EMBEDDING STRATEGIES TO ADDRESS FOOD INSECURITY IN MEDICAID MANAGED CARE CONTRACTS

MEDICAID FOOD SECURITY NETWORK

SHARE OUR STRENGTH

HEALTH BEGINS

AUTHORS

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ABOUT THE MEDICAID FOOD SECURITY NETWORK

The Medicaid Food Security Network is a group of healthcare and food security stakeholders, mobilizing Medicaid systems to become a key partner in addressing food and nutrition insecurity. Our mission is to support anti-hunger advocates to engage, influence, and partner with state Medicaid programs and managed care organizations in adopting and implementing effective strategies to connect Medicaid-enrolled children and families proactively to Food is Medicine services, with an emphasis on closing the enrollment gaps in SNAP and WIC.

ABOUT SHARE OUR STRENGTH

At Share Our Strength, we're ending hunger and poverty—in the United States and abroad. Through proven, effective campaigns and programs like No Kid Hungry, we connect people who care to ideas that work.

ABOUT HEALTHBEGINS

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.

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INTRODUCTION

Medicaid enrollees are at a high risk for food and nutrition insecurity, which negatively impacts physical and mental health and increases healthcare costs[1,2]. Medicaid agencies have an opportunity to incorporate strategies to address food insecurity into Medicaid Managed Care Contracts, often at no added cost to the state. Incorporation of these requirements should take into account changing financial and administrative pressures for Medicaid Managed Care Organizations and whether other requirements need to be adjusted to make these feasible.

This resource builds on the work of the Medicaid Food Security Network (MFSN), an initiative of Share Our Strength in partnership with HealthBegins, whose mission is to advance policy change through its Medicaid Food Security Partners Program (MFSPP) and develop resources such as the Food is Medicine is complementary with SNAP & WIC and Promising Medicaid-Based Strategies briefs. This brief provides specific recommendations for Medicaid agencies to add Medicaid Managed Care Organization (MCO) contract language to encourage, incentivize, or require MCO and provider activities to address Medicaid enrollee food and nutrition insecurity. Many of the strategies listed below do not increase state spending and could be cost-effective ways to bend the cost curve through incremental modification of how MCOs serve their members. This document was developed through careful review of Medicaid contracts, quality improvement documents, and other guidance materials. Example state strategies and links to the state MCO contracts can be found on the Medicaid Food Security Policy Dashboard. In addition to identifying leading state examples, this checklist was developed with the following principles and assumptions:

- **Accountability results in action:** Accountability, either through contractual requirements for submission of data or accountability created through payment or incentive structures, will increase fidelity to contract requirements.
- **Transparency increases insights:** Analyzing and sharing insights on population needs, referral pathways and acceptance of resources stratified by geography and demographics will improve community-wide understanding of resource gaps and process improvements to best serve the community.
- **Accessibility is critical to access:** For Medicaid-funded services to reach all intended Medicaid enrollees, populations with specific needs may need accommodations.
- **Member engagement improves impact:** Increasing input into design and implementation will ensure that interventions are effective.

HOW TO USE THIS RESOURCE

This document is organized with content groupings that parallel the organization of many MCO contracts. For each topic area, there is a checklist of contract language components that may increase the impact of that contractual requirement.

Policymakers or advocates can use these checklists in developing or providing comments on draft MCO contract language (often shared during the Request for Proposal Process).

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1 Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Manag Care. 2018 Sep;24(9):399-404. PMID: 30222918; PMCID: PMC6426124.

2 Gundersen C, Ziliak JP. Food Insecurity And Health Outcomes. Health Aff (Millwood). 2015 Nov;34(11):1830-9. doi: 10.1377/hlthaff.2015.0645. PMID: 26526240.

1. FOOD INSECURITY SCREENING AND REFERRAL

One first step to addressing food and/or nutrition insecurity is identifying it. Medicaid agencies can develop strategies for Medicaid Managed Care plans to administer screening (often through Health Risk Assessments) and/or can incentivize or support screening in clinical settings.

1.1 Health Risk Assessment

Per 42 CFR 438.208(b)(3), Medicaid MCOs are required to conduct health risk assessments (HRAs) for new members within 90 days of enrollment. Many states have incorporated social needs screening (SNS) as a required component of HRAs. Social needs screening generally includes food insecurity (FI) screening as a component of addressing multiple health-related social needs (HRSN). Empowering MCOs to conduct high-quality FI screening among Medicaid members can be a key part of a comprehensive strategy for connecting low-income families to food and nutrition security supports, including government benefits, and can complement screening and navigation conducted in clinical settings.

There are many promising social needs screening practices, as described in resources such as CMS guidance on the Accountable Health Communities model and the Social Needs Screening Toolkit from Health Leads[3,4]. MCO contract language that may support increased reach and efficacy of screening includes:

- Screening offered in multiple formats (verbal, paper, online, etc).
- Language accessibility including translated resources, use of multilingual staff and interpreter services.
- Accommodations for Medicaid populations with specific needs including individuals with developmental disabilities, those who are hard of hearing or deaf, those who are blind or have low vision, and those with limited phone access.
- Referrals for local and government resources provided immediately after a positive screening result (additional longer-term interventions are described in the "Assistance and Navigation" section below).
- Staff training on cultural competency, stigma, trauma-informed care, social needs impact on health, and/or social needs resources.
- Performance measurement and accountability such as through reporting to the state of screening rates and screening outcomes or screening as a key performance measure linked to an incentive payment. Ideally this incentive payment would be linked to closed-loop referral or screening outcome.
- Aggregate data sharing and transparency to maximize positive impact of screening such as the state Medicaid agency publishing data through public dashboards containing plan - or community - specific screening insights such as the rate of food insecurity.

3 Centers for Medicare & Medicaid Services. A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. CMS; 2023. Accessed May 22, 2026. https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion

4 Health Leads. The Health Leads Screening Toolkit. Health Leads; 2022. Accessed May 22, 2026. https://healthleadsusa.org/news-resources/the-health-leads-screening-toolkit/

Additional contract language that some states include that may have cost impacts:

- Mandated use of closed-loop referral systems or health information exchanges to capture and share data with healthcare provider teams and community-based organizations.
- Inclusion of social needs screening and closed-loop referral metrics as incentive measures in the contract.
- Mandated use of a standard health risk assessment using standardized social needs screening questions to ensure comparable data from every plan.

1.2 Social Needs Screening and Referral

To reach the full population effectively, MCO-driven screening should complement social needs screenings conducted in clinical settings. Social needs screening in clinical settings can improve clinical care plans, result in connection to resources and navigators, care coordinators or community health workers, and support connection to outpatient care services[5]. MCO contract language can direct MCOs to promote, support, and create accountability for clinical-level screening. Ideal contract language includes:

- Financial incentives or reimbursement strategies for clinical providers to conduct screening.
- Strategies to promote standardized clinical documentation, including use of ICD Z-codes to reduce undercoding and data quality issues.
- Clear strategies to support connection to resources after a positive screen.
- Connection to broader population health and value-based payment strategies.

Additional contract language or guidance that some states include:

- Processes to integrate MCO and clinical setting SNS to minimize duplicate screenings of patients such as through a requirement to share social needs screening data through a health information exchange or a closed-loop referral system.

5 Gottlieb L, Hessler D, Wing H, Gonzalez-Rocha A, Cartier Y, Fichtenberg C. Revising the logic model behind health care's social care investments. Milbank Q. 2024;102(2):325-335. doi:10.1111/1468-0009.12690.

2. ASSISTANCE AND NAVIGATION

Identification of food insecurity is most meaningful when followed by effective, person-centered assistance that connects members to a range of food resources and government benefits. This section establishes requirements for care coordination and community health worker support to help Members access food resources and enroll in governmental benefits.

2.1 Care Coordination / Care Management

Most Medicaid programs have robust infrastructure to support Medicaid enrollees who require care coordination or support in navigating healthcare and HRSN resources. The checklist here assumes the state already has clear stratification, scope, and intervention content. Ideal contract language that is not consistently present includes:

- Strategies to identify and engage Medicaid enrollees in care coordination whose only risk factor is a social need, especially children for whom those social needs become a significant risk factor for lifelong health risks and healthcare utilization.
- Multiple modalities for engagement, including choice of location (home, community, office, virtual); choice of format (in-person, virtual, phone, video, asynchronous, email, text); and choice of timing (ad hoc, scheduled, weekends, after hours).
- Robust staff training that addresses knowledge, skills and beliefs/values.
- Scope of practice definition that includes SNAP and WIC enrollment assistance.

2.2 Community Health Workers

A Community Health Worker (CHW) is a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."[6] CHW scope of practice, eligibility and intervention limits may be defined outside of the MCO contract, depending on how CHWs are authorized (for more information, see the National Association of State Health Policy State Community Health Workers Policies page). The components here may be useful either for the MCO contract or for other CHW policy guidance and parameters. Ideal contract language or policy guidance includes:

- Service covered for individuals with only a social need (without a qualifying medical diagnosis), especially for children for whom those social needs become a significant risk factor for lifelong health risks and healthcare utilization.
- Scope that includes connecting enrollees to food resources, including SNAP and WIC application assistance.
- Clear pathways for hiring from the communities served, including individuals who can speak languages commonly spoken by community members.
- Training that includes the unique needs of subpopulations including children and families, seniors, individuals with developmental disabilities, individuals with hearing or eyesight impairments, and other specific needs.
- Adequate reimbursement that enables a living wage for CHWs.

6 National Association of Community Health Workers. Frequently Asked Questions About the National Association of Community Health Workers. NACHW; 2020. Accessed May 22, 2026. https://nachw.org/frequently-asked-questions-about-the-national-association-of-community-health-workers/

3. QUALITY IMPROVEMENT, POPULATION HEALTH, AND SOCIAL DRIVERS OF HEALTH PLANS

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 risks, enrollee privacy and consent preferences, and documented in a publicly available data governance plan.

3.1 CBO Partnerships

Some MCO contracts have language encouraging partnerships or relationship-building with Community Based Organizations (CBO) in order to support referrals and collaboration around members with social and clinical needs. Ideal contract language includes:

- Dedicated and named MCO staff liaison for CBO relationship management.
- Formal relationships with CBOs including, if possible, funding strategies and in-kind support such as subsidized use of software, language lines, or other tools.
- Inclusion of CBO partnership activities in required reporting to the Medicaid agency.
- Support for clinical-social care integration such as creation of clinic-based food pantries, food strategies, and partnerships with clinical providers to support outreach and enrollment in government benefits.

3.2 SNAP Coordination

SNAP coordination may be heavily dependent on underlying infrastructure that allows MCOs to see SNAP enrollment spans (certification dates and recertification deadlines) and support applications through streamlined electronic systems and collection of virtual signatures, as allowable[7]. Ideally this data sharing would occur through statewide infrastructure such as health information exchanges, ensuring that any available data can be effectively incorporated and used. Since this infrastructure pertains to SNAP and Medicaid coordination, it might not be explicitly referenced in MCO contracts. Nonetheless, there are opportunities to embed SNAP application assistance into care coordination. Ideal contract language for MCOs should include:

- Proactive outreach to all potentially eligible enrollees who are not yet enrolled.
- Strategies to outreach and engage enrollees who need to be re-enrolled.
- Data sharing and data use requirements detailed.
- Education of clinical providers on SNAP.
- Co-location of human services staff that process benefit applications at clinical sites.

States may also want to consider SNAP enrollment as a performance measure for MCOs. This measure may be most productive if it is closely designed around where the MCO has direct influence and is supported by access to data.

7 Center on Budget and Policy Priorities. SNAP & Medicaid Telephonic Signature Toolkit. CBPP. Accessed May 22, 2026. https://www.cbpp.org/research/health/snap-medicaid-telephonic-signature-toolkit

3.3 WIC Coordination

Coordination between Medicaid and WIC is required under federal regulations; MCO contracts can encourage effective implementation of this regulation (42 CFR 431.635)[8]. Like SNAP, data sharing infrastructure may be a critical component of effective WIC and Medicaid MCO care coordination.

That may or may not necessitate changes to the MCO contract language. Data sharing for WIC could include a strategy around the exchange of clinical information to and from providers to enable enrollees to avoid duplicative medical testing required for WIC.

Ideally this data sharing would occur through statewide infrastructure such as health information exchanges, ensuring that any available data can be effectively incorporated and used. 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 60 days of the virtual appointment. Contract language must be tailored to the specific needs and opportunities within that state[9]. Ideal contract language should include:

- Proactive outreach to all potentially eligible enrollees who are not yet enrolled.
- Formal MOUs between the MCO and WIC clinics.
- Education of clinical providers on WIC referral process and how to provide anthropometric data (e.g., height, weight and hemoglobin) in order to reduce barriers to enrollment.

States may also want to consider WIC enrollment as a performance measure for MCOs. This measure may be most productive if it is closely designed around where the MCO has direct influence and is supported by access to data.

3.4 Quality Improvement Projects and Population Health Plans

Federal regulation 42 CFR 438 requires MCOs to engage in quality improvement activities and maintain a quality strategy. Ideal contract language includes:

- Social needs and connection to resources, including food as a critical component of a population health strategy.
- Data and evaluation that stratifies by race, ethnicity, sexual orientation, gender identity, disability, geography and primary language.
- Development of an overarching strategy that links Health Risk Assessments, Social needs screening, closed-loop referrals, value-added benefits, community reinvestment and value-based payment models into a cohesive strategy to improve health for the entire Medicaid population.
- Opportunities for Performance Improvement Plans (PIPs) related to social needs, including food.

8 National Archives 431.635 Coordination of Medicaid with Special Supplemental Food Program for Women, Infants, and Children (WIC). Code of Federal Regulations. Accessed July 20, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-M/section-431.635

9 US Department of Agriculture, Food and Nutrition Service. WIC Modernization: Flexibilities. USDA FNS. Accessed May 22, 2026. https://www.fns.usda.gov/wic/modernization/flexibilities

4. INVESTMENTS AND BENEFITS

This section does not provide Model language for 1115 waivers and In Lieu of Services (ILOS). The Medicaid Food Security Network enthusiastically supports those models, and the Medically Tailored Meal Sustainability Blueprint provides information about key choices states may make as they consider these and other financing pathways.

4.1 Community Reinvestment

Community reinvestment requirements redirect a portion of MCO profits into community-level investments. Ideal contract language includes:

- Clear requirements around the percent of funding that must be reinvested.
- Community engagement and a transparent approval process guiding a community reinvestment plan.
- Funding of local CBOs, typically defined criteria such as a physical presence or headquarters in the state or community where MCO members live, and/or having a certain percentage of food procured from same-state farms and food producers.
- Inclusion of food as a priority domain.

4.2 Medical Loss Ratio

The Medical Loss Ratio (MLR) is the percentage of premium dollars that a Medicaid MCO must spend on enrollee health services and quality improvement activities, rather than on administrative costs or profit. Federal regulations require Medicaid MCOs to meet a minimum MLR of 85%, meaning at least 85 cents of every dollar received must go toward enrollee health services. While activities that improve quality can be included in the numerator, some MCOs report lack of clarity on what constitutes a service that improves health care quality. Ideal contract language includes:

- Explicit naming of HRSN activities, including those that address food insecurity, that could be included, such as purchasing of food as part of food insecurity or food is medicine interventions, nutrition case management and navigation - including but not limited to SNAP and WIC outreach and SNAP and WIC application assistance- and cooking classes.
- If CHWs and doulas are not otherwise funded by the Medicaid program (preferred approach), explicit inclusion of services provided by HRSN-focused staff such as CHWs and doulas.
- Process for public transparency, as allowable, of percent of capitations spent on these types of activities.

States may want to explore whether it is possible to adjust the MLR as an incentive to increase these types of investments. For example, the MLR may normally be 90%, but MCOs who invest more in HRSN services would have an adjusted MLR down to 85%.

4.3 Value-Added Services

Value-added services are non-medical services MCOs offer voluntarily, funded from administrative dollars, and generally not included in capitation rate-setting. Some may be counted in the MLR. States can use RFP scoring questions to differentiate MCOs on their value-added food service proposals. Ideal contract language includes:

- Explicit naming of food insecurity as a priority investment.
- Requirement that value-added services be evidence-informed.
- Requirement that value-added services and eligibility for those services be listed on the plan website with clear guidance for how to access those services.

States may also want to consider using these value-added services as a differentiator when selecting MCOs as part of the RFP process.

4.4 Value-Based Payment and Hospital Financing-Related Projects

Value-based payment arrangements are payment models that tie provider reimbursement to quality outcomes and total cost of care, rather than the volume of services delivered. Value-based payments can provide flexibility to invest in food and nutrition strategies including food provision, food navigation, and nutrition education and counseling. Ideal contract language includes:

- Clear percent of capitation that should be invested in health-related social needs.
- Food and nutrition security as a named priority for value-based payment.
- Robust performance measures and a process for public reporting, including food insecurity rates and benefit enrollment.

LEARN MORE

Website: medicaidfoodsecuritynetwork.org
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Together, we are building a strong network that helps anti-hunger and healthcare advocates work with Medicaid programs and Medicaid-serving systems to meet the food needs of children and families, close SNAP and WIC enrollment gaps, and improve health and food security.
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