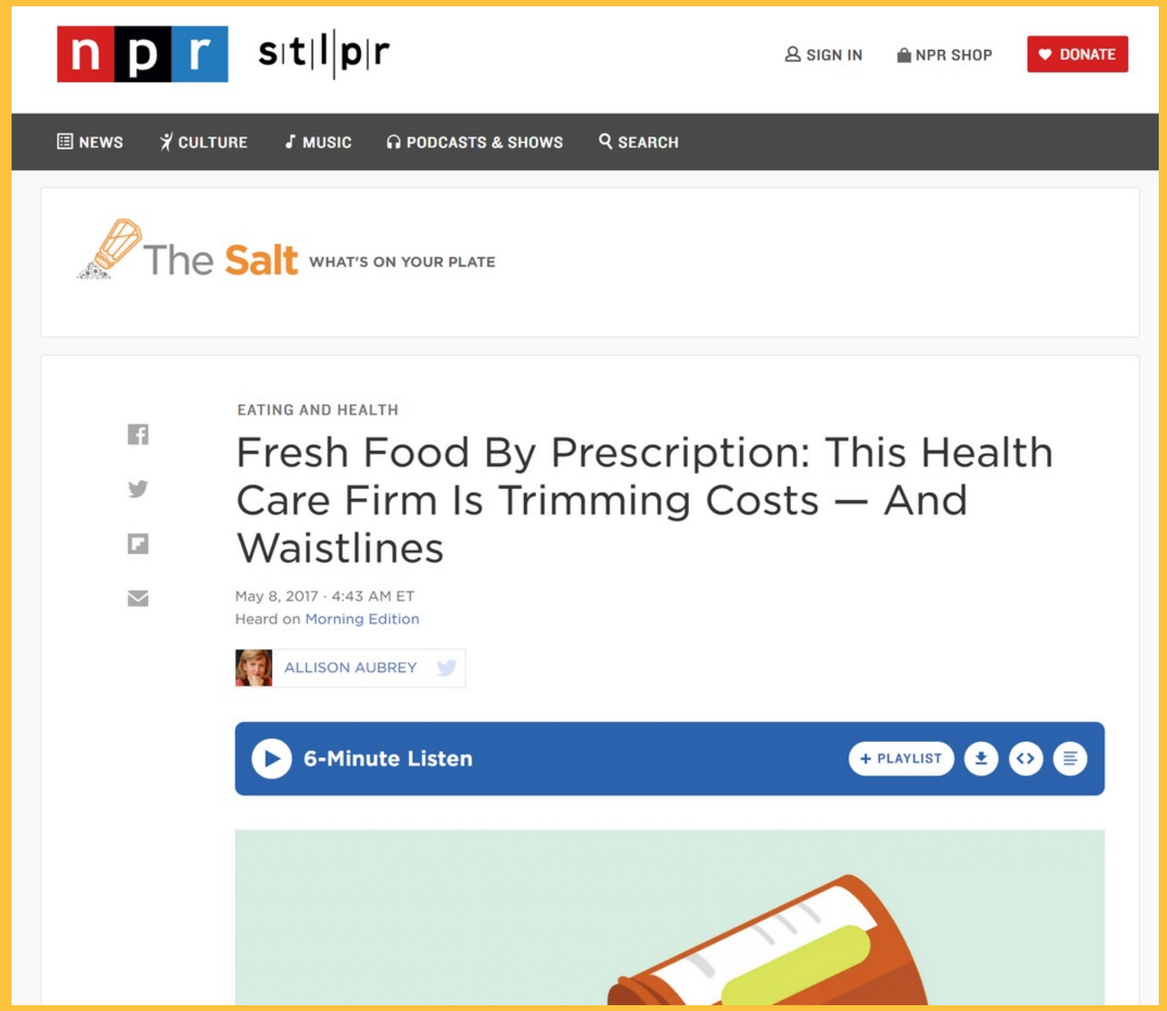
Food is Medicine

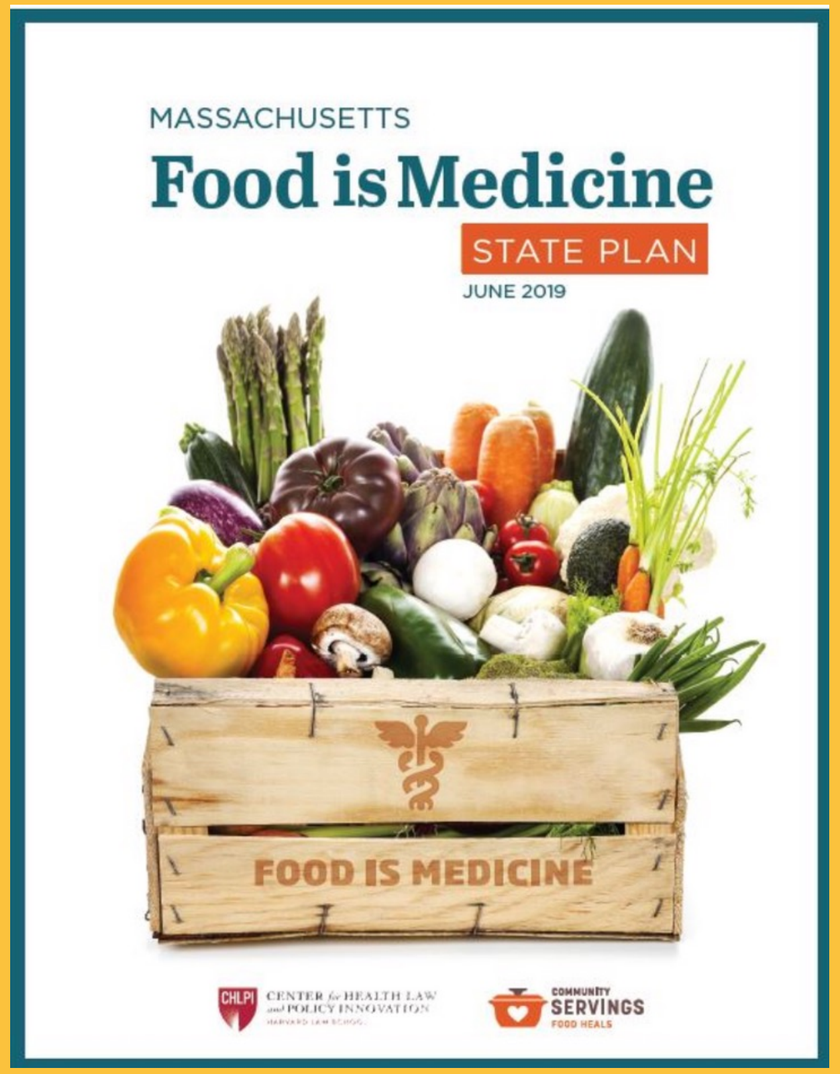
Looking Back

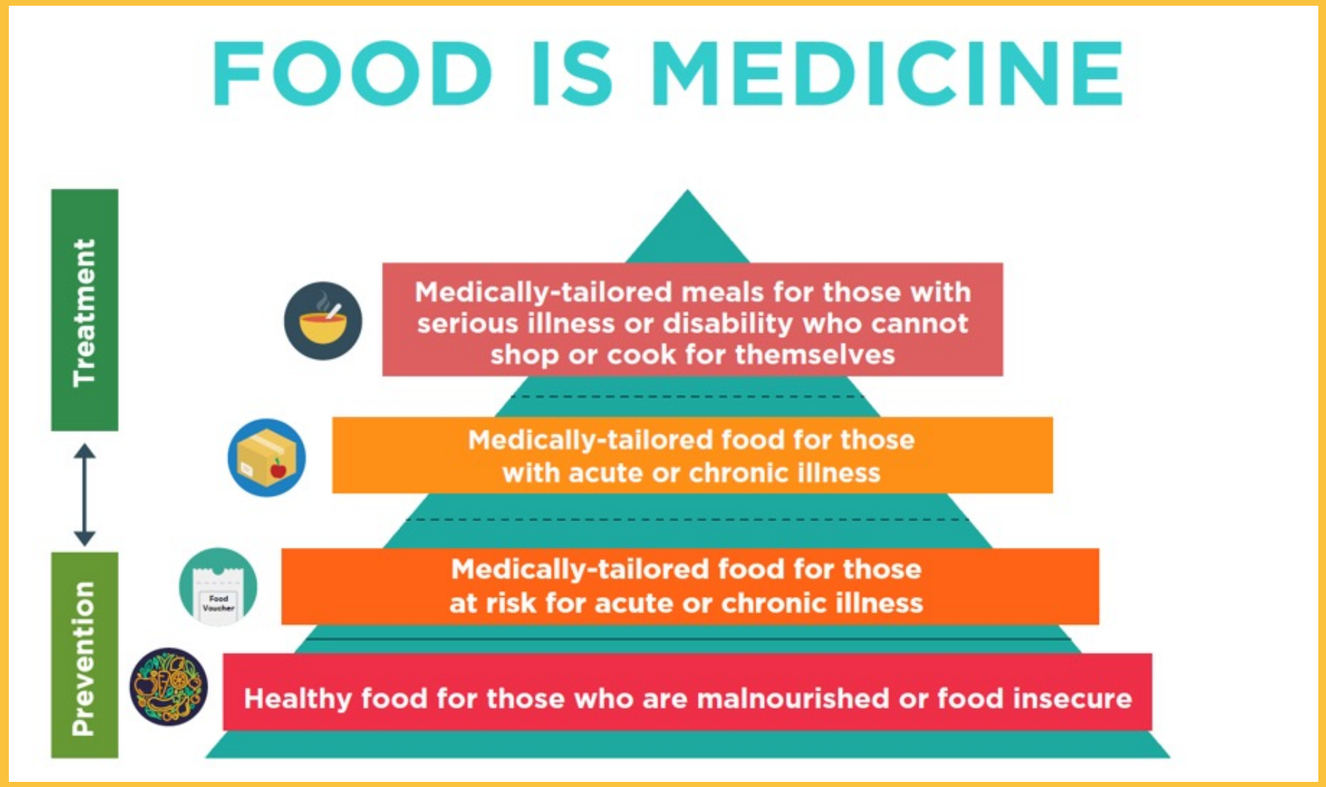
Where We've Been



Healthy Eating in Practice Conference
August 2018
Asheville, NC

Where We've Been





Where We've Been

Where We've Been

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 21-001
RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)

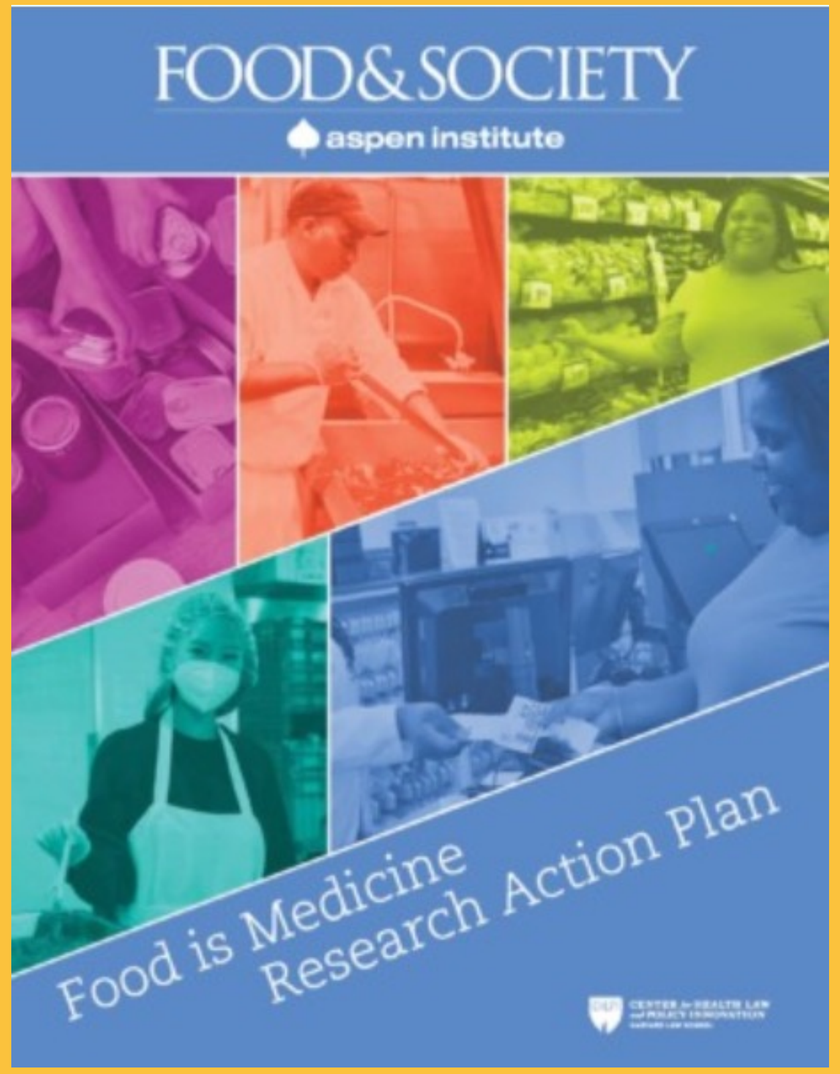
January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)[1] and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

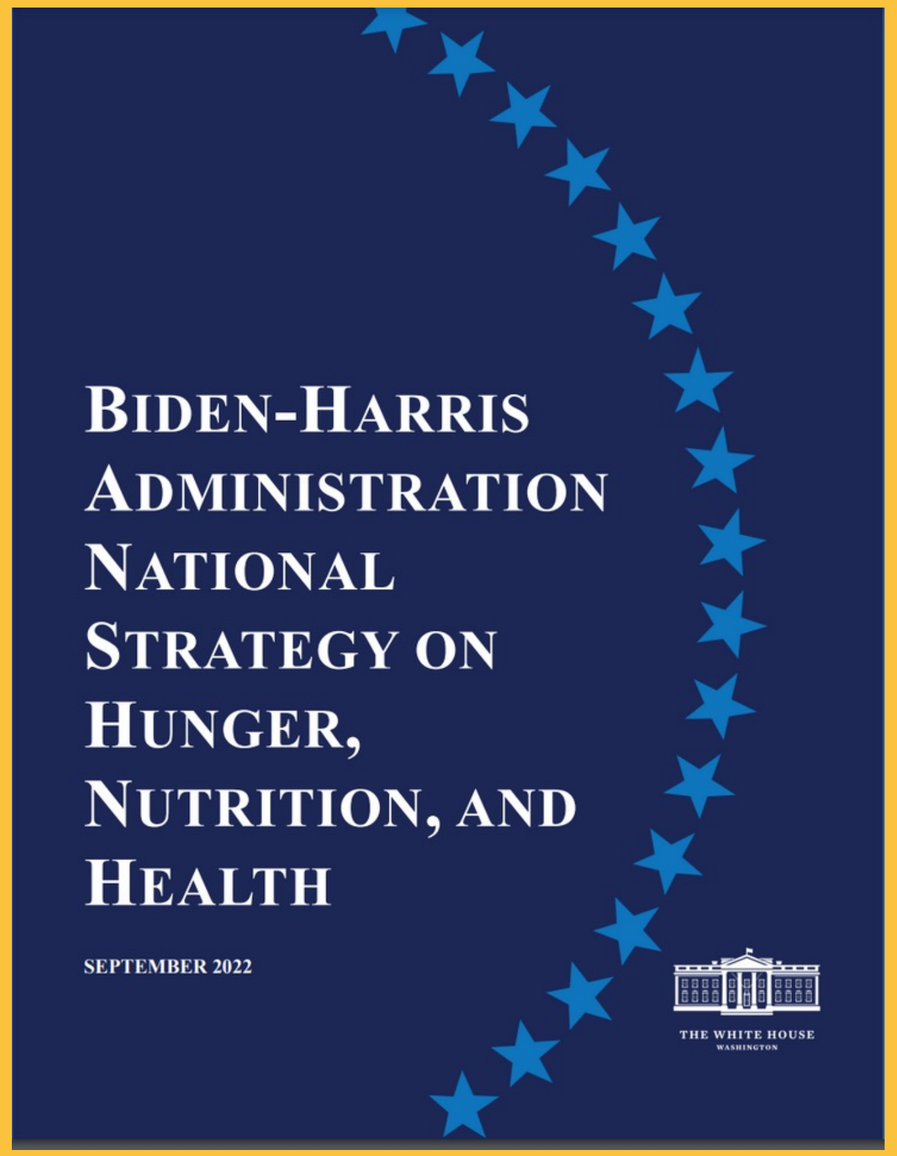
Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to SDOH, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

[1] The Centers for Disease Control and Prevention (CDC) refers to SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." See https://www.cdc.gov/socialdeterminants/about.html for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.



Where We've Been

WHITE HOUSE
CONFERENCE ON
HUNGER, NUTRITION, & HEALTH



Where We've Been

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Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD #: 23-001
RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care

January 4, 2023

Dear State Medicaid Director:

This guidance addresses an innovative option states may consider employing in Medicaid managed care programs to reduce health disparities and address unmet health-related social needs (HRSNs),[1] such as housing instability and nutrition insecurity, through the use of a service or setting that is provided to an enrollee in lieu of a service or setting (ILOS) covered under the state plan.[2] On January 7, 2021, the Centers for Medicare & Medicaid Services (CMS) published a State Health Official (SHO) letter (SHO#21-001)[3] that described opportunities under Medicaid and the Children's Health Insurance Program (CHIP) to better address social determinants of health (SDOH). Since CMS published that SHO, states have been working to implement changes in their Medicaid managed care programs to meet the HRSNs of Medicaid enrollees more effectively, including partnering with community-based organizations that routinely address HRSN. CMS is publishing this guidance to clarify an existing option that states can pursue to enhance and expand these efforts through the use of ILOSs.

ILOSs can be utilized by states and their managed care plans to strengthen access to care by expanding settings options and address certain Medicaid enrollees' HRSNs in order reduce the need for future costly state plan-covered services. This can improve population health, reduce health inequities, and lower overall health care costs in Medicaid. ILOSs can be used, at the option of the managed care plan and the enrollee, as immediate or longer term substitutes for state plan-covered services or settings, or when the ILOSs can be expected to reduce or obviate the future need to utilize state plan-covered services or settings. Managed care enrollees always maintain the right to elect to receive an ILOS or the state plan service, and cannot be required by a managed care plan to use an ILOS. The investments and interventions implemented through ILOSs may offset potential future acute and institutional care and improve quality, health outcomes, and enrollee experience. For example, offering medically appropriate and cost effective ILOSs, such as medically tailored meals for a clinically-oriented target population, may improve health outcomes and facilitate greater access to care for home and community-based services, thereby preventing or delaying enrollees' need for nursing facility care.

[1] HRSNs are an individual's social needs — such as for housing and food security — that may exacerbate poor health and quality-of-life outcomes when they are not met.
[2] ILOSs are authorized in accordance with 42 CFR § 438.3(e)(2).
[3] Opportunities in Medicaid and CHIP to Address Social Determinants of Health, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

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The American Journal of CLINICAL NUTRITION
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NEW DEVELOPMENTS from FEDERAL COLLEAGUES

New Developments from Federal Colleagues
Joel Mason, Section Editor

A Concept for Comprehensive Food is Medicine Networks or Centers of Excellence

Christopher J. Lynch

Acting Director, Office of Nutrition Research (ONR)

Office of Nutrition Research, Division of Program Coordination, Planning and Strategic Initiatives, Office of the Director, National Institutes of Health, Bethesda, MD, USA

Ending hunger in the United States by 2030 "is a goal within our reach," said President Joseph R Biden on 28 September, 2022, at a White House Conference on Hunger, Nutrition, and Health [1,2]. The historic gathering, 50 y after the 1972 conference convened by then President Richard Nixon, was a call to action for a coordinated strategy to drive a transformative change in the United States to end hunger, improve nutrition and physical activity, and close the disparities surrounding them. The White House staff and federal agencies that planned the conference, including the NIH, have continued to meet, reflect on, and discuss whole-of-society and whole-of-government approaches to these challenges.

The centrality of nutrition in our health and lives is well-known biologically, culturally, and economically. Notably, one of the White House Conference panels was "Food is Medicine: Bringing nutrition out of the healthcare shadows." Food is Medicine is a key element within the National Strategy on Hunger, Nutrition, and Health, which envisions complete integration of nutrition and health care [3]. Food is Medicine is an umbrella term for programs that respond to the critical link between diet and health involving (*1*) the provision of Food is Medicine services (medically tailored meals, medically tailored groceries, produce prescriptions, teaching kitchens, etc.), and (*2*) a nexus to the healthcare system hopefully deploying other nutrition or lifestyle medicine care to its communities. The nexus to the healthcare system recognizes healthcare providers as a trusted source of information and is a valuable opportunity not to be missed. Although only a few people report receiving dietary guidance from their healthcare providers, 78% of those that do receive such advice adjust their dietary habits [4].

Food is Medicine is a Growing Opportunity for System-Level Health Improvement

Food is Medicine is an evidence-based solution for addressing food insecurity and the many diet-related chronic diseases affecting millions in the United States and people worldwide. Food is Medicine interventions have been shown to reduce food insecurity, which is an independent risk factor for morbidity, medication compliance, depression, and mortality in a number of disorders [4]. Evidence is also mounting on how Food is Medicine strategies are associated not only with meaningful improvements in food security but also with health biomarkers (e.g., BMI, cardiometabolic parameters, and HbA1c), insurance costs, and health quality indicators (e.g., hospital readmissions for the same diagnosis) [4]. Consequently, these services are increasingly being covered by private medical insurance and federal payors through Medicare Advantage and Medicaid (via waiver programs). Now is the time to extend the research base on this topic so that we can critically assess the evidence to better integrate it into healthcare through evidence-backed policies.

Fully realizing the promise of Food is Medicine goes beyond delivery of interventions; it also requires an anchor point within the healthcare system that deploys community-based care related to nutrition, obesity, and lifestyle medicine. Doing so builds on strong community connections and existing trust between individuals and their healthcare providers. Sustainable clinical-community partnerships could act as an effective bridge between healthcare interactions and an individual's dietary and lifestyle behaviors.

Abbreviation: RFI, request for information.
E-mail address: christopher.lynch@nih.gov.

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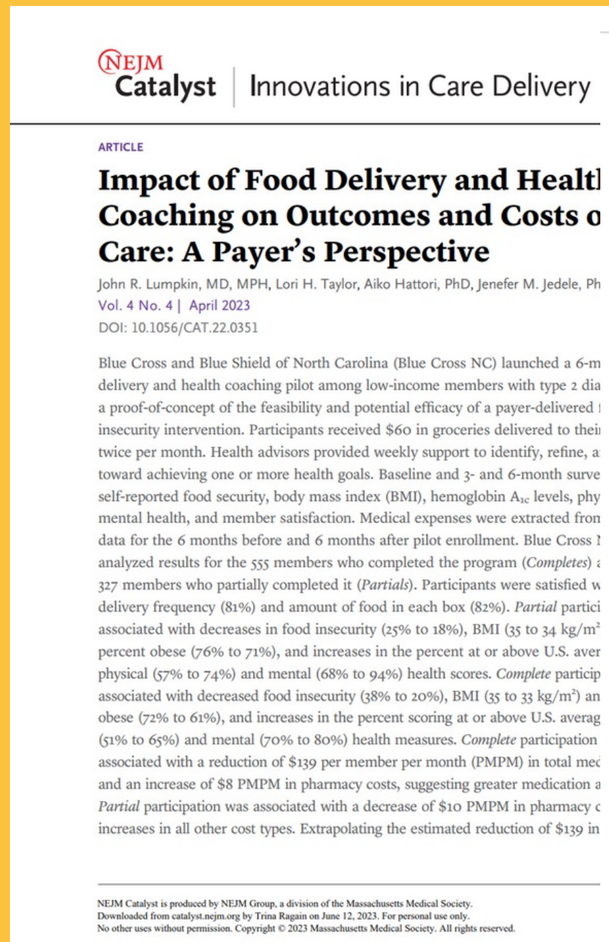
Where We're Going



NEJM Catalyst | Innovations in Care Delivery

ARTICLE

Impact of Food Delivery and Healt Coaching on Outcomes and Costs o Care: A Payer's Perspective

John R. Lumpkin, MD, MPH, Lori H. Taylor, Aiko Hattori, PhD, Jenefer M. Jedele, Ph

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DOI: 10.1056/CAT.22.0351

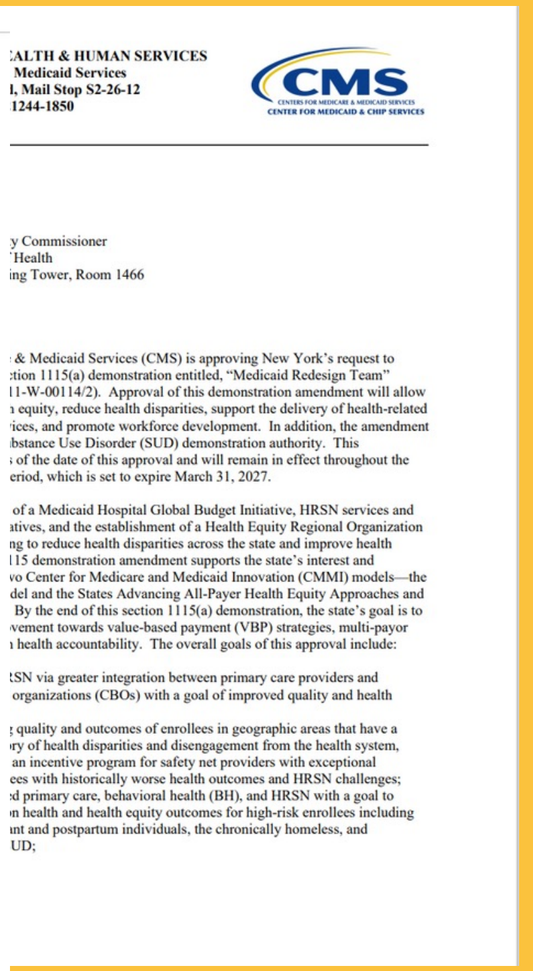
Blue Cross and Blue Shield of North Carolina (Blue Cross NC) launched a 6-m delivery and health coaching pilot among low-income members with type 2 dia a proof-of-concept of the feasibility and potential efficacy of a payer-delivered insecurity intervention. Participants received $60 in groceries delivered to thei twice per month. Health advisors provided weekly support to identify, refine, a toward achieving one or more health goals. Baseline and 3- and 6-month surve self-reported food security, body mass index (BMI), hemoglobin A_{1c} levels, phy mental health, and member satisfaction. Medical expenses were extracted fron data for the 6 months before and 6 months after pilot enrollment. Blue Cross analyzed results for the 555 members who completed the program (*Completes*) 327 members who partially completed it (*Partials*). Participants were satisfied w delivery frequency (81%) and amount of food in each box (82%). *Partial* partici associated with decreases in food insecurity (25% to 18%), BMI (35 to 34 kg/m^2 percent obese (76% to 71%), and increases in the percent at or above U.S. aver physical (57% to 74%) and mental (68% to 94%) health scores. *Complete* particip associated with decreased food insecurity (38% to 20%), BMI (35 to 33 kg/m^2) an obese (72% to 61%), and increases in the percent scoring at or above U.S. averag (51% to 65%) and mental (70% to 80%) health measures. *Complete* participation associated with a reduction of $139 per member per month (PMPM) in total mec and an increase of $8 PMPM in pharmacy costs, suggesting greater medication a *Partial* participation was associated with a decrease of $10 PMPM in pharmacy c increases in all other cost types. Extrapolating the estimated reduction of $139 in

Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)
November 2023

Health-related social needs (HRSN) are an individual's unmet, adverse social conditions that contribute to poor health outcomes. These needs, when unmet, can drive lapses in coverage and access to care, higher downstream medical costs, worse health outcomes, and perpetuation of health inequities, particularly for children and adults at risk for poor health outcomes, and individuals in historically underserved communities. By addressing HRSN, state Medicaid agencies can help their enrollees stay connected to coverage and access needed health care services. The Centers for Medicare & Medicaid Services (CMS) supports states in addressing HRSN through coverage of clinically appropriate and evidence-based HRSN interventions, care delivery transformations including improvements in data sharing, and performance measurement to create accountability for HRSN screening and connecting to needed supports as part of successful care management. States can address HRSN through a variety of Medicaid authorities, including state plan authorities, section 1915 waivers, managed care in lieu of services and settings (ILOSs) and section 1115 demonstrations.

This document lists HRSN services and supports considered allowable under specific Medicaid and Children's Health Insurance Program (CHIP) authorities and provides a discussion of the relevant considerations for each authority. The allowable HRSN services and supports enumerated here are based on robust evidence of strengthening coverage and improving downstream health outcomes, cost, and/or equity. All interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. States have flexibility to propose clinically focused, needs-based criteria to define the medically appropriate population, subject to CMS approval.[1] These services will be the choice of the enrollee; enrollees can opt out anytime; and provision of these services does not absolve the state or managed care plan of its responsibility to provide coverage for other medically necessary services. Medicaid-covered HRSN services and supports must not supplant the work or funding of another federal or state non-Medicaid agency and must be integrated with existing social services and housing assistance. Under Medicaid authorities, CMS will not approve federal financial participation payments for the costs of room and board outside of specifically enumerated care or housing transitions,[2] nor may CMS approve services that include room (i.e., rent and utility assistance) and board (i.e., meals or nutrition prescriptions) beyond durations specified below[3]. There are no time limitations to other services, unless otherwise specified. Under no circumstances will a state or managed care plan be permitted to condition Medicaid or CHIP coverage, or coverage of any benefit or service, on receipt of HRSN services. There are additional beneficiary protections, guardrails, and requirements for programming under specific authorities. For example, for states interested in pursuing section 1115 authority for HRSN services, CMS will impose limits on HRSN expenditures, such as establishing a ceiling on overall HRSN funding, and requirements to

[1] Examples of such include high-risk children, high-risk pregnant individuals, individuals who are or are at risk of becoming homeless, individuals with serious mental illness (SMI) and/or substance use disorder (SUD), and individuals experiencing high-risk care transitions (including transitions from institutional care or hospitals for people with disabilities and older adults).
[2] Allowable transitions include out of institutional care (NFs, IMDs, ICFs, acute care hospital); out of congregate residential settings such as large group homes; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; out of carceral settings; and individuals transitioning out of the child welfare setting including foster care.
[3] For additional information on the availability of Medicaid funding for housing and nutritional supports that are not considered room and board, see https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf



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Medicaid Services
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1244-1850

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y Commissioner
Health
ing Tower, Room 1466

& Medicaid Services (CMS) is approving New York's request to
tion 1115(a) demonstration entitled, "Medicaid Redesign Team"
11-W-00114/2). Approval of this demonstration amendment will allow
equity, reduce health disparities, support the delivery of health-related
ices, and promote workforce development. In addition, the amendment
bstance Use Disorder (SUD) demonstration authority. This
of the date of this approval and will remain in effect throughout the
eriod, which is set to expire March 31, 2027.

of a Medicaid Hospital Global Budget Initiative, HRSN services and
atives, and the establishment of a Health Equity Regional Organization
ng to reduce health disparities across the state and improve health
115 demonstration amendment supports the state's interest and
vo Center for Medicare and Medicaid Innovation (CMMI) models—the
del and the States Advancing All-Payer Health Equity Approaches and
By the end of this section 1115(a) demonstration, the state's goal is to
vement towards value-based payment (VBP) strategies, multi-payor
health accountability. The overall goals of this approval include:

SN via greater integration between primary care providers and
organizations (CBOs) with a goal of improved quality and health

quality and outcomes of enrollees in geographic areas that have a
ry of health disparities and disengagement from the health system,
an incentive program for safety net providers with exceptional
ees with historically worse health outcomes and HRSN challenges;
d primary care, behavioral health (BH), and HRSN with a goal to
n health and health equity outcomes for high-risk enrollees including
nt and postpartum individuals, the chronically homeless, and
UD;

We’ve Got This!