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Center for Health Care Strategies

Food for Thought: Medicaid Nutrition Benefit Design Approaches for Equitable Implementation

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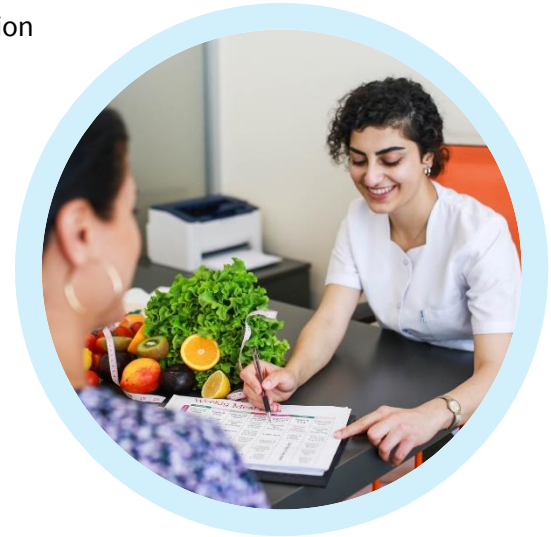
KEY TAKEAWAYS

- The diverse nutrition needs of the Medicaid population, which are closely linked to clinical outcomes, challenge state agencies to create nutrition interventions that fit their priorities, budgets, and resources.
- Taking a whole-person approach to assessing Medicaid member needs and centering member experience can help states create effective, culturally responsive nutrition-related programs.
- This brief outlines approaches Medicaid policymakers can take when implementing or evolving their nutrition strategies to best fit a range of state priorities and budgets based on insights and examples from state participants in the *Medicaid Health-Related Social Needs Implementation Learning Series*.

State Medicaid agencies are increasingly seeking to address Medicaid members' health-related social needs (HRSN). In November 2023, the Centers for Medicare & Medicaid Services (CMS) released state guidance explicitly outlining allowable HRSN interventions under Medicaid and CHIP authorities (i.e., In Lieu of Services (ILOS)), Home- and Community-Based Services (HCBS), and 1115 waivers). This guidance pre-approves certain interventions related to nutrition and housing. CMS allowable nutrition supports include:

- Case management for access to food/nutrition;
- Nutrition counseling and instruction;
- Home-delivered meals or pantry stocking tailored to health risk and eligibility category;
- Nutrition prescriptions tailored to health risk or nutrition-sensitive health conditions; and
- Grocery provisions.



Made possible through support from the Kaiser Permanente National Community Benefit Fund at The East Bay Community Foundation.

Data show nutrition insecurity is the most common social need among Medicaid members. In addition, Medicaid-based nutrition supports have been well received. Early implementation data from states like California and North Carolina show that nutrition-related services have a higher utilization than other HRSN services offered, demonstrating a need from providers and enrollees for these services.

However, adoption of these benefits is still nascent, and policymakers are grappling with policy design and implementation challenges. These include:

- Defining eligibility and benefit within budgetary and program parameters given the prevalence and diversity of food-related needs; and
- Designing a system for the delivery of nutrition services that supports high-quality choices and dignity while being scalable and efficient.

This brief, developed by the Center for Health Care Strategies (CHCS) in partnership with HealthBegins, offers three approaches for Medicaid policymakers to implement or evolve their HRSN nutrition strategy: (1) refine CMS-defined interventions to better meet Medicaid member needs; (2) ensure interventions are culturally appropriate and center the Medicaid member experience; and (3) define and standardize intervention eligibility to maximize impact and decrease burden. These approaches are based on insights from nine states participating in the *Medicaid Health-Related Social Needs Implementation Learning Series*, made possible through support from Kaiser Permanente through its National Community Benefit Fund at the East Bay Community Foundation.

Medicaid Approaches to Guide Equitable Nutrition Benefit Design

1. Refine CMS-defined nutrition interventions to better meet Medicaid member needs

Our understanding of nutrition insecurity and its impact on health has evolved significantly in recent years, moving beyond a simple "enough-or-not-enough" view to recognizing a full range of food and nutrition needs. Based on Satter's Hierarchy of Food Needs, food needs can range from *enough* food to *instrumental* food. Allowable nutrition interventions under CMS guidance can be used to span the range of Medicaid-enrollee food needs:

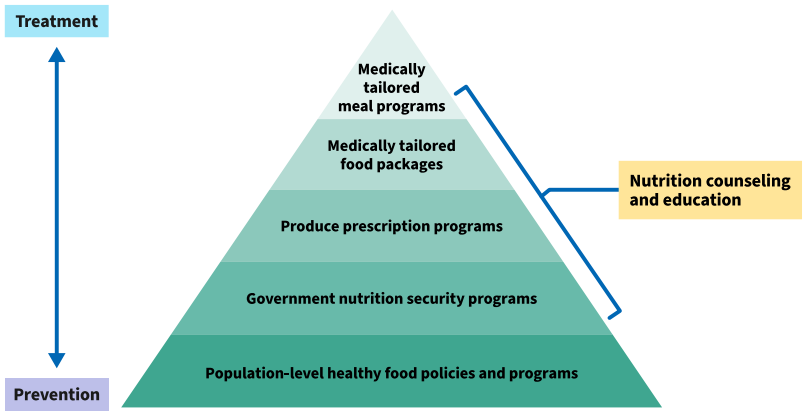
Satter's Levels of Food Need	How Federal Nutrition Supports Can Help
Enough Food *Food security*	The combination of case management to access other federal and state food supports and direct food investments (e.g., adding money directly to individuals' electronic benefit transfer cards) may close the gap on food quantity.
Acceptable Food *Nutrition security*	Medically tailored meals and pantry stocking combined with nutrition counseling and instruction may increase access to acceptable food.
Reliable Ongoing Access to Food *Sense of psychological safety around consistent access to food*	Enhancements like transportation (described below) may help enrollees overcome barriers to reliable access to food.
Good Tasting Food *Access to preferred food*	Grocery provisions may increase access to foods that satisfy enrollees' taste preferences.
Novel Food *Ability to experiment with new foods, especially critical for children and youth and exposure to healthy food items*	Nutrition prescriptions may allow enrollees to try new healthy foods without risk.
Instrumental Food *Ability to have traditional food for a particular holiday or food that is believed to have positive health effects. Ideal for "physical, cognitive, or spiritual outcomes"*	The extra resources for households may allow them to purchase foods that are important socially, culturally, or spiritually.

State participants in the learning series are exploring interventions to meet the full range of member needs, including:

- **Services for the entire household:** While health care interventions are typically specific to an individual, food is often a pooled family resource. For example, a food-insecure parent receiving a food box may share food intended for them with their children. As part of its approved 1115 waiver, Massachusetts' Flexible Services Program 2020-2024 (FSP) currently provides meals "at the household level" in cases where the eligible member is a high-risk child or pregnant individual. Pennsylvania's proposed 1115 waiver includes grocery delivery and food boxes for pregnant and postpartum Medicaid enrollees and their households.
- **Transportation:** Transportation can be a barrier for Medicaid enrollees to access covered food benefits. While many services include a home delivery option, some states are also adding transportation. Authorized by its approved 1115 waiver, New York Medicaid's nutrition supports include "private and public transportation to covered HRSN services and care management activities, including to farmer's markets and mobile markets." Currently, Massachusetts' FSP includes "assisting or providing the member with transportation to any of the (nutrition sustaining support) services or to support the member's ability to meet nutritional and dietary needs," such as transportation to the grocery store. North Carolina's Healthy Opportunities program allows members to access public or private health-related transportation through vouchers for public transportation, or ridesharing credits.
- **Food-related supplies or appliances:** Massachusetts (under the current FSP) and New York also include food-related supplies or appliances necessary to the Medicaid member to meet dietary needs. This could include kitchen cleaning and sanitation supplies, pots and pans, utensils, a microwave, or a refrigerator.
- **Packaging and combining Medicaid services:** Some Medicaid agencies are considering the relationship between interventions. California noted that many enrollees receiving nutrition assistance also receive Enhanced Care Management. Rather than considering care management as an independent service, they recognize it can also be an important strategy to ensure successful connection to other nutrition supports.

- **Coordinating with other federal food support programs:** States also recognize the need to better coordinate with existing federal food support programs. The Food is Medicine Pyramid (**Exhibit 1**) is a useful framework to show how nutrition services offered through Medicaid can supplement federal food support programs like the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) (at the bottom of the pyramid), rather than duplicate, to best meet the broad range of individuals' food-related needs.

Exhibit 1. Food is Medicine Pyramid



Adapted from *A Food is Medicine approach to achieve nutrition security and improve health*, https://pubmed.ncbi.nlm.nih.gov/36202998/

In addition to refining service offerings, states are grappling with how temporary interventions can have sustainable impacts. Medicaid members may have fluctuating clinical needs for tailored nutrition, economic security, and access to alternative nutrition supports, all of which make determining an appropriate, yet time-limited, duration challenging. In some cases, states are proposing different durations than conveyed in CMS guidance, which recommends up to six months with up to one additional six-month period for 1115 waiver-authorized nutrition supports. New York's waiver allows high-risk pregnant individuals to receive services for 11 months, not to exceed two months postpartum. Pennsylvania's proposed waiver includes similar language. Longer durations of interventions are supported by North Carolina's evaluation of its Healthy Opportunities Pilot, which found that a longer duration resulted in better health outcomes and that arbitrarily ending services at six months may not have the desired effect.

Additional Work Needed

For individuals or families who experience economic insecurity due to a life event such as a job loss or medical event, short-term nutrition supports may completely meet their needs or the gap between them and other food supports. However, for Medicaid enrollees who are experiencing generational poverty and have had long periods of food insecurity, more work may be needed to ensure that these temporary supports have sustainable and positive outcomes. Coordination with federal food support programs like SNAP and WIC is key to increasing food access and improving health.

2. Ensure nutrition interventions are culturally appropriate and center the Medicaid member experience.

A state participant in the learning series eloquently noted that the hope is for nutrition services to "center dignity and joy while minimizing stigma and shame." Many states see their HRSN interventions as critical to their larger health equity initiatives. To ensure nutrition benefits effectively minimize health disparities and improve health equity, states must design high-quality, dignity-centered, choice-driven, and culturally appropriate services.

Food Quality

Core to centering dignity and choice is ensuring that the food financed by Medicaid is high quality. This means it is fresh, tastes good to the member, and meets nutritional standards. To define and monitor food quality, states in the learning series have identified a few strategies:

- **Solicit ongoing member feedback**: Recipients of nutrition supports through the Healthy Opportunities Pilots in North Carolina are sent anonymous surveys to provide feedback on the food provided.
- **Ensure local storage is close to delivery**: States well into implementation recommended that nutrition service providers be required to partner with local producers and growers so food does not have to travel far to consumers.
- **Clear standards for nutritional quality**: North Carolina's Healthy Opportunities program requires fruit and vegetable prescription services to be "WIC-eligible," meaning they meet certain nutritional requirements. Michigan's recently released final ILOS policy guidance requires that:
    - Medically Tailored Home Delivered Meals meet the Food Is Medicine medically tailored meal nutritional guidelines;
    - Healthy Home-Delivered Meals meet one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences (except where inappropriate given an enrollee's nutrition-sensitive condition) and national nutrition-related guidelines such as the Dietary Guidelines for Americans;
    - Healthy Food Packs do not contain ultra-processed foods or foods with excessive sugar or salt; and
    - Produce Prescriptions are used for foods that align with "WIC-eligible fruits and vegetables, Gus Schumacher Nutrition Incentive Program-eligible fruits and vegetables and Double Up Food Bucks Michigan-eligible foods."

Food Choice and Cultural Appropriateness

Unlike other health care interventions, food has a unique relationship with culture and personal identity. Creating a nutrition services program that is culturally appropriate requires supporting member choice and local control:

- **Choice**: States report that members prefer nutrition supports where they can select their own food (rather than pre-prepared meals). This is being accomplished in several ways including providing members with vouchers (sometimes called prescriptions) to grocery stores and supporting a grocery-like experience at food banks. In North Carolina's service definitions, the healthy food box states that it should be furnished "using a client choice model."
- **Local control**: Medicaid agencies are working to build strategies into their programs to ensure that local nutrition service providers, especially those with specialized skills or expertise, are included. CalAIM's Policy Guide for their ILOS Nutrition Services "prompts [managed care plans] to work and contract with a new set of non-traditional providers that offer services and supports that historically have not been well integrated into the health care system including organizations that have experience delivering Community Supports services and an existing footprint in the communities they serve." Similarly, Michigan's ILOS final policy guide requires that 30 percent of ILOS providers be locally based. For Native American populations, Washington State's Native Hub will offer patients and providers a statewide network of culturally appropriate community-based food and nutrition services.

Additional Work Needed

While allowing choice and local control may appear straightforward, they both present implementation and budgetary challenges. A grocery model in a food bank is more expensive to administer than a prepackaged box. Similarly, organizations with a smaller scale may have higher per-unit pricing than national or regional organizations. States can consider developing a glide pathway to ensure local organizations can scale and sustain services as they enter the health care space.

3. Define and standardize nutrition intervention eligibility to maximize impact and decrease burden.

The CMS guidance on defining HRSN services for specific Medicaid populations states that "interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors." For nutrition, this guidance does little to narrow the population. Clinically speaking, overwhelming data shows a compelling link between food insecurity and a wide range of health outcomes, including oral health, behavioral health, chronic conditions (including diabetes), anemia, and limitations in activities in daily living in seniors. Social risk for nutrition needs can similarly be defined broadly. The U.S. Department of Agriculture defines nutrition security as "consistent and equitable access to healthy food and safe, affordable foods essential to optimal health and well-being." Rates of nutrition insecurity are likely much higher than rates of food insecurity, which is a much narrower definition focused solely on quantity of food.

Given the breadth of nutrition's impacts on health and the likely high rate of nutrition insecurity among Medicaid enrollees with low incomes, states are working on how to define and standardize eligibility to keep these interventions within the available budget while meeting member needs and ensuring successful implementation. This includes maximizing administrative simplicity and providing greater specificity on the eligible population.

Standardization and Administrative Simplicity

Clarity and simplicity of eligibility may be critical to successful implementation. One analysis of the Massachusetts flexible services program noted that complex eligibility criteria was a challenge for program administration. States have identified two strategies for creating administrative simplicity in eligibility for HRSN services:

- **Standardizing HRSN service eligibility**: For states that have packages of multiple HRSN services, standardizing eligibility across services can increase accessibility. North Carolina tries to align clinical eligibility requirements across services to the extent possible, and reports that this has been helpful for program administration.
- **Clinical and utilization criteria**: States reported that depending on the level of verification required, requiring clinical and utilization criteria can create administrative burdens. This is exacerbated if the utilization criteria confirmation is based on claims, which can have a significant lag. States are still exploring how best to overcome these workflow challenges, including assessing strategies like client or provider attestation.

Increasing Specificity for the Eligible Population

States are employing strategies to define a population within budget constraints while aligning with programmatic goals, including creating gating criteria and specifying clinical needs.

Massachusetts, North Carolina, Pennsylvania, and Washington all use (or plan to use) social need as a gating criterion for eligibility for nutrition services. This means that enrollees must meet the social need criteria through screening in addition to any of the potential clinical eligibility criteria. For some states, eligibility for nutrition services requires nutrition insecurity, while others have a broader list of social needs that would support enrollee eligibility. Examples include:

- Michigan's ILOS eligibility requires that a person "be at risk for nutritional deficiency or nutritional imbalance due to food insecurity."
- Washington State's eligibility requirement for nutrition services includes screening positive for food, housing, financial security, or being unable to meet medically recommended nutrition goals without assistance.
- Other potential eligibility criteria include homelessness or risk of homelessness and risk of experiencing or witnessing interpersonal violence.

Additional Work Needed

States are still considering how best to define clinical eligibility, which can be nuanced across services. In some cases, states may have narrower eligibility criteria for more specialized services like medically tailored meals and broader eligibility criteria for services like produce prescriptions.

The table on the next page includes examples of eligibility criteria that states in the *Medicaid Health-Related Social Needs Learning Series* are using, with the exact wording of the eligibility criteria, in both approved and proposed documentation. In practice, some states may be providing additional guidance about eligibility that may further specify these populations.

Nutrition Services Eligibility Criteria: State Examples

Sample Eligibility Criteria in Approved or Proposed 1115 Waivers or ILOS Policies			
ELIGIBLE POPULATION	**NARROWER DEFINITION**	**LESS NARROW DEFINITION**	**ADDITIONAL PROPOSED OR ADOPTED ELIGIBILITY CRITERIA**
People with unmet Health-Related Social Needs	Must be at risk for nutritional deficiency or nutritional imbalance due to food insecurity (Michigan, proposed)	Must screen positive for food, housing, or financial security or be unable to meet or maintain medically recommended nutrition goals without assistance (Washington, approved)	At risk of homelessness (in addition to homelessness) (Oregon, approved), at risk of experiencing or witnessing interpersonal violence (North Carolina, proposed), or a history of food insecurity (Pennsylvania, proposed)
Justice-Involved Individuals	Post-release justice-involved population with serious chronic conditions, substance use disorder (SUD), or chronic Hepatitis-C. Juvenile justice involved youth, foster care youth. (New York, approved)	Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities; (Oregon, approved)	Individuals with justice system experience, regardless of time horizon and individuals who are pre-release where appropriate (North Carolina, proposed)
Individuals Affected by Environmental Impacts	Individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon. (Oregon, approved)		Individuals who are currently or have been impacted by natural disasters in the past 12 months. (North Carolina, proposed)
Children	High-risk children (New York, approved)		
Pregnant and Postpartum People	High risk pregnancy or complications associated with pregnancy (including up to 60-days postpartum, their children up to one year of age, their children born of the pregnancy up to one year of age) (Massachusetts, approved 2020-2024)	Pregnant person's up to 12 months postpartum (New York, approved)	

Sample Eligibility Criteria in Approved or Proposed 1115 Waivers or ILOS Policies			
ELIGIBLE POPULATION	**NARROWER DEFINITION**	**LESS NARROW DEFINITION**	**ADDITIONAL PROPOSED OR ADOPTED ELIGIBILITY CRITERIA**
People with Behavioral Health or Substance Use Disorders	Adults and youth discharged from an Institution for Mental Diseases (IMD) (Oregon, approved)	The individual is assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (Massachusetts, approved 2020-2024)	Previously experienced three or more categories of adverse childhood experiences. (North Carolina, proposed)
Individuals with Chronic Conditions	Complex physical health need (persistent, disabling or progressively life-threatening physical disease). (Massachusetts, approved 2020-2024)	Individuals with chronic conditions (diet sensitive conditions including high-risk perinatal and behavioral health) (California, approved)	Diet sensitive conditions (Pennsylvania, proposed), chronic conditions (Washington, approved)
People with or at Risk of High Health Care Utilization	Medicaid High Utilizers (defined by Emergency Department, Inpatient or Medicaid spend, or transitioning from an institutional setting) (New York, approved)	Repeated ED Utilizer (two or more visits within six months, four or more visits within a year) (Massachusetts, approved 2020-2024)	Individuals being discharged from a hospital or skilled nursing facility at risk of readmission (California, approved)
People with Care Coordination Needs	Individuals enrolled in a New York State designated Health Home (New York, approved)	Individuals with extensive care coordination needs (California, approved)	
People Needing Assistance with Activities of Daily Living (ADL)	Individuals with Intellectual and Developmental Disabilities (New York, approved)	Requires assistance with one or more ADL or instrumental ADL (Massachusetts, approved 2020-2024)	Individuals transitioning from Medicaid-only to dual eligibility status (Oregon, approved)

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. CHCS supports 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**.

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