Reentry – 1115 Waiver Services Framework

DC MCAC HSR – Discussions

Service Name:	Peer Support Services	Behavioral and Physical Health Screening
Service Description:	At 1/9/25 discussion: • Participants suggested a broader definition of peers that include certified peer support specialists who are trained by the Department of Behavioral Health (DBH) to support individuals with substance use disorders and mental health conditions, and other support from trained individuals with lived experience (e.g. peer navigators) • Peer support services were described as playing key roles in both mental health and substance use disorder recovery, with peer navigators specifically focused on facilitating the provision of services during transitions. • DYRS shared that within the juvenile justice system, a peer support program is offered through "credible messengers," which operates on similar principles of peer support. It was suggested that there may be opportunities to review and enhance this system to expand peer support services and create additional opportunities for support.	During the 2/13/25: • Stakeholders encouraged alignment on standardized screening tools to ensure consistency in evaluations and appropriate program placement. These include standardized tools already in use in the District – for example standardized screening tools used by the Department of Behavioral Health (DBH) and certified providers, including the DLA-20 for adults and the CAFAS screening for youth to support comprehensive assessments. • It was suggested that nutrition screenings be incorporated, with an emphasis on pre-enrollment in SNAP to improve access to food resources. • Participants suggested integrating feedback from the DC Collaborative for Mental Health and Pediatric Primary Care to ensure a holistic approach to behavioral and physical health screenings. • It was noted that current screening processes may not capture all individuals in need, or may not capture individuals at a time when they are comfortable fully engaging in the screening process, emphasizing the importance of comprehensive screenings to prevent gaps in support. • Currently, initial screenings are conducted upon admission in partnership with Unity. • It was shared that the DOC provides DBH with intake lists, and in response, DBH shares mental health history information with Unity in the Jail to facilitate coordination.
Beneficiary Eligibility Criteria:	At 1/9/25 discussion: • Several participants suggested that the approach could remain broad, noting that the trauma associated with experiences before, during, and after incarceration supports making services accessible to all who request them. • In the context of behavioral health, it was suggested that tying services to assessments and identified needs could enhance their effectiveness. • Participants shared that connecting individuals with someone who has shared similar experiences might provide meaningful support and help align services with individual needs.	During the 2/13/25 discussion: • Participants suggested that eligibility criteria remain broad to promote inclusive access to services. • The group suggested removing restrictions on screenings to maximize identification of individuals who may benefit from services. • Screening all individuals upon intake was emphasized as an important practice to identify those who may not appear on existing DBH lists but could still benefit from services.
Frequency:	At 1/9/25 discussion: It was suggested that it should be linked to assessment and risk level (youth side), it was noted that youth transitioning back into the community may not always have opportunities to practice essential skills.	During the 2/13/25 discussion: • Participants suggested that screenings take place within 24-48 hours of intake to support the timely identification of needs. • It was suggested that screenings be conducted at multiple points to allow for ongoing assessment and continued support.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

<table>
<tr><td>Duration:</td><td>At 1/9/25 discussion: Participants suggested that duration should be tied to the goals of an individual’s care plan</td><td>Nothing was explicitly discussed during this session. (will continue discussion at next meeting)</td></tr>
<tr><td>Setting:</td><td>During the 2/13/25 discussion:
• Participants highlighted the value of in-person delivery of services to support individuals transitioning to the community and facilitate a smoother handoff process
• Though participants recognized the value of telehealth services, privacy concerns related to video conferencing were acknowledged, highlighting the need for clear privacy standards.</td><td>Nothing was explicitly discussed during this session. (will continue discussion at next meeting)</td></tr>
<tr><td>Provider Staffing Qualifications:</td><td>During the 2/13/25 discussion:
• Participants suggested that provider staffing qualifications include roles such as community support workers and encompass a range of existing programs.
• It was emphasized that lived experience is a key qualification for providers, as it can enhance support and relatability for those receiving services.
• For youth-focused roles, the group discussed whether the same lived experience qualifications should apply, noting that background check requirements may differ.
• There were differences of opinion and differences in current program requirements for the amount of time individuals would need to have post-release to serve in a peer support role. For example, one participant noted that credible messengers could have been released as recently as one year while other programs required 6 years post-release
• It was recommended that peer support staff undergo structured training and follow a facilitation guide, with appropriate monitoring in place.
• While background checks remain a requirement, there was recognition that peer support providers would have prior justice involvement, and this should be considered in the hiring process.
• Ongoing support and wellness resources were suggested to help prevent burnout and manage potential triggers for staff members.
• One participant recommended clinical oversight to ensure a well-rounded perspective and mitigate potential biases, including religious influences, while adhering to best practices.
• Participants noted that documentation and note submission should be incorporated into the supervision process to ensure accountability.
• Leads and directors within each organization were identified as key figures for providing oversight and guidance to peer support providers</td><td>Nothing was explicitly discussed during this session. (will continue discussion at next meeting)</td></tr>
</table>

	• The discussion emphasized the importance of an inclusive staffing approach, incorporating individuals with diverse educational and professional backgrounds, supported by structured training and onboarding processes.	
Staffing Ratio/ Caseload:	During the 2/13/25 discussion: • Participants suggested that caseload distribution be based on the level of need to ensure a balanced workload. It was noted that assigning one person exclusively to high-acuity cases could lead to burnout and should be avoided. • A 1:25 staffing ratio was shared as an example for community support workers to help maintain manageable caseloads and ensure effective support.	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)
Other Considerations:	There were significant gaps in understanding around current provisions for onsite visitation, particularly in DOC settings. Participants identified the need for provider training and communication, and were able to clarify some basic elements of the process: • Providers – considered "volunteers" by the jail can deliver services on-site after going through a standard DOC training • When going through this avenue, provider visits or contacts would not replace any necessary contacts with family or legal representatives DHCF will work with DOC and DYRS to provide follow up information in regards to best practices for on-site, video, and audio service delivery to share at upcoming HSR meetings	Nothing was explicitly discussed during this session. (will continue discussion at next meeting)

Housing – 1115 Waiver Services Framework

	Example – Arizona	*DC MCAC HSR – Discussions*
Service Name:	One-time Transition and Moving Costs	One-time transition and moving costs (e.g. security deposit, application and inspection fees, utilities activation fees and payment in arrears, movers, relocation expenses, pest eradication, pantry stocking (up to 30 days of food), cooking supplies, purchase of household goods and furniture) Source: CMS HRSN Framework, December 10, 2024
Service Description:	• One-time transition and moving costs, including utility costs such as activation expenses and back payments to secure utilities, (in accordance with ACOM 448 and the AHCCCS Housing Program Guidebook.) Funding can provide limited support for other housing related expenses beyond Permanent Supportive Housing rental subsidies. • Key activities may include: Housing move-in kits, Reimbursement to landlords for member caused damages, Landlord recruitment efforts, Move-in and/or utility deposits. • Utility Arrears – pay up to two months utility arrears not to exceed $1,000 per member • Move-in Assistance – pay move-in costs including required fees and deposits, security deposits, utility deposits, and first month's rent not to exceed $3,000 per member	• Participants suggested that eligibility for all populations under consideration for 1115 would be helpful, however some suggested prioritizing certain high-need individuals such as Medicaid beneficiaries with mental illness or those in temporary housing who are in need of emergency housing assistance. • It was noted that both mental and physical health considerations should be incorporated into the application process, as these factors can create barriers to accessing or securing stable housing (for ex. linkage to in-home supports like MHRS or EPD, or home modifications), and a comprehensive screening or assessment in the home is necessary to ensure that the individual is adequately served. • Participants stated that there is limited funding available to support these costs currently and that it is often a barrier to house Medicaid residents. • Participants commented on intersecting household and nutrition needs at time of housing transition and considerations for combining this with other benefits, such as home modification or pantry stocking would be helpful.
Beneficiary Eligibility Criteria:	• Members that meet criteria for the H20 program, namely individuals who have an SMI or are experiencing homelessness. • Limited to members receiving rent/temporary housing. • Members must require service either when moving into a new residence or because essential home utilities have been discontinued or were never activated at move-in and will adversely impact occupants' health if not restored. • Members must demonstrate a reasonable plan, created in coordination with care manager or case manager, to cover future, ongoing payments for utilities.	• Participants discussed ensuring access to housing services under the waiver for all Medicaid members in need, including individuals receiving services through DBH, Behavioral Health, SUD programs, children, and individuals with disabilities. • Consideration was given to refining eligibility criteria to better support individuals with complex care needs, reduce social risk factors, and improve access to essential services.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

Frequency:	• Members may receive this service at any point at which they meet service minimum eligibility criteria and have not reached the identified cap. • Awards are one-time per member per State fiscal year.	• It was noted that caps on eligibility and services should be operationalized in a way that is easy to manage by providers offering the service, and participants emphasized that services should be available as long as there is a demonstrated need while ensuring proper coordination to prevent inefficiencies or resource waste.
Duration:	N/A	
Setting:	N/A	
Provider Requirements and Qualifications:* ***Comparable to "Provider Staffing Qualifications" in standard framework**	• Statewide Housing Administrator will coordinate these services.	Participants suggested this service could be offered by housing providers offering other services such as 1115 housing navigation or PSH/1915i benefit and should be linked to the overall plan of care.
Staffing Ratio/ Caseload:	N/A	
Other Considerations:	• Move-in assistance is only available to members not already receiving a type of subsidy from another program or agency (any permanent housing assistance, including permanent supportive housing and rapid rehousing). • This service is furnished only to the extent the member is unable to meet such expenses or when the services cannot be obtained from other sources. • Members are not currently receiving duplicative support through other federal, state, or locally-funded programs. **Source:** AZ FINAL Housing Protocol (sent via email on 2.12.25) See also North Carolina's fee schedule and service descriptions document which includes services such as: • Inspection for Housing Safety and Quality • Housing Move-In Support • Essential Utility Set-Up • Healthy Home Goods • One-Time Payment for Security Deposit and First Month's Rent	• Participants discussed the importance of developing approaches to reduce duplication of services, ensuring resources are distributed efficiently. This could be accomplished through prior authorization or pairing with other services such as 1115 HRSN or PSH/1915i HSS. • The group considered the need to provide essential household necessities, including food, for individuals transitioning into new housing. • It was suggested that nutrition and medical needs be incorporated into the initial housing transition process, remediation efforts, or other medically necessary services to support overall well-being. • Participants discussed bundling services for initial move-in and home setup to include both food and household needs. A stacking approach, such as integrating SNAP into a combined application process, was suggested to streamline access and reduce administrative burdens. • Consideration was given to adjusting eligibility criteria to better prioritize individuals with complex care needs and identify service gaps. This approach was discussed as a way to address social risk factors and improve access to critical services.

	See also Washington's housing transition navigation services fee schedule document which includes services such as: • Security Deposits • First and Last Month's Rent • IDs and other documentation • Housing Application Fees • Transitional housing fees (drug screening, urinalysis) • Pantry Stocking • Basic household goods and furniture • Utility arrears • Utility set up fees • Relocation expenses	

	Example – North Carolina	*DC MCAC HSR – Discussions*
Service Name:	Home Remediation Services	Home remediations that are medically necessary (e.g. air filtration, air conditioning, ventilation improvements, heat pumps, heaters, refrigeration for medications, carpet replacement, mold and pest removal, housing safety inspections, generators in emergency/extreme climate situations) Source: CMS HRSN Framework, December 10, 2024
Service Description:	• Evidence-based home remediation services are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. • Home remediation services may include for example pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement. • Cost-based reimbursement up to a cap, up to $5,883.33 per year. • The cost associated with coordinating service delivery is included in the service rate. • The HSO that coordinates the contractors to deliver the Home Remediation Service will receive $147.08 per Home Remediation Service project that costs no more than $1,470.83 and will receive $294.17 per Home	• Participants noted that some providers offer gift cards to support services not covered by Medicaid, with furniture considered a covered expense and limited local funding available for additional resources. • The group discussed service agencies that provide goods to families supporting children with asthma. It was suggested that these services be considered under the medically necessary program, with comparisons made to requirements used by Children's National. • Participants discussed challenges related to individuals receiving poorly managed housing units, noting that HEPA vacuums have been provided in response to long-standing housing issues. It was observed that service utilization decreases when individuals receive coordinated, ongoing support. • Mold inspections were identified as an important intervention, with services being transferred to the Housing Administration for further action. Some participants raised concerns about requiring landlord notifications, noting that such requirements may not always be beneficial and should be limited to activities that require permission, such as those that could violate lease because of construction (wheelchair ramps for example). • A comparison was made to North Carolina's housing services, which focus on ensuring home safety and providing reimbursement for necessary modifications.

	Remediation Service project that costs between $1,470.83 and $5,883.33.	
Beneficiary Eligibility Criteria:	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. • The enrollee's landlord has provided written confirmation that they consent to have the approved home remediation service provided on behalf of the enrollee prior to service delivery. • Prior to service delivery, landlord or enrollee has provided written confirmation that the enrollee can reasonably be expected to remain in the residence for at least 6 months after the authorized home remediation service.	• Participants discussed challenges related to individuals receiving poorly managed housing, noting that HEPA vacuums have been provided in response to long-standing housing issues. It was observed that service utilization decreases when individuals receive comprehensive, ongoing support. • The group identified mold inspections as an important intervention, with services being coordinated through the Housing Administration. Some participants raised concerns about requiring landlord notifications, noting that such requirements may not always be beneficial. • It was noted that individuals transitioning into new housing or requiring safety interventions could benefit from additional support to help maintain stable housing for at least six months.
Frequency:	• Enrollees may receive home remediation services at any point at which they meet minimum service eligibility criteria and have not reached the cap.	Many participants supported the approach of allowing expenses up to a cap.
Duration:	N/A	
Setting:	Home remediation services occur in the enrollee's current place of residence or potential residence.	No concerns about approach from NC were shared.
Provider Requirements and Qualifications:* ***Comparable to "Provider Staffing Qualifications" in standard framework**	None found.	Same as above housing transition. Should be linked to overall care plan. Some individuals may need significant support to coordinate home modifications.
Staffing Ratio/ Caseload:	N/A	
Other Considerations:	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs. **Source:** NC HRSN fee schedule (sent via email 2.12.25)	• Participants noted that some providers offer gift cards to support services not covered by Medicaid, with furniture as a covered expense and local funding available for other needs. • The group shared that ERAP and LIHEAP funds may assist with utilities, allowing for greater flexibility in financial assistance. • Participants inquired about potential barriers to using vouchers for units that are not utilities included and that utility payments from other sources may assist with getting individuals housed and suggested exploring additional resources for coverage.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

	See also Washington's home remediation and adaptation home devices fee schedule document which includes services such as:
	• Home remediation services up to $5,000 per instance.
	  ○ Rates are based on the actual cost of the good/service being provided and may vary by geographic location, demand, etc.
	  ○ Modifications must be conducted in accordance with applicable State and local building codes. HCA may authorize an exception to this maximum through "Exception to Rule" process if an enrollee's physical condition or living situation has changed so significantly that additional modifications are necessary to ensure their health, safety, or independence.
	• Adaptation home devices (estimated cost per device, including delivery)
	  ○ Air conditioner – up to $660
	  ○ Air filtration device – up to $500
	  ○ Air filter replacement – up to $70
	  ○ Portable power supply – up to $1,590
	  ○ Heater – up to $290
	  ○ Mini refrigerator – up to $170
		• The group discussed the inclusion of relocation support to help beneficiaries with moving expenses, including for housed individuals that are vulnerable and need to move for accessibility reasons
		• It was suggested that relocation assistance, including moving services, could be structured for reimbursement through DHCF.
		• Participants highlighted the importance of aligning housing services with medical needs, recommending that clinical personnel be involved in service planning.
		• The 1115 waiver was discussed as a potential way to expand services for individuals who may not qualify under the 1915i program.
		• The group suggested structuring services to automatically connect individuals to related supports, reducing inefficiencies and improving coordination.
		• Participants raised concerns about service duplication and funding challenges, recommending strategies to enhance resource efficiency.
		• The group discussed flexible funding approaches to allow programs to address additional beneficiary needs based on individual assessments.
		• Participants suggested bundling services for move-in and home setup, integrating food and household needs. A stacking process, such as incorporating SNAP into a combined application, was discussed as a way to streamline access and reduce administrative burdens.

	Example – Arizona	*DC MCAC HSR – Discussions*
Service Name:	Medically necessary home accessibility modifications	Home/environmental accessibility modifications (e.g. wheelchair accessibility ramps, handrails, grab bars, others to generally align with allowable modifications under Money Follows the Person) Source: CMS HRSN Framework, December 10, 2024
Service Description:	• Home modifications shall have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in their own Home. • Services require a provider order, assessment of how the lack of modifications impedes their ability to function independently, and an assessment by a qualified	• Participants discussed the importance of clinician observation before a housing transition, with assessments guiding care progression based on individual needs. • It was noted that nurse visits and home care coordination should be included to provide additional support. • Participants emphasized that COC dollars should be tied to Medicaid for housing support, ensuring beneficiaries receive services not covered by DBH vouchers. Some of these services were noted as being included in the HUD budget.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

	professional (OT, PT or Certified Environmental Access Consultant). • Cost-based reimbursement up to a cap.	
Beneficiary Eligibility Criteria:	• Members that meet criteria for the H2O program, namely SMI and individuals experiencing homelessness.	• Participants suggested that all beneficiaries in need should be covered, with some services already included in the HUD budget.
Frequency:	• Members may receive home remediation services at any point at which they meet minimum service eligibility criteria for the H2O program and have not reached the cap.	• It was noted that services should be provided for as long as necessary, based on an individual assessment.
Duration:	N/A	
Setting:	N/A	
Provider Requirements and Qualifications:* ***Comparable to "Provider Staffing Qualifications" in standard framework**	• MCOs will coordinate this benefit with a referral to a Provider registered with AHCCCS and enrolled as Environmental (LTC) Providers and the Statewide Housing Administrator. • Provider must have an active status and in good-standing with the Registrar of Contractors.	Nothing was explicitly discussed during this session.
Staffing Ratio/ Caseload:	N/A	
Other Considerations:	• Members are not currently receiving duplicative support through other federal, state, or locally-funded programs. • The modifications cannot supplant a Landlord's obligation to provide reasonable accommodations under the ADA. **Source:** AZ FINAL Housing Protocol (sent via email 2.12.25)	• Participants suggested incorporating teaching and living skills into care plans to help individuals maintain stable housing. • It was noted that home navigation and supportive care through Care Management could be reimbursable to assist with accessing one-time services. • Some discussed the benefits of a bundled approach to service oversight, ensuring continued support beyond initial transitions. It was noted that a one-time transition may not provide sufficient long-term stability, highlighting the need for coordinated care.

Nutrition – 1115 Waiver Services Framework

	Example – Massachusetts		***DC MCAC HSR – Discussions***
Service Name:	Medically Tailored Food Boxes	Nutritionally Appropriate Food Boxes	Food package (delivered or for pick-up)

Service Description:	Medically Tailored Food Boxes consist of:
	• Medically Tailored Food Boxes
	  ○ An RDN or NDTR (overseen by an RDN) assessment of the Enrollee’s medical and nutritional needs
	  ○ Contain minimally prepared grocery items (including but not limited to fresh vegetables and fruits, cooked chicken breast, and cooked grains) for the Enrollee’s specific condition approved by an RDN or NDTR. To approve, an RDN or NDTR must develop or review box composition
	  ○ Must provided for a minimum of 12 weeks
	• Navigation
	  ○ Identify other available resources based on the initial needs assessment (e.g., benefits, entitlements, and discretionary services for which the Enrollee is potentially eligible)
	  ○ For identified needs, in coordination with the Enrollee’s Plan, connect and refer them to appropriate supports (e.g., SNAP Outreach Provider or food pantry)
		Nutritionally Appropriate Food Boxes consist of:
		• Nutritionally Appropriate Food Boxes
		  ○ Contain minimally prepared grocery items including, but not limited to, fresh foods (e.g. fresh vegetables and fruits) and other nutritionally appropriate food items (e.g. proteins, dried goods, seasonings, spices). This may take the form of a CSA share.
		  ○ Are based on the Provider’s assessment of Enrollee’s medical and nutritional needs
		  ○ An RDN or NDTR (overseen by an RDN) must be engaged in the curating of foods other than fresh foods to ensure adherence to appropriate nutritional standards (e.g., Dietary Guidelines for Americans)
		• Navigation (same as for Medically Tailored Food Boxes)
		• Nutritionally Appropriate Food Box Information (same as for Medically Tailored Food Boxes)
			• Participants discussed the need for clearer distinctions between medically tailored and nutritionally appropriate food boxes, suggesting labels such as "Medically Tailored" and "Healthy Choice."
			• It was noted that medically tailored food boxes should be prioritized for high-risk individuals, while nutritionally appropriate food boxes could serve broader populations.
			• Some emphasized the importance of flexibility, as dietary needs vary based on conditions such as diabetes, heart failure, and cancer.
			  ○ However, some other participants asserted that nutritional needs don’t vary significantly condition to condition and that some simplicity and standardization could keep costs down and allow more eligible beneficiaries to be served, particularly if there are significant cost pressures on DC Medicaid’s budget.
			• Michigan’s program was noted as a model, incorporating both medically tailored and healthy home delivery meals.
			• Participants highlighted the need for clear guidelines to balance nutritional requirements with meal flexibility.
			• Some noted that while standardized meal options improve cost-effectiveness, customization remains important for high-risk populations, including perinatal women and infants.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

	• Medically Tailored Food Box Information ○ Provide Enrollee materials related to the food provided (e.g., fact sheets on benefits of grocery items, recipes to make meals from items, total sodium count in items)		

Beneficiary Eligibility Criteria:	Enrollees must meet all of the following criteria:
	• HNBC: Have any of the following HNBC conditions that require improvement, stabilization, or prevention of deterioration of functioning
	  ○ HIV; Cardiovascular disease; Diabetes; Renal disease; Lung disease; Liver disease; Cancer; High-risk pregnancy (including up to 12 months postpartum)
	• Risk Factor: Be experiencing Very Low Food Security
	• Other Criteria: Enrollees or their authorized representatives or guardians (e.g., parents, caretakers) must be able to prepare meals
		Enrollees must meet all of the following criteria:
		• HNBC: Have an HNBC that does <u>not</u> require a Medically Tailored Food Box. Specifically having a condition <u>other than</u> those listed for Medically Tailored Food Box benefit.
		• Risk Factor: Be experiencing Very Low Food Security (same as Medically Tailored Food Box)
		• Other Criteria: Enrollees or their authorized representatives or guardians (e.g., parents, caretakers) must be able to prepare meals (same as Medically Tailored Food Box)
			• It was suggested that meal accessibility factors, such as refrigeration and cooking capacity, be considered when determining eligibility.
			  ○ Facilitators highlighted Massachusetts “other criteria” for eligibility which includes ensuring enrollees or their authorized representative/guardian is able to prepare meals.
			• Participants discussed expanding eligibility to include additional chronic conditions beyond traditional nutrition-related diagnoses, such as lead exposure, asthma, preeclampsia, hypertension, obesity, substance use disorder, and behavioral health conditions.
			• It was noted that different conditions may require tailored meal options and nutrition education, with registered dietitians overseeing dietary assessments.
			• Participants emphasized the importance of accurate screening tools, noting that the Hunger Vital Sign tool may not fully capture food insecurity severity. Some suggested a more detailed assessment and the use of SMS-based technology for streamlined screening.
			• It was noted that MCOs and referral entities play a key role in determining eligibility. Many states use a central hub model where MCOs screen members and authorize services, while some states, such as Massachusetts, rely on ACOs for centralized referrals.
			• Some emphasized the need to ensure that food access is not solely based on clinical referrals, as non-clinical providers can help identify individuals in need and nutrition services may be a tool to engage beneficiaries who are accessing other needed health care services.
			• Participants highlighted that food security alone should not determine eligibility, as nutrition support can reduce hospitalizations, emergency department visits, and long-term healthcare costs.

Frequency:			Nothing was explicitly discussed during this session.
Duration:			Nothing was explicitly discussed during this session.

Setting:			Nothing was explicitly discussed during this session.
Provider Staffing Qualifications:	Providers must meet the following criteria: • Have at least one year of experience providing medically tailored meals, medically tailored food boxes, or nutritionally appropriate food boxes to persons experiencing Food Insecurity with applicable health conditions (e.g., experience with Flexible Services, current nutrition focused contracts/grants with local, state, or federal agencies) • Have specialized staff with knowledge of medically tailored meals or food boxes, Food Insecurity or imbalance • Have specialized staff with education (e.g., Bachelor's degree, Associate's degree, certificate) or training in nutrition or anti-hunger services, or at least one year of relevant professional experience or lived experience • Have an RDN on staff or as a consultant to assess Enrollees and approve food boxes	Providers must meet the following criteria: • Have at least one year of experience providing medically tailored meals, medically tailored food boxes, or nutritionally appropriate food boxes to persons experiencing Food Insecurity with applicable health conditions (e.g., experience with Flexible Services, current nutrition focused contracts/grants with local, state, or federal agencies) • Have specialized staff with knowledge of medically tailored meals or food boxes, Food Insecurity or imbalance • Have specialized staff with education (e.g., Bachelor's degree, Associate's degree, certificate) or training in nutrition or anti-hunger services, or at least one year of relevant professional experience or lived experience • If curating foods other than fresh foods, have an RDN on staff or as a consultant to engage in curating such foods	• Participants noted that both professional and lived experience should be considered when establishing provider criteria. It was suggested that local providers may be well-positioned to source food and ensure alignment with community needs. • Some raised concerns about whether detailed provider requirements could create barriers for smaller organizations. It was suggested that structured meal packages tailored to health conditions could help streamline operations while maintaining service quality. • The importance of credentialed professionals in determining dietary recommendations was emphasized, with a recommendation to avoid reliance solely on standardized food lists. Some noted that while pre-approved lists could be useful, they should complement, not replace, expert assessments. • It was suggested that reviewing California's Medicaid model, which includes multiple Managed Care Organizations (MCOs), could provide insights into best practices for structuring food benefit programs. • Participants highlighted the role of registered dietitians in assessing allergies and ensuring that food offerings align with individual medical needs. It was noted that centering the program around beneficiaries while supporting provider compliance would be essential for effective service delivery.
Staffing Ratio/ Caseload:			Nothing was explicitly discussed during this session.
Other Considerations:	• Expected unit cost: $318.55 for one month's worth of food boxes (may include one large food box or multiple boxes) • Rates are inclusive of all activities in service description and related administrative costs.	• Expected unit cost: $318.55 for one month's worth of food boxes (may include one large food box or multiple boxes) • Rates are inclusive of all activities in service description and related administrative costs.	• Some participants suggested reinvesting resources into the local community by prioritizing DC-based businesses with established experience in food provision. • It was noted that the allocated food benefit amount in Massachusetts appeared higher than in some states. Offering a food pick-up option, where feasible, was suggested as a way to reduce costs while maintaining accessibility. • Some emphasized the value of providing both pick-up and delivery options to accommodate different needs. It was noted that some existing programs deliver meals beyond home addresses, including locations like dialysis centers.

Note: The views and opinions reflected in this document are those of the participants for the February 13, 2025 Health System Re-Design (HSR) Subcommittee meeting.

	Sources: MA Nutrition Service Manual and MA HRSN Fee Schedule (sent via email 2.12.25)	**Sources:** MA Nutrition Service Manual and MA HRSN Fee Schedule (sent via email 2.12.25)	• Concerns were raised about package security, as theft has become a growing issue in DC. Participants suggested incorporating strategies to ensure safe delivery and expanding pick-up options to improve accessibility. • It was suggested that the program explore partnerships with local organizations that have successfully addressed food insecurity. Prioritizing value-based procurement was highlighted as a way to align food provision with broader community engagement efforts.