What to Know Now About MassHealth ACOs

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TABLE OF CONTENTS

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I. INTRODUCTION

American health care costs much more and has inferior and inequitable results, compared with other wealthy nations.[1] Accountable Care Organizations (ACOs) are one tool in the effort to improve health care quality and value by reorienting how care is paid for and delivered. An ACO is a group of clinicians, hospitals, and/or other health care providers that take on the responsibility of coordinating health care services for the people they treat with the goals of improving the care received and controlling the costs of that care. ACOs get paid in a way that motivates lower costs and higher health care quality; the incentives are intended to focus health care on interventions that prevent illness and coordinate the services a member needs, and to move away from the fragmented "sick care"[2] that has characterized the U.S. medical system for decades. ACOs were designed to serve the ultimate goals of improving the population's health and creating a more effective, efficient health care system. Since 2010, more than 1,200 ACOs across the nation have contracted with Medicare, Medicaid, and/or commercial insurers, serving millions of patients.[3] Evidence of ACOs achieving their goals has been mixed. A recent review of Medicare ACO initiatives found modestly positive results to date, with physician-led ACOs tending to perform better than hospital-led ACOs, and ACO performance improving over time.[4]

MassHealth, Massachusetts' combined Medicaid and Children's Health Insurance Program (CHIP), introduced ACOs in 2018 as an option for most of its members under age 65. As of June 2023, over 1.3 million members – more than half of MassHealth's 2.4 million total members – are enrolled in one of 17 MassHealth ACOs. Implementing the ACO model has significantly shifted the way members' care is managed and how MassHealth pays for health care services. The ACO program has the potential to improve members' care experiences and health outcomes and to moderate the costs to the state, over the long term, of delivering care to MassHealth members. Additionally, MassHealth has recently made changes to the ACO model to reduce entrenched health disparities.

This report is a primer on the MassHealth ACO program. Section II reviews its history, basic structure, key features, and payment incentives. Section III describes who is eligible for MassHealth ACOs and lays out the enrollment process. Section IV details related services that are provided to certain ACO members, and Section V concludes by reviewing what is known about how ACOs have performed to date.

II. THE BASICS OF ACCOUNTABLE CARE ORGANIZATIONS

A BRIEF HISTORY OF MASSHEALTH'S ACO PROGRAM

MassHealth's ACO program is embedded in its 1115 Demonstration Waiver (referred to throughout the report as "MassHealth's Demonstration"). Section 1115 demonstration waivers allow states to depart from certain federal Medicaid standards in pursuit of programmatic and population health goals. They are granted by the federal Centers for Medicare and Medicaid Services (CMS) and must be renewed periodically (typically every five years). Over the past 25 years, Massachusetts has used the MassHealth Demonstration to drive reform, including significant coverage expansions and delivery system redesigns. The ACO program, launched in 2018, is the latest major evolution of delivery system redesign.

The current extension of MassHealth's Demonstration, which runs from 2022 to 2027, continues the ACO program with modifications informed by the lessons learned in the ACOs' first years of operation. MassHealth's goals for the ACO program for 2022 through 2027 include continuing to improve members' experience of care and care integration, reducing the cost of members' care and its rate of growth, and promoting health equity.

KEY FEATURES OF MASSHEALTH ACOS

MassHealth ACOs are provider-led entities that contract with MassHealth. ACOs are responsible for either providing or coordinating access to all MassHealth services for which their members are eligible. ACOs also get paid based, in part, on the quality of the care their members receive and the total cost of their members' care. These incentives are intended to encourage

high-quality, efficient, "value-based" care, emphasizing prevention to avoid more costly, intensive services when possible. There are expanded expectations with new financial incentives in the ACOs' most recent contracts, which began in April 2023, for ACOs to improve health equity. These financial incentives are described in more detail below.

ACOs are responsible for baseline care coordination for their members. This includes responsibilities such as:[5]

- Assigning enrollees to a primary care provider
- Ensuring enrollees are screened for physical health; behavioral health (BH); long-term services and supports (LTSS) needs; and health-related social needs (HRSN), such as housing and nutrition. Services available to help support members' BH, LTSS, and HRSN needs are described in more detail in Section IV.
- Ensuring that providers follow up on tests, treatments, and services
- Coordinating with service providers, community service organizations, and state agencies to improve the integration of enrollees' care – for example, by assisting members to obtain nutritional supports for which they may be eligible from the Women, Infants, & Children (WIC) Nutrition Program and the Supplemental Nutrition Assistance Program (SNAP)[6]
- Facilitating transitions to a different level, setting, or frequency of care, to better match the member's needs, for example, by moving from an acute care hospital to a rehabilitation setting
- Ensuring and facilitating communication among providers
- For enrollees under age 21, engaging and coordinating with enrollees' caregivers, schools, and other childhood supports

Additionally, for members with high needs for BH services or LTSS, MassHealth ACOs provide additional care management support and/or work with designated Community Partners (CPs) to coordinate those services. MassHealth ACOs may also provide services that address HRSN, such as housing and nutrition. The CP program and the HRSN services are described in more detail in Section IV.

THE TWO TYPES OF ACO MODELS

Seventeen ACOs provide health care and other services to eligible MassHealth members. There are two types of ACOs: Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (PCACOs). They are differentiated by 1) organizational and management structure; 2) the provider networks available to enrollees; and 3) the method by which MassHealth pays them. See Table 1 for a high-level overview of these differences. Despite the differences, they share the key features described above, most importantly the commitment to effectively manage and coordinate the care of their members and to control the costs of that care.

TABLE 1. MASSHEALTH ACO MODELS

ACO Model	Structure	Provider Network	Payment Method	Number of ACOs	Enrollment *(June 2023)*
Accountable Care Partnership Plan (ACPP)	Exclusive partnership between a provider-led ACO and MCO; partnership contracts with MassHealth	Network based on partner MCOs, for medical and BH services	Capitation for all ACO covered services;* ACPP is at risk for costs that exceed the capitation payment, and it benefits if costs are lower	15	987,000
Primary Care ACO (PCACO)	Provider-led ACO, contracting directly with MassHealth	Network of primary care providers, MassHealth network for other medical services; managed BH vendor for BH services	Capitation for primary care services, otherwise fee-for-service; shares savings and losses with MassHealth (measured against total cost of care target)	2	357,000

** ACPPs are not required to provide, but must coordinate access to, certain services including LTSS (both community- and facility-based), abortion care, dental services, vision care, nonemergency transportation, and transitional support services for substance use disorders.*[7]

ACCOUNTABLE CARE PARTNERSHIP PLANS (ACPP)

There are 15 MassHealth ACPPs, covering about 987,000 of the 1.3 million MassHealth members enrolled in ACOs. An ACPP is a managed care entity formed by the partnership of a provider organization (such as Cambridge Health Alliance or UMass Memorial Health Care) and a managed care organization (MCO) (such as Tufts Health Plan or WellSense, formerly called BMC HealthNet). ACPP enrollees receive most of their health care, including BH, from the ACO's provider network, as assembled by its MCO partner.[8] MassHealth pays ACPPs via capitation – a monthly, per-member fee – from which the ACO pays its providers and covers administrative costs. The payment model is described in greater detail below. See Table 2 for a list of ACPPs and their enrollment as of June 2023.

PRIMARY CARE ACOS (PCACO)

Two PCACOs cover the remaining 357,000 MassHealth members who are enrolled in ACOs. Rather than partnering with an MCO that puts together a provider network, a PCACO offers a network of primary care providers but otherwise uses MassHealth's provider network to deliver care to its members. PCACO enrollees receive BH services from MassHealth's managed BH vendor (currently the Massachusetts Behavioral Health Partnership). PCACOs are now required to pay primary care providers a capitation fee (described below), but MassHealth pays other providers directly for services delivered, on a fee-for-service basis. MassHealth and the PCACO share in the financial savings or losses generated based on how the cost of enrollees' care compares to an annual total cost of care target (described in more detail in the "payment" section below). See Table 2 for a list of PCACOs and their enrollment as of June 2023.

A third type of ACO – the MCO-administered ACO – was available during the first five years of the program. Only 1 percent of ACO members were enrolled in the single MCO-administered ACO, and so MassHealth discontinued this model, as of April 2023, "due to the lack of interest in the market, as well as challenges in operationalization."[9]

TABLE 2. MASSHEALTH ACOS AND ENROLLMENT

ACO Name	Enrollment (as of June 2023)	Share of total ACO enrollment
Accountable Care Partnership Plans		
Fallon Health–Atrius Health Care Collaborative	45,100	3%
Berkshire Fallon Health Collaborative	21,800	2%
Fallon 365 Care (Reliant Medical Group and Fallon Health)	41,700	3%
BeHealthy Partnership Plan (Baystate Health Care Alliance and Health New England)	53,300	4%
Mass General Brigham	164,800	12%
Tufts Health Together with Cambridge Health Alliance	41,500	3%
Tufts Health Together with UMass Memorial Health	51,700	4%
East Boston Neighborhood Health WellSense Alliance	33,200	2%
WellSense Beth Israel Lahey Health Performance Network ACO	83,600	6%
WellSense Boston Children's ACO	136,100	10%
WellSense Care Alliance (Tufts Medical and WellSense Health Plan)	67,500	5%
WellSense Community Alliance (Boston Medical Center ACO and WellSense Health Plan)	164,700	12%
WellSense Mercy Alliance	34,900	3%
WellSense Signature Alliance	25,500	2%
WellSense Southcoast Alliance	22,100	2%
Total ACPP	**987,500**	**73%**
Primary Care ACOs		
Community Care Cooperative (C3)	230,300	17%
Steward Health Choice	127,000	10%
Total Primary Care ACO	**357,300**	**17%**

ACOs are available to all eligible MassHealth members (as defined in Section III below) across Massachusetts. Every region of the state is served by at least three – and as many as 10 – ACOs. See figure 2 on page 7 for more detail.

PAYMENT

The way that MassHealth pays the ACOs is designed to motivate high quality, efficient health care. ACO payments consist of three components: their base payments, their nonmedical allotment, and their performance incentives. These components are described below, followed by a description of how ACOs are expected to pay for primary care services for their members.

BASE PAYMENT

All ACOs are at risk for managing the total cost of care (TCOC) of their members, meaning they are financially rewarded for savings they may generate through their care delivery methods, and penalized if their care is too costly.

ACPPs are paid with a capitation fee – a fixed amount per member per month, regardless of the amount of care any member receives that month. The ACO benefits if the capitation payments exceed the cost of the care it provides to its members. Conversely, if the cost of the care exceeds the capitation payments, the ACO absorbs a financial loss.

The payment model for PCACOs is different because those ACOs do not have a contracted provider network, instead relying on the MassHealth provider network. MassHealth pays providers for claims they submit for the services they deliver to PCACO members. The PCACO, however, is at risk to manage its costs against a spending target. MassHealth develops the spending target, called the TCOC benchmark, using the same principles and methodology as the ACPPs' capitation payments; it is based on members' historical eligibility, utilization, and claims experience, updated by any program and fee schedule changes and price trends.[10] The PCACO is at risk for some of the costs if they exceed the TCOC benchmark, and can share in some of the savings if they stay below it. This payment structure – combined with the performance incentives described below – supplies the financial motivation to deliver efficient, effective health care.

Capitation rates and TCOC benchmarks are both risk adjusted, meaning they are adjusted upwards for members with greater health care needs that may be more costly to treat. Risk adjustment removes a disincentive ACOs may have to enroll members with more complicated health or social factors because of inadequate compensation for the level of care they need. The MassHealth methodology adjusts for both medical factors (using diagnosis codes and demographics) and nonmedical factors (HRSN and neighborhood-based predictors) that affect health care needs and spending.

NONMEDICAL COMPONENT

Both ACPPs and PCACOs receive an allotment from MassHealth, calculated on a per-member basis, intended to cover the ACOs' nonmedical expenses. ACOs use this allotment to pay their CPs (CPs are described in Section IV below), which MassHealth paid directly prior to April 2023 from a special time-limited fund. The nonmedical component also covers an ACO's administrative costs, care management programs, and other expenses.

PERFORMANCE INCENTIVES[11]

The ACO payment model includes a performance incentive component. ACOs may receive payments based on their performance on measures of average quality, health equity, and (for ACPPs only) pharmacy utilization across their member population. ACOs may earn up to 5 percent of their capitation payment or TCOC benchmark from these incentives.

Quality

ACOs can receive a payment of up to 0.75 percent of their capitation payment or TCOC benchmark for their performance on a set of quality measures. There are 14 quality measures, in three domains:

- **Preventive and pediatric care**
- **Care coordination/care for acute and chronic conditions**
- **Member experience**

MassHealth will compute a composite quality score from these measures, based both on whether an ACO achieves certain population-level targets for the measures and on how much an ACO improves on the measures over time.

Health equity

ACOs may earn up to an additional 0.75 percent bonus for performance on a set of health equity measures. This payment is intended to create incentives to identify and reduce health inequities. The measures are in three domains:

- **Social risk factor data:** Collection of complete, member-level data on social factors including race, ethnicity, language, disability, sexual orientation, and gender identity. ACOs must have complete data to be able to identify inequities.
- **Reporting domain:** Reporting on some of the ACO quality measures in the three domains listed above, stratified by the social risk factors, to identify inequities.
- **Disparities reduction domain:** Reducing disparities between population subgroups (e.g., racial/ethnic groups, gender identity, disability status) on certain quality measures – for example, prenatal and postpartum care, controlling high blood pressure, and member experience with care delivery – where inequities have been identified.

Performance on these measures will be combined into a health equity score. Measures in the disparities reduction domain will not be included in the score until the second year of the ACO contracts.

In addition to the equity-related performance incentives, the new contracts for ACOs, which began in April 2023, laid out other new requirements for addressing equity; these are described in the box to the right.

Pharmacy utilization

ACPPs may receive incentive payments for meeting pharmacy utilization targets, which are tied to a contractual obligation to support MassHealth's collection of rebates in its pharmacy program (federal law requires manufacturers to pay rebates to states as a condition for the federal contribution toward covered outpatient prescription drugs).[12]

PRIMARY CARE SUB-CAPITATION

During the first five years of the ACO program, payment and financial risk sharing arrangements between MassHealth and the ACOs were clearly specified in their contracts. MassHealth required that providers participate meaningfully in value-based arrangements to promote financial and clinical accountability, but it did not require that ACOs pay providers in their networks using any specific method. Value-based arrangements are any payment arrangement that ties providers' compensation to the results they deliver (such as quality, equity, or cost), rather than to the amount of services they provide.[13]

This is changed for the new ACO contracts that began in April 2023. Under these contracts, MassHealth is extending the philosophy of value-based payment below the ACO level to primary care practices, with a primary care "sub-capitation" payment. All primary care practices that participate in the ACO program receive a sub-capitation payment, which is monthly, per-member payment to cover a defined set of primary care services their members need. MassHealth hopes that the primary care sub-capitation payment will support practices by providing

Additional ACO contract requirements addressing equity

ACOs are required by their contracts with MassHealth to establish a Health Equity Committee and to create a five-year Health Equity Strategic Plan. The strategic plan describes the ACO's approach to establishing a culture of equity and to ensuring that all its policies and procedures consider equity.

ACOs must conduct a population and community needs assessment and use it to inform the strategic plan, plan interventions to reduce inequities, and regularly measure and report its progress.

ACOs must ensure they are providing culturally and linguistically appropriate services and that all staff and network providers receive periodic training on health equity, anti-racism, implicit bias, and related issues. ACOs have a financial incentive to achieve Health Equity Accreditation from the National Committee on Quality Assurance.

ACOs are also required to establish and maintain a Patient and Family Advisory Committee, made up of representatives of their enrollees and family members. The PFAC is responsible, among other things, to be involved with the development and updating of cultural and linguistic policies and procedures, and advising on the cultural appropriateness and member-centeredness of necessary member or provider targeted services, programs, and trainings.

Other elements of the ACO program, described elsewhere in this report, also have the potential to help reduce health disparities. For example, the Flexible Services Program (detailed in Section IV) addresses nonmedical factors like housing and food that significantly affect people's health and contribute to inequities.

Source: ACPP Model Contract Section 2.21; PCACO Model Contract Section 2.12.

flexibility to implement delivery system improvements and support patients in ways that are not reimbursed under a fee-for-service system (such as implementing integrated, team-based primary care and focusing on BH integration, HRSN, and other delivery system improvements).[14] As with other value-based payments, the purpose of the sub-capitation payment is to change how care is delivered, with the goal of improving health outcomes. The flexibility it affords PCPs may also bring the added benefit of improving equity.

Primary care practices are classified as being in one of three tiers, representing increasing levels of care coordination and integration. To provide just a few examples of how MassHealth differentiates the tiers, Tier 2 practices are expected to provide brief interventions for BH conditions and assist patients with applications for food programs such as SNAP and WIC. Tier 3 practice expectations include a consulting BH clinician with prescribing authority and, for pediatric practices, a full-time staff member with children, youth, and family-specific expertise to support HRSN and BH needs and communicate with the children's schools and early childhood settings.[15] Primary care sub-capitation payments increase with tier level and are higher in all tiers for pediatric members relative to adult members.

The primary care sub-capitation departs from the standard payment method for PCACOs. Under the standard payment method, MassHealth had directly paid primary care providers who delivered care to PCACO members, using a fee-for-service model. Under the new sub-capitation model, MassHealth makes a primary care capitation payment to PCACOs, which in turn pay their members' PCPs the appropriate capitation rate. ACPPs, on the other hand, have the sub-capitation built into their overall capitation rate.

III. ELIGIBILITY AND ENROLLMENT

Under Medicaid rules, ACOs are considered "managed care arrangements" (health care delivery systems structured to manage cost, utilization, and quality), akin to earlier (and still available) forms of managed care in MassHealth: Managed Care Organizations (MCOs) and the Primary Care Clinician Plan (PCC Plan). MCOs and the PCC Plan are described in the box to the right. These four forms of managed care – the two ACO types, MCOs, and the PCC Plan – are available to the majority of MassHealth members under the age of 65. For a breakdown of enrollment in MassHealth by type of managed care arrangement, see Figure 1.

Most MassHealth members who meet the following three criteria must enroll in one of the four managed care options to receive their benefits:

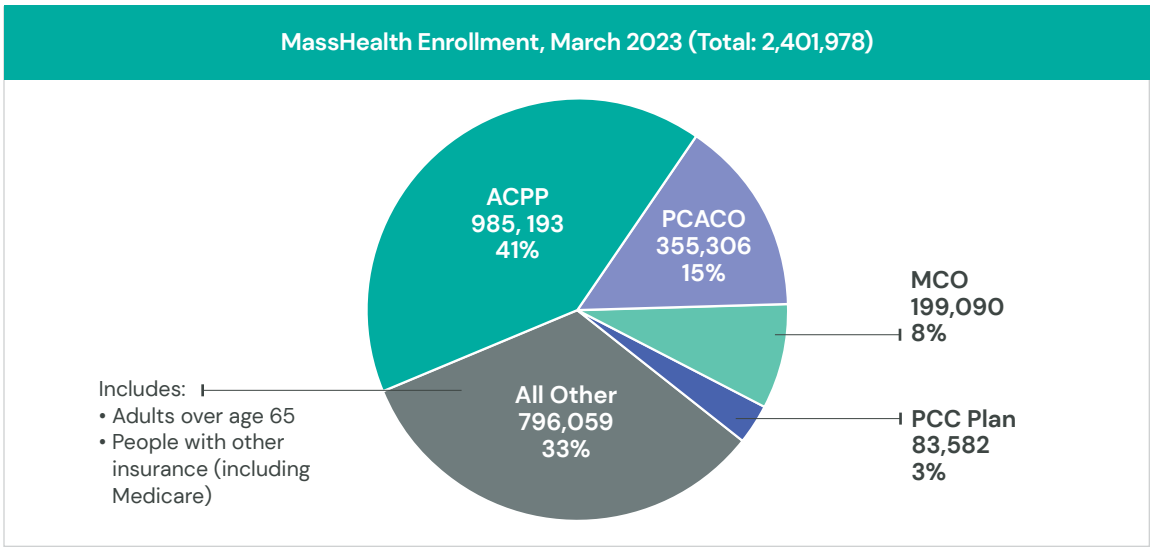
- Are younger than age 65
- Do not have other insurance (including Medicare)
- Live in the community (rather than, for example, a nursing facility)

Managed Care Organizations and the Primary Care Clinician Plan

MassHealth members who meet eligibility criteria for managed care can chose between one of the two types of ACOs (described in this report), an MCO, or the PCC Plan.

- **Managed Care Organizations** are health plans run through insurance companies that have their own provider networks and are not partnered with a provider-led ACO. MassHealth members may enroll in one of two available MCOs.
- The **Primary Care Clinician Plan**. In this plan, a member chooses a primary care provider from the MassHealth network and receives other services through that network and BH services from the Massachusetts Behavioral Health Partnership.

FIGURE 1. MASSHEALTH ENROLLMENT IN MANAGED CARE

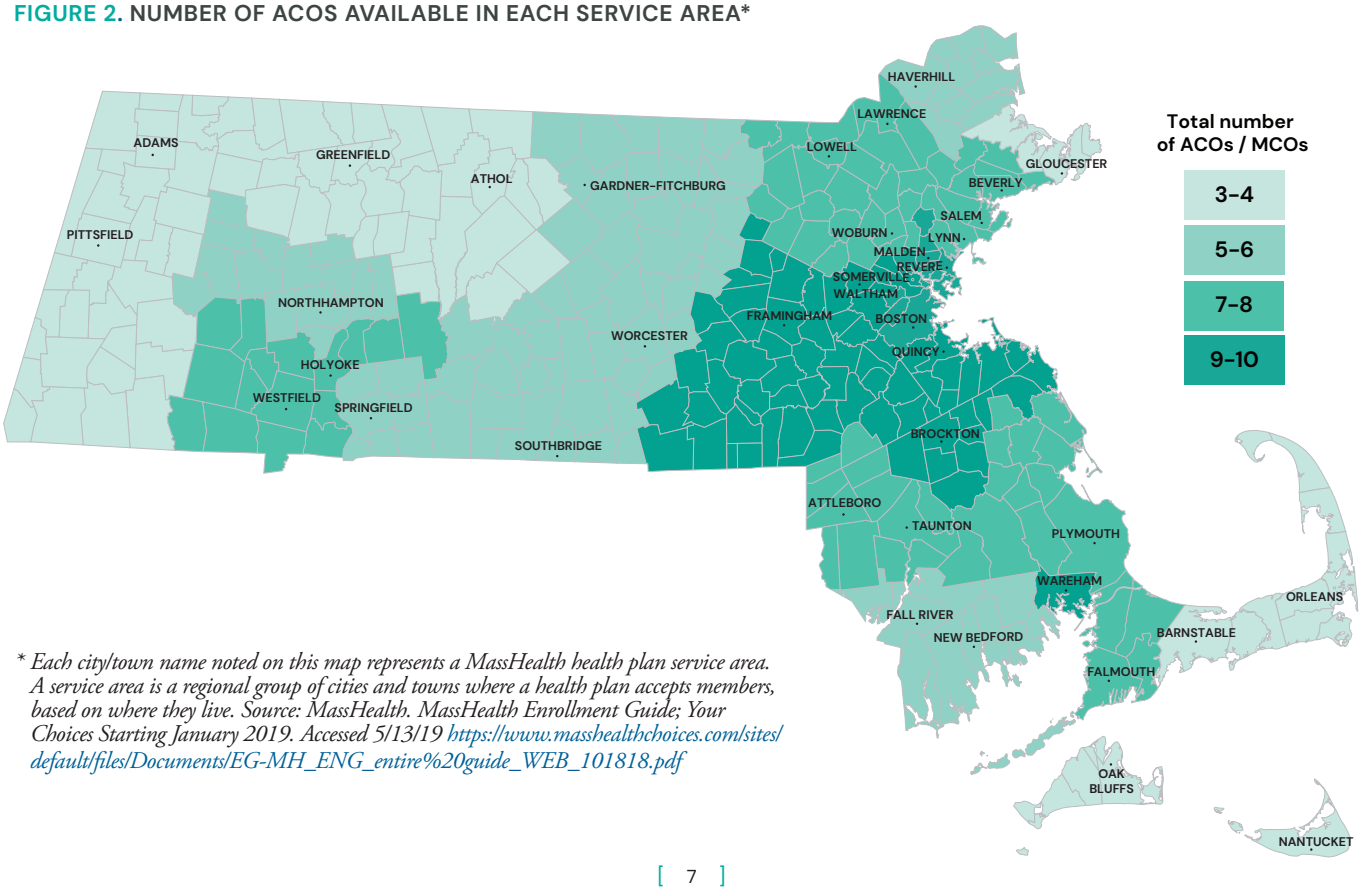


Source: MassHealth caseload snapshot and enrollment summary, June 2023

ENROLLMENT PROCESS

Enrolling in an ACO (or in any managed care arrangement) is a multistage process. The first step, common to all MassHealth members, is to complete the MassHealth application. When eligibility has been established, a member who meets the above criteria can choose a managed care plan in which to enroll. MassHealth gives the member information, for example, in the MassHealth Enrollment Guide[16] or the *MassHealth choices website*, about the managed care options available in their service area. MassHealth divides the state geographically into 38 service areas; there are at least three – and as many as 10 – ACOs available in every service area. Figure 2 shows the number of ACOs available across Massachusetts by geographic region.

FIGURE 2. NUMBER OF ACOS AVAILABLE IN EACH SERVICE AREA*



** Each city/town name noted on this map represents a MassHealth health plan service area. A service area is a regional group of cities and towns where a health plan accepts members, based on where they live. Source: MassHealth. MassHealth Enrollment Guide; Your Choices Starting January 2019. Accessed 5/13/19 https://www.masshealthchoices.com/sites/default/files/Documents/EG-MH_ENG_entire%20guide_WEB_101818.pdf*

If a member does not select a managed care plan within 14 days, MassHealth will assign the member to one that is available in the member's service area.[17]

FIXED ENROLLMENT PERIOD

When a member first chooses or is assigned to a plan, they have 90 days to transfer to another plan if they desire. This 90-day period, called the plan selection period, recurs annually. Outside of the 90 days, enrollees in ACOs and MCOs are not allowed to disenroll from or transfer to another plan until the next plan selection period, except for specific reasons described in the text box below. There are two exceptions to this rule. PCC Plan enrollees are not restricted by the fixed enrollment period; they are permitted to move to an ACO or MCO at any time. Children in the care or custody of the Department of Children and Families or the Department of Youth Services and children younger than 1 year old may also change plans at any time.[18]

Fixed Enrollment Period Exceptions

Members may change managed care plans during the fixed enrollment period for reasons related to access and quality, including:

- The member moves out of the plan's service area
- The plan no longer covers the member's service area
- The member is homeless and the plan cannot accommodate their geographic needs
- The member demonstrates that the plan has not provided access to providers that meet the member's needs
- The member demonstrates that the plan is not meeting the member's language, communication, or other accessibility needs and preferences
- The member's key providers – PCPs, specialists, BH providers – leave the plan's network

The full list of exceptions to the Fixed Enrollment Period is available *here*.

Source: 130 CMR 508.003(C)(3).

PRIMARY CARE PROVIDER EXCLUSIVITY

An important feature of the ACO program, which can influence a member's selection of an ACO, MCO, or the PCC Plan, is primary care provider (PCP) exclusivity. PCP exclusivity means that any PCP can only participate in one ACO and, if it does, may not provide primary care services to other MassHealth members eligible for managed care, including those enrolled in an MCO or the PCC Plan. The reason for exclusivity is "to ensure that accountability for cost and quality can accurately be assigned," and "to facilitate members' choice … if members wish to choose based on their preferred primary care provider."[19] Exclusivity applies only to MassHealth members eligible for managed care; PCPs that are in MassHealth's network may provide services to non-managed care MassHealth members.[20] Further, PCP exclusivity only applies to PCPs who wish to participate in an ACO; PCPs that participate in MCOs and/or the PCC plan (but do not participate in an ACO) do not have the exclusivity requirement.

CURRENT ENROLLMENT

As of June 2023, over 1.3 million members – more than half of MassHealth's 2.4 million total members – are enrolled in an ACO. Slightly more than half (56 percent) of ACO members are adults ages 21 to 64, a lower percentage than the 63 percent of adults in the non-elderly MassHealth population overall. People with disabilities comprise a small portion of ACO members (8 percent), a lower percentage than in the overall non-elderly MassHealth population (14 percent). ACO members are distributed roughly evenly over four of five geographic regions, with somewhat lower membership in the less populous western region of the state. (See Table 3).

TABLE 3. DISTRIBUTION OF MASSHEALTH ACOS MEMBERS, JUNE 2023

	Number	Percentage
Age		
Adults (ages 21–64)	751,900	56%
Children	592,600	44%
Disability Status		
Disability*	107,700	8%
No Disability	1,236,800	92%
Geographic Region		
CENTRAL (Athol, Attleboro, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester)	238,000	18%
GREATER BOSTON (Boston, Quincy, Revere, Somerville)	297,100	22%
NORTHERN (Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn)	315,300	23%
SOUTHERN (Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham)	300,900	22%
WESTERN (Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield)	193,200	14%

Source: MassHealth enrollment data.

* Members are classified as having a disability in this table only if they qualify for MassHealth in part on the basis of a disability, according to the standards set by federal and state law, and are assigned to specific rating categories. Not all MassHealth members who would self-identify as having a disability are included in these categories.

IV. RELATED SERVICES

COMMUNITY PARTNERS

Community Partners (CPs) are community-based organizations that work with ACOs to support their members with the most extensive behavioral health (BH) or long-term services and supports (LTSS) needs. (CPs are also able to serve members enrolled in MCOs.) CPs offer enhanced care coordination (described below) and connect members to other services in the community based on their needs. CPs are subcontracted with ACOs and ACOs are required to contract with at least one BH CP and one LTSS CP in each of their service areas.

As of June 2023, 31,078 members were enrolled in BH CPs, about 2.3 percent of all ACO enrollees, and 10,514 members were enrolled in LTSS CPs, about 0.8 percent of ACO enrollment.[21] See Appendix A for a complete list of BH CPs and LTSS CPs.

Eligibility Criteria for Community Partners

Members eligible for BH CP services are those ages 18 to 64 with serious mental illness, serious emotional disturbance, and/or substance use disorder. Members eligible for LTSS CPs are ages 3 to 64 and have physical disabilities, acquired or traumatic brain injury, and/or intellectual or developmental disabilities that give rise to LTSS needs.[22]

ELIGIBILITY FOR ENROLLMENT INTO THE CP PROGRAM

ACOs identify members for enrollment with CPs, according to the eligibility criteria outlined in the box above. Members may also be referred by their providers, by a CP, or self-refer. Under their new contracts, ACOs have enrollment targets and are currently expected to enroll approximately 3 percent of their members in BH CPs and about 1 percent in LTSS CPs.[23]

ENHANCED CARE COORDINATION

In addition to the ACOs' baseline care coordination (described in Section II), members engaged with a CP receive enhanced care coordination, the responsibilities for which the ACO delegates to the CP.[24] Enhanced care coordination supports include:[25]

- Outreaching and engaging members in the enhanced care coordination activities described in the bullets below
- Designating a multidisciplinary care team in accordance with the member's needs and preferences
- Performing a comprehensive assessment consisting of questions around: care needs; health conditions; medications; functional status; self-identified strengths, weaknesses, and goals; current and past mental health and substance use; accessibility requirements; available informal, caregiver, or social supports; risk factors for abuse or neglect; advance directives and guardianship status; and educational supports and services (for members under age 21)
- Developing a care plan, in collaboration with the member, the member's providers, and care team
- Supporting transitions of care, for example by working with a member leaving inpatient care or executing a "warm hand-off" of the member to a provider or program to which they have been referred following discharge
- Generating a list of a member's medications, reviewing a medication regimen with a member to identify confusion or discrepancies, identifying barriers to adhering to a medication regimen and developing strategies to maintain adherence, and supporting the care team in considering medication changes when a member's clinical or functional presentation changes
- Conducting health and wellness coaching activities
- Acting as the lead care coordinator among other state agencies that coordinate care for members
- For LTSS CP enrollees, connecting the enrollee to options counseling (information about services available to assist enrollees to live independently in their communities)
- For members under age 21, providing educational supports, communicating with school nurses and key school personnel, and supporting transition-aged youth to adult care

CPs are also required to collect member-level social risk factor data (including race, ethnicity, language, disability status, age, sexual orientation, gender identity, and health-related social needs) and to support the ACO's health equity initiatives.

PAYMENTS

Both ACPPs and PCACOs pay their contracted CPs a monthly payment based on the size of the CPs' enrolled panel. ACOs must also make annual payments to CPs based on their performance on quality measures, which MassHealth calculates and provides to the ACOs. The CP payments are made from the administrative component of MassHealth's payments to the ACOs.[26]

In addition, MassHealth is authorized to provide up to $20 million for infrastructure and capacity building payments to LTSS CPs. LTSS CPs are eligible to receive these payments due to an expansion in the responsibilities and expectations in their new contracts beyond those in the 2018 contracts. LTSS CPs' scope of responsibility is now equivalent to that of BH CPs. For example, MassHealth added conducting comprehensive assessments, serving as the lead care coordination entity, and forming and coordinating each enrollee's care team, which were previously responsibilities of the ACOs. LTSS CPs now also have more requirements for clinical staffing, including BH expertise and nursing. The infrastructure and capacity building payments are to support the CP's investment in and advancement of these capabilities, in areas including technology; staff development, recruitment, training, and retention; ramp up and startup costs; and operational infrastructure.

FLEXIBLE SERVICES PROGRAM

The Flexible Services Program (FSP) was introduced as a component of the MassHealth ACO program in 2018 and became operational in 2020. FSP reflects an acknowledgment that nonmedical factors can have an equal or greater effect on people's health than medical factors and health care services. In particular, the strong associations of adequate housing and nutrition with positive health outcomes are well-documented.[27] In addition, inequities in adequate food and housing exacerbate health problems for certain groups. Black and Latino households in Massachusetts experience far higher levels of food insecurity than White and Asian households do.[28] Similarly, Black and Hispanic households are more likely than White and Asian households to experience a rent cost burden, defined as paying more than 30 percent of income for housing.[29] FSP offers ACOs a vehicle to address these factors, thereby improving their enrollees' health, helping to address inequities, and avoiding downstream health care costs that might result from unstable housing and food insecurity.

ELIGIBILITY FOR FSP

Flexible Services are not currently an entitlement, meaning members with a need do not automatically receive them simply by being enrolled in MassHealth, as is the case with most other MassHealth benefits. ACO members must meet at least one health needs-based criterion and one risk factor (see table below), then they must be selected by an ACO to receive flexible services.[30]

Health Needs Criteria	Risk Factors
• BH need requiring improvement, stabilization, or prevention of deterioration • Persistent, disabling, or progressively life-threatening physical health condition(s) requiring improvement, stabilization, or prevention of deterioration • Need for assistance with one or more Activities of Daily Living or Instrumental Activities of Daily Living[31] • Two or more emergency department visits within six months, or four or more visits within one year • Pregnant and experiencing a high-risk pregnancy or pregnancy-related complications	• Experiencing homelessness (i.e., lacking a fixed, regular, and adequate nighttime residence) • At risk of homelessness (including fleeing, or attempting to flee, domestic violence) • At risk for nutritional deficiency or nutritional imbalance due to food insecurity

Every ACO is required to establish at least one FSP in the housing domain and one in the nutrition domain. ACOs may establish more specific eligibility criteria (from the list above) for each program they design, and they are expected to have at least 1 percent of their enrollees participating in the FSP, including children in rough proportion to the ACO's overall membership.

SERVICES AVAILABLE THROUGH THE FLEXIBLE SERVICES PROGRAM

Flexible services can include:[32]

- **Individual pre-tenancy supports,** including assistance budgeting for housing expenses, assistance applying for housing or housing supports and obtaining services, and assistance with or providing transportation and childcare needed to obtain any of the tenancy supports.
- **Transitional assistance,** such as one-time household set-up costs (first and last month's rent, security deposit) and move-in expenses (utility deposits, obtaining and correcting needed documentation).
- **Tenancy sustaining supports,** including assisting a member with communicating with a landlord regarding the member's disability and detailing the member's accommodation needs, and assisting in negotiations with a landlord.
- **Home modifications,** such as the installation of grab bars, doorway modifications, and HEPA filters.

- **Nutrition sustaining supports,** such as assisting members to obtain benefits, household supplies and access to foods that meet nutritional and dietary needs; providing home-delivered meals, nutrition education and skills development; and transportation and childcare needed to obtain any of these flexible services.

ACOs contract with community-based social service organizations to provide flexible services. A September 2022 directory lists over 80 FSPs. The relationships are not exclusive; some FSPs are offered by more than one ACO.[33] ACOs receive an annual FSP allotment from MassHealth based on their number of members and ACOs are required to spend at least 75 percent of the allotment during the contract year. No more than 25 percent of the allotment may be rolled over to the next year.[34]

In calendar year 2021, 10,466 unique members (roughly 1 percent of ACO members) received 15,328 services. About half of the services were in the "nutritional" domain, with the other half spread across the four "tenancy" domains.[35] From the start of the FSP in January 2020 through March 2023, 29,112 members received 36,992 services.[36]

MassHealth has signaled its long-term commitment to maintaining flexible services as part of the ACO program by taking steps to fully integrate flexible services into its managed care framework, in compliance with federal rules, by January 1, 2025.[37]

THE COMMUNITY SUPPORT PROGRAM

The Community Support Program (CSP) was established prior to ACOs, but it offers important HRSN-focused services to a targeted group of MassHealth members – including certain ACO enrollees. CSP navigators assist individuals by:

- Providing service coordination
- Assisting with obtaining public benefits (such as Social Security, SNAP, and others), housing, and health care
- Developing a plan in the event of a psychiatric or SUD crisis
- Fostering empowerment and recovery

Massachusetts recently expanded the CSP program and now operates three distinct programs serving members with three different types of health and social needs:

- CSP for Homeless Individuals (CSP-HI), for members experiencing homelessness. The new Demonstration expands eligibility for this specialized CSP to people who did not meet the narrower definition of "chronically homeless" under prior Demonstrations.
- CSP for Individuals with Justice Involvement (CSP-JI), for individuals who live in the community and have been released from a correctional institution within the past year and are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board. CSP-JI provides specialized services to improve and maintain health while transitioning back to the community and to promote successful community tenure. This enables the state to expand the Behavioral Health Supports for Justice-Involved Individuals (BH-JI) program, in which health care navigators engage with individuals prior to release from incarceration, post-incarceration, on parole, and on probation and assist them in accessing BH services and community supports.
- CSP Tenancy Preservation Program (CSP-TPP), for individuals facing risk of eviction as a result of behavior related to a disability (e.g. mental illness, intellectual disability, substance abuse, aging-related impairments).

V. IMPACT OF THE ACCOUNTABLE CARE ORGANIZATION PROGRAM

The MassHealth ACO program is a programmatic and operational innovation with ambitious goals. While it is still too early to know if the ACO program has brought long-lasting improvements to MassHealth members' health and to the program's costs, a number of studies have reported on the ACOs' early impacts. An independent interim evaluation of the MassHealth Demonstration, of which the ACO Program is a part, and several other academic studies, highlight some common themes, detailed below.

DELIVERY SYSTEM TRANSFORMATION

The interim evaluation, which covers the first two (or, for some measures, three) years of the program, reported higher than expected enrollment in ACOs – 75 percent of eligible members by the end of 2020, far exceeding the 35 percent target. There were favorable shifts towards more primary care visits and reductions in inpatient and "low-value" care – such as imaging for low back pain, use of opioids at high dosages in those without cancer, antibiotic use without strep testing – though emergency department visits did not similarly decline.[38] Another study, based on interviews with stakeholders in the ACO program, noted progress toward improving care delivery – fine tuning care management programs, adding community health workers to care teams, and expanding focus on HRSN, for example.[39]

ESTABLISHING PARTNERSHIPS

Organizations participating in the ACO program were generally enthusiastic about the prospects of new partnerships among ACOs, CPs, and social service organizations (SSO).[40] ACO leaders in one study thought the partnerships had the potential to improve patient experience, though they were less optimistic about their impact on health utilization and costs.[41] While there was broad consensus about the potential value of these partnerships, the work to establish them encountered early challenges, including administrative burden, data sharing, building relationships, lack of flexibility in CP program design and lack of structure in ACO-SSO relationships, communication, and workforce capacity, among others.[42, 43, 44, 45] MassHealth has been working with ACOs, CPs, and SSOs to address these challenges as the program matures. And certain factors facilitated partnerships, including MassHealth allowing ACOs to use FSP funds for administrative costs such as hiring enrollment staff and raising awareness of the FSP among ACO clinicians.[46]

CARE COORDINATION AND INTEGRATION

Many entities participating in the ACO program invested within and across organizations in strategies to improve coordination and collaboration.[47] The interim evaluation found that most surveyed members, providers, and staff reported high levels of coordination, both within organizations and with external providers, and a smaller majority reported good coordination with community resources.[48] One study surveyed primary care practices about care integration in five areas of service delivery and found higher degrees of integration with diabetes services, BH services, and other clinical services, and relatively lower levels of integration with social services and LTSS. The study found that clinical integration was positively associated with perceived care quality improvement; social service integration was positively associated with addressing equity; and BH and LTSS integration were positively associated with ACO satisfaction.[49]

PATIENT EXPERIENCE

In the interim evaluation, members consistently gave their care positive ratings in member surveys about primary care, BH, and LTSS. The interim evaluation did not assess the FSP in detail because it had not been operating for long, but in a published study of a single ACO, members who received nutrition services in the FSP reported increased healthy eating and food security. The FSP enrollees in that ACO reported higher satisfaction with the nutrition services than with the housing services.[50]

INCORPORATING SOCIAL FACTORS INTO THE CARE MODEL

The availability of services to address HRSNs has large implications for improving health equity and population health overall. As might be expected with a program innovation that required creating new processes and forging new organizational relationships, this aspect of the ACO program started slowly. The interim evaluation found that HRSN screening in ACOs was low in the first year (2018) and did not improve in the second, with just over 10 percent of members being screened.[51] Performance likely varied across ACOs; the study of one ACO's implementation experience with the FSP reported that 57 percent of members completed at least one social needs screening in the first 17 months of the program.[52] As the ACO program matures and program features designed to address HRSN (such as FSP) are permanently integrated into MassHealth, improvements in this area of ACO performance can be expected.

To summarize, the MassHealth ACO program has had a promising start, enjoys the support of members, providers, and affiliated organizations, and is moving care delivery for MassHealth members in a positive direction, according to published assessments. Lessons learned from the first five years will be applied in the next five. As data about health and cost outcomes emerge during this period, we may see these lessons and the further solidifying of processes and relationships contribute to the long-term success of the ACO program.

VI. CONCLUSION

MassHealth has extended its ACO program for another five years, with goals to continue the transformation of care delivery, improve members' experience of care, further instill the concept of value-based payment, and increase equity in health care access and health outcomes. The ACOs brought a new style of member-focused care, an emphasis on care coordination, and payment models that reward quality, cost management, and now, improvements in health equity. New ACO contracts seek to build on early successes and address identified challenges. Support for the program appears broad-based among stakeholders in Massachusetts and from the federal government. Over the next five years we may learn more definitively whether ACOs will realize their promise of improving care, controlling costs, promoting equity, and contributing to gains in population health.

APPENDIX A

MASSHEALTH COMMUNITY PARTNERS, AS OF APRIL 1, 2023

Name	Service Areas	Enrollment (as of 09/08/2023)
BH CPs		
Behavioral Health Network Inc.	Holyoke, Springfield, Westfield	1,999
Behavioral Health Partners of Metrowest	Beverly, Framingham, Gardner- Fitchburg, Gloucester, Haverhill, Lawrence, Lynn, Lowell, Salem, Southbridge, Waltham, Woburn, Worcester	4,671
Boston Health Care for the Homeless Program, Inc.	Boston-Primary	1,484
The Brien Center	Adams, Pittsfield	661
Clinical and Support Options, Inc.	Athol, Gardner-Fitchburg, Greenfield, Northampton, Pittsfield, Springfield	786
Community Care Partners, LLC	Attleboro, Barnstable, Boston-Primary, Brockton, Fall River, Falmouth, Haverhill, Lawrence, Lowell, Malden, New Bedford, Orleans, Plymouth, Quincy, Revere, Salem, Somerville, Taunton, Wareham	4,251
Community Counseling of Bristol County	Attleboro, Brockton, Fall River, New Bedford, Plymouth, Quincy, Taunton, Wareham	6,342
Eliot Community Human Services, Inc.	Beverly, Boston-Primary, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Quincy, Revere, Salem, Somerville, Waltham, Woburn	4,146
Innovative Care Partners LLC	Athol, Adams, Greenfield, Holyoke, Northampton, Springfield, Westfield	2,326
The Bridge of Central Massachusetts, Inc (DBA OpenSky Community Services)	Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester	1,795
Riverside Community Care, Inc.	Attleboro, Boston-Primary, Brockton, Framingham, Lynn, Malden, Quincy, Revere, Somerville, Southbridge, Waltham, Woburn	2,365
Stanley Street Treatment and Resources, Inc.	Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham	1,533
BH CP SUBTOTAL		**32,341**
LTSS CPs		
Behavioral Health Network, Inc.	Adams, Athol, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield	1,435
Boston Medical Center Corp.	Boston-Primary, Revere	1,384
Community Care Partners, LLC	Boston-Primary, Haverhill, Lawrence, Lynn, Lowell, Malden, Quincy, Revere, Salem, Somerville, Lowell	1,564
Family Service Association of Greater Fall River, Inc.	Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, Wareham	1,413
Greater Lynn Senior Services, Inc (DBA North Region LTSS Partnership)	Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Revere, Salem, Waltham, Woburn	1,461
Innovative Care Partners LLC	Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, Westfield	2,018

Open Sky Community Services	Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester	1,127
Seven Hills Family Services (DBA Massachusetts Care Coordination Network)	Athol, Attleboro, Barnstable, Beverly, Boston-Primary, Brockton, Fall River, Falmouth, Framingham, Gardner-Fitchburg, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Quincy, Salem, Southbridge, Taunton, Waltham, Wareham, Woburn, Worcester	3,017
LTSS SUBTOTAL		**13,419**
CP PROGRAM TOTAL ENROLLMENT (as of 9/8/2023)		**45,760**

Source: Commonwealth of Massachusetts, "List of MassHealth Community Partners," https://www.mass.gov/info-details/list-of-masshealth-community-partners, accessed June 19, 2023.

Source of enrollment numbers: Data warehouse as of 9/8/2023. These data are point-in-time, and include CP Enrollees who are enrolled in the CP Program that are DMH Adult Community Clinical Services (ACCS)/Post-ACC non-ACO/MCO members.

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5 Selected list; see Model Contract Section 2.6.A (ACPP) and Section 2.4.A (PCACO) for complete list.

6 WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children; SNAP, formerly known as the Food Stamps program, is the Supplemental Nutrition Assistance Program. Both are federal benefits for which many MassHealth members qualify.

7 Certain MassHealth-covered services – many long-term services and supports, for example – are outside the ACO's reponsbility to provide. The ACO must still coordinate access for its members to these services, however. Executive Office of Health and Human Services, Model Contract Appendix C, "ACO Covered Services."

8 Executive Office of Health and Human Services, ACPP Model Contract Appendix C.

9 Executive Office of Health and Human Services, "Section 1115 Demonstration Project Extension Request," December 2021.

10 Executive Office of Health and Human Services, "ACO Bidders' Conference #2: Pricing, Payment, and Finance," presentation slides, April 2022.

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