residential Rehabilitation Services (RRS) for substance abuse and Co-Occurring Residential Rehabilitation Services (COE RRS) through MassHealth's FFS program.

Non-24 hour and 24-Hour Diversionary Services

MassHealth requests to renew existing authority for the diversionary behavioral health services. As part of its request, MassHealth seeks to maintain authority for the CSP as a behavioral health diversionary service and further requests authority for the Specialized CSP services listed above as behavioral health diversionary services to reflect the historical purpose and scope of these services.[81] MassHealth is not seeking approval to renew its authority for ASAM Level 3.3 as a discrete level of care to align with the 4th edition of the ASAM Criteria.

- Continuing 24-hour diversionary services:
    - Short-term, intensive mental health services for adults and children as an alternative to hospitalization (CCS for adults and children/adolescents, and Community Based Acute Treatment (CBAT) for children/adolescents);
    - 24-hour addiction treatment (ASAM Level 3.7 Medically Managed Residential Treatment - Acute Treatment Services (ATS)), ASAM Level 3.5 Clinically Managed High-Intensity Residential - Clinical Stabilization Services (CSS), ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment -Residential Rehabilitation Services (RRS) for substance abuse and Co-Occurring Residential Rehabilitation Services (COE RRS)); and
    - Services for children and youth who are in the custody of the Department of Children and Families (DCF) and who are transitioning from an inpatient hospitalization to a residential program (transitional care unit (TCU) services).
- Continuing Non-24 Hour Diversionary Services:

[79] SMD #17-003, Strategic Opportunities to Address the Opioid Epidemic, November 1, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[80] SMD #18-011, Opportunities to Design Innovative Service Delivery for Adults with Serious Mental Illness or Children with Serious Emotional Disturbance, November 13, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

[81] Specialized CSP services are currently authorized under the Commonwealth's Health Related Social Needs Services authority, but the Commonwealth's section 1115 demonstration has previously included certain specialized CSP services as diversionary behavioral health services.

- Ongoing community-based treatment, rehabilitation, and support services for adults with severe and persistent mental illness to engage in an individual process of recovery (Program of Assertive Community Treatment (PACT)); and
- Community Support Program (CSP) including Specialized CSP services (CSP-JI, CSP High Intensity (CSP-HI), and CSP-TPP).
- Recovery Support Services
    - Peer recovery coaching
    - Recovery support navigation

Contingency Management

MassHealth seeks new authority to provide CM to members with a diagnosed StUD, which will provide a motivational incentive to members for meeting certain abstinence criteria.

MassHealth anticipates CM will only be available to members with a diagnosed StUD who can be treated in an outpatient setting. MassHealth may seek to limit the network of eligible providers and may offer the service in certain regions of the state, with the goal of expanding statewide. The Commonwealth intends to establish an annual cap on motivational incentive payments per member and may adjust this amount over the demonstration period. The value of motivational incentives will be excluded from participating MassHealth member modified adjusted gross income (MAGI)-based eligibility determinations.

Reentry Demonstration

A. Statement of Request

MassHealth seeks to continue its authority for its Reentry Demonstration. This authority aims to promote continuity of care for members releasing from incarceration, empower members to achieve independence, improve chronic health conditions, reduce overdose deaths, and increase community tenure by reducing recidivism and enabling members to find and retain employment.

As part of the Reentry Demonstration, MassHealth requests to continue authority to cover a set of pre-release Medicaid benefits for up to 90 days prior to expected release to "qualified individuals" (individuals in certain public institutions who, but for the Medicaid Inmate Exclusion Policy (MIEP), would otherwise be eligible for MassHealth), including:

- All individuals in County Correctional Facilities (CCFs) and state Department of Corrections (DOC) facilities; and
- Eligible youth committed to the care and custody of the state Department of Youth Services (DYS) who are currently excluded under MIEP.

These qualified individuals will receive certain pre-release or pre-discharge covered services that are included in the benefit plan for which they would be eligible but for MIEP (e.g., MassHealth Standard). Qualified individuals must meet MassHealth eligibility criteria. Enrollment in MassHealth will be voluntary for the qualified individuals.

B. Background and Goals

Massachusetts currently incarcerates approximately 6,200 individuals within the DOC, and the health burden within this population is acute.[82] As of late 2024, 42% of incarcerated men in DOC had a mental illness diagnosis and in need of a mental health intervention on an ongoing basis; 37% had an SMI; and 29% were on psychotropic medication. Among incarcerated women, the figures were even more striking: 78% had a mental illness diagnosis and in need of a mental health intervention on an ongoing basis; 74% had a serious mental illness; and 65% were on psychotropic medication.[83]

Research from across the country shows that, compared to the general public, individuals held in carceral settings face worse health outcomes relating to chronic disease including hypertension and asthma, as well as substance use disorder, oral health, and mental health

[82] Massachusetts Department of Corrections, *Jurisdiction Populations: Statistics and Frequently Asked Questions,* https://www.mass.gov/info-details/quick-statistics
[83] Ibid.

conditions, leading to poor health outcomes after release.[84] Individuals leaving carceral settings have increased risks of hospitalization and mortality.[85] Compared to the general population, individuals reentering the community after incarceration have 12.7 times the chance of death within two weeks of release, and they are over 120 times more likely to die of a drug overdose within two weeks of release.[86]

Individuals leaving carceral settings tend to experience difficulties accessing the care they need, largely due to challenges in establishing or reestablishing Medicaid coverage and connecting to post-release appointments. They are also more likely to lack health insurance.[87] Other barriers include trouble navigating the healthcare system, lack of transportation, interruption in medication, as well as nutrition insecurity and tenancy instability and homelessness.[88, 89, 90] Individuals reentering the community after incarceration are ten times more likely to be unhoused than the general public; experience unemployment rates five times greater than that of the general public; and are very likely to lack access to healthy foods, as 91% of adults recently released from state prisons report they were food insecure.[91, 92]

In April 2024, CMS approved MassHealth's Reentry Demonstration request to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for up to 90 days immediately prior to the member's expected date of release. MassHealth is working closely with correctional partners to operationalize the Reentry Demonstration and launching the program in phases. Demonstrating cross-agency partnership, since 2020, MassHealth has met frequently with leadership and representatives from DOC, the Massachusetts Sheriffs'

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[84] Sawyer W., Nam-Sonenstein B., Wagner, P.; *Mass Incarceration: The Whole Pie 2026,* Prison Policy Initiative, March 2026, https://www.prisonpolicy.org/reports/pie2026.html

[85] Frank JW., Linder JA, Becker WC., et al.; *Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: Results of a national survey,* Journal of General Internal Medicine, May 2014, https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC4139534/

[86] Massachusetts Department of Public Health, *An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 - 2015*), August 2017, https://www.mass.gov/doc/data-brief-chapter-55-opioid-overdose-study-august-2017/download

[87] Winkelman TN., et al.; *Health Insurance Trends and Access to Behavioral Healthcare Among Justice- Involved Individuals,* Journal of General Internal Medicine, December 2016, https://pmc.ncbi.nlm.nih.gov/articles/PMC5130958/

[88] Golzari M., and Kuo A.; *Healthcare Utilization and Barriers for Youth Post-Detention* International Journal of Adolescent Medicine and Health, 2013, https://pubmed.ncbi.nlm.nih.gov/23324374/

[89] Couloute, L.; *Nowhere to go: Homelessness among formerly incarcerated people*, Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html

[90] Wang EA., Zhu GA., Evans L., et al.; *A pilot study examining food insecurity and HIV risk behaviors among individuals recently released from prison*, AIDS Education and Prevention, August 2013, https://pmc.ncbi.nlm.nih.gov/articles/PMC3733343/

[91] Health Affairs, *Prison and Jail Reentry and Health*, October 2021, https://www.healthaffairs.org/content/briefs/prison-and-jail-reentry-and-health

[92] Couloute, L.; *Nowhere to go: Homelessness among formerly incarcerated people*, Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html

Association, the fourteen Massachusetts Sheriffs' Offices, DYS, the state Executive Office of Public Safety and Security (EOPSS), Parole and Probation agencies.

As part of its policy development process, MassHealth procured a Community Feedback Forum comprised of stakeholders with lived justice systems experience and expertise in incarceration in Massachusetts. Additionally, policy development and implementation benefited from the existing robust reentry program infrastructure of CSP-JI providers and stakeholders.

Massachusetts is in the process of launching the Reentry Demonstration with a specific set of services (pre-release case management, medication-assisted treatment (MAT), and medications upon release) for sentenced members who are inmates of facilities that demonstrate readiness. Additional correctional facilities may launch once they have demonstrated readiness. To support correctional facilities with achieving readiness, the Executive Office of Health and Human Services (EOHHS) has provided funding to support capacity building needs to DYS, EOPSS, and the Massachusetts Sheriffs' Association, which will distribute it to Sheriffs' Offices that run participating county correctional facilities. MassHealth also developed and hosted training and technical assistance to support correctional facilities with provider enrollment, billing, and service provisions, among other areas.

C. Program Design

The Reentry Demonstration aims to promote efficiencies by connecting correctional and community health settings. This initiative aims to bridge care between two previously siloed health settings by improving transitions of care and increasing collaborations between correctional agencies and community providers. Ultimately, this authority aims to enable care

continuity, member independence, better SUD and chronic disease management, community re-integration, and finding and retaining employment.

Eligible Facilities: Within the next demonstration period, Massachusetts intends to fully implement the Reentry Demonstration, including enrolling all county and state correctional facilities as Medicaid providers and conducting a Readiness Assessment for each of them.

Covered Services: MassHealth will ensure that the following Reentry Demonstration services are available to members incarcerated in participating correctional facilities during the pre-release period:

- Case Management;
- MAT; and
- Medications upon release
- Potential additional services:
    - Medications and medication administration;
    - Laboratory and radiology services;
    - Physical and behavioral health clinical consultations; and
    - Durable medical equipment and supplies upon release.

Eligibility: MassHealth will cover Reentry Demonstration services for individuals who meet the following qualifying criteria:

- For pre-release services, meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and are incarcerated in a state prison, county jail or house of correction, or youth correctional facility;
- Are enrolled in Medicaid or CHIP, or otherwise eligible for CHIP if not for their incarceration status.

Duration of Pre-Release Period: Eligible individuals may receive up to 90 days of pre-release services in the period immediately prior to their expected date of release. Providing services up to 90 days prior to release is critical to the success of the Reentry Demonstration. Based on Massachusetts' many years of experience providing reentry supports, correctional facilities and providers need sufficient lead time to arrange community-based services before release. This advance planning is crucial for creating post-release provider relationships, building trust and coordinating with community providers to improve rates of completing post-release appointments and connecting to critical resources such as employment or education.

The 90-day window for pre-release services is critical for providing enough time for pre-release case managers to engage individuals, conduct a comprehensive assessment, develop a care

plan, make referrals for post-release services, and coordinate a warm hand-off with post-release providers to most effectively promote continuity of treatment and case planning. MassHealth looks forward to monitoring and evaluating the rates of post-release engagement and health outcomes based on time of engagement prior to release.

Safety Net Care Pool

A. Statement of Request

MassHealth requests authority for two funding streams within the Safety Net Care Pool (SNCP). These funding streams are:

1. Disproportionate Share Hospital (DSH) allotment pool, supporting:
    a. Safety Net Provider funding (described further below);
    b. Health Safety Net payments to hospitals and community health centers;
    c. Uncompensated care provided at Massachusetts Department of Public Health (DPH) and Massachusetts Department of Mental Health (DMH) hospitals; and
    d. Payments to certain providers designated as IMDs for behavioral health care provided to MassHealth members ages 21-64 that is otherwise ineligible for FFP;
2. Uncompensated Care Pool (UCP), supporting care for uninsured patients through the Health Safety Net and at DPH and DMH hospitals, to the extent the Commonwealth's expenditures for uninsured care exceed (1) above

B. Background and Goals

For the 2022 to 2027 time period, MassHealth continued its commitment to align with the goals of the ACO program, while creating a path to sustainability for Massachusetts' safety net providers and maintaining the state's overall safety net for the uninsured and underinsured. The safety net hospitals are engaged and held accountable by linking Safety Net Provider payments to ACO participation and performance and continuing to fund care for the uninsured through the Health Safety Net and overall DSH Pool funding.

In the next demonstration period, MassHealth's proposed SNCP design reaffirms the Commonwealth's commitment to sustaining safety net providers. The proposal preserves core programs such as the Health Safety Net and Safety Net Provider Payments.

The IEIR reveals several positive outcomes from the current demonstration's SNCP investments. Supplemental payments have enabled Safety Net Hospitals (SNHs) to make meaningful improvements to their infrastructure. The interim findings on healthcare quality measures show promising results in several key areas, particularly for increasing child and adolescent well visits, decreasing all-cause ED visits, and decreasing ED visits for individuals with mental illness, addiction, or co-occurring conditions. These improvements suggest that targeted safety net funding is beneficial for critical aspects of care delivery for vulnerable populations.

The evaluation indicates that Safety Net Provider Payments are serving their intended purpose of supporting essential providers who care for a disproportionate share of uninsured and MassHealth members with greater medical complexity. The funding has enabled these critical

providers to maintain and enhance services for MassHealth members. The continued investment in safety net infrastructure represents an important commitment to preserving access to care for Massachusetts' most vulnerable residents, with ongoing opportunities to strengthen partnerships between SNHs and ACOs to further improve system performance and patient outcomes.

C. Program Design

The Safety Net Provider Payments are a funding mechanism to support the operational needs of safety net hospitals that made a commitment to partner with MassHealth in its delivery system reform efforts. To receive funding, eligible hospitals must demonstrate meaningful participation in MassHealth's ACO program. A portion of each year's funding is withheld, which providers may then earn based on ACO performance on ACO measures. MassHealth proposes to maintain the existing hospital eligibility requirements for these payments. To be eligible, hospitals must have a Medicaid and uninsured payer mix of greater than or equal to 20% and a commercial payer mix of less than or equal to 50%. MassHealth proposes to maintain the withhold structure for each year which ties the withheld payments to hospital outcome measures that mirror MassHealth's ACO and quality measures. While MassHealth recognizes that safety net providers need ongoing support above and beyond what other providers receive, it is critical that these same set of expectations around care delivery and value-based performance apply to these supplemental funding streams

MassHealth also proposes to maintain the structure of the SNCP in recognition of the Commonwealth's commitment to reimburse providers for otherwise uncompensated care delivered to uninsured and underinsured residents. Massachusetts proposes to continue the Uncompensated Care Pool for the Commonwealth's expenditures for uninsured care. Currently, MassHealth's Uncompensated Care Pool allotment is $100 million per year, and MassHealth seeks to update that level of expenditure authority to the total level of uncompensated care available as defined by CMS' requirements, less the amount accounted for by the Commonwealth's annual DSH allotment.

Eligibility

A. Statement of Request

In support of its objectives related to coverage and eligibility, MassHealth requests continued authority for all existing eligibility and eligibility/application processing authorities, except for those no longer allowable or which require modification due to changes in federal law or policy.

B. Background and Goals

The Commonwealth is committed to improving access to health coverage and health outcomes for low to moderate income residents. As one of the largest insurers in Massachusetts, MassHealth has significantly contributed to maintaining the Commonwealth's consistent near-universal insured rate at approximately 98% (highest in the nation).

MassHealth acknowledges that recent changes in federal law will make healthcare coverage harder to maintain for some Massachusetts residents. MassHealth's priority is maintaining coverage and care for as many Massachusetts residents as possible, while complying with all federal requirements and remaining good stewards of state and federal taxpayer dollars. MassHealth will outreach directly to all MassHealth members impacted by new federal policy changes, using notices, robocalls, text messages, or other means of communication, as well as train MassHealth staff, community partners, providers, and stakeholder groups who are uniquely positioned to help MassHealth members navigate the application and renewal processes.

MassHealth's eligibility policies authorized through the demonstration have historically helped Massachusetts achieve its high insurance rate. These policies include coverage for additional populations such as CommonHealth for disabled individuals and coverage for individuals with Breast or Cervical cancer or HIV, support with Medicare cost sharing for more individuals on MassHealth Standard and assistance with Employer Sponsored Insurance and Marketplace cost sharing. MassHealth continuously seeks to streamline applicant and member experience by minimizing disruption in coverage, reducing excessive barriers to gaining or maintaining health coverage, and promoting the core objectives of the Medicaid and CHIP program.

C. Program Design

As noted above, MassHealth is requesting continued authority for all existing eligibility and eligibility/application process policies, except for those no longer allowable, or those which require modification, due to changes in federal law or policy. Below are some examples of continuing policies.

MassHealth seeks to maintain its landmark CommonHealth authority to incentivize work and economic participation. CommonHealth, which provides full MassHealth coverage to disabled

adults and children with income over the thresholds for MassHealth Standard, allows persons with disabilities to maintain their MassHealth coverage even as their incomes increase from gainful employment by charging a sliding scale premium for those earning more money. This ensures that no such individual in the Commonwealth is forced to choose between the excellent healthcare they receive via MassHealth and engaging in gainful employment that enhances their lives and contributes to the economy.

ConnectorCare preserves affordability, coverage, and access to care through a combination of state-supported premium and cost sharing subsidies, in addition to the federal premium and cost sharing subsidies available to lower income Health Connector enrollees. Premium subsidies help to make it affordable for lower income residents to purchase health insurance, and cost sharing subsidies assure that they have access to care when they need it by reducing the cost of doctor's visits, prescriptions, and other care at the point of service, to a level that is affordable.

Under the streamlined renewal process, certain enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth.

Additionally, MassHealth seeks to continue its end of month coverage for MassHealth members determined eligible for subsidized Qualified Health Plans (QHPs) through the Commonwealth's Marketplace, the Massachusetts Health Connector, but not yet enrolled in a QHP.

IV. Summary of New and Modified Waiver & Expenditure Authorities Requested

Massachusetts is generally seeking to continue all federal expenditure and waiver authorities approved in the current Section 1115 demonstration and proposed transition and phase-out plans, including provisions, terms, conditions, (including STCs describing close-out costs) and all attachments of the current demonstration, except as modified or added below. In addition to the authorities that CMS has already noted will not continue, Massachusetts is not requesting authority to continue the hospital quality and equity program, infrastructure related to health-related social needs (HRSN), and payments to LTSS CPs.

The table below lists and summarizes the new or updated waiver or expenditure authorities proposed to support the goals and policy initiatives described in the preceding sections.

Table 1. Summary of New and Updated Authorities Requested

Policy	**Type of Authority**	**Statutory and Regulatory Citation (for waiver authorities)**
Authority to implement Contingency Management as a non-24-hour BH Diversionary service	Expenditure and Waiver	Section 1902(a)(1) of the Social Security Act (statewideness); Section1902(a)(10)(B) of the Social Security Act (comparability); Section 1902(a)(23)(A) (freedom of choice); Section 1902(a)(17) (amount, duration, and scope);
Move existing authority for Specialized CSPs to existing BH Diversionary authority	Expenditure	
Remove length of stay limitation for existing RRS authority when delivered through FFS	Expenditure	

Authority to cover traditional healing services for AI/AN members provided in, at, or as part of services offered by IHS and Tribal Facilities, and claim 100% FFP	Expenditure and Waiver	Section 1902(a)(1) of the Social Security Act (statewideness); Section 1902(a)(10)(B) of the Social Security Act and 42 CFR 440.240 (comparability)
Authority to implement the Hospital Innovation and Healthy Communities Program (HIH-C Program), including hospital global budgets and care delivery innovation incentives	Expenditure	
Authority to make 340B hospital access stabilization payments to eligible hospitals to replace lost 340B retail pharmacy margin.	Expenditure	
Authority to update our existing recuperative care authority to expand the pre-procedure component beyond colonoscopies to include other procedures that require bowel preparation.	Expenditure	
Close-out costs for Designated State Health Programs (DSHP) authority (close out claiming for DSHP for periods under the current demonstration and associated close out expenses)	Expenditure	

V. Quality

MassHealth's overall quality strategy reflects a steadfast commitment to high-quality care. MassHealth aims to use a data driven approach to identify opportunities and focused interventions to improve overall quality and reduce variation in quality performance and outcomes across and within the populations served.

External Quality Review, Quality Assurance and Performance Improvement Activities

In accordance with federal regulations at 42 CFR Part 438, MassHealth employs a variety of mechanisms to monitor the quality of and access to care provided to members enrolled in MassHealth's managed care programs, including those authorized under this demonstration.

External Quality Review

Since 2006 MassHealth has contracted with a qualified, independent External Quality Review Organization (EQRO), to analyze aggregated information on quality, timeliness, and access to the healthcare services that MCEs furnish to MassHealth members. External Quality Review includes four mandatory activities:

- Annual validation of performance measures reported to or calculated by MassHealth;
- Annual validation of performance improvement projects required by EOHHS;
- Annual validation of Network Adequacy; and
- At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart E, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

While most MCEs are required to meet all four standards defined above, PCACOs as Primary Care Case Management Entities participate voluntarily in two activities: validation of performance measures and triennial compliance review.

2024-2025 EQRO Results

Performance Measure Validation

The Performance Measure Validation process assesses the accuracy of performance measures either reported by MCEs or calculated by the state. The EQRO assesses all performance measures included as part of the state-defined quality slates for each MCE.

Across all validated measures, MCEs were found to have no underlying data quality issues and only two MCEs were found to be non-compliant with state specifications and reporting requirements. Any identified issues were discussed and remediated by the MCEs. MCE-specific

recommendations and performance trends in comparison to national performance can be found in the 2024 and 2025 reports.[93]

Performance Improvement Project (PIP) Validation

In 2024, MCEs began a new quality improvement cycle and selected PIP topics for the next three years. PIP topics varied across MCEs and included: Diabetes, Hypertension, Follow-up after Mental Health Hospitalization, Prenatal and Postpartum Care, Substance Use Disorder, Medication Management, Depression Screening, Readmissions, Colorectal Cancer Screening, and Transitions of Care. The EQRO assigns two validation ratings to each PIP. The first rating assesses overall confidence in the PIP's adherence to acceptable methodology while the second evaluates overall confidence in the PIP's ability to produce significant evidence of improvement. Both ratings use the following scale: high confidence, moderate confidence, low confidence, and no confidence. Across the 37 PIPs reviewed, the majority of MCEs received either high or moderate confidence in both ratings. The EQRO did not discern significant issues with the quality of the PIPs but did make recommendations potential improvements to the PIPs. MCE-specific PIP findings can be found in the 2024 and 2025 reports.[94]

Compliance Validation

The triennial compliance validation determines the extent to which MCEs are compliant with the quality standards mandated in 42 CFR Part 438, Subparts D and E. Also included as part of the compliance audit are related sections of the MCE contracts with MassHealth. In 2024, the EQRO conducted a compliance audit of a subset of the ACOs and MCOs; compliance validation for the Massachusetts Behavioral Health Vendor (MBHV) program will take place in 2026.

Based on regulatory and contract requirements, compliance reviews were divided into the following 14 standards:

- Disenrollment requirements and limitations
- Enrollee Rights requirements
- Emergency and post-stabilization services
- Availability of services
- Assurances of adequate capacity and services
- Coordination and continuity of care
- Coverage and authorization of services
- Provider selection

[93] MassHealth Quality Reports and Resources, https://www.mass.gov/info-details/masshealth-quality-reports-and-resources
[94] Ibid.

- Confidentiality
- Grievance and appeal systems
- Sub-contractual relationships and delegation
- Practice guidelines
- Health information systems
- Quality assessment and performance improvement program

Specific elements under each compliance standard are reviewed and scored by the EQRO as met, partially met, or not met. For those elements not fully met, MCEs were required to submit a corrective action plan for review and approval by MassHealth. Overall compliance scores for MCEs ranged from 90%-100%.[95]

Quality Assurance and Performance Improvement Activities

All contracts with MassHealth MCEs require the adherence, monitoring, and reporting of key aspects of quality, member experience, and access. These contract provisions serve as the foundation of quality management activities across the agency.

Compliance Reporting

Through its MCE contracts, MassHealth has established a series of reports to assess plan compliance with the various CMS programmatic and quality standards set forth in 42 CFR Part 438 Subparts D and E. In addition to these reports, MassHealth also establishes performance targets and timeframes for report submissions which can vary depending upon the report and may be annual, biannual, quarterly, or monthly. Reports are submitted to MassHealth and are reviewed accordingly. If reports indicate an MCE is not meeting performance targets, the MCE is required to submit an action plan indicating corrective actions to improve performance as well as any results of those improvements. The MassHealth EQRO also provides valuable compliance review function through its triennial compliance audit – see External Quality Review section above.

Quality Performance Measures

For each MCE, MassHealth established a quality performance slate consisting of select Healthcare Effectiveness Data and Information Set (HEDIS), CMS, and other nationally stewarded measures that are used to evaluate MCE performance. Quality indicators were focused on four priority domains:

- Maternal, Childhood, and Family Health Promotion
- Chronic Disease Prevention and Control
- Behavioral Health and Addiction Treatment

[95] Ibid.

- Member Experience

Where feasible, MassHealth aligned quality measures across managed care programs. Minor differences in quality measure slates exist but are reflective of the populations each program serves.

MassHealth assessed MCE performance on quality measure slates in CY2022, CY2023, and CY2024 and compared performance to National (MCOs and MBHV) and Regional (ACPPs and PCACOs) Medicaid benchmarks. Quality performance results are processed internally through MassHealth's Internal Quality Committee and MassHealth program leadership and are then publicly reported on the MassHealth website. MassHealth MCOs and the MBHV performed between the National Medicaid 75th and 90th percentiles for most quality measures.[96]

Each measure in the quality slate has or will have an "attainment threshold" and a "goal benchmark" based on local (i.e., historical MassHealth performance), regional or national standards. For both the 2022 and 2023 performance years, ACPP and PCACO performance exceeded attainment thresholds on nearly all of the 12 benchmarked clinical quality measures, with variation among ACOs presenting opportunity for improvement. ACPPs and PCACOs are also accountable for performance on two member experience measures for which ACPPs and PCACOs are performing well above attainment thresholds with opportunity for improvement.

Monitoring Measures and Other Measurement

In addition to the quality performance measures listed above, MassHealth monitors other quality metrics to ensure continued high quality of care and high performance. Monitoring measures are indicators that MassHealth may use to conduct longitudinal assessment over time and determine quality improvement objectives.

CMS Adult and Child Core Measure Sets (CY2024)

For MCE members and FFS members, MassHealth calculated and reported on 32 Adult Core and 23 Child Core Measures. When compared to measures with national benchmarks (i.e., n = 16 Adult, n = 15 Child), MassHealth performed at or near the top quartile for 10 of 16 Adult Core and 11 of the 15 Child Core measures reported for CY24.[97]

Healthcare Effectiveness Data and Information Set (HEDIS) Measures

MassHealth's experience with HEDIS measurement extends back to 1996 when it began collecting and reporting on HEDIS measures for managed care products. Since then, MassHealth

[96] Ibid.
[97] Medicaid and CHIP in Massachusetts, medicaid.gov/state-overviews/MA

has required that all contracted MCEs calculate and submit HEDIS data to MassHealth annually for review. HEDIS measures submitted by the plans cover several domains:

- Effectiveness of Care
- Experience of care
- Access and Availability of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

MassHealth also requires through its contracts that MCEs consider the results of HEDIS measures when developing quality improvement and assessment activities.

Member Experience Surveys

Similar to the HEDIS reporting, MassHealth requires collection and submission of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to MassHealth. MassHealth reviews performance on 5 composite measures:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making

When comparing MCE composite results to National Committee for Quality Assurance (NCQA) Quality Compass benchmarks, MassHealth plans perform at or near the 75th percentile.

Quality Improvement (QI) Activities

MassHealth requires that all MCEs conduct performance improvement projects (PIPs), per MassHealth and/or CMS specifications. MassHealth has established a QI measurement cycle that consists of a planning/baseline period and several re-measurement periods to allow for tracking of improvement gains. At the outset of each QI measurement cycle, MassHealth establishes a series of QI goal domains to focus MCE QI activity. MassHealth may designate or may allow MCEs to select measurement and quality improvement activities for each of those domains.

Annually as part of the QI process, MCEs submit a progress report, focused on planning and modification to the previous year's plans, and an annual report measuring progress from the previous year.

VI. Budget Neutrality

The federal government requires states to demonstrate that federal Medicaid spending for the demonstration does not exceed what the federal government would have spent in the absence of the demonstration. Since the inception of the demonstration, Massachusetts has met this budget neutrality test. The changes proposed in this demonstration request continue to meet budget neutrality requirements during the proposed period. The details of the budget neutrality calculation projections are presented in the Budget Neutrality Workbook.

Massachusetts submits required budget neutrality reporting to CMS on a quarterly basis. This reporting is in accordance with Massachusetts' STCs and CMS' current budget neutrality requirements which are described in State Medicaid Director (SMD) #24-003 RE: Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects. The calculations in the reporting demonstrate that Massachusetts meets the requirements for budget neutrality.

Massachusetts is aware of the new framework described in SMD #26-003 RE: Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects, and we look forward to working with CMS to align the budget neutrality documentation with the new policy and demonstrate compliance with the new requirements.

Historical and Projected Demonstration Enrollment and Expenditures

Table 2 below describes Massachusetts' historical enrollment and expenditures, which are reflected in the quarterly and annual budget neutrality reports to CMS. Demonstration Year (DY) 27 represents one quarter (October – December 2022) of enrollment and expenditures, while DY28 – 30 are all calendar years. Table 3 describes the state's enrollment broken down by Member Eligibility Group (MEG), as provided in budget neutrality reporting. Finally, Table 4 describes the projected enrollment and expenditures for the demonstration extension period.

The data in the tables below show a decrease of approximately 2.9 million member months and $603 million between Table 2, DY30 and Table 4, DY33. This estimated decrease reflects the expected drop in enrollment due to the various eligibility changes enacted by the WFTCA. Once the eligibility changes have gone into effect, the state estimates a small (0.5% per year) increase over the extension period. This projection will change if there are changes in Massachusetts or nationally which impact enrollment in Medicaid and CHIP programs.

Table 2. Historical Enrollment and Expenditures

Demonstration Year	DY 27 Quarter Ending (QE) Dec 22	DY 28 CY 23	DY 29 CY 24	DY 30 CY25
Historical Member Months	5,548,441	22,392,007	19,327,246	17,788,190
Historical Cost ($ in Millions, Total Computable)	2,857.2	12,843.9	12,743.9	12,449.2

Table 3. Historical Enrollment by MEG

Demonstration Year	DY 27 QE Dec 22	DY 28 CY 23	DY 29 CY 24	DY 30 CY25
Base Families	3,108,266	12,749,879	11,445,613	10,587,776
Base Disabled	684,810	2,825,117	2,830,037	2,690,175
1902 (r) 2 Children	120,969	479,475	153,841	115,278
1902 (r) 2 Disabled	63,068	226,476	160,928	165,365
BCCDP	4,197	16,006	14,102	14,920
CommonHealth	103,718	402,287	214,092	185,118
New Adult Group	1,458,720	5,669,726	4,476,062	3,996,354
FFCY	324	1,332	1,069	1,013
SUD	4,367	17,822	22,152	21,540
SMI IMD Services	-	3,887	5,584	5,005
e-HIV/FA Hypo	-	-	3,768	5,649

Table 4. Projected Enrollment and Expenditures

Demonstration Year	DY 33 CY 28	DY 34 CY 29	DY 35 CY 30	DY 36 CY 31	DY 37 CY 32
Projected Member Months	14,852,532	14,926,432	15,000,701	15,075,341	15,150,355

Projected Cost ($ in Millions, Total Computable)	11,996	12,451	12,922	13,413	13,924

VII. Evaluation

Interim Evaluation results of the current demonstration are attached in the IEIR.

Evaluation of the Proposed Demonstration Extension

For the requested 5-year extension of the demonstration starting January 1, 2028, the Commonwealth will develop and implement an evaluation design to study the success of the following goals:

1. Continue to promote value by **improving access, quality, and efficiency**
2. **Strengthen innovative care delivery** for primary care, behavioral health, and pediatric care, focusing on prevention, chronic disease management, and shifting the delivery system away from siloed, FFS healthcare
3. **Sustainably support the Commonwealth's safety net**, including through ongoing, predictable funding for safety net providers with a continued linkage to accountable care
4. **Maintain near-universal coverage** for all eligible Commonwealth residents

In partnership with an independent evaluator, MassHealth proposes to set specific and measurable evaluation goals in the domains listed below that will factor into providers' financial accountability to the state and the Commonwealth's financial accountability to CMS. State and provider performance against these measures will form the foundation of the quantitative evaluation of these goals and sub-goals under the demonstration. As a complement to the quantitative evaluation, the Commonwealth will use qualitative evaluation methods to give context to and illuminate the quantitative data and to investigate specific patterns or other findings in this data.

Evaluation of Goal 1: Continue to promote value by improving access, quality, and efficiency

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- ACO quality results (clinical quality and member experience)
- ACO spending results
- Reduction in avoidable utilization
- Reduction in state spending growth
- Acute care diverted to lower cost settings
- Increased health system coordination
- Health outcomes for members accessing traditional healthcare services

Evaluation of Goal 2: Strengthen innovative care delivery for primary care, behavioral health, and pediatric care, focusing on prevention, chronic disease management, and shifting the delivery system away from siloed, fee-for-service healthcare

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Primary care sub-capitation sustainability
- Primary care quality outcomes
- Pediatric-specific quality outcomes
- Member experience
- Behavioral health quality outcomes
- Outcomes of services addressing root causes of chronic disease
- Outcomes of the Reentry demonstration

Evaluation of Goal 3: Sustainably support the Commonwealth's safety net, including through ongoing, predictable funding for safety net providers with a continued linkage to accountable care

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Uncompensated care
- Accountability of safety net providers

Evaluation of Goal 4: Maintain near-universal coverage for all eligible Commonwealth residents

The Commonwealth anticipates that it will evaluate progress made towards these goals through evaluation of the domains listed below:

- Massachusetts insurance coverage rates, including comparisons to other states
- Rates of members with a gap in coverage
- Impact of enrollment in new and select ongoing programs under the Demonstration on insurance coverage rates

VIII. Public Notice

The public process for submitting this extension request conforms with the requirements of STC 3, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the Commonwealth's approved State Plan. In addition, the Commonwealth has implemented the transparency and public notice requirements outlined in 42 CFR § 431.408. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Notice

The Commonwealth posted the extension request for public comment on September 14, 2026. The public notice, the Request, which included the Budget Neutrality Impact section, and a Summary of the Extension (including the instructions for submitting comments) were also posted on the MassHealth website at: http://www.mass.gov/info-details/1115-masshealth-demonstration-waiver

The public notice with a link to the MassHealth website was published in the *Boston Globe*, the *Brockton Enterprise*, the *Cambridge Chronicle*, the *Lowell Sun*, the *Lynn Daily Item*, the *New Bedford Standard Times*, the *Quincy Patriot Ledger*, the *Springfield Republican,* and the *Worcester Telegram & Gazette*.

Public Hearings

The Commonwealth will host hybrid (virtual and in person) hearings, also referred to as listening sessions, to seek input regarding this extension request. The sessions will include Communication Access Realtime Translation (CART) services.

The first public hearing will be held virtually on **Thursday, October 1, 2026 from 10am – 12pm** and can be joined as follows:

Join Zoom Meeting
Meeting ID: 996 6225 3321
Passcode: 124374

The second public hearing will be held both virtually and in person on **Wednesday, October 7, 2026 from 12pm – 2pm** at One Ashburton Place, Boston MA, 02108, 2nd Floor. It can also be joined as follows:

Join Zoom Meeting
Meeting ID: 994 0470 9871
Passcode: 213343

Post Award Forum

MassHealth hosted its annual Post Award forum public meeting on April 29, 2026. 138 people attended. MassHealth staff shared updates and sought feedback on delivery system reform, investments in primary care, behavioral health, and pediatric care; advancing health equity, sustainably supporting safety net providers; and strengthening near-universal coverage. MassHealth also shared additional details regarding a subset of initiatives included in this extension request and provided time for participants to offer feedback. Among other items, participants inquired about SDOH/HRSN, expressed support for contingency management, and asked for clarification about certain eligibility initiatives.

IX. List of Acronyms

340B: 340B Drug Pricing Program

AAAP: American Academy of Addition Psychiatry

ACO: Accountable Care Organization

ACPP: Accountable Care Partnership Plan, also known as ACO Model A

AHEAD: Achieving Healthcare Efficiency through Accountable Design

AI: Artificial Intelligence

AI/AN: American Indian/Alaskan Native

AIR: All Inclusive Rate

ASAM: American Society of Addiction Medicine

ATS: Acute Treatment Services

BH: Behavioral Health

BHUC: Behavioral Health Urgent Care

BIPA: Benefits Improvement and Protection Act of 2000

CAA: Consolidated Appropriations Act

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CBAT: Community Based Acute Treatment

CBHC: Community Behavioral Health Center

CCF: County Correctional Facility

CCS: Community Crisis Stabilization

CDI: Care Delivery Innovation

CHIP: Children's Health Insurance Program

CM: Contingency Management

CMMI: Center for Medicare and Medicaid Innovation

CMS: Center for Medicare and Medicaid Services

COE RRS: Co-Occurring Residential Rehabilitation Services

CP: Community Partner

CSP: Community Support Program

CSP-HI: Community Support Program – High Intensity

CSP-JI: Community Support Program for Individuals with Justice Involvement

CSP-TPP: Community Support Program – Tenancy Preservation Program

CSS: Clinical Stabilization Services

CY: Calendar Year

DCF: Department of Children and Families

DMH: Department of Mental Health

DOC: Department of Corrections

DPH: Department of Public Health

DSH: Disproportionate Share Hospital

DY: Demonstration Year

DYS: Department of Youth Services

EA: Emergency Assistance

ED: Emergency Department

EOHHS: Executive Office of Health and Human Services

EQRO: External Quality Review Organization

FFP: Federal Financial Participation

FFS: Fee-for-service

FMAP: Federal Medical Assistance Percentage

FQHC: Federally Qualified Health Center

GENEROUS: Generating Cost Reductions for U.S. Medicaid

HCP-LAN: Health Care Payment Learning & Action Network

HEDIS: Healthcare Effectiveness Data and Information Set

HIH-C Program: Hospital Innovation and Healthy Communities Program

HRSN: Health-Related Social Needs

IEIR: Independent Evaluation Interim Report

IESR: Independent Evaluation Summative Report

IHS: Indian Health Service

IMD: Institutions for Mental Diseases

JI: Justice Involvement

LTSS: Long Term Services and Supports

MAGI: Modified Adjusted Gross Income

MAT: Medication-Assisted Treatment

MBHV: Massachusetts Behavioral Health Vendor

MCE: Managed Care Entity

MCO: Managed Care Organization

MEG: Member Eligibility Group

MIEP: Medicaid Inmate Exclusion Policy

MTM: Medically Tailored Meals

NADAC: National Average Drug Acquisition Cost

NCQA: National Committee for Quality Assurance

OUD: Opioid Use Disorder

PACT: Program of Assertive Community Treatment

PCACO: Primary Care ACO, also known as ACO Model B

PCC: Primary Care Clinician

PCCM: Primary Care Case Management

PCP: Primary Care Provider

PIP: Performance Improvement Project

PPS: Prospective Payment System

QE: Quarter Ending

QHP: Qualified Health Plans

QI: Quality Improvement

RRS: Residential Rehabilitation Services

SED: Serious Emotional Disturbance

SMD: State Medicaid Director

SMI: Serious Mental Illness

SNCP: Safety Net Care Pool

SNH: Safety Net Hospital

SOAP: Structured Outpatient Addiction Program

STC: Special Terms and Conditions

StUD: Stimulant Use Disorder

SUD: Substance Use Disorder

TCOC: Total Cost of Care

TCU: Transitional Care Unit

TPP: Tenancy Preservation Program

UCP: Uncompensated Care Pool

UIO: Urban Indian Organization

WAC: Wholesale Acquisition Cost

WFTCA: Working Families Tax Cut Act