MEDICAID FOOD SECURITY NETWORK

Promising Medicaid-Based Strategies to Address the Food Needs of Children and Families

April 2024

The Medicaid Food Security Network (MFSN) believes that every Medicaid program has an opportunity to address the food needs of Medicaid enrollees and increase enrollment and retention in SNAP and WIC. Food security in Medicaid enrollees will reduce healthcare costs and improve healthcare outcomes. Key opportunities to do so include increasing Medicaid enrollee connection to food resources, strengthening the network of community food resources for Medicaid enrollees, and increasing enrollment in the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

This Promising Strategies document provides an overview of promising strategies that food security advocates can use to collaborate with Medicaid agencies to incorporate food strategies in Medicaid Managed Care (MCO) contracts, benefit design and waivers. These strategies are designed to address the full range of food needs of Medicaid enrollees, especially children and families.

This document will outline the business case for Medicaid to address food insecurity and identify specific tactical strategies including:

- Medicaid Managed Care Organization (MCO) Procurement Process
- Food Insecurity Screening and Referral
- Assistance and Navigation
- Data, Evaluation and Continuous Improvement
- Food Security Investments and Benefits
- Integrated SNAP, WIC and Medicaid Infrastructure

The Value Proposition for Medicaid to Address Food Security

Medicaid enrollees are at a high risk of nutrition and food insecurity, which negatively impacts physical and mental health and increases healthcare costs.[1] [2] [3] Improving nutrition and food security will improve individual health outcomes and aid Medicaid programs in achieving their health outcomes, health equity and cost-reduction goals.

Optimizing participation in the two largest and highly effective federal nutrition assistance programs– SNAP and WIC –is a key foundation to improve nutrition and food security. These programs improve physical health, mental health, and educational outcomes while reducing healthcare costs.[4] [5] An analysis of adult Medicaid participants found that SNAP enrollment was linked to healthcare savings of $1,409 per year (about 30%).[6] Medicaid, SNAP, and WIC have overlapping eligibility requirements and stable federal funding, yet there are significant

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[1] https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of covid-19-response-efforts-issue-brief/

[2] https://pubmed.ncbi.nlm.nih.gov/26526240/

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6426124/

[4] https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care

[5] https://www.cbpp.org/research/food-assistance/wic-works-addressing-the-nutrition-and-health-needs-of-low-income-families 2021

[6] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653910

participation gaps in SNAP and WIC. Around 1 in 5 people who are eligible for SNAP are not enrolled.[7] About 1 in 2 people eligible for WIC are not enrolled, with the lowest enrollment rates among children aged 2 to 5.[8] In the case of WIC, adjunctive eligibility means that individuals enrolled in SNAP or Medicaid are automatically eligible for WIC if they also meet the demographic criteria for the program (i.e., pregnant, postpartum, and/or children under 5), yet there remain many barriers to enrolling.

With SNAP and WIC as the foundation, community-based food security supports can also play a critical role in improving Medicaid enrollee health and supplementing SNAP and WIC benefits. Like SNAP, medically tailored meals are associated with healthcare savings through reduced hospitalizations.[9] There is also evidence that nutrition incentive programs, like Double Bucks programs, and produce prescription programs, are associated with higher fruit and vegetable intake and better self-reported food security.[10]

Thus, there are significant opportunities for cooperation and collaboration across agencies that host these programs to support enrollment and participation in SNAP, WIC, and other food security programs.

Policy and Program Opportunities

The Managed Care Organization (MCO) Procurement Process

In most states, MCOs are competitively chosen through a Request for Proposal (RFP) process, also known as a procurement process. Typically MCOs must respond to questions defined by the Medicaid agency and the Medicaid agency has scoring criteria related to the responses that prioritize certain MCO skills and attributes. To assess MCO readiness to effectively implement food-related strategies, the MFSN recommends that Medicaid agencies include specific questions related to Health-Related Social Needs (HRSN) in their RFP. For maximum impact, the RFP could ask the applying MCO about their experience and plans to support food security including enrollment in SNAP and WIC, nutrition incentive programs, and related social benefits and community-based food resources. Through this process, Medicaid agencies could learn about existing MCO capacities, plans and partnerships, allowing the Medicaid agencies to establish realistic and timebound SNAP and WIC enrollment goals, and strategies to achieve them with each contracted MCO. In some states, these responses may even be binding.

In addition, the applying MCO could be encouraged to offer food-related value-added services and In Lieu of Services and to embed food strategies into value-based payment structures to incentivize and support primary care efforts.

Food Insecurity Screening and Referral

The MFSN recommends that all Medicaid agencies have policies and programs to ensure that every Medicaid Enrollee is screened annually for food insecurity and enrolled in food benefits using nationally recognized, standardized screening tools.

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[7] https://www.fns.usda.gov/research/snap/participation-rates-2020

[8] https://www.fns.usda.gov/research/wic/eligibility-and-program-reach-estimates-2020

[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797397 and https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2730768

[10] https://nutritionincentivehub.org/media/ojeddfqp/gusnip-y3-impact-findings-executive-summary.pdf

To achieve a goal of universal screening, screening may need to be offered by both plans and providers (e.g., primary care, hospital and behavioral health staff) in many formats (e.g., phone, online, text message). Screening should not be limited to clinical settings as this would lead to missing engagement and support for people who are not engaging with healthcare. In addition, screening workflows should consider language accessibility and accessibility for individuals with disabilities. Financial incentives for plans and providers such as adding a new screening benefit or a modifier to an existing screening benefit or incorporating screening metrics in value-based payment methodologies may be necessary to achieve desired screening penetration rates.

To ensure that screening connects Medicaid enrollees with resources, food resources and information should be provided immediately in response to a positive screen. If a Medicaid enrollee is transferred to a new person, system or organization for an identified need, some enrollees will never make that connection and may never receive a resource. The next section describes more in-depth navigation and assistance of identified food needs but given the importance of providing resources immediately, referrals are discussed here. In order to support this referral process, Medicaid payers and providers must have access to a community resource guide that is updated regularly.

Screening and referral on social resources requires specific knowledge, skills and messaging in order to reduce stigma and promote connection to resources. Medicaid MCOs can support staff knowledge and skill by offering regular food and nutrition resource training to all Enrollee-facing MCO staff (including those doing screening and referral and assistance and navigation) and to their network of primary care providers, hospitals, and behavioral health providers. Training could cover the health, food and economic security benefits of program participation, SNAP and WIC program details, strategies to address stigma, eligibility, enrollment best practices, recertification, the provider's role (i.e. supporting exemptions for people who are unable to work) and other relevant topics.

Setting clear year-over-year performance goals for screening process metrics and outcomes and reporting tied to those goals will enable the state to evaluate the impact of screening and support continuous quality improvement. One potential metric is the Healthcare Effectiveness Data and Information Set (HEDIS) social needs screening and intervention measure. Medicaid agencies should also consider strategies to encourage providers to code screening results (such as by using Z-Codes) as part of medical records and healthcare billing. This documentation should follow established standards and be managed in an interoperable manner, such as those set forth by the Gravity Project. In doing so, health plans, providers, and partner CBOs would be best-positioned to outreach to and provide services for Enrollees, while reducing duplicative or stressful re-screenings where possible.

To ensure that screening has the intended impact, Medicaid Managed Care Organizations should share performance metrics publicly (such as posted on their website) and have regular forums to engage Medicaid Enrollees, providers, and other stakeholders to identify opportunities for improvement in social needs screening and other HRSN strategies.

Screening results have the potential to improve other population health strategies within the state. Screening results can be used to improve risk stratification methodologies, the methods by which health plans categorize enrollees for eligibility for services like care coordination and

reimbursement methodologies, which may inappropriately stratify individuals who are underutilizing healthcare services. Aggregate screening results paired with physical health and behavioral health comorbidities can also be used by partners including public health and community-based organizations to support funding and community-based strategies around HRSNs.

Assistance and Navigation

Most Medicaid programs have robust infrastructure to support Medicaid Enrollees who require care coordination or support in navigating healthcare and HRSN resources. This pre-existing infrastructure could be leveraged to support connection to food benefits and food resources for children and families. Eligibility and prioritization for children for these services must be different than for adults, especially in light of the Early, Periodic, Screening, Diagnostic regulation that requires that Medicaid agencies provide necessary interventions to children and youth. One way to ensure children are receiving care navigation services is to have a specific risk category and strategy around Medicaid Enrollees with only a social risk (and no known physical or behavioral health risks).

In addition to having clear HRSN activities embedded in other care coordination and community navigation resources, the MFSN recommends that every Medicaid program establish a workforce with strong community connections, expertise in social resources, and the capacity to engage with Enrollees either in-person or through telephonic/virtual means, depending on their preferences. This workforce may include roles such as Community Health Workers, Promotoras, Community Health Representatives and Patient Navigators. This high-value workforce requires adequate and equitable reimbursement.

As part of whole-person care coordination, a Medicaid-funded navigator can support an Enrollee in completing the application for SNAP and overcoming any barriers in following through with the WIC process. Rather than requiring that a Medicaid Enrollee divulge highly personal and confidential information to a new person and find the capacity and time for that additional conversation, existing Medicaid navigators may be trusted individuals who are well-equipped to provide benefits enrollment support as part of whole-person care.[11] Increased communication and coordination with the state-specific entity responsible for processing applications may increase the success of submitted applications. In addition, some states are exploring innovative strategies like embedding government liaisons in clinical settings to support navigation through services.[12]

To ensure that care coordination processes work for CBOs who accept Enrollee referrals, we recommend that the MCOS and providers incorporating navigation and assistance services have formal partnerships with CBOs, especially local and regional community-based organizations that have deep relationships and expertise in the community. Those partnerships should include regular meetings to ensure ongoing collaboration and processes for developing and updating workflows. To the greatest extent possible, these CBOs should be compensated both for service

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[11] Note: Medicaid cannot fund activities funded by other federal funding streams. However, navigators funded to provide whole person care coordination can support the completion of applications for benefits. Healthcare organizations can also become contracted SNAP outreach partners and receive 50% federal reimbursement for allowable SNAP outreach costs.

[12] Additional details on how Medicaid and WIC can partner can be found here: https://www.cbpp.org/research/food-assistance/state-medicaid-agencies-can-partner-with-wic-agencies-to-improve-the

provision and the administrative costs of such partnerships.[13] In addition to direct compensation, states and MCOs should explore how to provide additional resources and support such as access to software or other tools.

Data, Evaluation and Continuous Improvement

Addressing food security in healthcare requires coordination across benefits, systems and organizations that have historically not closely collaborated; data to evaluate performance, information technology strategies to support coordination, and clear quality improvement approaches will improve the success of this cross-system coordination. These data and evaluation strategies should be built in collaboration with stakeholders with thoughtful consideration of Enrollee privacy and consent preferences and documented in a publically available data governance plan.

Integrating SNAP, WIC, and Medicaid data will allow a state to develop baseline and ongoing performance metrics around SNAP and WIC enrollment rates within Medicaid. For MCOs to effectively support SNAP and WIC enrollment and certification, MCOs must receive person-level detail on Medicaid, SNAP and WIC enrollment spans (the date of enrollment and when recertification is necessary). We recognize that the sharing of this data can result in a significant increase in work for MCOs and recommend a collaborative conversation between states and all relevant organizations around how to collectively support increased SNAP and WIC enrollment. Data sharing for WIC should include a strategy around the exchange of clinical information to and from providers to enable Enrollees to avoid duplicative medical testing required for WIC. Some states have chosen to continue waivers that enable certification and recertification processes to occur virtually, as long as required biometric data is captured by a healthcare provider and sent to WIC within sixty days of the virtual appointment.

Data and evaluation must have specific metrics and strategies to capture potential disparities in intervention impact by population, specifically looking at impact by race, ethnicity, gender, sexual orientation and gender identity (when available), disability, geography, and primary language.

Some states are investing in closed loop referral systems to support coordination across social and healthcare sectors.[14] To ensure these systems are adequately utilized, some states are funding CBO participation and requiring MCO and provider participation as part of other value based payment methodologies.

Food insecurity activities focused on children and families including screening, navigation and investments (described below) should be incorporated into Medicaid agencies' Quality Improvement Plan. Many states are using the Mandatory Child Health Care Core Quality Measure, "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents," as a starting point for this work.[15] Strategies could include having specific Performance Improvement Plans related to HRSN activities.

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[13] More information on reimbursement strategies for CBO services can be found in the Investments and Benefits section.

[14] https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations

[15] https://www.medicaid.gov/sites/default/files/2023-08/2024-child-core-set_0.pdf

Investments and Benefits

The MFSN encourages states to identify a range of strategies to invest in food benefits to supplement and complement SNAP and WIC to meet the health needs of children and families and to further strengthen the local food systems. In addition, food interventions should be available to entire households rather than just the single eligible Enrollee, recognizing that households typically eat together, and that parents, in particular, would opt to provide any food intervention they might receive to their children in households experiencing food insecurity.

Medicaid agencies could require that MCOs reinvest a portion of their profits into the community with a priority of investing in HRSN activities not otherwise funded by Medicaid. To ensure these investments are effectively allocated, the development of the plan should require community stakeholder input and publicly available detailed reporting on how funds are spent. To complement community reinvestment strategies, MCOs could be encouraged to offer food-related value-added services focused especially on populations and services that cannot be supported via other means. These services, under certain circumstances, can be counted under the services side of the Medical Loss Ratio.

We encourage states to consider leveraging all available authorities and adopting the full range of allowable food resources described in the recent Centers for Medicare & Medicaid Services Health Related Social Needs (HRSN) Coverage Guide.[16] Specifically the MFSN aims to have food incorporated in every Health Related Social Need (HRSN)-related 1115 waiver and will work towards as many states as possible incorporating 1115 waivers and/or In Lieu of Services. These benefits should include broad eligibility criteria that capture the unique risks and needs of children and families. Eligibility criteria should be inclusive of various subpopulations whose health would improve through better food security, including but not limited to people living with chronic illnesses or behavioral health conditions, pregnant and postpartum people, people who have high levels of avoidable hospitalizations, and emergency department utilization. They should also include a range of benefits (i.e., nutrition counseling, case management to support access to food and nutrition services, home-delivered meals or pantry stocking, fruit or vegetable or protein boxes, grocery provisions, medically tailored meals) to fit diverse family needs and preferences. To ensure adequate access, the benefit definition should support a broad range of allowable providers and there should be clear reimbursement guidance. CBOs, MCOS and providers will need infrastructure investments. For states implementing new investments through 1115 waivers, we recommend maximizing the infrastructure allocation amount.

Integrated SNAP, WIC and Medicaid Infrastructure

While many of the strategies above would actively assist individual Medicaid Enrollees in navigating complex systems, state governments can simultaneously work to streamline their benefit systems so that any Medicaid enrollee attempting to access these benefits would have a smooth client experience in applying for and utilizing them - especially in light of the overlapping eligibility requirements between Medicaid and SNAP, and the automatic conferred eligibility from Medicaid to WIC.

The MSFN will encourage state efforts to modernize and integrate the eligibility and cross enrollment processes for state benefits including Medicaid, SNAP, and WIC (as supported by the

[16] https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

U.S. Playbook to Address Social Determinants of Health).[17] The ideal client experience should replace separate applications with a joint application for enrolling or re-enrolling in Medicaid and SNAP and starting the WIC certification process, with more aligned processing deadlines and timelines. While WIC certification cannot occur purely online, there are opportunities for state Medicaid and SNAP agencies to prompt clients about WIC through proactive outreach, and referrals at the time of applying for Medicaid and/or SNAP.

From a state administration perspective, this could include more cross-agency alignment on areas such as cross-agency data sharing and/or integrated data systems, income verification with options to use expedited enrollment options, and adequate staffing with cross-benefit training. Indeed, data-sharing about benefits participation status among Medicaid, SNAP, and WIC agencies and with MCOs and CBOs is grounded in a strong legal basis with many existing precedents.[18] Many states are already engaging in such initiatives, and it is a matter of scaling these efforts up to meet the continued needs in our communities.[19]

The Medicaid Food Security Network

The Medicaid Food Security Network (MFSN) is a joint initiative of Share Our Strength, Benefits Data Trust and HealthBegins. The Network supports anti-hunger advocates to engage, influence, and partner with state Medicaid programs and Medicaid-serving systems in adopting and implementing effective strategies to support the full spectrum of food needs of children and families enrolled in Medicaid, with an emphasis on closing the enrollment gap in SNAP and WIC. MFSN provides the infrastructure for stakeholders to collaborate with peers across the country, as well as access to resources and information on Medicaid policy and practice.

Visit the Medicaid Food Security Network website for more information and sign up to join the Network and stay up-to-date on events and new resources.

About the MFSN Co-Designers

Share Our Strength aims to end hunger and poverty – in the United States and abroad – by connecting people who care to ideas that work through proven, effective campaigns like No Kid Hungry. *HealthBegins* partners with and trains courageous leaders to improve the social drivers of health and equity at all levels: individual social needs, community-level social determinants of health, and deeper structural determinants of health equity. *Benefits Data Trust* helps people live healthier, more independent lives by creating smarter ways to access essential benefits and services, including food, healthcare, and other critical needs.

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[17] https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf

[18] https://bdtrust.org/data-sharing-to-build-effective-and-efficient-benefits-systems_january-2023.pdf

[19] https://bdtrust.org/data-coordination-at-snap-and-medicaid-agencies-part-2_may-2023.pdf, https://bdtrust.org/a-report-on-data-coordination-at-snap-and-medicaid-agencies.pdf and https://www.cbpp.org/sites/default/files/10-1-21fa_rev11-14-22.pdf

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