

Addressing Nutrition *and* Food Access in Medicaid

OPPORTUNITIES AND CONSIDERATIONS



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Executive Summary

Access to affordable, healthy food is fundamental to health and well-being. Without such access, individuals face greater risk of diet-related disease, increased health care costs, and death. As a result, U.S. health care providers and health insurers are exploring new ways to meet patient nutrition needs. Many of these efforts focus on Medicaid—the public health insurance program serving millions of low-income individuals across the United States.

The purpose of this issue brief is to identify pathways for funding from state Medicaid programs to assist food access organizations, health care payers (i.e., public and private health insurers), and policymakers to improve access to nutrition interventions. To do so, the issue brief outlines:

- 1. Strategies that states and health plans have used to support access to healthy, affordable food for Medicaid participants; and**
- 2. Key considerations (identified by industry experts) that food access organizations, states, and health plans should bear in mind as they implement new programs.**

Food access organizations may be interested in this report to identify potential funding sources to help them enhance impact. Payers and policymakers may be interested to learn how they can utilize nutrition interventions to improve patient outcomes and reduce health care costs. Together, these stakeholders can build new partnerships to address food access, nutrition, and health in their local Medicaid landscapes.



I Introduction

FOOD AND HEALTH IN THE UNITED STATES

Stakeholders across the U.S. health care system are increasingly recognizing the critical role that nutrition plays in driving health outcomes and costs. Research shows that [food insecurity](#), or lack of consistent access to enough food for an active, healthy life,¹ and poor diet² are associated with a range of negative health outcomes. Poor diet is the [leading risk factor](#) for death in the United States.³ And for low-income adults, food insecurity is associated with a [higher probability](#) of serious chronic conditions such as hypertension, coronary heart disease, stroke, cancer, and diabetes (even when controlling for factors such as age, race/ethnicity, and insurance coverage).⁴ Similar trends have been documented across the lifespan, with research showing a clear link between food insecurity and decreased nutrient intake, being in fair or poor health, and depression.⁵



Unsurprisingly, food insecurity and diet are also associated with increased health care costs. A 2019 study estimated that adults experiencing food insecurity have annual health care expenditures that are \$1,834 higher than adults who are food secure. In total, this results in \$52.8 billion in excess health care costs in the United States each year.⁷ Diet-related diseases also play a key role in driving U.S. health care spending. Diabetes alone is responsible for one in every seven health care dollars spent in the United States, resulting in \$237 billion in direct medical costs each year.⁸

These trends have serious implications not only for U.S. health care quality and costs, but also for efforts to advance equity in the U.S. health care and food systems. Like many other issues in the United States today, food insecurity and diet-related disease disproportionately impact individuals who are Black, Indigenous, and People of Color (BIPOC). For example, in 2019, 10.9% of U.S. households were food insecure.⁹ White households fell below this average, with 8.1% of households experiencing food insecurity.¹⁰ In contrast, rates for Black, Latinx, and Native American households were 19.3%, 15.8%, and 23.5% respectively.¹¹ Since the onset of the COVID-19 crisis, these disparities have only deepened. According to estimates from *Feeding America*, U.S. food insecurity rates rose to 13.9% and 12.9% (42 million Americans) in 2020 and 2021, but for Black individuals, rates rose to more than 21% (more than 1 in 5 households).¹²

MEDICAID - FEDERAL GUIDANCE

Given these connections between food, health, and equity, many health care payers (i.e., public and private insurers) and policymakers are now exploring opportunities to connect patients to the foods they need to heal and thrive.

These efforts are occurring across the U.S. health care landscape,¹³ but have particular urgency for Medicaid, where low incomes and structural barriers may make it particularly challenging for participants to access healthy foods (for an introduction to the Medicaid program, see Section II).

In January 2021, the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the Medicaid program, released [new guidance](#) describing current pathways for addressing health-related social needs in Medicaid.¹⁴ This guidance lays an important foundation for states and plans interested in addressing issues such as food and housing insecurity. However, discussion of nutrition interventions in the guidance is limited—highlighting home-delivered meals, but few other approaches.¹⁵

This issue brief therefore seeks to build on the opportunities presented in the 2021 guidance by providing additional analysis and examples to promote innovative partnerships between food access organizations, Medicaid programs, and plans. By using the information here as a model for future work, these groups can better serve their state's Medicaid population.

FOOD SECURITY VS. NUTRITION SECURITY

Diet and food insecurity are closely linked. This issue brief therefore emphasizes the ways that Medicaid can support access to nutrition interventions—services that can help patients gain the knowledge and access to healthy foods needed to improve nutrition. Notably, though, some experts are also beginning to call for a broader shift in terminology to emphasize this link. These experts call for a focus on “nutrition security,” defined as “having consistent access, availability, and affordability of foods and beverages that promote well-being and prevent (and if needed, treat) disease.”¹⁶ This shift from the term “food security” to “nutrition security” is meant to emphasize the need for not only enough food, but enough *nutritious* food for a healthy life.

II Basics *of the* Medicaid Program

Medicaid is our nation's safety net health insurance program. Traditionally, Medicaid has provided health insurance coverage to low-income families, children, pregnant women, older adults, and people with disabilities. Under the Affordable Care Act, states now also have the option to provide coverage to the Medicaid expansion population, which includes all adults with incomes up to 138% of the federal poverty level. As of January 2021, Medicaid served more than 73 million individuals across the United States.¹⁶

Medicaid operates as a partnership between the state and federal governments. The federal government enacts laws and regulations which establish a basic framework for state Medicaid programs, including categories of mandatory and optional benefits¹⁷ and basic eligibility requirements.¹⁸ States then each administer their own Medicaid program, building upon this federal framework through their State Plan and, in some cases, Medicaid waivers. The costs of the Medicaid program are shared between the state and the federal government, with the proportion paid by the federal government (a.k.a. the Federal Medical Assistance Percentage (FMAP)) varying by state.¹⁹

Notably, states may use several approaches to administer their Medicaid program. Some states choose to directly pay individual health care providers for delivering Medicaid services (a.k.a. fee-for-service Medicaid), while others contract with private health plans (a.k.a. Medicaid managed care plans)²⁰ to do so. Some states are also experimenting with alternative payment models and value-based care. In these models, the state typically provides additional financial incentives for health care providers (or groups of providers such as Accountable Care Organizations) to improve health outcomes while controlling health care costs.

MEDICAID BENEFITS

For more information on which services state Medicaid agencies must cover (a.k.a. mandatory benefits) and which services state Medicaid agencies may choose to cover (a.k.a. optional benefits), see: <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>

MEDICAID ELIGIBILITY

For more information on Medicaid eligibility, see: <https://www.medicaid.gov/medicaid/eligibility/index.html>



III Strategies to Support Nutrition *and* Healthy Food Access in Medicaid

In recent years, state Medicaid agencies and Medicaid managed care plans, together with community-based organizations, have developed strategies to provide a spectrum of nutrition interventions to Medicaid enrollees, including:

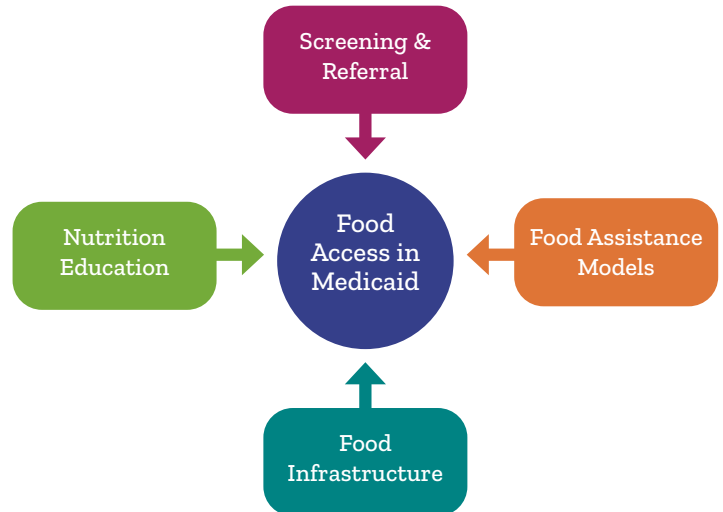
Nutrition Education: Education provided as a standalone service or as part of a broader disease management program (e.g., Medical Nutrition Therapy vs. Diabetes Self-Management Education).

Screening and Referral: Identification of participants experiencing food insecurity and referral to social service programs (e.g., Supplemental Nutrition Assistance Program [SNAP]).

Food Assistance Models: Strategies in which the state or health plan pays for the Medicaid participant to receive food items, typically through (1) a delivery or pick-up model (e.g., home-delivered meals) or (2) purchase assistance models. In some cases, these foods may be tailored to the participant's specific diagnosis and dietary needs. Such tailored interventions are sometimes referred to as "food is medicine" or "medically supportive food and nutrition" services (e.g., medically tailored meals, produce prescriptions, or medically tailored food packages).

Food Infrastructure/Community Investment: Strategies in which Medicaid managed care plans or health care provider entities fund the development of infrastructure needed to improve healthy food access in the community (e.g., to create new healthy food retailers).

This section outlines four strategies that CMS, states, and managed care plans have used to support the provision of these services for Medicaid participants: (1) State Plan coverage; (2) public and private grants/pilots; (3) Medicaid managed care; and (4) Medicaid waivers.



STATE PLAN COVERAGE

As noted in Section II above, Medicaid operates as a partnership between the state and federal government.

Federal laws and regulations establish baseline requirements for all state Medicaid programs, including broad categories of mandatory benefits (which states *must* cover) and optional benefits (which states *may* choose to cover).²¹ Each state then develops an individual State Plan. This State Plan builds upon the federal framework by filling in key details, including covered services. States have historically had the authority to cover some nutrition education and referral services under their State Plan, including:

Medical Nutrition Therapy: Medical Nutrition Therapy (MNT) consists of nutritional diagnostic, therapeutic, and counseling services provided by a Registered Dietitian Nutritionist or nutrition professional.²² While MNT is not a required Medicaid benefit, states can choose to provide coverage under benefit categories such as “other diagnostic, screening, preventive, and rehabilitative services.”²³ Roughly half of states currently provide some coverage of MNT or similar services.²⁴

Disease Management Programs: Nutrition education can also be included within broader disease management programs. Like MNT, states are not required to cover these programs in their Medicaid

WHAT BENEFITS DOES EACH STATE COVER?

Information regarding covered benefits is typically available on each state’s Medicaid website. Some state Medicaid agencies provide access to their full State Plan on their website. Others simply provide materials that summarize covered services. These websites also typically include contact information, that can be used to contact agency officials for further details.

State Plans. However, 34 states provide at least some coverage of Diabetes Self-Management Education (DSME) (as of 2016)²⁵ and seven states provide coverage of the National Diabetes Prevention Program (DPP) (as of 2019).²⁶

Case Management/Care Coordination: States may also cover case management and care coordination services under a number of mandatory and optional benefit categories (e.g., Early Periodic Screening, Diagnostic, and Treatment Services [EPSDT], case management, and health home services for enrollees with chronic conditions).²⁷ In some cases, these benefit categories are broad enough to include referrals to community and social support services (e.g., food access programs).

Services such as MNT, DSME, and the DPP can improve patient health by giving participants the skills and knowledge needed to adopt a healthy diet. Their impact may be limited, though, if participants cannot afford or access healthy foods. While case management services may include referrals to social service programs, some patients may require additional support to access the foods they need to maintain their health. Unfortunately, up to this point, CMS has not explicitly allowed states to cover the direct provision of food under any established Medicaid benefit category (with some limited exceptions, including coverage of enteral nutrition, such as tube feeding or nutrition supplements,²⁸ and state plan options to cover home-delivered meals as part of home and community-based services for individuals at risk of requiring institutional care²⁹).

Notably, federal policymakers could address this gap by adding nutrition interventions as an optional or mandatory category of Medicaid benefits or by interpreting existing categories to allow coverage. In the absence of federal action, though, support for many nutrition interventions has been limited to more flexible funding streams, including grants, managed care funding models, and waivers. Each of these options are described below.

PUBLIC AND PRIVATE GRANTS/PILOTS

Over the last decade, state and federal policymakers—as well as health care entities and philanthropic funders—have provided funding for a range of pilot programs that aim to address food access and nutrition in Medicaid populations. For example:

Grants/Pilots Funded by the U.S. Department of Health and Human Services (HHS)

- ♦ *Center for Medicare and Medicaid Innovation (CMMI), Accountable Health Communities (AHC) Model:* The AHC Model, operated by CMS's innovation center, provides federal grant support to evaluate “whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.”³⁰ While the model provides funding for screening, referral, and navigation, it does not provide funding for the direct provision of nutrition services.³¹ The AHC model is expected to run from 2017–2022, and currently involves 29 organizations across the United States.³²

Grants/Pilots Funded by the U.S. Department of Agriculture (USDA)

- ♦ *Gus Schumacher Nutrition Incentive Program (GusNIP) Produce Prescription Program Grants:* GusNIP offers federal grant support from USDA for projects designed to improve consumption of fruits and vegetables by low-income households. The Agriculture Improvement Act of 2018 (the 2018 Farm Bill) set aside up to 10% of funding available under GusNIP to support a new produce prescription grant program.³³ Under this program, applicants may apply through a competitive process for grants up to \$500,000.³⁴ These grants must be used to operate a program to prescribe fresh fruits and vegetables to individuals experiencing or at risk of developing a diet-related disease, who are eligible for the Supplemental Nutrition Assistance Program (SNAP) or enrolled in Medicaid.³⁵ GusNIP funded 9 new produce prescription projects in 2019 and 10 in 2020.³⁶

Grants/Pilots Funded by States

- ♦ *California Medically Tailored Meals Pilot:* In 2018, California launched a three-year, \$6 million pilot to evaluate the impact of providing 12 weeks of medically tailored meals to 1,000 Medicaid enrollees in eight counties.³⁷ This pilot was enacted through state legislation in 2017,³⁸ and specifically focuses on enrollees diagnosed with congestive heart failure.³⁹

Grants/Pilots Funded by Health Care Entities

- ♦ *Kaiser Permanente, Food for Life, SNAP Outreach Campaign:* As part of its Food for Life program, Kaiser Permanente, a large integrated health care system, has launched an outreach campaign to encourage eligible plan members to apply for SNAP benefits.⁴⁰ This campaign includes multiple forms of outreach—including text messages and phone calls—and provides guidance for SNAP enrollment.⁴¹ As of June 2021, the campaign had contacted more than 1.1 million potentially food-insecure households across Kaiser Permanente's service area, helping 73,000 people apply for SNAP.⁴²



These programs provide critical resources for launching, evaluating, and/or expanding access to nutrition interventions for Medicaid participants. But they are typically not long-term solutions. **Federal, state, and philanthropic grant and pilot programs are often time-limited. As a result, it is critical to ensure that sustainable funding pathways are available to maintain and expand successful nutrition programs after their initial grant/pilot periods.** Without such pathways, significant investment, infrastructure, and knowledge may be lost due to lack of long-term funding. Since coverage options within Medicaid State Plans are sparse, states and health plans have typically pursued two alternative pathways to establish more sustainable funding: managed care and waivers.

MEDICAID MANAGED CARE

As of 2019, 40 states delivered some portion of their Medicaid benefits through private health plans (a.k.a. Medicaid managed care).⁴³ Federal regulations governing Medicaid managed care establish a range of options for states and individual health plans to address food access and nutrition issues among Medicaid participants.

State Options

In order to deliver services via managed care, states must complete a procurement/contracting process. This process creates important opportunities for states to incentivize or require plans to offer services related to food access and nutrition. According to a [2020 analysis](#) conducted by the National Academy for State Health Policy, at least 33 states reference food in their managed care contracts in some way.⁴⁴ Specifically, states may leverage federal regulations requiring Medicaid managed care plans to assess the needs of new patients⁴⁵ and coordinate care⁴⁶ to contractually require plans to screen for and respond to food insecurity.⁴⁷ As of [2019](#), 25 states required their managed care plans to screen enrollees for social needs and 28 states required plans to provide referrals to social service providers.⁴⁸

States can also create opportunities to address food access through contract provisions regarding reporting/incentive arrangements or value-based payment models.⁴⁹ For example, by incorporating metrics related to food insecurity and diet-related diseases (e.g., diabetes) into reporting and incentive arrangements, states can motivate plans to address food access and nutrition in their patient populations.

WHICH STATES USE MEDICAID MANAGED CARE?

States typically provide information regarding their managed care programs on their state Medicaid website. The Kaiser Family Foundation also operates a helpful [Medicaid Managed Care Market Tracker](#).

WHAT'S INCLUDED IN EACH STATE'S MEDICAID MANAGED CARE CONTRACTS?

Most state Medicaid agencies post a copy of their managed care contract (and relevant attachments) on their website. These documents can be lengthy, and so it can be helpful to search through the document for key terms such as "food," "meals," "social determinants of health," and "health related social needs."

CASE STUDY

Ohio

Over the course of 2020–2021 Ohio has conducted its Medicaid [managed care procurement process](#), ultimately selecting six health plans to operate its "next generation managed care program."⁵⁰ Under its Request for Applications, Ohio indicated that it will require its managed care plans to take certain actions to address food access and nutrition at the individual and, potentially, community level. Specifically, plans must:

- Partner with community-based organizations and "contribute to solutions addressing [social determinants of health]-related needs" such as "lack of access to nutritious food";
- Ensure "active referral to and follow-up" on identified needs related to social determinants of health by: providing up-to-date community resources lists to patients and health care providers, reimbursing social determinant diagnostic codes (i.e., "z codes"), and reimbursing providers for follow-up after referral to confirm the member received the service; and
- Contribute 3% of the plan's annual profits to community reinvestment in support of population health strategies; this amount increases by 1% each year, up to a maximum of 5%.⁵¹

Managed Care Plan Options

Medicaid managed care plans must provide services covered by their Medicaid State Plan (or a designated subset of these services). However, plans also have a number of regulatory flexibilities that allow them to voluntarily provide extra services to their enrollees, including nutrition interventions. These flexibilities include: in lieu of services, value-added services, and activities that improve health care quality.

- ♦ **In Lieu of Services (ILOS):** Services approved by the state as a cost-effective substitute for services covered under the State Plan.⁵²
- ♦ **Value-Added Services:** Services not covered under the State Plan, but voluntarily offered by the managed care plan.⁵³
- ♦ **Activities that Improve Health Care Quality:** Activities not covered under the State Plan, but conducted by the managed care plan to improve health quality and outcomes.⁵⁴

When choosing among these options, plans can look at a number of factors, including whether the proposed service meets regulatory requirements (e.g., cost-effectiveness for ILOS), and how providing the service could impact the plan's Medical Loss Ratio and capitation rate.

- ♦ **Capitation Rate:** The per-member, per-month rate that the state pays each plan to manage delivery of Medicaid services.⁵⁵ For example, if a state set its capitation rate at \$250, it would pay the plan: $\$250 \times (\# \text{ of plan enrollees}) \times (\# \text{ of months})$.
- ♦ **Medical Loss Ratio (MLR):** The ratio which describes how much a managed care plan spends on claims (i.e., paying for patient services) as opposed to administrative activities. Capitation rates are set so that the plan will reasonably achieve an annual MLR of at least 85%.⁵⁶ Some states also require plans to achieve a minimum MLR, and penalize plans that fail to do so.⁵⁷

Plans may be particularly motivated to cover services that can be included in their capitation rate, as the cost of those services will be reflected in the payments they receive from the state. Similarly, plans may be most interested in covering services that can be included in the numerator of their MLR (e.g., considered claims), as those services will help them to achieve a higher ratio and meet state and federal requirements.

CASE STUDY

Differing Approaches to Managed Care Flexibilities

• **California – Allowing Coverage of Medically-Supportive Food and Nutrition Services:**

As part of its Advancing and Innovating Medi-Cal (CalAIM) initiative, California has developed a proposal to use ILOS authority to allow Medi-Cal managed care plans to provide additional, medically-appropriate services to their enrollees. In documents outlining the proposal, the California Department of Health Care Services (DHCS) has indicated that it plans to allow coverage of a range of [medically-supportive food and nutrition services](#)—such as medically tailored meals and produce prescriptions—as ILOS. Under the proposal, these services will be offered in lieu of more intensive services (e.g., hospitalizations and Emergency Department visits) that would be needed in their absence.⁶³

• **Kentucky/New Jersey – Activities that Improve Health Care Quality:**

WellCare, a Medicaid managed care plan operating in New Jersey and Kentucky, offers personalized nutrition services to its enrollees as an activity that improves health care quality. Specifically, WellCare contracts with [Good Measures](#), an organization offering disease prevention and management solutions with a nutrition focus, to deliver the Diabetes Prevention Program (DPP) and Diabetes Self-Management Education (DSME) to its enrollees. In these programs, participants receive one-on-one clinical coaching (via phone, email, text, and secure video), online group video classes (for the DPP), and access to a phone application/platform that provides tailored feedback on food choices and next best meal recommendations. The app also enables tracking of key data such as meals, physical activity, blood sugar, and medications to support a whole person approach to care.⁶⁴

For these reasons, ILOS is a particularly appealing coverage option. While services covered as ILOS must meet certain requirements (e.g., cost-effectiveness) and be approved by the state, the costs of ILOS may be included in both capitation⁵⁸ and the numerator of the MLR.⁵⁹ In contrast, value-added services and activities that improve health care quality may be included in the numerator of the MLR,⁶⁰ but often cannot be included in capitation (notably, though, Oregon has allowed its Coordinated Care Organizations to include the costs of activities that improve health care quality in the non-benefit portion of capitation⁶¹ under its Section 1115 Waiver, see case study on page 13).⁶²

MAY OTHER STAKEHOLDERS INFORM THE CONTRACTING PROCESS?

As discussed in Section V, some states have created formal opportunities (e.g., written comment periods) for community stakeholders to inform the development of Medicaid managed care contracts. In the absence of such opportunities, stakeholders can informally reach out to their state Medicaid agency (e.g., through organizational or sign-on letters) to encourage agency officials to address food access and nutrition in their next round of managed care contracting.

WHICH MANAGED CARE PLANS COVER NUTRITION SERVICES?

Medicaid managed care plans typically post materials (e.g., member handbooks) that describe their covered services on their websites. To determine which health plans contract with the Medicaid program in a given state, food access organizations and other stakeholders can visit the state's Medicaid website.

MEDICAID WAIVERS

Finally, states may also support access to nutrition interventions through Medicaid waivers. Waivers allow states to implement innovative Medicaid policies—such as paying for nutrition interventions as a covered benefit—that might not otherwise be allowed under federal guidelines.

To obtain a waiver, the state Medicaid agency must submit a request to CMS. CMS then approves or denies the request based upon federal requirements for each type of waiver (e.g., allowable changes in benefits, payment models, eligibility, etc.). Several types of waivers can be used to address food access and nutrition issues—each of which is named based upon the section of the Social Security Act in which it appears.

- ◆ **Section 1915(c) Home and Community-Based Services Waivers:** Section 1915(c) Waivers allow states to provide additional home and community-based services to individuals who would otherwise require institutional care.⁶⁵ Under these waivers, states may provide coverage of meal preparation supports or home-delivered meals, provided that delivered meals do not constitute a full nutritional regimen (i.e., three meals per day).⁶⁶
- ◆ **Section 1915(b)(3) Managed Care Waivers:** Section 1915(b) Waivers allow states to require a broader segment of their Medicaid population to enroll in managed care than would otherwise be allowed under a State Plan.⁶⁷ Under Section 1915(b)(3), states may then elect to use savings from their managed care program to provide additional services not covered under the State Plan.⁶⁸ CMS has stated that these additional benefits may include services designed to address a wide range of health-related social needs, such as nutrition needs.⁶⁹ These services must be approved by CMS in the waiver application.⁷⁰
- ◆ **Section 1115 Demonstration Waivers:** Section 1115 Demonstration Waivers are the most flexible of the Medicaid waiver options. States may use these waivers to launch demonstration—or test/pilot—projects that are “likely to assist in promoting the objectives” of the Medicaid program.⁷¹ States may also use 1115 Waivers to aid in state response to public emergencies.⁷²

Section 1115 Waivers permit states to waive certain provisions of the Medicaid Statute (e.g., statewideness and comparability requirements),⁷³ and cover services and populations that would not normally be allowed under federal rules.⁷⁴ Notably, though, CMS requires all Section 1115 Waiver proposals to be budget neutral to the federal government (i.e., not result in more costs to the federal government than would occur absent the waiver).⁷⁵ States such as Massachusetts,⁷⁶ North Carolina,⁷⁷ and Oregon⁷⁸ have used Section 1115 Waivers to address food access and nutrition among Medicaid participants (see case studies below).

FINDING MEDICAID WAIVERS

CMS provides a useful list of current and past Medicaid waivers, on its Medicaid.gov website: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>. This list can be filtered by state and type of waiver. The site also provides access to key waiver documents (such as waiver approvals) that contain the details of exactly what is included in each waiver. State Medicaid agency websites may also contain additional information regarding waiver programs.

CASE STUDY

Differing Approaches to Innovation via Section 1115 Demonstration Waivers

- **North Carolina – Creating Standardized Tools and Approaches to Address Food Access in Medicaid:**

North Carolina's Section 1115 Waiver, approved by CMS in 2018, moves the state's Medicaid program from fee-for-service to a managed care system.⁷⁹ Under this waiver, North Carolina has developed specific requirements and standardized tools to address health-related social needs—including food insecurity. Plans participating in the new managed care system will be required to screen their enrollees for health-related social needs using a standardized screening tool⁸⁰ and provide referrals to services in the community.⁸¹ In order to support this process, North Carolina, in partnership with the Foundation for Health Leadership and Innovation, has developed NCCARE360, a statewide, bi-directional electronic referral platform.⁸²

In addition to these screening and referral requirements, the waiver authorizes a \$650 million [Healthy Opportunities Pilots](#) program. This program will test “evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries.”⁸³ To guide the implementation of these pilots, North Carolina has developed a standardized fee schedule. The fee schedule includes “a service name, unit of service, service rate, and service definition for twenty-nine approved Pilot services.”⁸⁴ Nine of these 29 services are specifically designed to address patient food needs (e.g., fruit and vegetable prescriptions, healthy food boxes, and medically tailored home delivered meals).⁸⁵

- **Oregon – Using Flexible Funding Pathways and Community-Informed Processes to Address Food Access in Medicaid:**

Oregon's Section 1115 Waiver, approved in 2012, shifted delivery of the state's Medicaid services to Coordinated Care Organizations (CCOs)—health care entities made up of a network of health care providers.⁸⁶ The waiver has since been renewed and updated in 2017.⁸⁷ Under this waiver, Oregon has adopted a broad, flexible approach to addressing health-related social needs, with an emphasis on community engagement. CCOs operate under a global budget for physical, behavioral, and oral health services,⁸⁸ creating flexibility in CCO spending. State legislation passed in 2018 requires CCOs to spend a portion of their income/reserves on services designed to address health disparities and social determinants of health.⁸⁹

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Under the 2017 waiver renewal, CCOs also have added incentives to address health-related social needs by providing “health-related services,” a broad category that can include both “flexible services” and broader “community benefit initiatives.”⁹²

- **Health-related Services:** Services not covered under Oregon’s State Plan that are “intended to improve care delivery and overall member and community health and well-being” and that meet the federal definition of activities that improve health care quality.⁹³
- **Flexible Services:** “[C]ost-effective services offered to an individual member to supplement covered benefits”⁹⁴ (e.g., food vouchers).⁹⁵
- **Community benefit initiatives:** “[C]ommunity-level interventions that include members, but are not necessarily limited to only members, and are focused on improving population health and health care quality”⁹⁶ (e.g., developing a farmers market in a food desert).⁹⁷

In the waiver renewal, CMS and the Oregon Health Authority (OHA) clarified that spending on health-related services can be included in CCO capitation rates (as part of the non-benefit load) and in the numerator of the CCO’s MLR.⁹⁸ Since the waiver renewal, OHA has also stated that CCOs may provide “[f]ood services and supports” as part of these health-related services.⁹⁹ Taken together, this means that CCOs receive funding (through their capitation rate) that can be used to invest in services that address food access in their patient populations and communities.

Community members have a role in shaping these services and in each CCO’s broader activities related to health-related social needs. Each CCO must have a Community Advisory Council (CAC). CACs include representation from local government and community-based organizations, but the majority of members must be Medicaid participants.¹⁰⁰ The CAC oversees the development of a community health assessment and community health improvement plan for the CCO.¹⁰¹ The CAC must also play a role in determining how the CCO will spend funding on community based initiatives as part of its health-related services portfolio.¹⁰²

COORDINATED CARE ORGANIZATIONS (CCOs)

The Oregon Health Authority (the state’s Medicaid agency) defines a CCO as “a network of all types of health care providers (physical health care, addictions and mental health care and dental providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy.”⁹⁰ Notably, CCOs are similar in structure to Accountable Care Organizations (ACOs) established by Medicaid programs in states such as Massachusetts.⁹¹



IV Getting Started: Considerations *for* Nutrition Programs

For food access organizations, the process of moving from an idea to a pilot program to integration into the Medicaid system can be daunting. While each program's evolution will be unique, certain factors can help contribute to success. This section provides a brief overview of these factors—based upon existing sources and interviews with food access organizations.

IDENTIFYING PARTNERS & CHAMPIONS

A key first step to establishing a Medicaid nutrition program is to identify program partners. Program partners may include, for example: an organization responsible for providing the nutrition intervention (e.g., nutrition education, meals, produce, etc.), an organization responsible for identifying and referring patients to the program (e.g., a health care clinic), and an organization (or organizations) responsible for funding the program (e.g., a foundation, individual donor, or health care entity).

To find these partners, food access organizations can examine their existing networks—board members, coalition members, or community partners—to identify individuals and organizations that can either fill these roles directly or provide introductions to potential partners. Program partners will then need to work collaboratively to outline key elements of the program, including program design, evaluation, and infrastructure needed to launch the program (e.g., referral systems).

ESTABLISHING INITIAL FUNDING

Partners will also need to determine how they will initially fund the program. As noted earlier, pilot programs may be funded through a variety of sources, including state and federal grants, private philanthropy, individual donors, or health care entities. In seeking funding, partners will need to consider the full range of costs associated with the program, including administrative costs, the costs of the nutrition intervention itself, and costs associated with evaluation.



EVALUATING & REFINING THE PROGRAM

Program evaluation can be critical to refining and sustaining nutrition interventions. By taking the time to assess barriers affecting participation or success (e.g., lack of transportation, program hours, target health conditions, etc.), organizations can refine their approach over time. Additionally, by evaluating impact on participant health and well-being, organizations can build the case for integration into Medicaid funding streams. Wherever possible, organizations should include metrics in their evaluation that will resonate with their state Medicaid agency and plans. Such metrics may include, for example: impact on health outcomes, health care utilization, health care costs (i.e., return on investment), and retention in care.¹⁰³ However, when developing any evaluation plan, organizations should also carefully consider their own capacity (e.g., staff, funding, and access to data). In instances where capacity is limited, organizations can focus on evaluations of patient experience, behavior change, and patient-reported outcomes, all of which can still provide valuable insights to potential Medicaid partners.¹⁰⁴

ADVOCACY FOR INTEGRATION INTO MEDICAID FUNDING STREAMS

Finally, organizations can work to identify opportunities to advocate for the integration of nutrition interventions into Medicaid funding streams. This engagement can be formal—through public hearings and written comments—or more informal and educational—through

meetings or site visits with individual plans, Medicaid officials, or other policymakers. In each instance, food access organizations can use existing research and program evaluations to highlight how their services can help to address current goals of the Medicaid program or plan.

CASE STUDY

DC Greens¹⁰⁵

DC Greens, a community-based food access organization based in Washington, D.C., operates a produce prescription program in partnership with three Medicaid managed care plans, and Giant, a supermarket chain. This case study describes the evolution of this program, based on the steps described above.

- **Identifying Initial Partners/Champions:** In 2012, Dr. Luis Padilla, a physician from Unity Health Care's Upper Cardozo Health Center, proposed that DC Greens partner with Unity Health Care to establish a produce prescription program. Under this program, DC Greens would provide children and families participating in the health center's We Can! program with vouchers to purchase fruits and vegetables at a local farmers market.
- **Establishing Initial Funding:** To launch the program, DC Greens obtained one year of initial funding from Wholesome Wave, a nutrition-focused nonprofit and provider of seed funding for similar programs across the nation.
- **Evaluating and Refining the Program:**
 - **Initial Evaluation:** The initial pilot resulted in a 60% increase in patient retention in the We Can! program. As a result of the pilot's success—and Dr. Padilla's work to champion the effort—DC Greens was able to obtain private donations to expand the program across additional farmers markets and clinics in the Unity Health Care network.
 - **Program Refinement:** Through ongoing evaluation, DC Greens learned that some participants faced barriers to redeeming produce prescriptions at farmers markets (e.g., limited market hours). As a result, in 2019, DC Greens began partnering with Giant, a national grocery store chain serving key areas of the district, providing produce prescriptions redeemable at Giant grocery stores.
- **Advocacy for Integration into Medicaid and Other Health-Related Funding Streams:** In 2015, DC Greens and other local champions successfully advocated for the allocation of public health funding to support healthy food access, including \$50,000 specifically for produce prescriptions. In the same year, a DC Greens board member introduced the organization to AmeriHealth Caritas District of Columbia, one of D.C.'s Medicaid managed care plans. In 2016, AmeriHealth began to partner with DC Greens, with the goal of using produce prescriptions to reduce emergency department visits and improve patient-provider relationships. This partnership has grown over time, and now leverages DC Greens' partnership with Giant.

NEXT STEPS: In 2019, DC Greens and its partners successfully advocated for produce prescription funding to be shifted from the public health budget into the budget of D.C.'s Medicaid agency. This shift improved their ability to work with Medicaid managed care, leading to partnerships with two additional plans.¹⁰⁶ While much of the program remains funded by private philanthropy, DC Greens uses Medicaid funds to support program evaluation (conducted by Socially Determined, a technology company focused on measuring the impact of social determinants of health¹⁰⁷). In the years to come, DC Greens hopes to leverage findings from this evaluation to make the case to fully integrate produce prescriptions into D.C.'s Medicaid program.

Getting Started: Considerations *for* Plans and Policymakers

Like food access organizations, plans and policymakers interested in developing strategies to support access to nutrition interventions for Medicaid participants face a daunting array of choices and potential pathways. Below is an overview of factors that can drive success, based on existing research and interviews with industry experts.¹⁰⁸ These factors fall into three broad categories: (1) design considerations, (2) barriers to access, and (3) federal activity.

DESIGN CONSIDERATIONS

1. Community Engagement

Barriers to food access can vary significantly from community to community. Community engagement can therefore play a critical role in ensuring that Medicaid nutrition programs are designed to respond to community needs and local circumstances. A range of formal and informal approaches are available to promote successful and meaningful community engagement:

- ♦ **Formal Approaches to Community Engagement**
 - **Federal Requirements:** Federal laws and regulations governing many of the strategies described in Section III already require states and plans to take certain steps to formally engage their communities. For example, regulations governing Section 1115 Waivers require both public hearings and written comment periods prior to CMS approval.¹⁰⁹ Federal regulations also require state Medicaid agencies¹¹⁰ and Medicaid managed care plans¹¹¹ to have advisory committees that include Medicaid enrollees.
 - **State Requirements:** Some states have adopted additional community engagement strategies, such as establishing a formal comment period during the development of managed care contracts.¹¹²



♦ *Informal Approaches to Community Engagement*

- States and plans can also explore less formal community engagement strategies. These strategies can range from conducting focus groups to issuing surveys or to conducting one-on-one meetings with individual organizations and community members. For example, Kaiser Permanente, a large, integrated health care system, conducted individual conversations with community stakeholders, including individuals experiencing food insecurity, when developing their Food for Life nutrition strategy.

Payers and policymakers should remember, though, that the same barriers that they are hoping to detect may impact community members' ability to participate in community engagement opportunities. Some of the most successful community engagement strategies are therefore those that provide extra services and incentives to support participation (e.g., by providing transportation, stipends, and/or childcare during meetings).

2. Balancing Flexibility with Consistency

As demonstrated by the North Carolina and Oregon Section 1115 Waivers, states vary widely in how prescriptive they are when designing Medicaid responses to health-related social needs. In particular, states provide differing levels of flexibility on topics such as:

- ♦ *Allowable services;*
- ♦ *Screening tools;*
- ♦ *Referral platforms; and*
- ♦ *Evaluation metrics.*

This variation speaks to the tension between flexibility and consistency in program design. Allowing some flexibility can be helpful in allowing payers and providers to respond to the specific needs of individual communities. However, incorporating too much flexibility in program design can create unintended consequences, including additional burdens for community-based organizations (e.g., when asked to navigate multiple referral platforms), uncertainty for health care providers (e.g., when coverage varies between plans), or inaction (e.g., if payers or providers are insufficiently incentivized to provide nutrition services). Payers and policymakers must keep these tradeoffs in mind as they design new programs.

3. Infrastructure

When designing new programs to address nutrition and food access in Medicaid populations, payers and policymakers must also consider how to establish necessary infrastructure. Such infrastructure includes systems that allow: health care providers to refer patients to services, community practitioners and case managers to help match patients to services based on location, patients to access services, and food access organizations to bill for services.

One element of infrastructure requiring particular attention is the development of referral platforms. If health care providers are acting as gatekeepers to Medicaid nutrition interventions, they must be able to easily refer patients to services in the community. An [array](#) of electronic referral platforms have emerged to respond to this need, with an increasing emphasis



on “bi-directional” systems, which allow health care providers to communicate back and forth with social service providers to exchange information and confirm referral outcomes.¹¹³

In our interviews, industry experts particularly highlighted the efforts of states such as [Arizona](#) and [North Carolina](#) to create statewide referral platforms. While this approach requires greater investment at the state level—and potential need for public-private partnerships—it can create greater consistency, streamline efforts to identify community resources, and reduce the burdens on community-based organizations by limiting the need to navigate multiple platforms.

Plans and policymakers should, however, keep the practical needs of food access organizations in mind as they establish these new platforms. Food access organizations may be unwilling—or unable—to participate in new referral systems unless they are paired with funding to support the costs of responsive services. Effective approaches will include both sustainable funding and referral infrastructure.

4. Evaluation

Like food access organizations, payers and policymakers must also keep a number of considerations in mind as they design the evaluation of Medicaid nutrition interventions. Evaluations typically assess impact on health outcomes, health care utilization, and costs. The inclusion of costs in evaluation is understandable, given rising health care spending across the country. However, too narrow a focus on short-term cost-savings and return on investment may obscure other benefits of nutrition interventions. Payers and policymakers could therefore consider a range of alternative approaches:

- ♦ **Cost-Effectiveness:** Establishing short-term cost-savings can be difficult, and is rarely a requirement for coverage of traditional health care services (e.g., medications and procedures). In contrast, payers and policymakers can consider evaluating the *cost-effectiveness* of nutrition interventions, either alone or in comparison to alternative interventions (e.g., diabetes medications).
- ♦ **Patient Experience:** Nutrition interventions can also deliver value to the health care system beyond immediate cost-savings. For example, evaluations could assess impacts on patient experience, patient behaviors (e.g., healthy food choices), engagement with primary care, and stress—each of which can benefit payers over time.
- ♦ **Population Health:** One of the primary arguments for health care’s involvement in interventions that address upstream food access issues is to promote long-term prevention of diet-related disease and to respond to drivers of health disparities.¹¹⁴ While more difficult to evaluate, capturing (or modeling) impact on these issues would generate a more complete picture of the value of nutrition interventions.

Finally, in designing any evaluation, payers and policymakers should keep the capacity and resources of partner organizations in mind. It can be challenging for community-based food access organizations to participate in large-scale evaluations for a host of reasons—including costs, limited access to data, and lack of expertise. In order to keep evaluation from being a barrier to entry, payers and policymakers should therefore be prepared to narrow the scope of evaluation or to allocate additional resources, time, and/or staff to support more complex research goals.



POTENTIAL BARRIERS TO ACCESS - ACCESS TO CARE AND ACCESS TO FOOD

Payers and policymakers must also look beyond program design to consider the broader context surrounding Medicaid nutrition interventions. Because nutrition interventions must interact with both the food and health systems, barriers that impact access to care and access to food may impact program success.

1. Barriers to Accessing the Health Care System

Leveraging the Medicaid system to address nutrition needs can have important positive impacts on patient and population health. However, it also means that pre-existing barriers that prevent access to care may prevent access to Medicaid nutrition interventions.

- ♦ **Medicaid Eligibility:** For example, to access Medicaid nutrition supports, patients will first need to be eligible for Medicaid in their state. While [39 states](#), including Washington, D.C., have adopted Medicaid expansion, 12 states have not.¹¹⁵ As a result, many low-income adults may not be able to access Medicaid coverage—and therefore Medicaid services—in their state. Similarly, individuals enrolled in Medicare with incomes slightly too high to qualify for Medicaid, may experience a coverage “cliff” in which they cannot access Medicaid supports, and have difficulty paying the cost-sharing required to access Medicare services.¹¹⁶
- ♦ **Bias in the Health Care System:** Historic (and ongoing) biases within the health care system may also present a barrier to access. Issues such as systemic racism within the health care system have created a cycle of abuse, distrust, and disengagement for a variety of patients, but especially for patients from BIPOC populations.¹¹⁷ As a result, these individuals may be less likely to seek services through the health care system.

Payers, policymakers, and their food access organization partners should be aware of this context when developing new programs and think about how their efforts can respond to barriers or align with broader efforts to enact systemic change.

2. Barriers to Accessing Food/Nutrition Services in the Community

Millions of Americans also lack easy access to food retailers (e.g., grocery stores) in their communities.¹¹⁸ This issue, combined with transportation insecurity, can make it difficult for patients to redeem Medicaid nutrition benefits. In developing new interventions, payers, policymakers, and partnering organizations must be attentive to these barriers and incorporate strategies to overcome them such as:

- ♦ Partnering with the most commonly used and accessible food retailers in the target community, including those that sell culturally appropriate foods;
- ♦ Co-locating services to layer food/nutrition services into venues that community members have consistent, easy access to (e.g., health centers, schools, recreation centers, housing complexes, etc.);
- ♦ Incorporating transportation or delivery into program design; or even
- ♦ Using funds to support the establishment of new food retailers.

FEDERAL ACTIVITY

Finally, all stakeholders interested in advancing the role of nutrition in the Medicaid program should continue to monitor the federal policy landscape as it evolves. The federal government plays a critical role in developing and approving many of the opportunities described above. CMS is responsible for interpreting the scope of Medicaid benefit categories; establishing large-scale Medicaid demonstration models; approving Medicaid waivers; and setting Medicaid managed care regulations. Changes in federal leadership—such as those occurring in the wake of the 2020 election—may lead to new approaches that could open additional pathways to supporting Medicaid nutrition interventions.

Similarly, as federal priorities shift over time, Congress may pursue legislative changes that could reshape the current landscape. In the wake of the COVID-19 crisis, Congress has already acted to expand support for health-related social needs. For example, the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 included funds for the [Centers for Disease Control and Prevention \(CDC\)](#) to address social determinants of health as they relate to COVID-19,¹¹⁹ and the Consolidated Appropriations Act, 2021 included additional funding for USDA’s GusNIP grant program.¹²⁰ Members of Congress have also introduced [legislation](#) that could address some of the upfront costs associated with implementing and scaling Medicaid nutrition interventions, such as the costs of developing electronic referral platforms.¹²¹ By monitoring these developments, stakeholders across the food and health systems can maximize the impact of each policy change to improve food access and nutrition for the communities they serve.



VI Conclusion

A growing body of research clearly shows the urgent need to address the connection between food and health. Issues of food insecurity and poor diet pose serious risks to patient health, health care costs, and health equity across the United States. **Opportunities exist to build partnerships between food access organizations and Medicaid payers and providers. However, greater uptake is needed to establish widespread, equitable access.**

Existing policies, as well as economic and social pressures resulting from the COVID-19 pandemic, are deepening these issues, creating the need for system-wide solutions to address our nation's health disparities.

As a result, payers and policymakers are increasingly interested in incorporating nutrition services and supports into the Medicaid program. To promote new partnerships, this issue brief has outlined a range of strategies and considerations for integrating nutrition interventions into Medicaid delivery and financing.

By leveraging these strategies—and exploring the potential for policy change if they fall short—food access organizations, payers, and policymakers can both improve the health of their communities and chart a course for larger change.

If you would like additional information on any of the strategies or examples discussed in the issue brief, please contact Katie Garfield at: kgarfield@law.harvard.edu



About the Authors

The Food Trust

[The Food Trust](#) is a nationally recognized nonprofit organization that works with supermarkets, policymakers and other stakeholders on a comprehensive approach that increases the availability and affordability of healthy food.

Population Health Alliance

The [Population Health Alliance](#) (PHA) is the industry's only multi-stakeholder professional and trade association solely focused on population health, representing stakeholders from across the health care ecosystem that seek to improve health outcomes, optimize medical and administrative spend and drive affordability.

Center for Health Law and Policy Innovation

The [Center for Health Law and Policy Innovation](#) of Harvard Law School (CHLPI) advocates for health and food justice, with a focus on the needs of systemically marginalized individuals. CHLPI works with a range of stakeholders to expand access to high-quality health care and nutritious, affordable food; to reduce health and food-related disparities; and to promote more equitable and sustainable health care and food systems.

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This issue brief provides information and technical assistance on issues related to health reform, public health, and food law. It does not provide legal representation or advice. This document should not be considered legal advice. For specific legal questions, consult an attorney.



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Glossary

The table below contains a glossary of key terms used throughout this issue brief. Bolded words within each definition are separately defined in the glossary.

TERM	DEFINITION
Accountable Care Organization (ACO)	A health care delivery model found in Medicaid , Medicare , and private insurance that brings together health care providers (and, in some cases, payers) into one network that is accountable for the care of a designated set of patients. ACOs are often paid via alternative payment models , in which the ACO is rewarded for improving health outcomes and reducing health care costs within its patient population.
Activities that Improve Health Care Quality	Activities not covered under the State Plan , but conducted by a Medicaid managed care plan to improve health quality and outcomes.
Alternative Payment Model (APM)	APMs offer an alternative to fee-for-service models (i.e., models in which health care payers pay health care providers for each individual service/item provided). APMs include approaches such as capitation , bundled payments, and shared savings models. Generally, these approaches are designed to promote quality—rather than quantity—of care.
Bi-directional Referral System	Electronic platforms which allow health care providers to communicate with community-based organizations (CBOs) to perform tasks such as: (1) referring patients to services offered by the CBO; (2) sharing necessary patient information; and (3) confirming the outcome of referrals.
Capitated Payment	A payment model in which a Medicaid managed care organization or health care provider receives a fixed amount of money per patient per unit of time (i.e., per member per month).
Centers for Medicare & Medicaid Services (CMS)	The federal agency responsible for administering the Medicaid and Medicare programs. CMS sits within the U.S. Department of Health and Human Services. In addition to promulgating Medicaid regulations and guidance, CMS is responsible for approving key components of each state's Medicaid program, including Medicaid State Plans and waivers .
Coordinated Care Organization (CCO)	A network of all types of health care providers (physical health care, addictions and mental health care and dental providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Oregon's Medicaid program). CCOs focus on prevention and helping people manage chronic conditions like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. ¹²²
Federal Medical Assistance Percentage (FMAP)	The costs for operating each state's Medicaid program are shared between the state and federal government. The portion paid by the federal government is calculated based upon the state's Federal Medical Assistance Percentage (FMAP). FMAP varies by state based on per capita income, but must always be at least 50%.

Fee-for-Service Model	The traditional payment model in the Medicaid program. Under this model, health care payers pay health care providers for each individual service provided.
Food Insecurity	Lack of consistent access to enough food for an active, healthy life. ¹²³
Food is Medicine	Interventions tailored to respond to the connection between food and health by helping to prevent, manage, or reverse diet-related disease. Food is medicine interventions may also be referred to as medically-supportive food and nutrition services. Examples of food is medicine interventions include: medically tailored meals , produce prescriptions , and medically tailored food packages .
Health Care Payer	An organization responsible for paying health care providers for delivering Medicaid services. Payers may be public (e.g., a state Medicaid agency) or private (e.g., a health plan).
Health Care Provider	Individuals (e.g., physician, nurse, RDN) or institutions (e.g., hospitals) that provide health care services.
In Lieu of Services (ILOS)	Services provided by a Medicaid managed care plan that are approved by the state as a cost-effective substitute for services covered under the State Plan .
Managed Care Plan	Health insurance organizations that contract with a state Medicaid agency to pay for and manage the delivery of benefits to Medicaid participants. Managed care plans are paid via capitation (i.e., a set amount per member per month).
Medicaid	A federal and state-funded health insurance program that serves certain categories of low-income individuals. While each state's Medicaid program is different, federal laws and regulations establish baseline requirements. All states must provide coverage for children, pregnant women, parents, elderly, and disabled individuals meeting specified income criteria. States may also choose to cover all low-income adults with incomes up to 138% of the federal poverty level (i.e., the Medicaid expansion population). As part of their benefit package, states must cover certain mandatory categories of services. States then have flexibility to choose to cover other optional categories of services.
Medicaid Waiver	States may choose to apply for waivers in order to make changes to their Medicaid program that would not otherwise be allowed under federal guidelines. There several types of waivers that states may apply for, each titled based upon the section of the Social Security Act in which the waiver authority appears (e.g., Section 1115 Waiver).
Medical Loss Ratio (MLR)	The ratio which describes how much a Medicaid managed care plan spends on claims (i.e., paying for patient services), quality improvement activities, and fraud prevention activities as opposed to administrative activities. Capitation rates are set so that the plan will reasonably achieve an annual MLR of at least 85%.
Medical Nutrition Therapy (MNT)	Medical Nutrition Therapy (MNT) consists of nutritional diagnostic, therapeutic, and counseling services provided by a Registered Dietitian Nutritionist or nutrition professional. While MNT is not a required Medicaid benefit, states can choose to provide coverage under several benefit categories.
Medically Tailored Food Package	Medically tailored food packages (MTFP) include a selection of minimally prepared grocery items selected by a Registered Dietitian Nutritionist or other qualified nutrition professional as part of a treatment plan for an individual with a defined medical diagnosis. The recipient of a medically tailored food package is typically capable of shopping for and picking up the food and preparing it at home, and is referred by a health care provider or plan. ¹²⁴

Medically Tailored Meal	Medically tailored meals are delivered to individuals living with severe illness through a referral from a medical professional or health care plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction. ¹²⁵
Medicare	A federal health insurance program that serves individuals aged 65 and older and individuals with certain disabilities. The Medicare program is broken into four parts: Medicare Part A (hospital insurance); Medicare Part B (medical insurance); Medicare Part C (Medicare Advantage); and Medicare Part D (prescription drug coverage). Medicare participants can either receive coverage through Original Medicare (i.e., Medicare Parts A and B), operated by the federal government, or through a Medicare Advantage plan.
Medicare Advantage	A private health insurance plan that contracts with the federal government to pay for and manage the delivery of Medicare benefits for Medicare participants that enroll in the plan. While Medicare Advantage plans must typically cover the benefits covered under Medicare Parts A and B, they also have some flexibility to provide additional services as supplemental benefits.
Produce Prescription	A produce prescription is a medical treatment or preventative service for patients who are eligible due to a diet-related health risk or condition, food insecurity or other documented challenges in access to nutritious foods, and are referred by a health care provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy produce with no added fats, sugars, or salt, at low or no cost to the patient. When appropriately dosed, Produce Prescription Programs are designed to improve healthcare outcomes, optimize medical spend, and increase patient engagement and satisfaction. ¹²⁶
Section 1115 Demonstration Waiver	The most flexible of the Medicaid waiver options. States may use these waivers to launch demonstration—or test/pilot—projects that are “likely to assist in promoting the objectives” of the Medicaid program. Section 1115 Waivers permit states to waive certain provisions of the Medicaid Statute (e.g., statewideness and comparability requirements), and cover services and populations that would not normally be allowed under federal rules. CMS requires all Section 1115 Waiver proposals to be budget neutral to the federal government (i.e., not result in more costs to the federal government than would occur absent the waiver).
Section 1915(b)(3) Waiver	Section 1915(b) Waivers allow states to require a broader segment of their Medicaid population to enroll in managed care than would otherwise be allowed under a State Plan . Under Section 1915(b)(3), states may then elect to use savings from their managed care program to provide additional services not covered under the State Plan .
Section 1915(c) Waiver	Section 1915(c) Waivers allow states to provide additional home and community-based services to individuals who would otherwise require institutional care (e.g., nursing home care).
State Plan	The State Plan is the written agreement between the state and the federal government which describes how the state will administer its Medicaid program. The State Plan follows federal guidelines and outlines key components of the Medicaid program, such as covered benefits, participant eligibility, and provider reimbursement. The State Plan must be approved by CMS . To alter the State Plan, states must submit a State Plan Amendment.
State Medicaid Agency	The state agency which administers the state’s Medicaid program.
Value-Added Benefit	Services not covered under the State Plan , but voluntarily offered by the Medicaid managed care plan .

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