Since 2018, three Massachusetts state agencies have incentivized Medicaid accountable care organizations (ACOs) to forge partnerships with community-based organizations and social service agencies. These partnerships have improved the quality of care, with enhanced care coordination and social services support, for thousands of Medicaid enrollees. In the past year, the state has leveraged these partnerships to respond to the COVID-19 pandemic. This report explores how they did it.

Introduction

In the past three years, Massachusetts’ Medicaid accountable care organization (ACO) program policies have led to the creation of numerous partnerships between Medicaid ACOs and community-based organizations (CBOs) that now provide substantial care coordination and social services to thousands of Medicaid enrollees.

Two agencies have played key roles in fostering partnerships between Medicaid ACOs and CBOs. MassHealth (Massachusetts’ Medicaid agency) oversees Medicaid ACOs and the Department of Public Health (DPH) has helped CBOs build their capacity to form these unique partnerships and thrive within them.

A third agency, Massachusetts’ Health Policy Commission, plays an indirect role in supporting these efforts through its ACO certification and investment programs that often support the health care and community organization partnerships. This report explores the roles the three agencies have played and the lessons they have learned about fostering partnerships to address individual patient’s health related social needs and begin to move that work upstream to address the root causes of the social determinants of health (SDOH).
## Levers used by the three agencies to foster Medicaid ACO and community organization partnerships

<table>
<thead>
<tr>
<th>Agency</th>
<th>Levers</th>
<th>Results</th>
</tr>
</thead>
</table>
| MassHealth              | Establishes and monitors Medicaid ACO contract requirements, under which ACOs are required to:  
  - Partner with community partners, which are CBOs that provide care coordination to Medicaid members with complex behavioral health and long-term services and support needs;  
  - Pay for flexible services, which are mostly provided by social service organizations (SSOs), which are CBOs that provide services to meet individual’s health-related social needs; and  
  - Require certification by Health Policy Commission  
  Factors SDOH into ACO payment via risk adjustment.  
  Establishes and monitors CP contract requirements.  
  Distributes Delivery System Reform Incentive Payment (DSRIP) funding to CPs, Medicaid ACOs, and technical assistance partners, including the Public Health Department. (DSRIP funding is federal funding authorized under Massachusetts’ Medicaid Section 1115 waiver.) | As of July 2020,  
  - 27 community partners (CP) entered into 277 Medicaid ACO/CP partnerships  
  - 30 social service organizations partnering with ACOs to provide services under 45 programs  
  At the end of 2019, CPs were serving about 40,000 Medicaid patients.                                                                                   |
| Department of Public Health | Convenes learning forums for ACOs, CPs, and SSOs.  
  Administers Social Services Organization Flexible Services Preparation Fund (DSRIP-funded).                                                                                                                     |                                                                                                                                                               |
| Health Policy Commission | Certifies Massachusetts ACOs, including Medicaid ACOs.  
  Provides grant opportunities to provider organizations (including but not limited to Medicaid ACOs). Most relevant to the topic of integrating medical and social needs are:  
  - SHIFT-Care Challenge (2018-2019)  
  - Moving Massachusetts Upstream (MassUP) Investment Program (2020-2023)                                                                                                                                   | Indirect effect  
  About $12 million distributed through 19 awards to provider organizations often partnered with CBOs.                                                                                                      |
MassHealth

Massachusetts operates the MassHealth program under a Medicaid Section 1115 waiver. The 2017 renewal of that waiver authorized the Medicaid ACO program, the Community Partners (CP) program, and a Delivery System Reform Incentive Payment (DSRIP) program. MassHealth began contracting with ACOs in March 2018.

The agency reported that, as of November 2018, there were 885,401 Medicaid ACO enrollees representing about half of all Medicaid program participants. MassHealth has three different ACO contracting models (in one model MassHealth contracts directly with an ACO, in the other two with ACO/MCO partnerships). MassHealth uses the same approach to fostering effective ACO/CBO partnerships in all three models. The approach leverages not only the Medicaid ACO contracting process but also the DSRIP waiver.

The role of MassHealth:

- Requires Medicaid ACOs to enter into agreements with community partners (CPs) to provide care coordination support to qualified members and pay social services organizations (SSOs) to provide goods and services that meet members’ health-related social needs.
- Pays Medicaid ACOs based on their ability to contain the total cost of care (which is risk-adjusted for some social determinants of health), deliver quality care, and produce health outcomes.
- Select, contract with, and pay CPs, which are CBOs that provide care coordination.
- Distributes DSRIP funding to Medicaid ACOs to pay for flexible services provided primarily by SSOs.
- Provides and funds technical assistance for Medicaid ACOs and CBOs.

ACO Contracting

MassHealth fosters Medicaid ACO/CBO relationships through its Medicaid ACO contracting. As part of the contractor selection process, each potential ACO contractor had to supply information about any existing contracts or other formal arrangements it had with CBOs. Once under contract, each ACO has to maintain a DSRIP participation plan that includes a population and community needs assessment which identifies health-related social needs of the enrolled population, available community resources, and gaps in community services. The plan also must include an investment and spending plan that details, “efforts to address enrollees’ health-related social needs, including expanding community linkages…..” Finally, MassHealth uses its care planning requirements to ensure that the ACO/CBO partnerships are effective (meaning that the partnerships enable patients to obtain services to address the social needs that are impacting their health). These include requirements to consider a patient’s social needs during needs assessment and in care plans, as well as to consider community resources in care planning.

The ACO payment model itself fosters ACO/CBO partnerships. The Medicaid ACOs are paid based on their ability to contain the total cost of care (TCOC), deliver quality care, and produce health outcomes. State officials report that this model encourages the ACOs to go upstream to improve quality and produce cost savings. MassHealth reinforced this approach by risk-adjusting TCOC calculations for SDOH, such as homelessness. ACOs are also required to screen all
members for health-related social needs every year. MassHealth measures ACO success in meeting this requirement and factors that performance into ACO payment.

**Community Partners and Social Services Organizations**

MassHealth fosters two types of ACO/CBO partnerships. CPs provide care coordination while social services organizations (SSOs) provide social services, such as housing services. A single CBO can be both a CP and an SSO.

In July 2018, MassHealth began requiring all Medicaid ACOs to enter into agreements with certified CPs. CPs are CBOs that MassHealth selected through a contracting process to help coordinate the services delivered to Medicaid ACO enrollees who have significant behavioral health or complex long-term services and supports (LTSS) needs. Among other goals, this program is designed to foster collaboration among ACOs, MCOs, and existing CBOs, especially those CBOs with expertise in caring for people with behavioral health or LTSS needs. CPs provide care coordination to those ACO members who qualify for their services, including connecting patients to social services and community resources. Recognizing the different resources and skill sets needed to coordinate care for people with behavioral health and LTSS needs, MassHealth has divided the CPs into two groups based on which population the CP serves. MassHealth pays each CP a set amount for each qualified member it serves for each month in which the CP completes a key step in the care coordination process for the individual (e.g., outreach, production of a plan of care). These key steps, referred to as qualified activities, are defined by the CP contract.

Because MassHealth pays for the services that CPs provide, Medicaid ACOs are not required to do so. ACOs, however, are required to enter into formal agreements with those CPs that serve the ACO’s catchment area. These agreements define how the two organizations will work together to serve qualified Medicaid enrollees and the ACO contract details the specific topics each agreement must address. MassHealth envisions that, over time, some of these agreements will include payments from the ACO to the CP, such as shared savings. Officials report that, as of July 2020, there were 27 CPs. These CPs have established 277 different agreements with Medicaid ACOs. Officials report that standardization is key to efficient state administration and ACO/CP operations. Areas that have been standardized include referral platform, service descriptions, CP billing or payment arrangements, and the comprehensive screening tool.

In January 2020, MassHealth launched its flexible services program through which it plans to spend up to $149 million of DSRIP funds. Flexible services are nutrition or housing supports that meet the health-related social needs of qualified ACO enrollees. Within these broad categories, each ACO decides which specific services it will provide and documents these choices in its DSRIP plan. The services must be evidence-based, cost effective, and not otherwise covered by Medicaid. In order to qualify for the services, ACO enrollees must be medically and socially high risk — the specific criteria enrollees must meet was negotiated between MassHealth and the Centers for Medicare & Medicaid Services (CMS). The ACOs may either provide the services themselves or partner with an SSO to provide the service. Because MassHealth wanted to avoid duplication of services and foster a “buy, not build” approach, the agency required ACOs seeking to deliver the social services themselves to first consult with the local community and
prove that there was no local SSO with the expertise to provide the service. If there is no qualified SSO available, then the ACO has to demonstrate that it will have the same outcomes as if it had worked with an external SSO.

Each year, each ACO is allotted a specific amount of money to spend on flexible services that vary based on the number of Medicaid enrollees enrolled in the ACO. MassHealth makes prospective payments to ACOs based on each ACO’s allotment and approved program budgets — 25 percent of anticipated expenditures are disbursed each quarter. MassHealth pays prospectively to prevent delays in SSO receipt of reimbursement for their services. In order to help ACOs manage the cost of these services, ACOs may limit the number of enrollees who receive the service or establish, subject to state approval, more stringent eligibility criteria for the service.

As of July 2020, 30 SSOs were delivering services in partnership with Medicaid ACOs under 45 flexible services programs. State officials reported that helping ACOs meet their members’ health-related social needs was an important part of the state’s response to the COVID pandemic. To encourage rapid ACO/SSO response, officials created a separate process for reviewing, approving, and administering flexible service programs developed to respond to the COVID-19 pandemic.

For example, instead of asking ACOs to develop plans for state approval, officials provided an example plan to ACOs. ACOs could receive expedited approval of their plans if they used the language from the example. As of July 2020, MassHealth had approved eight COVID-19 programs with two SSOs. State officials report that, across both COVID-19 and non-COVID-19 programs, about one-third of the ACO/SSO payment arrangements are fee-for-service, one-third are up-front lump sum payments, and one-third are another type of model, such as a bundled payments. According to one report, ACOs are more likely to partner with SSOs to provide housing assistance than nutritional assistance.

MassHealth also funds ACO, CP, and SSO capacity building and technical assistance through its DSRIP waiver. MassHealth delivers some technical assistance directly but also funds others, most notably the Department of Public Health, to provide the assistance.
Department of Public Health

The Massachusetts Department of Health’s (DPH) primary role in fostering partnerships between ACOs and CBOs is supporting CBOs’ capacity building. It both provides direct assistance to CBOs and provides a forum for CBOs and ACOs to work together to address common challenges.

The DPH operates the Social Services Organization Flexible Services Preparation Fund. MassHealth dedicated about $4 million in DSRIP funding to the fund, which helps SSOs make the investments they need to develop and thrive within partnerships with Medicaid ACOs (i.e., MassHealth’s flexible services program). Only SSOs that were already partnered with Medicaid ACOs for the program were eligible to apply for the grants. In January 2020, the DPH awarded 18-month grants of up to $250,000 to 19 SSOs.

The SSOs can use the funding to:

- Purchase and install technology to support care management processes (e.g., referrals), reporting, and financial management;
- Develop business or operational practices needed to deliver flexible services (e.g., a formal agreement with a Medicaid ACO);
- Enhance delivery of flexible services (e.g., staff training and certification or informing material for ACO members); and
- Electronic equipment for new staff (e.g., cell phones).

In addition, the DPH also allowed SSOs to propose to spend grant funds for other infrastructure needs, but those were individually negotiated with the selected SSOs.

The DPH has also established a learning collaborative of SSOs and ACOs to support this work. Collaborative members work together on topics such as data exchange and privacy requirements, and learn how to adjust programs to respond to the COVID-19 pandemic.

The role of the Department of Public Health:

- Funds SSO investments needed to effectively partner with Medicaid ACOs to deliver health-related social services through the flexible services program.
- Convenes learning forums to enable CBOs and Medicaid ACOs (among others) to share best practices and lessons learned.
Health Policy Commission

The Health Policy Commission indirectly fosters ACO/CBO partnerships through both its certification and investment programs. These programs have enabled ACOs and CBOs to enter into partnerships that address the health-related social needs of individual ACO members and partnerships that seek to address the SDOH that affect all members of a given community, regardless of where they receive medical care. While the objectives differ in their scope and point of intervention, they are ultimately complementary. As one interviewee explained, addressing community-level SDOHs should decrease health-related social needs among individuals.

ACO Certification

The commission began certifying ACOs in 2017. The certification program is not payer-specific, and certified ACOs may enter into contracts with both commercial and public payers. Among payers, currently only MassHealth requires its contracted ACOs to establish and maintain certification. The 2019 certification standards require each ACO to operate at least one population health management program that addresses health-related social needs. Many ACOs partner with CBOs to meet this requirement.

Investment Programs

The commission uses funding from the Massachusetts Healthcare Payment Reform Fund and other sources to build the capacity of providers and provider organizations (some of which are or participate in Medicaid ACOs), including their efforts to coordinate and partner with CBOs. Two of these efforts, which are referred to as investment programs, are relevant to partnerships to address health-related social needs and/or SDOH.

In 2018, the commission released a request for proposals (RFP) for the SHIFT-Care Challenge. The RFP sought proposals from providers and provider organizations for projects that would implement new care delivery models that reduced avoidable acute care by either addressing patients’ health-related social needs or improving their access to behavioral health services. The commission invested $9.7 million in 15 projects. All applicants seeking to address health-related social needs were required to partner with at least one CBO.

In late 2019, the commission, in collaboration with the Department of Public Health, launched its Moving Massachusetts Upstream (MassUP) investment program, which funds partnerships between CBOs and health care provider organizations to address the root causes of poor health and health inequities. Providers and provider organizations could apply on behalf of themselves and their partners, at least one of which had to be a CBO. This investment was designed to build the capacity of both provider organizations and CBOs to create sustainable partnerships to

The role of the Health Policy Commission:

- Certifies ACOs, including all Medicaid ACOs, as meeting performance standards that include criteria for addressing social needs.
- Builds the capacity of providers and provider organizations (including Medicaid ACOs) to address patients’ social needs and community-level SDOH through grant opportunities.
address SDOH and health equity. To date, the commission has awarded four, three-year grants for a total investment of approximately $2.5 million to four hospital-based systems. Three of these systems participate in a Medicaid ACO although it is not yet clear how, or if, the systems will involve these ACOs in the MassUP projects. Regardless of how the ACOs’ specific roles develop, the commission believes that MassUP will produce knowledge that ACOs could use to move their efforts to address the SDOH upstream to effect change at the community level.

Lessons Learned and Summary

Contracts were an effective lever for creating ACO/CBO relationships. The Medicaid ACO and CP programs launched in 2018 and the flexible services program launched in early 2020. By July 2020, the contract requirements had resulted in agreements between 27 CPs and Medicaid ACOs, as well as partnerships between 30 SSOs and the ACOs. Also, near the end of 2019, CPs were already serving about 31,500 people with behavioral health conditions and 9,000 with LTSS needs.3

Partnering across agencies was critical to success. Representatives of all three state agencies reported that the work to foster Medicaid ACO/CBO partnerships to address the SDOH cut across the responsibilities of multiple agencies and working together enabled them to leverage the strengths of each to achieve their mutual goal. However, achieving that level of partnership took work and a willingness to set aside traditional agency roles. Interviewees found that although their goals were the same, agency priorities often differed and came to view those differences as facilitators rather than barriers. Several interviewees pointed to the SSO Flexible Services Preparation Fund as an example of leveraging the strengths of MassHealth and the Department of Public Health (DPH) to achieve their shared goals. One MassHealth representative stated, “We launched the SSO prep fund program to deal with the early recognition that for the flexible services program to work, there needed to be this infrastructure-building fund for SSOs.” The representative viewed the DPH, with its understanding of SSO needs and strong connection to those organizations, as the best agency to deliver that support, and Medicaid dedicated $4.4 million to that effort.

Finally, these three agencies continue to build their cross-agency efforts. They joined with the Office of the Attorney General, Executive Office of Elder Affairs, and Executive Office of Health and Human Services, to form a state-level policy workgroup that seeks to reduce state policy barriers to addressing SDOH and provides a forum for cross-agency coordination and planning. This workgroup functions under the MassUP umbrella as a distinct but complementary effort to the MassUP investment program.

Strategies were contingent on the type of ACO/CBO partnership sought. Together, Massachusetts state agencies worked to foster three kinds of ACO/CBO partnerships:

- Those that delivered care coordination;
- Those that directed goods/services to meet health-related social needs; and
- Those that address SDOH at the community level.
MassHealth, which sought to foster partnerships to deliver care coordination and direct goods/services to meet health-related social needs, used a two-pronged process. The agency established separate programs for CBOs seeking to partner with Medicaid ACOs to provide care coordination (CPs) and those seeking to provide goods and services to meet health-related social needs (SSOs). As a result, CBOs could choose which opportunity to pursue depending on what they wished to offer the ACOs. The two programs had separate, targeted, selection processes, contracting and performance requirements, and payment policies. In addition, MassHealth’s CP contract required CPs to partner with Medicaid ACOs while the Medicaid ACO contract required ACOs to partner with CPs. The Health Policy Commission sought to foster partnerships to address individual health-related social needs through its certification program. The commission also offered several funding opportunities that could support partnerships to address health-related social needs or the SDOH.

Efforts to address upstream SDOH require all stakeholders to reorient their thinking away from narrowly defined, attributed populations to a broader, community-level perspective. One interviewee described how the population for which an ACO is responsible is still defined by contract and utilization. This may incentivize ACOs to put more emphasis on delivering critical services to the individuals for whom they are clearly responsible rather than on addressing the root causes of SDOH at a community level. Another pointed out that addressing upstream social and economic factors that impact health requires a systemic approach, which may be challenging for some health care and social service provider organizations that are fully consumed by the day-to-day tasks of delivering services to enrollees or community members. The MassUP investment program is the commission’s initial effort to support partnerships between provider organizations and CBOs to work together to address the SDOH in a more fundamental and long-term way. Interviewees hope this and similar efforts will point the way toward sustainable partnerships that leverage the strengths of the health care sector to bolster community-led efforts to improve the SDOH.

Both ACOs and CBOs benefitted from technical support in developing partnerships. State officials reported that SSOs needed help preparing and presenting a business case for their services. ACOs needed help identifying potential partners. Both needed help exchanging data about services provided to ACO members and moving their partnership from a grant model to a transactional, service-based model.

Among the first steps to partnership is helping the ACOs and CBOs understand the value each offers and developing relationships. Before launching the flexible services program MassHealth first met with the ACOs and SSOs separately to help each group better understand what the other had to offer. ACOs, for example, heard presentations on nutrition and housing, potential partner organizations, and how partnering with SSOs could help them achieve their goals. After this MassHealth fostered face-to-face meetings
of the two groups by making them aware of opportunities for such meetings. MassHealth also collected contact information from the ACOs so that CBOs could reach out to them.

**Electronic exchange of service data is one of the biggest challenges for ACO/CBO partnerships.** Both MassHealth and the DPH identified the electronic exchange of data as one of the biggest challenges that Medicaid ACOs and CBOs face in their partnership efforts. There are both policy and technical aspects to this challenge. Exchanging data about a service provided to an individual Medicaid enrollee raises privacy concerns that CBOs did not previously encounter — and requires the ACOs and CBOs to enter into a business associate agreement. ACOs and CBOs are looking to an electronic platform that would enable medical providers and CBOs to easily exchange referrals, including ‘closing the loop’ to ensure that the medical providers learn the results of the referral. Electronic data exchange was also one of the topics discussed in the learning community convened as part of the SSO FS preparation fund.

**DSRIP funding was critical for both ACOs and CBOs to develop needed infrastructure.** Both ACOs and CBOs needed to change their business operations to partner. Not only did they need to develop and implement the previously discussed data exchanges, but they also needed new staff. For example, many CPs needed to hire engagement coordinators and eligibility specialists to determine which Medicaid enrollees qualify for the services and engage them in the programs. New infrastructure was also needed for care planning. All interviewees reported that the DSRIP funding was critical to quickly creating a large number of functioning partnerships because that flexible funding could be used to meet ACO and CBO infrastructure and training needs. Other states seeking to foster these types of partnerships will need to consider how they can meet these important needs and, if necessary, alter their plans and timelines to reflect available resources.

**State officials believed that the impact of the COVID-19 pandemic would ultimately reinforce the need for this work.** Although responding to the COVID-19 pandemic has required the agencies to focus on other priorities, state officials believe that the pandemic has also highlighted the importance of addressing the underlying social needs that are major contributors to health inequities and drive cost. One described the racial justice movement as building momentum to improve health equity.

MassHealth has already used the flexible services program as part of its response to the pandemic. The agency has made it easier for Medicaid ACOs to establish partnerships that seek to address the health-related social needs (housing and nutrition) arising from the pandemic and the job losses it has caused. As a result, eight COVID-19 programs are currently operating.

“[Social service organizations] know how to do the work, but the new thing is how to share the information back and forth and how to get referrals.”
— Massachusetts state official

“People are seeing these things [COVID-19 and the racial justice movement] in a sense as a collective force compelling people to be reflective about addressing equity issues as a necessary bedrock to future systems.”
— Massachusetts state official
Summary

Massachusetts’ cross-agency approach to addressing the SDOH has already produced many Medicaid ACO/CBO partnerships, impacted the delivery of care to thousands of Medicaid enrollees, and helped the state respond to the COVID-19 pandemic. Despite this success, challenges persist, especially those related to the electronic exchange of referral and service information between medical and social services providers.

Notes

Acknowledgements: The National Academy for State Health Policy (NASHP) would like to thank the state officials from MassHealth, the Massachusetts Department of Public Health, and the Massachusetts Health Policy Commission who contributed to this brief as well as Health Resources and Services Administration Project Officers Carolyn Robbins and Diba Rab, and their colleagues for their feedback and guidance. The author also wishes to thank Trish Riley, Jill Rosenthal, and Elinor Higgins of NASHP for their contributions to the paper. This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under co-operative agreement number UD3OA22891, National Organizations of State and Local Officials. The information, content, and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the US government.

2 See sections 2.5.F and 2.5.G of the ACO model A contract for community partner agreement specifics.