Title: Multilevel evaluation of the Massachusetts Medicaid Flexible Services program to address food and housing insecurity

Abstract

Background: From 2020 to 2023, Massachusetts piloted the Flexible Services program (Flex), which provided funding to Medicaid accountable care organizations (ACOs) to contract with social service organizations (SSOs) to address food and housing insecurity.

Objective: To assess the implementation of Flex from the perspectives of one ACO and its affiliated SSOs and Flex enrollees.

Methods: This mixed methods study examined the proportion and demographics of adult (≥21 years) ACO members enrolled in Flex compared to non-enrolled Flex-eligible members. Semi-structured interviews with Flex enrollees (N=28) assessed satisfaction and challenges with Flex participation. Interviews with ACO staff (N=12) and Flex SSOs (N=11) assessed barriers and facilitators of Flex implementation. Interviews were analyzed using the Framework Method.

Results: Among 16,301 Flex-eligible adults, 15.1% were enrolled in Flex: 83.9% in nutrition services and 22.3% in housing services. Flex enrollees were more likely to be female (75.8% vs 67.4%), Hispanic (45.4% vs 34.5%), and Black (21.2% vs. 16.5%) compared to non-enrolled Flex-eligible members. Most nutrition service enrollees reported high satisfaction. Enrollee-reported Flex challenges included transportation, language barriers, and poor fit of services (e.g., undesirable foods). Enrollees recommended longer duration (≥1 year) and more personalization of services. Many housing service enrollees reported dissatisfaction due to low housing availability. Implementation challenges reported by ACOs and SSOs included data sharing difficulties, lack of standard ACO-SSO financial contracts, and frequent state budget changes. SSOs reported payment challenges (e.g., delayed reimbursements) and administrative burden. ACOs reported communication challenges with SSOs and burdensome state reporting requirements. Implementation facilitators included state funding to build SSO infrastructure for Flex administration, data sharing tools, and routine ACO-SSO communication.

Conclusion: Approximately 1-in-6 Flex-eligible ACO members were enrolled in Flex services over 3 years. Health system partnerships with community-based SSOs should consider personalizing nutrition services, implementing standardized financial contracts and data sharing platforms, funding administrative infrastructure, and facilitating cross-sector communication.