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Addressing Hunger & Nourishing Health: Medicaid's Journey into Food as Medicine and Community Based Solutions

June 3, 2024

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State of the States

Medicaid 1115 Waivers

- **23 states have approved or pending 1115 waivers** that include nutrition services; 8 approved and 6 pending include the direct provision of food
  - *Approved: CA, DE, MA, NC, NJ, NY, OR, WA*
  - *Pending: HI, IL, NM, PA, DC,* RI* – *state comment period only*
  - Majority include other services such as housing supports (CA, MA, NC, NJ, NY, OR, WA, HI, IL, DC*), transportation to access HRSN (NC, NY), interpersonal violence supports (NC, IL), and more
- **7 states have pending legislation** to further a 1115 waiver or state plan amendment for nutrition services: CA, AK (passed), CO, FL, IN, MN (passed), PA

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

When talking to payers, states…

"Food is Medicine" is quickly becoming an emerging and competitive market

For-profit and venture/private equity backed companies are hungry to provide services under 1115 waivers. If CBOs do not meet the initial need, competitors are actively looking to win contracts with MCOs.

A

Medical & functional foods

Condition-specific perishable and non-perishable foods that generally require further meal preparation.

B

Medically tailored meals & groceries

Ready-to-eat meals and foods that can provide more than 50% of caloric needs.

C

Produce prescriptions & subsidies

Supplemental nutrition programs that provide produce vouchers or other methods of accessing healthy groceries.

Food-is-medicine market map Venn diagram

B: DAY TWO, perfood, modifyhealth

Moms & GA have dominate market share: MOM'S MEALS, GA foods

A & B: faeth, Filtricine

B&C: SEASON, tangelo

A: FOOD PERIOD, Lantmännen

C: bitewell, FREEFROM MARKET

B — Medically tailored meals & groceries

A — Medical & functional foods

C — Produce prescriptions & subsidies

A & B; B&C; A&C; A, B&C

Medicaid vs. Medicare

As an organization, what do you think are some of the main differences in working in Medicare vs. Medicaid?

Regulatory Breakdown

- Medicare is operated at the federal level and there is more consistency in policy across states
- Medicare plans can have more flexibility in how they spend dollars

Transparency in Data and Rates

- Medicare data is reported more systematically and easier to access

Population

- Medicare plan members tend to be on their plans longer
- Medicare members tend to have higher capitation or PMPM rates

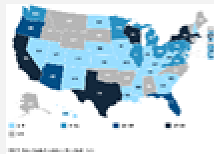
So why work in Medicaid…

Overall, more "untapped market" potential – opportunity (payment/policy) is emerging	Fragmentation creates more opportunities to test and iterate	The space is riper for innovation – they want to test new ideas! Overall, less incumbents	Further advances health equity and has more societal impacts	Targeting certain demographics – children and maternal health

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

56
Medicaid Agencies

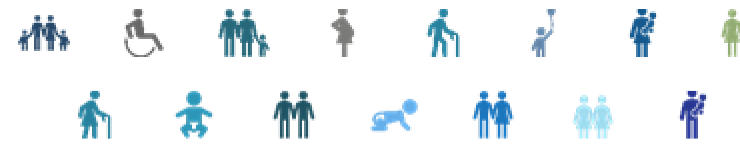
290+
MCOs covering 72% of lives



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

Providers/ Innovators

84.5M
Beneficiaries w/ unique needs



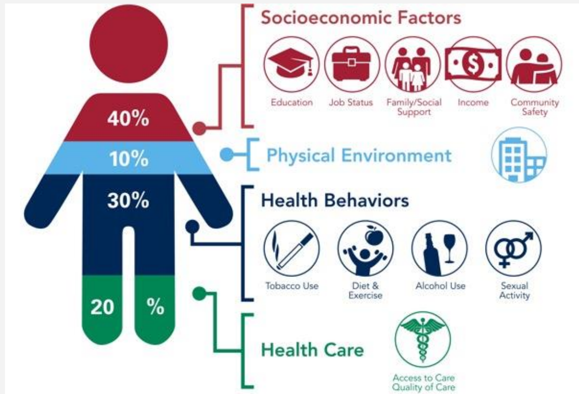
Thus, when you've seen one Medicaid Agency, you've seen one Medicaid Agency.

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.

Where is the market going? Addressing inequalities through the health plan is good business

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, & CMS are adopting more policies & pathways to address beneficiaries' health related social needs (HRSN)

Select examples of interventions from 1115 Demonstrations

Amongst other services, the **Healthy Opportunities Pilot** funds:

Housing

Food

FIMily Interventions

Transportation

New York's recently approved waiver will invest $6 ***B*** in federal funding to deliver better health care to the neediest populations

Substance use disorder (SUD) services

13 social care networks to coordinate HRSN

Health Equity Regional Organization

CalAim was a groundbreaking demonstration, pushing SDOH and HRSN interventions forward with 14 Community Supports

Justice-Involved

Housing

Asthma

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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

ILOS may be included in both capitation and the numerator of the MLR.

In CA (pre-1115), they started ILOS food benefits in lieu of hospital/ER costs

Parts of Gateway

87.1¢ of every dollar is spent on medical and pharmacy benefits.

Source: SFY 2016 -334 Day FSR Filings, Texas Health and Human Services Commission (HHSC) ... (Pre-Tax) - Not adjusted for all MCO incurred expenses including capital investments and value added services. ... administrative costs are expenses related to ... benefits and payments and coordinating care, including managing the provider network, customer service & creating ... care plans, IT and patient database ... fraud & abuse detections and timely payment processing.

MLR

Payer Direct

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

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."

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

Most ideal buyers for Onsite or Indirect

Providers need data, **enough time**, and impact define health conditions to achieve more complex payment models

Today's majority of payments in Medicaid

- Fee for service
- Pay for activity/ coordination
- Pay for performance
- Bundle payment (single bearer of risk)
- Bundle payment (risk among providers)
- Shared savings
- Just upside
- Shared risk
- Upside & downside risk
- Global payment/ capitation

FQHC (Community Health Center)

Ex: A knee surgery bundle

Medicare Risk-bearing PCP Groups (ChenMed, Cityblock)

Payment for service or activity | Attain measure targets | Manage event/ condition | Manage a population

Degree of Risk Managed by Provider

Level of Provider Sophistication and Transformation

Defining Value-Based Payments

- Reimbursement payments are tied to care delivery and the quality of care provided
- It that rewards providers for both efficiency and effectiveness
- Providers/Innovators 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.

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Opportunities to affect social outcomes AND what buyers care about and are measured on:

Payers care most about a combination of these items. By positioning a solution against a series of these factors we can solve the “wrong pockets” problem?

* Indirectly impacted

Value Props	HEDIS	CMS Medicare STARs	Community Health/ Equity/RFP Responses	Risk Adjustment/Rate Cell Adjustment	STARS	Member Engagement	Enhanced Navigation	CMS Health Equity	NCQA Health Equity	Total Cost of Care	ER/Hospital Reductions
Medicaid MCO Plan	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare (MA) Plans	✓	✓	N/A	✓	N/A	✓	✓	✓	✓	✓	✓
Commercial Plans	✓	✓	N/A	N/A	N/A	✓	✓	N/A	✓	✓	✓
ACO Reach*	✓	N/A	✓	✓	N/A	✓	✓	✓	*	✓	✓
Providers	*	N/A	✓	✓	*	✓	✓	N/A	N/A	N/A	*

Editors Note: This slide was shared in Network prep calls in March but not at Washington DC meeting

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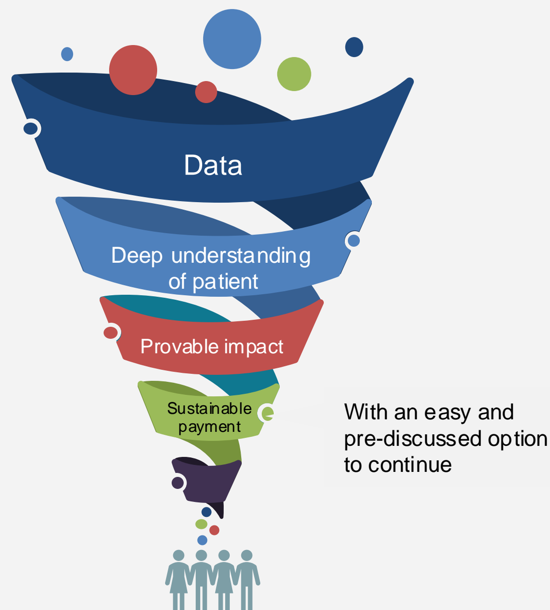
Avoiding the Death by Pilot

Solutions need to gain traction, but often can spiral in endless pilots that don't translate to scale.

A pilot should have...



With an easy and pre-discussed option to continue

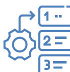
Common pitfalls

Wrong pocket problem

- "This is great, but it doesn't fit into **my** budget."

Need for results – quickly.

- "Your data is good, but how can you prove these results?"
- "Can you show me a 6-month ROI?"



Changing priorities

- "Last year the Medicaid Director wanted us to focus on…"
- "We won't have an RFP till 2027"
- "We restructured that department"

Payer's reach/impact may be limited

- "We only serve this county"
- "This works in North Carolina **but** not in South Carolina"

Pace of MCOs doesn't match innovation

- Contracting timeline overruns burn rate
- Especially with data, "legal needs to take a look at this…"

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Questions?