MassHealth 1115 Demonstration Waiver
Extension Proposal – Public Notice

September 2026

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a request to extend the MassHealth Section 1115 Demonstration ("Request") to the Centers for Medicare and Medicaid Services. The MassHealth 1115 Demonstration provides federal authority to advance health care delivery reforms, address whole-person health, improve quality outcomes for MassHealth members, and drive accountability for costs with health care providers.

MassHealth is the Commonwealth's Medicaid and CHIP program, covering nearly 1.9 million residents, and critical to maintaining Massachusetts's level of health insurance coverage at 98%[1] the highest in the nation. Under the current 2022-2027 demonstration, MassHealth has strengthened integrated, value-based care, holding providers accountable for the quality and total cost of care, and improving the integration of physical health, behavioral health, long-term services and supports, and other supports such as nutrition services to address the root causes of health problems and empower members to take control of their health. The current demonstration period ends December 31, 2027. We are requesting another five-year demonstration from January 1, 2028 – December 31, 2032.

This fall, MassHealth will submit an 1115 demonstration extension request to continue progress in value-based care and whole-person health.

Under the current 2022-2027 demonstration, the Commonwealth has seen early success across programs:

- Successful implementation of new initiatives (e.g. primary care capitation, hospital quality and equity incentive program)
- Non-fatal and fatal overdoses decreased, and MA saw positive impact on access to community-based behavioral health services
- Primary care capitation led to increased and expanded services for members in primary care settings
- Nutrition and tenancy support services, and the Community Support Programs, positively impacted members' food insecurity, housing status, and self-reported physical/mental health status
- Member experience improved in many areas

The goals of the 2028-2032 Extension Request build upon successes from previous demonstrations, while promoting the Commonwealth's affordability strategy by strengthening prevention, accountability, and value-based care to improve outcomes for members, while ensuring responsible stewardship of state and federal resources.

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

- Continue MassHealth's value-based **ACO program**, maintaining core pillars of accountability for quality, member experience, and total cost of care, and emphasizing increased expectations for delivering value for the Commonwealth moving forward.

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

- Offer new coverage of **Traditional Healthcare Services** for members eligible to receive care at Indian Health Service (IHS) or tribal facilities.
  - Traditional healthcare services can include offerings like sweat lodges or smudging, and are reimbursed at a 100% federal match (no cost to the Commonwealth).
- Build on current efforts to incentivize hospitals to deliver value-based care in line with the Commonwealth's priorities through a new **Hospital Innovation and Healthy Communities Program (HIH-C),** which 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:
  - The CDI program will reward:
    - Care models that provide necessary acute care in the lowest-cost, most appropriate setting;
    - Tech-enabled interventions that empower patients to take control of their health; and
    - Hospital and ACO partnerships that target avoidable utilization.
  - Leveraging a **hospital global budget** model aligned with CMS' Innovation Center AHEAD model will drive delivery system reform across payers.
    - Hospital global budget sets a prospective budget for a limited subset of hospitals that incorporates (at least) inpatient and outpatient expenses.
- To maximize rebates from drug manufacturers and support stability for safety net hospitals, make 340B hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin.

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 health care;

- Continue MassHealth's **primary care sub-capitation program**, which strengthens primary care through prospective capitation to support team-based, integrated care.
  - Support expansion of primary care capitation to include Medicare payments, aligned with the CMS Innovation Center's AHEAD model,[2] and work with commercial payers to adopt capitation as well.
- Continue **diversionary behavioral health and substance use disorder services** and care delivered in settings that qualify as institutions for mental diseases (IMDs).
  - New coverage of **Contingency Management**, an evidence-based treatment for stimulant use disorder.
- Continue **nutrition and tenancy supports** to address the root causes of chronic disease.
  - By addressing upstream drivers of health, these services can lead to decreased hospitalization and emergency department use, increased cost savings, and improved whole-person health.
  - Continue the **Reentry Demonstration** Initiative which allows Medicaid coverage for certain individuals prior to release from incarceration to support the transition back to the community and re-connection to care.
- Discontinue Workforce Initiatives, authorized under the 1115 Demonstration (Student Loan Repayment and Nurse Practitioner Residency), as directed by CMS.[3]

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

[3] CMS Letter, Section 1115 Demonstration Authority for Workforce Initiatives, https://www.medicaid.gov/resources-for-states/downloads/workforc-ltr-to-states.pdf

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

- Maintain sustainable financing for the Commonwealth's health care providers through ongoing **Safety Net Care Pool** authority.
  - This will include: Continued authority for the Health Safety Net, Safety Net Provider Payments, and payments for IMDs and state-owned hospitals.

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

- Maintain **premium assistance, Connector subsidies**, and **Medicare cost-sharing supports**
- Continue to cover expanded populations such as CommonHealth, HIV Family Assistance and Medicare Savings Program eligibility.
- Continue policies to streamline eligibility processing, such as hospital presumptive eligibility and provisional eligibility for certain populations.
- MassHealth will be required to **discontinue continuous eligibility** (for justice-involved and homeless populations) and **adjust retroactive coverage** from 3 months to 1 month or 2 months, per changes in federal policy.

Timeline for MassHealth's 1115 demonstration extension request

September 2026 – Post for state public comment
November 2026 – Submit extension request to CMS
January 2028 – Anticipated start date for new demonstration period

MassHealth's demonstration extension request reflects intensive and ongoing stakeholder engagement with sister agencies and stakeholders to inform policy design, including holding public meetings to provide opportunities for public engagement and verbal and written feedback.

Public Comment Period

EOHHS will host two Public Hearings to hear public comments on the Request. Stakeholders are invited to review the Request in advance and share with EOHHS staff at the hearings any input and feedback, or questions for future clarification. The public hearings are scheduled as follows:

Public Hearing #1 will be held virtually on:
Thursday, October 1, 2026 from 10:00-12:00
Join Zoom Meeting
Meeting ID: 996 6225 3321
Passcode: 124374

Public Hearing #2 will be held both virtually and in-person on:
Wednesday, October 7, 2026 from 12:00-2:00
One Ashburton Place, Boston MA, 02108, 2nd Floor
Join Zoom Meeting
Meeting ID: 994 0470 9871
Passcode: 213343

Live transcription and closed captioning will be available at both events. Please contact 1115WaiverComments@mass.gov at least one week in advance of each hearing to request reasonable accommodations or additional language translation for either date.

EOHHS will accept written comments on the proposed Request through Monday, October 19, 2026. Written comments may be delivered by email or mail. By email, please send comments to 1115WaiverComments@mass.gov and include "Comments on Demonstration Extension Request" in the subject line. By mail, please send comments to: EOHHS Office of Medicaid, Attn: 1115 Demonstration Comments, One Ashburton Place, 10th Floor, Boston, MA 02108. Comments must be received by 5 pm on October 19, 2026 in order to be considered. Paper or electronic copies of the extension request documents and/or submitted comments may be obtained by emailing a request to1115WaiverComments@mass.gov or by mailing a request to EOHHS Office of Medicaid, Attn: 1115 Demonstration Comments, One Ashburton Place, 10th Floor, Boston, MA 02108. EOHHS will post comments on the MassHealth 1115 Demonstration website with the final submission to CMS: http://www.mass.gov/info-details/1115-masshealth-demonstration-waiver

Impact on MassHealth Enrollment and Expenditures

In calendar year (CY) 2025, MassHealth enrollment included 17.79M waiver member months. Average enrollment is expected to increase by approximately 0.5% per year from CY 2028 – CY 2032. Actual waiver expenditures were $12.45B in CY 2025 and are expected to increase on average by approximately 3.8% per year from CY 2028 – CY 2032. The requested changes to the demonstration in total are not expected to add additional expenditures to the extension.

Hypothesis and Evaluation Parameters

The evaluation will examine MassHealth initiatives against the demonstration's four goals. Statewide and provider performance on measures under each goal will form the foundation of the quantitative evaluation of these goals under the demonstration. As a complement to the quantitative evaluation, the independent evaluator 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 each initiative will include logic models, research questions, hypotheses, and evaluation plans. The independent evaluator will also include information on impacted populations, comparison groups, data sources and the analytic approach. Sample hypotheses may include:

Hypothesis 1. Integration across the care continuum (e.g., physical health, behavioral health, long term services and supports, acute care, social services) will increase.

Hypothesis 2. Members will report improved experiences of healthcare services and supports.

New and/or modified waiver and expenditure authorities requested

- Authority to implement contingency management as a non-24-hour behavioral health diversionary service – *expenditure and waiver authority*
- Move existing authority for Specialized CSPs to existing Behavioral Health Diversionary authority – *expenditure authority*
- Remove length of stay limitation for existing Residential Rehabilitative Services (RRS) authority when delivered through fee-for-service (FFS) – *expenditure authority*

- Authority to cover traditional healing services for AI/AN members provided in, at, or as a part of services offered by IHS and Tribal facilities, and claim 100% federal financial participation (FFP) – *expenditure and waiver authority*
- Authority to implement the Hospital Innovation and Healthy Communities Program (HIH-C Program), including hospital global budgets and care delivery innovation incentives – *expenditure authority*
- Authority to make 340B hospital access stabilization payments to eligible hospitals to replace lost 340B retail pharmacy margin – *expenditure authority*
- 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 authority*
- 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 authority*