



Mainstreaming Produce Prescriptions in Medicaid Managed Care: A Policy Toolkit and Resource Library

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CENTER for HEALTH LAW
and POLICY INNOVATION
HARVARD LAW SCHOOL

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The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective health care and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy. CHLPI is comprised of the Harvard Law School Health Law and Policy Clinic and the Harvard Law School Food Law and Policy Clinic.

DC Greens

DC Greens' (DCG) mission is to advance health equity by building a just and resilient food system. The organization works to transform the District into a place where health equity is a priority, healthy food is a human right, and all residents are included in developing and evaluating programs and policies that affect their communities. To achieve this vision, DCG combines community engagement with direct service programming and robust policy advocacy. DCG helped to launch and now coordinates the District's Produce Rx program, which allows local health care providers to prescribe fresh fruits and veggies to patients with lower incomes managing diet-related illnesses such as diabetes, pre-diabetes and hypertension. DCG also operates The Well, a community-based farm that promotes physical, mental, and financial wellness by holding space for neighbors and hosting programming that addresses the root causes of inequities. At the policy level, DCG advocates for a government that is directly accountable to and reflective of the needs of its people. DCG has helped to pass foundational health and wellness policies in the District (ex., Healthy Students Amendment Act of 2018) and focuses on policy efforts that reduce hunger, improve health outcomes, and democratize wellness. Kristin Sukys bridges the gap between DCG's programmatic and policy work as the organization's Health Policy Consultant, leading strategic planning and policy development on critical food as medicine and healthcare-sector interventions. .

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Disclaimer

This report provides information and technical assistance on issues related to health reform, public health, and food law. It does not provide legal representation or advice. This document should not be considered legal advice. For specific legal questions, consult an attorney.

SUGGESTED CITATION

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About this Report

Mainstreaming Produce Prescriptions in Medicaid Managed Care: A Policy Toolkit and Resource Library, is the third report in a series exploring policy pathways to increase access to Produce Prescriptions (PRx) through the U.S. health care and food systems. PRx are medical treatments or preventive services that provide access to healthy fruits and vegetables for patients with diet-related health risks or conditions who are food insecure or face documented challenges in accessing nutritious foods.

The first report in the series, *Mainstreaming Produce Prescriptions: A Policy Scan*, provides a high-level overview of current opportunities to sustain and scale PRx via U.S. health care and food policies. *Mainstreaming Produce Prescriptions: A Policy Strategy Report* then builds on this framework by providing policy recommendations addressing five core challenges limiting access to these vital programs: Funding, Research, Patient Data and Privacy, Infrastructure, and Advancing the Field. As part of these recommendations, authors explore opportunities to strengthen support for PRx across a broad array of programs including Medicaid, Medicare, Veterans Affairs, private insurance, as well as within the Gus Schumacher Nutrition Incentive Program (GusNIP), the Supplemental Nutrition Assistance Program (SNAP), and the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).

This report, the third in the series, goes a step further by taking a deep dive into one of the most critical and widely available pathways for supporting PRx in the U.S. health care system: Medicaid Managed Care (MMC). MMC is the dominant model for delivering health care services within Medicaid—the United States’ safety net health insurance program serving individuals with low incomes. Forty states and the District of Columbia currently use risk-based MMC to administer some portion of their Medicaid program, and 34 states and the District of Columbia now enroll over 75% of their Medicaid beneficiaries in MMC.¹

While federal law and policy do not yet allow broad coverage of nutrition interventions in Medicaid, MMC offers unique flexibilities at the state and plan levels to support PRx. This Toolkit seeks to assist PRx stakeholders as they navigate these opportunities. It provides information and guidance organized into three sections, each focused on a key step in the process of achieving MMC policy change²:

- **Articulating the Problem:** The United States is experiencing an epidemic of diet-related chronic disease, resulting in negative health outcomes and escalating health care costs. PRx can play an important role in responding to these trends, but access remains limited across the United States. As a first step towards policy change, PRx stakeholders must clearly articulate this problem. **Section I** of the Toolkit begins with an overview of the case for expanding access to PRx, including key points that stakeholders can share at the local, state, or national level.

- **Identifying a Policy Solution:** Once decision-makers understand this problem, they may need assistance in identifying and/or weighing potential policy solutions. **Section II** outlines a range of actions that could be taken at the federal, state, or health plan level to improve access to PRx through MMC.
- **Building Capacity for Change:** While articulating a problem and identifying a solution are critical first steps, PRx stakeholders can also use an array of strategies to set the stage for MMC policy change. From socializing the concept of PRx, to developing champions, to broader coalition-building, each PRx stakeholder can play an important role—large or small—to build towards change. **Section III** describes common strategies that PRx stakeholders can consider as they build capacity for change at the local, state, or national level.

Note on Additional Resources: For more information on each of these topics, readers can consult the **Resource Library** at the end of the Toolkit, which provides links to additional articles, reports, and online tools.

Articulating the Problem

The Case for Produce Prescription Programs

Today, nearly 85% of American adults eat less than the recommended daily fruit intake and 90% eat below the recommended daily vegetable intake.³ Diets low in fruits and vegetables are a leading risk factor for many chronic conditions such as diabetes, coronary heart disease, and some cancers.⁴ Six in ten U.S. adults now have at least one chronic disease and four in ten have two or more.⁵ These high rates of chronic conditions are associated with overwhelming human and economic costs. More than two-thirds of all deaths are caused by one or more of five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes—many of which are diet-related.⁶ And every year, over \$1 trillion is spent nationally treating diet-related chronic conditions.⁷

Despite this clear connection between diet and health, access to fruits and vegetables remains limited for many populations in the United States. Low-income individuals and communities of color, in particular, face a disproportionate number of barriers to accessing fruits and vegetables due to structural inequities and systemic racism.⁸ And generally, cost continues to be a primary barrier to accessing healthy foods, even for individuals enrolled in federal food assistance programs like SNAP and WIC which provide resources for food.⁹



PRx Definition: PRx is a medical treatment or preventive service for patients who are eligible due to (1) diet-related health risk or condition, (2) food insecurity or other documented challenges in access to nutritious foods, and (3) referral by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy fruits and vegetables with no added fats, sugars, or salt, at low or no cost to the patient.¹⁰ – **National Produce Prescription Collaborative (NPPC)**

Produce prescriptions address barriers to accessing fruits and vegetables in order to increase fruit and vegetable consumption and improve health. PRx programs operate via partnerships between coordinating entities, health care clinics, and retail redemption sites. Typically coordinated by non-profit community-based organizations (CBOs) or local health departments, these programs allow health care providers to address the needs of low-income patients with diet-related chronic conditions by writing “prescriptions” for free or discounted produce. Patients can then redeem these prescriptions at a variety of types of food retailers, depending on the program.

A growing body of evidence shows that PRx programs are a cost-effective¹¹ approach to increase food insecurity, boost fruit and vegetable consumption, and improve health. Specifically, current research shows that these programs have led to:

- Increased fruit and vegetable consumption;¹²
- Improved hemoglobin A1c levels in individuals with diabetes,¹³ body mass index (BMI) scores,¹⁴ and blood pressure;¹⁵
- Decreased depression scores;¹⁶
- Decreased fruit and vegetable avoidance based on cost;¹⁷ and
- Decreased hospitalization and emergency room utilization.¹⁸

PRx programs have also been found to bolster patient-provider relationships¹⁹ and stimulate local business.²⁰ For additional research support, see the **Resource Library** at the end of this Toolkit.

PRx is part of a growing Food is Medicine (FIM) movement that seeks to integrate a range of medically tailored food and nutrition services into the health care system to address rising rates of chronic illness and health care costs.²¹ FIM interventions represent a spectrum of programs and services—ranging from medically tailored meals, to medically tailored groceries, to PRx—that (1) provide food to support health and (2) have a nexus to the health care system.²² This FIM movement is part of a broader shift in the health care system to place greater emphasis on addressing the social determinants of health (SDOH) and health-related social needs (HRSNs).²³

Key Terms:

Social Determinants of Health (SDOH): the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.²⁴

Health-Related Social Need (HRSN): the social and economic needs that individuals experience which affect an individual's ability to maintain their health and well-being—such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.²⁵

Growing Support

The early development of PRx can be traced from Dr. H. Jack Geiger and his colleagues in late 1960s Mississippi;²⁶ to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in the 1970s;²⁷ and to the expansion of farmers market nutrition programs throughout the 1980s through the 2000s.²⁸ Finally, the past 20 years have seen increased investment in and integration of these programs into the health care system.

Historically, financial support for PRx has been provided on a limited or pilot basis by private sources that have aimed to emphasize the programs' ability to support local agriculture.²⁹ As outcomes from pilot programs have begun to showcase their ability to improve health outcomes and enhance patient experiences, federal support has grown. The 2014 Farm Bill dedicated \$100 million to support various nutrition incentive programs, including PRx.³⁰ In 2018, the Farm Bill renamed this program the Gus Schumacher Nutrition Incentive Program (GusNIP) and expanded funding to \$250 million, with up to 10% of program funds dedicated to PRx.³¹ During the COVID-19 pandemic, the country grappled with the impact of destabilizing rates of chronic conditions and widespread food insecurity.³² In response, crisis relief efforts, such as the American Rescue Plan, provided funds to increase food access programming, including PRx programs.³³

In recent years, PRx has also gained significant executive-level support. In September 2022, the Biden-Harris Administration held the second-ever White House Conference on Hunger, Nutrition, and Health and at the same time, released a National Strategy with an array of proposals to combat food insecurity and diet-related disease in the United States. In this National Strategy, the Biden-Harris Administration encouraged expanded access to PRx programs by:

- Supporting states' use of Medicaid demonstrations to test the expansion of coverage for these interventions;
- Implementing and evaluating a National PRx Pilot Program within Indian Health Services (IHS); and
- Supporting the implementation and evaluation of various food programs within the Veterans Administration (VA), including PRx programs.³⁴

The Need to Expand Access

However, despite growing federal interest—and a growing body of evidence—access to PRx remains limited or non-existent in many areas of the country.³⁵ The following sections therefore present an array of policy solutions that, if implemented, could increase access through one of the most widely available pathways in the United States: Medicaid Managed Care (MMC).

Identifying a Policy Solution

Introduction

Medicaid

Medicaid is the United States' safety net health insurance program for low-income adults and children, qualified pregnant people, older adults, and people with disabilities. As of October 2022, over 84 million individuals received their health coverage through Medicaid.³⁶ Medicaid operates as a federal-state partnership with shared costs. Federal laws and regulations create a broad framework for state Medicaid programs, outlining basic requirements regarding topics such as eligibility standards,³⁷ enrollment processes,³⁸ and mandatory and optional benefit categories.³⁹ States then have autonomy within the federal framework to administer their programs. States establish the details of their Medicaid program through the development of their State Plan, which they can amend with federal approval via State Plan Amendments (SPAs).⁴⁰ States can also seek flexibility in design and administration of their Medicaid programs with federal approval through various Medicaid waivers.



Medicaid Expansion

Under federal law, states are required to provide Medicaid coverage to certain populations, like low-income families, qualified pregnant people, and people with disabilities. States are also allowed to choose to provide coverage for additional groups of individuals, such as individuals with tuberculosis.⁴¹

In 2010, the Affordable Care Act allowed states to expand their Medicaid programs to cover all individuals, including childless adults, under 65 who have incomes at or below 138% of the Federal Poverty Line.⁴² As of February 2023, 40 states and the District of Columbia have adopted Medicaid expansion.⁴³

Medicaid Managed Care

States use different approaches to deliver Medicaid services to enrollees. Traditionally, the Medicaid system was designed as a fee-for-service model in which states directly paid health care providers for services rendered. Now, the majority of states favor managed care arrangements, in which the state outsources care delivery and provider payment to private health insurance plans, called Medicaid Managed Care Plans (MMC Plans).

Managed care arrangements vary considerably by state. Generally, states pay MMC Plans a per-member per-month rate, called a capitation rate, to provide Medicaid enrollees with services covered under the managed care contract. To deliver services, MMC Plans contract with their own provider networks who they pay via a fee-for-service system or through alternative payment arrangements (e.g., value-based payment models, which provide incentives for providers to improve care quality and health outcomes).

To implement an MMC system, states must request permission from the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for overseeing the Medicaid and Medicare programs. States can request permission through three federal authorities: a Section 1932(a) SPA, a Section 1115 Demonstration Waiver, or a Section 1915(a) or (b) Waiver.⁴⁴ As of July 2021, 41 states, including the District of Columbia (DC), provide care for at least some of their Medicaid populations through MMC.⁴⁵ Thirty-five states, including DC, enroll over 75% of their Medicaid beneficiaries into MMC Plans.⁴⁶

Key Terms:

- **Medicaid State Plan:** the agreement between a state and the Federal government outlining how the state will administer its Medicaid program, including its eligibility criteria, covered services, provider reimbursement methodologies, and administrative activities.⁴⁷
- **Fee-for-Service (FFS):** the traditional model of delivering and paying for Medicaid services in which the state contracts directly with health care providers and pays them directly for each covered service received by a Medicaid beneficiary.⁴⁸
- **Medicaid Managed Care (MMC):** a system of delivering and financing Medicaid services in which the state contracts with a private health insurance plan (a/k/a MMC Plan) and pays the plan a per-member-per-month fee to coordinate the delivery of and payment for Medicaid services. MMC Plans contract with health care providers, paying them for the provision of Medicaid benefits and additional services outlined in the plan's contract with the state.⁴⁹ Many states use a combination of FFS and MMC delivery systems.
- **Medicaid Managed Care Plan (MMC Plan):** a private health insurance organization paid by the state to coordinate delivery of and payment for Medicaid services.⁵⁰ MMC Plans may be non-profit or for-profit entities. Often, MMC Plans are referred to as managed care organizations (MCOs), but terminology may differ depending on MMC



arrangement and state structures.⁵¹ For example, North Carolina utilizes “Medicaid Pre-Paid Health Plans (PHPs)” in their managed care system.⁵² For clarity, this Toolkit will standardize language, using ‘MMC Plan’ to describe all types of managed care arrangements and naming schemes.

- **Health Care Providers:** the individuals, groups, institutions, or groups of institutions who provide health care services.⁵³ Physicians, hospitals, and Federally Qualified Health Centers (FQHCs) are all considered health care providers. Some states also utilize accountable care arrangements or groups of health care providers and facilities that coordinate the delivery of Medicaid services, sharing financial risk of and rewards for meeting health care quality and cost goals.⁵⁴ Accountable Care Organizations (ACOs) are a common accountable care arrangement. In this report, we use the term ‘health care provider’ to describe all health care provider types and arrangements.
- **Capitation Rate:** the per-member per-month rate the MMC Plan receives for arranging the delivery of and payment for Medicaid services.⁵⁵

Coverage of Produce Prescriptions in Medicaid Managed Care

Federal laws and regulations establish broad categories of mandatory benefits (which states *must* cover in their Medicaid programs), and optional benefits (which states may *choose* to cover).⁵⁶ States use these categories to determine which specific services they will cover—and therefore pay for—under their State Plan. MMC Plans must cover all services included in the State Plan (or a designated subset of those services).⁵⁷ Importantly, though, MMC Plans also have the flexibility to build upon the State Plan by covering *additional* services for their enrollees.

To date, the federal government has not explicitly allowed states to cover nutrition interventions under any established mandatory or optional Medicaid benefit category (with some limited exceptions, including coverage of enteral nutrition⁵⁸ and State Plan options to cover home-delivered meals as part of home and community-based services for individuals at risk of needing institutional care⁵⁹). Because the federal government has not yet approved coverage as part of mandatory or optional benefits, MMC and its flexibilities, as described in this Toolkit, have become essential in advancing PRx within the U.S. health care system. **Broadening PRx access through MMC not only increases food security and improves health for Medicaid enrollees, but also creates opportunities to expand the evidence supporting PRx and improve the readiness of our health care systems for adoption of a potential future federal PRx benefit.**

Managed Care Challenges & Considerations

As stakeholders leverage the opportunities presented by MMC, they should be aware of broader considerations and trade-offs that come with MMC enrollment and investment.

As compared to a traditional fee-for-service model, MMC Plans limit patients' choice of providers, and may have stricter prior authorization and utilization management criteria and processes that deny or delay access to medically necessary care at higher rates.⁶⁰ Additionally, the federal government has emphasized the need for states to improve MMC oversight and transparency to ensure beneficiaries have access to quality care. Of particular focus has been MMC Plans' network adequacy standards, which generally refer to an MMC Plan's ability to provide its enrollees with timely access to a sufficient number of in-network providers and the health care services included in its benefit contract.⁶¹ The federal government has also placed much-needed attention on transparency in reporting on MMC spending, which can help ensure plans are spending government funding on quality health care services and delivery, and not spending too much on administrative costs or reaping outsized profits.⁶²

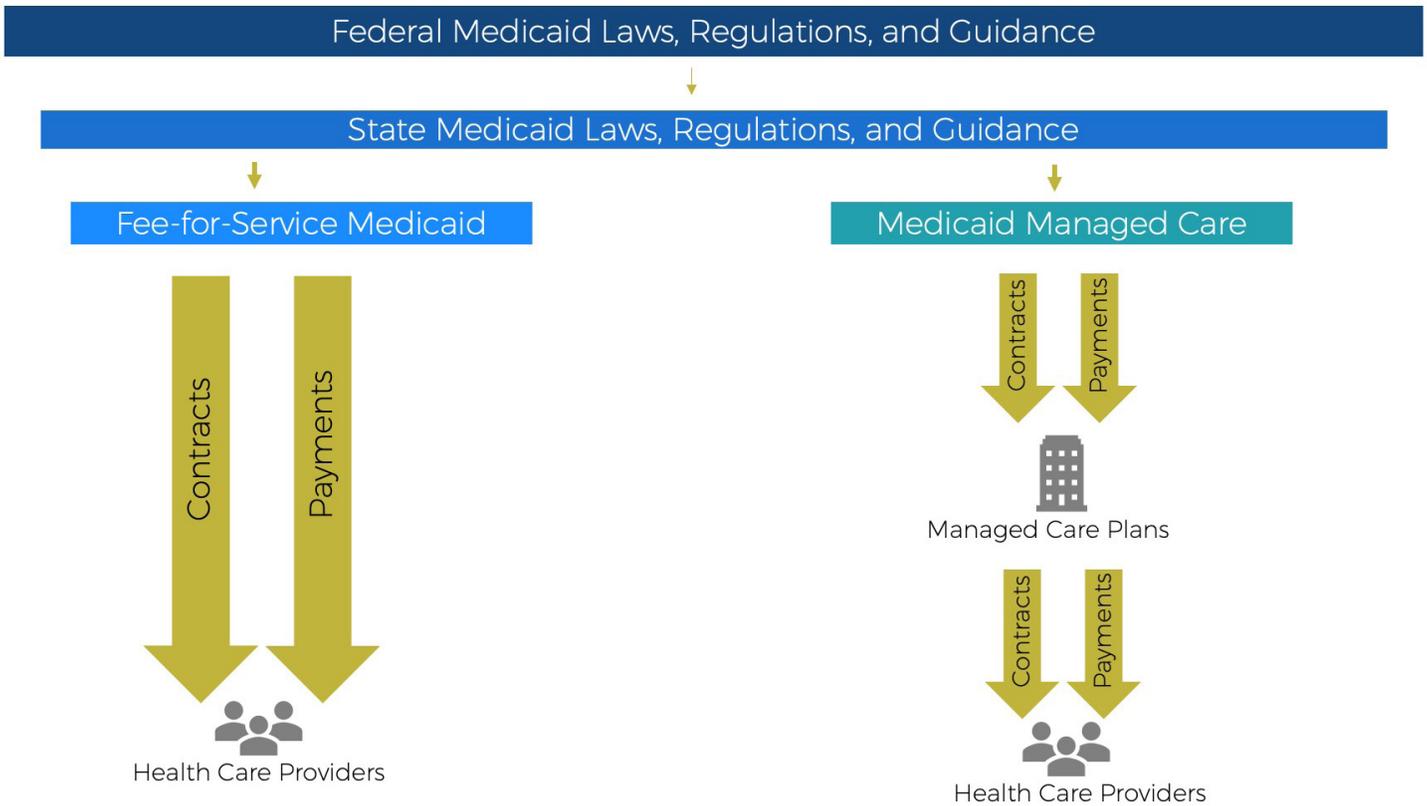
While the focus of this Toolkit is to highlight the role of MMC as a pathway to health care coverage for PRx, stakeholders should be aware of potential tradeoffs between traditional fee-for-service Medicaid and MMC. Stakeholders should be sure to evaluate any potential impacts on the patient experience of MMC policy change proposals and investigate opportunities to improve transparency and access in MMC wherever possible.

A Multi-Layered Policy System

MMC programs—and the opportunities they create for PRx—are governed by layers of policy at the federal, state and plan levels. At each layer, law, regulations, guidance, and contracts outline requirements and accountability mechanisms, but also afford flexibilities to innovate. As a result, each state MMC program and individual MMC Plan is highly unique.

The following sections of the Toolkit examine each level of this multi-layered system, outlining concrete opportunities to change MMC policy at the federal, state, and plan levels to improve patient and provider access to PRx.

Figure 1: Medicaid Managed Care: A Multi-Layered Policy System



Federal Medicaid law and regulations create requirements for state Medicaid programs. States may implement Medicaid programs via fee-for-service and/or managed care payment and delivery systems. If a state contracts with MMC Plans, the MMC Plans must comply with federal requirements and state contractual requirements, but also have flexibilities to deliver additional services. Health care providers such as hospitals, primary care practices, and ACOs, in a managed care arrangement must abide by contracts with the MMC Plan and deliver services to patients accordingly.

Federal-Level Opportunities for Innovation in Managed Care Policy

All state Medicaid programs are governed by the federal framework of Medicaid and managed care laws, regulations, and guidance. For example, in addition to setting baseline requirements for eligibility and benefits for *all* state Medicaid programs, federal laws and regulations dictate minimum required provisions that must be included in states' MMC contracts,⁶³ capitation rate standards,⁶⁴ and MMC enrollee rights and protections.⁶⁵ Additionally, the federal government has increasingly used guidance to expand opportunities for states, MMC Plans, and providers to address health-related social needs through existing MMC pathways.⁶⁶

This section describes two opportunities to use federal-level policy change to embed and expand access to PRx within MMC: **(1) establishing coverage of PRx in standard Medicaid benefits and (2) improving uptake of existing MMC pathways to pay for PRx.**

Establish Coverage of PRx in Standard Medicaid Benefits

As noted above, federal policy plays a key role in determining which services MMC Plans must provide to their enrollees. MMC Plans must typically cover all of the services included in their state's Medicaid State Plan.⁶⁷ States choose their State Plan services based on federal laws and regulations, which outline both mandatory services that states *must* cover and optional services that states *may* cover. However, the federal government has not yet explicitly authorized coverage of PRx under either mandatory or optional Medicaid benefit categories. As a result, PRx is not a standard part of coverage in any state Medicaid program. As explained in more detail in the previous report in this series, *Mainstreaming Produce Prescriptions: A Policy Strategy Report*, policy change to establish Medicaid coverage of PRx could occur through federal administrative action to clarify coverage within existing Medicaid benefit categories or federal legislation to establish a new Medicaid benefit.⁶⁸ In doing so, policymakers would ensure that states must require coverage of PRx for *all* qualifying Medicaid enrollees (if established in a mandatory category) or states could do so (if established in an optional category).

Establishing a broadly available PRx benefit within Medicaid would arguably have the greatest impact of any of the opportunities outlined in this Toolkit.

However, this approach may also be the least feasible politically and may have the disadvantage of adding new costs to the Medicaid program. For example, in their 2019 modeling study, Lee et al. found that providing a 30% fruit and vegetable subsidy for all Medicaid and Medicare enrollees would cost \$122.6 billion for policy implementation (though these researchers also found that the change would be highly cost-effective over time given the resulting health improvements and reductions in health care costs).⁶⁹

Given these potential challenges, federal policy change to incorporate PRx into standard Medicaid benefits may take time. The remainder of this Toolkit, therefore, focuses on policy approaches that state agencies and MMC Plans may use to go *beyond* Medicaid baseline benefits to more immediately provide coverage of PRx for their Medicaid enrollees.

Provide Guidance and Technical Assistance to Improve Uptake of Existing MMC Pathways

While efforts to establish a Medicaid benefit at the federal-level are ongoing, federal agencies could support more immediate access by providing guidance and technical assistance regarding current opportunities to support PRx. Specifically, CMS could provide additional formal guidance, webinar series, and trainings to states, MMC Plans, and other interested parties explaining how existing legal and regulatory flexibilities can provide opportunities to pay for PRx within MMC.

CMS recently released helpful guidance in January 2021 that provides a summary of existing policy pathways to pay for services that respond to HRSN, including nutrition interventions.⁷⁰ The January 2021 guidance, like this Toolkit, provides a menu of policy opportunities, allowing stakeholders to identify options that are tailored to their state and community's political and social environment. Still, more clarity from CMS would assist states and other stakeholders in understanding the parameters of these opportunities and where PRx would be appropriate.

- **Example: In Lieu of Services (ILOS):** Under ILOS authority, states may provide approval for MMC Plans to cover otherwise non-covered services as medically appropriate, cost-effective substitutes for services covered under the State Plan.⁷¹ However, federal regulations governing this policy option are vague. In 2021, California received approval for a Medicaid waiver that includes an expansive approach to ILOS. Under the waiver, California allows plans to use ILOS authority to cover nutrition interventions like PRx to replace utilization of both *current* state plan services and *future* state plan services (e.g., to help *prevent* the need for future hospitalizations or ER visits).⁷² CMS then released guidance in January and a proposed rule in May 2023 officially endorsing this approach,⁷³ thereby providing other states with confidence to follow California’s lead. CMS could likewise provide guidance to states clarifying the breadth of other legal authorities so that states, MMC Plans, and other stakeholders can take full advantage of all policy options to expand access to PRx. In developing such guidance, CMS should seek to maximize equitable access to services, and should therefore minimize extra requirements for states and MMC plans wherever possible.

As states across the nation are innovating to address HRSNs via MMC, there is also ample opportunity for learning and collaboration. CMS could harness this energy by creating an MMC learning collaborative for states interested in learning from one another. CMS could also provide professional development and training opportunities for Medicaid officials or MMC Plan staff interested in advancing HRSN activities in MMC systems. By providing these forums—and, where possible, shared tools such as template contract language—CMS could also mitigate state fears surrounding the legality of innovation and ease the transition of PRx programs into the health care space.

State-Level Opportunities for Innovation in Managed Care Policy

Although federal laws, regulations, and guidance establish the overarching framework for Medicaid, states play a crucial role in determining the actual details of their program. As part of this process, states have several options to use the design of their MMC program to expand access to PRx and support PRx programs with sustainable funding streams. This section provides an overview of these state-level MMC policy opportunities as well as examples of how states have used these opportunities to increase access to PRx and other nutrition interventions. These opportunities are divided into two categories, based upon the entities involved:

1. State-Federal Opportunities

- A. State Plan Amendments (SPAs)
- B. Medicaid Waivers

2. State-MMC Plan Opportunities

- A. State MMC Plan Procurement
- B. State MMC Plan Contracting
- C. State MMC Plan Oversight

State-Federal Opportunities

When designing Medicaid programs and managed care systems, states must adhere to federal rules and regulations. However, through State Plan Amendments and waivers, state Medicaid agencies can apply for and receive federal approval to change aspects of their existing programs. In some cases, these state-initiated, federally-approved policy changes can be used to establish payment and/or infrastructure for PRx programs, either within MMC specifically or across the entirety of a state's Medicaid program (i.e., in both MMC *and* fee-for-service programs).

A. State Plan Amendments (SPAs)

SPAs traditionally change administrative features of a state's Medicaid plan, such as provider payment rates or optional benefits. In contrast to many waiver options (described below), SPAs implement permanent changes and typically have no cost-neutrality or other budgetary requirements.⁷⁴ In the context of this Toolkit, SPAs are a noteworthy policy opportunity because states can use SPAs to request federal approval to: (1) implement MMC and (2) to establish coverage of new benefits within the State Plan.

- **SPAs to Establish MMC:** Under Section 1932 of the Social Security Act, states may use a SPA to establish an MMC program.⁷⁵ When establishing an MMC program through a SPA, states can bypass federal requirements for statewideness, comparability, and choice of providers.⁷⁶ This allows states to implement their MMC programs in select areas of their state, offer different benefits for managed care enrollees compared to fee-for-service enrollees, require beneficiaries to receive services within managed care models, and/or limit choice of providers to certain networks.
- **SPAs to Establish Coverage of New Benefits:** SPAs can also be used to add or alter coverage of benefits within the State Plan (but not eliminate coverage of mandatory benefits).⁷⁷ Therefore, states could submit a SPA to request approval from CMS to cover PRx within an existing benefit category (e.g., within the rehabilitative services optional category). In doing so, states could seek to establish coverage across their program in both fee-for-service and managed care populations. As noted above, CMS has not yet explicitly authorized coverage for PRx under any existing benefit category, and so no states currently have an approved SPA for PRx coverage.⁷⁸ However, states interested in pursuing permanent coverage for PRx in their Medicaid program *could* attempt to submit a SPA, thereby encouraging CMS to use its administrative authority to allow such coverage. If CMS were to approve such an application, SPAs could become an important pathway for state Medicaid agencies to establish widespread coverage and access to services.

B. Medicaid Waivers

Medicaid waivers allow states to test innovative models that may not otherwise be allowed under federal rules (e.g., changes in benefits, payment models, and/or eligibility). There are various types of waivers, each named for the section of the Social Security Act in which it appears. Each type of waiver also focuses on different features of the Medicaid program and has different requirements. Waivers are time-limited and must be cost effective or cost neutral.⁷⁹ Some states have numerous programs outlined within a single waiver and some states operate multiple waivers simultaneously.

Section 1115 Demonstration Waivers: Section 1115 of the Social Security Act allows the federal government to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program.⁸⁰ These waivers give states immense flexibility, permitting states to bypass provisions of the Medicaid Statute to allow coverage of populations and services that may not normally be allowed under federal rules, and allowing implementation of innovative service delivery systems. Section 1115 Demonstration Waivers must be budget neutral to the federal government and are initially approved for no more than 5 years, though many states apply for extension or renewal.⁸¹

In December 2022, CMS publicly released a framework outlining the ways that states can use Section 1115 Waivers to address HRSNs.⁸² Importantly, this framework explicitly stated that CMS will allow states to use Section 1115 Waivers to provide coverage for nutrition supports, including PRx. The framework also established guardrails for states when using 1115 Waivers in this way, including time limits for services, limitations on overall spending for HRSN services (no more than 3% of the state’s annual Medicaid spend), and expectations for Medicaid agencies to work with other state agencies to connect enrollees to related social service programs (e.g., SNAP and WIC). Finally, the framework announced several new policy decisions aimed at making the use of Section 1115 Waivers both simpler and more effective. For example, the framework allowed states to apply for infrastructure funding to support implementation of HRSN initiatives and made it easier for states to meet 1115 Waiver budget neutrality requirements.

Table A, on the following page, provides examples of how states are currently using Section 1115 Waivers to support access to PRx both within and beyond MMC.



Table A: State Examples of Section 1115 Demonstration Waiver Programs

State	Key 1115 Demonstration Innovation(s)
<p>Massachusetts (approved)</p>	<p>Massachusetts uses an 1115 Waiver to establish their Accountable Care Organization (ACO) delivery system and to test approaches to address HRSNs of Medicaid patients.</p> <p>In 2016 Massachusetts received CMS approval to implement a \$149 million Flexible Services Program within their Medicaid system (called MassHealth) via a Section 1115 Demonstration Waiver.⁸³ The Flexible Services Program provides funding for MassHealth ACOs—most of which partner closely with an MMC Plan—to address HRSNs of eligible individuals by providing access to tenancy preservation and nutrition sustaining supports.⁸⁴ To receive nutrition services, members must be at risk for nutrition deficiency or nutritional imbalance due to food insecurity.⁸⁵ Nutrition sustaining supports include one or more of the following services: home-delivered meals, services that increase food access to meet nutritional or dietary needs, assisting members with entitlement benefits, providing or helping to access local nutrition education, helping members afford food preparation supplies, assisting members with transportation to food resources, and helping members maintain access to nutrition benefits via assistance with legal services when needed.⁸⁶ PRx is an approved nutrition sustaining support.</p> <p>In 2022, CMS approved MA’s 1115 Waiver Extension Request, which outlined the future of the Flexible Services Program. Starting in 2025, MassHealth will integrate funding for the provision of these services more directly into standard funding streams, for example, into capitated payments for MassHealth ACOs.⁸⁷</p> <p>The waiver extension also authorized the establishment of a Social Service Organization (SSO) Integration fund (a continuation/evolution of the previous waiver’s SSO Preparation Fund), to provide funding to support development of infrastructure needed for successful implementation of the Flexible Services Program.⁸⁸</p>
<p>North Carolina (approved)</p>	<p>North Carolina uses an 1115 Waiver to establish their health care delivery system through Prepaid Health Plans (PHPs) (their version of MMC Plans) and test new structures and supports to address HRSNs of Medicaid patients.</p> <p>In 2018, North Carolina received CMS approval for a \$650 million Section 1115 Demonstration Waiver to establish their Healthy Opportunities Pilots.⁸⁹ These pilots were implemented in select regions across the state to test and evaluate the impact of providing evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety and toxic stress to high-needs Medicaid enrollees.⁹⁰ The budget included \$100 million for capacity building to develop infrastructure, provide technical assistance, and improve partnerships between CBOs, social service agencies, and health care.⁹¹ The state incorporated value-based payments to incentivize the delivery of high-quality care within the pilot by linking incentives to health and socioeconomic outcomes.⁹²</p> <p>Food support and meal delivery services that are authorized for the pilot include, but are not limited to:</p> <ul style="list-style-type: none"> • Assisting enrollees with SNAP and WIC applications; • Nutrition counseling and education, including healthy meal preparation; • Providing funding to assist food banks and other community-based food programs for meals and food for medical condition-specific “healthy food boxes”; • Assisting enrollees in locating food banks and summer and school food programs; and • Providing funding for targeted nutritious food or meal delivery services for individuals with medical or medically-related special dietary needs (programs must not constitute a “full nutritional regimen” (3 meals per day, per person)).⁹³ <p>Through the pilot, enrollees can receive up to \$210 per month for fruit and vegetable prescription programs.⁹⁴</p> <p>By December 2023, the state must provide CMS with a plan regarding how the state will incorporate effective pilot service programs into its managed care program.⁹⁵</p>

State	Key 1115 Demonstration Innovation(s)
<p>Oregon (approved)</p>	<p>Oregon uses an 1115 Waiver to establish their Coordinated Care Organization (CCO) delivery system (their version of ACOs) and to test approaches to address HRSNs of Medicaid patients.</p> <p>Oregon's 2022 CMS-approved 1115 Waiver clarifies and expands the payment pathways available to CCOs for HRSN services. While the waiver maintains a number of pre-existing payment pathways, it most notably establishes one additional payment pathway in the state: Health-Related Social Needs (HRSN) Services.</p> <ul style="list-style-type: none"> • HRSN Services: Housing, nutrition, and case management/education supports that the state and CCOs may cover for Medicaid enrollees experiencing certain life transitions (e.g., homelessness, transitioning to dual Medicaid-Medicare enrollment, etc.). These services may be offered to individuals enrolled in the CCOs and individuals in Oregon's fee-for-service program. The federal government and state share the costs of these services and the state may include the costs of services in capitation rate setting.⁹⁶ <p>Under this pathway, nutrition supports may include: nutrition counseling and education, medically-tailored meals, meals or pantry stocking, and fruit and vegetable prescriptions (most up to 6 months).⁹⁷</p> <p>The waiver also establishes funding for infrastructure investments to support the development and implementation of HSRN services including technology; the development of business or operational practices; workforce development; and outreach, education, and stakeholder convening.⁹⁸</p>
<p>Washington (proposed)</p>	<p>Washington uses an 1115 Waiver to outline their managed care delivery system supported by regional Accountable Communities of Health organizations (ACHs) and to test approaches to address HRSNs of Medicaid patients.</p> <p>Washington's latest 1115 Waiver renewal application, Medicaid Transformation Project 2.0 (MTP 2.0), submitted June 2022 (still under CMS review as of February 2023), proposes to establish the Taking Action for Healthier Communities (TAHC) program. This program would focus on developing and implementing community-based care coordination hubs, health-related services, health equity programs, and community-based workforce.⁹⁹</p> <p>The state further proposes to address HRSNs through the provision of health-related services and supports (HRS). The state proposes to pre-approve and allow MMC Plans to cover HRS as ILOS* for the managed care population.¹⁰⁰ The state also requests CMS authorization to provide the same HRS to fee-for-service enrollees.¹⁰¹</p> <p>The HRS listed in the proposed waiver renewal include:</p> <ul style="list-style-type: none"> • medically tailored meals; and • medically supportive foods, including healthy food box delivery, fruit and vegetable prescriptions, and complementary wellness programs. <p>The proposed target population for these interventions includes individuals with chronic conditions or individuals who have extensive care coordination needs.¹⁰² Similar to California, Washington seeks to be able to use ILOS to both immediately substitute covered services and to prevent the need for covered services in the future.¹⁰³</p> <p>The waiver proposal also requests approval for CBO capacity building funding (e.g., to address workforce needs, workflow development, operational requirements and oversight, closed-loop referral, billing systems/services).¹⁰⁴</p>

* As explained in more detail in the **MMC Plan-Level Opportunities** section of this report, in lieu of services (ILOS) authority allows states to provide approval for MMC Plans to cover otherwise non-covered services as medically appropriate, cost-effective substitutes for services covered under the State Plan.

Other Waiver Authorities: States may also utilize other types of waivers to implement MMC and/or to approve additional services for certain populations. Relevant waivers for PRx stakeholders include:

- **Section 1915(b) Waivers:** Sections 1915(b)(1)-(4) of the Social Security Act allow states to request CMS approval for waivers to require a larger portion of their Medicaid population to enroll in managed care.¹⁰⁵ The managed care systems outlined must be cost effective, efficient, and consistent with the principles of the Medicaid program. States must typically seek CMS approval for these waivers every two years.¹⁰⁶ Among these 1915(b) Waivers, 1915(b) (3) Waivers are particularly notable as they allow states to reallocate cost savings from MMC to provide additional services not covered under the State Plan.¹⁰⁷ Therefore, if MMC models allow state Medicaid programs to save money, states may use those savings to pay for interventions addressing HRSNs, including PRx.
- **Home and Community Based Services Waivers:** These waivers allow states to provide additional home and community-based services (HCBS) to maintain Medicaid enrollees in the community who might otherwise require a more intensive setting (e.g., care in a nursing facility).¹⁰⁸ States can choose to implement HCBS waivers through MMC by pairing them with an MMC waiver (e.g., a Section 1915(b) Waiver) or other MMC authority (e.g., Section 1932 state plan option). Several types of HCBS waivers may provide opportunities for PRx coverage. For example:
 - **Section 1915(c) Home and Community Based Services Waivers:** Section 1915(c) Waivers allow states to provide home and community based services to individuals who would otherwise need institutional care.¹⁰⁹ These waivers allow states to bypass statewideness, comparability, and income and resource rules normally required by the Medicaid statute.¹¹⁰ CMS currently allows states to offer home-delivered meals through this waiver authority, provided they do not constitute a full nutritional regimen.¹¹¹ States could also propose to use these waivers to authorize funding for PRx.¹¹²
 - **Section 1915(i) Home and Community-Based Services SPAs/Waivers:** 1915(i) SPAs and Waivers allow states to cover any services allowed by 1915(c), however, the eligibility requirements are looser and based on state-defined needs-based criteria.¹¹³ For example, individuals covered by 1915(i) SPAs/Waivers may not yet require institutionalization. As with 1915(c) Waivers, CMS currently allows states to offer home-delivered meals through this authority, provided they do not constitute a full nutritional regimen.¹¹⁴ Again, states could propose to use these waivers/SPAs to authorize funding for PRx.¹¹⁵

Table B, on the following page, provides examples of how states are currently using these additional waiver authorities to support access to nutrition interventions both within and beyond MMC.

Table B: State Examples of Other Waiver Authority Programs

State	Waiver	Innovation
California	1915(b) Waiver	<p>California's 2021 CMS-approved 1915(b) Waiver is authorized under sections 1915(b) (1) and 1915(b)(4) of the Social Security Act.¹¹⁶ The waiver was approved as a combined Section 1115/1915(b) Waiver.¹¹⁷ The waiver authorizes MMC Plans to provide 14 categories of Community Supports that are pre-approved ILOS.* Medically Tailored Meals/Medically Supportive Foods is one category of Community Supports, which includes:</p> <ul style="list-style-type: none"> • Medically Tailored and Home-Delivered Meals; • Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies (encompassing PRx); and • Behavioral, cooking, and/or nutrition education, when paired with direct food assistance as enumerated above.¹¹⁸
Michigan	1915(b) Waiver and 1915(c) Waiver	<p>Michigan's "MI Health Link HCBS" 1915(c) HCBS Waiver serves individuals who are 65 and older and individuals aged 21-64 with physical disabilities, who are eligible for both Medicaid and Medicare (i.e., dual eligibles), and who, absent the waiver, would require services in a nursing facility. This waiver authorizes the provision of home-delivered meals.¹¹⁹</p> <p>Michigan uses a concurrent 1915(b) Waiver to require individuals participating in this waiver to enroll in MMC Plans.¹²⁰</p>
Illinois	1915(c) Waiver	<p>Illinois currently has three 1915(c) Waivers that include coverage of home-delivered meals as HCBS for three populations: individuals living with HIV/AIDS, brain injuries, or disabilities.¹²¹</p>
Texas	1915(i) SPA	<p>Texas' 1915(i) SPA allows the provision of home delivered meals for older individuals and individuals with disabilities.¹²²</p>

* As explained in more detail in the **MMC Plan-Level Opportunities** section of this report, in lieu of services (ILOS) authority allows states to provide approval for MMC Plans to cover otherwise non-covered services as medically appropriate, cost-effective substitutes for services covered under the State Plan.

State-MMC Plan Opportunities

States also have a range of policy opportunities available to them as they create their MMC program and structure their relationships with MMC Plans. Unlike the state-federal opportunities described above—which may impact MMC or the state’s Medicaid program as a whole—these state-MMC pathways are specific to managed care. These opportunities can be separated into three categories, based on the three distinct stages of the state-MMC relationship in which they occur: **(1) State-MMC Plan Procurement; (2) State-MMC Plan Contracting; and (3) State-MMC Plan Oversight.**

A. State-MMC Plan Procurement

MMC Plan procurement is the process some states use to decide with which health plans they will contract in their Medicaid program. States have a considerable amount of flexibility when designing their MMC procurement process as long as it remains similar to other state-driven procurement processes.¹²³ Decisions states must make include: procurement timeline and frequency, the number of plans with which the state is willing to contract, and how proposals will be evaluated and scored.¹²⁴

Procurement can be a lengthy process, often extending as long as 18-24 months and including multiple steps, such as: (1) development and release of a Request for Proposals (RFP); (2) submission of bids; (3) review and award of bids; and (4) readiness review and implementation.¹²⁵ States therefore often use the procurement process to set multi-year contracts—to allow time for implementation of contract changes, build in time for the next procurement cycle, etc. However, timelines for procurement are not always stable, as states may decide to extend contracts for additional years or may re-procure on a shorter timeline than expected due to changes in the MMC program, litigation, or requirements from the state legislature or administration.¹²⁶

States can use the use the MMC procurement process to learn about MMC Plans' SDOH-related activities and/or incorporate SDOH-related activities into MMC procurement scoring. Focusing on SDOH in procurement can give states the information needed to partner with plans that are prioritizing the HRSN of MMC enrollees and can give plans incentives to address these needs. For example, if plans with services and partnerships that address HRSN are more likely to earn higher procurement scores and are thus more likely to earn MMC contracts, this may motivate MMC Plans to cover PRx.

B. State-MMC Plan Contracting

MMC contracts are the legal agreements between states and MMC Plans, binding plans to federal and state requirements when delivering and paying for Medicaid services. These documents are the strongest policy lever that states have to control what services and supports MMC Plans provide to Medicaid enrollees. Federal law and regulations set baseline rules that states must follow when developing MMC contracts.¹²⁷ However, states have significant flexibility within this framework to fill in critical details, thereby establishing state- and program-specific requirements. For example, states can use the contracting process to set policies on important issues such as care management and coordination, service coverage, quality standards and reporting, and payment approaches. Guidance documents often further detail implementation of the MMC Plan contracts.

States can use contracting in a variety of ways to require or incentivize MMC Plans to cover PRx. For example, states can include contract provisions that require SDOH screening and referral, explicitly approve PRx as ILOS, create performance incentives and other value-based payment requirements or initiatives for addressing HRSN and/or nutrition insecurity, and more.

C. State-MMC Plan Oversight

Federal regulations require states to develop and maintain quality strategies, which help assess MMC quality and identify measurable goals and targets for improvement.¹²⁸ States can then connect these quality strategies to policies regarding financial incentives such as bonuses, withholds (when a portion of the expected capitation payment is withheld from the MMC Plan) and value-based payment models to encourage plans to meet outlined quality objectives.¹²⁹ These Quality quality strategies can include reporting requirements, objectives, and performance measures that incorporate metrics related to SDOH, food insecurity, and/or diet-related diseases to

incentivize MMC Plans to provide PRx and other nutrition interventions. States must obtain input through public comment and other processes before submitting quality strategies to CMS for approval.¹³⁰ MMC Plans are required to explicitly comply with or conduct the monitoring and data gathering necessary to comply with state quality strategies via their state contracts.



Transparency in Medicaid Managed Care: Federal law imposes few requirements regarding transparency in MMC. As a result, state Medicaid agencies have different approaches to providing public access to reports and metrics regarding their MMC programs. By requiring/providing public reporting of MMC Plan information, states can increase accountability for substandard performance, enhance opportunities for additional evaluations by interested third parties, and can potentially incentivize MMC Plans to improve their performance based on public scrutiny.

Within these three categories of opportunities, states have a long list of specific policy levers at their disposal to require or incentivize MMC Plans to address food-related needs of MMC enrollees. In doing so, states can motivate MMCs—or health care providers within an MMC’s network—to partner with PRx programs to meet contract requirements. Notably, though, these requirements/incentives may be vague—encouraging plans to address food insecurity or HRSNs broadly, but not requiring specific actions to do so. Therefore, to ensure these contracting pathways result in real opportunities for utilization of PRx, stakeholders may need to engage at the state and plan level to encourage clarity in the contract itself and to help plans understand how utilization of PRx can help them meet their obligations.

Table C, on the following page, provides examples of how states are currently using the levers within MMC procurement, contracting, and oversight to encourage MMC Plans to address SDOH/HRSNs and to support access to nutrition interventions.



Table C: Opportunities via State-MMC Plan Levers

Policy Lever	Opportunity	Example(s)
<p>State-MMC Plan Procurement</p>	<p>Use the MMC procurement process to learn about MMC Plans’ SDOH-related activities</p> <p><i>States can use the procurement process to assess the level of engagement and experience MMC Plans have in addressing the SDOH.</i></p>	<p>Oklahoma RFP, Question 33: “Describe your approach for addressing Social Determinants of Health in accordance with the requirements of Model Contract Section 1.6.9: “Social Determinants of Health.” In addition, provide an example of an innovative approach you took to address Social Determinants of Health, the results achieved, and how you will apply this experience to SoonerSelect. Limit your examples to 2015 or later.”¹³¹</p> <p>Ohio RFP, Question 5: “Describe how the Applicant will identify and address the social determinants of health (SDOH) affecting its membership in the context of the Applicant’s population health management strategy. Include an example of Applicant’s experience and success addressing SDOH to improve population health outcomes.”¹³²</p>
	<p>Incorporate SDOH-related activities into MMC procurement scoring</p> <p><i>Including SDOH-related activities as part of the procurement scoring assessment for MMC proposals can give plans incentives to address the HRSN of patients.</i></p>	<p>Washington DC added HRSN-related scoring to their recent RFP, stating that proposals will be evaluated based on their approach and methodology to administer services and supports to address social factors that impact the overall health care of enrollees. Offerors may receive 0-10 points depending on the information they provide.¹³³</p>
<p>State-MMC Plan Contracting</p>	<p>Implement comprehensive care coordination requirements to include SDOH screening, partnership with CBOs, and/or use of bidirectional referral systems</p> <p><i>Federal regulations outline required MMC Plan care coordination activities, including assessing the needs of new patients and coordinating with community and social support providers.¹³⁴ Some states have required or incentivized MMC Plans to address HSRNs through contract care coordination requirements that include screening, infrastructure and partnership provisions.</i></p>	<p>Arizona’s model MMC Plan contract mandates that contractors “utilize the Statewide Closed-Loop Referral System (CLRS) and actively promote provider network utilization of the CLRS to properly refer members to CBOs providing services addressing social risk factors of health.”¹³⁵</p> <p>Kansas’ procurement scope of work requires MMC Plans that contract with the state to partner with CBOs and provide service coordination that addresses the SDOH, including nutrition.¹³⁶</p> <p>Texas’ STAR+PLUS Medicaid 2022 procurement scope of work requires MMC Plans to use an evidence-based screening tool for HRSNs, coordinate and track referrals to CBOs for services and resources, and provide health care staff with information about resources available in the community.¹³⁷</p>

Policy Lever	Opportunity	Example(s)
State- MMC Plan Contracting	<p>Encourage MMC Plans to offer nutrition-related ILOS* and specifically pre-approve PRx</p> <p><i>MMC Plan contracts and RFPs often include language summarizing federal requirements for ILOS, reminding plans that the ILOS authority is available, though not mandatory, and that receipt of services is optional to beneficiaries. States can expand upon this language in contracts and RFPs to encourage MMC Plans to leverage ILOS to address SDOH or specifically list FIM services as pre-approved ILOS. Some states include additional ILOS information on agency webpages or through guidance documents. This additional information is helpful for MMC Plans interested in offering PRx as ILOS.</i></p>	<p>Rhode Island's RFP indicates that the state has approved services from Meals on Wheels as an ILOS.¹³⁸ The state provides MMC Plans with additional information through their ILOS Policy and Procedures document¹³⁹ and has posted an ILOS request form online for MMC Plans to use.¹⁴⁰</p> <p>Florida's model MMC Plan contract provides a list of pre-approved ILOS that do not need agency approval for plans to provide and includes an additional list of services that would require agency approval.¹⁴¹</p> <p>New York has pre-approved medically tailored meals as ILOS and provides details regarding MMC Plan use of ILOS on their website¹⁴² and in a guidance document.¹⁴³</p> <p>Oregon provides a variety of resources regarding ILOS, including introductory presentations, technical assistance webinars, and office hours with Oregon Health Authority staff.¹⁴⁴</p>
	<p>Encourage MMC Plan use of value-added services** to address SDOH</p> <p><i>MMC Plan contracts and procurement RFPs often contain federal regulation language stating that valued-added services are optional for MMC Plans to offer and for patients to accept. States can specify the types of services that can count as value-added services and can encourage MMC Plans to provide certain categories of value-added services to advance HRSN services, like PRx and other nutrition interventions.</i></p>	<p>Hawaii's RFP requires MMC Plans to develop a work plan describing how they will provide value-added services to address SDOH. The SDOH work plan is a sub-component of the MMC Plans' Quality Assurance and Performance Improvement program.¹⁴⁵</p> <p>Nevada's procurement scope of work expressly encourages the use of care coordination from community health workers as a value-added service.¹⁴⁶</p> <p>Washington DC's RFP encourages MMC Plans to offer value-added services to address SDOH, reduce costs, and promote overall health and wellness.¹⁴⁷</p>
	<p>Implement SDOH-related value-based payment (VBP) requirements</p> <p><i>States can require MMC Plans to adopt VBP arrangements for provider payments and states can choose to direct these payments towards investments in social supports.¹⁴⁸ States can use VBP provisions in MMC contracts to require or encourage MMC Plans to partner with CBOs to provide SDOH-related services, like PRx. States can also require that VBP arrangements have specific goals, such as addressing food insecurity or diet-related chronic conditions, which can encourage MMC Plans to consider providing access to PRx programs.</i></p>	<p>Pennsylvania's model MMC Plan contract specifies that MMC Plans must incorporate CBOs into VBP arrangements, either by contracting with them directly or contracting with Network Providers that subcontract with CBOs.¹⁴⁹</p> <p>New York included robust VBP requirements in a VBP Roadmap updated in May 2022, which the state plans to incorporate into their model MMC Plan contract.¹⁵⁰ The state also established a Bureau of Social Determinants of Health in 2017 to implement the VBP Roadmap requirements regarding SDOH.¹⁵¹</p>

Policy Lever	Opportunity	Example(s)
State- MMC Plan Contracting	<p>Create performance incentives or withhold payments tied to quality benchmarks</p> <p><i>States can use MMC contracts to create financial incentives for MMC Plans to tie their health care provider payments to certain quality metrics.</i></p>	<p>Michigan's Pay for Performance program allows health plans to earn “bonuses” under their MMC Plan contracts including by adopting programs that address food insecurity.¹⁵²</p>
	<p>Adjust capitation rates to account for social risk factors (a/k/a risk adjustment)</p> <p><i>States can use waivers or federal innovation partnerships to adjust MMC Plan capitation rates to account for the social risk factors of their enrollees. For example, states can pay plans higher capitation rates for members who are food insecure. This opportunity could provide additional resources to address key social needs of patients, potentially providing more flexibility for MMC Plans to pay for PRx.</i></p>	<p>Minnesota used a CMS innovation grant to adjust its quarterly population-based payments to ACOs to account for social risk factors including homelessness, mental illness, substance use disorder, past incarceration, and child protection involvement.¹⁵³</p> <p>Massachusetts' Section 1115 Waiver includes social risk factors in setting capitation rates for their ACOs.¹⁵⁴</p>
	<p>Institute community reinvestment requirements</p> <p><i>States can require MMC Plans to reinvest a portion of their profits into their communities. Similar to other state-level opportunities, this contract provision could theoretically benefit PRx programs, but additional stakeholder engagement would be required to persuade MMC Plans to invest in PRx.</i></p>	<p>Arizona's model MMC Plan contract requires MMC Plans to reinvest 6% of their profits into the local communities in which they operate.¹⁵⁵</p>
State- MMC Plan Oversight	<p>Develop Quality Strategy reporting requirements, objectives, and performance measures that incorporate metrics related to SDOH, food insecurity, and/or diet-related diseases</p> <p><i>States can include Quality Strategy reporting requirements, objectives, and performance measures that incorporate metrics related to SDOH, food insecurity, and/or diet-related diseases to incentivize MMC Plans to provide PRx and other nutrition interventions. MMC Plan contracts require MMC Plans to explicitly comply with or conduct the monitoring and data gathering necessary to comply with state Quality Strategy reporting and requirements.</i></p>	<p>Michigan's Quality Strategy Report emphasizes metrics and reporting related to SDOH, including food insecurity, and assesses how MMC Plans incorporate SDOH into quality assessment and improvement processes. The Health Equity Report component tracks the outcomes of measures over time.¹⁵⁶ Michigan's model MMC Plan contract then requires MMC Plans to comply with all state reporting requirements and requires data gathering regarding SDOH, supplying the state with the information it needs to complete the Quality Strategy Report.¹⁵⁷</p> <p>Washington DC's 2019-2023 Medicaid Managed Care Quality Strategy includes two quality objectives that can be tied to PRx: (1) improve management of pre-diabetes and diabetes; and (2) promote preventative care.¹⁵⁸ The state's RFP indicates that MMC Plans are required to develop policies and procedures that align with the Quality Strategy.¹⁵⁹</p>

* As explained in more detail in the **MMC Plan-Level Opportunities** section of this report, in lieu of services (ILOS) authority allows states to provide approval for MMC Plans to cover otherwise non-covered services as medically appropriate, cost-effective substitutes for services covered under the State Plan.

** As explained in more detail in the **MMC Plan-Level Opportunities** section of this report, value-added services (VAS) are optional services MMC Plans can voluntarily provide in addition to State Plan services.

MMC Plan-Level Opportunities for Innovation in Managed Care Policy

MMC Plans must typically cover all services included in their Medicaid State Plan (or a designated subset of those services).¹⁶⁰ However, federal regulations also provide plans with several pathways to voluntarily offer *additional* services to their enrollees. This section provides an overview of two of these regulatory pathways and the opportunities they present for PRx:

1. **In Lieu of Services; and**
2. **Value-Added Services**

When choosing whether to offer an optional service using these pathways, MMC Plans are likely to consider several factors. For example, plans may consider whether using the pathway will result in any additional administrative or regulatory burdens (e.g., whether they will need to complete an application process to use the pathway). Plans may also weigh the financial implications of each potential pathway, including whether the pathway allows them to include the costs of the added services in both: (1) their capitation rate (i.e., whether the costs will be reflected in the payments they receive from the state) and (2) the numerator of their medical loss ratio (MLR) (i.e., whether the costs will be considered claims, thereby helping the plan to meet federal and state MLR requirements).

Key Terms:

- **Capitation Rate:** per-member per-month rate the MMC Plan receives for delivering Medicaid services.¹⁶¹ Per federal regulation, rates are set by the state and approved by CMS. The rates must be “actuarially sound,” meaning they are calculated to cover anticipated health care costs of enrollees and appropriately balance profit and risk.¹⁶²
- **Medical Loss Ratio (MLR):** describes the proportion of premiums or capitation managed care plans spend on clinical services and quality improvement versus administrative costs and profits.¹⁶³ The federal government requires states to set capitation rates paid to managed care plans so that plans are reasonably expected to achieve an MLR of at least 85% (i.e., spend at least 85% of their funding on services and quality improvement activities).¹⁶⁴

Importantly, while these policy levers may help MMC Plans meet quality benchmarks and reduce the cost of care, they remain optional for plans to provide and optional for patients to accept.

In Lieu of Services (ILOS)

The ILOS pathway allows MMC plans to offer otherwise non-covered services *in lieu of* benefits covered under the State Plan. These services must be approved by the state as medically appropriate, cost-effective substitutes for State Plan-covered services.¹⁶⁵ All state-approved ILOS must be listed in MMC Plan contracts.¹⁶⁶ Despite these requirements, ILOS can be a particularly appealing coverage option for MMC Plans because plans can include the cost of providing ILOS in their capitation rates¹⁶⁷ and in the numerator of their MLR.¹⁶⁸

In 2016, CMS released final regulations establishing contractual and rate setting requirements for ILOS.¹⁶⁹ Since that time, many MMC Plans have used ILOS to provide non-traditional services, including a range of behavioral health and community-based services. Notably, several states have recently adopted even more expansive approaches to ILOS, including using ILOS to allow MMC Plans to cover of nutrition interventions as substitutions for the hospitalizations and emergency department visits they are designed to prevent.

- **California:** Through its 1115/1915(b) Waiver, California received approval from CMS to authorize 14 specific categories of ILOS, including a spectrum of nutrition interventions such as PRx.¹⁷⁰ As a part of this new program, California took the innovative approach of allowing MMC Plans to cover these ILOS to prevent the need for *future* state plan services, as well as to substitute for *current* services.¹⁷¹ This allowed substitute services to be utilized as preventive care. For example, PRx can be covered as a substitute for patients with diabetes when the service is a cost-effective substitute for hospitalization of those patients in the future. Previously, PRx may have only been available under ILOS for patients with diabetes who needed hospital-level care currently.
- **New York:** New York has approved/identified medically tailored meal services as ILOS to substitute for Personal Care Aide services, in-patient hospital stays, and/or emergency department visits in certain circumstances for certain populations. At least seven MMC Plans in the state are voluntarily offering these benefits.¹⁷²

As noted earlier in this Toolkit, in January 2023, CMS released guidance clarifying the scope, legal requirements, and reporting obligations of ILOS.¹⁷³ As an initial matter, CMS explicitly endorsed the use of ILOS to address health disparities and unmet HRSNs. CMS also endorsed California's approach to ILOS, affirming that ILOS can be used to prevent the need for current services *and* future services. For example, according to CMS, medically tailored meals could be covered in lieu of the future need for nursing facility care.¹⁷⁴ Additionally, CMS advanced thresholds for measuring whether ILOS services, like PRx, can be considered “medically appropriate” and “cost-effective” substitutes for State Plan services; reiterated that enrollee rights and protections still apply to ILOS; and detailed various state monitoring and oversight requirements, including the collection of stratified utilization data.¹⁷⁵ In May 2023, CMS released a proposed rule which would codify this guidance into federal regulation.¹⁷⁶

Value-Added Services (VAS)

MMC Plans can also voluntarily choose to provide services not covered by the State Plan as VAS.¹⁷⁷ This pathway provides plans with more flexibility than ILOS because services do not need to be deemed medically appropriate and cost-effective substitutes for State Plan services by the state. However, the costs associated with offering VAS are not included in MMC Plans' capitation rates,¹⁷⁸ lessening the incentive to utilize this option. While the costs of VAS are not included in plans' capitation rate, value-added services *can* count towards the numerator of the plan's MLR if they qualify as “activities that improve health care quality” (as defined at 45 C.F.R. §158.150).¹⁷⁹ PRx appears to fit squarely within this definition. Oregon, for example, has allowed coverage of food vouchers as an activity that improves health care quality.¹⁸⁰



Additional Pathways in Dual Eligible Plans and Programs:

This Toolkit highlights opportunities to expand access to PRx for *all* Medicaid beneficiaries enrolled in managed care. However, it is worth noting that plans serving a particular subset of these individuals—dual eligibles—may have additional opportunities to pay for PRx. Dual eligible beneficiaries are individuals who are enrolled in *both* Medicaid and Medicare. Dual eligible beneficiaries experience higher rates of chronic illness, and their health care costs account for a larger share of spending in the Medicaid and Medicare programs than non-duals.¹⁸¹ Several unique Medicaid-Medicare health care plans and programs are specifically available for and target this population. For example, Dual Eligible Special Needs Plans (D-SNPs) are specialized plans with limited enrollment for individuals who are entitled to both Medicare and Medicaid. Like other Medicare Advantage plans, D-SNPs may offer an array of additional benefits—including PRx—as Special Supplemental Benefits for the Chronically Ill (SSBCI).¹⁸² Additionally, dual demonstration projects offer an opportunity for innovation in coverage of nutrition interventions, like PRx. Several of these programs currently allow coverage of nutritional counseling and home-delivered meals¹⁸³ and could, potentially, provide similar coverage for PRx.

Notably, each of these pathways present important opportunities for plans to improve patient care (e.g., by addressing HRSNs) and to achieve financial and administrative goals (e.g., improving MLR; allowing inclusion of costs in capitation through ILOS). However, some plans have noted a lack of clarity regarding their use.¹⁸⁴ As a result, many plans are still covering additional services through their reserves, profit margins, and grant funding.¹⁸⁵ While this out-of-pocket investment by MMC Plans speaks to the *value* of the additional services plans choose to offer, funding through the pathways described above is more sustainable and better integrates delivery of these services into health care. There is therefore an ongoing need to provide outreach, education, and technical support to MMC Plans to improve uptake. The same is true for many of the opportunities described throughout this Toolkit. The next section focuses squarely on this issue, providing information, examples, and resources on how stakeholders can work together to improve awareness of both the need for PRx and the opportunities to expand access through MMC.

Building a Capacity for Change

As noted at the start of this Toolkit, identifying a problem and a potential policy solution are critical first steps on the road towards policy change. However, they may not be sufficient, on their own, to move from idea to implementation. To make this shift, PRx stakeholders can use an array of strategies to build capacity for change at the federal, state and MMC Plan level. This final section of the Toolkit provides an overview of some of these strategies, with concrete examples of how they have been implemented across the field of Food is Medicine in recent years.

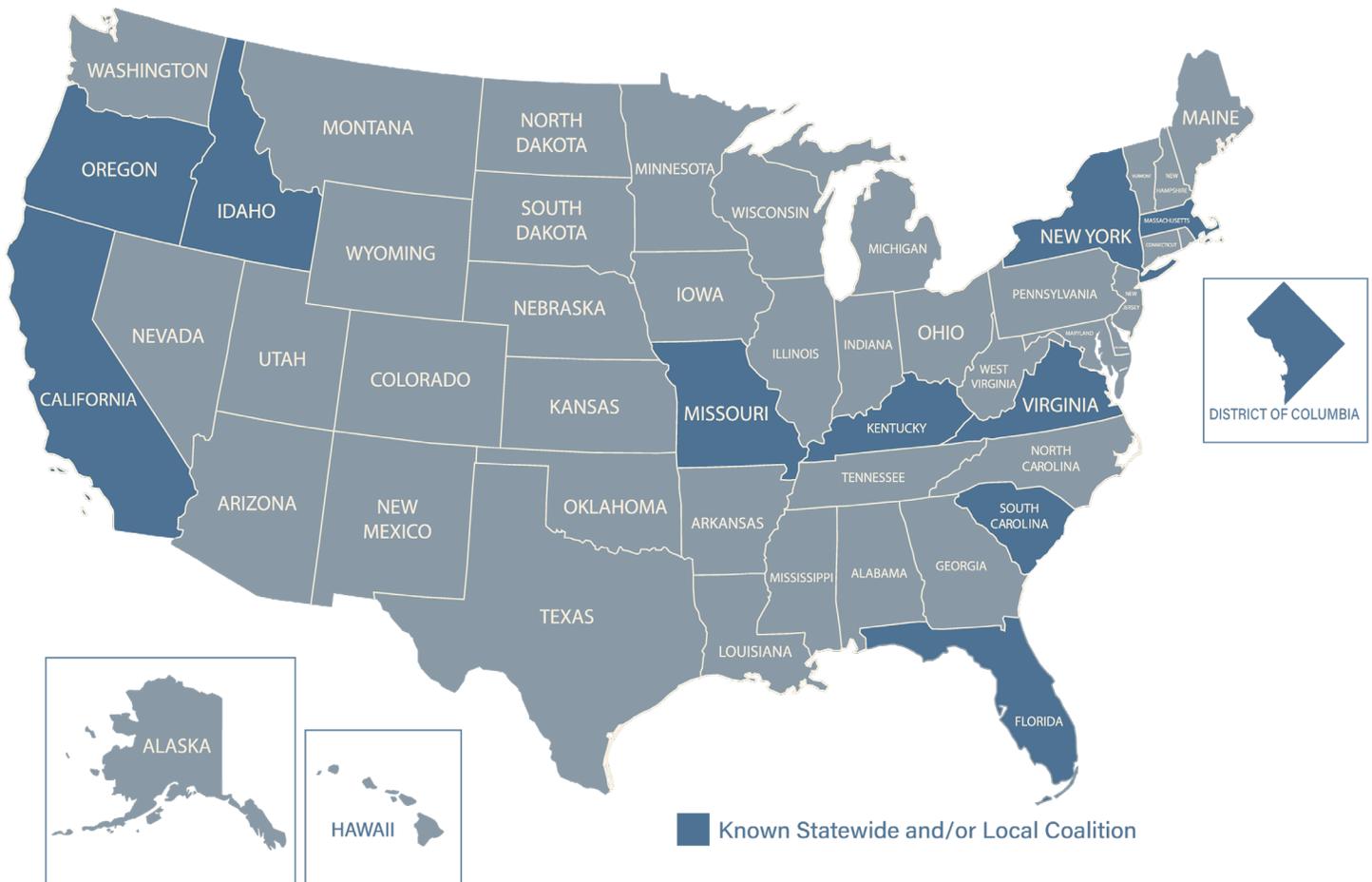
Building State and Local Coalitions

From socializing the concept of PRx, to developing educational materials, to engaging with agency and plan officials, everyone with hands-on experience with the impact of PRx can play an important role in building towards change. However, it can be difficult for any single stakeholder to fulfill all of these roles. Coalitions can therefore be a powerful tool for pooling resources to improve capacity. For example, coalition structures can be used to enhance research and information digestion, collectively fill in information gaps, align messaging, and amplify information-sharing.

Throughout the country, state and local coalitions are supporting the integration of PRx and other FIM interventions into the health care system by leading policy work, supporting research projects, expanding support networks, and strengthening program infrastructure.



Fig 2. Known State and Local Coalitions Supporting PRx



Currently, there are at least 13 state and local coalitions and/or workgroups supporting the integration of PRx into the health care system. Each has a unique origin story and structure, but most identify similar policy and project goals to mainstream PRx in their area. Some coalitions are solely focused on PRx, while others aim to support integration of an array of FIM interventions. National coalitions—such as the [National Produce Prescription Collaborative \(NPPC\)](#)—are doing similar work at the national level.

If no relevant coalitions currently exist in your state or local landscape, PRx stakeholders can consider joining together to develop one. Below is an overview of steps stakeholders can take to build successful coalitions with examples from the field.

Identify Goals

Clear, achievable goals are essential for coalition success. Articulating these overarching goals early on can help to define the scope and role of the coalition. Some common goals that have catalyzed state and local coalitions in this space include:

- **Broad policy research efforts:** In Massachusetts, the process to create the [Massachusetts](#)

[Food is Medicine State Plan](#), a 2-year, multi-stakeholder data collection and analysis effort, led to the creation of the Food is Medicine Massachusetts (FIMMA) coalition.

- **Specific policy goals:** California-based FIM stakeholders organized with the common goal of “shifting healthy food interventions from being supported by philanthropy to being standard covered health insurance benefits” and formed the [Medically Supportive Food and Nutrition Steering Committee](#) to advocate for coverage in Medi-Cal (California’s Medicaid program). This coalition seized a timely policy opportunity and informed California’s combined 1115/1915(b) Waiver proposal.
- **Collective long-term planning and vision setting:** Some coalitions have brought stakeholders together for consensus building to collaboratively outline long-term visions. For example, the Oregon Community Food Systems Network Veggie Rx Group recently published its [2021-2025 Strategic Plan](#) and the Food as Medicine Collaborative (FAMC), a Bay-Area based coalition, has developed a [2023 Logic Model \(a/k/a road map\)](#).

Build a Constituency

Coalitions can include a variety of stakeholders with varying perspectives and expertise. Often, a coalition’s identified goals will determine the breadth of a coalition’s constituency, from narrow (e.g., limited to PRx providers) to wide (e.g., all interested stakeholders).

Typical FIM and PRx stakeholders include representatives from the following groups:

- CBOs (e.g., FIM programs)
- Health Care Payers (i.e., private and public health insurance organizations)
- Health Care Providers (e.g., physicians, RDNs, hospital and health center leaders)
- Academic Researchers
- Health Policy Experts
- Advocacy Organizations
- Professional Associations
- People with Lived Experience
- State or Local Agency Officials
- Food Retailers and Produce Farmers and Distributors
- Community Leaders of All Types

To find these partners, stakeholders can examine their existing networks—board members, coalition members, or community partners—to identify individuals and organizations that can either fill these roles directly or provide introductions to potential partners.

Additionally, stakeholders can think creatively about which organizations and individuals may be interested in participating in coalition work. Individuals who interact directly with PRx models may be obvious constituents, but individuals and organizations interested in related topics—such

as other HRSNs (housing, transportation, etc.), value-based care, and health equity—may also be valuable contributors to coalition work.

Grassroots and Grasstops

In developing your constituency, it may be helpful to think in terms of “grassroots” and “grasstops.” A wide array of individuals and organizations may have an interest in expanding access to PRx. By bringing in this large constituency—creating a grassroots coalition—you can create powerful alignment and messaging from many voices. Additionally, though, you can also consider how to engage “grasstops”—individuals who may have connections or influence with key decision-makers at MMC Plans or state agencies—as partners or members of your coalition.



When working with these partners, it is important to understand what they need and what they can offer. This way you know how to ask for their support such that they can add value and receive value back for their time investment. Everyone in the constituency should bring some addition to the collaborative effort, this can include funding, stories, sweat (in kind labor), credibility, etc. To build engagement, it is important to check in regularly for updates and to share informational updates to these partners in an accessible way.

Determine an Effective Structure

A coalition’s identified goals will help determine its internal structure and workplan. Many coalitions create task forces or committees which focus on particular projects, policy objectives, or themes of work. For example, [Food is Medicine South Carolina](#), a committee of the South Carolina Food Policy Council, has multiple subcommittees and communities of practice including, Food Insecurity Screenings and Referrals; FIM Map; Nutrition Education for Health Professionals; Research and Evaluation; and PRx Community of Practice.

Some coalitions have steering committees or advisory boards that ground the work and maintain mission alignment. The [FIMMA](#) Steering Committee, for example, provides input to help direct major policy advocacy actions taken by the coalition. The Steering Committee also has voting powers that are used to approve public-facing materials, such as public comment letters to state or federal agencies and position statements speaking for the coalition.

Identifying Opportunities in Your Local Landscape

Section II of this Toolkit provided an overview of opportunities at the federal, state, and plan level to use MMC policy to expand access to PRx. However, the value and feasibility of each of these opportunities will vary based upon features of your local policy landscape—such as whether your state has implemented MMC, whether your state has already received approval for relevant waivers, and whether your local MMC Plans are already covering additional services to address HRSNs. Assessing your policy landscape is a useful initial step that can help you to evaluate the status quo and identify gaps that may require policy change.

Table D, below, provides examples of useful resources for this mapping process (for additional resources, see the **Resource Library** at the end of this Toolkit). Additionally, stakeholders should consider reaching out to policy experts, such as local health advocacy organizations, academic institutions, or, for specific questions, Medicaid agency or plan staff. By leveraging existing expertise, stakeholders can more rapidly expand their policy capacity, obtain answers to key questions, and gain useful context on the MMC landscape that may not be readily available through public sources.

Table D: Resources for Policy Research

MMC Policy Level	Example Resources
Resources for Tracking Federal-Level MMC Policy	<ul style="list-style-type: none"> • Federal Regulations: Federal Register • Medicaid Guidance: Medicaid.gov • Periodicals: Health Affairs • Podcasts: Tradeoffs, What the Health, or Politico Pulse Check
Resources for Tracking State-Level MMC Policy	<ul style="list-style-type: none"> • State Medicaid Websites: State Medicaid agency websites often provide overviews of state MMC policies as well as access to key documents (e.g., waivers, guidance, MMC contracts, procurement documents, and quality reports) • Medicaid.gov: Medicaid.gov also provides access to key resources, including: <ul style="list-style-type: none"> • State MMC Profiles and Program Features • Medicaid State Plan Amendments • Medicaid State Waivers List
Resources for Tracking Plan-Level MMC Policy	<ul style="list-style-type: none"> • State Medicaid Websites: State Medicaid agency websites may also provide helpful information regarding plan-level policies, including lists of current MMC Plans, links to individual plan websites, guidance regarding approved ILOS, and comparison charts of plan offerings • MMC Plan Member Handbooks: Typically available on websites for individual MMC Plans, member handbooks provide important information on each plan’s covered services, including any ILOS or value-added services the plan may provide

Your assessment of policy options should also include an exploration of important questions and considerations, including the potential pros/cons of individual opportunities for key audiences. This process can help you to identify which opportunities are most feasible in your landscape and lay the groundwork for effective messaging in the future (discussed in more detail below). **Tables E and F** provide a starting point for this analysis for several of the state- and plan-level opportunities described in **Section II**.

Table E: Potential Pros and Cons of State-Level Policy Opportunities

Policy Opportunity	Potential Pros	Potential Cons
Section 1115 Demonstration Waivers	<p>States: Waiver can allow the state to use Medicaid dollars to pay for services not otherwise covered in Medicaid (e.g., PRx)</p> <p>Plans: Waiver may provide plans with new funding to pay for nutrition interventions</p> <p>Patients: Waiver may establish <u>statewide</u> access to nutrition interventions</p> <p>CBOs: Waiver may include funding for CBO <u>services</u> and <u>infrastructure</u></p>	<p>States: Lengthy application process. Must be <u>renewed</u> every 5 years</p> <p>Plans: May impose new <u>requirements</u> on plans</p>
Home and Community Based Services Waivers	<p>States: Well-established pathway; exists in most states</p> <p>High-Need Patients: May be eligible</p> <p>CBOs Who Provide Meals: CMS has historically allowed coverage of meals in these waivers</p>	<p>Patients with Less Intense Health Care Needs: Often <u>not</u> eligible</p> <p>CBOs Who Provide PRx: States have not typically covered non-meal benefits in these waivers</p>
State-MMC Plan Contracting: Value-Based Payment (VBP) Requirements	<p>State: Can use VBP requirements to encourage plans/providers to control costs, improve outcomes, and address HRSNs</p> <p>Plans: May have discretion over VBP model choice and implementation</p> <p>CBOs: If appropriately structured, VBP can create opportunities to contract with plans and/or health care providers</p>	<p>CBOs: Funding may not automatically flow to CBOs. Must ensure that VBP models include payment (not just referrals) for services and any financial risk involved is reasonable for CBOs</p>

Table F: Potential Pros and Cons of MMC Plan-Level Policy Opportunities

Policy Opportunity	Potential Pros	Potential Cons
In Lieu of Services (ILOS)	<p>Plans: Very flexible. Plans can include ILOS in capitation; plans have <u>discretion</u> to choose which approved ILOS to cover</p> <p>CBOs: Variety of nutrition interventions can be covered as ILOS</p>	<p>Plans/CBOs: Process to request ILOS approval may be time-intensive (this varies by state)</p>
Value Added Services (VAS)	<p>Plans: Have <u>discretion</u> to choose what VAS to cover</p> <p>CBOs: Variety of nutrition interventions can be covered as VAS</p>	<p>Plans: <u>Cannot</u> include cost of VAS in capitation</p>



Preparing for Implementation

When assessing policy opportunities, PRx stakeholders should be aware of the infrastructure that may need to be built in their state to support successful implementation. The policies explained in this Toolkit primarily aim to open doors for health care to pay for PRx services. However, there are other changes that will have to be made to truly treat PRx like other medical interventions in the health care system. For example, the health care workforce needs to be educated about the services available to patients and trained to conduct effective screening and referrals for those services.¹⁸⁶ Additionally, technological systems must be established to support effective communication between clinical partners and CBOs providing PRx.¹⁸⁷ CBOs providing services also need to be aware of potential legal barriers when contracting and sharing data with health care entities.¹⁸⁸ Stakeholders should therefore consider these infrastructure needs—and the opportunities to address them—as part of feasibility analysis.

Socializing the Issue

Regardless of whether your policy priorities are far-reaching—such as an upcoming Medicaid waiver—or more targeted—such as coverage within a local MMC Plan—effective communication will be important to driving change. This section provides information on two key steps that PRx stakeholders can take to socialize the concept of integrating PRx into MMC: **(1) craft effective messaging and (2) create resources for education and outreach.**

Craft Effective Messaging

Effective communication and dynamic storytelling can play an important role in generating interest in PRx. Effective communication typically includes:

- Illustrating the problem;
- Identifying a solution; and
- Highlighting opportunities for action.

How you frame this message depends on your audience. Consider what problems they are looking to solve, and what factors may impact their decision-making. Then, be clear and concise in communicating how PRx relates to their goals. For example, some of the benefits of PRx programming that may resonate with key audiences include:

- **Improving Health Outcomes:** Increasing access to PRx within MMC can help to improve patient health outcomes. As a result, providing coverage for PRx may improve performance on quality metrics and overall quality scores. For example, PRx programs are associated with:
 - Improved HbA1c,¹⁸⁹ blood pressure,¹⁹⁰ and BMI,¹⁹¹ and
 - Improved patient experience¹⁹²
- **Increased Food and Nutrition Security:** PRx provides free or discounted access to fruits and vegetables, increasing household food security and improving diet quality.¹⁹³

- **Cost-Effectiveness:** Food insecurity is associated with ten of the costliest and most deadly preventable diseases.¹⁹⁴ And every year, over \$1 trillion is spent nationally treating diet-related chronic conditions.¹⁹⁵ Modeling shows that providing a subsidy for healthy foods can be a highly cost-effective strategy to address the connection between food and health—improving patient health outcomes, while lowering long-term health care costs.¹⁹⁶
- **Health Equity:** Individuals with lower-incomes disproportionately suffer from diet-related chronic conditions.¹⁹⁷ This includes a disproportionate number of people of color, immigrants, and people with disabilities, who are over-represented in lower socio-economic income brackets due to policies and systems that have historically denied equal opportunity for employment, health care, and nutrition supports.¹⁹⁸ Integrating PRx programs into Medicaid—a program serving millions of individuals with low-incomes across the country—can help to improve health equity by addressing access to financial resources, access to health care, and access to healthy food.¹⁹⁹
- **Supporting Local Food Economies by Benefitting Local and Regional Farmers:** Expanding access to PRx programs can have added benefits for local economies and local agriculture. For example, PRx programs can support regional farmers by sourcing locally.²⁰⁰
- **Increasing Fruit and Vegetable Sales in Retail Settings:** PRx programs can benefit food retailers such as supermarkets, farmers markets, and community-supported agriculture programs (CSAs) by boosting fruit and vegetable sales directly and increasing customer flows and sales at large.²⁰¹ Increasing access to PRx therefore has the potential to grow retail engagement in your community.

Research can be a powerful tool to frame and support your message. For a list of helpful reports, white papers, and peer-reviewed articles regarding the current case for PRx, see the **Resource Library** at the end of this Toolkit. When possible, it can be especially helpful to highlight data specific to your state or region to localize the issue.

Storytelling as a Tool

Storytelling can be a compelling way to communicate the real-world impact of PRx. Consider incorporating stories from a variety of viewpoints—such as program participants, health care providers, health plan staff, community leaders, and food retailers—into messaging to reinforce your points.



Create Resources for Education and Outreach

Developing written and visual materials can help align messaging across your constituency and expand your communication opportunities. Coalitions and workgroups, in particular, can play a valuable role by pooling resources to develop written materials to support education and outreach.

While a wide variety of resources can be useful in socializing the concept of PRx, some common materials include:

- **One-Pagers:** A number of coalitions across the country have created one-pager documents—or “fast facts”—that provide an overview of specific nutrition interventions (e.g., PRx), illustrate the need for those services, and highlight potential service impacts. For example, the [DC Food as Medicine Coalition](#) and the [VeggieRx Group](#) of the Oregon Food Systems Network have created one-pagers to communicate key messages from their work.
- **Talking Points:** Coalitions can also develop and share core talking points—such as those described above—to guide messaging on specific topics or for specific audiences. Talking points should be short, broad, and evidence-based to maximize impact.
- **Process Guides:** The concept of PRx may be new to some audiences, such as potential health plan partners or state Medicaid officials. Developing process guides that provide an overview of common issues such as program design, workflows, and payment options can help answer key questions and increase understanding of the PRx model. For example, the Produce Rx Evaluation & Policy Collaborative developed a [guide](#) on promising practices for implementing PRx programs in health care settings.
- **Mapping Resources:** Several coalitions have also developed resources to help relevant stakeholders—such as patients, health care providers, and health plans—identify FIM programs operating in their states. For example, Food is Medicine Massachusetts has developed a [Food is Medicine Service Inventory](#) for Massachusetts and SPUR, the Food as Medicine Collaborative, and the UCSF Center for Vulnerable Populations has developed a [landscape analysis](#) report for California.
- **Policy Materials:** Finally, coalitions can also pool resources to create targeted materials to raise awareness of—or respond to—specific policy opportunities. For example, during the development of California’s recent 1115/1915(b) Waiver, the California Medically Supportive Food and Nutrition Steering Committee developed a [position paper](#) and a [public comment letter](#) (for which they collected sign-ons from over 95 organizations) urging the Department of Health Care Services to include food and nutrition services within the state’s proposed list of ILOS.

Building Relationships and Engaging with Decision-Makers

Identify Decision-Makers

Once your organization or coalition has identified the policy opportunities in your MMC landscape and developed its messaging, a key next step can be to identify and build relationships with decision-makers. Often, it is useful to map these decision-makers’ spheres of influence to identify relevant contacts. For example, a Chief Medical Officer of a health care center, executives of an MMC Plan, or the Director of a state Medicaid agency may be the ultimate gatekeepers of significant policy decisions, yet it may be unlikely that you will be able to schedule frequent meetings with these policymakers. Instead, you may be able to identify individuals who report to these leaders and develop relationships with influential, but accessible, staff who can answer key questions and/or advocate for you.

Table C, below, provides examples of decision-makers—and supporting staff—who can play important roles in advancing access to PRx through MMC policy at the federal, state, or plan level.

Table G: Examples of MMC Policy Decision-Makers

MMC Policy Level	Example Decision-Makers
Federal-Level MMC Policy	<p>Federal Agency Officials</p> <ul style="list-style-type: none"> • Centers for Medicare & Medicaid Services (CMS) –agency within the Department of Health and Human Services (HHS) responsible for Medicaid, Medicare, and the Children’s Health Insurance Program (CHIP) • Center for Medicaid and CHIP Services (CMCS) – center within CMS responsible for Medicaid and CHIP policy
State-Level MMC Policy	<p>State Medicaid Agency Officials</p> <ul style="list-style-type: none"> • State Medicaid agency websites may provide an organizational chart. Staff members whose titles relate to health care transition, population health, or strategic partnerships and innovation may be particularly interested in PRx.
Plan-Level MMC Policy	<p>MMC Plan Leaders and Staff</p> <ul style="list-style-type: none"> • All MMC Plans have a unique organizational structure, so finding key decision-makers can take time. Staff members who may be particularly interested in PRx include: <ul style="list-style-type: none"> • Chief Medical Officers • Staff with titles related to population health, quality, or member experience, case management, or care coordination

Engaging with these decision-makers can take several forms—from individual meetings, to submitting public comments, to participating in key forums and groups. For example, all states are required to coordinate Medical Care Advisory Committees, which include provider, consumer, and government representatives, to participate in policy development and program administration.²⁰²

Participating in these types of advisory committees—or making nominations to them—can be one way to ensure that individuals knowledgeable about PRx have a voice in MMC policy in your state. States and the federal government are also required to solicit community input through public hearings and written comment regarding proposals for Section 1115 Demonstration Waivers.²⁰³ Stakeholders have opportunities to provide input and feedback both before the state submits its proposal to CMS and after the state’s submission but before CMS makes its decision regarding the proposal.

In any of these interactions, assess how your messaging may need to be adjusted to resonate with your audience. Consider:

- What are their stated priorities, value systems, or goals?
- Do they have incentives for reaching their goals?

Think creatively about opportunities. For example, check to see when MMC Plan quality and performance reporting is released, as these scores may incentivize plans to look for opportunities to improve or maintain performance. Staying abreast of plan-level communication—such as public comments by plan leadership and press releases—can also provide opportunities for engagement.

Quality Reporting as Tool:

MMC Plans are incentivized to use levers such as ILOS and value-added services to achieve specific quality measures set by the state. PRx stakeholders and coalitions may be able to leverage outcomes on quality metrics to persuade MMC Plans to adopt new strategies, like PRx, to help maintain or improve their ratings. Aside from reporting available on state websites, the National Committee for Quality Assurance (NCQA) provides publicly available [Health Plan Report Cards](#) which rate Medicaid plans based on their combined quality scores and accreditation status.

Activate Champions and Mobilize Your Constituency

Additionally, remember that engagement can occur through a variety of messengers—from program participants, to health care providers, to retailers, researchers, and community leaders. All of these champions can play an important role in advancing policy change, especially if activated in a moment of opportunity for PRx (e.g., to engage with plans during MMC procurement or with state Medicaid officials during the development of an 1115 waiver proposal).

Champions

Individual champions can play an important role in socializing the concept of PRx. While PRx program administrators have deep knowledge of the design and benefits of PRx, other voices may also have particular impact. For example, patients and health care providers are in many ways key customers for MMC Plans—as patients often have the opportunity to choose between plans when enrolling in MMC, and providers may choose which managed care networks they decide to join. These “customer” voices may therefore carry particular weight with plan decision-makers.

Coalitions can also leverage their *broad* constituency to amplify messaging in key moments, often having lead organizations take on a coordination role. Coalition leaders can develop templates, sign-on letters, or talking points that can be circulated to their constituency to create a collective response in key moments of opportunity. For example, to maximize engagement during a recent Section 1115 Waiver comment period, stakeholders in New York circulated a summary of key provisions from the waiver amendment proposal and information on how organizations and individuals could comment before the deadline.

Celebrating Wins

Finally, recognizing and celebrating wins is important for tracking progress and keeping spirits up when working to expand access through MMC, particularly because policy change can, at times, feel slow and nebulous. When developing your policy priorities, outline intermediary signs of progress across a variety of larger goals, such as those related to relationship building, community education and awareness, and engagement in the policymaking process. Sometimes “wins” may look differently than you expect, such as outreach from community partners about your initiative or requests to provide feedback on an idea. At other times, progress and impact may be more apparent. Regardless of the accomplishment, be sure to pause to appreciate progress before moving on. And importantly, take a moment to acknowledge and thank the constituents and decision-makers who made progress possible. Acknowledging these efforts can be an important investment in future change.

Conclusion

Our health care system is in a moment of transition, with policymakers at the federal level supportive of expanding access to nutrition interventions to address food insecurity and high rates of diet-related chronic conditions. Despite this support, access to PRx remains limited in many areas of the United States in part due to the fact that PRx is not yet a standard covered benefit in programs like Medicaid.

In this environment, flexibilities within Medicaid Managed Care present important opportunities to incrementally increase access to PRx. This Toolkit has outlined a range of pathways at the federal, state, and plan levels that stakeholders can use to integrate PRx deeper into MMC care delivery and financing structures. **Together, by leveraging these opportunities, we can mainstream produce prescription programs in MMC and continue to build towards broader change.**

Resource Library

The amount of research and analysis exploring PRx, Food is Medicine, and the integration of nutrition programs into health care has been growing rapidly over the last 5 years. This Toolkit aims to synthesize much of the information surrounding policy opportunities to support PRx in MMC. However, we recognize that the Toolkit cannot cover everything and may spur further exploration. The Resource Library below presents additional reports, research, and tools to help PRx stakeholders dive deeper into the topics covered in this Toolkit.

Produce Prescription Program Research

While the evidence-base is still strengthening and expanding, a plethora of studies analyze the clinical and non-clinical impacts of PRx programs.

- [Food is Medicine Research Action Plan](#), Food & Society at the Aspen Institute & Center for Health Law and Policy Innovation of Harvard Law School, 2022.
- [Food as Medicine: How Food and Diet Impact the Treatment of Disease and Disease Management](#), Center for Food As Medicine, Hunter College New York City Food Policy Center, 2022.
- [Produce Prescription Programs: Health Impacts of Fruit and Vegetable Consumption](#), Michigan Farmers Market Association, 2021.
- [Food is Medicine: Peer-Reviewed Research in the U.S.](#), Center for Health Law and Policy Innovation of Harvard Law School, 2020.
- [A Systematic Scoping Review of How Healthcare Organizations Are Facilitating Access to Fruits and Vegetables in Their Patient Populations](#), Veldheer et al., 2020.
- [The Promise and Uncertainty of Fruit and Vegetable Prescriptions in Health Care](#), Hager et al., 2020.

Illustrating the Need for Produce Prescription Programs

Data points illustrating the need for PRx can include the burden and costs associated with food insecurity, low fruit and vegetable consumption, and diet-related chronic conditions. When possible, finding data highlighting the local and regional context can also be persuasive.

- [State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity](#), Berkowitz et al., 2019.
- [An Avoidable \\$2.4 Billion Cost: The Estimated Health-Related Costs of Food Insecurity and Hunger in Massachusetts](#), Children's HealthWatch and the Greater Boston Food Bank, 2018.

Produce Prescription Program Landscape Assessments

Landscape assessments can assist stakeholders to identify policy priorities and can also help illuminate common barriers to scaling programs. State-level assessments are useful examples of how stakeholders can identify programs and experiences in your state.

National-Level Landscape Assessments

- [Produce Prescription Programs U.S. Field Scan Report: 2010-2020](#) and [interactive map](#), Wholesome Wave, DAISA Enterprises, 2021.
- [The Food is Medicine Map](#), Teaching Kitchen Collaborative, Wholesome Wave, Gretchen Swanson Center for Nutrition, God's Love We Deliver, & Geisinger, 2021.

State-Level Landscape Assessments

- [The Food is Medicine Massachusetts Service Inventory](#), Food is Medicine Massachusetts (FIMMA), 2022.
- [The Landscape of Produce Prescription Programs in Michigan](#), Michigan Farmers Market Association, 2022.
- [Food sovereignty, health, and produce prescription programs: A case study in two rural tribal communities](#), Nugent et al., 2022.
- [Integrating Food into Health Care: A Landscape Analysis of Medically Supportive Food and Nutrition Interventions in California](#), SPUR, Food as Medicine Collaborative, UCSF Center for Vulnerable Populations, 2021.
- [The Massachusetts Food is Medicine State Plan](#), Center for Health Law and Policy Innovation of Harvard Law School & Community Servings, 2019.

Integrating Produce Prescription Programs and Other Food-related Programming into Health Care and Food Policy

Several resources analyze policy pathways and provide advice on how to enhance implementation and integration of nutrition interventions into health care.

- [State Policy Options: Leveraging Produce Prescriptions to Treat and Prevent Diet-Related Illness](#), National Produce Prescription Collaborative & Center for Health Law and Policy Innovation of Harvard Law School, 2022.
- [Addressing Nutrition and Food Access in Medicaid: Opportunities and Considerations](#), Center for Health Law and Policy Innovation of Harvard Law School and the Food Trust, 2021.
- [Mainstreaming Produce Prescription Programs: A Policy Strategy Report](#), Center for Health Law and Policy Innovation of Harvard Law School, 2021.
- [Produce Prescriptions: A U.S. Policy Scan](#), Center for Health Law and Policy Innovation of Harvard Law School, 2020.
- [Food is Medicine: Actions to Integrate Food and Nutrition into Healthcare](#), Downer et al., 2020.
- [Rooting Food As Medicine in Healthcare: A Toolkit for Primary Care Clinics and other Health Care Settings](#), All in Alameda County, 2019.
- [Program: Fruit and Vegetable Incentives: Prescribing Nutrition](#), Health Care without Harm, 2018.

Addressing SDOH/HRSN Broadly in Medicaid and Medicaid Managed Care

Many of the policy levers discussed in this Toolkit can also be leveraged to increase access to other HRSN services such as housing supports or transportation assistance.

- [Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review](#), Center for Health Care Strategies, 2023.
- [Addressing Health-Related Social Needs Through Medicaid Managed Care](#), State Health and Value Strategies, 2022.
- [Financing Strategies to Address the Social Determinants of Health in Medicaid](#), MACPAC, 2022.
- [A Guide for Health Care Advocates: Medicaid Managed Care Procurement](#), Georgetown University Health Policy Institute Center for Children and Families, 2022.
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- [How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps](#), Duke and Milbank Memorial Fund, 2021.
- [Finding and Analyzing Medicaid Quality Measures](#), National Health Law Program, 2021.
- [Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health](#), NORC at the University of Chicago, 2020.

Medicaid Managed Care Trackers and Tables

Trackers and tables that monitor MMC trends can be helpful to learn about your state and see how it compares.

- [Medicaid Managed Care Contract Analysis Database, SDOH Topic Category](#), The Commonwealth Fund.
- [Medicaid Managed Care Tracker](#), Kaiser Family Foundation.
- [Medicaid Managed Care Quality Initiatives](#), Kaiser Family Foundation.
- [State Procurement Map](#), National Association of State Procurement Officials.
- [Procurement Regulations and Resources in States with Medicaid Managed Care](#), National Association of State Procurement Officials.

Building Capacity for Change Resources

Capacity building encompasses a variety of skill sets and activities from storytelling and policy analysis to understanding your limits based on the tax status of your organization.

- [The NACCHO Advocacy Toolkit](#), The National Association of County and City Health Officials, 2021.
- [Public Health Policy Advocacy Guidebook and Toolkit](#), The Association of Public Health Nurses, 2021.
- [Policy & Advocacy: Tool Kit Planning & Monitoring](#), The Living Planet Centre, 2017.
- [Administrative Advocacy: Influencing Rules, Regulations, and Executive Orders](#), Bolder Advocacy.
- [Guidelines for 501\(c\)\(3\) Public Charities](#), Bolder Advocacy.
- [Guide to Creating and Maintaining Coalitions and Partnerships](#) and [Community-Building](#) chapters, The Community Toolbox.

Implementation Resources

As programs begin to move towards formal integration into the health care system, stakeholders should be prepared to build the necessary infrastructure to support sustainable integration.

Best Practices Resources

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- [Integrating Produce Prescription Programs into the Healthcare System: Perspectives from Key Stakeholders](#), Auvinen et al., 2022.
- [Produce prescription projects: Challenges, solutions, and emerging best practices – Perspectives from health care providers](#), Stot et al., 2022.
- [Rural Produce Prescription Program Toolkit](#), No Kid Hungry and Vouchers4Veggies, 2022.
- [Mainstreaming Produce Prescriptions: A National Strategy Report](#), Center for Health Law and Policy Innovation of Harvard Law School, 2021.
- [Promising Practices: Implementing a Produce Prescription Program in a Health Care Setting](#), The Produce Rx Evaluation & Policy Collaborative, 2021.

- [Understanding the Produce Prescription Programs in the U.S.: A Focus on Program Models, Facilitators and Barriers, and Participant Experiences](#), Newman, 2020.
- [Produce Rx Program Manual](#), Adelante Mujeres and Virginia Garcia Memorial Health Center, 2018.
- [CusNIP Nutrition Incentive Hub Searchable Resource Library](#)

Data Sharing

- HIPAA Issue Brief Series, CusNIP Nutrition Incentive Hub and the Center for Health Law and Policy Innovation of Harvard Law School, 2022:
 - [Issue Brief 1: Introduction to Patient Privacy Laws for Produce Prescription Grantees](#)
 - [Issue Brief 2: Developing HIPAA-Compliant Approaches to Information Sharing](#)
 - [Issue Brief 3: HIPAA, Program Evaluation, and Research](#)
 - [Issue Brief 4: Business Associate Arrangements](#)
 - [Issue Brief 5: Developing a Privacy Program](#)
- [Incorporating Social Determinants of Health Data from Health Care Partners and Community-Based Organizations into a Common Data Architecture](#), Public Health Informatics Institute, 2022.
- [Legal & Policy Strategies for Health Care & Food System Partners Introduction: Partnerships Between Health Care & Food Systems](#), ChangeLab Solutions, 2021.
- [Food Banks as Partners in Health Promotion: Navigating HIPAA](#), Center for Health Law and Policy Innovation of Harvard Law School and Feeding America, 2020.

Infrastructure

- [Back to Basics: Medical Coding for Food Based Interventions](#), SPUR, 2022.
- [Working With Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies](#), Manatt, 2022.
- [Community Resource Referral Platforms: A Guide for Health Care Organizations](#), SIREN, 2019.
- [An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities](#), Hunger Vital Sign™ National Community of Practice, 2018.

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