Medicaid Food Security Network Quarterly Meeting

January 30, 2025

HEALTH BEGINS | SHARE OUR STRENGTH

Welcome!

Share the following with us in the chat:

Name / Pronouns

Organization & Title / Role

What questions or thoughts are you bringing to the meeting today?

MEDICAID FOOD SECURITY NETWORK

Housekeeping

Zoom Recording: This meeting will be recorded and available on the Network website.

Use the chat feature: Feel free to submit questions through the chat. We also will have time for Q&A near the end of the meeting.

Make sure you are muted: Please stay muted while others are presenting. Feel free to use the chat and/or hand raising features.

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MFSN Meeting Objectives

Increase awareness of new resources in the field available to support partnering with Medicaid to address food and nutrition security

Articulate innovative strategies and inspirational case studies related to program and policy opportunities to address food security, focusing on Medicaid managed care regulations and flexibilities to support food security.

Foster collaboration and engagement among attendees through breakout discussions, Q&A, and sharing of insights, aiming to generate actionable ideas and commitments for ongoing engagement with MFSN initiatives

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Meeting Flow

1. Welcome & Introductions (10 min)
2. Coding4Food (10 min)
3. Medicaid Managed Care Flexibilities (40 min)
4. Federal Collaboration (5 min)
5. Breakout Room Discussions (20 min)
6. Closing Remarks (5 min)

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Refresher: The Network's **Mission & Vision**

Support anti-hunger advocates to **engage, influence, and partner** with state Medicaid programs and Medicaid-serving systems **in adopting and implementing effective strategies** to support the full spectrum of food needs of **children and families** enrolled in Medicaid with an emphasis on **closing the enrollment gap in SNAP and WIC.**

The MFSN will provide state and national anti-hunger and healthcare advocates, and other stakeholders with the **infrastructure for collaboration, technical assistance, and tools for policy and advocacy**. MFSN participants will be able to successfully **identify, advocate for, and implement** effective, **state-specific policies and programs** for every state Medicaid program.

MFSPP:
RFP Now Available

Grant Opportunity: Share Our Strength, in collaboration with HealthBegins, is launching a grant funding opportunity

Focus: Funding four state-based organizations or coalitions to support:

- Advocacy or implementation of promising food-security policy initiatives within state Medicaid programs
- Strategies that promote SNAP and WIC enrollment

Award amount: $75,000 per organization

RFP Submission Deadline: Feb 14, 2025

- Questions can be found in RFP + webinar recording: link here

MFSPP: Application Process

- Navigate to online form to apply
  - Progress/draft saved for 30 days when signed into Google
  - To find draft response for form, reopen form URL in the same Google Account you used to created draft
- Submission Deadline
  - Application responses must be received by **11:59 pm ET on 2/14/25**
- RFP Questions
  - Questions can be found in RFP + webinar recording: link here

Medicaid Food Security Partners Program Application

Share Our Strength and HealthBegins are launching the second cohort of grant funding for the Medicaid Food Security Partners Program. Share Our Strength will be funding four state-based organizations or coalitions to pursue creation or implementation of state Medicaid regulatory or administrative changes that promote promising food and nutrition security policy initiative(s), with a special focus on strategies that promote SNAP and WIC enrollment among children and families. Grantees will receive $75,000 for an 18-month period as well as full cohort learning opportunities and individualized technical assistance. Preference will be given to candidates with the necessary relationships, strategy, and positioning to reasonably achieve success. The Medicaid Food Security Partners Program is an initiative of the National Medicaid Food Security Network.
Please note that some of these questions are part of a standardized set of questions Share Our Strength asks from grant applicants. Some questions may not feel relevant to your organization or this project - if this is the case, do your best to respond or put "not applicable" as needed. Reach out at mfsn@strength.org with any questions.

DEADLINE: February 14 at 11:59 PM EST

Note: when signed into your Google account, your progress is saved as a draft for up to 30 days. To find a draft response for a form, reopen the form URL in the same Google Account you used to create the draft. However, we recommend that you download this Word document version of the application questions, so that you can draft outside of the form and then copy-paste responses into the survey form once you're ready to submit.

Update from Coding4Food

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What is a code? What is a claim?

- **Code**- Numeric or Alphanumeric representation of a healthcare diagnosis, procedures, services, or equipment
- **Claim**- A request for payment for services and benefits received that is communicated through codes.
- **Claims Data**- Also known as administrative data, is information collected on millions of clinicians' appointments, bills, insurance, and other patient-provider communications directly from notes made by the health care provider, and happens at the time patient sees the
- The **electronic claim (ebill)** travels seamless between clinicians, payers (both public and private) and those who offer services in clinical and community settings to assist patients, in order to facilitate reimbursement
- The flow also enables use for research and population health analysis

Definitions from the "Finding and Using Health Statistics" tutorial from the National Library of Medicine

Example: Gravity Food Security Terminology

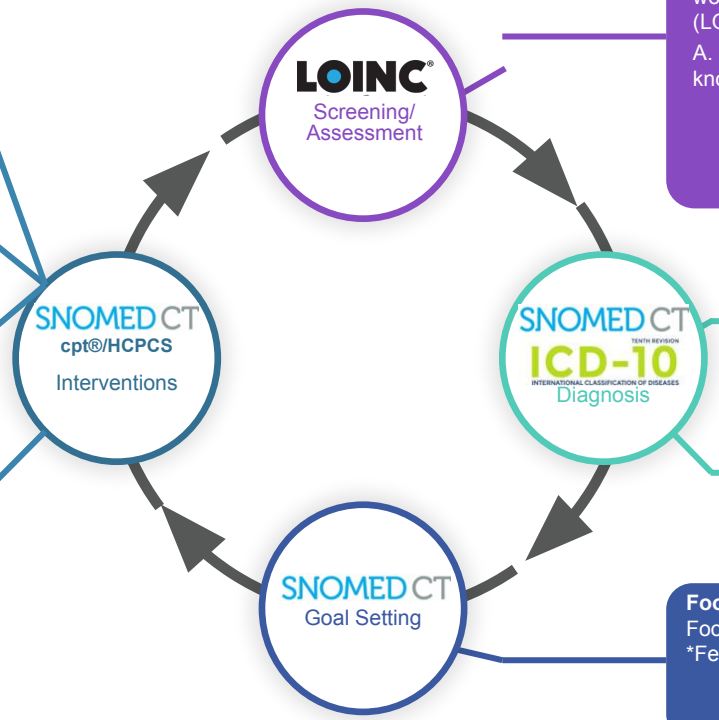
*The current meal code is insufficient for MTM.

PROCEDURE: Home delivered meals, including preparation, per meal S5170* (HCPCS)

PROCEDURE: Provision of food voucher 464411000124104 (SNOMED CT)

PROCEDURE: Referral to Community Health Worker 464131000124100 (SNOMED CT)

FUTURE PRODUCT/SERVICE: Produce Prescription or other FIM intervention (new HCPCS Level II code)



Food Insecurity Screening/Assessment
Q. Within the past 12 months we worried whether our food would run out before we got money to buy more. 88122-7 (LOINC)
A. Often true, Sometimes true, Never true, don't know/refused. LL4730-9 (LOINC)

Food Insecurity Diagnoses
Food Insecurity 733423003 (SNOMED CT)

Food Insecurity Diagnoses
Food Insecurity Z59.41 (ICD-10-CM)

Food Insecurity Goals
Food Security 1078229009 (SNOMED CT)
*Feels food intake quantity is adequate for meals

Proposed. Not final.

The Problem

A lack of medical codes that accurately describe the full spectrum of food as medicine interventions

- S5170 (home-delivered meals) and S9977 (meals per diem) are too broad to accurately represent Medically Tailored Meals
- No codes exist for other food as medicine interventions

Which leads to:

- A lack of accurate food as medicine intervention documentation in medical records
- Creating parallel systems to pay for food as medicine services outside of traditional healthcare operations
- The rise of state-based, provider and payer approaches to coding

Food & Nutrition Landscape: Many names, Similar Services

Medically tailored home delivered meals (MA, MI)
Medically Tailored (Meals CA,WA, OR, NY, IL)

Nutritionally appropriate food boxes (MA)
Healthy Food Pack (MI)
Pantry Stocking (NJ, WA, OR, IL, DC)
Short-term grocery provision (NJ, WA)
Healthy food boxes (NC)
Grocery provision (IL,DC)
Protein boxes (DC)

Kitchen supplies (MA)
Cooking supplies necessary for meal preparation (NY, DC)

Nutrition education classes and skills development (MA)
Cooking education (CA)
Teaching Kitchen

Medically-Indicated home delivered meals (NJ)
Clinically appropriate meals (NY)
Nutritionally appropriate home delivered meals (MA)
Healthy home-delivered meal (MI)
Meals (WA, OR)
Home delivered meals (IL, DE, NM, DC)

Medically tailored food prescriptions and vouchers (MA)
Produce Prescriptions (MI)
Nutritionally appropriate food prescriptions and vouchers (MA)
healthy food vouchers (CA)
fruit and veg prescriptions (WA, OR)
Medically tailored food prescription (NY)
Clinically appropriate food prescription (NY)
Nutrition prescriptions (IL, NM)
Fresh produce prescription (DC)

Medically tailored food boxes (MA)
Medically tailored groceries (CA)

Mission

The Coding4Food (C4F) project is a community-informed initiative aiming to create new Healthcare Common Procedural Coding System (HCPCS) codes to define a spectrum of Food as Medicine interventions.

Vision

As a result standard codes will be used across the country to accurately track, bill, and evaluate a spectrum of food-based interventions.

Phase 1 Work Groups

August-December 2024 with submission to CMS in January 2025

Medically Tailored Meals

Medically Tailored Groceries

Produce Prescription

Healthy Groceries

Phase 2 Work Groups

February-June 2025 with submission to CMS in July 2025

Cooking Education / Teaching Kitchens / Food Pharmacy

Cooking and Kitchen Supplies

Project Timeline

How do I get involved?

1. Join Gravity public calls every other Thursday 4-5:30 Eastern
   a. View the HL7 calendar for meeting details: https://confluence.hl7.org/display/GRAV/Upcoming+Meeting+Information

2. Sign up for Coding4Food email list at https://www.msfnca.org/coding4food

Medicaid Food Security Network: Medicaid Managed Care Rules

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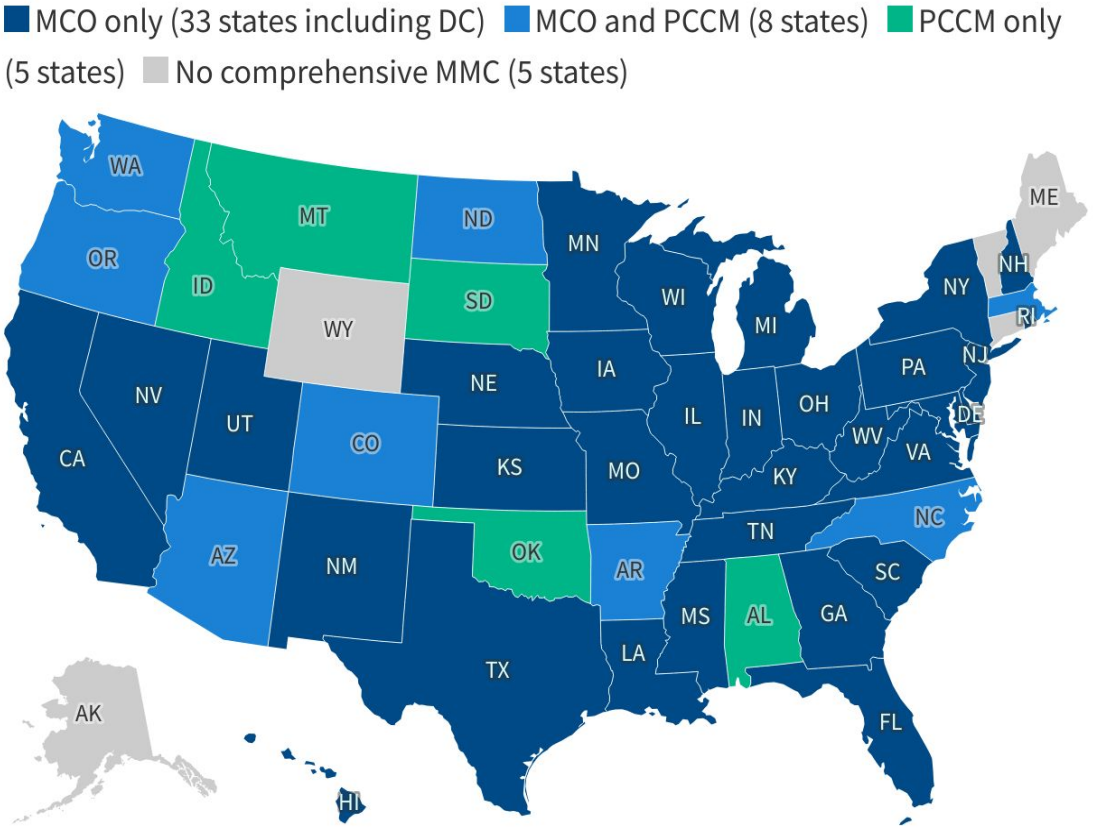
As of July 2023, 41 States Used Capitated Managed Care Models to Deliver Services in Medicaid.



Most states have **Medicaid managed care** - Medicaid administered through contracted health insurance companies or **Managed Care Organizations (MCOs)**

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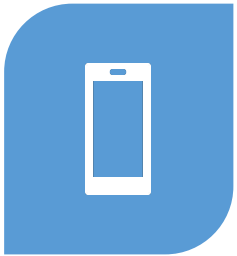
Opportunities to address food insecurity using Managed Care Authority

FOOD INSECURITY SCREENING & REFERRAL

SNAP & WIC ENROLLMENT INFRASTRUCTURE



ASSISTANCE & NAVIGATION

DATA, EVALUATION, & CONTINUOUS IMPROVEMENT

INVESTMENTS & BENEFITS

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MFSN Policy Dashboard

Examples that follow are pulled from MFSN Policy Dashboard where users can filter by state and policy strategy and navigate to individual policy summaries.

Follow link bit.ly/MFSNdash or QR code →

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Food Insecurity Screening and Referral

MCO Strategy	#	State Example
Health Risk Assessment	16	Iowa: MCOs conduct health risk screening using a state mandated tool. The plan is expected to screen 70% of new members within 90 days and annually thereafter.
Social Needs Screening and Referral	8	Ohio: MCO must reimburse SDoH codes (Z codes) and reimburse network providers for following up after referrals to confirm member received service to address social needs.
Community Resource Directory	4	Nebraska: To support these care management activities, the MCO must develop, subscribe to, or acquire a community resources tool.
Staff Training	3	West Virginia: MCOs are required to educate MCO staff and contract providers on how to recognize and screen for enrollees' social needs, why addressing enrollees' social needs is important, how it impacts enrollees' care, how to connect enrollees with available community resources and social services, cultural competence, and implicit bias.

SNAP and WIC Enrollment Infrastructure

MCO Strategy	#	State Example
Initiatives to Improve Public Awareness	1	Michigan: MCO must implement educational, public relation, and social media initiatives to member and provider awareness of programs and community-based resources that are designed to reduce impact of SDoH.
WIC Coordination	1	Wisconsin: The MCO is encouraged to use the data sharing agreement template between the Division of Medicaid Services and the Division of Public Health as a guide to establish agreements with local WIC agencies for the purpose of coordinating care and referrals.
SNAP coordination	1	Indiana: MCOs for the Hoosier Healthwise program are required to identify members who could be eligible for SNAP in the first and third quarter of each contract year. The MCOs are then required to conduct an educational outreach campaign to all identified members, including information on SNAP benefits, eligibility, and how to enroll.

Assistance and Navigation

MCO Strategy	#	State Example
Care Coordination	14	Pennsylvania: Under the Community Based Case Management (CBCM) program, MCOs must partner with with CBOs, hospital/health systems and providers to mitigate SDoH barriers, reduce health disparities, and address maternal and child health. The CBCM team may include CHWs. The MCO must spend at least $0.75 Per Member Per Month on the program. This funding and these activities can be performed by the CBO.
Community Health Workers	21	Kansas: Kansas reimburses for CHW services under its Medicaid state plan. Two MCOs use CHWs to implement required Medicaid care coordination.
CBO Partnerships	5	Mississippi: The MCO must enter into agreements with community-based and social services organizations to address SDoH in each region of the state.

Data Evaluation and Continuous Improvement

MCO Strategy	#	State Example
Quality Improvement	8	Hawaii: The MCO contract requires each health plan to develop a SDoH workplan as part of its Quality Assurance and Performance Improvement plan that includes strategies for increasing collection and documentation of Member-level SDoH data, Promoting the use of ICD-10 Z codes, Increasing provider understanding of SDoH; linking beneficiaries to identified SDoH needs; and Providing relevant SDoH value-added services offerings
Closed Loop Referrals	9	Georgia: The MCO is required to follow-up after referral to CBOs fThe MCO must report on performance of Closed Loop Referral Management and must report and improve metrics associated with utilization of services to address SDoH needs.
Data Aggregation or Use	2	Ohio: The MCO must participate with both of Ohio's health information exchanges and use them to close referral loops for SDoH.
Coding	3	Arizona: Medicaid MCOs must "monitor, promote, and educate providers on the use and importance of 'Z' codes" with the goal of identifying and addressing health disparities.

Investments & Benefits

MCO Strategy	#	State Example
In Lieu of Services	3	California: Medicaid MCOs can elect to offer In Lieu of Services food that includes: 1) meals delivered to the home immediately following a nursing home or hospital discharge; 2) Medically Tailored Meals; and 3) Medically-supportive food and nutrition services including medically tailored groceries, healthy food vouchers, and food pharmacies.
Medical Loss Ratio	3	Mississippi: MCOs may include activities that improve healthcare quality in the Medical Loss Ratio (MLR) expenditures report. This may include identifying and addressing SDoH as identified through screening.
Community Reinvestment	9	Nevada: MCOs must invest 3% of annual pre-tax profits. Investment plans are due March 1 of each year. Two plans in the last report planned to invest in food.
Value Added Services	8	Florida: MCOs can elect to provide value added services. The MCO summary document states that all MCOs have chosen to offer Home Delivered Meals.
Value Based Payment	8	Nebraska: MCOs must submit to the state a proposed plan for value-based purchasing agreements with providers that include strategies to, among other things, address health equity and “SDoH gaps.”

Deep dive: Medicaid Managed Care tools to support enrollee food security

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Deep Dive: Medicaid Managed Care tools to support enrollee food security

Medicaid Food Security Network – Quarterly Meeting

Jan. 30, 2025

About Health Management Associates and Strategy & Transformation

Health Management Associates

Is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We are a team of more than 500 national experts with vast experience in every facet of the healthcare system particularly focused on Medicaid policy, delivery, and value-based design. Our team has been the architects to much of the value-based Medicaid models deployed across all 56 Medicaid markets.

About the Strategy & Transformation Practice

An HMA Company, is a healthcare advisory firm focused on investigating healthcare strategy, policy, payments, and delivery. With extensive experience across the healthcare spectrum, The Focus Group offers an array of services that include market intelligence, strategy development, and business transformation.

Experts are former:

- State and city/county commissioners of mental health and substance use
- Medicaid policymakers
- Health plan executives
- Child welfare leaders
- Health system executives
- Community BH organization leaders (clinical and operational)
- Inpatient and acute care providers
- Addiction and substance providers
- Public health and prevention policymakers
- Community organizers
- Federal Health Information Exchange (HIE) policymakers
- Primary care and BH clinical leaders
- Justice-involved facilities BH leaders

Our core client groups include:

- **Government**
  Federal agencies, States, Counties, Cities
- **Behavioral health provider organizations**
  Mental health, Substance use, Primary care, Integrated, Certified Community Behavioral Health Clinics (CCBHC)
- **Health plans**
  National Medicaid managed care plans, Local BH managed care plans
- **Health systems**
  Emergency departments, Crisis and diversion, Acute care units, Ambulatory integrated care
- **Community-based organizations**
  Collective impact, Health plan negotiations

In the past eight years, HMA has helped:

- More than 20 state Medicaid agencies
- Over 20 non-Medicaid state agencies
- All national and more than 20 regional health plans
- Hundreds of community-based provider organizations
- More than 15 health systems
- Over 60 CCBHC projects
- More than 30 organizations to achieve CCBHC funding with successful CCBHC-Expansion Grants

Contents

01

Managed Care Organizations

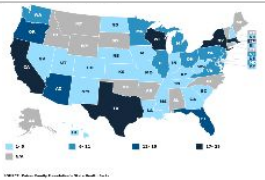
“What do you want to do? I don't know, what do you want to do?”

When pitching to payers…

Medicaid is a federally funded program run by each state, built on the foundations of Federalism

56
Medicaid Agencies

290+
MCOs covering 72% of lives

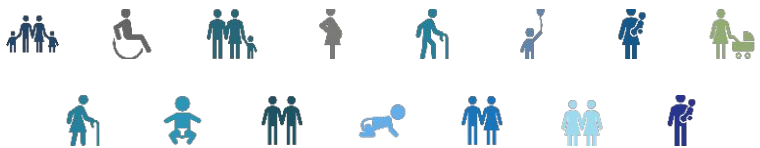


CENTENE Corporation · Elevance Health · MOLINA HEALTHCARE · aetna

The map is a bit outdated.
- NC should be blue.
- OK is moving to managed care.

Providers/Innovators

79.4M
Beneficiaries w/ unique needs



Thus, when you've seen one Medicaid Agency, you've seen one Medicaid Agency.

Fragmentation makes scale challenging but testing innovation more possible.

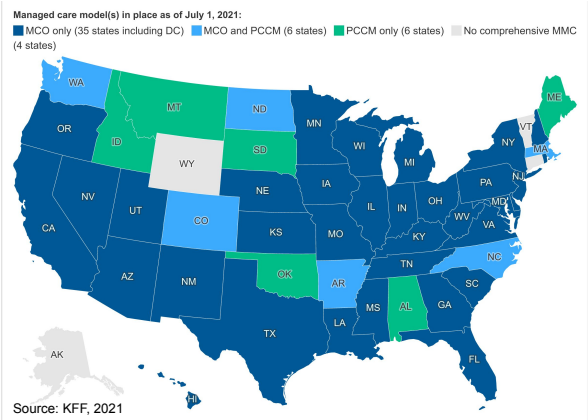
There is a greater importance of selecting the best state/territory to ensure your model aligns with the Medicaid agency.

Understanding Managed Care Organizations (MCOs) - Payers

Most states allocate a monthly capitation rate to risk-based, for-profit or non-profit MCOs that administer benefits to beneficiaries.

Where are MCOs?

- MCOs serve as primary Medicaid insurers in most states, with the percentage of beneficiaries in an MCO varying by state.
- Certain conditions such as disability, behavioral health, or long-term services and supports are further “carved-out” and paid either by the state fee-for-service or on a Special Needs Plan (SNP).



Source: KFF, 2021

Who are MCOs?

Major National MCO Players:

CENTENE Corporation, Elevance Health, MOLINA HEALTHCARE, aetna

- Centene is the largest (15M+ members) and goes by different names in different markets (i.e., Health Net in CA, and Western Sky in NM)

Local Plans:

- There are local and regional plans as well, most common in California, such as Inland Empire and L.A. Care.

Example: Louisiana's MCOs

MCO Plan Name	Corporate Ownership	Mar. 23	%
LA Healthcare Connections	Centene	519,431	27.60%
UnitedHealthcare	UnitedHealth Group	466,097	24.76%
Healthy Blue	Elevance	351,919	18.70%
AmeriHealth Caritas	AmeriHealth Caritas	236,003	12.54%
Aetna	CVS	173,259	9.21%
Humana	Humana	135,501	7.20%
Total		**1,882,210**	

How do MCOs make money?

Most MCOs **are at risk** – meaning if they spend less than the capitation rate, they keep the difference, if they over-spend, they take a loss. What they spend on healthcare claims is the MLR (medical loss ratio).

The Average Managed Care Dollar at Work:

If a health plan spends more, they take the loss.
If they spend less, they increase their profits.

$$MLR(\%) = \frac{Medical\ Claims\ (\$)}{Total\ Capitation\ (\$)}$$

Setting the Per Member Per Month Rates (PMPM)

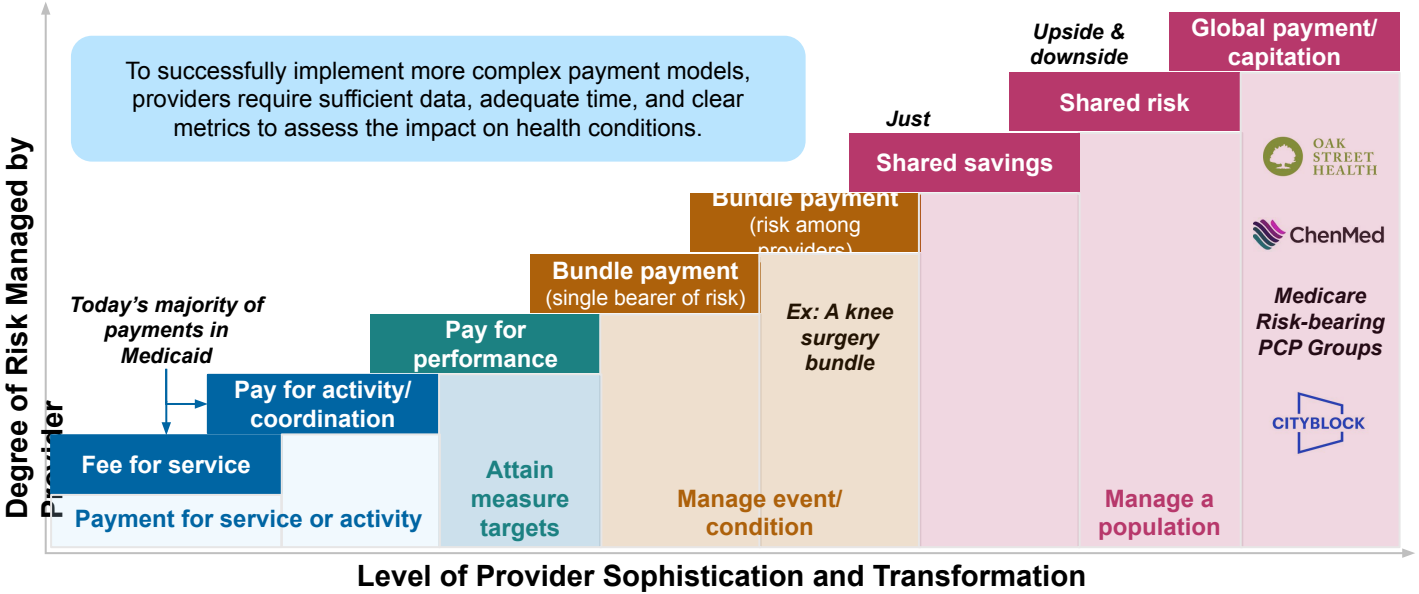
Capitation Rates

- MCOs receive a capitation rate of a per member per month (PMPM) revenue to manage health expenses.
- Rates are set by the state and agreed on by the MCO, each state (and even region of that state) is different

Special Rate Cells

- Different rates are set for population subgroups (referred to as “rate cells”) considering eligibility category, age, gender, location, among other factors.
- ***Example:*** Someone who is pregnant will have a higher capitation rate than a “your average 13-year-old.”

MCOs can pay providers and innovators through a multiple risk arrangements - still most payments in Medicaid are fee-for-service



Defining Value-Based Payments (VBP)

- Reimbursement payments are tied to care delivery and the quality of care provided.
- It rewards providers for both efficiency and effectiveness.
- Providers can get paid through a **per member per month** (PMPM) or per engaged member.

Bringing it Back to Equity

- Fee-for-service rewards a "**sick-care system**" and is reactive to health needs.
- Moving to value-based payments will allow providers to offer upstream solutions and early interventions that will keep people healthier and out of the hospital.

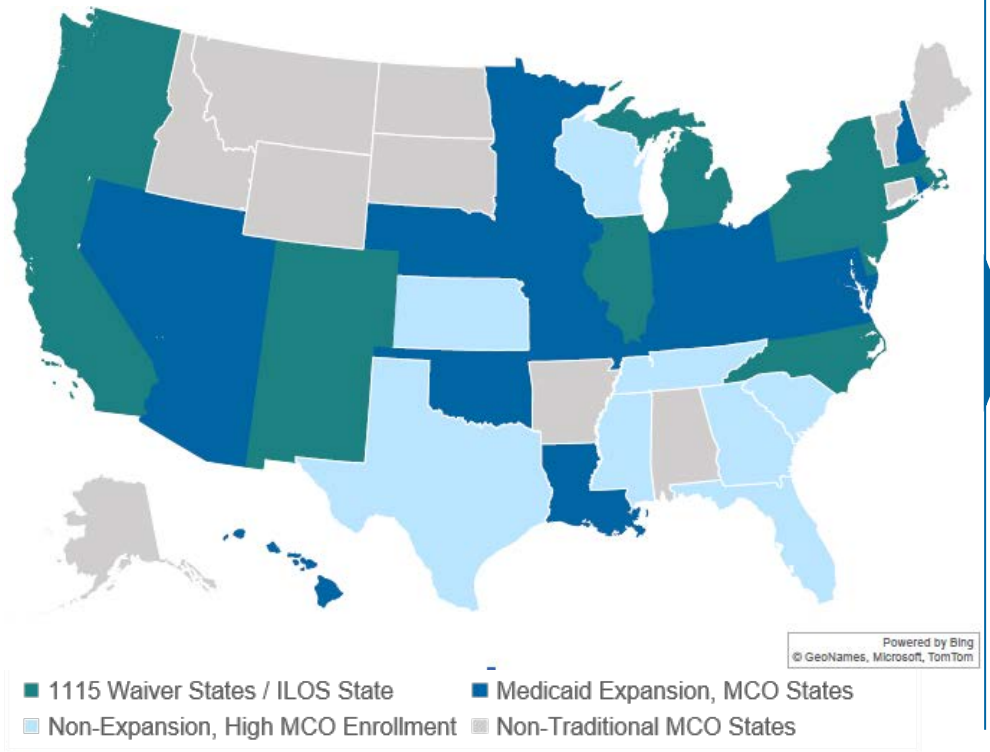
Learn More: a16z Risked-based Contracting for Value-based Care

03

Medicaid Managed Care Regulations and Flexibilities

In Practice: Looking at the National Landscape

For an SDOH Service like "Food Is Medicine," States Have Different Policy Dynamics, Creating Varying GTM Strategies

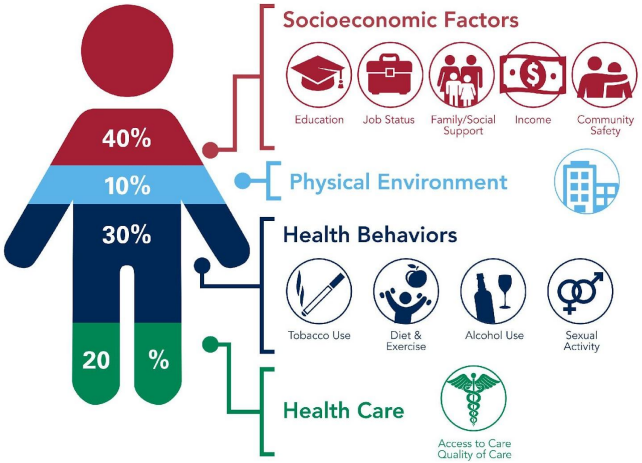


Anticipated Changes under Trump's Second Administration

State Leadership	More Medicaid decisions will be made at the state-level versus national direction from CMS.
Less Emphasis on Health Equity	Expect to see themes of self-sufficiency and "graduating out of Medicaid".
Previous 1115s were Passed	CalAIM and the Healthy Opportunities Pilot in North Carolina were passed under Trump's first administration.
Anticipate the Greatest Impacts in the Expansion Population	Expansion populations and those enrolling in the ACA Marketplace will be most effected.

Addressing inequalities through the health plan is good business

Food Is Medicine (FIM) is the idea that healthy food can help prevent, treat, and manage disease. Providing “upstream interventions” such as support for housing, food, and better access to primary care and behavioral health have shown to decrease higher downstream costs.



Social determinants impact whole person health

- **Only 20%** of a person’s health and well-being is related to **access to care** and **quality of services.**
- The physical environment, social determinants, and behavioral factors drive **80%** of health outcomes.
- Higher social vulnerability risks increase healthcare costs.

States, Health Plans, and CMS are adopting more policies and programs to address beneficiary *health-related social needs (HRSN)*

Policy Changes

Medicaid

States are implementing 1115 Demonstrations, In Lieu of Service provisions, or including language in the RFP for MCOs to offer food interventions

Medicare Advantage

More plans are offering Value-Added Benefits that include food interventions or through SSBCI benefits to address chronic conditions through food

Program Innovations

In Medicaid, states across the country have implemented Food is Medicine programs.

Other states like Florida and Virginia included HRSN and food interventions in their latest managed care re-procurements

Health Impacts of Food

Michigan Medicaid recently published an Evidence Review of FIM
Among adults dually eligible for Medicaid and Medicare who received medically tailored meals (MTMs):

- Approximately 50% fewer inpatient admissions
- Approximately 70% fewer emergency department (ED) visits
- Approximately 70% fewer uses of emergency transportation

Payment Levers for Food Is Medicine Initiatives

How will a plan pay for a Food Is Medicine service?

		"Pot of Money"	Pros	Cons
Medicaid	**In Lieu of Service (ILOS)**	Substitutes from other spend (example: ER or inpatient)	✔ "Easiest" policy lever ✔ Example from Michigan ✔ Part of MLR	✘ Needs to be passed by DMAS ✘ States are waiting to see process
	Quality Improvement Activities	Quality (part of MLR)	✔ Included in MLR ✔ Has more "return" – i.e. Quality/HEDIS	✘ Can add additional complications to the model
	Value-Added Service or Enhanced Benefit	Payer Administrative Dollars	✔ The state has specifically asked payers to offer these programs for their members	✘ Admin dollars are always harder to sustain than MLR
	Community Reinvestment	% of annual profits and/or funds from not meeting minimum MLR requirements	✔ Creates sustainable financing mechanism	✘ Limited reach ✘ Potential for additional costs (admin, marketing)
	1115 Demonstration	CMS approved budgetary flexibilities	✔ Includes admin and infrastructure dollars ($$$)	✘ Longest timeline ✘ Will include additional caveats and mandates

CMS Provides Fresh Direction On ILOS For SDOH Needs

Expanding In Lieu of Service (ILOS) provisions creates opportunities outside of 1115 waiver states.

Overview of ILOS

CMS Takes Action	In 2024, CMS released new guidance for how states and MCOs can address (and pay for) health related social needs (HRSNs). Source.
ILOS	Relevant authorities included in lieu of services (ILOS) as a payment mechanism **(it's a permissible delivery method financed within an MCO cap rate, not a payment mechanism in and of itself)** to offer services.
Defining Opportunity	With this new guidance, states with Medicaid managed care plans can approve nutrition supports as an in lieu of service.
Creating the Right Value Prop	Under that authority, the service would be optional for MCOs to provide, and thus only available to Medicaid members enrolled in plans that make that service election.

Food Benefits Allowed under ILOS

All interventions need to up to 2 meals / day

- **Home delivered meals or pantry stocking,** tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals
  - **Example from CMS**: Medically tailored meals to high-risk expectant individuals at risk of or diagnosed with diabetes
- **Nutrition prescriptions**, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement:
  - **Examples from CMS:** Fruit and vegetable prescriptions, Protein boxes, Food pharmacies, Healthy food vouchers
- Grocery provisions, for high-risk individuals to avoid unnecessary acute care admission or institutionalization.

Take-aways

- From a policy perspective, ILOS is the easiest and most efficient path.
- Learnings from Michigan can be applied moving forward.

ILOS Payment Mechanics… In Lieu Of What?

Substituting services to achieve quality and cost objectives.

ILOS are alternative services that Medicaid MCOs can provide instead of traditional Medicaid benefits without the need for waiver approval.

ILOS can be used as either immediate or longer-term substitutes for state-covered services or settings to improve the quality and health outcomes for Medicaid program enrollees.

ILOS services are voluntary for MCOs to provide and voluntary for enrollees to use.

ILOS **must…**

- Advance the objectives of the state Medicaid program.
- Be more cost-effective than covered services.
- Be provided in a manner that preserves enrollee rights and protections.
- Be subject to appropriate monitoring and oversight.
- Be subject to retrospective evaluation, when applicable.

Example

Supporting Food Is Medicine initiatives "in lieu of" paying for hospital inpatient and emergency department visits due to the chronic conditions affected by poor health.

QIAs are an Increasingly Important Payment Lever

Funded as a medical expense, Quality Improvement Activities (QIAs) are health plan initiatives designed to improve outcomes.

- FarmboxRx, for example, uses this model aligning their programs with health plans' desire for increased member engagement

Medical Loss Ratio (MLR) =

$$\frac{\text{Medical Expenses (Claims + QIAs)}}{\text{Total Premiums}}$$

States may have similar MLR requirements that safeguard members against care cuts, with QIAs serving as a valuable tool helping meet performance targets, improve health outcomes, avoid CMS rebates, and reinvest in members

How Reimbursable Is Referral Coordination?

MCOs are increasingly likely to pay for referral coordination, especially to SDOH services.

Regulatory & State Support

- Many states are leveraging MCO contracts to promote SDOH strategies.
- Federal Medicaid managed care rules allow MCOs to cover non-medical services as "in-lieu-of" or "value-added" services.

Value Based Care Models

- The shift towards value-based care models incentivizes MCOs to invest in preventive services and address SDOH, reducing costs and improving outcomes.
- Adopting closed-loop referral systems by MCOs also demonstrates a commitment not only to making referrals but tracking outcomes as well.

Financial Incentives

- Spending on referral coordination services can count towards MCOs MLR requirements.
- Some states may incentivize MCOs by incorporating the cost of referral coordination into capitation rates.

Examples of Referral Coordination Programs

Organization	Overview	Payment Model	Referral Operations
AmeriHealth Caritas (PA)	Works with community-based care coordination teams to address social needs like housing, food, and transportation	CBOs are contracted on a per-member-per-month) basis to provide care coordination and referral services	CBOs identify Medicaid members' SDOH needs, refer them to community resources, and follow up to ensure services are accessed
CareSource (OH)	Collaborates with FindHelp to streamline referrals to CBOs for services like food assistance, transportation, and housing	CBOs may receive payments for referral-related services through administrative or subcontracting agreements with CareSource	The FindHelp platform enables CBOs to track referrals, document services provided, and report back to CareSource
Humana's Gold Bold Initiative (TX, TN, FL, KY)	Partners with CBOs to address food insecurity, transportation, and housing needs among Medicaid and dual-eligible members	Payments are often tied to administrative contracts and may include performance incentives for improving specific health outcomes related to SDOH interventions	CBOs conduct SDOH screenings, make referrals, and report outcomes back to Humana for performance tracking

04

Case Studies

Policy Has Created An Advantage For CBOs (For Now)

Through policy, CBOs are finally being recognized as vital partners in the delivery of Health-Related Social Needs.

Michigan

- "MDHHS has a strong preference for ILOS Providers to be locally-based. However, MDHHS recognizes that locally-based ILOS Providers may need to develop infrastructure, capacity and experience to deliver ILOS. In contract year 2025, MDHHS is **requiring at least 30% of ILOS be provided by locally-based** ILOS Providers. To be a locally-based ILOS Provider, an organization must be a community-based organization, have a physical presence in Michigan, defined as having one or more office locations in Michigan - preferably in the Region(s) the ILOS is being provided, and participate in the Michigan food economy." (Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide)

North Carolina

- In North Carolina, the Healthy Opportunities Pilot states, "Human Service Organizations (HSOs) are community-based organizations or social service agencies that are contracted to deliver Pilot services."
- The state recognizes that "[Human Service Organizations] play a critical role in delivering the 29 Pilot interventions to Pilot enrollees and other members of the community" (Healthy Opportunities Pilots).
- Human Service Organizations are contracted by Network Leads to provide interventions in the community.

Oregon

- The Oregon Health Plan (OHP) also notes the importance of community-based organizations and calls them "integral to this work" (Oregon Health-Related Social Needs).
- Furthermore, Oregon provided funding for community-based organizations. "[The state] has been approved to spend up to $119 million in community capacity building funds, specifically to support investments to enable partners to provide health-related social needs services"

California

- Through CalAIM, the California Department of Health Care Services (DHCS) has worked with Medi-Cal managed care plans (MCPs) to create a robust provider network for their 14 Community Supports services.
- CalAIM relies on community driven referrals and connections. From the California Department of Health Care Services, "By the end of Q2 2023, managed care plans reported having approximately 1,374 provider contracts active for Community Supports" (Community Supports).

Key Takeaways:

- Michigan's strong preference for local ILOS providers
- North Carolina's Healthy Opportunities Pilot program's recognition of HSOs
- Oregon's Health Plan support and funding for community organizations
- California's CalAIM initiative and managed care integration with CBOs

Michigan ILOS

Michigan's rollout of their ILOS creates a repeatable model to follow.

Michigan adds services through an "In Lieu of" contract update

March 2024:

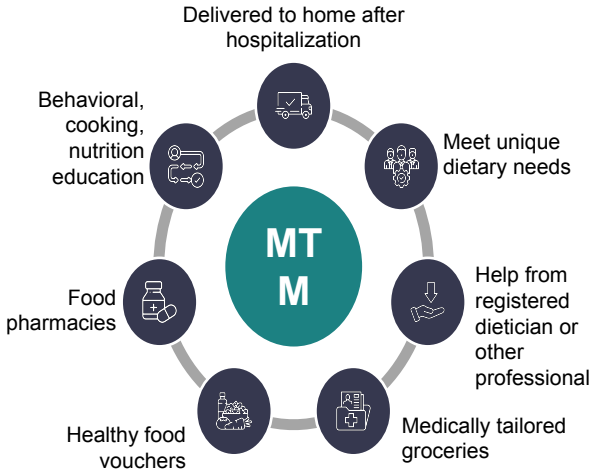
- MDHHS released an RFI to seek public input and proposals for nutrition-focused in lieu of services.
- Michigan's Medicaid agency **will encourage** Michigan's Medicaid Health Plans (MHPs) participating in the Comprehensive Health Care Program to offer ILOS that address Medicaid members' health-related nutrition needs.
- MDHHS will designate **a set of federally approved** ILOS that MHPs may offer starting **in January 2025**.

Document	Summary of Contents
ILOS Overview	Defines service and role of CBOs
ILOS Request for Information	RFI details service definitions and requirements for CBOs
ILOS Final Policy Guidance	Example of service definitions, provider guidelines, and technology requirements
ILOS Evidence Review Summary	Documents potential impact and outcomes
ILOS Standard Agreement Terms	Outlines provider requirements
Optional In Lieu of Services (ILOS) Pricing Guidance	Pricing table and rationale

CalAIM's Medically Supportive Food & Nutrition Services

California's CalAIM Initiative allows Medi-Cal Managed Care Plans to provide medically tailored meals through ILOS.

CalAIM provided a broad definition of Medically Tailored Meals (MTM)



MCOs have purposely left the definition of MTMs vague, open to interpretation, and include multiple options. There is no prescription of what *needs* to be included in a food box.

Meals are not covered to respond solely to food insecurities:

1. Individuals **with chronic conditions**, including:
   - Diabetes
   - Cardiovascular disorders
   - Congestive heart failure
   - Stroke
   - Chronic lung disorders
   - HIV
   - Cancer
   - Gestational diabetes
   - Or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders

2. Individuals being **discharged from the hospital or a skilled nursing facility** or at **high risk** of hospitalization or nursing facility placement.

3. Individuals with extensive **care coordination needs.**

Allowable Providers

- Eligible providers must have experience and expertise in medically tailored meals. Examples include but are not limited to:
  - ❑ Home Delivered Meal Providers
  - ❑ Area Agencies on Aging
  - ❑ Nutritional Education Services to help sustain healthy cooking and eating habits
  - ❑ Meals on Wheels Providers
  - ❑ Medically Supportive Food & Nutrition Providers

- **Becoming a Provider:** Providers should consider if their services are aligned with medically tailored meals service definition and whether the population they serve may be eligible for Medi-Cal managed care, prepare questions they may have for county and plan representatives, and reach out to managed care plans in the county for more information on how to participate.

Food / Nutrition-Related Interventions in North Carolina's 1115 Demonstration

An organization can decide to offer a variety of services to members who meet specific eligibility criteria, as North Carolina has through their 1115 Demonstration.

Eligibility

Overview

- Beneficiaries eligible for Healthy Opportunities Pilots services must meet at least one needs-based criteria and at least one risk factor.

Risk Factors

- As defined by the USDA report on Food Insecurity in America: either the person is **Low Food Security**, **Very low food security**, **or food insecure** as defined based on the principles in the questions establishing food insecurity in the state's SDOH screening tool.

Sample Needs-based Criteria

- Needs are different for adults (+21), pregnant women, and children.
- Example for adults: 2 or more chronic conditions such as but not limited to: BMI over 25, chronic mental illness/SUD, cancer, autoimmune disorders, or repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions.

	Service Name	Unit of Service/Payment
Case Mgt/ Education	Food and Nutrition Access Case Management Services	15-minute interaction
	Evidence-Based Group Nutrition Class	One class
	Diabetes Prevention Program	Four classes (first phase) Three classes (second phase)
Food Interventions	Fruit and Vegetable Prescription	Cost-based reimbursement up to a cap
	Healthy Food Box (For Pick-Up)	One food box, typically weekly for 3 months
	Healthy Food Box (Delivered)	One food box, typically weekly for 3 months
	Healthy Meal (For Pick-Up)	One meal
	Healthy Meal (Home Delivered)	One meal (often 14 per week)
	Medically Tailored Home Delivered Meal	One meal (often 14 per week)

04

RFP Procurement

Leveraging RFPs to Support SDOH

Examples from Other States

Florida

- Pathways to Prosperity in Florida's Medicaid RFP emphasizes holistic support through expanded benefits, including ***food assistance***, housing, and non-medical services, aimed at enabling economic self-sufficiency and reducing Medicaid dependence.
- In the RFP, plans were asked to select which benefits they would provide and an associated per member per month cost.
- MCOs are required to establish partnerships with CBOs to reinvest in community services.

Virginia

- Virginia's Department of Medicaid Assistance Services (DMAS) states the need for HRSN services and non-medical resource supports to be delivered through CBOs.
- Addressing ***food insecurity*** for members is one of two priority DMAS goals to improve HRSN, with an emphasis on ***food access*** and housing stability.
- MCOs are asked to provide a description of proposed ILOS and Enhanced Benefits offerings, which can include food access/interventions.

Illinois

- The Illinois Department of Healthcare and Family Services (HFS) announced on Sept. 3, 2024 that it will release an RFP for Health Choice Illinois (HCI), the state's statewide Medicaid managed care program, in summer 2025.
- HFS will host at least five stakeholder listening sessions where it hopes to receive public feedback prior to the procurement process
- The RFP is expected to prioritize health equity, maternal & child heath, behavioral health, and accountability.

Upcoming Procurement Calendar

Date	State/Program	Event	Beneficiaries
December 2024 - Delayed	Illinois D-SNP	Awards	79,000
Feb. 10, 2025 - March 14, 2025	Nevada	Awards	674,000
March 21, 2025	Florida Children's Medical Services	Awards	88,000
Summer 2025	Illinois	RFP Release	2,800,000
July 1, 2025	Iowa	Implementation	260,000
July 1, 2025	Colorado	Implementation	1,100,000
July 1, 2025	Rhode Island	Implementation	370,000
Fall 2025	Oregon	RFP Release	1,200,000
Sep. 2025 - Nov. 2025	Texas STAR & CHIP (Pending)	Implementation	4,600,000
October 1, 2025	Arizona ALTCS-EPD	Implementation	26,000
Dec. 2025 - Feb. 2026	Texas STAR Kids	Awards	150,000
January 1, 2026	MI HIDE SNP	Implementation	35,000

- Most states that use an MCO system will re-issue a Medicaid procurement through an RFP every 4-8 years, with some exceptions like Maryland and South Carolina that use application processes instead of RFPs.
- RFPs are competitive bids and contracts MCOs are looking to win and are often hundreds of pages long and can get tied up in legal arguments.
- When an MCO is preparing for a bid, that is the ideal time to approach them with an innovative idea or concept.

Payers want to increase food-based interventions due to the impact on health outcomes and costs

Studies have found real impacts with potential ROI for SDOH and food-specific interventions.

SNAP Interventions

Children who lose some or all of their SNAP benefits are more likely to have poor health and be food insecure compared to those who remain covered.

Impact:

- 16-30% Reduction in members with Food Insecurities
- 30% Reduction in the costs related to medication non-adherence (among elderly with diabetes)
- 23% Reduction in nursing home admissions (among elderly)
- 25% Reduction in overall health care costs (among low-income adults)

Source: SNAP Is Linked With Improved Health Outcomes and Lower Health Care Costs

Non-Medically Tailored Meals

A Meals on Wheels–type nontailored food program that delivered nutritious meals but did not tailor to participants' medical needs.

Impact:

- 44% Reduction in ED Visits
- 12% Reduction in Inpatient admits
- $10 net savings/month

Source: Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries

Voucher Interventions

Participants received monthly group-based diabetes self-management education and monthly vouchers ($28–$140/month) redeemable for fruits & vegetables.

Reviewed 13 studies through 2020 -
Impact:

- 4 found improved Food Security status

Fruit & vegetable intake or diet quality

- 7 found improvements
- 3 found no change

Health

- 2 found decreases in BMI
- 1 found decreases in HgbA1c; with no changes in weight or blood pressure
- 1 found improved mental health; with no changes in weight

Sources:

- De Marchis, 2019;
- Veldheers, 2020;
- Oronce, 2021

Medically Tailored Meals

Ten nutritionally tailored MTM's per week for a mean of 8 months in each year of intervention.

Impact:

- 37-52% Reduction in hospitalization risk
- 70% Reduction in ED visits
- 16% - 31% lower monthly healthcare costs
- $2,500 Reduction in the per patient net costs the year following participation (after accounting for meal costs)

Source: Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US

06

Implementation Considerations

What do payers care about? What do they want to see in your solution?

A Pressing & Compiling Problem

- Need to create a “burning platform”
- Start with targeting a certain demographic and condition
- What’s the total cost of care?
- Is this a broader societal issue? Has the state shown signals that they care about it?

Team Experience

- Payers often do not like to be the “guinea pig”
- Find ways to show team expertise and personal experience
- Industry relationships
- Have a systematic way to track and collect impact and results data

No / Low Integration Costs

- Payers are not going to rework their processes to implement your solution
- Solution needs to be interoperable with their systems
- Easy to deploy and understand the value
- Does not overly disrupt their provider network

ROI

- Put the bottom-line up front
- Framing, and showing “what’s in it for the payer” is key
- This is the most important number in your pitch (to payers) deck

Ways to frame ROI to payers

Total Cost of Care 1	Quality 2	Member Engagement 3
• Most important metric, and what you will be asked first. • For the condition you are solving, understand what drives up costs and how you can impact that. The per member per month payment needs to be justified with the impact.	• Quality bonuses and penalties impact a health plan's profitability. • Innovators should understand and design solutions that help the buyer improve national quality standards. • Speaking to specific quality standards will help build early interest from the buyer.	• Medicaid has historically low metrics for member engagement which leads to poorer outcomes. • Payers are interested in proven solutions that can boast member participation. • "Softer" than quality or total cost of care
Takeaway		
• Develop and continuously refine your cost savings model. • Use CMS data to find current state, and then how your solution could impact costs.	• Match and build your solution to national quality metrics and standards. • Innovators should tie their impact and solution to metrics like HEDIS, NCQA standards, and Star Ratings.	• Don't fall victim to the "if you build it, they will come" fallacy. • Customer-centric design and understanding customer needs and messaging is key for building member engagement.

Medicaid MCOs and state agencies addressing food insecurity an emerging yet rapidly evolving field.

Coordinate Back-end Operations

- Smaller CBOs working with large and cumbersome MCOs for the first time have encountered challenges.
- CBOs in other states such as Oregon have struggled to create effective billing systems and processes.
- Some of these CBOs have continued to rely on self and philanthropic funding instead of billing under their 1115.

Seek Technical Assistance Support

- CBOs working with MCOs can be challenging.
- MCOs and states can offer technical assistance programs.
- For example, our HMA colleagues in California provide this technical assistance to providers looking to partner with plans.

Local Advantage (for now)

- State Medicaid agencies and MCOs want to (and are incentivized to) work with local organizations
  - California and Oregon encourage working with local providers
- However, national companies are vying for these contracts.
  - Companies like Moms Meals, grocery chains like Kroger, and delivery services like InstaCart are notable incoming competitors.

Takeaways

- Coordinating back-end processes is just as, if not more, important than aligning service delivery.
- Using a common platform can help.

- Follow, track, and attend any upcoming state webinars, or presentations on state or MCO Medicaid SDOH efforts
- Follow the state/plans' guidance on technical assistance options and create an internal technical assistance team.

- Start (and continue) building relationships with MCO leaders.

06

Questions

Thank you

A question about federal collaboration

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Priority Topics for Federal Collaboration Poll

To increase SNAP access and use for Medicaid enrollees, which of the topics/areas of federal collaboration opportunities are most important for us to continue to discuss?

A. Federal regulation to increase Medicaid's responsibility to coordinate with SNAP, including SNAP outreach and referral
B. Federal guidance around how SNAP and Medicaid outreach funding can be braided and blended
C. Federal guidance and examples around data sharing from SNAP to healthcare organizations, including Medicaid managed care organizations and hospital systems
D. Other (please put in chat)

Discussion:
Breakout Rooms

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Breakout Rooms by Topic

Breakout Room 1: Medicaid Managed Care Rules	**Breakout Room 2:** Coding4Food	**Breakout Room 3:** Federal Collaboration	**Breakout Room 4:** MFSN Partners Program RFP
Facilitator: RJ Notetaker: Julian Xie	Facilitator: Katie Ettman Notetaker: Amanda Bank	Facilitator: Kathryn Jantz Notetaker: Hannah Garelick	Facilitator: Alejandra Cabrera Notetaker: Katrina Scott

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Share Out

What were highlights from your breakout room discussion?

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Closing Remarks
Network Events and Next Steps

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SAVE THE DATE!

MFSN In-Person Summit

May 7-8, 2025

Omni Shoreham Hotel
Washington, DC

MFSPP:
RFP Now Available

Grant Opportunity: Share Our Strength, in collaboration with HealthBegins, is launching a grant funding opportunity

Focus: Funding four state-based organizations or coalitions to support:

- Advocacy or implementation of promising food-security policy initiatives within state Medicaid programs
- Strategies that promote SNAP and WIC enrollment

Award amount: $75,000 per organization

RFP Submission Deadline: Feb 14, 2025

- Questions can be found in RFP + webinar recording: link here

Contact

For any questions related to the MFSN, please contact:

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Q&A

What questions can we answer?