

The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success

MAY 2021



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Design: Madolyn Allison

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NOTE FROM THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

This analysis of MassHealth's Accountable Care Organization (ACO) program is primarily based on qualitative interviews conducted with 34 individuals, who represent stakeholders directly involved in and affected by the ACO program. These interviews were conducted between fall 2019 and spring 2020; the great majority were conducted prior to two major events that have since shaped the priorities of policymakers, administrators, and stakeholders in Massachusetts' health care system:

- **The global COVID-19 pandemic**, which has infected over 600,000 and killed more than 17,000 Massachusetts residents, triggered a marked uptick in behavioral health challenges, and dramatically increased the social needs of Massachusetts residents. These effects are especially pronounced in economically and socially marginalized communities and communities of color—which are disproportionately served by MassHealth and by the stakeholders interviewed for this report.
- **Increased national recognition of longstanding structural racism and racial injustices.** The murder of George Floyd in May 2020 brought renewed attention to racism and its devastating effects that pervade nearly every aspect of American life—including our health care system. In the wake of this heartbreaking event, Massachusetts' health care stakeholders have renewed their commitment to addressing and remedying health inequities that kill tens of thousands of people of color in the United States every year.*

These events surfaced two important reminders relevant to the MassHealth ACO program: 1) that communities that are economically, socially, and racially marginalized bear disproportionate health and economic burdens and need enhanced attention in our policies and programs, and 2) that being proactive about addressing structural racism and resulting health inequities must be at the forefront of our policy and program development considerations.

Because most interviews were conducted prior to these pivotal events, these themes are largely absent from this report. They are significant issues that must be considered as policymakers and administrators continue to build on and refine the MassHealth ACO program.

*Satcher D et al. "What If We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000." *Health Affairs*. Vol 24(2). 2005. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.24.2.459>.

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INTRODUCTION

MassHealth, which administers the Massachusetts Medicaid program and the Children’s Health Insurance Program (CHIP), launched its Accountable Care Organization (ACO) program in March 2018 to improve coordination of care and health outcomes while lowering costs.¹ The ACO program is part of the state’s Delivery System Reform Incentive Payment (DSRIP) program 1115 waiver, a federal authorization that allocates \$1.8 billion over five years (July 1, 2017–June 30, 2022) to transform the Commonwealth’s Medicaid delivery system.^{2,3} The 1115 waiver built on prior work on the MassHealth ACO Pilot Program (see sidebar for more information on 1115 waivers),⁴ which was developed through the state’s \$44 million State Innovation Model testing grant from October 1, 2013, to April 14, 2018.⁵

What is an 1115 waiver?

In order to test program innovations, states may request approval from the federal government to gain flexibility in how they deliver and pay for Medicaid services under federal Medicaid regulations. Massachusetts’ waiver first took effect in 1997 and has evolved through six extensions to expand coverage, support the safety net, provide incentives for delivery system innovations, and serve as a platform for health care reform.

Under the ACO program, MassHealth enters into value-based payment (VBP) contracts with ACOs. Under these contracts, ACOs take financial accountability for the cost, quality, and experience of care for their members. ACOs’ cost accountability includes physical health services like physician and hospital services, as well as behavioral health (BH)⁶ and pharmacy services.⁷ VBP contracts are designed to align incentives for organizations delivering care to members and to improve health outcomes and lower costs.⁸ In the MassHealth ACO program, ACOs are provider-led organizations that can consist of one or more provider organizations and in some instances a managed care organization (MCO). There are three ACO models in MassHealth’s ACO program, which vary somewhat in the level of involvement of MCOs and the payment model, but all three focus on the same cost and quality goals (see sidebar below for more on ACO models). A list of MassHealth’s 17 ACOs can be found in Appendix A.

MassHealth’s reform efforts also include the Community Partners (CP) Program and the Flexible Services Program. CPs are community-based entities that focus on supporting eligible MassHealth members with BH or long-term services and supports (LTSS)⁹ needs, or both. CPs are identified as a BH CP or an LTSS CP, though some organizations are designated as both.¹⁰ CPs and ACOs are required to work together on members’ person-centered treatment plans, which are designed to help members with BH and LTSS needs receive coordinated care across settings.¹¹ A list of all current CPs can be found in Appendix B.

The Flexible Services Program, which was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2018, allows ACOs to spend Medicaid funds to address certain qualifying MassHealth members’ nutrition and housing supports needs. Before the Flexible Services Program was approved, MassHealth was typically unable to reimburse for these types of nonclinical services to address health-related social needs (HRSNs).^{12,13,14} This new program recognizes that many MassHealth members’ health is deeply affected by housing, nutrition, and other social needs that

For ease of reading, all types of MassHealth ACOs—including those with MCO involvement—will be referred to as “ACOs” in this report.

The MassHealth ACO program has three different ACO “types”, or models. Model A ACOs are Accountable Care Partnership ACOs, where a provider organization or group of provider organizations work with a single MCO to form an ACO. Model B ACOs are Primary Care ACOs, where a provider organization or group of provider organizations directly contract with MassHealth, and MCOs are not involved. Model C ACOs are MCO-Administered ACOs where a provider organization contracts with multiple MCOs and the MCOs contract with MassHealth.

For more information on the ACO models, please see [What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations](#).

clinical services often cannot address. Nutritional supports in the Flexible Services Program may include services such as home-delivered meals for members, while housing supports may include helping members interact with landlords and making home modifications needed to ensure members' health and safety.¹⁵ ACOs are encouraged but not required to contract with Social Service Organizations (SSOs) to deliver these services. SSOs are community-based organizations that have demonstrated success providing social services to MassHealth members in a culturally appropriate way and that have the capacity to partner with ACOs and accommodate an increased number of referrals.¹⁶ Organizations that participate as CPs may also be SSOs.

Additional information on the structure and design of the MassHealth ACO program can be found on MassHealth's website¹⁷ and in the Massachusetts Medicaid Policy Institute's report "What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations."¹⁸

The Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation, enlisted the Center for Health Care Strategies (CHCS) and John Snow, Inc. (JSI) to perform a qualitative analysis of the MassHealth ACO program over its first two years of operation to identify what is working well, challenges stakeholders are facing, and what programmatic changes could be made to strengthen the ACO program as it evolves. This qualitative analysis is designed to complement the formal qualitative and quantitative evaluation that will be conducted by the University of Massachusetts, and to provide a timely resource to inform program improvements available to the state through its 1115 waiver renewal in June 2022 and other opportunities.

This analysis of the ACO program is informed by interviews conducted with 34 individuals representing 21 organizations, including ACOs, MCOs, LTSS and BH CPs, SSOs, and other stakeholders involved in the ACO program. The interviewees were chosen based on criteria designed to ensure balanced representation in relation to geographic distribution, participation in different ACO models, and types of populations served. CHCS and JSI conducted background research to understand the landscape of the MassHealth ACO program, identify which organizations should be included in the larger assessment, and pinpoint which issues were most salient for ACOs, MCOs, CPs, SSOs, and other stakeholders involved in the ACO program. This background research helped inform some of the themes presented in this analysis. After synthesizing the background research, CHCS and JSI conducted a series of interviews between October 2019 and May 2020. Appendix C includes a list of the organizations whose representatives were interviewed.

While the stakeholders interviewed provided valuable perspectives, the authors acknowledge that more input from MassHealth members and on-the-ground providers who participate in the ACO program would be beneficial. Although member advocacy organizations and some practicing physicians who are part of ACO administration were interviewed, CHCS and JSI also planned to interview members and providers who are not involved in ACO administrative duties. This proved difficult, however, due to the onset of the COVID-19 pandemic, which did not allow these perspectives to be represented in the group of interviewees.

KEY THEMES

The authors distilled key themes from the stakeholder feedback, focusing on elements that (a) were most consistent across interviewees, regardless of organization type; (b) were most likely to have an impact on the ACO program's current and future success; and (c) could be altered to improve the ACO program. Five key themes emerged:

1. Interviewees overwhelmingly support the Accountable Care Organization program and praise MassHealth's stakeholder engagement efforts to improve the program.
2. Interviewees report progress toward improving care delivery but acknowledge that making a measurable impact on health outcomes takes time.
3. The Accountable Care Organization program sparked the formation of beneficial partnerships among Accountable Care Organizations, Community Partners, and Social Service Organizations.
4. The Community Partner Program's complexity created a burden for Accountable Care Organizations and Community Partners.
5. The Flexible Services Program is promising, but relationships between Accountable Care Organizations and Social Service Organizations could benefit from more structure.

Interviewees made additional noteworthy observations about specific areas of the ACO program that are also discussed in this section. While they recommended ways to improve specific aspects of the ACO program, no interviewee suggested that the ACO program as a whole should be reconsidered.

1. Interviewees overwhelmingly support the Accountable Care Organization program and praise MassHealth's stakeholder engagement efforts to improve the program.

Interviewees across all types of organizations support the goals of the ACO program and recognize that it can help move the Commonwealth's health care delivery system toward a VBP approach that improves health outcomes and lowers costs. The ACO program's focus on moving incentives from volume of services to value-based care, and its support for primary care, reflect a broader movement within Massachusetts, as many provider organizations are already participating in Medicare and commercial VBP models. Many interviewees also felt the ACO program had already improved care delivery for MassHealth members (more details on these care improvements are outlined in the next theme).

Interviewees indicated that the ACO program's early implementation was rocky at times. For example, when the program first launched and members were initially auto enrolled in ACO health plans based on their primary care physician, members' specialists were not always included in their new ACO network. MassHealth anticipated this challenge and made exceptions for certain members. For example, MassHealth allowed members who were pregnant to continue seeing their existing OB/GYN providers throughout their pregnancy and up to six weeks postpartum.¹⁹ MassHealth also responded to these concerns by extending the initial 30-day continuity of care period for medical care to 90 days, during which members who had not yet transitioned to their plan's in-network providers could continue to see their existing providers. While these flexibilities did help with the transition, they were temporary, and members still had to adjust to their new networks. Interviewees also mentioned challenges forming and working within new partnerships, learning new care planning processes, implementing new data systems, and understanding program rules and requirements. However, many interviewees acknowledged that was to be expected with such a dramatic restructuring of the MassHealth health care delivery system, which included most MassHealth members simultaneously changing their health plans.

The great majority of interviewees reported that MassHealth was a valuable partner in managing and improving the ACO program and working with stakeholders to make sure that their concerns were heard. Part of this effort was organizing formal stakeholder advisory groups like the Delivery System Reform Implementation Advisory Council (DSRIC), which advises the state on implementation of the ACO program broadly, and the Social Services Integration Workgroup (SSIWG), which focuses on opportunities within the program to address health-related social needs. Interviewees who participated in these groups praised the groups' work. Interviewees also noted that MassHealth responded effectively to concerns raised by stakeholders through these and other forums and are continuing to engage stakeholders to develop solutions for ongoing challenges. One interviewee praised MassHealth's response to the challenges of the CP Program (detailed in later themes in the report), noting that the agency is "taking a step back and trying to think about some ways [to] modify the program" and described that work as "really important." Another noted that "MassHealth has been great to work with ... We can sit down and have a conversation and when you have a bunch of providers in the room saying 'These are two elements you've got to fix, it's not working,' they listen, and they respond." However, some interviewees reported that even as positive changes took place, some of those changes were disruptive and led to their organization's failure to develop a "rhythm" during early program implementation. In general, while there were some concerns about the program rollout, the overall impression of the ACO program was very positive, and interviewees noted that a lot of progress had been made since the ACO program was implemented.

2. Interviewees report progress toward improving care delivery but acknowledge that making a measurable impact on health outcomes takes time.

Any large-scale innovation like the ACO program will inevitably take time to fully roll out and have an impact, and interviewees acknowledged this reality. However, many interviewees also reported making significant progress on activities designed to improve MassHealth members' health and reduce costs over the ACO program's first two years.

Many interviewees said that one of the major benefits of the ACO program is that they were able to invest DSRIP funds to significantly expand ongoing work. While ACOs are working on developing new programs as well, many emphasized that making existing activities more robust or "fine-tuning" program elements to more effectively meet the needs of MassHealth members was what they focused on to make an immediate impact. For example, Partners HealthCare Choice ACO²⁰ used DSRIP funding to expand a successful provider-led care management program—the enhanced Partners Health System Integrated Care Management Program (iCMP PLUS)—to MassHealth members. Founded in 2006, iCMP provides home-based care, care coordination, and access to enhanced services for high-risk patients, and it has been shown to improve patient outcomes.^{21,22} As another example, Boston Children's Hospital's Rainbow and Kids and Adolescents with Special Abilities (KASA) programs, which serve children with complex medical and social needs, were augmented with additional staff to better engage patients and their families (see "Boston Children's ACO-Enhanced Rainbow and KASA Programs Reduced Emergency Department Visits" on page 13 for more information). These additional investments made by the ACOs in care management programs offered a tangible benefit and avoided spending time and money "reinventing the wheel." The expansion of existing programs has benefited others outside the MassHealth ACO populations as well. One interviewee noted that their organization now applies the care coordination improvements made possible by the ACO program to all the populations it serves, not just MassHealth members.

Many organizations also shared that they had used DSRIP funds to add new members to their care teams, including community health workers (CHWs) and other nonclinical health care workers. CHWs can be a critical part of achieving ACO program goals; they have been shown to improve health outcomes, promote health and economic equity, improve patient engagement, and generate a financial return on investment for the health care organizations that utilize them.²³ BeHealthy Partnership ACO used DSRIP funds to hire, train, and integrate CHWs into their care teams (see "BeHealthy Partnership Embraces Community Health Workers' Importance to Team-Based Care" on page 14 for more detail about their experience).

The ACO program has also helped participating organizations expand their focus on health-related social needs (HRSNs), such as adequate housing and nutrition. Because social determinants of health contribute significantly to persistent and pervasive health disparities, particularly in communities of color,²⁴ some interviewees noted that they believed the ACO program's focus on HRSNs would ultimately help improve health equity for the populations they serve. Interviewees said that while many relationships among ACOs, CPs, and SSOs already existed, the ACO program allowed these relationships to take a more formal structure, under which the organizations could undertake new collaborative efforts to address HRSNs. Interviewees also noted that the ACO program's focus on screening for social needs has spurred ACOs and CPs to pay more attention to their patients' HRSNs. For example, BeHealthy Partnership ACO worked to develop a shorter, more effective screening tool for HRSNs, which is now in widespread use in their ACO provider locations in Western Massachusetts. One representative of an ACO noted that its staff have observed a significant change in how providers think about patients' social needs, and that providers are now more likely to take these needs into account when providing care. Likewise, the development of shared care plans—in which ACOs, CPs, and other providers, with member input, develop a single document outlining care coordination responsibilities and goals—has expanded the scope of how providers think about individual members' needs. One interviewee said that the development of care plan goals focused their attention on the members' own priorities, specifically noting that for one patient, getting their child to school on time was more important to them than managing their own blood sugar levels. This additional knowledge helps providers develop a greater understanding of their patients' life circumstances, and, in turn, provide patients with optimal person-centered care and supports.

While interviewees shared many individual elements of program success, they also noted that this progress may not be picked up immediately in quantitative measures of health outcomes and total cost of care. Interviewees acknowledged that rigorous evaluation of programs as expansive as the ACO program takes time. For example, an interviewee at a BH CP noted that this early in program implementation, insufficient quantitative data is available to show sustained impact from their work. This is also a major factor in efforts to address HRSNs, as many interventions targeting HRSNs take considerable up-front investment but may provide longer-term health care cost savings.

Interviewees also indicated that data lags and privacy concerns limit the ability to achieve improvements in quantitative health outcomes and total cost of care. Many interviewees noted that some data from MassHealth is significantly delayed. Some lag time is common for claims data regardless of the payer, and MassHealth reports it is generally able to achieve next-month delivery of claims feeds, which they believe to be on par with or only slightly slower than industry standards. Nonetheless, interviewees noted that the delays in summary reports from MassHealth in particular limited ACOs' ability to track patient progress, effectively manage total cost of care, or analyze population-level data in a meaningful way.

Interviewees noted that various federal privacy laws and regulations have also made it challenging to access a complete picture of their patients' health and service utilization. Interviewees cited learning to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) as having delayed and created obstacles in the sharing of information between SSOs and ACOs. They also pointed to a federal regulation, 42 C.F.R. Part 2, that restricts sharing of substance use disorder (SUD) data. A BH CP interviewee referred to problems accessing SUD-related data for the "vast majority" of their organization's patients who have an SUD, as a result of 42 C.F.R. Part 2. This federal rule, intended to protect patient confidentiality related to SUD data, requires that patients affirmatively consent to this type of data exchange. But it can also significantly hamper sharing this data for care coordination among health care organizations and constrains communication between BH CPs and ACOs.²⁵ Finding ways to work within or around these data limitations will take time to develop and get right, but is an essential step to ultimately making a measurable impact on health outcomes and total cost of care.

Many interviewees also noted that the financial incentives provided by the ACO program thus far have not fully deterred volume-based approaches to care delivery. One interviewee noted that value-based health care creates opportunities for providers and provider organizations to receive positive rewards for managing patients' care correctly

and keeping them healthy. The interviewee also noted, however, that enough fee-for-service architecture remains in the health care system overall that providers now “feel like they have to do [the value-based health care work] and see 20 patients in the course of the day.” Enough of the overall budget of this interviewee’s ACO was based on fee-for-service payments that they still felt “shackled” to the fee-for-service system. Payment transformation has also been slow to move from the ACO to the individual provider level, with many individual providers not having their compensation changed directly by the ACO program. This is not, however, uncommon in ACO and other VBP programs.²⁶

3. The Accountable Care Organization program sparked the formation of beneficial partnerships among Accountable Care Organizations, Community Partners, and Social Service Organizations.

Perhaps the theme that interviewees mentioned most consistently as a success of the ACO program was the value of the new relationships established among ACOs, CPs, and SSOs in the program’s first two years. ACOs noted that the ACO program created a valuable opportunity for health care, community-based, and social service organizations in Massachusetts to collaborate on important topics, like HRSNs and social risk factors. By creating financial incentives to better address patients’ HRSNs in order to improve quality and reduce the total cost of care, the ACO program fostered an environment where ACOs are working with CPs and SSOs to collaborate on approaches to improve members’ health in a way that was not incentivized in the fee-for-service model.

Notably, several participating organizations consisted of partnerships established to take part in the ACO program. Seven Hills Foundation established the Massachusetts Care Coordination Network (MCCN), a coalition of five partner organizations, to serve as an LTSS CP in multiple regions of the state. MCCN noted that the ACO program created incentives to extend its network and allowed it to “look at who does [this work] best, and who [MCCN] can learn the most from.” Likewise, Community Care Cooperative (C3) is a coalition of health centers established to collectively participate in the program as an ACO. An interviewee from one of these organizations noted that the relationships between the partner organizations were enhanced by participating in the ACO program, and that organizations were more enthusiastic about sharing best practices to benefit ACO members than previously.

Interviewees also reported that the ACO program helped strengthen existing relationships among ACOs, CPs, and SSOs, and allowed them to establish formal structures with one another. One BH CP noted that they had long worked informally with a number of organizations before the ACO program was launched, but the ACO program allowed these organizations to make a natural transition to participate together as a BH CP, formalizing and enhancing their relationship.

“Everybody we’re working with wants this [ACO program] to work. Everyone at the hospital system is trying to get to yes, on every problem. We are not fighting each other. I think we’re fighting some of the systems that we have to wade through, but we’re not fighting each other at all. And that’s great.”

While much of the new or improved relationships made within and among ACOs, CPs, and SSOs were cited in a positive manner, interviewees also stated that actually formalizing relationships between these different types of entities was difficult due to ACO program requirements. These concerns are discussed at length in the following themes.

4. The Community Partner Program’s complexity created a burden for Accountable Care Organizations and Community Partners.

Almost universally, interviewees noted that the formation of close partnerships between ACOs and community-based LTSS and BH providers through the CP Program was a step in the right direction and that more comprehensive care coordination for complex patients who needed those services was a valuable goal. One ACO representative stated that partnering with community-based BH providers through the CP Program allowed the ACO to dramatically expand its BH network. However, the ambitious scope and structure of the CP Program has created significant challenges for those participating as CPs and the ACOs contracting with them. The CP Program’s complexity was identified as a major challenge and came up unprompted in nearly all interviews, across ACOs, CPs, SSOs, and other stakeholders.

“It’s putting a big, complicated program in a big, complicated program. So it’s complicated.”

Almost all ACOs and CPs interviewed described the structure of the CP Program as rigid, administratively complex, and an impediment to successful care coordination. Some interviewees stated that the structure lacks flexibility and therefore “discourages innovation.” Most interviewees involved indicated that the significant amount of documentation and paperwork required to chronicle their ACO-CP relationship took valuable time and resources away from actually building collaborative relationships and delivering care to members.

The most frequent structural issue of the CP Program cited by interviewees was how member care plans are developed. BH CPs and ACOs are required to work together to develop a person-centered treatment plan, and LTSS CPs and ACOs are required to develop a LTSS care plan for patients who are attributed to these CP types. While ACOs and CPs did appreciate the need to coordinate with each other on care planning, the structure of the program left them

COMMUNITY PARTNERS (CPs)—OVERVIEW OF SUPPORTS

	Behavioral Health CP	LTSS CP
Outreach and engagement	•	•
Comprehensive assessment and person-centered treatment planning	•	
Care coordination and care management across medical, behavioral health, and LTSS	•	
Supports for transitions of care	•	•
Medication reconciliation support	•	
Health and wellness coaching	•	•
Connection to social services and community resources	•	•
LTSS care planning including providing informed choice of services and providers		•
LTSS care coordination		•

Source: www.bluecrossmafoundation.org/sites/g/files/cspkhs2101/files/2020-09/ACO_PrimerUpdate_Sept2019_Final.pdf.

What Are CPs, and What Are Their Responsibilities?

CPs are community-based organizations that work with ACOs to offer support services for individuals with extensive long-term services and supports (LTSS) and/or behavioral health (BH) needs. There are currently 18 BH CPs and nine LTSS CPs participating in the program, and ACOs were initially required to contract with all BH CPs and at least two LTSS CPs in the geographic area that they serve. However, recent policy changes, effective in 2020, allow ACOs and CPs to pursue “preferred relationships” and request permission to end ACO-CP contracts that are burdensome. BH CPs are responsible for performing care management, care coordination, health promotion, transitional care, member and family support, and referral to community and social supports for identified ACO members. LTSS CPs are responsible for providing support to ACO members with LTSS needs. ACOs are required to delegate responsibilities to LTSS CPs for needs assessments for specific services, member and family support, and referral and navigation assistance. While CPs provide coordination and participate in the care team, they do not authorize services or perform utilization management.*

Until recently, MassHealth was responsible for identifying members for BH or LTSS CP supports, based on the members’ past service use, and assigning them to a CP in their service area. The responsibility to identify and assign members to CPs now lies with ACOs. This change is intended to provide ACOs with the flexibility to assign their members to the CP that will best support successful member outreach and implementation of the model. When a member is assigned to a CP, the CP will first conduct outreach. Once a member is contacted, next steps in the process include engaging the member by completing a care plan with the member’s input and beginning to deliver CP supports.

* Blue Cross Blue Shield of Massachusetts Foundation. *The Masshealth Waiver 2016– 2022: Delivering reform*. Available at: <https://bluecrossmafoundation.org/publication/masshealth-waiver-2016%E2%80%932022-delivering-reform>.

little flexibility as to how to do so. The delineation of the work between the CPs and the ACOs—that the CPs engage members and develop care plans and deliver them to ACO primary care providers (PCPs) for approval—was criticized by both parties as too restrictive and not flexible enough to allow for productive ACO-CP relationships to form organically. One interviewee specifically noted that the process of CPs developing the care plans and then sharing with ACOs for PCP signoff presented two key problems: (1) while CPs are paid for some initial outreach and engagement work for assigned members, they ultimately need the ACO/PCP to sign off on the care plan to receive full payment, thus creating financial uncertainty for the CPs after having invested time and resources in care plan development; and (2) CPs, which historically have focused on meeting members’ nonmedical needs, are now responsible for developing care plans that are medically focused. ACO interviewees, some of whom are practicing physicians, also found this process suboptimal. Some ACO interviewees explained that they felt like they were signing something that they did not necessarily agree with and did not have a significant role in developing. However, one CP noted that although the process to actually create a member’s care plan was arduous, the care plan itself was a valuable resource for the ACO, CP, and member to collectively manage the member’s health, and once completed, the plan only needed to be updated as needed from that point forward.

In addition to the problems with the care planning process, ACOs and CPs stated that the CP Program’s requirements for the structure of ACO-CP relationships led to forced relationships that were not productive. For example, one interviewee from an ACO noted that their organization had in-house resources to meet some of their members’ complex BH and/or LTSS needs, but it still had to contract with CPs to comply with program requirements that ACOs partner with all BH CPs and at least two LTSS CPs in their service area (described in more detail below). As a result, those existing in-house resources were underutilized since some members received the same services in-house that others received through CPs. MassHealth noted that the requirement for ACOs to partner with CPs for these services was intentional despite such tradeoffs, in order to promote a community-based approach to care coordination support rather than centering these supports in a hospital-system-based environment.

The ACO program’s initial requirement that ACOs in a region contract with all BH CPs and at least two LTSS CPs in the region, while meant to ensure that members who needed services could receive them without complication, created a significant burden for both ACOs and CPs. For CPs, the more ACO relationships they had, the more contracting processes and administrative tasks were necessary, and in some areas the complexity of those relationships could be overwhelming. One CP interviewee noted that the

administrative burden the program placed on their organization caused the CP to hire a full-time “tracker,” whose sole job was to manage the details of the CP’s relationships with ACOs, which included monitoring how patients were engaged, what types of data to send to which ACO, how to send the data, and other purely administrative concerns. The tracker also had to follow up with different ACOs on different time frames—the interviewee indicated that some ACOs have dedicated staff to help return care plans quickly, but others could take four months to send care plans back. A Boston-area CP interviewee noted that ACO program requirements meant that they had to contract with 10 ACO partners, whose contracts were all significantly different. This resulted in the CP negotiating an estimated 12–14 different processes for activities like patient outreach, engagement, and care management. This “turned out to be 140 different documented processes because each ACO had a different way of communicating.” In 2020, MassHealth updated its contracting policy, allowing ACOs and CPs to pursue “preferred relationships” and request permission to end ACO-CP contracts that are burdensome.²⁷ This added flexibility could help ACOs and CPs streamline the number of their relationships and contracts, though more granular aspects of the relationship like the contract terms may still prove challenging.

“One [ACO] has to use box.com. Another uses Dropbox. Others use [Secure File Transfer Protocol] sites. Others, you have to fax. Some want to use the Mass Hlway....It’s all over the place.”

Despite the multitude of ACO-CP contracts, interviewees also mentioned that there were many more MassHealth members who are eligible for BH support through the CP Program than BH CPs had the capacity to serve—causing

some eligible MassHealth members to not be served by the CP Program. This effectively created two systems of care plan development and coordination for these members: those served by CPs working with an ACO, and those served solely by the ACO. It was not apparent from interviews whether this occurred more commonly in some geographic areas than others. MassHealth acknowledged that more members meet the BH criteria than end up being assigned to the CP Program, but MassHealth indicated that this problem is specific to BH CPs; LTSS CPs still have capacity. At the same time, however, MassHealth noted that the number of assigned members that BH CPs ended up “fully engaging” (i.e., members whom CPs have contacted, completed a comprehensive assessment of their needs, and developed and obtained PCP sign-off on a care plan) has been lower than the number of members BH CPs report they’re able to support. Similar challenges were noted by interviewees.

CPs also indicated that the lists of members eligible for CP supports that they received from MassHealth presented their own challenges. Interviewees reported that much of the data was not accurate and that it took up to six months just to track down some of the members on their list. When those members were finally identified, many were no longer enrolled in MassHealth. Data accuracy is a common challenge for Medicaid programs; for example, New York struggled with similar data accuracy issues during early implementation of its health homes program.²⁸ Some CPs found creative means to work around the issues. MCCN, for example, found that experienced care coordinators grew frustrated with being unable to contact members, leading to high staff turnover. Therefore, it hired individuals experienced in fundraising who were skilled at making cold calls for initial outreach and who handed the members over to experienced care coordinators once engaged.

Despite its complexities, the CP Program did encourage some positive developments noted by interviewees. One interviewee from a BH CP noted that the ACO program improved the level of coordination between physical health care and BH providers, particularly through shared care plans and integrated care with ACOs. This BH CP interviewee also noted that the ACO program allowed the organization to scale its care management program considerably, through the “stable source of financing” provided to cover the care needs of the 1,200 patients it had been assigned from the ACOs.

5. The Flexible Services Program is promising, but relationships between Accountable Care Organizations and Social Service Organizations could benefit from more structure.

While interviewees noted that the CP Program was hampered by its rigidity and complexity, the representatives of many ACOs, CPs, and SSOs expressed the desire for more structure in the ACO program’s efforts to address HRSNs. Given that the Flexible Services Program was not rolled out until January 2020, interviewees had some experience setting up the program but very little experience actually implementing it at the time of the interviews for this report. However, those who did comment on the Flexible Services Program expressed optimism about the program’s scope and potential.

Representatives of ACOs, CPs, and SSOs expressed support for the Flexible Services Program and noted some early successes. Interviewees from SSOs and ACOs suggested that despite initial challenges (discussed below), new relationships and approaches related to addressing MassHealth members’ HRSNs were taking shape. For example, About Fresh, an SSO, is working with Mass General Brigham ACO and Brigham and Women’s Hospital to address food access through its mobile and pop-up markets (see “Prescribing Food to Address Health-Related Social Needs” on page 15).

Some interviewees also pointed out the limitations of addressing deeply entrenched problems, like the lack of affordable housing in Massachusetts, through the ACO program. For example, one interviewee noted that they are able to connect MassHealth members to public housing resources (assisting members with obtaining and completing housing applications is one of the housing supports covered by the Flexible Services Program), but that connection is unlikely to help their members because there is currently a seven-year wait for placement in public housing. Another interviewee worried that the power imbalance between ACOs and SSOs would lead to relationships and arrangements that tended to “medicalize” some of the work related to HRSNs. As a result, this interviewee feared that supports and services previously delivered through and in community-based settings would increasingly be delivered via medical facilities,

health care providers, and health care system processes. The interviewee did, however, note the benefits of co-location—embedding ACO staff in an SSO, and vice versa. Similarly, MassHealth noted that such models could have certain advantages for MassHealth members, such as better integration of social services with medical care.

Some SSO interviewees reported that they did not yet interface well with the health care system. ACO and SSO interviewees noted that the electronic health records and medical software used by ACOs were not interoperable with the data systems and programs used by SSOs, resulting in the need to enter the same data into two different programs. One interviewee explained that there were challenges understanding privacy regulations around transmission of member data, specifically noting that both the SSO and ACO provider teams were initially unsure whether data exchange with the SSO would comply with the federal Health Insurance Portability and Accountability Act (HIPAA). The interviewee noted that the launch of the formal partnership between the SSO and ACO was significantly delayed by the need to research these requirements, implement the steps to ensure compliance, and conduct a separate technology review required by the ACO before data could be exchanged.

SSO interviewees also felt that more infrastructure support may be needed for SSOs to participate fully in the program. All SSO interviewees noted that the Social Services Organization Flexible Services Preparation Fund (Prep Fund), a grant program (with an associated technical assistance program, including a learning community) run by the Department of Public Health to help SSOs overcome organizational and technological barriers that may limit their ability to provide services to ACO members, helped with specific infrastructure needs (see sidebar). Interviewees, however, also noted that more financial and/or technical assistance was needed to get SSOs where they needed to be to fully engage in the program.

Some ACO interviewees also said that the return on investment for SSO-delivered services was not guaranteed the way returns were for providing a particular drug or medical procedure, and therefore ACOs were hesitant to invest significantly in infrastructure to support the delivery of Flexible Services models. Another interviewee remarked that because the ACO program has a clear goal of yielding cost savings as measured on an annual basis, it may lead to a focus on short-term return on investment. As a result, this interviewee feared, some housing or nutrition-related interventions that might have great benefit to members but did not generate a financial return in the medical care the members needed in the short term would not be pursued. The interviewee suggested first focusing on program quality measures, such as how frequently consumers used Flexible Services and engaged with SSOs—especially in the early years of the Flexible Services Program.

Social Services Organization Flexible Services Preparation Fund (Prep Fund)

The Prep Fund is a grant program run by the Massachusetts Department of Public Health (DPH) to help SSOs that are partnering with ACOs in the Flexible Services Program overcome the organizational and technological barriers that could limit their ability to provide services to ACO members. As of February 2020, the Prep Fund had provided 18-month grants to 14 SSOs, ranging from \$95,796 to \$250,000. One SSO, for example, received \$250,000 to create a bi-directional referral system by connecting its existing case management/database system to its ACO partner's referral system. In addition to funding, Prep Fund grantees and their ACO partners receive technical assistance from DPH, including learning labs (e.g., legal or technology issues, staff training practices, etc.) and racial equity training.

Source: MassHealth Delivery System Reform Implementation Advisory Council Meeting #18 slide deck (February 7, 2020).

Finally, while both SSO and ACO interviewees recognized the value of addressing ACO members' HRSNs, they often differed on the best way to do so. Unlike with the CP Program, ACOs are not required to contract with SSOs, and one interviewee voiced concern that some ACOs would be inclined to “build” capacity to address members' HRSNs in-house rather than “buy” these services from SSOs. All SSO interviewees underscored their desire to be true partners alongside ACOs, and felt they had unique expertise to improve care for MassHealth members. It's important to note that most interviews for this analysis were conducted before the Flexible Services Program had fully launched, so interviewees had not yet seen complete data on how many Flexible Service Programs “built” capacity within an ACO rather than buying services from SSOs. According to data subsequently provided by MassHealth, as of January 2021 over 85 percent of approved Flexible Services Programs for calendar year 2021 involve partnerships with SSOs, indicating that in the majority of these programs approved by MassHealth, ACOs “bought” rather than “built” these services.²⁹ To remedy the potential for duplication and address the power imbalance between ACOs and SSOs in the

negotiation of Flexible Services Programs, SSOs suggested that ACOs be required to contract with SSOs to address HRSNs, much as they are required to contract with CPs. They also recommended that a model contract would be helpful to streamline ACO-SSO arrangements.

Additional Noteworthy Observations

Some interview content did not fit into the five primary themes described above. Additional feedback gathered through the interviews, outlined below, includes insights that may have been expressed by only one type of interviewee (e.g., ACOs, MCOs, CPs, SSOs); general thoughts regarding an ACO program element; or forward-thinking suggestions on what the ACO program could do in the future.

Value of Patient and Family Advisory Councils and Consumer Advisory Boards

Some ACO and CPs interviewees highlighted Patient and Family Advisory Councils (PFACs) and Consumer Advisory Boards (CABs) as key components of the ACO program. All ACOs were required to establish a PFAC to connect with the community members they serve, while CPs were required to form a CAB to better engage the members they serve. PFACs and CABs were required to have a relationship with the governing board of the ACO or CP. Most ACO and CP interviewees were enthusiastic about the process, and in many cases the PFACs and CABs were another area where the ACO program allowed organizations to build on existing efforts to gain consumer input. An ACO interviewee shared that the PFAC allowed them to focus less on technical issues related to managing care delivery processes and systems and, instead, focus on “those who we’re caring for.” It is important to note that while most ACO and CP interviewees value PFAC and CAB input, PFAC and CAB members were not interviewed for this report, and therefore it is not known if the members of these groups found the experience positive.

Suggestions to Streamline the Data-Sharing Process

Representatives of ACOs, CPs, and SSOs indicated many data-sharing challenges, which were mentioned in several of the five primary themes. In response to these challenges, numerous interviewees expressed a desire for MassHealth to create a single, standardized data-sharing system in place across the Commonwealth that ACOs, CPs, and SSOs could access as needed. One CP interviewee described investing time, money, and energy in a health data software system and related workflows early in the ACO program’s implementation, only to later transition to another system that better met their programmatic needs. This interviewee wished MassHealth had established or recommended a specific data exchange system early in the roll-out of the ACO program so their organization could have avoided wasting resources. MassHealth reports that it has had substantial engagement with ACOs, CPs, and SSOs on this topic, and that it has received mixed feedback on the utility of standardizing data-sharing software—especially at this stage in the implementation of the program, since organizations have already invested heavily into their current software and data-sharing processes.

Concern About Risk Adjustment for Social Factors

In 2017, MassHealth launched one of the first risk adjustment models in Medicaid that incorporates social risk factors, including housing status, income level, and a measure of the economic stress in the member’s neighborhood (this includes indicators such as percent of families below the federal poverty level and percent of adults who are unemployed in the neighborhood). Multiple interviewees expressed concern about whether the ACO program’s risk adjustment methodology could accurately determine rates for complex patients. Interviewees noted that these risk factors, particularly homelessness, were higher drivers of risk and costs than the model calculated, which could lead to significantly insufficient rates for high-need, high-cost members. Some interviewees mentioned that this effect was likely more pronounced in ACOs with many members experiencing homelessness and members with a high number of social risk factors.³⁰ MassHealth has adjusted and enhanced the model since most of these interviews were conducted, and it continues to engage with MCOs, providers, and other stakeholders to further improve the risk adjustment approach.

That the risk adjustment approach has required ongoing modifications is not surprising. MassHealth is one of the first Medicaid programs in the country to incorporate social risk factors, and other state programs that have incorporated these factors, such as Minnesota's Integrated Health Partnerships,³¹ have faced similar challenges. Calculating a risk score is an intricate, complex process, and social risk factor models are not as well tested as medical risk models. Therefore, MassHealth may need to continue to work with its partners to understand how accurately the risk adjustment tool accounts for actual experience and how it can continue to be refined and improved over time.

Insufficient Focus on the Pediatric Population

Interviewees representing pediatric practices participating in the ACO program noted that there is not much evidence that VBP models improve quality of care and achieve a return on investment for pediatric populations. In addition, Boston Children's ACO, the one ACO that is entirely focused on the pediatric population, noted that pediatric patients do not present clear-cut opportunities for streamlining processes and creating provider incentives for savings. Many healthy pediatric patients are low cost, and those who are high cost are typically very complex patients receiving well-coordinated care. Moreover, specialty care and expertise in pediatrics is concentrated in academic medical centers, and there are currently few, if any, options to move that care to less costly settings. Interviewees from Boston Children's ACO noted that their organization dramatically expanded a medical and social care coordination program as a result of participating in the ACO program (see "Boston Children's ACO-Enhanced Rainbow and KASA Programs Reduced Emergency Department Visits" on page 13). However, interviewees were still concerned that since the return on investment for children is typically long term, these goals and investments may be in tension with shorter-term financial expectations.

Additionally, one CP interviewee noted that families with children were receiving supports from other sources outside the ACO program, such as schools. Therefore, it was more difficult to engage these families in care planning, since families often thought that an *additional* care manager or resource specialist was not necessary to meet their needs. Since CPs were required to develop and deliver the care plan to their attributed ACOs, CPs had to engage in further coordination to work with those other existing care managers.

Interviewees also noted, however, that MassHealth has recognized that pediatric populations may need a unique focus. Along these lines, the Child and Adolescent Health Initiative (CAHI) work group, a multisector work group convened by the Massachusetts Chapter of the American Academy of Pediatrics, has provided feedback on the pediatric experience of the current 1115 waiver's implementation. MassHealth has engaged with CAHI and discussed how to incorporate aspects of this feedback into the ACO program. CAHI has also offered recommendations to inform the design of the 1115 waiver renewal in June 2022. The resulting report, "Moving to the Vanguard on Pediatric Care: Child and Adolescent Health Initiative Recommendations for the MassHealth Section 1115 Waiver Renewal," was released in September 2020.³² MassHealth is currently running a structured public engagement process to collect broader feedback and recommendations on this waiver renewal, including on how best to invest in pediatric care.³³

Sustainability Concerns

Many interviewees expressed concerns about the long-term sustainability of the ACO program once the Commonwealth's federal DSRIP funding ends in June 2022. As a result, interviewees felt the pressure of delivering significant results in a short period of time to sustain existing investments in technology, personnel, and other areas. Achieving this goal was made more difficult by a variety of factors, including the complexity of the ACO program, significant challenges to meaningfully addressing HRSNs in a short period of time, and the fact that the Flexible Services Program did not launch until January 2020 (midway through the five-year 1115 waiver). Many also felt pressure to design their models to deliver quick results, rather than focusing on more comprehensive, transformative approaches that may take longer to realize their potential.

Boston Children’s ACO–Enhanced Rainbow and KASA Programs Reduced Emergency Department Visits

MassHealth’s DSRIP investments allowed Boston Children’s ACO¹ to enhance two similar programs (based at two different primary care sites) that already served children with complex medical and social needs. These are the Rainbow program, based at Children’s Hospital Primary Care Center at Longwood, and the Kids and Adolescents with Special Abilities (KASA) program, based at Boston Children’s at Martha Eliot Health Center in Jamaica Plain. These programs provide coordinated and multidisciplinary care for children and young adults with a single severe or multiple medical conditions with life-limiting implications (that is, conditions for which there is no cure and that can cause the child to become increasingly dependent on parents and caregivers).² Patients served by the Rainbow and KASA programs typically also have complex social needs that are often missed during standard screenings. These programs create a “safe and secure primary care medical home” to comprehensively manage patients’ unique and varied health and social needs. They achieve this by providing a more robust set of care coordination services and fostering meaningful patient and family engagement with the care team. Ninety percent of those enrolled in the Rainbow and KASA programs are MassHealth ACO members.

Before DSRIP funds allowed Boston Children’s ACO to enhance these programs, patients in the programs received a little extra time with their providers and access to some social services. But using its DSRIP funds, the ACO hired four full-time and two part-time nurse care coordinators that are dedicated to the programs’ patient populations. These nurse care coordinators provide patients with a wide range of comprehensive supports, including offering care between scheduled visits with the patients’ primary care providers; coordinating care across primary and specialty providers; helping patients navigate the complex and lengthy process to obtain approval for and access to needed durable medical equipment and supplies (such as customized wheelchairs); serving as the point of contact for schools; and coordinating with discharge planners to ensure that patients and families have all they need when leaving the hospital. Nurse

care coordinators, having clinical training and being integrated into the medical care team, can also provide direct services—for example, helping troubleshoot a problem with a gastrostomy tube or other equipment in the context of a visit. Families have direct telephone access to nurse care coordinators and know them by name, allowing for close relationships in which patient and family needs are assessed and addressed in real time.

Having dedicated nurse care coordinators has allowed Boston Children’s ACO to spend more time getting to know these high-risk patients and understanding their complex social needs. By doing so, Boston Children’s ACO reports, its nurse care coordinators have become more effective at outreach to and engagement with these patients and their families. And because of the relationship of trust that they’ve built together, according to the ACO, the families are better able to engage with the health care system. For example, families call the dedicated care manager line for guidance when they are considering a trip to the emergency department. The care coordinators are often able to ensure that the patients receive high-quality care in the best setting for their particular needs, which helps to reduce avoidable emergency department visits.

These DSRIP-funded enhancements to the Rainbow and KASA programs, including the increased care management services, have helped to reduce avoidable emergency room visits and associated costs. According to data provided by Boston’s Children’s Hospital, emergency department visits for patients enrolled in these programs have declined by 15 percent since March 2018, the beginning of the ACO program.³

¹ Boston Children’s ACO is an ACO formed between the Boston Children’s Health ACO and Tufts Health Public Plans, and it is the only MassHealth ACO fully dedicated to serving children.

² Does not include pediatric patients diagnosed with autism or behavioral health conditions, which are served through other specialized pediatric programs.

³ This decline in emergency department (ED) visits is based on ED utilization data prior to the COVID-19 pandemic beginning in March 2020 and does not account for the more dramatic drop in ED utilization associated with the COVID-19 public health emergency.

BeHealthy Partnership Embraces Community Health Workers' Importance to Team-Based Care

The BeHealthy Partnership (a partnership made up of Health New England, the Baystate Health Care Alliance, Caring Health Center, and four other Baystate Health Community Health Centers) used DSRIP funds to hire and train 19 community health workers (CHWs) and embedded these CHWs directly into primary care teams working with MassHealth members. The BeHealthy Partnership considers the CHWs and their integration into the primary care teams a key success factor for improving health outcomes for its MassHealth members—a central goal of the ACO program.

Unlike most health care providers, CHWs often connect with members in the communities where they live and work, including through home visits, to establish positive and supportive relationships with members whose complex health and/or social needs put them at higher risk of poor health outcomes. The CHWs work with these members on an ongoing basis to help them navigate and access health and community-based services and to support the adoption of healthy behaviors. The CHWs who work with BeHealthy Partnership members serve a variety of functions, including assisting with medication adherence; reminding patients about upcoming appointments; arranging help with transportation; coaching patients in self-care and effective management of their chronic conditions; and developing health management plans that support the members in achieving their health and wellness goals. Moreover, because CHWs are integrated into the primary care team, they help providers understand members' unique needs and potential barriers to health—which can inform the development of better-tailored care plans. CHWs also help translate information and medical guidance from the clinical care team in a way that members can understand and integrate into their lives.

One essential function of CHWs in the BeHealthy Partnership's model is connecting members to community resources to address health-related social needs—such as inadequate food, transportation, and housing; and physical/emotional safety or financial strain—identified through a social determinants of health (SDOH) screening.¹ The BeHealthy Partnership found that CHWs are often more successful than other care team staff at connecting members to

resources to help address their health-related social needs. There are several reasons for this. CHWs have specific training in making these linkages effectively, and they have extensive knowledge of the communities they serve and the local resources and supports available, so they can direct members to culturally and linguistically appropriate organizations and services. Additionally, successfully connecting a member with a service or community resource can take substantial time that primary care providers and other clinical staff often don't have built into their schedules. Arranging for services often requires multiple telephone calls and extensive coordination between the patient and the community resource. Not only are CHWs positioned to devote the time needed to make these connections, they are also often able to help identify translation and transportation services that a member may need to successfully access these supports.

The BeHealthy Partnership's analysis of its member data suggests these interventions by CHWs can have a profound effect on improving health outcomes. For example, BeHealthy Partnership members with a diagnosis of diabetes who self-reported a health-related social need were engaged by a CHW who connected them to a social service agency or other community support to help address their need. These members' HbA1C levels—a measure of how well controlled a person's blood sugar has been over a period of about three months—were tracked over time. The percentage of these members with poor blood sugar control (HbA1C above 9) decreased from 62 percent at baseline (2018) to 47 percent after they worked with CHWs to connect to supports for their health-related social needs (2020).

Even before the MassHealth transition to the ACO model, Caring Health Center used this team-based care model with integrated CHWs in its practice. After seeing the success of this model at improving members' care experience and outcomes, the BeHealthy Partnership decided to expand this model to other health centers. It used DSRIP funds to pay for CHW salaries, CHW core competency trainings, and consultants to support their integration into care teams. BeHealthy Partnership CHWs are now providing supports to address members' unique needs in all five of the ACO's health centers.

¹ All MassHealth ACOs are required to screen their members for health-related social needs. At the BeHealthy Partnership, this screening occurs in various settings, depending on the member, including at registration or check-in for primary care appointments and during CHW home-visits. If another health center staff member conducts the screening, a referral is made to the CHW to work with the member to address the identified health-related social needs.

Prescribing Food to Address Health-Related Social Needs

In January 2020, MassHealth launched its Flexible Services Program, allowing MassHealth ACOs to pay for health-related social supports in the areas of housing and nutrition. As part of the Flexible Services Program, Brigham and Women's Hospital (BWH), a member organization of Mass General Brigham ACO,¹ contracted with About Fresh, an SSO described below, to improve access to healthy foods (fruits and vegetables) for certain eligible ACO members.

About Fresh aims to address the three primary factors shaping healthy food consumption in low-income communities: affordability, proximity, and cultural alignment. Many low-income communities lack any grocery store at all, leaving them in so-called "food deserts" without convenient access to the foods that they need to be healthy. The problem is further complicated when the healthy foods available are not aligned with shoppers' culture and traditions. About Fresh envisioned a new grocery store model by developing Fresh Truck—a mobile market selling culturally aligned fresh fruits and vegetables to the people and communities in Boston that need them the most.

About Fresh recognizes, however, that affordability is the greatest barrier to healthy eating and believes—based on the consensus of research—that people will purchase healthy foods when they have the financial power to do so.² To increase the purchasing power of shoppers and offer the health care sector a tool for addressing diet-related health risks, About Fresh developed Fresh Connect in 2018.

Provider organizations that have the ability to cover food costs for certain patients can use the Fresh Connect platform to prescribe food for their patients. Health care providers can enroll patients when they screen positive for food insecurity (being without reliable access to a sufficient quantity of affordable, nutritious food) or diet-related disease. Upon enrollment, patients receive a Fresh Connect prepaid debit card (paid by the provider organization) to use to shop for healthy food. About Fresh sends program engagement reports to providers, and the providers use those reports—along with usage and

health outcomes data—to identify the impacts of the program.

BWH has partnered with About Fresh to make Fresh Connect available to certain eligible MassHealth members through the MassHealth-funded Flexible Services Program. To be eligible to participate in this program, Mass General Brigham ACO members must be identified as food-insecure during their social needs screening and must meet at least one of the program's health-needs-based criteria, including uncontrolled diabetes, obesity, and/or high-risk pregnancy.³ BWH enrolls patients meeting these criteria in Fresh Connect. Participants receive \$100 a month for up to 12 months to buy healthy food. At present, Fresh Connect shoppers can use their cards at any of About Fresh's 20 Fresh Truck weekly markets, held in low-income Boston neighborhoods. Members identified by BWH may also use their Fresh Connect funds to purchase home-delivered prepacked boxes of culturally aligned healthy food. Later in 2021, About Fresh will enable Fresh Connect shoppers to purchase fresh fruits and vegetables from a much wider network of vendors, including farmers markets and grocery chains in the region.

BWH staff appreciate being able to offer concrete nonmedical supports to ACO members with health-related social needs. Through its electronic medical record system, BWH is able to track changes in enrolled patients' health status over time in order to evaluate the impact of the program. About Fresh has received extremely positive feedback from shoppers about the power Fresh Connect gives them to purchase the healthy foods they want to eat but could not always afford or access.

As of February 2021, About Fresh and BWH have enrolled 369 eligible ACO members and were adding about 50 new members per month.

¹ Effective March 1, 2021, Partners HealthCare Choice ACO changed its name to Mass General Brigham ACO.

² Smith, Stephen, The New York Times, Dec. 24, 2004, "When eating healthily feels like a splurge," www.nytimes.com/2004/12/24/your-money/when-eating-healthily-feels-like-a-splurge.html.

³ The following is a complete list of the health-needs-based criteria specified by BWH for its Flexible Services Program with About Fresh: uncontrolled diabetes (A1c > 8); uncontrolled hypertension (BP > 140/90); obesity (BMI > 30); major depression or generalized anxiety (PHQ-9 score, GAD-7 score of 10 or greater); high-risk pregnancy (pre-eclampsia, gestational diabetes, or referral to high-risk maternal fetal medicine); cancer (adult and pediatric); malnutrition and failure to thrive (adult and pediatric); asthma exacerbations: 2 or more per year (pediatric); and HIV/AIDS (adult and pediatric).

PROGRAMMATIC RECOMMENDATIONS

Interviews with representatives of ACOs, MCOs, CPs, SSOs, and other stakeholders uncovered a great deal of optimism about the ACO program. It was clear that stakeholders valued the ACO program and would like to see it continue.

However, interviewees also pointed to areas in which the ACO program can and should be improved. The interviews and research conducted for this analysis suggest that the ACO program could be significantly improved if MassHealth focuses on two key priorities: (1) support improved communication and data sharing among ACOs, CPs, and SSOs; and (2) address structural elements that hinder partnerships in the CP and Flexible Services Programs. Although implementing these recommendations in the near term will be challenging given the continued impacts of the COVID-19 pandemic on the Commonwealth, these proposed enhancements are critical to the overall success of the ACO program and its sustainability beyond the current 1115 waiver period. As a result, MassHealth and its stakeholders will need to work together to prioritize the most critical and cost-effective way to implement these recommendations.

Detail is provided below on the two recommended priorities, as well as potential approaches for each. In addition, an overarching recommendation informed by stakeholder interviews is that MassHealth continue to prioritize and leverage its greatest strength identified through the implementation process: its trusting partnership and effective engagement with its key stakeholders in the ACO program. This could be leveraged to continue to improve the ACO program and address these two key priorities, as well to address other challenges outlined in the report, such as developing a program sustainability plan, more meaningfully integrating the pediatric population, and further refining risk adjustment for social factors. MassHealth established formal stakeholder work groups to inform the development of the 1115 waiver renewal, and the issues MassHealth has identified for work group discussion include the challenges surfaced in this report.

Support Improved Communication and Data Sharing among Accountable Care Organizations, Community Partners, and Social Service Organizations

One theme that consistently emerged during interviews is that ACOs, CPs, and SSOs have difficulties sharing data and communicating with one another. Interviewees reported that data being shared across organizations, especially across different types of organizations, was often not timely or accurate, thus hampering the ability of ACOs and their partners to effectively create care plans and coordinate care. Improving data sharing and communication will not be an easy task, and Massachusetts is certainly not alone in facing these challenges. Data integrity and transfer challenges are experienced by all states implementing bold delivery system reforms, especially those that are looking to share data across disparate data platforms including physical health care, BH,^{34,35,36} LTSS,^{37,38} and social services³⁹ in order to coordinate care across all aspects of a member's health. While certain federal privacy barriers, such as HIPAA and 42 CFR Part 2, are likely to remain impediments to data sharing, there are several approaches outlined below that MassHealth and its stakeholders can consider to facilitate more timely and accurate data sharing.

Improve timeliness and accuracy of data shared by MassHealth, as well as organizational IT capacity. Interviewees indicated that issues related to data exchange and care coordination were widespread. Many limitations on program data and care coordination stemmed from the timeliness and accuracy of claims and enrollment data being shared by MassHealth and through the Mass HIway (the state's electronic health information exchange). MassHealth reports that it is generally able to achieve next-month delivery of claims feeds, which they believe to be roughly on par with or slightly slower than industry standards. Nevertheless, interviewees reported that such issues, and particularly delays in summary reports, profoundly affected the ability of ACOs, CPs, and SSOs to use data effectively and must be addressed in order for the ACO program to achieve its potential.

There were additional issues at the CP and SSO levels. In order to facilitate more timely and accurate data sharing between these organizations—which in turn would lead to improved care coordination for members—it is also necessary to improve the IT capacity of organizations transmitting data, particularly CPs and SSOs. This is a challenge

that MassHealth and the Executive Office of Health and Human Services recognized and responded to through the creation of the Social Services Organization Flexible Services Preparation Fund (Prep Fund). This grant program (with an associated technical assistance program, including a learning community) was run by the Department of Public Health to help SSOs overcome organizational and technological barriers that may limit their ability to provide services to ACO members (see the sidebar on page 10 for more information on the Prep Fund). One interviewee mentioned that the Prep Fund was helpful in making infrastructure improvements, but noted that the Prep Fund alone would not be sufficient to meet the need. This challenge is, in part, a tradeoff with the flexible framework for the Flexible Services Program, which allows each ACO to develop its own SSO partnerships rather than requiring them to partner with a defined set of state-credentialed SSOs. This flexibility was intentional, in an effort to enable participation among a wide range of SSOs. It may also have expanded the number of SSOs needing IT and infrastructure support, diffusing available funding across SSOs as a result of this programmatic flexibility. Nevertheless, additional funding, continued technical assistance (particularly to improve data sharing across organization types), and training to help CPs or SSOs make infrastructure improvements in order to work effectively inside more “medicalized” software could speed up the meaningful sharing of data among ACOs, CPs, and SSOs.

Standardize data resources, care coordination protocols, and requirements. Interviewees reported that significant resources were spent by all parties on reporting data to other organizations and MassHealth. As a result, many interviewees suggested that standardization of data transmission processes and resources among ACOs, CPs, and SSOs would be beneficial.

Numerous interviewees expressed a desire for MassHealth to create a single, standardized data-sharing system in place across the Commonwealth. A universal portal for data sharing of medical and nonmedical records would be a helpful tool for this purpose. For example, a universal portal, such as the NCCARE360 model in North Carolina, that will connect health care and social service organizations statewide, and allow them to access resource directories, share information, and make referrals securely,⁴⁰ could help ease the burden of data sharing for organizations that are not used to exchanging data through electronic health records. While this approach may merit further consideration as MassHealth plans for future iterations of the ACO program, MassHealth has engaged ACOs, CPs and SSOs extensively on this topic and received feedback from many stakeholders indicating that it would be difficult to standardize *software* at this point in the rollout of the ACO program, as many systems have already been established. However, as ACOs, CPs, and SSOs continue to upgrade software and systems over time, the state will need to continue to monitor the situation to determine whether a more coordinated statewide approach is needed.

At present, MassHealth and its stakeholders may still be able to work together to develop or standardize certain care coordination protocols (such as reports, screening tools, and requirements for data to be shared across organizations) that would go a long way toward easing the current data-sharing burden. While recognizing the need to balance calls for standardization with requests for flexibility among the numerous partners involved in this program, MassHealth has taken many steps toward standardization for CP processes—for instance, implementing standardized care plan domains in January 2020. Interviewees suggest even more standardization could be helpful. This effort could include establishing norms on the timeliness of data transfer between organizations that require active collaboration, such as care plans and also cost, claims, and race, ethnicity, and language (REL) data. Standardization with respect to the collection of REL data, or at least consistency in reporting requirements, will be critical to enabling MassHealth, and the Commonwealth more broadly, to address inequities in health. Standardized data could also support evaluation efforts, allowing for analysis across ACOs, CPs, and SSOs. For example, one interviewee noted that standardized social-needs screening data could help identify gaps in regional and statewide resources to address social needs. Finally, a standardized business associate agreement for data sharing with specific protocols and expectations in place for how data should be shared between ACOs and CPs or ACOs and SSOs could be helpful.

Address Other Structural Elements That Hinder Partnerships in the Community Partner and Flexible Services Programs

Improving data sharing and care coordination will certainly help organizations collaborate more effectively, but there are also structural elements of the MassHealth ACO program—specifically the CP and Flexible Services Programs—that could better facilitate partnerships among ACOs, CPs, and SSOs and improve member care.

Streamline the CP Program. While interviewees had differing opinions on many aspects of the ACO program, almost all interviewees from ACOs and CPs, and many other interviewees, expressed dissatisfaction with the structure of the CP Program—with many citing the structure of the CP Program as the major flaw of the ACO program. Many ACO and CP interviewees indicated that the structure of the CP Program prevented ACOs and CPs from interacting effectively. Many difficulties were related to data sharing, while others were caused by rigid requirements related to the care planning process. Conversely, interviewees also indicated that more standardization could facilitate how ACOs and CPs interact—including simplifying contract terms, which could streamline the large number of resulting processes that result from the varied contractual stipulations.

In addition to some of the data-sharing recommendations mentioned in the previous section, MassHealth should continue to work with ACOs, CPs, and advisory groups like the Delivery System Reform Implementation Advisory Council (DSRIC) to identify and address the complexities of the CP Program and find the right balance of structure and flexibility. The flexibility MassHealth authorized in January 2020, which allows ACOs and CPs to end ACO-CP contracts that are burdensome, is a step in this direction, as is continuing to improve the care planning process. MassHealth could also consider streamlining contracting methods by either issuing model ACO-CP contracts or by working with stakeholders to develop contracting best practices, which could benefit ACOs and CPs alike. MassHealth could also consider standardizing language, since ACOs and CPs do not always use a common language or terms when discussing aspects of care coordination, services, or even medical or social needs.

Address barriers to establishing ACO/SSO relationships. The Flexible Services Program is one of the more innovative aspects of the ACO program and is popular among interviewees. However, getting relationships between ACOs and SSOs off the ground has been challenging, as many SSOs and ACOs were not experienced in contracting with each other, even if they had previously worked together. An ACO-SSO model contract template, or the formation of regional SSO networks (which would enable ACOs to contract with a single lead SSO entity in each region that could then connect them to other SSOs in the network)⁴¹ could help reduce the administrative complexity of partnership development and avoid duplication of resources. Input from stakeholder work groups, the Social Services Integration Workgroup (SSIWG), and the learning community tied to the Prep Fund should continue, and further support for SSOs in the form of technical assistance or additional funding to improve infrastructure could also be considered. The Managed Care Technical Assistance Center of New York, a training, consultation, and educational resource center serving all behavioral health agencies in New York state, may be a model worth exploring.⁴²

CONCLUSION

Despite the inevitable growing pains encountered with implementing a large-scale health care system transformation and the sustainability challenges that await once DSRIP funding ends, the ACO program is well positioned to continue to improve care for MassHealth members in the coming years. The ACO program has strong stakeholder support, which is critically important in enabling the state to successfully address and improve the areas that could be strengthened in the ACO program while exploring pathways for program sustainability. While many of the proposed program adjustments will require a significant effort, none of them seem to alter the fundamental framework or design of the ACO program. For that reason, and because of the strong established partnership and collaboration between MassHealth and its stakeholders, the ACO program is well positioned to address these concerns and to continue to evolve in a positive direction.

APPENDIX A: LIST OF CURRENT MASSHEALTH ACOS⁴³

- BeHealthy Partnership
- Berkshire Fallon Health Collaborative
- BMC HealthNet Plan Community Alliance
- BMC HealthNet Plan Mercy Alliance
- BMC HealthNet Plan Signature Alliance
- BMC HealthNet Plan Southcoast Alliance
- Community Care Cooperative (C3)
- Fallon 365 Care
- Lahey Clinical Performance Accountable Care Organization (contracts with Tufts Health Together MCO and BMC HealthNet Plan MCO)⁴⁴
- My Care Family
- Partners HealthCare Choice (now known as “Mass General Brigham ACO”)
- Steward Health Choice
- Tufts Health Together with Atrius Health
- Tufts Health Together with BIDCO
- Tufts Health Together with Boston Children’s ACO
- Tufts Health Together with CHA
- Wellforce Care Plan

APPENDIX B: LIST OF CURRENT MASSHEALTH COMMUNITY PARTNERS

Behavioral Health Community Partners⁴⁵

- Behavioral Health Network Inc.
- Behavioral Health Partners of Metrowest, LLC
- Boston Coordinated Care Hub
- Brien Center Community Partner Program
- Central Community Health Partnership
- Clinical and Support Options, Inc.
- Community Counseling of Bristol County, Inc.
- Community Healthlink, Inc.
- Community Care Partners, LLC
- Coordinated Care Network
- Eliot Community Human Services Inc.
- Innovative Care Partners, LLC
- Lowell Community Health Center, Inc.
- Lahey Health Behavioral Services
- Riverside Community Partners
- Southeast Community Partnership, LLC
- South Shore Community Partnership
- SSTAR Care Community Partners

Long-Term Services and Supports Community Partners⁴⁶

- Boston Allied Partners
- Care Alliance of Western Massachusetts
- Central Community Health Partnership
- Family Service Association
- Innovative Care Partners, LLC
- LTSS Care Partners, LLC
- Massachusetts Care Coordination Network
- Merrimack Valley Community Partnership
- North Region LTSS Partnership

APPENDIX C: LIST OF STAKEHOLDER INTERVIEWS

Background Interviews

- Alliance for Community Health Integration
- Boston Health Care for the Homeless
- Community Care Cooperative ACO (C3)
- Disability Policy Consortium
- Health Care For All
- Massachusetts Association of Community Health Workers
- Massachusetts Health Policy Commission
- Public Health Institute of Western Massachusetts
- University of Massachusetts Medical School

Interviews for Qualitative Analysis

- About Fresh
- Alliance for Community Health Integration
- Alliance of Massachusetts YMCAs
- Behavioral Health Partners of Metrowest
- BeHealthy Partnership
- BMC HealthNet Plan Community Alliance
- Boston Children's Hospital
- Boston Coordinated Care Hub
- Community Care Cooperative ACO (C3)
- Lahey MassHealth ACO
- Partners HealthCare Choice (now known as "Mass General Brigham ACO")
- Revitalize Community Development Corporation
- Seven Hills Family Services
- Tufts Health Plan

ENDNOTES

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- 3 Mass.gov. “Currently Approved 1115 MassHealth Demonstration (“Waiver”).” Available at: <https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver>.
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- 14 Even before CMS approved MassHealth’s Flexible Services Program, MassHealth was able to pay for certain housing supports for a small subset of MassHealth members as part of the Community Support Programs (CSP). Home modifications have also been reimbursable for certain members under certain Home and Community Based Services waivers. The Flexible Services Program expanded the group of MassHealth members who are eligible for these services and also widened the range of nonclinical goods and services to address health-related social needs that MassHealth can reimburse.
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