
MEDICAID FOOD
SECURITY NETWORK
Medicaid Food
Security Network Summit
MAY 7-8, 2025
WASHINGTON, DC
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HEALTH
BEGINS

Conversations on Food Justice

SNAP and WIC's role in the Food is Medicine Spectrum

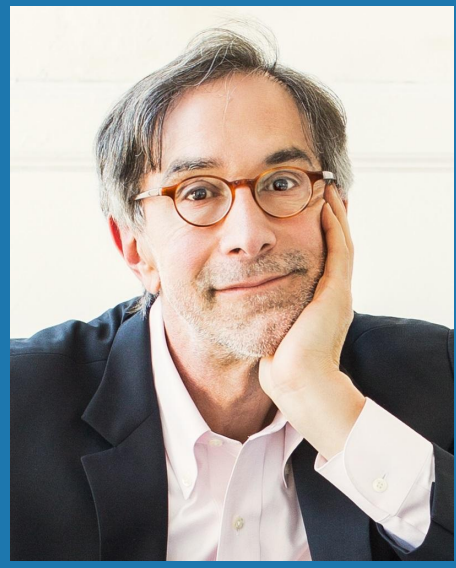
May 7th, 2025

Medicaid Food Security Network Summit 2025

Session Speakers

Chuck Scofield
Executive Vice President, Share Our Strength

Kelleen Zubick
Managing Director, Health Systems, Share Our Strength



Corby Kummer
Executive Director of Food & Society, The Aspen Institute

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Session Speakers

SHARE OUR STRENGTH™

Dr. Caree Cotwright
Associate Professor,
University of Georgia

Liz Landa
Resident Services
Manager II, Mercy
Housing

Dr. Kofi Essel
Food as Medicine
Director, Elevance Health

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State case studies on Medicaid food and nutrition supports

May 7th, 2025

Medicaid Food Security Network Summit 2025

Agenda

1. Introduction from Julian Xie, Share Our Strength
2. Talks by each state speaker
3. Moderated Q+A

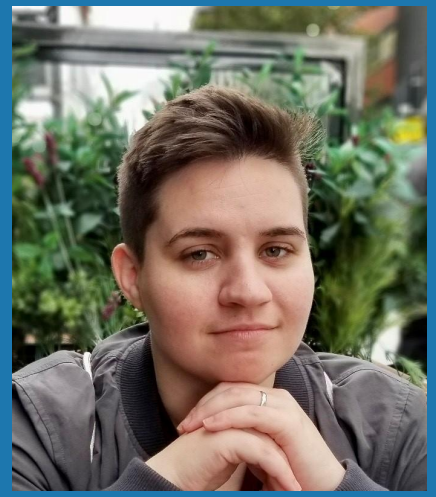
MEDICAID FOOD SECURITY NETWORK

Session Speakers

SHARE OUR STRENGTH™

Dr. Palav Babaria
Chief Quality & Medical Officer and Deputy Director of Quality and Population Health Management, DHCS

Maria Ramirez Perez
Associate Director, Healthy Opportunities, NC DHHS



Allison Rich
Senior Program Manager of Social Services Integration, MassHealth

Alexandra Alam El Din-Meeks
Empire State Fellow, New York State Executive Chamber

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NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

State Case Studies on Medicaid Nutrition Supports

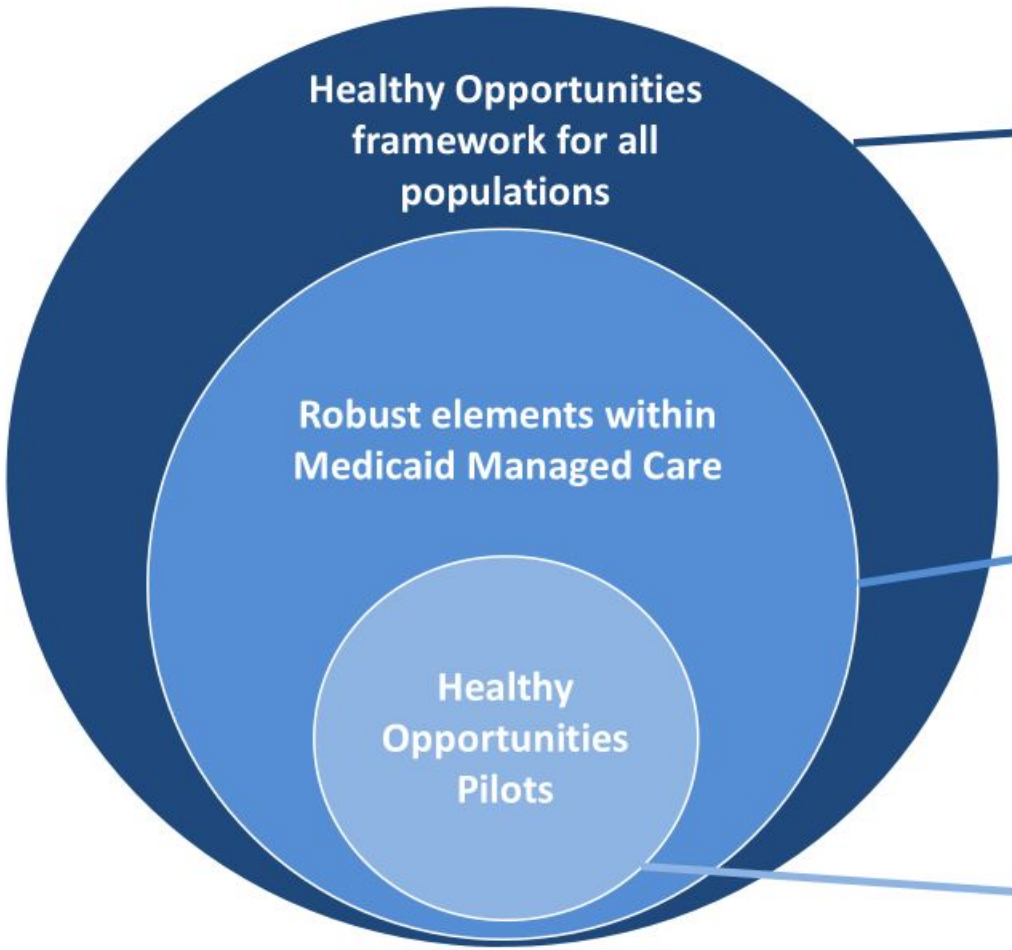
State: North Carolina

Maria Ramirez Perez
Associate Director of Healthy Opportunities

May 7, 2025

Building Statewide Multi-components Shared Infrastructure

NC DHHS has built shared assets that can be used across populations, as well as targeted initiatives to build the evidence base, to bridge health care and human services across diverse populations & geographies at scale.



Shared assets and infrastructure across all populations:

- Healthy Opportunities "Hot Spot" Map
- Standardized social needs screening questions
- NCCARE360 - closed-loop referral platform
- Workforce development – Community Health Workers
- COVID-19 Isolation and Quarantine Supports

Embed shared assets and infrastructure in Medicaid as a base for other payers:

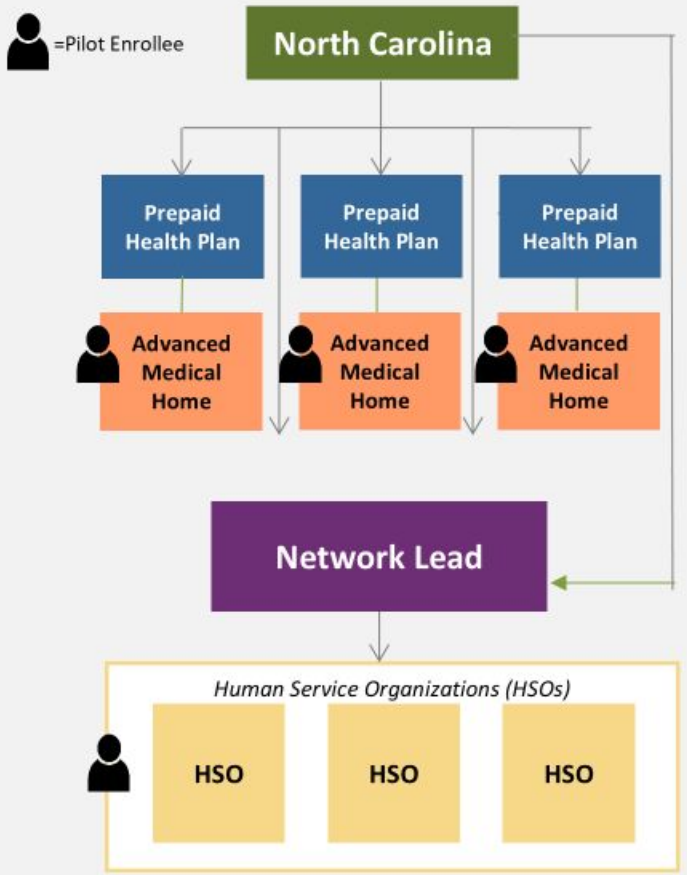
- Care management:
  - Standardized screening questions, NCCARE360, workforce
- Quality strategy
- Value-based payment
- Value added services and in-lieu-of-services
- Community Investments
- Integration with Department partners (DSS, LHDs, SNAP, WIC, etc.)

Targeted initiative to develop systems, financing, and evidence base to drive future policy changes: Healthy Opportunities Pilots

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

Healthy Opportunity Pilots: Overview

Sample Regional Pilot



Healthy Opportunities Pilot Overview

- **NC's 1115 Medicaid transformation waiver** authorizes state and federal Medicaid funding for the Healthy Opportunities Pilots
- **Pilot funds are used to:**
  - Pay for 28 **evidence-based, federally-approved, non-medical services** defined and priced in NC DHHS' Pilot fee schedule
  - **Build capacity of local community organizations** and **establish infrastructure** to bridge health and human service providers[1]
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for high-risk Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluation:**
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
    - Rates of screening and connection to non-medical services; improvement in social risk factors; community impact
    - Which services are highest value & impact for which populations
    - Impacts to sectors outside of health care (e.g. enrollment in SNAP and WIC, school attendance)
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**

Healthy Opportunities Pilot Regions

Network Leads, Health Plans, and Human Services Organizations will work with communities in three geographic areas of the state to implement the Pilots.

Highlights

- DHHS awarded **three Network Lead contracts** in 2021 as part of a competitive procurement process
    - Impact Health, a grant-making foundation, CCLCF and Access East, care management entities).
- Pilot regions cover 33 predominantly **rural counties** of North Carolina's 100 counties.
- Healthy Opportunities Pilots have served over 30,000 members since launching in **March 2022**. Addressing food, housing, transportation, and interpersonal safety needs.

8 MCOs (Tribal Option and CFSP, pending)
3 Network Leads
23 Care Management Organizations
140+ Health Service Organizations

Healthy Opportunities Pilots: Services and Reimbursement Rates

NC DHHS defined and priced 29 services that could be covered by the Healthy Opportunities Pilots. The 28 services which launched are reimbursed via fee-for-service (FFS), per-member per-month (PMPM) payments, or cost-based reimbursement up to a cap and include. The rate was determined via feedback from the field derived through research, working sessions, and an RFI.

Housing

- Housing navigation, support and sustaining services
- Inspection for housing safety and quality
- Housing move-in support
- Essential utility set-up
- Home remediation services
- Home accessibility and safety modifications
- Healthy home goods
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Food and nutrition access case management
- Evidence-based group nutrition class
- Diabetes Prevention Program
- Fruit and vegetable prescription
- Healthy food box (pick-up or delivered)
- Healthy meal (pick-up or delivered)
- Medically Tailored Home Delivered Meal

Transportation

- Reimbursement for health-related public or private transportation
- Transportation case management

Interpersonal Safety

- Interpersonal safety case management
- Violence intervention services
- Evidence-based parenting curriculum
- Home visiting services

Cross-Domain

- Holistic high-intensity enhanced case management
- Medical respite
- Linkages to health-related legal supports

Interim Evaluation Report (IER): Early Findings

The IER results, which examined several health, utilization, and cost indicators, show that the HOP concept—investing in housing, nutrition and other services to buy health—*works.* Receiving services provided through HOP has reduced social need, utilization and total cost of care for the studied population.

HOP participation results in:

- Significantly lower health care expenditures with $85 less per beneficiary per month, after accounting for HOP service delivery spending[1]
- Decreased hospital utilization, including:
  - Decreased emergency department utilization relative to non-HOP beneficiaries.
  - Decreased inpatient hospitalization for non-pregnant adults relative to non-HOP beneficiaries.
- Reduced risks of food, housing and transportation needs

HOP Engagement as of November 30, 2023:

- 50,585 beneficiaries (9.1% of total population) in Pilot Regions screened for qualifying needs
- 13,271 unique individuals enrolled
- 89% of HOP Members with an unmet need received at least one HOP service

[1] This finding is based on interrupted time series and difference-in-difference analysis and highlights lower health care expenditures relative to what would have occurred in the absence of the Pilot.

Lessons Learned

From CalAIM Policy to Practice: Addressing Food Security in Medi-Cal

Palav Babaria, MD, MHS

Chief Quality & Medical Officer

Deputy Director, Quality & Population Health Management

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

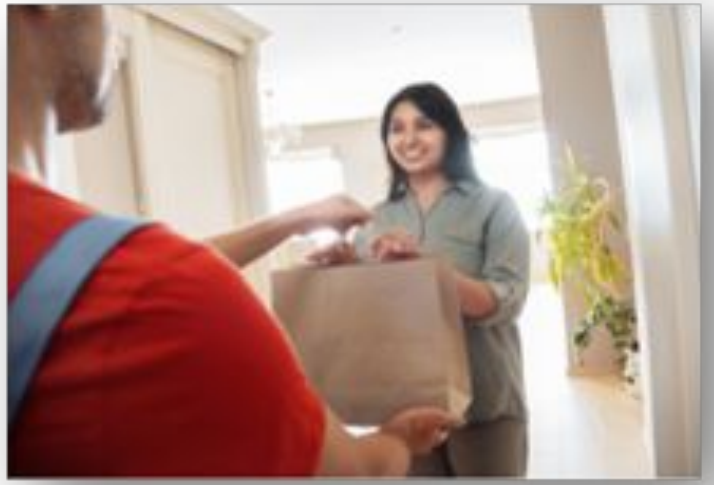
CalAIM Supports Californians' Ability to Stay Healthy in All Areas of Life

CalAIM's bold Medi-Cal transformation expands on the traditional notion of "the health care system." It is much more than a doctor's office or hospital; it also includes community-based organizations and non-traditional providers that together can deliver equitable, whole-person care.

- **Population Health.** One in three Californians are enrolled in Medi-Cal, with more than 65% of enrollees identifying as people of color
- **Children & Youth.** Medi-Cal covers >40% of all births in California, with about two-thirds of children enrolled in Medi-Cal identifying as Black and Latino
- **Complex Needs & Unmet Care.** More than two in three patient days in a California long-term care facility are covered by Medi-Cal
- **Justice-Involved.** At least 80% of justice-involved individuals are eligible for Medi-Cal

Community Supports MTM/MSF Overview

Community Supports are services in the Medi-Cal managed care delivery system that offers cost-effective and medically appropriate alternatives to other covered services. They are designed to address social drivers of health and health related social needs.



- California originally launched its Medically Tailored Meals/Medically Supportive Foods ("MTM/MSF") service in January 2022 as one of its 14 "Community Supports" authorized by CMS under CalAIM as an "in lieu of services" to provide **cost effective and medically appropriate alternatives to traditional medical care**

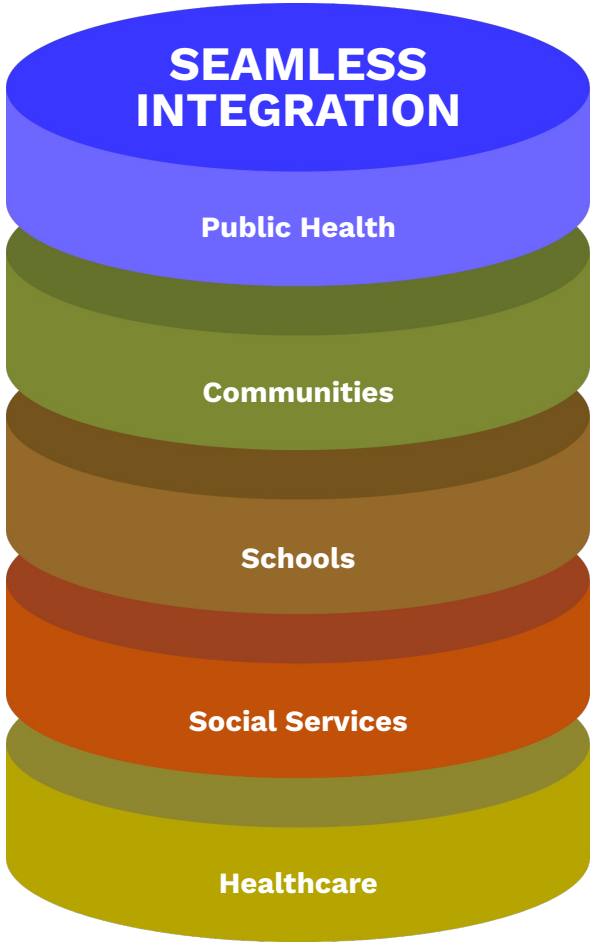
- **Nearly every Medi-Cal managed care plan has elected to offer MTM/MSF services** in the counties they serve.

- The service includes:
  - **Medically Tailored Services**:
    - Medically Tailored Meals
    - Medically Tailored Groceries
  - **Medically Supportive Foods:**
    - Medically Supportive Groceries
    - Produce Prescriptions
    - Healthy Food Vouchers
    - Food Pharmacies

Detailed Definitions of each service and additional requirements can be found at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

Whole Person Data Integration

- Breaking out of healthcare's four walls
- Medi-Cal Connect:
  - DHCS' Population Health analytics platform will aggregate, link, and provide access to a variety of data types and support key population health functions
  - Current pilots supporting integration across Medicaid, WIC and SNAP data sets



MassHealth's 1115 Waiver and Health Related Social Needs: Nutrition Supports

Overview of MassHealth and MassHealth ACOs

- In Massachusetts, Medicaid and the Children's Health Insurance Program are collectively called **MassHealth**, and provide health insurance for 2M members
- MassHealth has implemented **managed care options** since the early 1990's, and introduced **Accountable Care Organizations** (ACOs) into its managed care framework in **March 2018** under a five-year contract
- MassHealth has completed a **re-procurement of the ACO program** for another five years, beginning **April 2023**

- ACOs are **provider-led entities** (e.g., groups of providers or a health system) responsible for **total cost of care (TCOC)** and **quality** for members
- TCOC accountability incentivizes ACOs to implement strategies to be more efficient and spend less than their TCOC budget, such as by addressing a **member's health-related social needs (HRSNs)**

MassHealth's *Previous* 1115 Waiver

- Much of MassHealth's managed care framework, including the ACO program, is authorized under its **Section 1115 Waiver**
- MassHealth's *previous* Section 1115 Waiver (July 2017 to September 2022) also authorized several programs addressing HRSNs:

Community Supports Program (CSP) for Chronically Homeless Individuals

- **Managed care benefit** for chronically homeless individuals with behavioral health (BH) needs
- Supports included **housing search and placement services**, **transitional assistance**, and **tenancy sustaining supports**

Flexible Services Program (FSP)

- $149M pilot program supporting MassHealth ACO members with **nutrition and housing supports**
- Included as part of MassHealth's **$1.8B Delivery System Reform Incentive Payment (DSRIP) Program**

MassHealth's *Current* 1115 Waiver

In September 2022, CMS extended MassHealth's 1115 waiver until **December 2027** – this extension included the following key goal:

> ***Waiver Extension Goal #3***
> *Continue to improve access to and quality and **equity of care**, with a focus on initiatives addressing **health-related social needs** and specific improvement areas related to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community*

- As part of this extension, CMS **reauthorized and expanded** both the Community Supports Program and the Flexible Services Program, along with **$687.9M** of expenditure authority
- One condition of CMS's reauthorization is that MassHealth must **transition the Flexible Services Program out of pilot mode into the managed care framework** by 1/1/25
  - MassHealth has authority to cap the number of individuals using HRSN Services in recognition of **federal "budget neutrality" policy**

Selecting HRSN Supplemental Services

ACOs must choose at least **one** HRSN Category 1 Supplemental Nutrition Service and at least **one** HRSN Supplemental Housing Service. ACO selections will be documented in a new Contract appendix.

MassHealth HRSN Housing Services for 2025

FOR MEMBERS EXPERIENCING HOMELESSNESS

- Housing Search
- Transitional Goods

FOR MEMBERS AT RISK OF HOMELESSNESS

- HRSN Housing Navigation

FOR MEMBERS LIVING IN HOUSING THAT IS UNHEALTHY, INACCESIBLE, OR UNSAFE

- Healthy Homes

MassHealth HRSN Nutrition Services for 2025

Category 1: Food Services*

1. Home Delivered Meals

- Medically Tailored Home Delivered Meals

OR

- Nutritionally Appropriate Home Delivered Meals

2. Food Boxes

- Medically Tailored Food Boxes

OR

- Nutritionally Appropriate Food Boxes

3. Food Prescriptions

- Medically Tailored Food Prescriptions and Vouchers

OR

- Nutritionally Appropriate Food Prescriptions and Vouchers

Category 2: Food Services Enhancements

Nutrition Education

- Nutrition Education Classes and Skills Development
- Nutrition Counseling

Kitchen Supplies

- Kitchen Supplies

*If ACOs choose to provide more than one Category 1 service, they may only select one 'service type' from each Category 1 service ("Medically Tailored" or "Nutritionally Appropriate").
**Nutrition assessment and coordination is integrated into all Category 1 Services.

Thank You!

Allison Rich

Senior Manager, Social Services Integration

MassHealth

Allison.Rich@mass.gov

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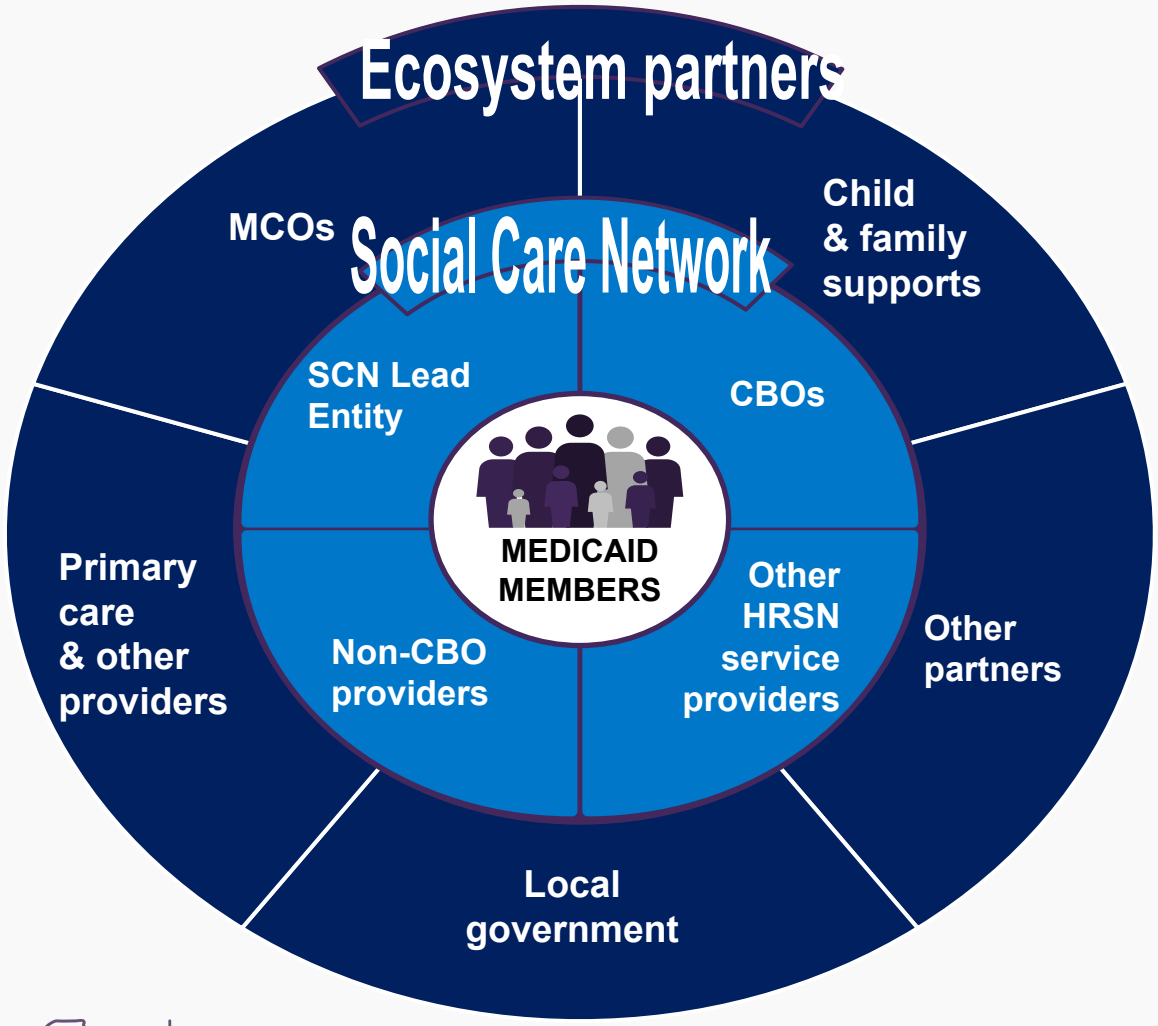
Social Care Network (SCN) Program Overview

Medicaid Food Security Network National Summit

Alex Alam El Din, Empire State Fellow, New York State Executive Chamber

MAY 7, 2025

OVERVIEW OF SOCIAL CARE NETWORKS



Launched in January 2025, Social care networks (SCNs) connect **community-based organizations, providers, insurers** and **other partners,** such as WIC and SNAP programs, to address health-related social need (HRSN) services among New York Medicaid members by:

- **Screening members for unmet HRSNs**
- **Navigating members to existing services and newly covered enhanced services**
- **Delivering enhanced HRSN services**

NEW YORK STATE | Department of Health

Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

HEALTH-RELATED SOCIAL NEEDS SERVICES PROVIDED BY THE SCN

Enhanced HRSN services

Screening

- Medicaid Members can choose to be screened for HRSNs using the Accountable Health Communities HRSN screening tool

Navigation

- Medicaid Managed Care Members are eligible for navigation to existing or enhanced HRSN services
- Medicaid Fee-For-Service (FFS) Members are eligible for navigation to existing local, state, or federal services (e.g., SNAP)

Nutrition

- Nutritional counseling and classes
- Medically tailored home-delivered meals
- Food prescriptions
- Pantry stocking
- Cooking supplies (pots, pans, etc.)

Housing

- Medically necessary home modifications and remediation, incl. asthma remediation
- Medical respite
- Rent / temporary housing
- Utility set-up / assistance
- Housing Navigation
- Pre-tenancy services
- Community transitional services
- Tenancy sustaining services

Social care management

- Navigation to social care services (including other enhanced HRSN services and existing services such as education, childcare, interpersonal violence resources, etc.)

Transportation

- Public and private transportation to connect to HRSN services and HRSN care management activities (e.g., get to an appointment with housing navigator)

Duration of each service varies depending on service type and Member need

NEW YORK STATE | Department of Health

Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

FOOD AND NUTRITION SERVICES PROVIDED BY SCNS

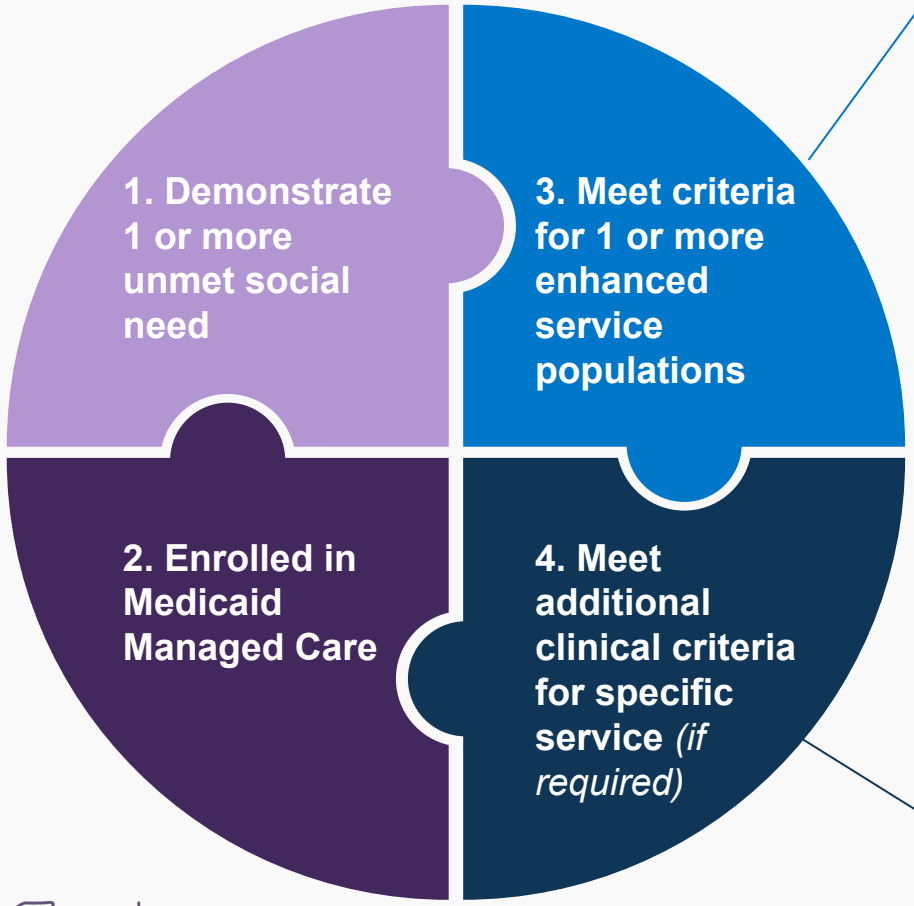
Nutrition counseling & education	Medically tailored meals	Food prescriptions	Pantry stocking	Cooking supplies
Meal prep education Food/diet related planning related to conditions such as diabetes, obesity, etc.	Home delivered, medically tailored or clinically appropriate meals	Medically tailored or clinically appropriate food boxes or nutrition vouchers	Fresh produce and non-perishable groceries (may include delivery)	Provision of materials necessary for meal preparation (e.g., pots, pans, plates, bowls, cups, silverware)

NEW YORK STATE | Department of Health

Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024; SCN: Summary of Eligibility for Enhanced Health-Related Social Needs (HRSN) Services, January 2025

ELIGIBILITY FOR ENHANCED HRSN SERVICES

Criteria to receive enhanced services



Populations of focus

- Members with substance use disorder and/or serious mental illness
- Members with intellectual and developmental disabilities
- Pregnant or postpartum persons
- Members recently released from incarceration and have chronic health condition(s)
- Children under 18 – including youth involved in foster care, juvenile justice, or kinship care – with select chronic health conditions
- Frequent health care users (e.g., emergency room, hospital stays)
- Members enrolled in a Health Home

Certain enhanced HRSN services will require additional clinical criteria be met (e.g., physical disability)

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Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

OVERVIEW OF SCREENING, NAVIGATION, AND SERVICE DELIVERY

Screening

Screenings will be conducted using the standardized AHC tool via SCNs

There are a range of individuals and channels that may conduct screening including SCN Navigators, HRSN service providers, Health Homes, FQHCs, providers, behavioral health providers, hospitals, etc.

Members may also self-screen on the SCN website.

Social care navigation[1]

Social Care Navigators conduct eligibility assessment, gathering information through the following channels:

1. Member information from MCO (e.g., claims data)
2. Additional information gathered by the Social Care Navigator (e.g., discussion with Member, requesting provider attestation)

Social Care Navigators may be employees of the SCN lead entity or contracted in the SCN

HRSN services

Enhanced HRSN services

Eligible Members are referred to HRSN service providers in the Network for enhanced HRSN services

Existing services

Any Member can receive navigation to existing federal, state, and local services (e.g., SNAP, WIC)

Enhanced HRSN services to existing services The Navigator ensures that the Member has their needs met related to the service

NEW YORK STATE | Department of Health

1. Members can be navigated to enhanced services by SCN Social Care Navigators or providers.

Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

SCN PROGRAM UPDATE

Progress to date

- **9 regional SCN Lead Entities** have begun developing robust networks of HRSN service providers
  - **Statewide, HRSN providers are delivering food and nutrition services**. Examples of food/nutrition providers participating in SCNs include food banks, community centers, faith-based social service organizations, mobile meal programs, etc.
- Thousands of Medicaid members have **started to be screened and receive services –** program has set an ambitious goal to screen every Medicaid members annually

Current priorities

- SCNs continuing to **contract with and onboard** CBOs and other providers
- SCNs **onboarding Social Care Navigators** to enable Screening and Navigation to services
- SCNs **expanding partnerships with health care providers** in their regions to reach Medicaid members and potentially provide Screening and Navigation

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SOURCE: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

EARLY LESSONS FROM SCN PROGRAM IMPLEMENTATION

Clear, early guidance on technical requirements and **operational workflows** is key to achieving an integrated experience across health and social care

Providing **funds for capacity-building** (e.g., hiring RDNs/CDNs need for nutrition service delivery) and **designing straightforward, intuitive workflows** are needed to help CBOs to in scale up service delivery

Navigators have a critical role in creating a coordinated, accessible ecosystem – **Navigators need training on facilitating warm hand-offs** to existing services (e.g., SNAP and WIC) following enhanced nutrition service delivery to meet members' long-term needs

Program success requires ongoing **feedback and engagement of community partners** through a variety of forums, including webinars, partner meetings, and SCN-led governing bodies

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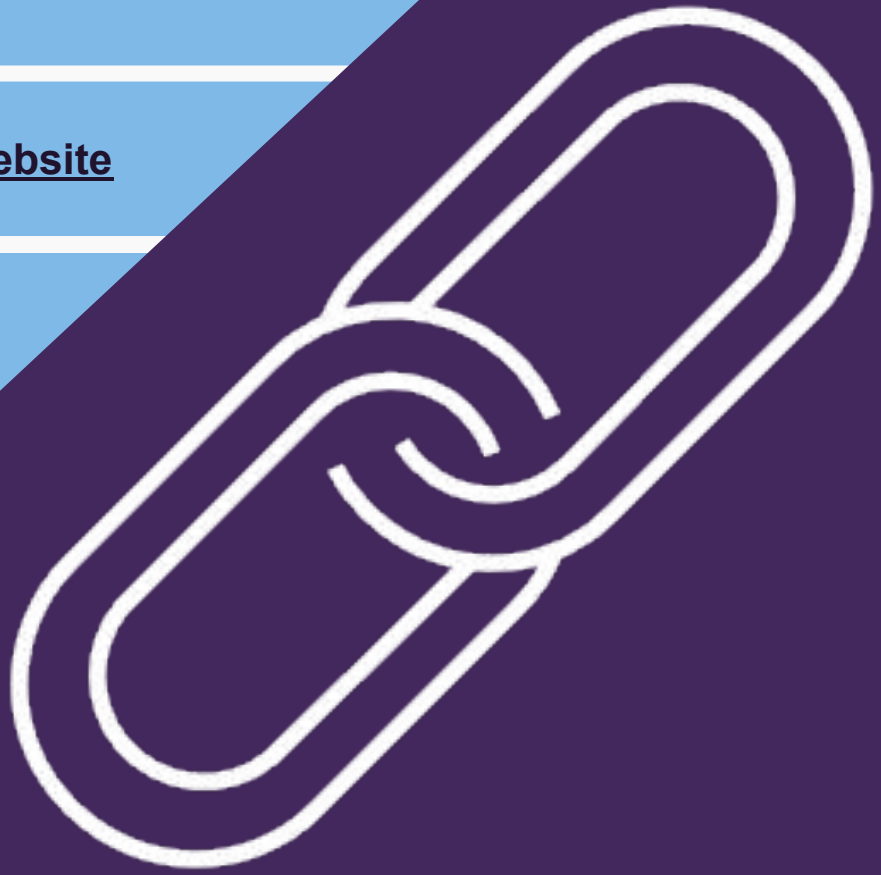
ADDITIONAL RESOURCES

- New York 1115 Waiver Website
- Current Special Terms and Conditions
- New York Social Care Networks Website
- Subscribe to MRT Listserv



If you have questions regarding New York Health Equity Reform Amendment programs, please contact us at: NYHER@health.ny.gov

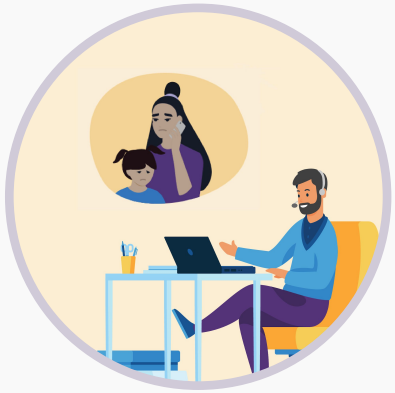
Department of Health

APPENDIX

NEW YORK STATE | Department of Health

THE MEMBER JOURNEY: AN ILLUSTRATIVE EXAMPLE

Dani is a single mother who is expecting her second child. Dani often runs out of money for groceries by the end of the month



Dani calls her regional SCN to see if she qualifies for help. The SCN Navigator screens Dani to identify her needs and verifies that she meets eligibility criteria for food assistance

The SCN Navigator creates a referral to a community-based organization that offers food box services

The CBO contacts Dani to coordinate food box delivery for her determined service duration

Dani receives the food box delivery, helping her to prepare nutritious meals

Dani remains connected to a network of social care providers in her community that she can access for assistance in the future

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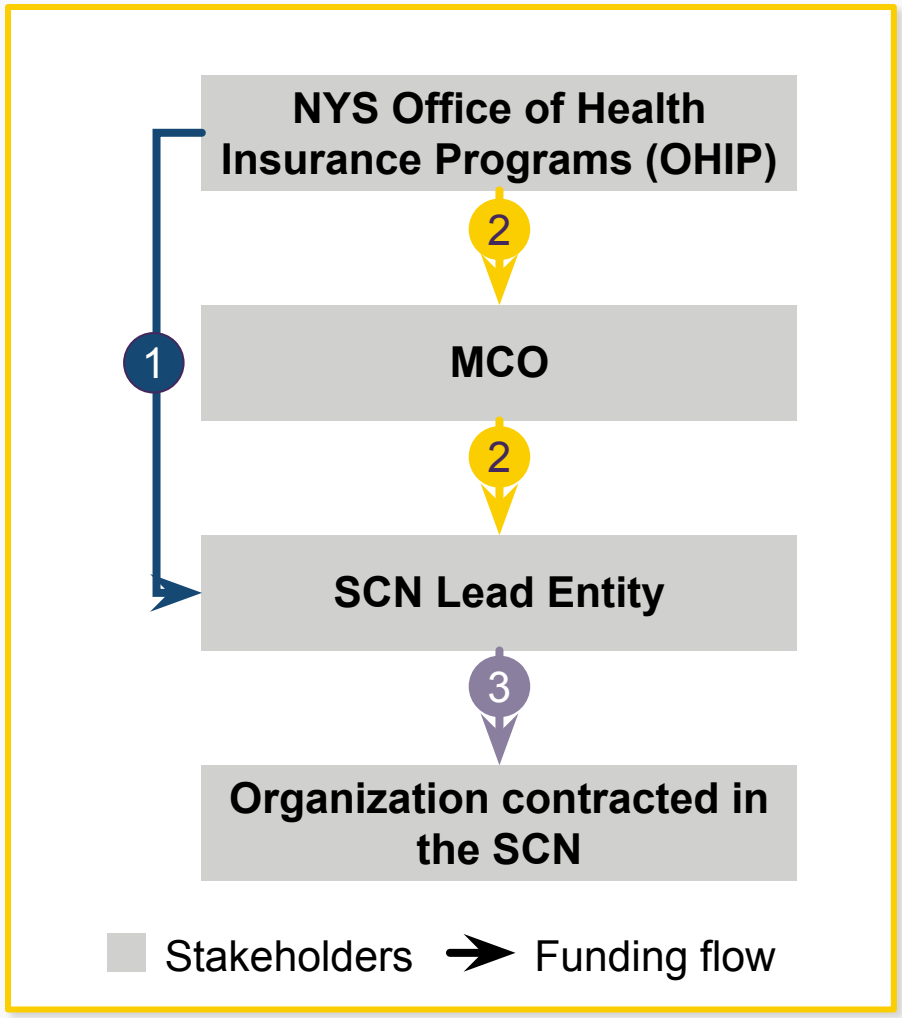
Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

SCN PAYMENT FLOW



1 **Infrastructure grant funding:** Funding to SCN Lead Entities for operational setup of the program. SCNs use infrastructure funding to build necessary functionality of the network

2 **Per-Member-Per-Month (PMPM) payments:** Payments for screening, navigation, and HRSN services flow from the NYS OHIP to the MCOs and from MCOs to SCN Lead Entities

3 **Payments for services delivered:** SCN Lead Entities will pay for screening, navigation, and enhanced HRSN services delivered according to a set fee schedule by region

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Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

THANK YOU

Your feedback is important to us, please take a moment to fill out our survey. The first 10 respondents get a $10 e-gift card, and you can submit the survey multiple times if you think of more to share.

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Q + A