Sparking Change with Health Policy: 1115 Waiver Evolution and Trends

March 21, 2024
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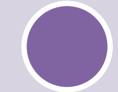
Director, Whole Person Care
Center for Health Law and Policy Innovation, Harvard Law School

The Food is Medicine Moment

September 2022
White House Conference on Hunger, Nutrition, and Health and National Strategy



December 2022
CMS Framework for Addressing Health-Related Social Needs in Section 1115 Demonstrations

July 2023
IHS Produce Prescription Pilot Program Grant Recipients Announced

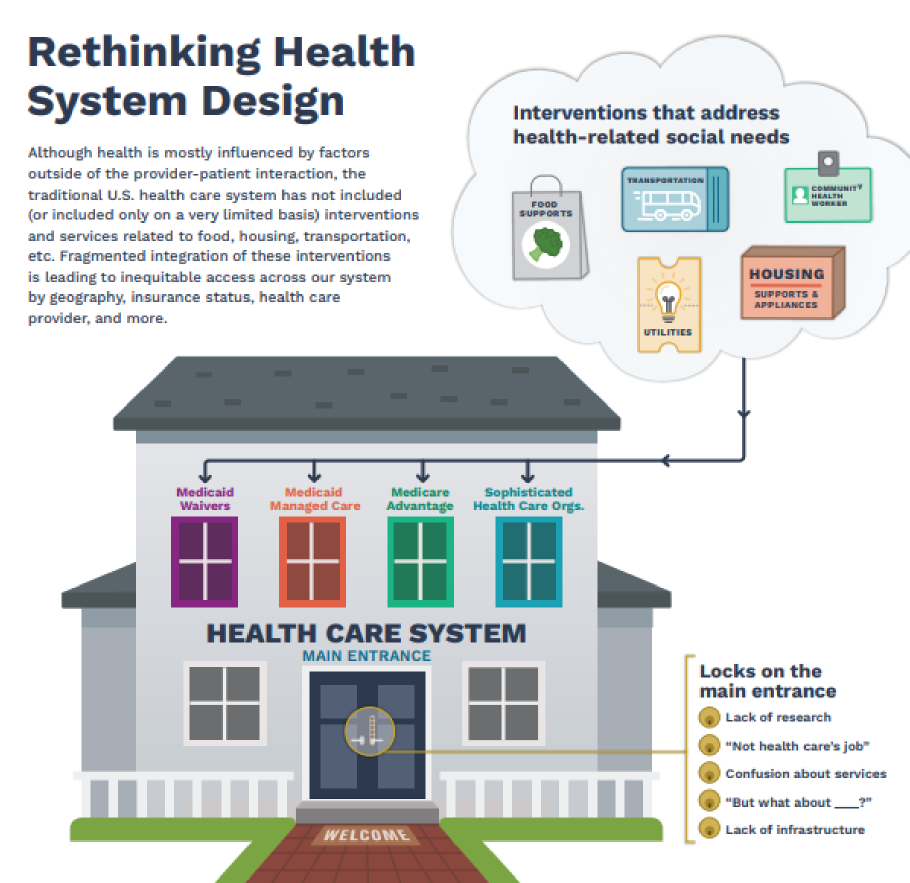
October 2023
HHS Office of the Assistant Secretary for Health Food is Medicine Initiative Announced

November 2023
CMS Guidance for Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and CHIP

POLICY PATHWAYS

No current coverage of Food is Medicine services (direct provision of food) – beyond limited circumstances – in baseline Medicaid coverage or Original Medicare under federal law

Must utilize legal and regulatory flexibilities such as state waivers in Medicaid and supplemental benefits in Medicare Advantage



Medicaid

Waivers
- 1115 Demonstration Waivers
- 1915(b) Waivers
- HCBS Waivers and Amendments

Managed Care
- In Lieu of Services
- Value-Added Services
- Contracting, e.g., Value-based payment (VBP) requirements

State Pilots
- State legislation, appropriation

Medicare

Medicare Advantage
- General Supplemental Benefits
- Special Supplemental Benefits for the Chronically Ill (SSBCI)

What Are Section 1115 Waivers?

- With **CMS approval**, states can implement experimental, pilot, or demonstration projects
- Can cover **services** and **populations** not included under federal law
- Requirements:
  - ✓ Must **promote the objectives** of the Medicaid program
  - ✓ Must be **budget neutral** (but flexibility for certain HRSN services)
  - ✓ Initial **5-year approvals**, can be renewed for 3–5-year periods
  - ✓ States must contract with **independent evaluators** to conduct periodic evaluations and **provide CMS with reports** on the waiver's outcomes
- Examples:
  - ✓ Provide residential substance use disorder (SUD) treatment in Institutes of Mental Disease (IMDs)
  - ✓ Mandate enrollment in managed care
  - ✓ Cover nontraditional services to address health-related social needs (HRSN)

FEDERAL GUIDANCE

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO# 21-001
RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)

January 7, 2021

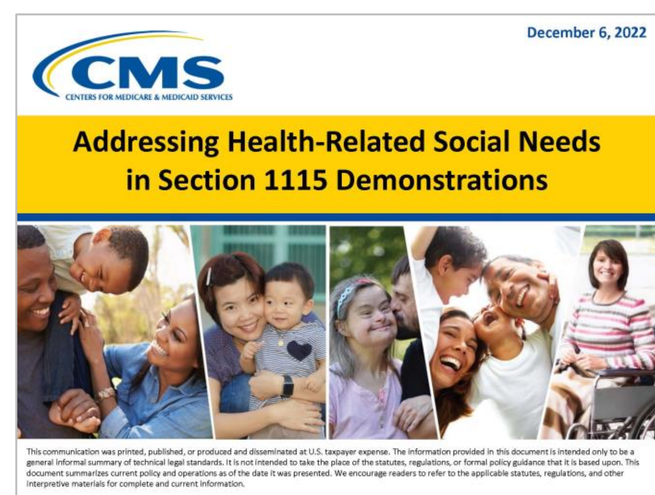
Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)[1] and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to SDOH, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

[1] The Centers for Disease Control and Prevention (CDC) refers to SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." See https://www.cdc.gov/socialdeterminants/about.html for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.

CMS, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (Jan. 7, 2021)



December 6, 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Addressing Health-Related Social Needs in Section 1115 Demonstrations

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CMS, Addressing Health-Related Social Needs in Section 1115 Demonstrations (Dec. 6, 2022)

Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)
November 2023

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting[6]**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)[7]**	**Section 1115 demonstrations[8]**	**CHIP HSI[9]**
Nutrition				
11. Case management services for access to food/nutrition, including, for example: • Outreach and education • Linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees	Yes	Yes	Yes	NPA
12. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example: • Guidance on selecting healthy food • Healthy meal preparation	Yes	Yes	Yes	Yes
13. Home delivered meals or pantry stocking,[21] tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals, including, for example: • Medically tailored meals to high-risk expectant individuals at risk of or diagnosed with diabetes	Yes – less than 3 meals / day	Yes – less than 3 meals/day[22]	Yes – up to 3 meals/day,[23] for up to 6 months[24]	NPA

CMS, Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP) (Nov. 2023).

HRSN-Specific 1115 Waiver Guidance

REQUIREMENTS	SERVICES ALLOWED	PATIENTS REACHED

• Budget neutrality flexibility for HRSN
• **HRSN costs** limited to 3% of annual Medicaid spend
• **Infrastructure funding** available, limited to 15% of HRSN spending
	• 10 Housing Services
	• 5 Nutrition Services
	• Other Services w/ CMS Approval
		• Can be **statewide**
		• HRSN services must be **medically appropriate** under state-determined clinical and social risk factors
		• Example **populations targeted**:
		  • Chronic diet-related conditions
		  • Pregnant/post-partum
		  • SMI/SUD
		  • Above health conditions w/
		    • Risk of/homelessness
		    • Food insecurity
		  • Recently released from incarceration

1115 WAIVER MOMENTUM

Category	State	Status	Date
SCREENING	Georgia	Approved	10/29/2010
SCREENING	Maine	Approved	4/19/2019
SCREENING	Virginia	Approved	5/6/2021
SCREENING	Michigan	Approved	7/15/2021
EDUCATION	Florida	Approved	7/31/2014
EDUCATION	Maryland	Approved	12/22/2016
EDUCATION	Illinois	Approved	5/7/2018
EDUCATION	New Mexico	Approved	12/14/2018
EDUCATION	Rhode Island	Approved	12/20/2018
EDUCATION	Utah	Approved	6/30/2022
EDUCATION	Arkansas	Approved	11/1/2022
FOOD IS MEDICINE	Massachusetts	Approved	8/3/2016
FOOD IS MEDICINE	Oregon	Approved	1/12/2017
FOOD IS MEDICINE	North Carolina	Approved	10/19/2018
FOOD IS MEDICINE	California	Approved	12/29/2021
FOOD IS MEDICINE	New Jersey	Approved	3/30/2023
FOOD IS MEDICINE	Washington	Approved	6/30/2023
FOOD IS MEDICINE	New York	Pending	9/15/2022
FOOD IS MEDICINE	New Mexico	Pending	12/15/2022
FOOD IS MEDICINE	Delaware	Pending	12/28/2022
FOOD IS MEDICINE	Illinois	Pending	6/23/2023

SOURCE: Erika Hanson et al., The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A U.S. Survey, Health Affairs Scholar, qxae013, https://doi.org/10.1093/haschl/qxae013

1115 Waiver Momentum: Direct Provision of Food

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Legend
Approved Waiver
Pending Waiver

Source: Map Generated via MapChart, https://www.mapchart.net/

SERVICES

Nutrition Supports in 1115 Waivers

1. **Case Management**
2. **Nutrition Counseling** including guidance on selecting healthy food and healthy meal prep
3. **Home Delivered Meals** or **Pantry Stocking** tailored to health risk and eligibility criteria
4. **Nutrition Prescriptions**, e.g., fruit and vegetable prescriptions, protein boxes, food pharmacies, healthy food vouchers
5. **Grocery Provisions** for high-risk individuals to avoid unnecessary acute care admission or institutionalization

Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)
November 2023

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SOURCE: CMCS Informational Bulletin, Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program and CMS Coverage Table (Nov. 16, 2023)

Target Populations

The primary target populations of nutrition services within these demonstrations are individuals with **chronic diet-sensitive conditions**, **mental health or substance use disorders**, and/or who are **pregnant or post-partum**.

SOURCE: Erika Hanson et al., The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A U.S. Survey, Health Affairs Scholar, qxae013, https://doi.org/10.1093/haschl/qxae013

Table 2. Populations targeted for Medicaid Section 1115 demonstration nutrition services, by state.

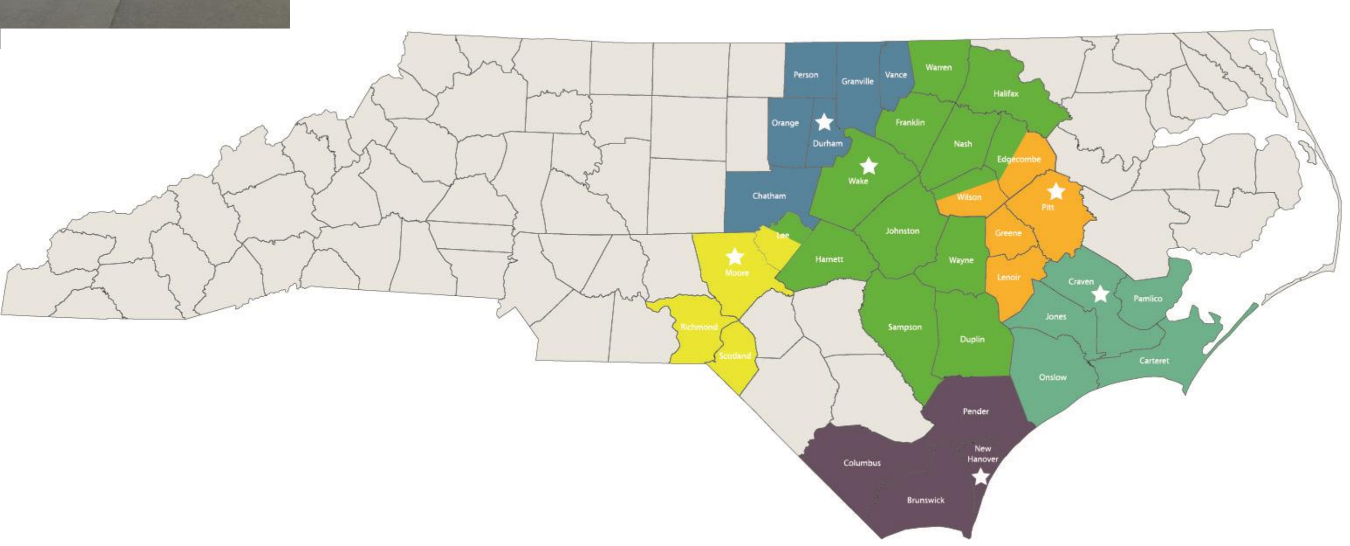
Category	State demonstration waiver	Population(s) targeted					
		Health status			Social determinant		Additional populations or factors[b]
		Chronic conditions[a]	Pregnant/ postpartum	Serious mental illness/substance use disorder	Risk of homelessness	Food insecurity	
Screening	Georgia		X				
	Maine	X					
	Michigan						X
	Virginia			X			
Education	Arkansas	X	X	X			
	Florida		X				
	Maryland	X	X				
	Rhode Island		X				
	Utah[c]			X	X		
Food is Medicine	California	X	X	X			X
	Massachusetts[c]	X	X	X	X	X	X
	New Jersey		X				
	North Carolina[c]	X	X		X	X	
	Oregon[c,d]	X	X	X	X	X	X
	Washington[c,d]	X	X		X	X	X
	Delaware (pending)		X				
	Illinois (pending)[c]	X	X	X		X	
	New Mexico (pending)		X				
	New York (pending)		X	X	X		X

[a]Qualifying conditions differ by state, see Tables S1 and S2. Common conditions that may qualify include diabetes, cardiovascular disorders, HIV, and cancer.
[b]Additional populations or factors vary by state, see Tables S1 and S2. For example, Michigan's screening evaluation provision applies to all enrollees in the demonstration, Massachusetts targets individuals with complex physical health needs, and Oregon has proposed targeting individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon.
[c]Beneficiaries must meet a health needs–based criterion and have at least 1 social determinant factor.
[d]State has yet to finalize its eligibility requirements for services. Further details included in Tables S1 and S2.

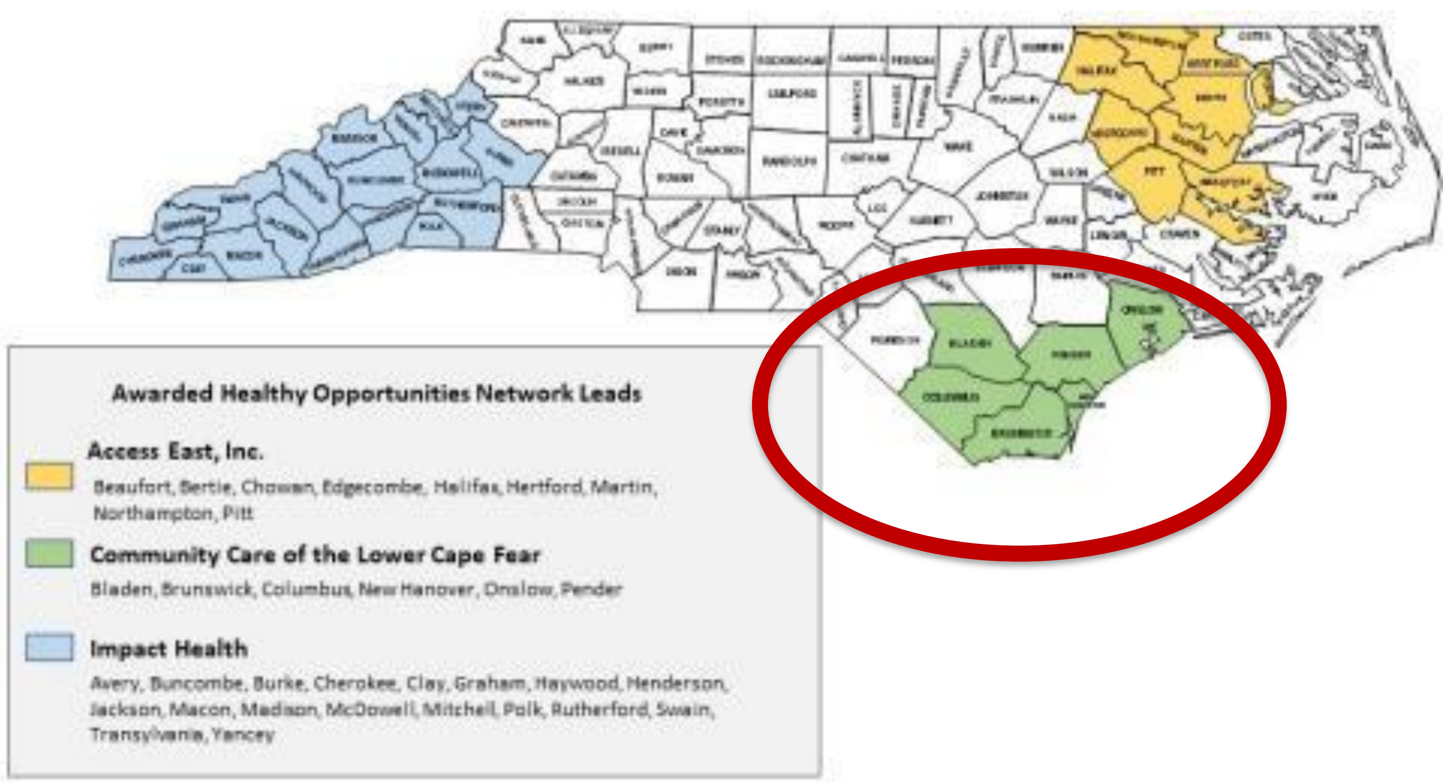
Key Considerations/Decision Points

Topic	Questions	Examples
Scope of services	• What interventions should be included in a pilot/demonstration?	• NC: Full spectrum of FIM (MTMs, healthy meals, healthy food boxes, produce prescriptions,etc.) • NJ: MTMs
Target Populations	• Who will be eligible to receive the interventions?	• MA: risk factor (food insecurity) + health needs based criteria (5 categories) • NJ: 300 pregnant individuals/year
Infrastructure	• Who will identify eligible patients? • Who will make referrals? • Is there a need for additional technology/staffing/etc.?	• Screening: Screening tools • Screening/Referrals: Screening and referrals being conducted by plans, providers, or both • Technology: Funding to support development/alteration of EHR, referral systems, etc. at providers and CBOs
Evaluation	• How will the state measure success?	• Metrics: Food insecurity measures, health outcome measures (e.g., A1c), cost measures, patient experience measures

Food Bank of Central & Eastern North Carolina



Healthy Opportunities Pilot (HOP)



What is HOP?

- First comprehensive program in the nation to test/evaluate the impact of providing select evidence-based, non-medical interventions as a response to the Social Determinants of Health.
  - 29 services offered across 4 sectors
    - **Food**, Housing, Transportation, Interpersonal Safety
- Strengthen community capacity to provide high-quality, member-centered services to really see change
- Unique opportunity to shape integrated healthcare moving forward

The Healthy Opportunities Pilot

CMS authorized $650 million in Medicaid funding for the pilot over five years. Funding for the pilot is part of the broader Section 1115 waiver in which the state must demonstrate budget neutrality to the federal government – meaning federal costs under the waiver must not exceed what federal costs would have been for that state without the waiver.

Key Pilot Entities

- Medicaid Pre-Paid Health Plans (PHPs)
  - Manage participants' physical, behavioral and social needs
- Care Managers
  - Work with PHPs to identify eligible Medicaid enrollees
  - Propose services to benefit enrollee
- Network Leads
  - Connect the health care and social service sectors
  - Manage HSO/service provider network
- **Human Service Organizations (HSOs)**
  - Community-based/social service agencies
  - Deliver needed social services to Pilot enrollees
  - **The Food Bank is an HSO in our Pilot region**

Who does HOP serve?

- HOP participants must:
  - Be eligible **NC Medicaid Managed Care** members
  - Live in a Pilot region (shown on map)
  - Have at least one qualifying physical or behavioral health condition*
  - Experience one qualifying social risk factor*

*determined by the DHHS

The Healthy Opportunities Pilot

Figure 1

North Carolina Healthy Opportunities Pilots Eligibility Criteria and Services

Health Risk Factors	Social Risk Factors	Pilot Services
• Adults with two or more chronic conditions or repeated emergency room use or hospital admissions • High-risk pregnant women • High-risk infants and children or infants and children with one or more chronic conditions	• Homelessness and housing insecurity • Food insecurity • Transportation insecurity • At risk of witnessing or experiencing interpersonal violence	• Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance • Food support and meal delivery • Non-emergency health-related transportation • Interpersonal violence-related transportation, legal referrals, and parent-child supports

Source: KFF analysis of CMS, Special Terms and Conditions, #11W00313/4, North Carolina Medicaid Reform Demonstration, Attachment G: Enhanced Case Management and Other Services Pilot Program Eligibility and Services (approved Nov. 1,2019-Oct. 31, 2024, amended April 25, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

Questions so far?

The Healthy Opportunities Pilot

Healthy Opportunities Pilots Fee Schedule		
Service Name	Unit Of Service/Payment	**Rate or Cap**
Food		
Food and Nutrition Access Case Management Services	15 minute interaction	**$13.27**
Evidence-Based Group Nutrition Class	One class	**$22.80**
Diabetes Prevention Program	• Four classes (first phase)	• **Phase 1: $275.83** • **Completion of 4 classes: $27.38** • **Completion of 4 additional classes (8 total): $54.77**
	• **Three classes (second phase)[6]**	• **Completion of 4 additional classes (12 total): $68.46** • **Completion of 4 additional classes (16 total): $125.22** • **Phase 2: $103.44** • **Completion of 3 classes: $31.02** • **Completion of 3 additional classes** • **(6 total): $72.42**

The Healthy Opportunities Pilot

Healthy Opportunities Pilots Fee Schedule		
Service Name	Unit Of Service/Payment	**Rate or Cap**
Food		
Fruit and Vegetable Prescription	Cost-Based Reimbursement Up to A Cap	**Up to $210 per month[7]**
Healthy Food Box (For Pick-Up)	One food box	• **Small box: $89.29** • **Large box: $142.86**
Healthy Food Box (Delivered)	One food box	• **Small box: $96.79** • **Large box: $150.36**
Healthy Meal (For Pick-Up)	One meal	**$7.00**
Healthy Meal (Home Delivered)	One meal	**$7.60**
Medically Tailored Home Delivered Meal	**One meal**	**$7.80**

The Food Bank's Role

- 3 services within the Food Sector
  - Food & Nutrition Access Case Management
  - Fruit & Vegetable Prescriptions
  - Healthy Food Boxes

Service #1:
Food and Nutrition Case Management

- 1:1 resource navigation carried out by Community Support Associates over phone and email
- Can help complete SNAP/WIC applications, navigate the Food Finder, etc.
- Medicaid reimburses us for time spent chatting on the phone/gathering resources for participants' individualized need

Service #2:
Fruit and Veggie Rx

- CSA-style boxes of fresh fruits and veggies delivered to participants 2x/month
  - 3–6 month service period
- Vendor Ripe Revival sources, packs, and delivers the parcels
- Food Bank covers case management, starting services, fielding member feedback, correcting delivery issues, etc.
- Medicaid reimburses for food cost

Fruit and Veggie Rx Box Photo

Service #3: Healthy Food Boxes

- Shelf-stable food boxes delivered to members weekly
  - 3–6 month service period
- Available in small or large allocations based on participant's need
- Nutrition education materials included with for delivery
- Utilize a subcontractor network of partners to serve 5 counties

CHLPI

CHLPI

Current State

- **575** active cases (650+ open cases)
  - **25** Food & Nutrition Access Case Management
  - **125** Fruit & Vegetable Prescriptions
  - **425** Healthy Food Boxes

The Healthy Opportunities Pilot

About
News & Events
Funding Opportunities
NCServes
For Network Partners
For Individuals

About NCCARE360

NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. NCCARE360 helps providers electronically connect those with identified needs to community resources and allow for feedback and follow up. This solution ensures accountability for services delivered, provides a "no wrong door" approach, closes the loop on every referral made, and reports outcomes of that connection. NCCARE360 is available in all 100 counties across North Carolina.

What We've Learned

- Listening to neighbors is of paramount importance
- Nutrition education materials are received very well by participants
- Delivery eliminates many barriers to food access
- Real, positive health outcomes can come from these interventions

Where We're Going

- Implementing more client surveys to gather feedback about the service experience
- Building capacity to accommodate the growing number of referrals in our area
- Continuing to find ways to make this Pilot sustainable for the foreseeable future

Massachusetts Medicaid 1115 Waiver: Supporting Food is Medicine in FQHCs

Kim Prendergast, RDN, MPP

Community Care Cooperative

About Community Care Cooperative (C3)

- We are a non-profit, Federally Qualified Health Center (FQHC)-led Accountable Care Organization (ACO)
- Our mission is to **leverage the collective strengths of FQHCs** to **improve the health and wellness** of the people we serve
- We started in Massachusetts in 2016 and have grown to 40+ FQHCs in 7 states with contracts in Medicaid

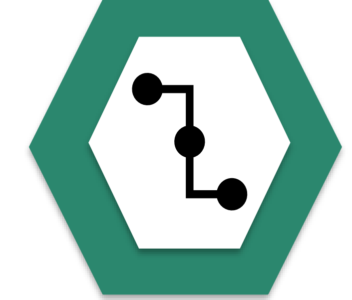
WHAT IS AN ACO? A group of providers that come together to:

- **Provide High Quality Care & a Great Member Experience** - Ensure patients get the right care at the right time without unnecessary procedures
- **Share the savings** from spending health care dollars wisely – at C3, we re-invest these savings in FQHCs, our workforce, and health equity programs

Our Social Health Strategy

Identify Health-Related Social Needs (HRSNs)

Screening members for food insecurity, housing instability & other needs using the Accountable Health Communities Tool



Connections to Resources

Training FQHC staff through webinars on topics such as Food Insecurity, Housing, Utilities, Social Connection, Internet, transportation, & more

Programs & Partnerships

Investing in Flexible Services Nutrition & Housing programs
Creating partnerships to assure SNAP & WIC application support

Policy & Dissemination

Conducting program evaluation
Sharing data and best practices
Advocacy for Social Health programs, CMS HRSN regulations, coding, and funding

MassHealth 1115 Waiver & Flexible Services

The Section 1115 Waiver supported a major restructuring of Medicaid in Massachusetts in 2018, including the creation of the ACO program and investment in Social Services Integration through Flexible Services.

- **Program Overview:** Launched in 2020 with funding for Massachusetts ACOs to address food & housing as health-related social needs
- **Goal:** Improve members' health outcomes, health equity and reduce Total Cost of Care

- **Program Eligibility:** ACO members who meet specific criteria for both health and social needs
- **Delivery of Services:** ACOs should partner with high-capacity Social Service Organizations (SSOs) to provide services
- **Flow of Funds:** Medicaid Agency to ACOs to SSOs
- **Non-duplication requirement:** Programs must avoid duplication of state and federal programs (e.g., SNAP, WIC)
- **Capacity-Building:** Grant funds were available to support SSOs with technology and staff

C3 Approach: Food is Medicine Interventions

Food Referral Navigation & Support

Connect members to a **Nutrition Coordinator** for **resource navigation**, including

- Assuring they are connected to programs like SNAP and WIC
- Assessing the household's food security needs and providing direct services that are appropriate for the member's needs
  - Support disease management and increase healthy eating and cooking skills through **nutrition education and coaching**
  - Encourage safe and healthy cooking through provision of **kitchen items and appliances**

Nutrition Goods & Supports

Healthy Food Vouchers

Healthy Food Vouchers

Increase access to healthy food by providing reloadable EBT cards or grocery store gift cards.

Meal Kits

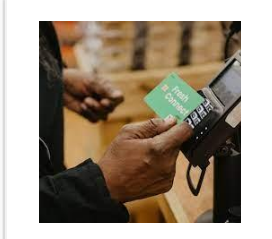
Meal Kits

Home delivered meal kits with ingredients and easy to follow recipes, providing members with a fun cooking experience and healthy eating skills.

MTM

Medically Tailored Meals

Home delivered prepared meals for members with specific dietary needs to manage their health conditions



Fresh Produce

Produce Prescriptions

Increase access to healthy food by providing reloadable produce EBT cards for purchasing power for fresh produce or direct delivery of produce boxes.

Our Big Wins!

2,200 Active Members

- 1,900 members receiving nutrition supports across 6 social service partners
- 430 members receiving housing support across 14 social service partners

$23M in Services & Goods

- Invested $6-8 million each year into the community to expand the capacity of trusted social service partners
- Funding is spent on direct services and goods for members to improve food security or housing instability

14,250 MassHealth Members Referred

- Represents members from all 24 C3 health centers in MA
- Engaged over 200 CHWs and patient advocates in workflows to identify & refer eligible members

93% members successfully connected

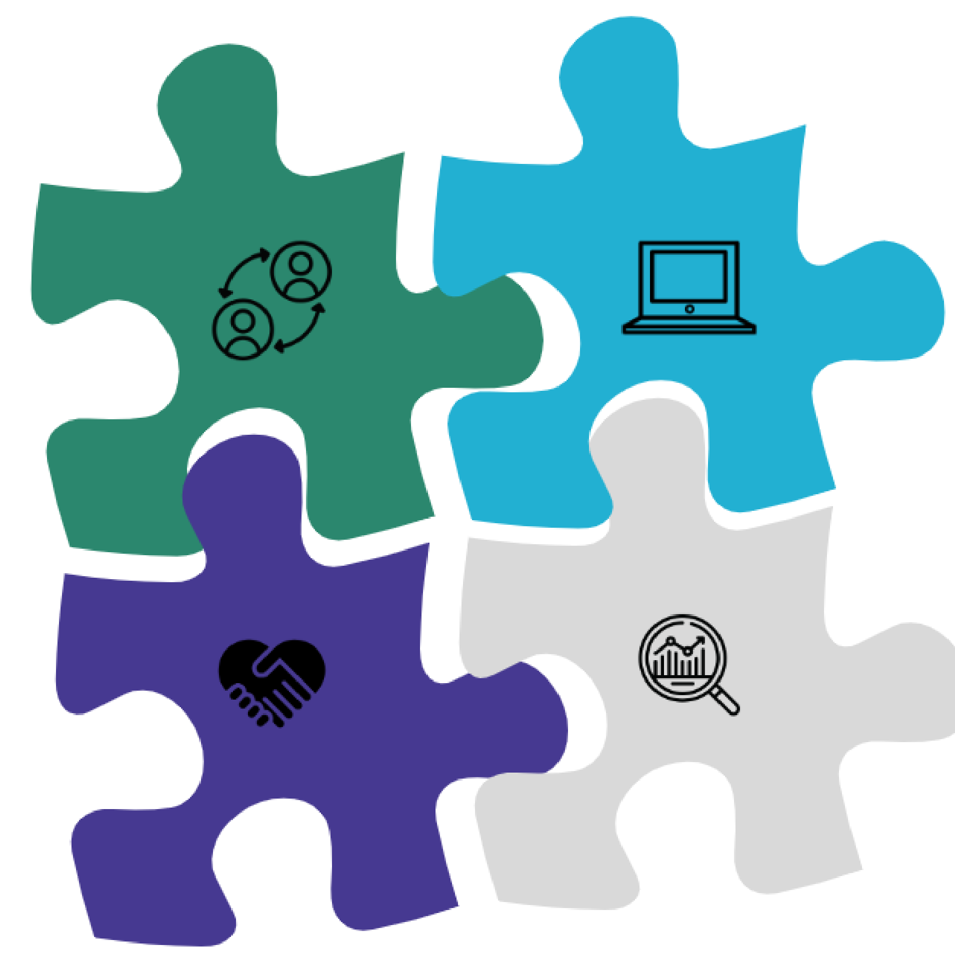
- Support closed loop referrals through trainings, close communication with SSO partners, and customized referral platform

Coming Soon!

Flexible Services Program Evaluation Report sharing impact on Diabetes control, ED visits and TCOC

Lessons Learned: What's Important to Our Success

Co-Design Programs as <u>Partnerships</u> with Social Service Organizations



Technology System & Data Analytics

Member Engagement

Performance Improvement & Program Evaluation

What's Next for Food Is Medicine in Massachusetts?

- 2024 is the final year of the 5-year "Grant Funded" Flexible Services Program

- Beginning January 1, 2025 Health Related Social Needs programs move into the Managed Care Framework
  - Funds are part of the overall Cost of Care
  - MassHealth will set allowable rates for Goods & Services
  - SSOs will enroll as "HRSN Providers" and will bill for services via claims

NEW YORK STATE

FOOD AS MEDICINE

COALITION

Image

Proudly supported and facilitated by

NYS FOOD AS MEDICINE COALITION

Mission

A statewide coalition will promote communication and collaboration across regions in New York while serving as a resource and partner to decision-makers on topics and policy initiatives that relate to Food as Medicine.

Our intent is not to replace or duplicate the efforts of existing groups or coalitions but to harness our collective expertise at this critical moment of opportunity to integrate Food as Medicine into NYS policy and practice.

Membership

The statewide FAM Coalition will be inclusive of representatives from each regional FAM Coalition from across the state, individuals with lived experience, community-based organizations, associations and task forces, medical providers, nutrition experts, producers, distributions, payers, academic and research representatives, and policy makers.

Vision

It is vital for us to maintain a collective voice on FAM in efforts to effect policy change with NYS executive agencies, the NYS Legislature, local governments, and social care community non-profit programs.

This Coalition will foster collaboration, in areas such as best-practice programming, research, resource sharing and grant-partnerships. We will gather and make available resources to inform and educate our partners and our communities.

NYS FOOD AS MEDICINE PROJECT

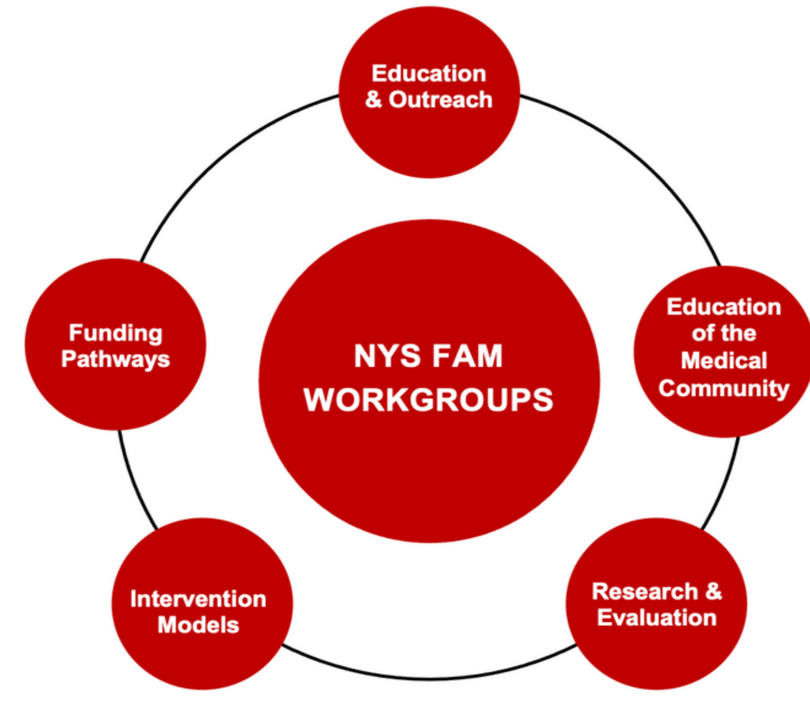
BUILDING ON PROJECT STAKEHOLDER GROUPS

FAM Steering Committee

United over **50** individuals from over **40** organizations representing **every** region of NYS

FAM Project Workgroups

Over **60** individuals from **40 statewide** organizations



NYS FAM PROJECT 1115 RECOMMENDATIONS

Framework

- Building an integrated social care delivery system rooted in health equity
- Supporting the inclusion of robust nutrition treatment and education in practice and program models
- Creating and maintaining a digital health infrastructure
- Sustaining, scaling, and demonstrating the impact of programming and implementation beyond the term of the waiver

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

1. Provide infrastructure funding, technical assistance, and guidance for the full menu of Food as Medicine (FAM) interventions covered under the New York Health Equity Reform (NYHER) 115 Waiver

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

2. Implement a comprehensive, statewide digital health system that includes a standardized payment model, closed-loop referral processes, and interoperable data sharing

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

3. Provide guidance and technical assistance to the 1115 Waiver Amendment Social Care Networks to promote collaboration, equitable, and diverse vendor networks to foster partnerships between FAM providers, CBOs and healthcare providers

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

4. Develop appropriate reimbursement rates to support the inclusion of a continuum of FAM services with minimal access barriers

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

5. Identify a standardized nutrition security assessment to supplement the Accountable Health Communities Health Related Social Needs Screening Tool when food insecurity is indicated. Provide onboarding and culturally responsive training guidance for Qualified Health Providers and Community Health Workers to implement best practices in their use of both screening tools to identify and connect vulnerable populations to services addressing social needs.

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

6. Support the Statewide Health Equity Regional Organization (HERO) in their provision of guidance on best practices for compliance, promotion of health equity, data collection and reporting, implementation and evaluation strategies, and the use of enrollment data across social care programs to enhance the impact of the provision of FAM for eligible populations

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

7. Direct the Statewide HERO under the 1115 Waiver Amendment to promote inclusive and expansive service guidelines when designing value-based payment models with health and social service partners

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

8. Fund a robust, required, and standardized monitoring and evaluation plan of the New York Health Equity Reform 1115 Waiver Amendment, led by the Statewide HERO, to assess the implementation process, evaluate the health and cost impacts of FAM intervention, and inform the ongoing development of the delivery systems where FAM is provided

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

9. Embed Medicaid coverage in value-based payment arrangement for social determinant of health (SDOH) screening and referrals (including FAM interventions) provided by Community Health Workers, registered dietitians and nutritionists, and food access navigators employed by non-Medicaid billing entities

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

10. Support the continued education of Qualified Health Providers who are practicing within Medicaid and Medicare

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

11. Direct health and social service partners to adopt flexible program guidelines that will maximize the impact of FAM interventions

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

12. Ensure that individuals receiving FAM interventions have access to an appropriate level of medical nutrition therapy and education services from a registered dietitian nutritionist (RDN) to best address medical and nutrition needs. Specifically, in the provision of medically tailored meals, RDNs should be integrated into the entire intervention process, from menu design to intake, assessment, ongoing medical nutrition therapy, nutrition counseling, and nutrition education based on the assessment of eligible participant needs

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

13. Enable Medicaid Managed Care and encourage Medicare Advantage plans to reimburse for SDOH screening and FAM eligibility referrals as a part of care coordination and case management programs

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

14. Broaden the scope and depth of FAM evaluation by partnering with the philanthropic community and private payers to fund research extending beyond the required statewide 1115 Waiver Amendment monitoring and evaluation plan to inform future FAM policies by generating evidence

NYS FOOD AS MEDICINE COALITION 1115 RECOMMENDATIONS

15. Partner with the NYS FAM Coalition to regularly review and integrate evidence from monitoring and evaluation activities – including recommendations from FAM stakeholders and program participants – to regularly update implementation policies and to inform best practices for the delivery of FAM services

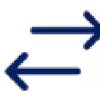
New York 1115 Waiver Amendment: Background and Objective

NYS aims to better coordinate regional social care service delivery and improve health equity and health outcomes through this 1115 waiver amendment, **New York Health Equity Reform [NYHER]: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic**

Overall Goal: *"To advance health equity, reduce health disparities, and support the delivery of social care."*

- New York seeks to build on the investments, achievements, and lessons learned from the DSRIP to scale **delivery system transformation**, improve **population health and quality**, deepen **integration** across the delivery system, and **advance health-related social need (HRSN) services.**
- The waiver amendment will require the standardization and collection of data that will allow the state to stratify measures to **evaluate impacts on underserved** communities, **enhance Medicaid services** to best serve all populations, and implement **social risk adjustment**.
- This would be achieved through targeted and **interconnected investments** that will augment each other, be directionally aligned, and be tied to accountability. These **investments focus on:**

Population Health



Social Care Networks

Strengthening the Workforce

NEW YORK STATE
FOOD AS MEDICINE
COALITION
Thank you!
Natasha Pernicka, MPA
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https://thefoodpantries.org/home/new-york-state-food-as-medicine-project/
The Alliance
for a Hunger Free New York
WORKING TOGETHER
THE FOOD PANTRIES
TO FEED THE HUNGRY

What excites you? What concerns you? What questions do you have?

Small group discussion