

***Expanding Access to Healthy Food for Medicaid Beneficiaries***

**Medicaid – Facts and Figures**

- Medicaid is the nation’s public health insurance program for low-income individuals and families.
- The program serves several special populations, including pregnant women, children, elderly adults and people with disabilities.
- It operates under a federal-state partnership model and is projected to cover approximately 76 million Americans in fiscal year 2019.<sup>i</sup>
- Nearly two-thirds of Medicaid beneficiaries are enrolled in private managed care plans that contract with states to provide comprehensive services.<sup>ii</sup>
- Medicaid beneficiaries report the highest incidence of chronic health conditions compared to individuals receiving insurance coverage from other sources.<sup>iii</sup>
- Studies have indicated that as many as 62.1 percent of Medicaid beneficiaries have been diagnosed with 1 or more chronic conditions, including incidence rates up to 11.8 percent for heart disease, 12.7 percent for diabetes and 27.4 percent for hypertension.<sup>iv</sup>
- Leading experts agree that increasing access to healthy, nutrient-dense foods could help prevent, manage and/or mitigate the negative effects of chronic diseases in the Medicaid population.

**Introduction**

While there's little debate over the fact that having access to and consuming nutritious foods are good for people’s health and well-being, efforts to expand programs that provide healthy, nutrient-dense meals and foods to Medicaid beneficiaries have been stymied by cost-related concerns and opposition to providing free or discounted food under a program that was designed and authorized primarily to provide access to health insurance coverage and medical care for low-income Americans.<sup>v</sup> With that said, however, having access to insurance and a core set of mandated benefits are only part of the equation when examining the factors that affect Medicaid beneficiaries’ physical and mental health.

The American Heart Association (AHA) recognizes the importance of "food as medicine" programs and supports activities that aim to increase access to healthy food across the care continuum.

"Food as medicine" programs leverage targeted interventions to prevent and treat disease by improving nutrition among children and adults to help them get well and stay well.

Further, as it pertains to the Medicaid population, the AHA supports efforts by

public and private stakeholders to increase access to balanced or medically-tailored meals and healthy foods, including fresh fruits and vegetables, that might be cost-prohibitive or otherwise unattainable.

As an organization, the AHA strongly believes that targeted nutritional interventions play an important role in both well- and sick-care, spanning the prevention and treatment strati and complementing the standard medical services and care provided to millions of Medicaid beneficiaries across the United States. Given the direct correlation between dietary habits and health, as well as the abundance of evidence supporting how even small dietary changes can help prevent and treat disease, making access to healthy food a formal part of the benefits and services available to Medicaid beneficiaries could increase quality and satisfaction, improve outcomes and lower costs. Therefore, the AHA will advocate for the development of data-centric demonstration and pilot projects

that test the feasibility, scalability, and viability of innovative programs in the Medicaid arena that explore the link between access to and consumption of healthy foods with positive health outcomes and reduced morbidity and mortality risks.

**Food Insecurity and Health**

Food insecurity is broadly defined as a lack of access to adequate food because of limited money or other resources.<sup>vi</sup> According to the U.S. Department of Agriculture, nearly 12 percent of American households were classified as food insecure in 2016.<sup>vii</sup> While food insecurity has long been known to have a profound impact on health outcomes, initiatives to increase the availability of healthy, nutrient-dense food for those in need have historically been viewed as beyond the scope of programs designed to provide access to

medical coverage and care (e.g., Medicaid). Given the increased attention being paid to social determinants and population health, however, programs that integrate insurance coverage and clinical care with social services and supports have been recognized by stakeholders as important tools to help address the underlying causes of poor outcomes and increasing costs in the U.S. healthcare delivery system.

## Food Insecurity and the Medicaid Population

Under Medicaid, beneficiaries experience rates of food insecurity that are significantly higher than those of the general population. The International Food Information Council Foundation's *2018 Food and Health Survey*<sup>viii</sup>, conducted in partnership with The Root Cause Coalition, found that:

- 32 percent of Medicaid beneficiaries often purchase less-healthy food options than they otherwise would because of lack of money, compared to 13 percent of non-recipients;
- 28 percent of Medicaid beneficiaries purchase less food overall due to a lack of financial means, compared to 10 percent of non-recipients;
- 27 percent of Medicaid beneficiaries worry that their food will run out before they get money to buy more, compared to 7 percent of non-recipients; and
- 43 percent of Medicaid beneficiaries skip at least one meal per day due to a lack of food, compared with 28 percent of non-recipients.

"Treat-or-Eat" refers to a phenomenon whereby individuals, due to financial constraints, must choose between feeding themselves and their families or receiving and paying for medical care (e.g., filling a prescription, visiting the doctor, putting of a necessary procedure).

Further exacerbating the issue of food insecurity is the fact that many Medicaid beneficiaries, despite limited to nominal cost-sharing and out-of-pocket expenses,<sup>ix</sup> still face the so-called "treat or eat" dilemma: they often cannot afford to pay for both healthy food and their medical care expenses. Thus, they often make significant nutritional trade-offs to ensure that they're able to pay for their medical care while simultaneously maximizing the consumer or public assistance dollars that they spend on food. In practice, this behavior leads many Medicaid beneficiaries to make sub-optimal

purchasing and lifestyle decisions, including: dropping healthier foods (e.g., proteins, whole grains, vegetables and fruit) in favor of cheap energy-rich foods (e.g., starches, added sugars, vegetable fats);<sup>x</sup> eating at fast food or budget-friendly restaurants that serve many, nutrient-poor foods at relatively low prices;<sup>xi</sup> or overeating when food does become available, resulting in the chronic ups and downs that accompany the "feast or famine" cycle (e.g., stress, lethargy, metabolic changes).<sup>xii</sup>

To combat food insecurity and lessen the likelihood that Medicaid beneficiaries are forced to make imprudent choices that could have a deleterious effect on their health, well-designed and deployed interventions in the form of both preventive and ameliorative measures can result in improved health outcomes for Medicaid beneficiaries while simultaneously decreasing programmatic costs.<sup>xiii</sup>

## Intervention Models

Generally speaking, there are two broad intervention models that allow for Medicaid beneficiaries to access healthy food options via "prescriptions" written by authorized providers:

1. Delivery or pick-up programs that allow beneficiaries to receive medically-tailored, prepared meals (e.g., heat-and-eat) or food packages with the necessary ingredients to cook meals.

"Direct Provisioning" is defined as providing medically-appropriate meals or food to beneficiaries in need of intervention.

Example: Launched in April 2018, a \$6 million pilot project in California is funding 6 nonprofit organizations in 8 counties in California that will deliver free meals to select Medi-Cal (i.e., the California Medicaid program) beneficiaries that need a specific diet to help them manage their congestive heart failure.<sup>xiv</sup> Under the Medically Tailored Meals (MTM) Pilot Program, participants receive 3 medically tailored meals per day for 12 weeks.<sup>xv</sup> Medi-Cal beneficiaries with a diagnosis of congestive heart failure, who are high utilizers of health care services, can be referred

to the program by their physician or another clinician. After referral, the non-profit organization administering the program within the patient's locality will work with the referring provider to verify patient eligibility and, upon acceptance, prepared meals can begin being delivered in as little as 24 hours.<sup>xvi</sup>

2. Purchase assistance programs that allow beneficiaries to buy healthy foods, such as fruits and vegetables, at participating grocery stores, farmers markets or other locations (e.g., food pharmacies).

"Food Purchasing Incentives" are defined as subsidies or incentives that encourage beneficiaries to purchase medically-appropriate foods.

Example: Launched in 2010, the Fruit and Vegetable Prescription Program (i.e., FVRx), which was developed by Wholesome Wave, brings healthcare providers and participating food retailers and outlets together to serve at-risk individuals and families that cannot afford fresh produce. Under the model, individuals or families are identified by their physician or another clinician as being at-risk for nutritional deficiencies. Combined with a referral for nutritional counseling and information on available community resources, provider-generated "prescriptions" (e.g., pre-paid checks for use at partner sites, discount cards or codes that reduce the purchase cost, vouchers that provide a set quantity of specific items at no cost) for fruits and vegetables can be redeemed at participating outlets (e.g., grocery stores, farmers markets, hospital-based food pharmacies). Wholesome Wave's FVRx programmatic model, which has been implemented by 34 health care clinics in 10 states to-date<sup>xvii</sup>, can be tailored to meet the requirements of a specific state or region within a state and can be implemented in a variety of delivery formats to ensure the purchasing needs and desires of enrollees in a community are met. Results indicate that 69 percent of enrollees increase daily fruit and vegetable consumption and 47 percent of enrollees decrease body mass index (BMI) while participating in the program.<sup>xviii</sup>

## **Policy Recommendations**

The AHA supports a multi-pronged approach to expand access to healthy foods for Medicaid beneficiaries at little to no out-of-pocket cost for eligible individuals and families. Specifically, we recommend that policymakers:

### ***I. Utilize Existing Medicaid Funding Mechanisms and Pathways to Increase Access to Healthy Foods for Beneficiaries***

Because Medicaid is run jointly by federal and state governments, significant flexibility exists on the program design and operation fronts. Federal law sets broad requirements and mandates coverage of some populations and benefits, but each state has the responsibility of making many of the decisions that would affect coverage of food and nutrition interventions for eligible beneficiaries.<sup>xix</sup> For most beneficiaries, Medicaid does not currently provide coverage for the direct provisioning or incentivized purchasing of healthy foods as a health care benefit.

The AHA supports state efforts to increase access to healthy foods by applying for waivers (i.e., Home and Community-Based Services 1915(c) Waiver, Section 1115 Demonstration Waiver) and/or a State Plan Amendment (SPA). Any attempts to expand the services currently allowed under Medicaid through waivers, an SPA or any other mechanism, however, should not endanger or diminish the integrity of the state-based program or pose a potential harm to current or future beneficiaries.

### ***II. Support Public-Private Partnerships that Encourage Innovation and Promote Programmatic Efficiency***

Collaboration between public and private stakeholders can spur more inclusive and sustainable growth in programs that aim to increase access to healthy foods for the Medicaid population. Through strong cooperative agreements and joint investments, private organizations (e.g., foundations, non-profits, community health centers) and public entities can produce multi-faceted solutions that benefit those they aim to reach and serve.

The AHA supports public-private partnerships that focus on increasing the affordability and accessibility of healthy and nutritious foods and meals for Medicaid beneficiaries. Further, the AHA strongly encourages public and private stakeholders to engage in an open dialogue on how working hand-in-hand and leveraging their shared strength can increase the well-being and health of underserved and at-risk communities.

### ***III. Encourage Medicaid Managed Care Organizations (MCOs) to implement Programs to Address Members' Barriers to Accessing Healthy Food***

Although not all state Medicaid programs contract with MCOs, a large and growing majority do, as evidenced by the fact that more than half of all Medicaid beneficiaries nationally receive most or all of their care from a private, risk-based plan.<sup>xx</sup> Unlike state-run programs, private Medicaid plans have the discretion to spend funds on services that don't constitute direct medical care.

The AHA supports food and nutrition interventions as a covered benefit under Medicaid MCO plans and encourages states to exert pressure on MCOs with effectuated contracts to add benefits and services that increase access to healthy foods for their members. Further, the AHA strongly suggests that states seeking the services of an MCO via the posting of a Request for Proposal (RFP) specifically request that private plans include details on how they would expand access to healthy food as a component of providing a full spectrum of integrated benefits and services to a state's Medicaid population. In issuing an award, states should award contracts only to MCOs that provide coverage of innovative food and nutrition interventions for members.

### ***IV. Expand the Availability of Nutritional Services and Supports from Qualified Professionals***

Federal law requires states to provide certain “mandatory” benefits and allows states the choice of covering other “optional” benefits for most Medicaid beneficiaries. Coverage for nutritional services and supports, in the form of dietary counseling, behavioral therapy, and risk-based screening for nutritional deficiencies, food insecurity or obesity, is not specifically referenced by the Centers for Medicare & Medicaid Services in its list of optional benefits<sup>xxi</sup> and there is considerable variability in states’ coverage policies based on a variety of factors (e.g., specific populations served, coverage exclusions and limitations).

The AHA supports unimpeded access to nutritional services and supports provided by qualified professionals (e.g., physicians, mid-level providers, licensed nutritionists, registered dietitians) for all Medicaid beneficiaries. The AHA also supports a team-based, patient-centric care approach and encourages collaboration between all individuals involved in a patient’s care.

**V. *Create Synergies in Medicaid and the Supplemental Nutrition Assistance Program (SNAP) for Dually Eligible Individuals and Families***

While SNAP has been instrumental in combating food insecurity, the fact that approximately 80 percent of the program’s recipients also qualify for and receive benefits through Medicaid<sup>xxii</sup> signifies why the two mechanisms must work side-by-side to better serve individuals and families. While some argue that SNAP was not meant as a health benefit and Medicaid was not designed to support access to food, evidence strongly suggests that continuing to allow the programs to operate independently represents a missed opportunity to create synergies that could benefit dually eligible individuals and families.

The AHA supports efforts by policymakers to fund research initiatives that explore the overlap between SNAP and Medicaid, focusing heavily on how integration can be achieved. Further, the AHA strongly encourages alignment of initial and renewal applications for dually eligible individuals and families, the development of coordinated policies and streamlined processes, the inclusion of both programs in the same eligibility systems, and continued updates to delivery systems to ensure beneficiaries are able to access benefits and services without delay and with greater ease. With that said, however, conforming eligibility criteria across programs should not endanger or limit the ability of an individual or family to participate in any federal or state program intended to help support low-income or other vulnerable populations.

**VI. *Leverage the Power of Data Analytics and Research to Determine Impact***

Obtaining data and funding research that demonstrate the efficacy of healthy food interventions is of critical importance to determine the real, measurable impact that they have on patient health and costs of care. Any funded demonstration and pilot projects should be fully prepared to collect and analyze data and research findings to help assess and evaluate programmatic outcomes.<sup>xxiii</sup>

The AHA supports the use of data and research to demonstrate the impact that including nutrition services and supports in Medicaid beneficiaries’ benefits packages has on health outcomes and cost savings. The AHA strongly opposes any attempts to rely solely on cost-based metrics to restrict eligibility and benefits and/or to determine the relative success or failure of a demonstration or pilot project.

*The Policy Research Department links scientists, clinicians and policymakers to improve cardiovascular health and decrease heart disease and stroke mortality. For more information, visit <http://bit.ly/HEARTorg-policyresearch> or connect with us on Twitter at @AmHeartAdvocacy using the hashtag #AHAPolicy.*

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