Massachusetts Medicaid 1115 Waiver: Supporting Food is Medicine in FQHCs

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Community Care Cooperative

COMMUNITY CARE COOPERATIVE

Goals for Today

- About Community Care Cooperative (C3)
- Leveraging Section 1115 Medicaid Waivers
- Our Massachusetts Flexible Services Program Food is Medicine Program
- Discussion

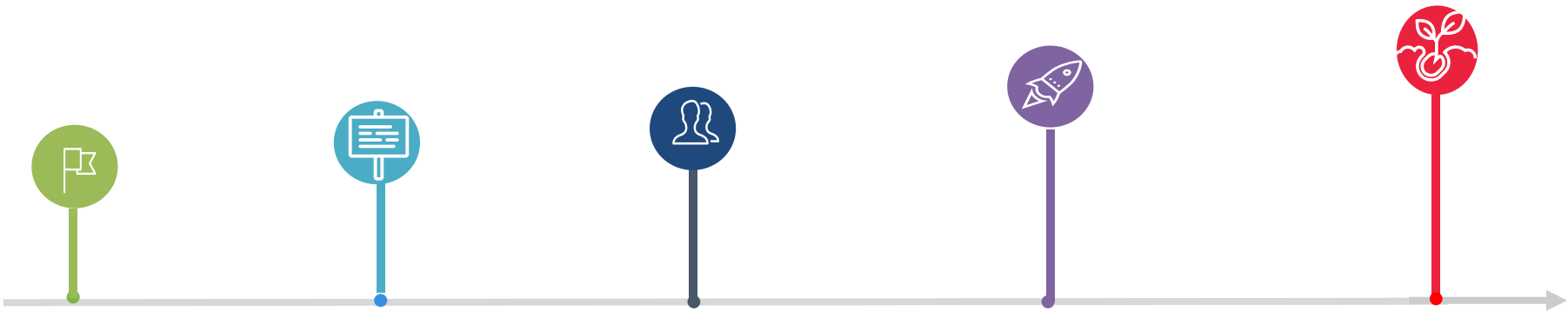
About Community Care Cooperative (C3)

- 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.
- **Goals of an ACO:**

  1. Ensure patients get the right care at the right time without unnecessary services and procedures – provide high quality care and a great member experience

  2. Share in the savings produced by spending health care dollars more wisely – for C3, this means re-investing in FQHC, workforce, and health equity programs

Our Story



Early 2016

Nine health center leaders created Community Care Cooperative to play a leading role in a redesigned Medicaid program in MA

2018

We launched our MassHealth (MH) ACO with 15 FQHCs and 110,000 Medicaid members

2019-2020

We grew to 17 FQHCs serving 125,000 Medicaid members making us the largest MH ACO in Massachusetts

2021-2022

We added two new FQHCs and new risk contracts

We launched the Flexible Services Program

We launched subsidiaries to support pharmacy and technology

COMMUNITY TECHNOLOGY COOPERATIVE

COMMUNITY PHARMACY COOPERATIVE

2023-2024

In 2023, we grew to 24 FQHCs including one in Louisiana

For 2024, we will have a presence in 7 states with more than 40 FQHCs and Affiliated Provider Practices.

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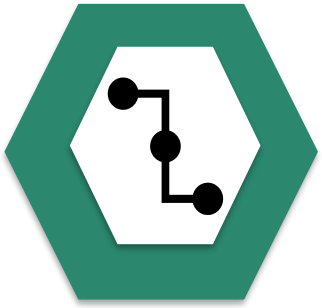
Our Social Health Strategy

Identify Health-Related Social Needs (HRSNs)

Screening members directly (in-person, telehealth, portal) using the Accountable Health Communities Tool
Documenting social needs using Z-codes



Connections to Resources

Training webinars for staff on topics such as Food Insecurity, Housing, Utilities, transportation, and more
Findhelp.org resource & referral platform

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

Medicaid Section 1115 Waivers: Overview

- **Section 1115** of the Social Security Act gives HHS the authority to approve demonstration or pilot projects that:
  - Promote the objectives of the Medicaid program
  - Demonstrate and evaluate state-specific policy approaches
- Waivers are generally approved for 5 years
- Can be used in a variety of ways, such as support for expanded eligibility, expanded benefits, or continuous enrollment
- Many Section 1115 Waivers allow for Medicaid funds to support **Nutrition/Food is Medicine interventions** as well as other Health-Related Social Needs (HRSN) interventions
- Current Section 1115 waivers for Nutrition Supports: AR, DE, MA, NC, NJ, NY, OR, WA
- CMS Guidance allowable services: medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

MA Flexible Services Program

Program Authority	• Section 1115 Waiver allows for Medicaid funding to support Nutrition and Housing needs of eligible members
Program Goals	• Improve Health Outcomes & Health Equity, Reduce Total Cost of Care
Partnership Model	• ACOs partner with high-capacity Social Service Organizations (SSOs) to deliver services. • Flow of Funds: Medicaid -> ACOs -> SSOs
Eligibility	• Members must 1) meet health criteria and 2) screen positive for food insecurity and/or housing instability

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

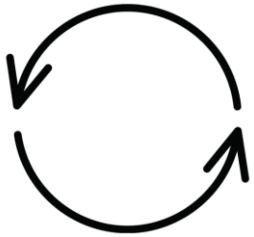
Produce Prescriptions

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

Roles of Each Partner

Health Center Staff

- Identify eligible patients
- Make referrals to Flexible Services SSO providers
- Share relevant details about the member situation and goals



ACO Staff:

- Manage partnerships, training, & referrals
- Assure compliance
- Manage budget and pay invoices
- Evaluate program and disseminate learnings

SSO Staff:

- Conduct assessment of patients' specific food needs
- Set goals to improve nutrition access
- Provide goods & services aligned with care plan
- Logs case notes, share updates with ACO & health centers

Our Program Impact

14,000 members referred
Represents members from **24 FQHCs** and nearly **300 CHWs** and advocates

2000 Active members
1,600 members receiving Nutrition supports from 6 different SSO partners **and 600 members from 14 Housing partners** (some members receive both)

93% of Members Successfully Connected
Our closed loop referrals assure successful connections

$22 Million in Goods & Services
Investments to **expand the capacity** of trusted social service partners

Better diabetes control
HbA1c decrease from Pre-enrollment to post-engagement

- All members with diabetes, mean HbA1c decrease 0.65 (9.9->9.25)*
- Members with poorly controlled diabetes (HbA1c >9.0), mean decrease 1.07 (10.62->9.55)*

Reduced Emergency Department visits
Decreased ED utilization from mean 9.5 visits/year to 5.6 visits/year*

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Questions & Discussion

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