

SELLERS DORSEY WHITE PAPER



Nutrition Supports in Medicaid:

Bridging the Gap Between Federal Programs and Managed Care Initiatives

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Introduction



Food insecurity is a household and community-level social and economic condition of limited or uncertain access to adequate food, both in amount and in nutritional value. The USDA defines food insecurity as **“a lack of consistent access to enough food for every person in a household to live an active, healthy life.** This can be a temporary situation or last a long time.”⁶ Food insecurity is a public health issue because people experiencing it often consume a nutrient poor diet. Poor nutrition contributes to chronic diseases such as **heart disease, hypertension, diabetes, obesity, and depression.**^{7,8} Food insecurity often forces affected households to choose between paying for food and paying for other expenses such as medical expenses, prescriptions, rent, and/or utilities, and is **most often associated with low-income communities.** Additionally, Food insecurity and nutrition-related diseases **disproportionately affect people of color (POC)** and low-income communities. Low incomes and structural barriers often make it especially challenging for enrollees to access healthy and affordable food. Also, food insecurity was further exacerbated by the COVID-19 pandemic. As a result, the rate of food insecurity has continued to **increase due to job loss, poor health, and a historical lack of government support.**

Food Insecurity Facts⁹ (as of 2021)



34 million people in the United States are food insecure.



Nine million children in the United States are food insecure.



53 million people turn to food assistance programs



10.5% of households are food insecure.



100% of counties in the United States have food insecurity.

In recent years, experts have begun to call for a change in terminology to focus on nutrition security rather than food security. **Nutrition security** is defined as having consistent access, availability, and affordability of foods and beverages that promote well-being and prevent (and if needed, treat) disease.¹⁰ This change from the term food security to nutrition security is meant to highlight the need for not only enough food, but sufficient, nutritious food for a healthy life. Food insecurity and a nutritious diet are directly associated with **increased healthcare costs.** A study conducted in 2019 by the Centers for Disease Control and Prevention (CDC) found that food insecure adults have annual healthcare expenditures that are approximately \$1,834 higher than adults who are food secure. Overall, this contributes to a \$52.8 billion in excess healthcare costs in the United States every year.¹¹

Given the widespread and longstanding issues related to nutrition and food security within the United States, the federal government has created and implemented many programs and legislation that address food gaps and nutrition support. These initiatives continue to vary in eligibility, scope, and

coverage, and include the SNAP and National School Lunch Programs, numerous Farm Bills, and healthcare flexibilities and supports. The direct connection between food and health has led state governments, healthcare payers, providers, and community-based organizations to work together to improve the health of the country’s most vulnerable through addressing food insecurity and nutrition. Collaborations between state Medicaid agencies, managed care organizations (MCOs), community-based organizations (CBOs), and other public-private partnerships help extend the reach and success of these programs. While the urgency to address food and nutrition insecurity throughout the nation persists, there is a **unique opportunity for Medicaid to implement food services** and supports that will address the most vulnerable and medically underserved populations in the country. Medicaid programs are able to test how Medicaid funding can be leveraged to implement programs to address food and nutrition insecurity as part of their overall efforts to improve the health and care of Medicaid beneficiaries.

Background and History of Nutrition Supports¹

1939 – 1943

The first food stamp program (FSP) was implemented in 1939 and allowed eligible people to buy orange stamps equal to their normal food expenditures. For every \$1 worth of orange stamps purchased, 50 cents worth of blue stamps were received.

1943

The first food stamp program ended in the spring of 1943 because “the conditions that brought the program into existence -- unmarketable food surpluses and widespread unemployment -- no longer existed.”

1943 – 1960

The seventeen years that followed the initial food stamp program were filled with studies, reports, and legislative proposals.

1959: PL 86-341 authorized the Secretary of Agriculture to operate a food stamp system through January 1962. The Eisenhower administration never used the authority.

1961 – 1964

1962: President Kennedy’s first executive order called for expanded food distribution and he announced the Food Stamp Pilot Program.

1964: President Johnson requested that Congress pass legislation to make the food stamp program (FSP) permanent. It was estimated that participation would eventually reach 4 million and cost \$360M annually.

1960s – 1970s

Throughout the 1960s and early 1970s, participation in the FSP continued to grow from half a million individuals in 1965 to 15 million in 1974. These rapid increases in participation were mostly due to geographic expansion.

1971 – 1974

1971: The Food Stamp Act Amendment of 1970 was passed in January 1971 and established uniform national standards of eligibility and work registration requirements and provided \$1.75B in appropriations for FY1971.

1973: The Agriculture and Consumer Protection Act of 1973 was passed in August 1973 and included seeds and plants that produce food for human consumption and required states to expand the program to every political jurisdiction.

1974: The FSP began operating nationally on July 1, 1974.

1977

The Food and Agriculture Act of 1977 eliminated the purchase requirement, established access provisions, and instituted eligibility requirements.



1980s

In the early 1980s, the FSP was reviewed by the President and Congress and major legislation in 1981 and 1982 enacted significant cutbacks.

The Food Stamp Act of 1985 required all states to implement an Employment and Training (E&T) program by April 1, 1987. An E&T program was defined as having one or more of the following components: job search, job search training, workfare, work experience or training, or other programs as approved.

Identification and recognition of the severe domestic hunger problem in the United States led to incremental improvements in the FSP in both 1985 and 1987.

The Hunger Prevention Act of 1988 and the Mickey Leland Memorial Domestic Hunger Relief Act of 1990 further addressed the domestic hunger issues and established Electronic Benefit Transfer (EBT) as an issuance alternative.



1993 – 2004

1996: The Personal Responsibility and Work Opportunity Act of 1996 mandated that states implement EBT systems prior to October 1, 2002.

1996: The FSP was reauthorized in the 1996 Federal Agriculture Improvement and Reform Act, also known as the 1996 Farm Bill, but major changes were made to the program that eliminated eligibility for immigrant groups, froze the standard deduction, vehicle limit, and the minimum benefit, and revised provisions for disqualification.

2000: The Electronic Benefit Transfer (EBT) Interoperability and Portability Act of 2000 established a national standard of interoperability and portability applicable to electronic food stamp benefit transactions.

2002: The Farm Security and Rural Investment Act of 2002 permitted group homes and other institutions to redeem EBT benefits directly from banks in areas where EBT has been implemented instead of going through authorized wholesalers or other retailers.

2004: By July 2004, all 50 states, the District of Columbia, the Virgin Islands, and Guam operated statewide, citywide, and territory-wide EBT systems.

2008

The 2008 Farm Bill (The Food, Conservation, and Energy Act of 2008) was enacted May 22, 2008, through an override of the President's veto. In an effort to fight stigma surrounding food assistance, the law changed the name of the federal program to the Supplemental Nutrition Assistance Program or SNAP as of October 1, 2008, and changed the name of the Food Stamp Act of 1977 to the Food and Nutrition Act of 2008.

The law transformed the program by recognizing EBT as the standard issuance tool, removing the need for coupons one year from enactment.

2009

The American Recovery & Reinvestment Act of 2009 (ARRA) was passed in response to the Great Recession that started in December 2007. ARRA was designed to stimulate the economy and facilitate economic recovery and included provisions surrounding the authority to increase SNAP benefit levels.

2010

The Healthy, Hunger-Free Kids Act of 2010 (HHFKA) reauthorized school nutrition programs and was signed into law on December 13, 2010. The Act also had implications for SNAP nutrition education and restructured SNAP-Education as the Nutrition Education and Obesity Prevention Grant Program, changed its financial structure to 100% federal grant funding with no state contribution or match.

The number of states with approved SNAP-Education plans increased from seven in 1992 to 52 state agencies by FY2010.

2014

The 2014 Farm Bill made considerable changes to SNAP, including pilot testing the use of mobile devices to redeem SNAP benefits and accepting SNAP benefits through online transactions. It also permitted Food Insecurity and Nutrition Incentive (FINI) Grants to incentivize the purchase of fruits and vegetables among SNAP participants at grocery stores and farmers markets.

2018

The Agricultural Improvement Act of 2018 initially failed in the House of Representatives. All Democrats and 30 Republicans voted against the bill because of the proposed changes to the

SNAP program that would impose work requirements and the belief that a handful of the bill's provisions would loosen immigration policies. The 2018 Farm Bill finally passed, with compromise, by the end of the year, without the inclusion of work requirements.

2020-2022

In March 2020, the COVID-19 pandemic began and resulted in an increase in the food insecure population across the United States. The federal policy response included expansions of existing USDA programs, flexibilities in ongoing USDA programming, and the rapid development of new programming, such as the Pandemic EBT program.²

o States, cities, and school districts sprang into action and launched new ways to improve food access while other safety net programs offered innovative and collaborative support to individuals experiencing food insecurity.³

2023

The federal COVID-19 public health emergency declaration expired on May 11, 2023. When the PHE expired, stakeholders continue to push for the permanent implementation of some of the nutrition- and food-related COVID-19 flexibilities.⁴

Debt ceiling deal

- The package calls for temporarily broadening of work requirements for certain adults receiving food stamps. The legislation increased the upper limit of the mandate to age 55 in phases.
- The package will also expand exemptions for veterans, people who are homeless and former foster youth.
- All the changes will end in 2030. The provisions are projected to boost enrollment by 78,000 people in an average month when fully implemented.
- The package also tightened the current work requirements in the Temporary Assistance for Needy Families (TANF program), primarily by adjusting the work participation rate credits that states can receive for reducing caseloads.

Federal Context, Regulations, and Programs



Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) has a winding history in the United States, having originally been the Food Stamp Program implemented in 1939 as a key component of the New Deal program. Through the Food Stamp Program, food assistance was made available to low-income individuals through the purchase of food stamps and some household items. Throughout many years and administrations, the Food Stamp Program was cut, reintroduced, revised, modified, and restructured. In the early 2000s, significant changes were made as participation in the Food Stamp Program was extended to immigrants and children under 18 years of age. In the 2008 Farm Bill, legislators focused on placing greater emphasis on nutrition and renamed the Food Stamp Program the Supplemental Nutrition Assistance Program.¹² Today, SNAP is the **largest domestic food and nutrition assistance program in the nation** and provides supports for low-income families, low-income adults ages 60 years and older, and individuals with disabilities.¹³

While the federal government pays the full cost of SNAP benefits, they split the cost of administering the program with the states that operate the program. In FY2021, the federal government spent about \$111B on SNAP, of which \$105B (94%) went directly to households for food purchase.¹⁴ As of 2022, to qualify for SNAP benefits a household must meet three criteria, although states have flexibility to adjust these limits:

- 1 Most households receiving SNAP benefits must have a gross monthly income at or below 130 percent of the poverty line (FPL) and net monthly income at or below 100 percent of FPL. Households with a member who is age 60 or older or has a disability must only meet the net income requirement (100 percent of FPL).
- 2 Net monthly income must be less than or equal to the poverty line.
- 3 Assets must fall below certain limits.^{15,16}

Individuals aged 18-50 without dependents are limited to only three months of SNAP benefits every three years. This additional requirement does not apply if individuals are working or in a work training program for a minimum of 20 hours a week.¹⁷

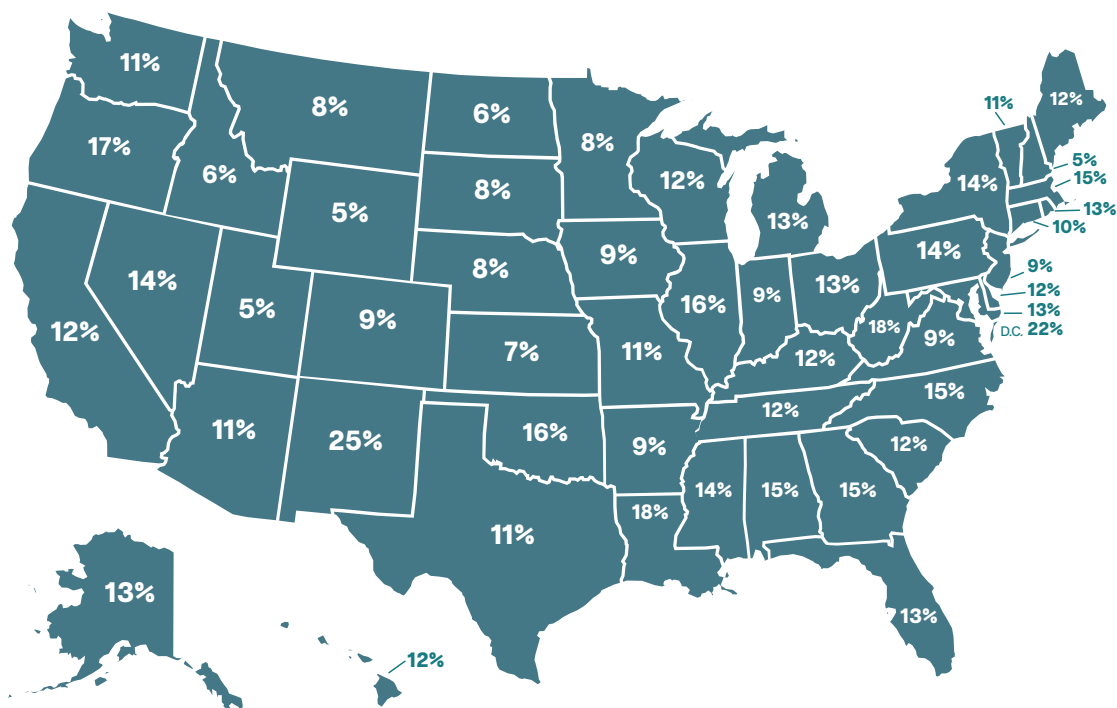
As the COVID-19 pandemic swept the nation in 2020, the demand for accessible food rose. Congress increased SNAP benefits to provide emergency benefit supplements and allow states to deliver more food to struggling individuals and families. The Families First Coronavirus Response Act of March 2020 gave the USDA temporary flexibility to address food needs and support

the economic shock of the pandemic. The Act temporarily suspended SNAP's three-month time limit on benefits, improved access to SNAP by encouraging online or telephone applications, allowed participants to continuously have SNAP without reapplying, included a temporary boost of emergency supplementary benefits and school meal replacement benefits.¹⁸ Many of these temporary changes were extended and strengthened by legislation throughout the first term of the Biden presidency. The end of the public health emergency was declared on May 11, 2023, and since, some of these flexibilities have sunset. For example, the temporary suspension of the three-month time limit for SNAP eligibility will resume with July 2023 being the first countable month towards the time limit. Participants who are unable to work or train for 20 hours a week will lose their SNAP benefits in October.¹⁹

Studies show that **SNAP improves food insecurity, improves participants current and long-term health outcomes, and reduces healthcare costs overall.**²⁰ Additionally, SNAP has an inherent ability to protect the country's economy by being an effective form of economic stimulus when there is any sort of recession or critical challenge (such as a pandemic). By providing low-income individuals with food resources, they are in turn able to spend critical dollars on other needs. Analysis done by the Center on Budget and Policy Priorities on the government's Supplemental Poverty Measure found that before the pandemic, SNAP kept nearly 8 million people above the poverty line annually.²¹ Results from various studies point to **SNAP as being one of the strongest anti-poverty federal programs that exists today.**

Federal Context, Regulations, and Programs (cont)

In fiscal year 2022 the following percentage of each state's population was using SNAP benefits:



The USDA 2023 Farm Bill

The first Farm Bill was enacted in 1933 as part of President Roosevelt's New Deal, in response to the Great Depression.²² In 1939, Congress then instituted the program on a permanent basis, to be renewed every five years. The 2018 Farm Bill expires in 2023. This significant legislation contains provisions for food stamps, disaster aid, climate change, and agricultural funding.

Congress is in the process of writing the 2023 Farm Bill and discussing modifications to its provisions. The 2023 Farm Bill is expected to reach \$1.5T over ten years, and when considering budget discussions, SNAP is expected to be a substantial part of that discussion as it, and other nutrition assistance programs, is where most of the bill budget goes.²³

Anti-hunger stakeholders and liberal legislators are seeking to make the above-referenced increased pandemic benefits permanent while defending the 2021 Thrifty Food Plan, the plan used to set SNAP benefits. The Thrifty Food Plan represents the cost of purchasing groceries for a family of four - two adults between the ages of 20-50, and two children between the ages 6-8 and 9-11. The plan is designed to meet the nutritional needs of an average person consuming a healthy, cost-conscious diet at home, and is the lowest cost food plan developed by the USDA. When reevaluated in 2021, the Thrifty Food Plan included updated data on food prices, food composition, consumption patterns, and dietary guidance, resulting in a 21% increase in

purchasing power for the first time since it was originally introduced in 1975. Alternatively, conservative legislators are focused on decreasing SNAP while expanding work requirements.

The School Breakfast and National School Lunch Programs

The School Breakfast Program (SBP) provides compensation to states to operate breakfast programs in both schools and residential childcare institutions. The Food and Nutrition Service (FNS) operates the SBP at the federal level. State education agencies operate the program at the state level, and local school food authorities operate the program within schools. The SBP began in 1966 as a pilot project and was made a permanent program in 1975.²⁴

The National School Lunch Program (NSLP) is a federally-assisted program operating in both private and public schools, as well as in residential childcare institutions. This program **provides nutritionally balanced, low-cost or no-cost lunches to children each day** they are in school. The Food and Nutrition Service (FNS) operates the NSLP at the federal level, and at the state level. The NSLP is administered by state agencies, which operate the program through agreements with school food authorities. The program was first established under the Richard B. Russell National School Lunch Act, and signed into law by President Harry Truman in 1946.²⁵

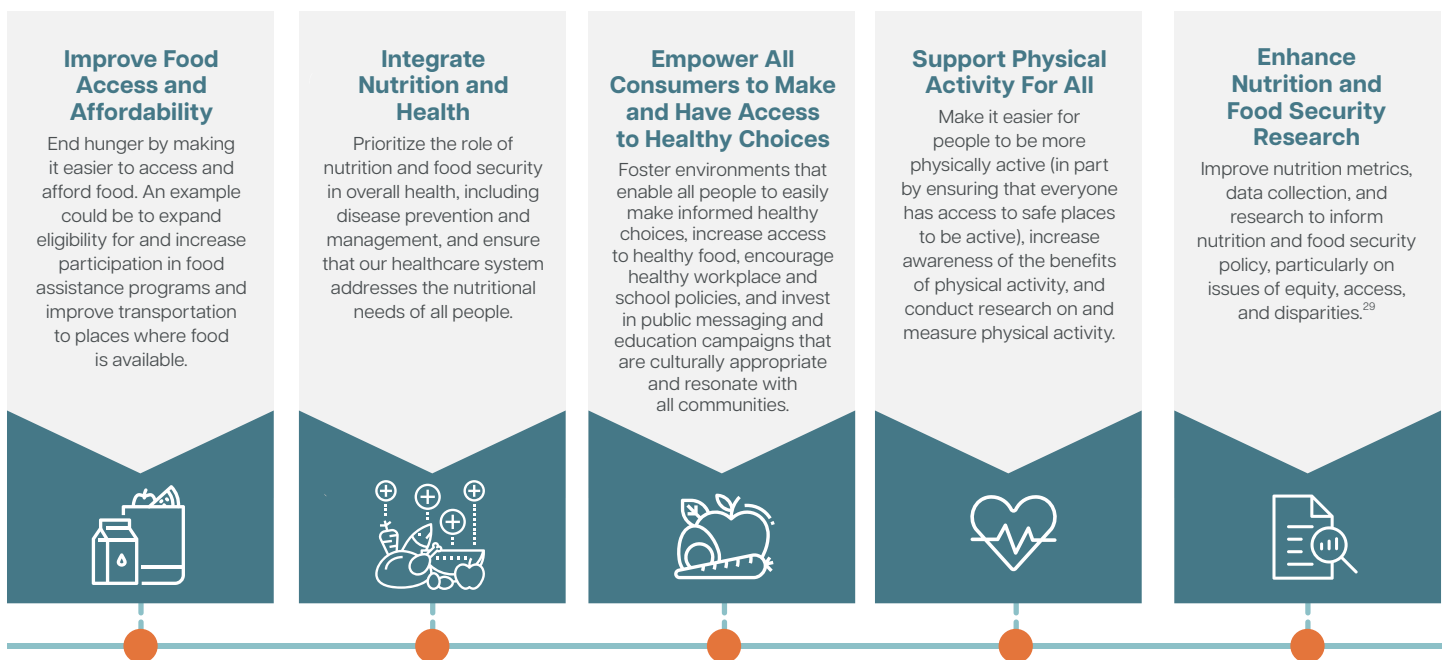
These programs serve millions of children every year.

Program Name	Categorically Eligible	>130% FPL	130% - 185% FPL	>185% FPL
School Breakfast Program	Children are typically deemed as categorically eligible through participation in certain federal assistance programs, such as SNAP and Head Start, or a comparable state-funded pre-kindergarten program.	Eligible for free breakfast.	Eligible for reduced priced breakfast – schools are not permitted to charge more than \$0.30 for each breakfast.	Eligible for low-cost, full price breakfast. The average cost of these meals is \$1.70 for elementary school, \$1.79 for middle school, and \$1.82 for high school. ²⁶
National School Lunch Program	Children are typically deemed as categorically eligible through participation in certain federal assistance programs, such as SNAP and Head Start, or a comparable state-funded pre-kindergarten program.	Eligible for free lunch.	Eligible for reduced priced lunch – schools are not permitted to charge more than \$0.40 for each lunch.	Eligible for low-cost, full price lunch. The average cost of these meals is \$2.75 for elementary school, \$2.94 for middle school, and \$3.01 for high school. ²⁷





Social Determinants of Health (SDOH), Health-Related Social Needs (HRSNs), Medicaid Dollars, and Food/Nutrition Supports

Traditionally, the federal food programs described above are anti-poverty driven, which can lead to gaps in services being provided. Medicaid programs support the most low-income and vulnerable populations throughout the country by focusing on social determinants of health, such as housing or food, which can contribute to improved health outcomes for enrollees. Because the federal government and Medicaid programs run and implement concurrent and siloed food programs and supports, there are gaps in services being provided. However, there are also **opportunities to both enhance what services and supports are being provided through SNAP** and other programs and improve outcomes within Medicaid and other healthcare programs. In September 2022, for the first time in 50 years, the Biden administration held a conference at the White House on Hunger, Nutrition, and Health.

The conference laid out **five pillars to identify actions** that can be taken by the federal government, state, local, and territory governments; nonprofit and community groups; and private companies.²⁸



In 2021, CMS released a State Health Official (SHO) letter, [SHO# 21-001](#), describing opportunities for states to address Social Determinants of Health (SDOH) in Medicaid and CHIP programs.³⁰ Then, on December 6, 2022, CMS held an [All-State Medicaid and CHIP](#) call that further clarified and provided guidance for these opportunities and explained its position that the key to advancing equity is addressing beneficiaries' HRSN through care delivery, quality, and coverage of clinically appropriate HRSN interventions.³¹ The ways in which states can address SDOH include state plans, 1915(c) waivers, managed care in lieu of services (ILOS), and section 1115 waiver demonstrations. States being able to address SDOH and HRSN give them the ability to meet beneficiaries where they are, and **nutrition supports are a key piece in helping prevent and diminish food insecurity**. In their guidance, CMS developed a framework describing the nutrition supports that can be provided under an 1115 waiver demonstration:

-  **Nutrition counseling and education:** including healthy meal preparation.
-  **Medically-tailored meals:** up to 3 meals a day delivered in the home or other private residence, for up to 6 months.
-  **Meals or pantry stocking:** for children under 21 and pregnant individuals up to 3 meals a day delivered in the home or other private residence, for up to 6 months.
-  **Fruit and vegetable prescriptions and/or protein box:** for up to 6 months.

Additionally, state Medicaid agencies are highly encouraged by CMS to partner with other state agencies, community-

based organizations, and other social service providers to ensure that beneficiaries are connected to programs like SNAP, WIC, and TANF if experiencing food insecurity.

Research and data suggest that addressing food insecurity, along with other SDOH, can not only improve health, but deliver savings by **decreasing the need for medical visits, prescription medications, and helping control chronic and other serious illnesses**.^{32,33} Starting in 2023, the Biden administration began allowing states to use Medicaid dollars to pay for groceries and nutritional counseling in an attempt to learn more about **“food as medicine.”** While food as medicine is not a novel concept, it emerged in the United States around the 1980s to help manage the treatment of HIV/AIDS. While there is no set definition for food as medicine, the concept refers to the **utilization of nutritious food to prevent, treat, or reverse disease**.³⁴ Today, food as medicine can be seen in states' 1115 waivers where states can choose to cover food prescriptions, food education programs, or meal delivery services.

On January 4, 2023, CMS issued a State Medicaid Director (SMD) letter, [SMD# 23-001](#), providing additional guidance on the ILOS option for states to use in Medicaid managed care programs to reduce health disparities and address the unmet health-related social needs of Medicaid and Children's Health Insurance Program (CHIP) enrollees. The letter also clarifies previous guidance issued in [SHO# 21-001](#), “Opportunities in Medicaid and CHIP to Address Social Determinants of Health,” and the [2016 Medicaid and CHIP managed care final rule requirements for ILOS](#).³⁵ The Biden administration's goals, CMS' guidance and additional flexibilities, and state Medicaid pilot programs addressing food and nutrition demonstrate a significant shift in healthcare thinking with movement away from prescriptive solutions and towards preventative measures and treatments.



Current Medicaid Programs: A Mixed Approach to Nutrition Supports and Food Security

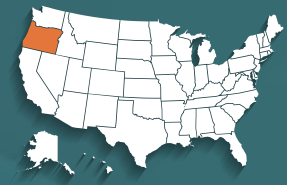


While states spend billions of Medicaid dollars each year addressing enrollees' health needs and conditions, chronic conditions such as diabetes or heart disease persist at growing rates across the country. Research shows that the most beneficial way to treat and prevent chronic conditions is through healthy diet; however, more Medicaid enrollees report not having access to healthy food when compared to individuals with other types of insurance.³⁶ Thus, a cyclical pattern repeats itself in America: **food insecurity leads to poor nutrition options and increased stress, creating chronic conditions and increased medical and hospital expenses.** While the federal government has created anti-hunger programs, such as SNAP, these programs exist outside of the healthcare system and are subject to separate regulations and limitations.³⁷ It is therefore imperative that **Medicaid, and specifically the managed care organizations in charge of delivering healthcare services to enrollees in most states, use the inherent flexibilities and guardrails within the program to tackle food insecurity** and ultimately preventable diseases and conditions. Discussed below with concurrent state examples, there are various ways in which Medicaid programs can incorporate food services and supports; through section 1115 demonstration waivers, 1915(b) waivers using value-added services, and in-lieu of services.

1115 Waivers

Section 1115 of the Social Security Act (SSA) gives the Secretary of HHS the express authority to waive provisions of major health and welfare programs, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is given if the HHS Secretary determines that the state's proposal will assist in promoting the objectives of the Medicaid program. Comprehensive 1115 waivers allow broad changes in eligibility, benefits, cost-sharing, and provider payments. Alternatively, narrower 1115 waivers can focus on specific services and/or populations. 1115 demonstration waivers are most often used when a state wants to make experimental or pilot changes to its Medicaid program.³⁸

Most recently, in December 2022, CMS provided states with guidance about how states can address HRSN through 1115 waivers. HRSN services that will be considered under the new framework include housing supports, nutrition supports, and HRSN case management, with other services being provided on a case-by-case basis. **Under Section 1115, states have more flexibility to define target populations and services compared to the ILOS option,** for example, states cannot cover rent/temporary housing under ILOS, but can under 1115 demonstration waiver authority. Additionally, **states have the ability to add the services to the benefit package and require that MCOs must offer the services to eligible enrollees.** HRSN services must be medically appropriate, using state-defined clinical and social risk factors, and be chosen by the beneficiary.³⁹



OREGON

On September 28, 2022, CMS originally approved Oregon’s section 1115 waiver demonstration, Oregon Health Plan (OHP). Oregon amended the Basic Health Plan section of the demonstration and received approval again on April 20, 2023. The aim of the demonstration is to transform the state’s Medicaid program to better serve beneficiaries by building on the state’s previous healthcare transformation success and creating a more equitable system through initiatives related to addressing health inequities, health related social needs, continuous eligibility, and coverage expansion.⁴⁰ The waiver authority will expire on January 1, 2027.

When it comes to nutrition supports, Coordinated Care Organizations (CCOs) are required to contract with HRSN services providers to deliver HRSN services authorized under the demonstration and are required to establish a network of providers and ensure that the contracted providers have sufficient experience and training in the provision of their applicable HRSN services.⁴¹

Oregon offers the following nutrition supports to their Medicaid population within the OHP 1115 waiver:⁴²



Nutrition counseling and education: including healthy meal preparation.



Meals or pantry stocking for children under 21: YSHCN, and pregnant individuals; up to 3 meals a day delivered in the home or private residence, for up to 6 months.



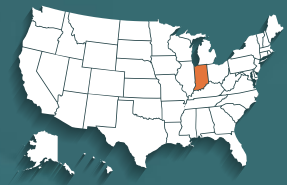
Medically-tailored meals: up to 3 meals a day delivered in the home or other private residence, for up to 6 months.



Fruit and vegetable prescriptions: for up to 6 months.

Value-Added Services

Value-added services (VAS) are additional services outside of the traditional Medicaid benefits provided through the state plan or managed care contracts. Traditionally, VAS were the primary way for states and MCOs to test and implement SDOH and HRSN services that focused on prevention and disease management. While various MCOs provided food programs as VAS for many years, CMS overtly recognized that managed care plans can voluntarily provide VAS and that such services are not included when determining payment rates in the 2016 Medicaid Managed Care Rule.⁴³ These services are optional, left to the managed care plans’ discretion, and are not included in capitation rates. However, VAS aim to improve overall quality and health outcomes while reducing the need for expensive long-term care and therefore reduce costs.⁴⁴ Additionally, they assist states and CMS in data collection on health outcomes and shed light on areas to reduce other healthcare spending. There are several reasons MCOs would opt to provide VAS. Investing in services aimed at achieving improved health outcomes and quality ratings are ultimately financially beneficial and result in healthier populations.⁴⁵ By offering VAS to enrollees, MCOs also have the potential to set themselves apart and enhance their national reputations. VAS also addresses social determinants of health and can ultimately round out the health services and experience that MCOs provide.



INDIANA

While not contractually required, the Healthy Indiana Plans (HIP) are encouraged to provide some VAS, as seen in the MCO contract language:

“The State encourages the Contractor to cover programs that enhance the general health and well-being of its HIP members, including programs that address preventive health, risk factors or personal responsibility. These enhanced programs and services are above and beyond those covered in the HIP program. For enhanced services developed for HIP, the enhancements shall be developed to align with the overall program goals aimed at creating a commercial market experience and encouraging member participation in HIP Plus.”

Enhanced services may include, but are not limited to, such items as:

- Enhanced transportation arrangements (i.e., transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.);
- Enhanced tobacco treatment dependence services;
- Disease management programs or incentives beyond those required by the State;
- Healthy lifestyles incentives; and
- Group visits with nurse educators and other patients.⁴⁶

Three out of the four managed care plans in the state of Indiana provide VAS and all three have programs that address food-related services. For example, Anthem provides several options for enrollees depending on population and eligibility:



Healthy Meals: 10 frozen healthy family meals delivered to enrollees' home.



Fresh Fruits and Veggies Program: One produce box per month for three months delivered to enrollees' home. For pregnant or nursing moms six weeks postpartum.



Post-discharge meals: Two customized meals per day for seven days (up to 14 meals) delivered to enrollees' home.⁴⁷

In Lieu of Services

The 2016 Medicaid managed care final rule formally recognized and defined In Lieu of Services (ILOS) as substitutes for covered services or settings that are deemed medically appropriate and cost-effective.⁴⁸ Since ILOS are authorized through Medicaid managed care regulations, 1115 demonstration waiver authority is not required to provide ILOS. However, the services provided must be similar to a service already covered under the State Plan. While managed care plans historically had the flexibility to cover alternative services to meet enrollees' needs, CMS' decision to codify ILOS in the rule streamlined plans' use of alternative services. Unlike VAS, ILOS may be included in calculations of the medical portion of managed care capitation rates.⁴⁹

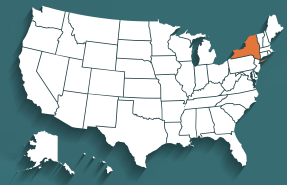
In 2022, CMS approved California's "California Advancing and Innovating Medi-Cal" (CalAIM) program through a five-year extension of the State's 1115 demonstration waiver and Medicaid managed care 1915(b) waiver. The CalAIM initiative is unique in relying on a combination of federal authorities through its 1115 waiver, 1915(b) waiver, and managed care contracts. Within this initiative, CMS allowed California to use ILOS, through their 1915(b) authority, to provide an expansive list of health-related services including medically tailored meals for individuals struggling with food insecurity or chronic health conditions. This approval was significant in its extensive interpretation of how ILOS could be used to address health needs. However, CMS set clear expectations for other states seeking ILOS including the need to demonstrate through concrete

evidence that ILOS will be cost-effective. States using ILOS must monitor cost-effectiveness and document that all services are medically appropriate.⁵⁰

In January 2023, CMS issued a State Medicaid Director Letter, SMD# 23-001, providing additional guidance on how states can leverage ILOS to address health-related social needs.⁵¹

While many states use ILOS to cover services not covered by their state plans, the guidance was significant in formally opening the door for states to use ILOS to address SDOH, such as food services and supports. Notably, the guidance states that ILOS can be preventative instead of immediate substitutes for standard Medicaid services. Additionally, the guidance provides financial guardrails, monitoring and evaluation requirements, enrollee protection, and oversight requirements. It is now required that states have actuaries establish annual projected costs of ILOS and states that CMS may not approve of any ILOS that are projected to have costs over 5% of managed care capitation.⁵² However, if the projected ILOS cost percentage is over 1.5%, states must provide descriptions of their processes to demonstrate that each ILOS is medically appropriate and cost effective. Some of these descriptions proving medical appropriateness and cost effectiveness of ILOS could be based on the results and evaluation of previous VAS or early adopted ILOS. Using ILOS allows managed care organizations to exercise preventative health-related services and supports that are both cost-effective and lead to better overall health outcomes for enrollees.





NEW YORK

Following the 2016 Medicaid managed care rule, New York clarified the ILOS services that would be approved by the state and offered through their MCOs. The state identified **medically tailored meals as an approved ILOS** with the following definition:

“Medically Tailored meals will be tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN) and designed to improve health outcomes, lower cost of care, and increase patient satisfaction. This is an alternative service in lieu of Personal Care Aide (PCA) service hours used for meal preparation and food shopping, or hospital inpatient stays and/or emergency department visits.”⁵³

The medically tailored meals in New York state are limited to 3 meals per day for a six-month period, with the ability to reauthorize based on member reassessment and need. Adult enrollees ages 18 and older and living with a severe illness are considered eligible for ILOS. All seven of New York state’s MCOs (Amida Care, Capital District Physicians’ Health Plan (CDPHP), Excellus, Healthplus Health Plan, Highmark, Independent Health, and MetroPlus Health Plan) offer medically tailored meals as an ILOS in collaboration and partnerships with organizations such as **God’s Love We Deliver, The Food Pantries for the Capital District, FeedMore of Western New York, and Mom’s Meals.**⁵⁴

Value-Based Payment (VBP) in MCO Contracts

As more Medicaid beneficiaries receive services under a managed care model, states are increasingly using MCO contracts as a vehicle to change how providers are paid for delivering these services. Historically, state Medicaid agencies have relied on MCOs to oversee value-based payment (VBP) arrangements with contracted providers as they step back from volume-driven fee-for-service (FFS) payments.⁵⁵ With increased attention on multi-payer alignment, specifically through the State Innovation Model Initiative, states are proactively leveraging MCO contracts to

accelerate adoption and progress.⁵⁶ More advanced VBP arrangements pay healthcare providers based on patient outcomes and the quality of care they deliver, not volume. VBP models aim to decrease cost, increase quality, and promote equity in care.⁵⁷ In addition to more traditional Medicaid regulatory and policy flexibilities, MCOs can also pay for SDOH screenings or referrals. As it relates to nutrition supports, states have begun to require VBP contracting goals for MCOs, tying financial incentives to these goals.

Other Medicaid-Specific Services and Programs

In addition to VAS and ILOS, some states offer added services and have additional programs in place for their entire Medicaid population. State Medicaid agencies, managed care organizations, and community-based organizations have development strategies to provide a spectrum of nutrition interventions to Medicaid enrollees both within managed care and outside of managed care. These can include the following:



Nutrition education: such as Medical Nutrition Therapy (MNT)



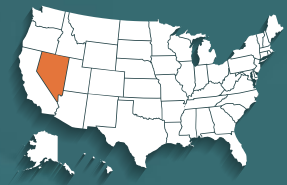
Food assistance models: models where the state (or MCO) pays for food items for Medicaid beneficiaries. These can include home-delivered meals, fruit and vegetable prescriptions, and medically tailored meals/food as medicine.



Screenings and referrals: identification of enrollees experiencing food insecurity and referral to SNAP, TANF, and/or other social services.



Investment and development of expanded infrastructure: states, community-based organizations, and healthcare providers can fund the development of food infrastructure, such as food banks, farmers markets, food retailers, etc., needed to increase food access in the community, ultimately leading to better health outcomes for these populations.



NEVADA

Nevada provides **Medical Nutrition Therapy (MNT)** to all Medicaid enrollees. MNT is defined as, “Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian nutritionist (RDN) or other nutrition professional” and is a specific application of the nutrition care process in clinical settings. MNT is focused on the **management of diseases and involves in-depth nutrition assessment** and individualized duration and frequency of care.⁵⁸

Community-Based Organizations and Other Partnerships

Medicaid programs are increasingly focused on addressing the SDOH needs of beneficiaries, such as food insecurity. An integral first step in establishing nutrition supports and combatting food insecurity is the identification of program partners.⁵⁹ Partnerships between community-based organizations (CBOs), managed care organizations, public/private sector organizations, and other collaborations offer an additional pathway to these needs in the Medicaid population. By working with external partners, additional and critical resources can be provided to launch, evaluate, and expand access to nutrition supports and interventions for Medicaid beneficiaries. There are five key factors that will provide resources needed to allow these partnerships to successfully work and likely result in best outcomes for enrollees. These can include the following:

1

Initial funding may be time-limited through a grant or pilot program, but these relationships can also help safeguard sustainable funding to maintain and even expand programs after their initial grant or pilot period.

2

Use of policy levers, such as value-based contracts, managed care regulations and contracts, and state plan amendments (SPAs).

3

External organizations can help provide input as it relates to metrics and other key performance indicators for evaluation of the program or service.

4

Provision of incentives to providers to address SDOH and connect beneficiaries with additional resources both internally and externally.

5

External partner organizations may know more about what issues communities are facing and can provide integral information and data that best exemplifies what needs should be met and in what order.⁶⁰

As it relates to nutrition supports specifically, partnerships for consideration would be organizations that can provide the nutrition support services (e.g., home-delivered meals provider), organizations that can refer beneficiaries to the program (e.g., MCOs, federally qualified health clinics (FQHCs), and/or social services organizations), and an organization(s) that can assist with funding the program (e.g., charity/foundation, individual benefactor, or MCO).

Discussion



For the past 84 years, throughout wars, depressions, recessions, and a pandemic, the federal government has recognized the continued need for food and food assistance programs and innovated to meet those needs. Programs like SNAP, legislation such as the Farm Bills, and the National School Breakfast and Lunch Programs have been developed and implemented in order to serve the country's most vulnerable populations when it comes to food supports. These programs and bills have been crucial in addressing access to food. However, these programs exist outside of the healthcare system and therefore can struggle to address both health preventative measures and a whole-person care approach. Additionally, as federal programs, they are subject to bipartisan political debate and discussion, as seen with SNAP during the recent debt ceiling negotiations. Medicaid has the potential to fill these gaps in food programming and services while being cost-effective and taking a preventative approach by addressing beneficiaries' social determinants of health.

The COVID-19 pandemic increased levels of food insecurity and exacerbated the inability to access nutrition supports across the country. As a result, the Biden Administration took a strong stance on both food insecurity and nutrition supports by focusing in on food as medicine, a non-traditional and preventative approach. As previously discussed, food as medicine is not a new approach in other countries, but as a new governmental tactic in the United States, there is the question of how to scale or measure this intervention within the healthcare space. Food as medicine interventions are typically funded through the government, healthcare payers and providers, and/or charitable donations. These interventions incorporate food strategies to prevent health issues and/or improve enrollee's overall health status in the structure and funding of the healthcare system, rather than in traditional ways like treatment after the fact.

Regardless, the program has opened the door for new flexibilities, as seen in CMS' approval of recent 1115 demonstration waivers and 1915(b) waiver approvals that incorporate food as medicine through services such as meal delivery, nutrition counseling, food prescriptions, and more. Today, more and more states seek CMS approval for pilots that incorporate food services and supports. If these pilots prove to be successful in reducing food insecurity and improving health outcomes, there is the potential these services could become more widely available through Medicaid on a national level.

Implementing food and nutrition supports through Medicaid managed care has significant benefits but does not exist without challenges. Some barriers include the fact that MCO programs are designed for specific populations (e.g., postpartum or disease-based), have time limits for providing benefits (e.g., 2-3 weeks post-discharge from hospital), struggle to create partnerships with local organizations, and have not created qualitative measures to analyze outcomes. Value-added services are optional to each MCO, and therefore have potential to not be statewide or available to all Medicaid enrollees. However, value-added services create opportunities for MCOs to set themselves apart and improve quality measures and outcomes. ILOS must be medically appropriate and cost-effective, and recent CMS guidance has imposed stricter financial guardrails on these services in addition to monitoring, evaluation, and oversight. However, MCOs leveraging ILOS allows them to address root causes of disease by providing specific preventative tools and services. Even with their challenges, each of these unique Medicaid flexibilities are ways that Medicaid managed care can address both food insecurity and nutrition supports for beneficiaries.

Conclusion

Despite challenges faced by the federal government, states, Medicaid agencies, managed care organizations, and the community-based organizations they partner with, the goal to eradicate food insecurity and provide nutrition services and supports remains the same. No singular program will be able to achieve this complex and ever-increasing goal. Therefore, there is a need for support from all levels including federal, state, and local, to work together and fill gaps to address food insecurity and nutrition supports and services from all sides. This can help further prevent and manage chronic disease and improve health outcomes.

Appendix

50-State Scan of Nutrition Support Approaches

Only 1115 waivers, VAS, and ILOS that include nutrition-specific supports are included in this table. If marked with an X, the state/at least one MCO provides nutrition supports in that category. If marked with a dash, the state/at least one MCO does not.

State	Managed Care (Yes/No)	1115 Waiver	Value-Added Services (VAS)	In-Lieu of Services (ILOS)
Alabama	No	-	-	-
Alaska	No	-	-	-
Arizona	Yes	X	X	-
Arkansas	No	X	-	-
California	Yes	X	-	X
Colorado	Yes	-	-	-
Connecticut	No	-	-	-
D.C.	Yes	-	-	-
Delaware	Yes	-	X	-
Florida	Yes	-	X	-
Georgia	Yes	-	X	-
Hawaii	Yes	X	X	-
Idaho	No	-	-	-
Illinois	Yes	X	X	-
Indiana	Yes	X	X	-
Iowa	Yes	X	X	-
Kansas	Yes	-	X	-
Kentucky	Yes	-	X	-
Louisiana	Yes	-	X	-
Maine	No	-	-	-
Maryland	Yes	-	X	-
Massachusetts	Yes	X	X	-
Michigan	Yes	-	X	-
Minnesota	Yes	-	X	-
Mississippi	Yes	-	X	-
Missouri	Yes	-	X	-
Montana	No	-	-	-
Nebraska	Yes	-	X	-
Nevada	Yes	-	X	-

50-State Scan of Nutrition Support Approaches (continued)

State	Managed Care (Yes/No)	1115 Waiver	Value-Added Services (VAS)	In-Lieu of Services (ILOS)
New Hampshire	Yes	-	X	X
New Jersey	Yes	X	X	-
New Mexico	Yes	X* pending request	X	-
New York	Yes	X* pending request	X	X
North Carolina	Yes	X	X	-
North Dakota	Yes	-	-	-
Ohio	Yes	-	X	-
Oklahoma	Yes	-	-	-
Oregon	Yes	X	-	-
Pennsylvania	Yes	-	X	-
Rhode Island	Yes	X	X	-
South Carolina	Yes	-	X	-
South Dakota	No	-	-	-
Tennessee	Yes	X	X	-
Texas	Yes	X	X	-
Utah	Yes	X	-	-
Vermont	No	X	-	-
Virginia	Yes	X* pending request	X	-
Washington	Yes	X	X	-
West Virginia	Yes	-	X	-
Wisconsin	Yes	-	X	X
Wyoming	No	-	-	-

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