Nutrition Incentive Hub

CREATED BY GUSNIP NTAE CENTER

Implementing Medicaid Payments for "Food is Medicine"

Early Learnings from North Carolina's Healthy Opportunities Pilots

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Funding: The Nutrition Incentive Program Training, Technical Assistance, Evaluation, and Information Center (NTAE) is supported by Gus Schumacher Nutrition Incentive Program grant no. 2019-7003030415/project accession no. 1020863 from the USDA National Institute of Food and Agriculture.

November 2022

Case Study Purpose

The purpose of this case study is to share some initial learnings from the North Carolina Department of Health and Human Services (NCDHHS) Healthy Opportunities Pilots (HOP). The study was commissioned by Fair Food Network on behalf of the Nutrition Incentive Hub with funding from the USDA Gus Schumacher Nutrition Incentive Program (GusNIP) National Technical Assistance & Evaluation Hub (NTAE). While many stakeholders (such as funders and policy makers) may be interested, this study is primarily written to support awarded and prospective GusNIP Produce Prescription (PPR) grantees to better understand a pilot effort in North Carolina to use federal Medicaid funding to scale and sustain community-based implementation of a combination of produce prescription programs, medically tailored meal programs, and nutrition education.

The NC HOP initiative is an early example of the use of a 1115 Medicaid Demonstration Waiver by a state to address food access needs through investments in social determinants of health. 1115 Demonstration Waivers are exciting because they represent great learning opportunities for states and the federal Secretary of Health and Human Services:

> Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.[1]

Demonstration initiatives are approved for five-year terms and are intended to be "budget neutral," meaning that no additional federal funds beyond the original Medicaid allocations are incorporated.[2]

"Food is medicine" programs (including medically tailored meals and produce prescription programs), like those offered through HOP, are likely to expand as the White House has cited them in its White House National Strategy on Hunger, Nutrition, and Health: "HHS CMS [US Health and Human Services, Centers for Medicare and

[1] "About Section 1115 Demonstrations." Medicaid.gov. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[2] "About Section 1115 Demonstrations." Medicaid.gov. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

Medicaid Services] will also issue guidance on how states can use section 1115 demonstrations to test the expansion of coverage for these interventions."[3] CMS authorized up to $650M in state and federal funding for this initiative.

Non-clinical community-based organizations (CBOs) played a key role in advocating for NCDHHS to apply for this waiver program, with great optimism about seeing produce prescriptions and medically tailored meal programs sustained and scaled (in addition to housing, interpersonal violence, and transportation programs). CBOs now form a core component of the NC HOP program delivery structure, as CBOs are tasked with providing referred Medicaid participants with the non-medical services.

Networks of qualified CBOs in target regions of the state have been selected and contracted to provide food programs to Medicare beneficiaries and are compensated for these services (including food and nutrition care management) according to preset, CMS-approved rates. The services that food-based CBOs can be reimbursed include pick up or delivery produce prescriptions, prepared meals, medically tailored meals, and evidenced-based group nutrition classes.

Many individuals, organizations, and governments throughout the country are watching closely as the NC HOP work unfolds; some initial conversations with leaders of this work were captured in the Duke Margolis Center for Health Policy panel discussion[4] recorded on July 28, 2022, and in a digital post on August 15, 2022 from the NC Institute of Medicine.[5] But these offerings did not have a chance to delve deeper into the CBO perspective.

This case study focuses primarily on the food-based CBO perspective, to provide additional insights to those considering how to implement similar pilot programs in other states and territories. The CBO perspectives in this study are food-focused because of the particular interest in produce prescriptions of the GusNIP NTAE and Nutrition Incentive Hub, who coordinate reporting and evaluation for produce prescription projects across the country, and because food-focused CBOs were the first CBOs to begin service through NC HOP. It should be noted that this is an early snapshot. The HOP initiative is not complete, and many lessons are still to be learned. There are

[3] Biden-Harris Administration National Strategy on Hunger, Nutrition, and Health. September 2022. https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf

[4] North Carolina's Healthy Opportunities Pilots: A Medicaid Managed Care Program to Address Social Needs. July 28, 2022. https://healthpolicy.duke.edu/events/north-carolinas-healthy-opportunities-pilots-medicaid-managed-care-program-address-social

[5] Lessons Learned Thus Far From North Carolina's Healthy Opportunities Pilots. August 15, 2022. https://nciom.org/lessons-learned-thus-far-from-north-carolinas-healthy-opportunities-pilots/

already shifts happening in the program implementation. This case study should be considered in addition to the reference materials cited above and ongoing data and evaluation that will emerge from the NC HOP evaluation team led by the Cecil G. Sheps Center for Health Services Research throughout the next five years (2022-2027).[6]

NC HOP Background

The US Secretary of Health and Human Services approves state-requested 1115 waivers to allow flexibility for experimental, pilot, or demonstration projects to better serve Medicaid populations. Amongst several 1115 waivers approved nationwide with exciting food and nutrition elements,[7] NC HOP is "the nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety and toxic stress to high-needs Medicaid enrollees."[8]

Delayed for two years by the COVID-19 pandemic, NC HOP officially launched in early 2022. Over five years, NCDHHS will design, implement, and evaluate whether Medicaid dollars spent on social determinants of health (namely food, housing, transportation, and interpersonal violence and toxic stress) impact health outcomes for participants that receive these services. Evaluators are doing rapid cycle evaluations to produce learnings and adjustments to the programs in real time, and ultimately federal funders are looking to see whether paying for upstream impacts of health are cost-neutral or even reduce total Medicaid expenditures.

NC HOP is administered by the NCDHHS, which selected three regions for initial pilot work. These three regions were selected to represent geographic diversity, racial/ethnic diversity, variations in healthcare/food/transportation/services access, diversity in types/size/scope of community-based organizations, and other forms of diversity. Each region has a network lead, participating Medicaid prepaid health plans, care managers, and CBOs (also called Human Services Organizations or HSOs) involved in the effort to connect patients to services.

The three regions across North Carolina with their associated network lead are:

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[6] UNC Cecil G. Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/

[7] Such as Massachusetts Flexible Services (see: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82006 for information about the Massachusetts' MassHealth Section 1115 Demonstration) or Oregon's Medicaid Waiver (see: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82956 for additional information about the Oregon Health Plan Section 1115 Demonstration).

[8] NC Healthy Opportunities Pilots. North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots. Last updated August 24, 2022.

- **Access East, Inc.** - counties: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt.
- **Community Care of the Lower Cape Fear** - counties: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender.
- **Impact Health** - counties: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey.

All three regions are utilizing the NCCare360 digital platform to facilitate services. *More about NCCare360 can be found at https://nccare360.org/.* Food services were the first to launch in March 2022, followed by housing and transportation, and finally interpersonal violence and toxic stress in late 2022. Out of the approximately 64 CBOs participating in HOP in November 2022, 26 provided produce prescriptions, 5 provided medically tailored meals, 56 provided other prepared meals, and 13 provided evidenced-based group nutrition classes (please note that many CBOs provided more than one service). Each region had at least 4 CBOs offering produce prescriptions.[9]

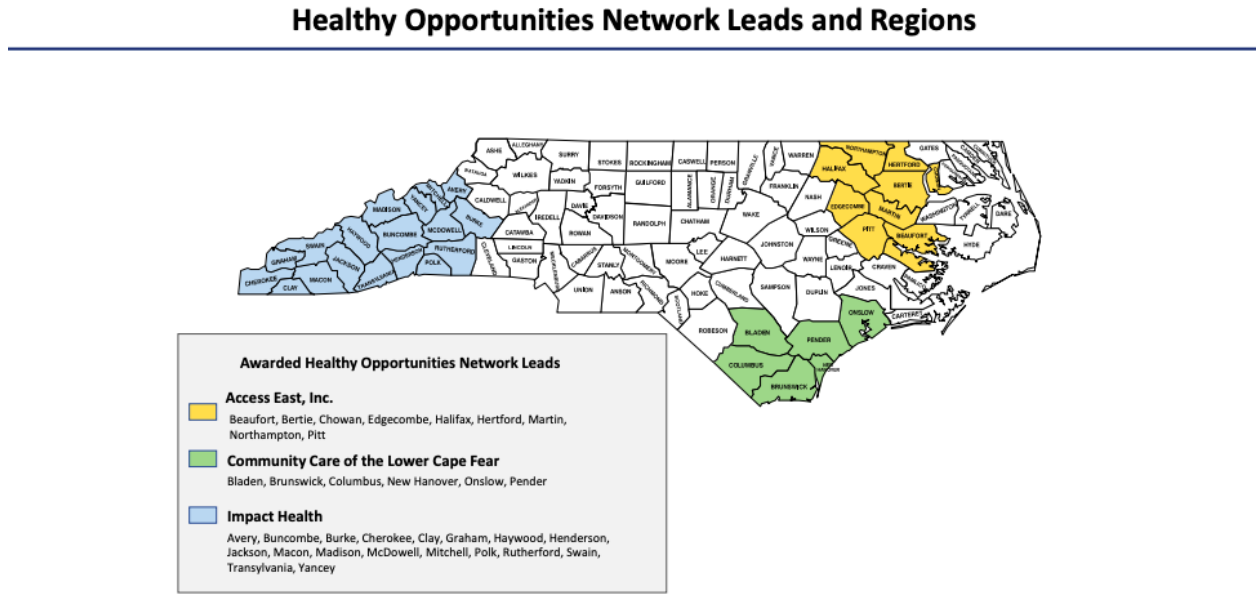

Figure 1: NC Healthy Opportunities Network Leads and Regions. NC Department of Health and Human Services, August 24, 2022. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

[9] See: Access East HSO Network (https://www.accesseast.org/hso-network/), Impact Health HSO Network Directory (https://impacthealthatdogwoodhealth.my.site.com/partner/s/hso-network-directory), Cape Fear HOP HSO Directory (https://onedrive.live.com/edit.aspx?resid=A4C162E21284FF9!36106&ithint=file%2cxlsx&authkey=!AH9thCvfNyGVnmc)

Methods

The data for this case study was collected in a variety of ways, including in-person interviews, site visits, and virtual interviews with CBOs as well as others involved in NC HOP design and implementation (see Appendix B). The data was collected April through October 2022 by DAISA and FIG staff members; the report was written by FIG and DAISA in November 2022. DAISA is a national team of equity-focused consultants working at the intersection of food, culture, and health. FIG is a team of researchers, innovators, policy strategists, and consultants working collaboratively with individuals and organizations who share their vision and values. To protect participant privacy, we only refer to participants by their role (e.g., CBO, network lead, etc.).

Limitations: *This is not a fully representative sample of CBO needs and perspectives, as only seven HOP CBO representatives (out of approximately 64 at that time) participated in these interviews and all of them represent primarily food-based programming. Additionally, over the course of this case study, NCDHHS, HOP network leads, and the Medicaid prepaid health plans decided they were no longer going to engage with outside organizations while they focused on the work of HOP implementation, evaluation, and real-time adjustments. This limited our ability to connect with others who may have had further valuable insights about the programs. We expect some of those perspectives will be collected by the internal HOP evaluation team and shared in the future with the broader public.*

Findings

A total of 11 individuals participated in the data collection phase of this work—five completed virtual interviews, and six participated in site visits and/or in-person interviews. Of the 11 participants, seven represent CBOs, two are experts in fields related to food systems and social determinants of health, one supports a network lead agency, and one represents NCDHHS. All CBOs included in this case study are involved in food programs because food was the first intervention to launch through NC HOP in March 2022. Below we distill common themes and note any opposing viewpoints related to a series of questions posed to participants.

NC HOP development

Even before NC HOP was approved, CBOs were especially vocal about the need for Medicaid in North Carolina to engage in upstream interventions around the social determinants of health (SDOH), including food, housing, and transportation. Several CBOs and field experts interviewed for this case study reflected on their tireless efforts to have NCDHHS pursue the 1115 Waiver for HOP. CBOs and local health

professionals felt they best understood how medical services were falling short and held a vision for how upstream interventions could change the health outcomes and overall wellbeing of patients in Medicaid programs. Rural and urban local health providers and CBOs involved in early NC HOP design conversations were instrumental in raising awareness about many challenges that would need to be worked out in order to successfully launch the HOP programs.

CBOs also felt that while they pushed for the original concept and had early involvement in program design, the detailed work of NC HOP program design did not sufficiently include CBO input (see below for more details).

What motivated CBOs to take part in the HOP program?

CBOs providing produce prescriptions were drawn to HOP for several reasons, the most common of which was a variation on this theme: “The idea of investing in upstream health care approaches makes total sense and [we] wanted to be part of that.” CBOs represent the communities they serve, and having seen the impact of disinvestment in social determinants of health, they wanted to join a pilot focusing on addressing issues of food, housing, transportation, and interpersonal violence and toxic stress.

Other reasons CBOs came to HOP include an interest in finding sustainable funding for the community food work they were already doing. They are particularly interested in models that center Medicaid and other insurers as payers for these services. As one CBO described, “As a non-profit always writing grants…a program like HOP offers the opportunity for sustained funding, which is exciting and would help so much with consistency and peace of mind.” One CBO explicitly reported the goal of supporting local farmers through HOP, again, as a way to find sustainable funding for ongoing community-based projects that directly and indirectly impact the health of local communities.

In line with seeking sustainable funding to support SDOH for the communities they serve, both CBOs and the NCDHHS representative we spoke with highlighted the need for the pilot to build the capacity of CBOs to do this work now and in the future. Participants understood that while the original design centered around CBO participation and support, many CBOs were not ready to jump straight in as HOP providers successfully. The CBOs interviewed for this case study identified the need for ongoing conversations and documentation of what is truly needed for CBOs to start and sustain this work, to share with other organizations and regions thinking about HOP-style efforts.

What have been the key barriers for CBOs work thus far?

Barriers to success experienced by CBOs were divided into three categories: those that impact a CBO entering the NC HOP pilot, those that impact the current work, and those looming on the horizon post-pilot.

Barriers to entry

One CBO described the barriers to entry this way: "...they wanted [CBOs] that…were shovel ready. A lot of other organizations didn't have the capacity to be shovel ready at the time of application (like our org was)." "Shovel ready" was understood to mean that CBOs would have staffing, management and tracking technology, bookkeeping systems, and logistics capacity in place to readily manage patient registration and reimbursements and to deliver food services to registered participants at significant scale. From the start, many CBOs interested in this work were not included because capacity building dollars were not provided before CBOs applied to participate in HOP. So, CBOs may have self-screened, or applied and were rejected, because they did not have the necessary capacity to apply or coordinate entry into HOP. Only after CBOs had been identified and committed to the work were funds distributed to CBOs to help with start-up costs: each region had a pool of funds and could determine how to distribute those funds; the highest reported dollar amount for capacity building was almost $500,000 in Year 1 of the pilot.

Additional front-end barriers included a protracted and iterative contracting process with the state. The state did not have contract templates that could be adapted to the HOP context, and the process of creating and completing those contracts with all HOP participants was long and challenging for everyone involved.

Many CBOs also faced a steep learning curve to use the technology platforms required in the pilot, designed for social service referrals but not explicitly set up for management of produce prescription program integrations. In a May 1, 2023 public release, Reinvestment Partners, a large CBO HOP participant, raised extensive concerns about the UniteUs/NCCARE360 platform used to manage the HOP initiative, saying, "Despite the large contract, the platform is not fulfilling the day-to-day needs of human service organizations (HSOs), care managers, network leads, or prepaid health plans (PHPs)." The public statement cited concerns about the effectiveness of the platform in patient data tracking, billing and payments, and referral functionality.[10]

[10] "Unite Us/NCCARE360 Functional Failures," Reinvestment Partners, Publicly Released Statement, May 1, 2023.

Challenges in the current work

The primary concern for the interviewed CBOs during the first six months of NC HOP was the slow and cumbersome patient referral process. Six CBOs and the NCDHHS representative agreed that CBOs were expecting many more referrals in the early months to sustain operations through reimbursement for services; within the first month of launch the number of Medicaid patients referred for HOP services was fewer than 100 Medicaid patients in the three HOP regions, and as of October 17, 2022, NCDHHS Deputy Secretary Dave Richards reported 1,600 HOP participants across all three regions and three of the five official service areas (food, housing, transportation).[11] Food-focused CBOs were told to expect 5,000-10,000 referrals by this point in the process and had ramped up their business planning accordingly.

CBOs and NCDHHS concur that the referral process is complicated because generally a care manager, not the medical provider, has to screen a patient. The care manager has to know about all the different services available. The referrals have to be processed through a digital portal. The CBO then makes contact with the participant, and, if the participant chooses to use the services provided, the CBO finally gets reimbursement for these services. In addition, food CBOs want more information than the care manager or referral process provides to better tailor offerings for each client. Right now, CBOs are not getting that level of detailed information; information is coming only after the CBO makes initial contact with the participant directly.

[11] [The latest available numbers at the time of this report's completion of research: 2,824 enrolled participants as of December 15, 2022.]

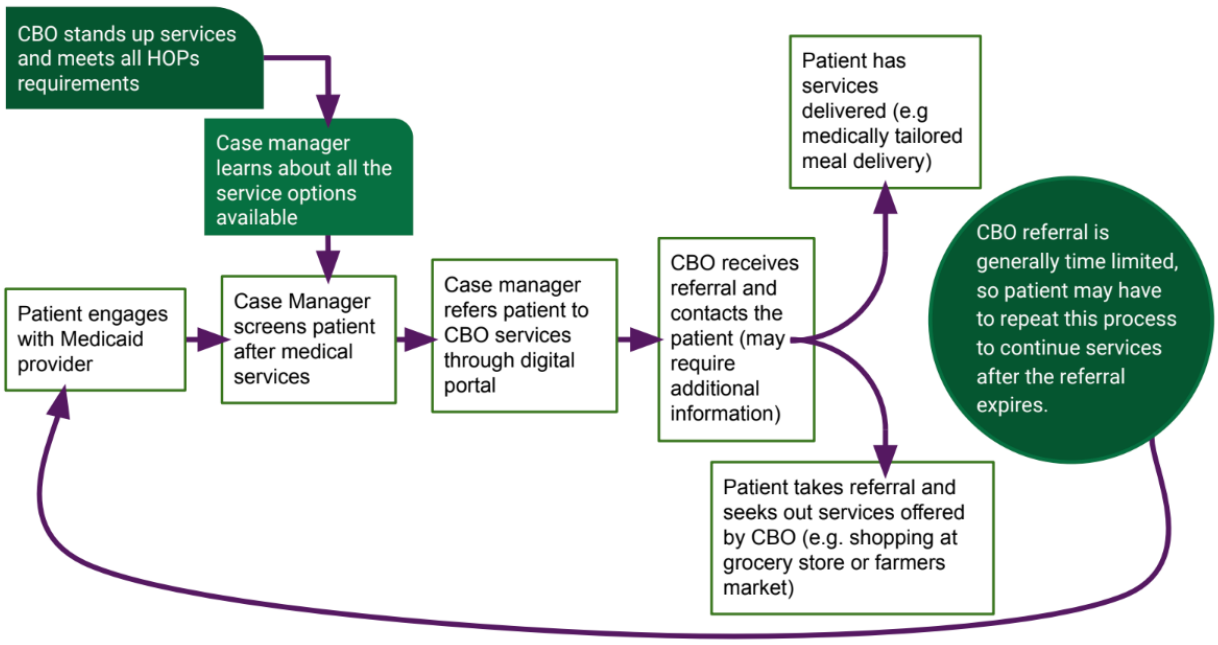

Figure 2: Illustration of the CBO participation/HOP referral process

CBOs realized after starting the work they did not ask for enough capacity building funds to make the necessary upfront investments in program management and operations capacity. No one was "following a script" as one CBO participant described, so they did not know what their needs were going to be until they got deeper into the work. Another barrier that emerged as the work got started in 2022 was that patient referrals would time out if the referral was not used within a certain amount of time. As one interviewee said, "...with HOP, every single individual has a different start and end date, so it's hard for us to manage. Also, the patient is then responsible for following up with their care manager if they want to continue the service in the future." If a current participant drops out of Medicaid coverage or stops using Medicaid services, they are automatically ineligible for the HOP services they were receiving, adding further tracking complexity for CBOs working with the HOP program.

Monthly invoicing for HOP reimbursement is new and burdensome on cashflow for many CBOs used to operating with grant funds that are provided upfront before services are rendered. Additionally, the reimbursement rates set for the pilot are perceived to be too low: "Once [outside grants] go away – [should be some point in 2024] – we would only get $5.25 per person to cover our administrative costs, and right now we have like 8 people [enrolled], so we would have like $45 dollars to do this whole program, when it takes the bookkeeper a whole day to do the invoicing of this."

Finally, as this program is a pilot, no one at any level has all of the answers when new challenges arise. A barrier to success identified by one CBO interviewed was the slow and sometimes nonexistent responses or mixed messaging from the state about who – the network leads, NCDHHS, or CMS – has authority to develop solutions or provide answers to challenges and questions as they arise.

April 2023 update: NCDHHS announced an Expedited Enrollment Initiative pilot (see Appendix A) in March 2023 to improve aspects of the referral process. The update resulted in approximately 2,500 additional enrollees over its first six weeks.[12] The NCDHHS initiative rolled out after we finalized interviews for this report.

Post-pilot concerns

Future concerns that surfaced for CBOs include questions about the efficacy of the planned evaluation and how the success of NC HOP will be measured. NCDHHS has a public document detailing its evaluation plans for NC HOP.[13] A few metrics include: HbA1c control, blood pressure control, health related quality of life, birth weight, numbers served, total costs, emergency room visits, etc. Many CBOs see the value of HOP programs but fear the most important impacts on individual recipients will not be able to be understood within the timeframe of the evaluation. As one CBO noted, “One big issue is that it takes a long time to see results. They might be 20 years down the line and it's hard to see the change.” CBOs maintained that despite the lack of ability to see impact short term, they have heard anecdotes of their clients having valuable experiences in the program. Many still worry the pilot will end before they are able to demonstrate its value.

Another challenge of this particular pilot is all three HOP regions are primarily rural, and there is no urban-centered region. This presents two challenges: the first is there will be no lessons learned specifically from an urban perspective; the second is at least two participants felt rural regions were less likely to have strong CBO networks already in place, so there was more work to do to stand up individual organizations and networks before digging into the actual service of patients in these communities. Another concern for the future includes the need to create better last-mile delivery for food programs in extremely remote regions of the state. Several CBOs commented that while they are working in rural communities, they still do not have scalable models for the most remote

[12] According to remarks by Reinvestment Partners CEO Peter Skillern during the Food Is Medicine National Summit, “How Community Centered Programs are Building the Infrastructure” panel presentation.

[13] Enhanced Case Management and Other Services Pilots: Evaluation Design. North Carolina Department of Health and Human Services, June 24, 2019. https://www.ncdhhs.gov/media/8590/download

clients. One CBO expressed interest in teaching other CBOs within their region to provide food to Medicaid patients via HOP but have not yet found interested organizations or organizations with enough capacity to see a way to get started.

CBOs, NCDHHS, and the network lead support person all concurred that the goal of the pilot was to build sustainable revenue models for CBOs to provide services. They agreed that they do not yet have the vision of what those sustainable models can be. Finally, a network lead support person described the need for policies at the state level to be nimble and adaptive across all regions and providers, to help foster success for CBOs going forward to accommodate regional and organizational variations.

What have been the key facilitators to this work thus far?

One NC HOP region, from both CBOs and the network lead support person's perspectives, reports very good partnerships across the network. In particular, that region identifies the inclusion of not just the network leads and CBOs but also subject matter experts, including in food production and logistics, and customer care, as a key support to make the work go as smoothly as possible. CBOs in the other two regions reported some positive partnerships and general support from network leads as well but were not as effusive about the collaboration and support as those in the first region described.

Facilitators of the work include:

- **Delivery option:** The opportunity to deliver directly to people's homes. This is a benefit for participants and allows CBO staff to check on participants and identify other cross-sectional services needed.
- **Capacity building funds:** The implementation of some capacity building funds to CBOs to get the work started, with the caveat that CBOs feel larger sums of money were actually required now that they have a better sense of the work.
- **Slow start:** While CBOs were generally frustrated by the delayed start to the pilot as a result of the COVID-19 pandemic, the NCDHHS representative noted the slow start was ultimately helpful for those other than CBOs because it gave time for Medicaid (HHS) and other actors to realize that capacity dollars to build up CBO infrastructure and administration were required for a successful launch. Two CBOs also felt the slow start provided time to stand up their processes and systems.
- **Community organizing:** When challenges such as missing regulations or procedures – specifically a lack of nutrition and content standards for food boxes and meals – were identified, CBO and state experts were able to form a group themselves to address the issue.

- **Outside funding:** One CBO made clear that HOP participation would not have been possible for their organization without first receiving grant funds for very similar work from a philanthropic agency. Those funds paid for the CBO to build out the model and to float food costs upfront while waiting for HOP reimbursement money to arrive.
- **Communication technology:** A network support lead identified using Salesforce to communicate with CBOs and store information for CBOs as a very helpful tool in this process. That said, Salesforce does not store protected health information or identifying participant information, so the three network leads are still grappling with how to safely gather, store, and communicate sensitive participant information.
- **Policies already in place:** Medically tailored meals are considered direct-to-consumer meals, and therefore require less burdensome USDA oversight than other forms of packaged foods. Some produce prescription programs are also doing medically tailored meals using common logistics and tracking platforms and so this facilitator has increased overall viability.
- **Adaptability:** The nimbleness of the CBOs, state agencies, and all of the systems to work together to make this system work. A lot of the CBOs reported working with state agencies to create systems like new contracting agreements, new invoicing systems, and new coalitions across CBOs to troubleshoot emergent issues.

How have key actors collaborated and interacted throughout the pilot?

CBOs, the network lead support person, and the NCDHHS representative generally reported positive interactions among regional players. There was a feeling that all of those involved are rooting for the pilot's success, so everyone in the three regions is eager to roll up their sleeves and work through the challenges together. The NCDHHS representative pointed to the selection of network leads based on their demonstrated prior connections to regional CBOs as a key to success thus far.

All interviewees reported anecdotal positive feedback from early clients, although we must emphasize we did not speak with clients directly. From the CBO food service provider perspective, they reported hearing a mix of positive and negative feedback about the content of produce prescriptions, meal boxes, prepared meals, and medically tailored meals, which is to be expected with a new program. That is why CBOs would like more direct communication with clients – to collect that feedback and make adjustments to their offerings.

Four CBO representatives mentioned feeling left out of the design phase of NC HOP, and that some challenges (including standardized nutrition guidelines and artificially low reimbursement rates) could have been better addressed before the pilot launched if CBOs had been more involved in program design. The opacity of how reimbursement rates were generated exacerbates the low rates because CBOs feel the pinch and do not know what is or is not being assumed in these calculations.

Three CBOs noted less interaction across service regions, as opposed to within service regions. They were not clear if inter-regional communication would be helpful, but two CBO representatives thought it might help to share best practices within service type (produce prescription program, housing repair, etc.).

What is important to do next in this work?

While the general tone from our case study participants was one of determined optimism, interviewees have a number of ideas for what needs to be done to both achieve success in the short-term pilot and to achieve sustainability of these programs and services long-term.

In the immediate future, CBOs want a **more predictable flow of referrals**, a **speedier referral system**, a **better flow of participant information** to help with tailoring service delivery, and **more frequent customer feedback** opportunities to adjust the services provided. One CBO suggested more direct communication between care managers and CBOs would facilitate all of these changes. CBOs want to scale up the number of referrals to increase reimbursements and support more clients and also to test their own capacity to serve larger numbers. Rural service delivery remains a challenge, and one that will loom larger if pilots are expanded to reach even more remote locations.

During the pilot, two CBO participants suggested the state should be more transparent when it does not have a clear answer and bring the network leads and CBOs together to craft meaningful solutions. Additionally, several CBOs and supporters emphasized reimbursement and payment issues, including adjusting the online technology platform to handle payment and invoicing; increasing reimbursement rates for food boxes, meals, and particularly administration; and creating policies and procedures whereby reimbursement rates are automatically adjusted for inflation and price hikes due to fuel and supply shortages.

In the future, CBOs and supporters recommended rules be developed that would keep Medicaid reimbursement dollars local to support service providers truly rooted in community, to maintain deep understanding of cultural preferences, and to create more of a circular economy through local purchasing. CBOs also want future evaluations that

include impacts of HOP on local businesses, organizations, and producers to understand the indirect effects of this type of program.

One person we spoke with suggested other states start off similar work by grounding their pilots and ideas with subject matter experts in food, meal delivery, or medically tailored meals who "really understand the issues and who can make those sticky decisions." In short, they are suggesting roles for subject matter experts separate from network lead/CBO/healthcare provider/insurer roles who can advise the state agency on matters beyond its expertise.

Someone also suggested a "no wrong door approach" for clients seeking services, which could help support greater uptake of services (e.g., clients could ask for a referral from a medical provider, a care manager, or the CBO itself). This model does not exist in the current version of the pilot.

Three different participants identified the need for ongoing work to create "overlapping systems of support," namely multiple funding sources that all support these service delivery models, so that CBOs have the funding they need, as well as have multiple ways to reach those who need the services. Still, no one is holding their breath for a single payer to provide the sustainable funding and broad reach and impact that CBOs are looking for.

Additional thoughts

Unexpected demand for service

A few CBOs reported unique experiences, such as when word of mouth created a demand for services faster than the official care manager pipeline did. "It was unexpected, having folks who had heard about the program elsewhere call their doctors and ask them how they can get involved, rather than the other way around, which is cool." The situation was positive, but overall, it was challenging for these Medicaid patients to pursue a referral through the registration system all the way to successful participation in the program. A more formal "no wrong door" approach would provide the infrastructure and plan to execute quickly and efficiently.

Measuring success

Two interviewees asked a similar question: if the formal evaluation process does not show healthcare cost savings, what will happen here in North Carolina and elsewhere? Both individuals expressed concern that it might not be that the programs are not effective, but rather that there would be inadequate implementation, the wrong

outcomes were evaluated, and/or the data will not show effect until after the pilot period is over.

Client benefits

The Network lead support and two CBO representatives agreed that, anecdotally, the participants who report the most transformational experiences are those who receive services in more than one sector (food, housing, transportation, interpersonal violence and toxic stress, cross sectional). One example shared by an interviewee:

> "**...[a CBO was] working with a client to give them prepared meals and [the client's] fridge went out. [The CBO was] able to reach out to the care manager to get the client a home remediation referral so that they could get a new refrigerator (for the meals), and then the manager was also able to connect that client with another CBO so that they could have access to shelf stable meals in the meantime. Then, once the fridge was in place, [the client was] then re-referred to [the CBO] for fresh and frozen meals. A great example of different CBO's working together and also talking with the care manager to provide complete services for one person to make sure there was no interruption of services."**

Recommendations

As other states and communities consider similar HOP-style efforts, we can share some very early lessons learned as shared by the 11 participants in the Findings section above with a focus on the CBO perspective. Their recommendations include:

- An early design process that includes representatives from CBOs, not just state leads and field experts.
    - This includes all rules, regulations, and procedures formation. If questions arise once the work is underway, have a cross-sectional team available to support joint strategic decision making.
- Adequate funding for CBO capacity building, including capacity building efforts that start even before CBOs are brought into an official program, so that CBOs with deep community roots and programming can adapt to meet new requirements.
    - Funders should expect to fully support CBOs for several months while the referral process gets up and running. Do not expect CBOs to shoulder the burden of staffing up and having no reimbursements coming through the pipeline.
- Simplify the referral process as much as possible, increasing options for participant enrollment by CBOs, while maintaining data privacy.
    - Invest more in provider and care manager training and education so they are aware of all services available to their patient population in order to facilitate increased referrals.
- Assume Medicaid reimbursements will not be the only source of funding to make these programs sustainable. Begin the process of network building to support diversified strategies for CBO service providers, bringing together such parties as interested foundations, Community Development Finance Institutions, and state agencies, to increase access to capital.

Much more data, evaluation, and lessons learned are expected from NC HOP over the coming years. Other states and agencies have a lot to gain from North Carolina's experiences. NC CBOs were critical advocates for the state to apply for the waiver to establish HOP, and CBOs are a critical component of this pilot's operation and success. It is vital that their voices and experiences continue to be centered in this work. We hope that GusNIP produce prescription program operators and CBO advocates in other states can find inspiration and learnings in this example of a Medicaid waiver program.

Appendices

Appendix A

Expedited Enrollment Initiative

New Initiative for Enrollment by NCDHHS

We are excited to share details about an **expedited HOP enrollment** initiative that the state is launching this week. This new approach is intended to rapidly increase the number of HOP participants and referrals across our network. The first phase of this initiative is being tested with one health plan and one HSO that serves all three pilot regions. Learnings from this phase will inform the development of a process that enables additional HSOs and health plans to participate in the expedited enrollment pathway.

In the first phase, launching on March 15, Healthy Blue will send text messages to a select list of beneficiaries in the HOP regions. The text messages will include a link to the member-facing Eat Well portal hosted by Reinvestment Partners. Medicaid members receiving these texts are presumed eligible for HOP based on the state's analysis of existing Medicaid data.

The member can opt-in to receive a Fruit and Vegetable Prescription debit card from Reinvestment Partners via the Eat Well portal. The member can use this debit card for up to 6 months while care managers from Healthy Blue reach out to these members to assess them for full HOP enrollment and additional services and service providers via NCCARE360. We hope this method will enable us to reach members that were previously unaware of the program and its benefits. The direct-to-consumer model of the portal removes enrollment barriers previously experienced by some members.

In the second phase of this initiative, NCDHHS is planning to incorporate lessons learned from phase one and expand this solution to include additional HSOs, health plans, and services. The launch date for phase two is still to be determined and will be shared once available. Serving NC's Medicaid Managed Care members is our top priority; this initiative works towards that priority by accelerating and increasing enrollment in the pilot and, in turn, improving health outcomes in the Medicaid community.

Thank you all for your continued partnership and for contributing to the HOP success story!

Appendix B. Summary of questions for case study participants

Interview Guide for Regional Partners in HOP Case Study Prepared By FIG in Collaboration with DAISA	
Question	**Rationale/Reasoning**
What motivated you to take part in the HOP program? ● **PROBE:** What benefits did you imagine from a program like this?	*To understand expectations organizations had, and what they thought they might be able to do with the funding. Getting at the vision of each partner.*
Is this program working for your organization's internal processes? ● **PROBE:** What's working especially well? ● **PROBE:** What's been especially difficult to achieve? ● **PROBE:** Have you had to develop any new capacities or systems? ○ How were you able to do so? ● **PROBE:** What can you tell me about the effectiveness of the reimbursement model for your organization?	*To understand what is working/not working for each of the participants. Could be useful in understanding where to probe deeper in future conversations and what (if any) successes can be gleaned from the program.*
Is this program working for the clients your organization serves? ● **PROBE:** What's working especially well? ● **PROBE:** What's been especially difficult to achieve? ● **PROBE:** What can you tell me about the effectiveness of the reimbursement model for your organization?	*To understand what is working/not working for each of the participants. Could be useful in understanding where to probe deeper in future conversations and what (if any) successes can be gleaned from the program.*
What have been the key barriers to this work thus far? What have been the key facilitators to this work thus far?	*To understand specific barriers and facilitators to the work that has happened so far. Could be useful in understanding where to probe deeper in future conversations and what (if any) barriers or facilitators can be taken from the program.*

How do you perceive and interact with the other actors involved in the program? • **PROBE:** Do you wish the interaction you have with other partners was different? How? • **PROBE:** Can you tell me about the development of the nutrition guidelines? • **PROBE:** Do the leaders of this program (Regional Leads and/or state policy people) listen to your feedback? How?	*To better understand how the HOP partners work with one another. Are they sharing best practices and lessons learned? In what ways is this program creating a community of learning amongst partners to encourage sustained implementation of the program?*
What challenges or successes are you experiencing that you think are particular to your region?	*To better understand regional differences amongst the partner organizations that may be arising due to populations, geography etc. And to better understand if there are some places/ structures that work better than others.*
What challenges or successes are you experiencing that you think are particular to your work/model?	*To better understand differences amongst the partner organizations that may be arising due to their business/work mode. etc. And to better understand if there are some places/structures that work better than others.*
What is important to do next in this work? • **PROBE:** What would most support your work in NC? • **PROBE:** What would most shift national policy?	*To understand tangible next steps and recommendations. Also to gather recommendations to probe other interviewees with.*
Do you have any recommendations for other organizations/activists in other states trying to replicate your successes?	*What have folks learned that can/should be replicated?*

Interview Guide for Evaluation Team in HOP Case Study **Prepared By FIG in Collaboration with DAISA**	
Question	**Rationale/ Reasoning**

Tell us about your (team's) role in the HOP evaluation? ● **PROBE:** What are mandated requirements for this work? ● **PROBE:** What is not covered in your SOW? ● **PROBE:** What has not been mandated that you intend to add to the scope?	*To understand the evaluation team's roles, responsibilities, and vision for their efforts related to the HOP program.*
How were you connected to the HOP program? ● **PROBE:** By whom? At what stage in the process (design phase? After the program had launched? etc.) ● **PROBE:** What were some of the initial goals/ motivations that you were presented with?	*To understand how evaluation was or was not envisioned at the outset of HOP implementation. To possibly understand motivations for selection of this particular group or individual for this role. And to understand what the desired outcome of the evaluation was (improvements, to recommend policy etc)*
What are barriers to the evaluation of the HOP programs thus far? What are the facilitators to the evaluation of the HOP programs thus far?	*To understand specific barriers and facilitators to the work that has happened so far. Could be useful in understanding where to probe deeper in future conversations and what (if any) barriers or facilitators can be taken from the program.*
What are your observations of the HOP programs in general (beyond evaluation)?	*To gain additional insight into how HOP is and is not rolling out as intended.*
What is important to do next from this work?	*To understand tangible next steps and recommendations. Also to gather recommendations to probe other interviewees with.*
Do you have any recommendations for other organizations/activists in other states trying to replicate these efforts? ● **PROBE:** Any lessons/insights learned so far that you can share?	*What have folks learned that can/should be replicated?*

Additional questions

1. Key factors allowing for growth of initiatives in NC?
2. How involved are you?
3. Level of involvement in planning NC waiver food systems work?
4. Who were some of the other key players?

    a. What additional factors or efforts may have played an important role? (i.e., GusNIP, etc.)
5. What were some of the important outcomes for you?
6. What were barriers for your involvement and/or others?
7. How has this Waiver usage impacted or shifted program operations? (i.e., patient recruitment and participation, healthcare or retail partnerships, program evaluation metrics, etc.)
8. How do these different stakeholders troubleshoot when there are issues? How can they be better supported?
9. What are the gaps to seamless delivery of services?
10. What is important to do next from this work? To better embed and sustain….
    a. …to support your work in NC?
    b. …to shift national policy?
11. Recommendations for other organizations/activists in other states trying to replicate your successes?

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About

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Jessie is passionate about creating liberation through the ways we enjoy, grow, buy, sell, and eat food. For the past 9 years, she has worked throughout the Bay Area on issues ranging from equitable planning, to community training, to COVID relief food coordination.

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About Food Insight Group

We are researchers, innovators, policy strategists, and consultants working collaboratively with individuals and organizations who share our vision and values. Committed to building just, equitable, and resilient food systems. We believe that all people have the right to access good food — food that nourishes people, communities, and the planet. Good food for the common good.

About DAISA Enterprises

A national team of equity-focused consultants working at the intersection of food, culture, and health. We partner with social enterprises, nonprofits, community leaders, policy makers, and mission-aligned investors to support the realization of equitable food systems and vibrant communities.

https://www.daisaenterprises.com/

Acknowledgments

The Nutrition Incentive Program Training, Technical Assistance, Evaluation, and Information Center (NTAE) is supported by Gus Schumacher Nutrition Incentive Program grant no. 2019-7003030415/project accession no. 1020863 from the USDA National Institute of Food and Agriculture.

Suggested Citation

GusNIP NTAE, Nutrition Incentive Hub and DAISA Enterprises. (2023, February). *NC HOP Case Study Food-based CBO Needs and Perspectives*. GusNIP NTAE, Nutrition Incentive Hub. Retrieved from www.nutritionincentivehub.org

The Nutrition Incentive Hub

The Nutrition Incentive Program Training, Technical Assistance, Evaluation, and Information (NTAE) Center is led by the Gretchen Swanson Center for Nutrition. In partnership with Fair Food Network, they created the Nutrition Incentive Hub, a coalition of partners to support this work. Nutrition Incentive Hub partners include practitioners, retail experts, researchers, and evaluators from across the country bringing decades of experience and leadership in technical assistance, training, reporting, and evaluation. The Nutrition Incentive Hub is dedicated to building a community of practice to maximize program impact and ensure that all Americans have access to the healthy foods they need.