Food is Medicine

Looking Back
Where We’ve Been

MASSACHUSETTS
Food is Medicine
STATE PLAN
JUNE 2019

FOOD IS MEDICINE

- Medically-tailored meals for those with serious illness or disability who cannot shop or cook for themselves
- Medically-tailored food for those with acute or chronic illness
- Medically-tailored food for those at risk for acute or chronic illness
- Healthy food for those who are malnourished or food insecure
Where We’ve Been

*Everything hurts and I’m dying.*
Where We’ve Been

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 Officer (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH) 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 currently 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 75 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,

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/pdfs/infographic-sociodemographic-variables.pdf for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2020, 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 2020 was released in 2020 and sets 122 objective national objectives to improve health and well-being over the next decade. Healthy People 2020 SDOH objectives can be found here.
Where We’ve Been

Biden-Harris Administration National Strategy on Hunger, Nutrition, and Health
SEPTEMBER 2022
Where We’ve Been

DEPARTMENT OF HEALTH & HUMAN SERVICES
Center for Medicare & Medicaid Services
7000 Security Boulevard, Mail Stop 52-30-12
Baltimore, Maryland 21244-0001

SMD D-12-001
RE: Additional Guidance on Use of In Line 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 healthcare-related social needs (HRSNs), such as housing instability and mental illness, through the use of a service or setting that is provided in an enrollee in a line of service or setting (ILoS) covered under the state plan.1 On January 7, 2021, the Centers for Medicare & Medicaid Services (CMS) published a State Health Official (SHIO) letter (SMD-12-001) 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 SHIO, 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 HRSNs. CMS is publishing this guidance to clarify an existing option that states can pursue to enhance and expand these efforts through the use of ILOs.

ILOs 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.2 In order to reduce the need for future costly state plan-covered services, this can improve population health, reduce healthcare costs, and lower overall health care costs in Medicaid. ILOs can be used, at the option of the managed care plan and the enrollee, as an alternative or add-on service to state plan-covered services or settings, or when the ILOs 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 seek 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 ILOs may offer potential future acute and institutional care and improve quality, health outcomes, and enrollee experience. For example, offering medically appropriate and cost-effective ILOs, such as medically oriented 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 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 ILOs are authorized in accordance with 42 CFR § 439.3(a)(2).

The American Journal of CLINICAL NUTRITION

New Developments From Federal Colleges

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

Christopher J. Lynch

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Dieting longer in the United States by 2020 “is a goal without a couch,” said President Joseph B. Elston on 20 September, 2012, at White House Conference on Hunger, Poverty, and Nutrition in the 21st Century. The White House Conference and Food and Drug Administration (FDA) to address the current obesity (see the Policy Brief on obesity and food systems) of the United States and improve nutrition and physical activity and close the education and health gaps. Hence, The White House Conference and FDA introduced a concept to prevent obesity, including the NHLBI, have committed to state, affect, and, disease-related obesity and weight of appropriate approach to these challenges.

The concept of obesity in our health and its social determinants is well-known, biologically, culturally, and commercially. Notably, one of the White House Conference states was Food is Medicine: Bringing nutrition out of the healthcare silo. Food is Medicine is a key element within the National Strategy on Hunger, Nutrition, and Health, which outlines complete integration of nutrition and health care [2]. Food is Medicine is an umbrella term for the programs required to bridge the link between diet and health involving (1) the provision of Food is Medicine services (medically, nutritionally, culturally, and herbal medicine, personal health, public health, education, research, etc.), and (2) the research on the healthcare systems to support the provision of Food is Medicine services. The research on the healthcare systems must support the provision of Food is Medicine services. The research on the healthcare systems to support the provision of Food is Medicine services.

Food is Medicine is a Crossing 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 progressed from the Food First to make food first, which is an independent risk factor for morbidity, mortality, and cost in a number of countries [1]. Evidence is also growing for how Food is Medicine strategies are associated with not only changes in individual health outcomes but also improvements in well-being and quality of life, including quality of life, and quality of life, and quality of life, and quality of life, and quality of life, and quality of life.

For more information on the Food System and Health initiatives, please contact the National Institutes of Health (NIH) Food System and Health Programs. Food is Medicine is a Crossing Opportunity for System-Level Health Improvement.

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Impact of Food Delivery and Health Coaching on Outcomes and Costs of Care: A Payer’s Perspective

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How Cross and Blue Shield of North Carolina (Blue Cross NC) launched a 6-week delivery and health coaching pilot among low-income members with type 2 diab to a proof-of-concept of the feasibility and potential efficacy of a payer-delivered diabetes intervention. Participants received twice a month delivery and health coaching from a low-income member with type 2 diabetes. The pilot enrolled 57 participants who completed the program (Complete) and 32 participants who completed less than 50% of the program (Partial). Participants were offered $5 in food delivery and $5 in food delivery and health coaching. The total cost of the program was $400 per participant. The pilot was associated with a decrease of $105 per member month (PMPM) in total costs and an increase of $8 PMPM in pharmacy costs, suggesting that medication intervention is more cost-effective in all cost types. Extrapolating the estimated reduction of $85 in total costs to a population of 50,000 members per year, this intervention has the potential to save $4.25 million per year.

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 health-related social needs, 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 services, 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. Medicaid State Plans have implemented these strategies.

This document lists HRSN services and supports considered under applicable 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 quality. This document lists all services and supports that states can choose to cover to address HRSN under applicable authorities. CMS will issue the final version of this document in the near future.

1. Examples include high-risk children, high-risk pregnant individuals, individuals who are at risk of becoming homeless, individuals with serious mental illness (SMI) or substance use disorder (SUD), and individuals experiencing high-risk care transitions (including transfers from institutional care or hospitals for people with disabilities and elders at risk). These services may be covered for members in rural areas and for members in underserved communities.

2. Allowable transitions include out-of-state institutional care and SUD, and transition from institutional care or hospitals for people with disabilities and elders at risk. Transitions out of inpatient care do not include transitions out of the child welfare system.
We’ve Got This!