

# Expanding the Menu: Opportunities for Medicaid to Better Address Food Insecurity

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## KEY TAKEAWAYS

- Food insecurity is on the rise across the U.S., and low-income, marginalized communities are most at risk.
- The federal government is calling on Medicaid agencies to play a role in addressing individuals' health-related social needs, including food insecurity, in addition to continuing to leverage existing federal food support programs, like the Supplemental Nutrition Assistance Program.
- State Medicaid agencies require sustainable financing mechanisms and a coordinated approach across relevant stakeholders to identify individuals who are food insecure and connect them to appropriate food programs and culturally relevant interventions.
- This brief explores Medicaid policy levers to address food insecurity, which is critical to improve health outcomes and advance health equity.

**F**ood insecurity, a leading contributor to illness, death, health inequity, and health care costs, is on the rise in the U.S.<sup>1,2</sup> This comes amid the unwinding of the COVID-19 public health emergency, which afforded families extra food benefits through the Supplemental Nutrition Assistance Program (SNAP) and eliminated the burden of re-enrolling in Medicaid.<sup>3</sup> The end of these provisions, as well as the persistent high inflation rate around the country, are leading individuals to make difficult choices between food and addressing other needs, like housing and health care.<sup>4</sup>

The federal government is increasingly calling on Medicaid agencies to play a role in addressing the health-related social needs (HRSN) of individuals served by Medicaid, including food insecurity, in addition to continuing to leverage existing federal food support programs, like SNAP.<sup>5,6</sup> There is also growing momentum across health care and food security stakeholders to mobilize Medicaid programs to become key partners in addressing food insecurity.<sup>7</sup> These efforts align with the White House's *National Strategy on Hunger, Nutrition, and Health*, which set the bold goal of ending hunger in America by 2030.<sup>8</sup>



Despite aligned strategic goals across Medicaid and SNAP, misalignment across program focus areas, eligibility thresholds, and administrating agencies at the state and county levels has led to siloed food systems and supports, and gaps in services provided.<sup>9</sup> In addition, these complex systems often fail to center the member experience, making it difficult for those eligible to navigate.<sup>10</sup>

This brief is a product of the [Improving Data Coordination Between SNAP and Medicaid](#) project, led in partnership by the Center for Health Care Strategies (CHCS) and Benefits Data Trust (BDT) with support from the Robert Wood Johnson Foundation. It outlines strategies for state Medicaid agencies to help people experiencing food insecurity obtain continuous access to nourishing food, which is critical to improve health outcomes and advance health equity.

## Key Terms

Shared language is important for working together in addressing Medicaid enrollees' social needs.

- **[Social Determinants/Drivers of Health \(SDOH\)](#)** are the conditions in which people are born, grow, work, live, and age and are shaped by a wider set of forces and systems including the distribution of money, power, resources. These condition(s) influence individuals' choices around living and working to maintain good health and well-being, for better or worse.
- **[Social Risk Factors](#)** are adverse social conditions associated with poor health, such as homelessness, housing insecurity/instability, food insecurity, financial insecurity, and lack of transportation. Social risk factors are identified at the individual level. Many screening tools are available to identify social risk factors; examples include [PRAPARE](#) and [health risk assessments](#).
- **[Health-Related Social Needs \(HRSN\)](#)** are social risk factors that individuals identify as their priorities for receiving assistance to maintain health and well-being.

# Four Key Opportunities to Address Food Insecurity for Medicaid Beneficiaries

This brief outlines four opportunities for state Medicaid agencies to use existing policy levers to address food insecurity more effectively, including: (1) covering HRSN services; (2) encouraging investments in food security infrastructure; (3) incorporating an equity lens in social risk factor screening and referrals; and (4) streamlining state and federal program benefits and enrollment.

## 1. Covering Health-Related Social Needs

The Centers for Medicare & Medicaid Services (CMS) encouraged states to address HRSN, including food insecurity, in its 2021 State Health Official (SHO) Letter about addressing SDOH, which outlined federal authorities and other opportunities state Medicaid agencies can leverage in these efforts.<sup>11,12</sup> In November 2023, CMS released a framework outlining 15 distinct HRSN services and supports that are allowable under Medicaid and Children’s Health Insurance Program (CHIP) authorities, demonstrating a continued commitment from the federal government to help states advance HRSN activities.<sup>13</sup> Listed services include:



- **Case management services for access to food/nutrition**, including outreach and education and linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.
- **Nutrition counseling and instruction**, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including guidance on selecting healthy food and healthy meal preparation.
- **Home-delivered meals or pantry stocking**, tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals, including, for example, medically tailored meals to high-risk expectant individuals at risk of or diagnosed with diabetes.
- **Nutrition prescriptions**, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including fruit and vegetable prescriptions, protein boxes, food pharmacies, and healthy food vouchers.
- **Grocery provisions**, for high-risk individuals to avoid unnecessary acute care admission or institutionalization.

The following section describes five opportunities states can use to create sustainable financing approaches to address food insecurity: (a) Section 1115 demonstration flexibilities; (b) *in lieu of services* and settings (ILOS) in Medicaid managed care; (c) home- and community-based services (HCBS); (d) community health worker (CHW) state plan amendments (SPA); and (e) CHIP health services initiatives (HSIs).<sup>14</sup>

### Section 1115 Demonstration Flexibilities

In December 2022, CMS announced that states can use Section 1115 demonstration authority to cover nutrition supports and HRSN case management, among other services, as reimbursable benefits under Medicaid for certain populations, as defined by the state.<sup>15</sup>

Nutrition supports may include the services listed on the previous page, including nutrition counseling and education; medically tailored meals; meals or pantry stocking for children under 21 or pregnant people, including two months postpartum; fruit and vegetable prescriptions; and protein boxes.<sup>16,17</sup> Case management services may include outreach to Medicaid enrollees and linkages to other state and federal benefit programs, like SNAP, including benefit program application assistance and benefit program application fees.<sup>18</sup>

States can use Section 1115 demonstrations to offer nutrition supports to more Medicaid members, beyond those traditionally served by HCBS programs, and waive laws limiting the extent to which Medicaid can pay for “room and board.” For example, states can provide a full three meals a day or grocery provisions at 200 percent of the maximum monthly SNAP allowance (“board”), for up to six months, and renew that intervention for additional six-month periods, if needed.<sup>19</sup> The state can also use Section 1115 authority to provide additional support for not only the Medicaid member, but the household of a child or pregnant person. In exchange for the flexibility provided under Section 1115 demonstrations, states must fulfill mandatory implementation, monitoring, evaluation, and reporting requirements to CMS.<sup>20</sup>

### CMS Matrix: Coverage of Allowable HRSN Services in Medicaid and CHIP

The [CMS coverage framework](#) clearly outlines what nutrition services can be covered under ILOS, Section 1115 demonstrations, CHIP HSIs, and several waiver and state plan HCBS authorities. This matrix can inform states interested in exploring vehicles for federal approval of nutrition supports services covered by Medicaid, and not only Section 1115 demonstrations.

### Promising Practice: Feeding the Household

Under [Massachusetts’](#) Section 1115 demonstration, medically tailored meals may be provided to the whole household, not only the Medicaid member eligible for the service — acknowledging that a food insecure parent will often give their nutrition supports to a hungry child, rather than feed themselves.

## In Lieu of Services and Settings in Medicaid Managed Care

In January 2023, CMS released guidance for state Medicaid agencies on the use of ILOS to meet the HRSN of Medicaid enrollees.<sup>21</sup> ILOS are substitutes for traditional state-plan covered services or settings provided at the option of health plans and deemed medically appropriate, cost-effective, and immediate or long term. In contrast to more traditionally used value-added services, costs relating to ILOS can be factored into managed care rate setting, which creates a sustainable pathway for managed care organizations (MCOs) to offer these services long term.<sup>22</sup> In CMS' guidance, medically tailored meals are included as an example of an ILOS that helps to facilitate greater access to care and improve health outcomes.<sup>23</sup> As noted in CMS' November 2023 guidance, states can also provide a wide array of nutrition supports using ILOS authority, but those supports must be equivalent to less than three meals a day.<sup>24</sup>

### Promising Practice: Pre-Approving ILOS

To encourage health plan adoption of ILOS, some states pre-approve a list of potential ILOS. Both [California](#) and [New York](#) include medically tailored meals as a pre-approved ILOS for managed care plans in their states.

## Home- and Community-Based Services

HCBS programs support community integration for eligible individuals, often as an alternative to institutional care. States have traditionally provided home-delivered meals as a part of HCBS programs, and CMS' November 2023 guidance clarified that less commonly used state-requested services, like groceries, nutrition prescriptions, and pantry stocking, can be provided under HCBS programs as well.<sup>25</sup>

Different HCBS authorities have different functional eligibility requirements. For example, 1915(k) Community First Choice programs and 1915(c) waivers require individuals to meet an "institutional level of care" (e.g., eligibility criteria for care in a nursing facility). Section 1915(i) state plan HCBS requires individuals to meet state-defined needs-based criteria; examples include people with behavioral health conditions or people with a certain disease or condition, such as Acquired Immune Deficiency Syndrome (AIDS).<sup>26</sup>

## Community Health Worker State Plan Amendments

States can also reimburse for CHW services under Medicaid.<sup>27</sup> States can make CHW services a formal Medicaid benefit, available statewide, using a SPA.<sup>28</sup>

States with existing and proposed CHW SPAs generally include three service categories: health education, health promotion and coaching, and care coordination or resource referral for HSRNs, including food insecurity.<sup>29</sup>

## CHIP Health Services Initiatives

CHIP HSIs can be used to cover programs aimed at improving the health of children in families with low-income, under their CHIP 10 percent administrative cap. States have used CHIP HSIs to provide nutrition counseling to children in families with low-income but other nutrition supports may be “potentially approvable,” as noted in CMS’ November 2023 guidance.

## 2. Encouraging Investments in Food Security Infrastructure

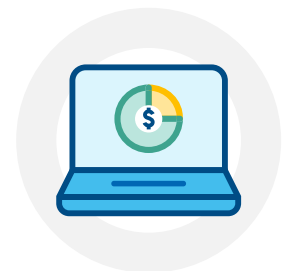
To build the HRSN service delivery infrastructure, CMS’ new 1115 demonstration HRSN policy framework grants states federal authority and funding to cover HRSN infrastructure-building activities.<sup>30</sup> For example, Washington State, under its Section 1115 demonstration approval, can spend up to \$1.5 billion on HRSN services and an *additional* \$270 million to fund HRSN infrastructure-building activities.<sup>31</sup> Covered infrastructure-building activities may include:

- Funding systems upgrades across health and social care providers to address data interoperability challenges;
- Expanding health care organizations (HCO) referral networks of relevant social care providers in communities;
- Developing business or operational practices; and
- Increasing health care staffing.<sup>32</sup>

Another avenue to encourage infrastructure investments, particularly at the community level, beyond the Section 1115 demonstration, is through community reinvestment requirements for MCOs. Also outlined in CMS’ 2021 SHO Letter, this allows states to direct MCOs to reinvest a portion of profits, reserves, or after-tax

### Promising Practice: Leveraging CHWs to Cover Nutrition Services

[Nevada’s](#) CHW SPA covers nutrition-related education in its list of covered services.



### Promising Practice: Requiring MCOs to Invest in Local, Culturally Relevant Interventions

[Arizona’s](#) Medicaid program includes a community-reinvestment provision for its MCOs, which requires plans to spend six percent of annual profits on community-based services. Plans must regularly obtain community input on local and regional needs to ensure services offered are culturally appropriate. Food security-related activities may include non-medical transportation services to increase access to healthy food and food banks.

underwriting margin into local communities, often with an explicit focus on resources to address SDOH.<sup>33,34</sup> Examples of community re-investments targeting food insecurity include building or investing in community gardens, farmers markets, community supported agriculture, farm-to-institution programs, or grocery stores in food deserts.<sup>35</sup>

### 3. Incorporating an Equity Lens in Social Risk Factor Screening and Referrals

To better coordinate across medical and social care to address food insecurity, many states require health care provider organizations to screen patients for social risk factors and make referrals to appropriate community-based services.<sup>36</sup> The following section outlines how Medicaid agencies can explicitly center equity in these activities.



#### Equitable Social Risk Factor Screening

Starting in 2024, more providers and health plans will screen for social risk factors in response to new CMS requirements and quality measures.<sup>37</sup> These screening processes may be new to some providers, or an extension of common food insecurity screenings already integrated into the delivery of care in response to state or health system initiatives. For example, many providers, especially pediatric practices, use the Hunger Vital Sign, a two-question food insecurity screening tool recommended for providers to identify households at risk for food insecurity.<sup>38</sup> The Texas Incentives for Physicians and Professional Services payment program includes a food insecurity screening measure that captures uptake of the Hunger Vital Sign tool.<sup>39</sup>

Underlying factors, like structural racism, influence communities' access to healthful foods and resources to alleviate hunger and produce health inequities. Social risk factor screening helps providers identify and address individual-level HRSN borne from these community-level drivers. Nonetheless, screening practices themselves can either build or harm trust.<sup>40</sup> A recent study showed that Black patients are twice as likely to be screened for social needs compared to white patients, but about 90 percent less likely to report a need.<sup>41</sup> Health care system and government agencies may not have earned the trust of patients who experience racism, who may also report discomfort self-reporting or identifying sensitive needs. State Medicaid agencies and their partners can take steps to ensure screening practices promote health equity and do not perpetuate inequities. For example, Oregon's social

#### Promising Practice: Developing a Patient-Centered Strategy to Address Social Needs

To ensure mandatory screening for HRSN does not cause further harm to historically marginalized communities, work must be done in communities to frame social risk factor screening in a way that increases patient comfort and acceptability. While it sounds simple, providers must [ask patients](#) if they want assistance before making referrals to related resources.

risk factor screening measure includes process elements to ensure that screening and referral are implemented in an equitable and trauma-informed manner, and done in partnership with culturally-specific community-based organizations (CBOs).<sup>42</sup>

### Equitable Health-Related Social Needs Referrals and Partnerships

An increase in social risk factor screening may result in the detection of more food-insecure households, leading to an influx of referrals from HCOs to CBOs, like food banks, in addition to SNAP.<sup>43</sup> Community food banks are uniquely positioned to provide food and groceries, as well as become trusted partners for health care providers by offering health promotion activities.<sup>44</sup> Food bank-based activities to improve health may include offering evidence-based nutrition education programs, providing medically tailored meals, and helping clients navigate enrollment with other community resources and public benefit programs.<sup>45</sup>

While integrating CBOs into the traditional health care landscape is becoming increasingly common, there are often power imbalances and cultural differences between CBOs and HCOs, which can undermine CBOs' abilities to provide needed services. To mitigate this power imbalance and ensure CBOs are able to do their work effectively, states can consider ways to strengthen and support CBO-HCO partnerships.<sup>46</sup> Factors contributing to success include: mutual understanding, agreement on populations served and metrics for success, viable operational and financial agreements for both partners, and glide paths for CBOs.<sup>47,48</sup> HCOs should also seek to partner with existing CBOs that have established ties in the communities they serve, ensuring care is locally focused, culturally congruent, and community centered. In addition, the CBO Networks model can be used to help bridge the gap between HCOs and CBO services.<sup>49</sup>

#### Promising Practice: Developing a State-Based System to Close the Loop When Addressing Social Needs

North Carolina, through its Healthy Opportunities Pilots program, incorporates [standardized screening questions](#) within its Medicaid managed care program to identify patients with unmet HRSN, including food insecurity. To assist in connecting individuals with identified needs to community resources, the state developed a statewide coordinated care network ([NCCARE360](#)) and partnered with [Network Leads](#) to help coordinate a network of CBOs. Network Leads, care managers, and health plans, with help of the NCCARE360 platform, can connect patients to nutrition supports, [including](#) healthy food delivery services that offer patients fresh produce, grains, and meat on a weekly basis.



## 4. Streamlining State and Federal Program Benefit and Enrollment

While Medicaid has many levers to address food insecurity, state Medicaid agencies should work to align with federal food support programs, like SNAP.<sup>50</sup> Improving coordination and application processes across Medicaid and SNAP can make enrollment easier and more efficient for applicants, eligibility staff, and program administrators. This reduces the administrative burden of maintaining benefits, increases food access, and significantly improves health.<sup>51</sup>

Investment in coordinating these programs can better center the member experience and reduce inefficiencies for both clients and state staff. States, including Colorado, North Carolina, and South Dakota, are deploying novel strategies to advance cross-program data coordination efforts.<sup>52</sup> These involve innovations like streamlined enrollment technology, joint program application, and document management systems. Enrollment policy options are useful to consider as well, including the ex parte review of applications, which is the attempt to redetermine program eligibility based on reliable information available to a state agency without requiring information from the individual. In addition, some states are working with external partners to improve outreach to potential enrollees. For example, Washington State is working with BDT to create a 20-minute application for residents to apply to eligible public benefit programs, decreasing the application from the current 65 minutes.<sup>53</sup>



### Promising Practice: Leveraging Public-Private Partnerships to Address Food Insecurity

States can leverage [existing public-private partnerships](#) that help address food insecurity in communities. For example, SNAP enrollees can get discounted memberships and home-delivered groceries through common services like Amazon Prime, Walmart+, and Instacart. Food banks and food pantries have also used technology platforms, like DoorDash, to get food and meals to their clients. These services allow people to shop SNAP-eligible groceries online and have them delivered to the home, which can help individuals with mobility and transportation issues as well as childcare challenges.

## Looking Forward

Food insecurity is a significant issue across the U.S., but there are clear opportunities for Medicaid agencies to support access to nutritional food for enrollees. Better coordination across Medicaid and relevant programs and stakeholders can create a system that identifies individuals who are food insecure, connects them to appropriate food programs and culturally relevant interventions, and supports those interventions through sustainable financing mechanisms. As states continue to navigate the end of the COVID-19 public health emergency and related rise in food insecurity, there is an imperative to better coordinate and bolster existing opportunities across Medicaid and federal food support programs, supporting a multi-sector approach to end hunger.



## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit [www.chcs.org](http://www.chcs.org).

## ABOUT BENEFITS DATA TRUST

Benefits Data Trust (BDT) improves health and financial security by harnessing the power of data, technology, and policy to provide dignified and equitable access to assistance. Together with a national network of government agencies and partners, we efficiently connect people today to programs that pay for food, healthcare, and more while helping to modernize benefits access for tomorrow. Learn more at [bdtrust.org](http://bdtrust.org).

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