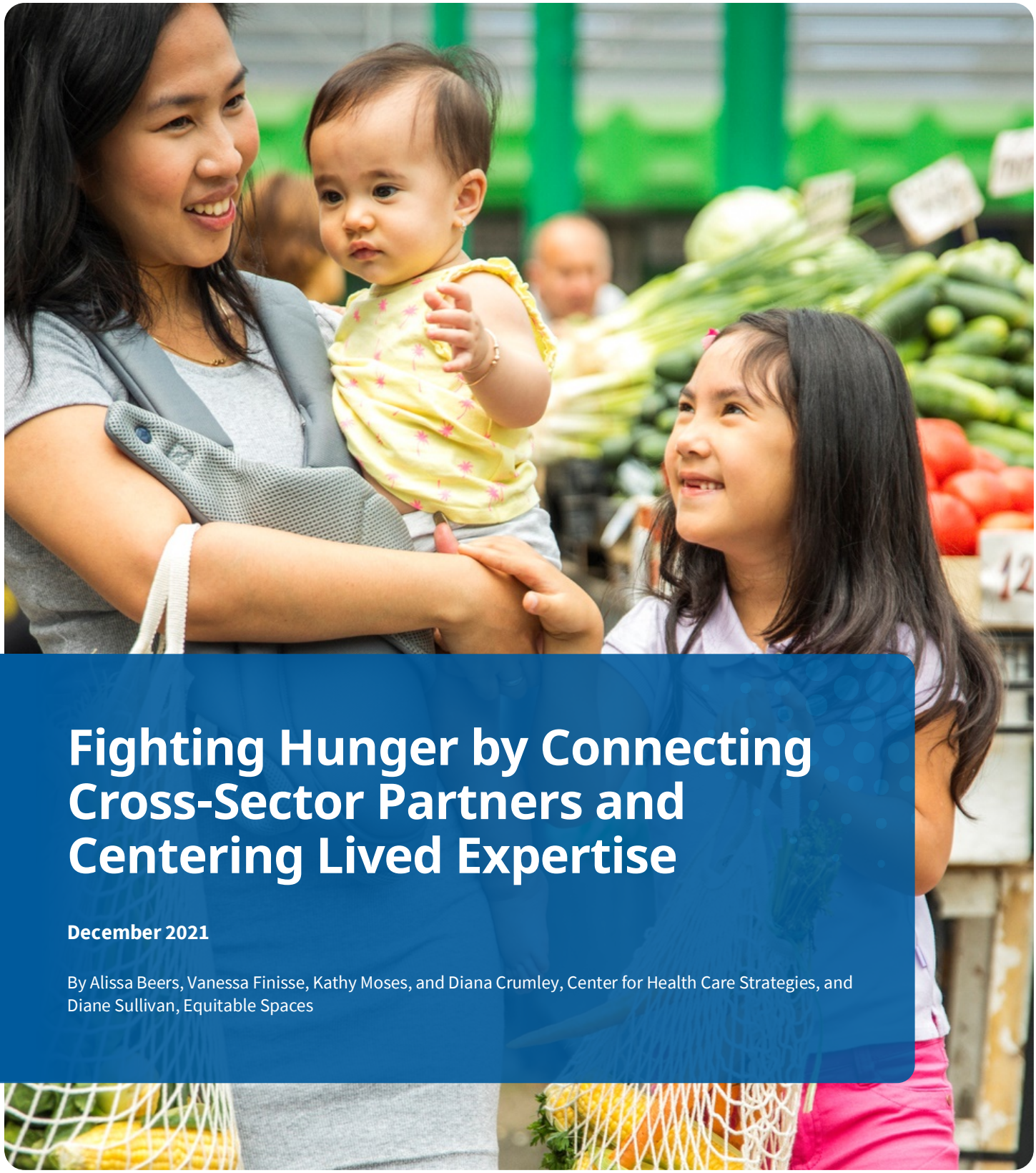
Center for Health Care Strategies



Fighting Hunger by Connecting Cross-Sector Partners and Centering Lived Expertise

December 2021

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Support for this report was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Contents

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**.

ABOUT EQUITABLE SPACES

Equitable Spaces (ES) — led by community members with lived expertise — provides customized training and support to local, state, and national groups that seek to engage individuals with the lived and living experiences of poverty and related issues in research and policy design and implementation. Its mission is to create equitable and inclusive opportunities for community members with lived and living experiences to incorporate their knowledge, perspectives, and expertise into the policies and programs that directly impact their lives. For more information, visit **www.equitablespaces.org**.

Acknowledgements

The authors are immensely grateful to the following individuals for their partnership, wisdom, and guidance throughout this project: **Alice Aluoch**, founder and executive director, Mfariji Africa; **Maryann Broxton**, coordinator, Multidimensional Aspects of Poverty Research, ATD Fourth World Movement; **Yolanda Gordon**, manager, Expansion and Advocacy, RESULTS; **Barbie Izquierdo**, consultant and national spokesperson/community empowerment manager, HungerFree America; **Jimmieka Mills**, co-founder, Equitable Spaces; and **Tamika L. Moore**, consultant with lived expertise. As partners, each of you have taught us that *who* is in a conversation, in a room, and/or in a project shapes the dialogue and outcomes that take place. Thank you for your invaluable partnership and for sharing your lived expertise with us.

The authors also gained valuable insights from an advisory group of individuals and organizations with policy, program, and lived expertise. We are grateful to the following individuals for their contributions: **Lindsay Browning**, Director of Medicaid Programming, National Association of Medicaid Directors;
Joelle Johnson, Campaign Manager, Healthy Food Access, Center for Science in the Public Interest; **Erin Henderlight**, Director of Policy, Benefits Data Trust; **Jamila McLean**, Healthcare Policy Manager, Benefits Data Trust; and **Diane Sullivan**, co-founder, Equitable Spaces.

The authors are grateful to **every participant** (see Appendix) who generously lent their time and insights to inform this report through one-on-one interviews, small group consultations, and convening conversations.

And for making this important work possible, the authors thank the **Robert Wood Johnson Foundation** for its generous support of this exploratory project and the development of this report.

Introduction

Health is about more than access to health care. State Medicaid agencies are increasingly focusing on prevention, health-related social needs (HRSN), and otherwise moving upstream to improve the health of individuals served.[1] This broadened perspective often includes strategies to enhance access to safe, nutritious, and affordable food, particularly in the wake of the COVID-19 pandemic and growing evidence that participation in programs like the Supplemental Nutrition Assistance Program (SNAP) is associated with meaningfully lower health care use and cost.[2,3,4]

Food insecurity (the disruption of food intake or eating patterns because of lack of money and other resources) is behind some of the most common and costly health issues in the U.S., including hypertension and diabetes.[5,6] Access to affordable, nutritious food is a significant challenge for many individuals enrolled in Medicaid, which was intensified through the COVID-19 pandemic. Among Medicaid adults, 20 percent reported food insufficiency (sometimes or often not having enough to eat) in March 2020, and 23 percent reported food insufficiency in July 2020, which has short- and long-term implications for the health of Medicaid members.[7,8] Additionally, states' health care and health and human service agencies have faced unprecedented demand for health care and food access services from newly eligible households since the onset of the pandemic. For instance, an estimated four million people were added to SNAP during March and April 2020, and enrollment in Medicaid increased to 82.3 million, an increase of 11.1 million or 15.5 percent, between February 2020 and April 2021.[9,10,11]

TAKEAWAYS

- Consistent access to affordable, nutritious food is a significant challenge for many individuals enrolled in Medicaid. The substantial overlap in eligibility for Medicaid and food support programs, such as the Supplemental Nutrition Assistance Program, provides opportunities for states to coordinate their policies and processes to improve participation, customer service, partnerships, and program administration.
- State agencies, including Medicaid and social service agencies, increasingly recognize the importance of integrating individual and community voices into the policymaking process, especially people from communities of color who experience disparities in food security.
- Experts with lived experience, state policymakers, and representatives from national health care and social services organizations were invited together to reimagine how to address hunger by increasing cross-agency partnerships and involving people with lived expertise in co-identifying solutions.
- Opportunities to increase food access through improved state policies and program implementation include: (1) develop a sustainable community engagement infrastructure that enable states to build meaningful relationships with and incorporate individuals with lived expertise in policy and program design; (2) center equity, humanity, and dignity in policymaking and in service provision to better serve people enrolled in Medicaid and nutrition programs; (3) address persistent eligibility and enrollment challenges through cross-agency partnerships; and (4) use state levers and authorities to advance coordination and innovations.

Further, COVID-19 is exacerbating long-standing racial and ethnic disparities in food insecurity. Black and Hispanic households with children are nearly twice as likely to be struggling with food as white families.[12]

Medicaid alone cannot dismantle the structural and political factors that contribute to food insecurity and the barriers to accessing affordable, nutritious food. Further, there is an increasing recognition of the value and importance of centering individuals' and communities' voices in the policymaking and implementation processes, especially those from communities of color who experience disparities in food security.[13]

What is Lived Expertise?

For this report, lived expertise is defined as the experiences of individuals who know:

- ✓ The realities of hunger, poverty, and other societal issues by living them daily;
- ✓ How those experiences impact health and wellness;
- ✓ The challenges of navigating public benefits programs for supports and services; and
- ✓ That their perspectives uniquely qualify them as informed stakeholders who can help to shape more equitable policy.

Addressing food insecurity requires a broad, collaborative approach, informed by:

1. The root causes of food insecurity and the lack of consistent access to affordable, nutritious food, including poverty and racism;
2. Opportunities for increased coordination among agencies that administer Medicaid, SNAP, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), among other programs; and
3. The lived expertise of people who have experienced hunger, including recipients of SNAP and WIC.

By understanding the landscape of food insecurity and engaging the perspectives of people currently and formerly enrolled in food support programs — or otherwise eligible and not accessing them — cross-agency partners can work together to dismantle barriers and advance more effective, coordinated approaches that improve the health of enrollees and those eligible, particularly among Black and Latino individuals and families facing disproportionately high rates of food insecurity.[14,15]

This report is a product of ***Exploring Cross-Agency Partnerships to Address Food Insecurity***, an initiative led by the Center for Health Care Strategies (CHCS) with support from the Robert Wood Johnson Foundation, which sought to better understand opportunities, barriers, and cross-sector strategies to improve the health of individuals enrolled in Medicaid and food programs specifically.

Through an environmental scan, key informant interviews, a small group convening, and conversations with individuals with lived expertise, CHCS explored the following questions:

- *How are state Medicaid agencies, managed care organizations, and providers currently partnering with state agencies that administer food programs, such as SNAP and WIC, and/or directly addressing food insecurity?*
- *What are the biggest opportunities to improve healthy food access for Medicaid enrollees, particularly for individuals who are food insecure or have nutrition-related health care conditions? What are the barriers?*
- *How can states use partnerships between Medicaid and food programs to intentionally advance food security and health equity?*
- *How can state governments break down silos and dismantle systemic barriers to food security and healthy food access?*
- *How can states better serve individuals who are enrolled in Medicaid and food programs, and involve communities and enrollees in policy design efforts?*

Opportunities for Action: Key Insights

To be successful, policies and programs that address health and food insecurity (and other HRSN) must be person centered. This requires moving from a transactional service delivery focus toward building trusting relationships and ultimately engaging community members in policymaking and implementation processes in meaningful ways. Focusing on trust and relationship-building with community members who are most impacted must come before diving into the weeds on any specific policy discussion. Without the insight of community members, policies often fail or have unintended consequences.

This report offers recommendations in four distinct categories for policymakers to integrate individuals with lived expertise as partners in program and policy design, implementation, and evaluation to address food insecurity more effectively. While these recommendations emerged in discussions specific to addressing food insecurity, many are broadly relevant to Medicaid policymaking in general.

1. **Reimagine sustainable community engagement strategies** to incorporate expertise from individuals with lived experience who are most impacted by historic inequities in states' policy and program design, implementation, and evaluation efforts;
2. **Center equity, humanity, and dignity in policymaking and implementation** to better serve individuals enrolled in Medicaid and food programs by focusing on implementing cultural and practice changes that promote healing and reduce the risk of re-traumatization;
3. **Address persistent eligibility and enrollment challenges** through cross-agency partnerships to meet individuals' needs; and
4. **Use Medicaid levers to screen for food insecurity and provide needed services** to advance coordination and innovations, including through Medicaid managed care contracts or 1115 demonstrations with additional food-related services, like food prescriptions and medically tailored meals.

1. Reimagine Sustainable Community Engagement Strategies

A key factor for successfully addressing food insecurity and other HRSN linked to poverty and racism is the direct participation of impacted community members in the development and implementation of solutions and policy decisions. State government agencies that oversee programs like Medicaid and SNAP have tools and protocols for basic community engagement (e.g., Medical Care Advisory Committees), but many of these do not go beyond discrete activities for a particular project or policy and often have limited 'seats at the table' for community members with lived expertise.

> **The value is hearing from people — about the value of these programs to them and where the pain points are in accessing services. Often, legislators have little understanding of these programs and the day-to-day lives of the people they serve.**
>
> - Tom Hedderman, Director of Food and Nutrition Policy, New York State Office of Temporary and Disability Assistance

State interviewees were asked about current strategies to ensure policies and programs that address food insecurity are person-centered and informed by community member perspectives. While states have some mechanisms to engage individuals and families, interviewees acknowledged that there is significant work needed to strengthen partnerships with community members, especially within communities most affected by structural racism, inequities, and historical trauma.

Following are examples of state strategies to engage community members in policy and program planning:

- The **Indiana** Family and Social Services Administration's Office of Healthy Opportunities and Division of Family Resources is partnering with advocates and individuals with lived expertise to redesign the SNAP denial notice to ensure it is straightforward in helping individuals understand available next steps to a denial, such as the process to submit missing application information or appealing the decision. The Office of Healthy Opportunities is also working to implement a new community engagement team focused on equity that employs people with lived or living experience in receiving services, who can provide first-hand perspectives about what about these programs is and is not working for them.

> **State agencies can listen to individuals who are eligible and/or participating in public assistance programs about what would make it easier for folks to engage in these services and what they need to get out of these services over time.**
>
> - Rachel Lane, Chief Transformation Officer, Office of Healthy Opportunities, Family and Social Services Administration, Indiana

- **Virginia**'s Department of Social Services conducts community outreach and enrollment assistance to ensure that individuals and families eligible for services can receive help connecting to needed supports. Additionally, they conduct listening sessions and town halls throughout the state focused on ending hunger. During these listening sessions, the state clearly heard that, "hunger is a room in the house of poverty," as stated by a community participant. The feedback shared during these sessions is guiding broader policy and systems changes within the department, including exploring coordination opportunities with Medicaid and other state programs.

> **Some of the obstacles we run into during family engagement work are things that we should be able to figure out. But we run into roadblocks like, 'How do we pay families for their input?' 'How do we take care of their kids while they're giving us their input?' 'How do we get approval to buy them dinner?'**
>
> - Daniel Haun, Director of Self Sufficiency Programs, Oregon Department of Human Services

- **North Carolina's Buncombe County's** Department of Health and Human Services engages community members through town halls and community initiatives. The town hall meetings provide an opportunity to hear about different communities' needs within the county, which is supported by a dedicated county public engagement team of staff. One interviewee shared that they learned the hard way why it is important to listen to community members. Without engaging the community, they established satellite offices where they presumed there was a need, and ultimately disbanded those. This happened prior to the establishment of the public engagement team. Now their conversations start with asking what the community needs are and how the community envisions receiving supports.

THEMES

States and community members recognize that increased alignment between public health, social services, and health care systems can support progress toward meeting communities' goals and health needs. Participants noted that they have seen progress with state agencies investing more in partnerships with community-based organizations for community outreach and engagement efforts. Participants, however, underscored that to develop meaningful and equitable partnerships with community members to address health inequities and food insecurity, states must listen to *learn* from individuals with lived experience and value their expert insights. To do this, states should invest time and resources in relationship building. In doing so, states should be open to learning about the impact — good and bad — of existing policies and programs on community members to understand the potential disconnect between intent and impact. Participating community members underscored that individuals' experiences should be used to guide long-term policy and program changes rather than informing one-off solutions that only address short-term, individualized responses.

Following are themes from conversations with individuals with lived expertise about opportunities to improve community member engagement to drive systemic changes:

- **Recognize that this work is *relational* not transactional**. Policymakers benefit more from community members' insights in early stages of policy development rather than in reaction to policies that have already been designed. Developing a more proactive approach to community engagement requires meaningful trust and partnership-building, addressing power imbalances, and promoting mutually beneficial relationships. Trust-building requires a shift in how state agencies approach relationships with community members. Oftentimes, community members are invited into spaces to share their personal stories relating to certain programmatic or policy issues but are not treated as equal partners with valuable expertise, despite their intimate knowledge and understanding of solutions. Individuals with lived expertise represent more than their stories and data points. They have direct insights into how programs and policies ought to be designed, implemented, and evaluated — and should be valued for this expertise.

- **Take a multi-pronged approach to community partnerships**. Facilitating community members' participation in solutions development and decision-making first requires multi-faceted and inclusive outreach efforts. Building relationships with community-based organizations can help states understand the unique issues that a community faces and create opportunities for individuals to engage in safe and trusted spaces. States must recognize, however, that there are hard-to-reach populations uninvolved in community work and advocacy but whose perspectives are vitally important. Further, not every community-based organization engages community members equitably. A multipronged approach to engagement can address these potential gaps in outreach.

I shared my insights about health and hunger in Texas. It was a great experience, but if I wasn't aligned with that one [community] organization, I would have never had that opportunity. There needs to be a way they can reach out directly to community members because not everybody is aligned with an organization.

- Jimmieka Mills, Equitable Spaces

- **Provide equitable compensation for the value of lived expertise**. Interviewees with lived expertise noted a lack of consistent and equitable pay for community members' time and contributions. This reinforces the need for a cultural shift where individuals with lived experience are seen as more than storytellers and treated as experts with valuable insights into Medicaid and SNAP (and other public benefits programs) and their impact on communities. State interviewees similarly noted challenges around the ability to compensate for community engagement due to existing state and/or federal level legislation.

RECOMMENDATIONS

Following are recommendations for strengthening community engagement strategies suggested by state representatives and individuals with lived expertise:

- **Reimagine states' community engagement efforts to shift power and allow for shared decision-making**. Including individuals with lived expertise in policy design processes from the start is essential for co-creating policies that meet both state objectives and the needs of the people they are intended to serve. Doing so will help interrupt practices that uphold systemic racism and perpetuate existing disparities in hunger and health. By investing in partnerships with community members and learning from their expertise, states can develop programs and policies that are impactful, equitable, and respectful.

  Many states leverage existing community member advisory boards to inform state-level programs and policies. Interviewees representing both states and community members contend that advisory committees or similar forms of engagement often do not promote a participatory role that includes bi-directional conversations and inclusion in decision-making processes. Many stressed how valuable it is to incorporate enrollees' perspectives early and use those insights to guide how the state implements and/or redesigns its programs and policies related to hunger and health. Creating participatory roles for community members that move beyond story-banking to employment and consultation helps foster economic empowerment as well as co-created solutions that address systemic barriers to food security. Community members' interactions with multiple state agencies and familiarity with their own communities uniquely qualifies them to support the development of more equitable, whole-person care. Strengthening meaningful opportunities for community engagement will help states understand problem areas for individuals most impacted by state and federal policies and programs, and facilitate opportunities to co-create actionable strategies to address those barriers.

- **Support relationship- and trust-building with community partners to drive engagement and cross-sector collaboration.** State interviewees shared that state government agencies recognize the value of centering community members in program and policy design efforts. States, however, struggle with how to operationalize meaningful engagement of individuals with lived expertise and incorporate their guidance in policies and programs. Trust is often an essential missing ingredient. States need support to strengthen their capacity to build trusting relationships with individuals with lived expertise, as well as to engage them to share their input to inform policy design and implementation. Community members engaged in partnerships with state officials also need support to maximize their involvement given existing power imbalances. It is important to invest resources into relationship- and trust-building to create a strong community engagement foundation that can successfully inform policy and program design to better address community needs. Co-design is essential for effective and equitable policymaking as policies designed without meaningful input from those most impacted can have unintended

consequences that further traumatize intended program participants. And, co-design cannot happen without trust and transparency.

States can consider hosting community meetings, listening sessions, and other community-led events to learn directly from community members and make connections within the community. For instance, states may consider hosting community events to connect directly with residents, leveraging technology (e.g., using mobile applications to text program applicants or participants) for more consistent outreach, and hiring individuals with lived expertise to drive outreach efforts and make connections within the community. Further, states should consider attending community-led events where those with lived expertise are directly responsible for agenda setting and facilitation.

- **Compensate for time and expertise.** States may consider addressing barriers to equitably compensating community members across agencies, including amending statutes that prohibit states from providing stipends or other payment arrangements for community members' time and penalize program participants with the loss of benefits for receiving these stipends. In some cases, philanthropic dollars may be available to help support community engagement efforts. State interviewees suggested a human-centered approach when engaging with community members by covering financial costs associated with participation, such as transportation, and equitably paying everyone involved for their time and contribution, similar to how they would any other government consultant or contractor. This will require a shift in how states and organizations perceive work with individuals with lived expertise. It also requires coordinated efforts across state agencies to: (1) overcome regulatory hurdles (e.g., having to report a stipend received for participating in a focus group to public assistance programs); (2) explore additional funding streams; and (3) embed engagement efforts into budgets.
- **Hire Medicaid and social services agency staff with lived expertise to better inform program planning, implementation, and evaluation.** There is an opportunity to move away from conventional ideas like asking people to simply share their stories (which can be exploitive and potentially retraumatizing), and instead, create opportunities for economic mobility by hiring individuals with lived expertise as employees and consultants. This can facilitate meaningful dialogue that focuses on co-created solutions based on lived expertise that can be mutually beneficial.

2. Center Equity, Humanity, and Dignity in Policymaking and Implementation

Interviewees from all stakeholder groups noted that it is important to explore how to improve public assistance programs, like Medicaid, SNAP, and WIC, and the ways in which they coordinate with one another to better serve individuals and families. They suggested that to improve public assistance programs, it is critically important to improve the culture in which these systems operate. Organizational culture change is critical to successfully achieve the core objectives of Medicaid and SNAP programs in a person-centered manner. States have an opportunity to not only design programs and policies that improve health and control costs, but design programs and policies that promote healing, dignity, and compassion.

THEMES

Following are themes that emerged during conversations with state representatives and individuals with lived expertise:

- **Promote compassion and support over fear, stigma, and judgment.** There is pervasive stigma about food assistance in the U.S., which can be perpetuated and exacerbated by state and federal actions, such as policies and practices that create barriers to access (e.g., complex application and enrollment processes) or contribute to fear that applying for assistance programs like SNAP and Medicaid might affect immigration status. Stigma in the context of hunger and health is associated with the false narrative that if an individual works hard, they can afford and access food and other basic needs that support health and well-being.

> **When you apply for assistance, you are looked at like someone who is trying to cheat the system. Instead, it should be seen as courageous for someone to go in, share their pain, and try to approach solutions. Individuals have the will and determination to succeed, persevere, and overcome, and deserve respect, empathy, and compassion.**
>
> - Barbie Izquierdo, Consultant and National Spokesperson/Community Empowerment Manager, Hunger Free America

This false narrative does not reflect the many systemic barriers to accessing nutritious, affordable food. The state-level systems often prioritize program integrity and payment accuracy due to federal-level reporting requirements over prioritizing efforts to ensure that people who need assistance are supported and respected during a difficult time.

- **Support trauma-informed policies and service delivery.** Individual trauma results from an event or set of circumstances experienced by an individual as physically or emotionally harmful and that has lasting adverse effects on the individual's mental, physical, social, or emotional well-being.[16] The experiences of living in poverty and enduring systemic discrimination are forms of chronic trauma that can heighten health risks for individuals. Community member interviewees underscored that the act of applying for public assistance programs has a social-emotional impact on people in addition to existing traumas they are already experiencing.[17]

> **It can be traumatizing for people to repeatedly complete screening questionnaires since some questions may re-trigger someone. We're trying to ensure that once someone has a treatment plan to address their needs in a whole-person way, we track progress against their needs.**
>
> - Erin Holve, Director, Health Care Reform and Innovation, Department of Health Care Finance, Washington, D.C.

Trauma-informed care has become more widely adopted throughout the human services field, and a framework for trauma-informed social policy exists.[18] Involving community members with lived expertise can help identify opportunities to promote equitable, dignified, and trauma-informed treatment of community members most impacted by policies and programs related to addressing hunger and health.

> **Being trauma-informed in public assistance programs allows people to share their stories and shows the link between things that occur in their lives that cause trauma — like intimate partner violence, experiencing racism, or other traumas — you can begin to understand what brings them to you. It also says that you are willing to listen as another human being.**
>
> - Yolanda Gordon, Manager, Expansion and Advocacy, RESULTS

- **Address structural racism**. There are clear racial disparities in rates of food insecurity. The prevalence of food insecurity among Black and Latino households has been significantly higher than in white households prior to and during the COVID-19 pandemic.[19,20] Food insecurity is driven by income insecurity, both of which are associated with major disparities, with Black and Latino families and individuals facing disproportionately high rates of food insecurity.[21,22,23,24,25]

Localized implementation of assistance programs like SNAP (meaning states and localities can adopt their own policies) can exacerbate racial inequities.[26] In fact, people of color are more likely to be subject to stricter regulations, harsher punishments, and more scrutiny just by virtue of the states they live in.[27] Interviewees, especially individuals with lived expertise, underscored that addressing hunger and health requires tackling the racism that underlies many social safety net systems and structures across the U.S.[28]

Wisconsin has been undertaking huge efforts related to equity and inclusion. One project is focusing on what demographic data is helpful in understanding and being able to promote better health. This includes race and ethnicity data as well as information about housing, food security, and other social needs.

- Rebecca McAtee, former director, Wisconsin Department of Health Services, Bureau of Eligibility and Enrollment Policy

RECOMMENDATIONS

Following are recommendations from state representatives and individuals with lived expertise for leveraging cross-agency partnerships to address food insecurity from a person-centered, trauma-informed, and equity-centered lens:

- **Convene state policymakers/program administrators, enrollment staff, and community members** to discuss the current system and learn from individuals with lived expertise.
- **Prioritize and incentivize increasing access to Medicaid and food assistance programs** rather than preventing fraud, since the latter often contributes to trauma or re-traumatization and stigma, and disproportionately harms Black and Latino individuals and families.
- **Conduct trauma-informed policy and service delivery training programs** for Medicaid and SNAP program administrators and frontline workers so they can better assess and assist individual needs of applicants and enrollees.
- **Develop and implement education programs for state and local Medicaid and SNAP staff** (and other public assistance programs, like WIC) about the history of inequitable policies and systems, including "race neutral" policies that perpetuate structural racism, and how to operationalize these learnings.[29]

- **Embed equity impact assessments into policymaking processes** prior to approval for implementation. Equity impact assessments can help policymakers understand how groups that have been — and continue to be — disenfranchised and discriminated against, will likely be affected by a proposed action or decision. Policymakers can use equity impact assessments to help understand the unique perspectives and needs of various populations to find solutions that are beneficial for all. Previous strategies mentioned, such as engaging directly with community members before policy or process changes can be implemented, and hiring individuals with lived expertise as staff or consultants to identify policies that may look good on paper but have unintended negative consequences for enrollees, support equity as well.

3. Address Persistent Eligibility and Enrollment Challenges Through Partnerships

Determining eligibility for and enrollment in state and federal programs designed to assist individuals in need are critical components of efficient program operation. Challenges within eligibility and enrollment processes, however, often make services difficult to access, navigate, and maintain.

THEMES

Following are themes related to challenges to eligibility and enrollment processes in state and federal programs that emerged during conversations with state representatives and individuals with lived expertise:

- **Misalignment across federal programs and agencies.** Federal poverty guidelines are used to set eligibility thresholds for programs like SNAP, the National School Lunch Program, and the Children's Health Insurance Program (CHIP).[30] These federal thresholds vary from program to program. For example, SNAP is generally available up to 130 percent of poverty, but coverage varies by state. CHIP can cover children in families with up to 300 percent of the poverty level, but the level is also determined by individual states. Depending on a family's income, they may be eligible for some supports and not others.

> **Trust me — people are still poor when they are 'over the limit' for SNAP and continue to need assistance to feed their families. Why does the federal government acknowledge one level of need for health coverage and another for food?**
>
> - Tamika L. Moore, Consultant with Lived Expertise

- **Lack of coordination across state programs.** Programs are overseen by various state agencies, with separate eligibility workers and funding sources. As a result, individuals often have to apply for multiple programs across a variety of locations, sharing the same information repeatedly. Critical data (name, address, income, etc.) are often not shared across programs, and case workers are typically not cross-trained to provide information about multiple programs. An unintended consequence — called the SNAP Gap — is that some individuals, though eligible for SNAP benefits, go without SNAP due in part to the lack of coordination between systems.[31] The SNAP Gap refers to the difference between the number of individuals receiving Medicaid benefits who are likely SNAP eligible and the number of individuals actually receiving SNAP.

> **Finding staff who can talk about multiple programs — in a way that's auditable and meets federal criteria — is a challenge. You often need to send people to one person for Medicaid and another for SNAP. It's like you need a PhD in navigating poverty to survive poverty. And once you've done that, do you have the energy to stabilize your family, get on an economic mobility path, and take care of your physical and mental health? No, you're exhausted just navigating the system.**
>
> - Daniel Haun, Director of Self Sufficiency Programs, Oregon Department of Human Services

- **Missing insights from those that use supports.** Eligibility determination and enrollment processes are important because they ensure that federal requirements are being upheld. Unfortunately, the unintended consequence can be that this structure is often unnecessarily onerous and confusing to the individuals trying to access benefits. Without "real-life, on-the-ground" insights as to how the processes work or do not work, state officials do not have the information necessary to ensure that the system reflects a positive — and not traumatizing — experience for people trying to navigate the benefits.

> **If you are living in poverty and trying to survive day to day, why is the system set up to make it harder for everyone — each family — to prove they need help?**
>
> - Alice Aluoch, Founder and Executive Director, Mfariji Africa

RECOMMENDATIONS

Following are recommendations for improving the enrollment and eligibility process shared by state representatives and individuals with lived expertise:

- **Invest in data and technology systems.** Invest in information technology infrastructure that bolsters data-sharing across programs and allows caseworkers to facilitate an application to another program that an individual may also be eligible for. States can also establish data-sharing agreements between partnering agencies to improve access to programs. Further, states can

engage community members with lived expertise in these processes to help identify potential unintended consequences.

  - *Update systems to support multichannel document submission.* Doing so could allow individuals to submit their supporting documentation via text or other means that do not require them to be in-person.

  - *Create a common application.* Streamlining enrollment processes across eligible programs with a common application can eliminate duplicative efforts. For instance, Texas uses a common application across state programs.[32]

- **Engage in redesign at the federal level.** Some federal programs have not been revamped in over a decade, with many programs overseen by different agencies with varying requirements impacting alignment.

  - *Reassess the eligibility requirements across federal programs.* For example, allow SNAP and WIC to determine recertification similar to the ex parte recertification process allowed in Medicaid wherein an individuals' coverage is automatically renewed based on information in their case or in electronic data sources.[33]

  - *Develop consistent standards across states by working with the federal government*. Individuals with lived expertise shared that if some eligibility and enrollment rules were made consistent at the federal level, there would be more equity across states in how easy it is to access and maintain benefits. For instance, reporting requirements for SNAP vary significantly between states. In Massachusetts, individuals must report every six months unless they are disabled or elderly, whereas in Texas individuals must report monthly for continued access to SNAP benefits.

  - *Consider realities of employment in determining eligibility.* Depending on the type of employment, an individual's income can vary drastically from month to month and can impact eligibility unnecessarily. Particularly for individuals who are self-employed or gig workers, a standard self-employment deduction that could be applied automatically to the gross income would help ease this constraint and added administrative burdens on agencies.[34] Partnering with individuals with lived expertise can inform re-design efforts that take lived experiences into account.

- **Involve individuals with lived expertise to refine outreach and enrollment processes.** States can collaborate with the community and individuals with lived expertise to ensure that outreach and enrollment strategies meet community needs. The state can use a human-centered design process to reimagine the eligibility and enrollment process. In this process, individuals with lived expertise are engaged to help state officials better understand what individuals in need are facing. States have an opportunity to focus on the customer experience in order to optimize how the system works.

- **Explore innovative multi-sector partnerships.** At the state level, identify opportunities to involve sister agencies or departments (i.e., those that administer SNAP, WIC, Older Americans Act Nutrition programs) in Medicaid policy development relating to food insecurity. This may be accomplished through streamlined and simplified eligibility processes or complementary service delivery initiatives (mentioned below). States can seek opportunities to coordinate beyond their usual partners to enhance eligibility and enrollment. For instance, school food programs may offer opportunities to promote cross-program information.

4. Use Medicaid Levers to Screen for Food Insecurity and Provide Needed Services

There are several broad policy levers available to Medicaid programs to support individuals that participate in Medicaid who are or are at-risk of becoming food insecure and bolster nutrition benefits already administered under SNAP, WIC, and Older Americans Act Nutrition Programs. Following are key Medicaid levers that can be used to address food insecurity:

- **Benefit Design.** Medicaid state agencies can define benefits that seek to address nutrition-related needs or connect individuals to community resources (e.g., targeted case management).

  Examples: States can provide home-delivered meals as a home- and community-based service, and obesity counseling and healthy diet counseling as "other diagnostic, screening, preventive, and rehabilitative services."[35]

  States can also leverage 1115 demonstrations to pilot new nutrition-related benefits, including food boxes and SNAP enrollment support. See Massachusetts and North Carolina examples below.

- **Delivery System.** Managed care plans can provide care coordination, quality improvement initiatives, and additional services that seek to identify and address food insecurity and nutrition-related needs (i.e., in lieu of services and value-added services). States can encourage this work through tailored incentive arrangements, as well as explicit contract requirements.

  At the provider-level, alternative payment models, value-based payment arrangements, and funding provided through 1115 demonstrations can help support whole-person models of care and encourage providers to invest in services that address food insecurity and nutrition. At both the plan-level and provider-level, state Medicaid agencies encourage and sometimes require partnerships with community-based organizations.

  Example: California allows plans to choose among 14 pre-approved, rigorously defined in lieu of services (recently retitled "community supports") — with medically tailored meals and medically supportive food as one option. The state will reward capacity-building efforts for community supports providers through managed care incentive arrangements and is seeking additional funding for technical assistance for community supports providers through an 1115

demonstration.[36] For the first year of implementation (starting in January 2022), 81 percent of plan-county pairs are providing medically tailored meals and medically supportive food, growing to 83 percent by July 2022.[37]

- **Cross-Agency and Program Partnerships.** Better coordination among state agencies and divisions that administer Medicaid, SNAP, and WIC could benefit beneficiaries through streamlined and simplified eligibility processes or complementary service delivery initiatives.[38]

  Examples: States can use Fast Track as an enrollment strategy, a federal policy option through which states can use information on file from means-tested public benefits such as SNAP to determine eligibility for Medicaid.

  Pennsylvania's Department of Human Services developed a list of more than 200,000 people not on Medicaid but who were participating in SNAP or were parents of children on Medicaid. Using individual-level data, a dedicated outreach campaign (e.g., U.S. mail; a contact center, etc.) was implemented through the Pennsylvania Benefits Center to help clients enroll in Medicaid.[39]

  The U.S. Department of Agriculture also launched a *National School Lunch Program and School Breakfast Program Demonstration Project* opportunity in 2021 to evaluate direct certification with Medicaid.[40]

THEMES

In interviews, listening sessions, and the small group convening, participants noted the following common state Medicaid activities:

- **Strengthening screening and referral processes.** Increasingly, state Medicaid agencies expect —and often contractually require — Medicaid managed care organizations (MCO), accountable care organizations (ACO), and providers to screen for social risk factors, like food insecurity, and to connect individuals to benefits and resources that address those needs, like SNAP enrollment assistance or food pantries. Technical tools, like community resource referral platforms, can ease this work, but many aspects require investments in *people*, like community health workers. For example, **Commonwealth Care Alliance** shared its person- and community-centered approach to navigation, which involved hands-on relationship

> **It is not enough to just connect a person with a service. There needs to be an end-to-end process where social needs are identified in a consistent way, referred to local organizations who have adequate funding and infrastructure to provide the service, and who close the loop to let the referrer know that the service was provided. That process requires both a people and technology infrastructure.**
>
> - Zachary Wortman, Chief Operating Officer for Opportunity and Well-Being at North Carolina, DHHS

building, information gathering, and warm handoffs — particularly during COVID-19 when food pantries adjusted their operating hours and eligibility criteria.

- **Designing effective incentives and requirements.** States often ask other organizations, like Medicaid MCOs and ACOs, to test innovative approaches to address HRSN, including food insecurity. In designing incentives and requirements for MCOs and ACOs, states weigh whether to require specific activities, or to allow MCOs and ACOs to develop their own unique initiatives based on the specific needs of enrollees and communities. For example, **Minnesota's** integrated health partnerships (IHPs), the state's Medicaid ACOs, must suggest a health equity intervention and related measures. Six of the state's 27 IHPs are working on nutrition-related initiatives in response to this requirement. One of these six IHPs, Lakewood Health System, partners with organizations to provide multiple food-related interventions, such as onsite "acute care packs" filled with non-perishable food items, a food prescription program, and a food at discharge program. The initiatives are designed to respond to the needs of its rural community, which — despite being in farm country — faces acute food access issues.

  Deferring to individual health care organizations to form local partnerships can complicate efforts to strengthen the capacity of community-based organizations to enter into these relationships. One interviewee shared how its national organization can provide the administrative backbone for local affiliated programs interested in engaging in Medicaid-related initiatives and partnerships (e.g., managing networks and collecting and managing data). A state agency could potentially work with a single organizational partner to recruit and manage a network of local providers of food- and nutrition-related services, allowing for greater effectiveness and operational efficiency.

- **Measuring progress.** In the context of value-based payment initiatives, managed care programs, and 1115 demonstrations, state Medicaid agencies often look for appropriate measures to track work relating to HRSN broadly, and food insecurity specifically. But this step requires state Medicaid agencies to move beyond the typical clinical quality measures that have dominated Medicaid programs, such as those in the Medicaid adult and child core sets.[41]

> **We see our role as trying to create the right incentives using the levers we have at hand. Almost anything we do would have to be indirect because we're not the ones delivering services on the ground.**
>
> - Mat Spaan, Manager, Care Delivery & Payment Reform, Minnesota Department of Human Services

States have begun to define process-focused measures relating to social risk factor screening, infrastructure development, and partnership creation. For example, **Texas** included a food insecurity screening measure as part of a proposed directed payment program (i.e., a state-defined payment model for managed care plans to use when paying certain providers).[42] The measure gauges the percentage of patients screened for food insecurity using Hunger Vital Sign, a validated two-question screening tool.[43] The Centers for Medicare & Medicaid Services also integrated these two questions into its Accountable Health Communities (AHC) Screening Tool.[44,45] **Rhode Island** integrates an SDOH infrastructure development measure as part of its Medicaid Accountable Entities program, and has used the Pathways to Population Heath Compass tool to assess the strength of partnerships among accountable entities, health equity zones, and individuals with lived expertise for a diabetes-related health equity challenge.[46,47]

States have expressed interest in moving beyond these process-oriented measures to outcome measures but are often unsure how to proceed. For example, states have considered using measures like "Healthy Days," and tracking the impact of an intervention on utilization measures like readmission rates.[48] State Medicaid agencies have not typically engaged communities and individuals with lived expertise to define relevant measures.

- **Providing nutrition-related services**. State Medicaid agencies have begun to roll out benefits and flexibilities that address the intersection of health, hunger, and nutrition. Some of these explorations are an expansion of established home- and community-based services benefits, such as home-delivered meals. Other service expansions are in the context of major Medicaid reform initiatives and explored in conjunction with proposed and approved 1115 demonstrations. For example, starting in Spring 2022, **North Carolina**, as part of its Healthy Opportunities Pilots, will provide a subset of Medicaid enrollees medically tailored meals, healthy food boxes, healthy meals, case management for food and nutrition access, nutrition classes, and participation in the Diabetes Prevention Program.[49] The state has identified common tools to support program implementation, including a community-based resource referral platform, a common screening tool, and a fee schedule.[50] **Massachusetts** encourages its ACOs to provide "nutrition sustaining supports," including SNAP enrollment support and groceries and nutrition vouchers.[51] Massachusetts supported partnerships between ACOs and social service organizations through the Flexible Services Preparation Fund and the Moving Massachusetts UPStream Investment Program.[52,53] For example, About Fresh, which runs a mobile market for fruits and vegetables, provided Mass General Brigham ACO members a FreshConnect prepaid debit card that enabled them to buy fresh produce.[54] AboutFresh received a grant from the Flexible Services Preparation Fund to engage in this partnership.

RECOMMENDATIONS

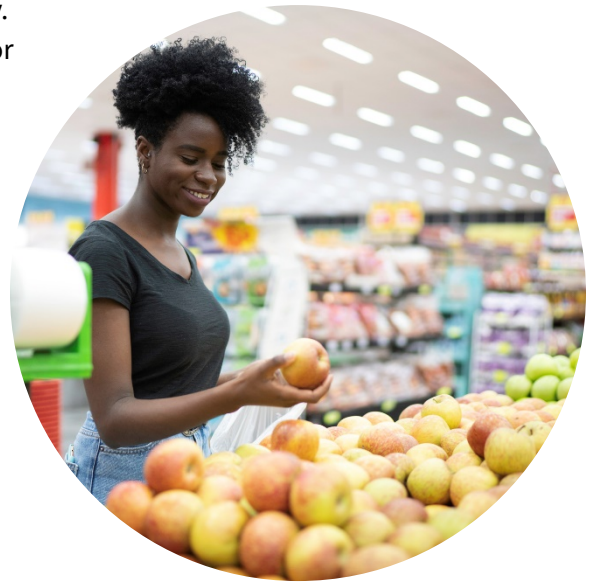
Following are recommendations for using Medicaid policy levers to screen for food insecurity and providing needed services suggested by state representatives and individuals with lived expertise:

- **Strengthen community resources**. Across the country, state Medicaid agencies and health care organizations are working to expand screening for social risk factors, but often worry that individuals will not be able to access services that address identified needs. While scarce resources can complicate navigation and referral, screening results can nonetheless help inform clinical decision-making and help Medicaid members access SNAP, which as an entitlement program does not have as many service limitations as compared to housing programs with waitlists, for example. Furthermore, aggregated data from screening and referral processes can help state Medicaid agencies and others to visualize the depth of food insecurity needs; map gaps in community resources; and attempt to close those gaps with Medicaid initiatives, as appropriate. States can consider ways, for example, to use Medicaid funding to expand access to nutrition-related services and build the infrastructure needed to support longstanding, sustainable partnerships between health care organizations and social service organizations. State Medicaid agencies can also elevate critical needs to state and federal legislatures to support funding.

- **Identify accountability measures that resonate with communities and individuals with lived expertise.** Community-defined measures can help keep governments accountable to the people they serve. Regional organizations, like accountable health communities and health equity collaboratives, can help facilitate discussions with community members and ensure that policy development is collaborative, transparent, and responsive to community needs and priorities. For example, the **Rhode Island** Department of Health partnered with the Community Health Assessment Group to develop a core set of measures to track the impact of health equity zone interventions after a robust community engagement process. Two of the newly developed measures relate to food (i.e., SNAP enrollment and rates of food insecurity).[55] Additionally, there are innovative patient-centered measurement initiatives supporting health care stakeholders in moving toward an equitable, patient-driven measurement ecosystem.[56]

- **Expand access to healthful, culturally preferred meals and foods.** Medicaid can help individuals access nutrition supports that are otherwise unavailable through SNAP. For example, individuals experiencing homelessness, individuals who need assistance with activities of daily living, or people recovering from an inpatient stay may have difficulty preparing meals using groceries purchased by SNAP. At the time of this writing, SNAP benefits cannot be used to purchase prepared foods, and as the payer of last resort, Medicaid can pay for health-related nutrition supports that are not available elsewhere.[57] Medicaid enrollees should have the dignity to choose among meals and food that they enjoy, and to receive foods that contain the calories needed to alleviate hunger.

Looking Ahead



No one should go to bed or wake up hungry. To improve the health of people eligible for Medicaid and food assistance programs, states have an important opportunity to coordinate with sister agencies and programs to improve access and service delivery and better meet people's health care and health-related social needs. In doing so, states — working across silos — can reimagine their policies and programs by involving individuals with lived expertise in communities most affected by structural racism, inequity, and trauma. The insights and state examples highlighted in this report offer guidance for pursuing cross-sector and community partnerships and actions. By considering the concrete, actionable recommendations herein, states can explore and implement these ideas in a broad, collective approach to address food insecurity in a person-centered, equitable manner.

Appendix. Project Participants

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