Mainstreaming Produce Prescriptions:

A Policy Strategy Report

Executive Summary

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CHLPI CENTER for HEALTH LAW and POLICY INNOVATION
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About the Authors

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. CHLPI's statement on equity can be found at www.chlpi.org/about-us/mission-statement.

The authors of *Mainstreaming Produce Prescriptions: A Policy Strategy Report* are Katie Garfield, Emma Scott, Kristin Sukys, Sarah Downer, Rachel Landauer, Julianne Orr, Rebecca Friedman, Margaret Dushko, Emily Broad Leib, and Robert Greenwald. We appreciate the research and contributions of MJ McDonald and Gayoung Kim. The report was also developed with the advice, support, and input of Kate Fitzgerald, Richard Pirog, and Kolia Souza.

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The Center for Health Law and Policy Innovation's Executive Summary provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal representation or advice. For specific legal questions, consult an attorney.

Acknowledgement

Mainstreaming Produce Prescriptions: A Policy Strategy Report is a synthesis of policy analysis and findings from over 60 interviews with organizations, practitioners, and academics. Many of these individuals have been tirelessly working for over a decade to study, improve, and advocate for Produce Prescription Programs as an indispensable health intervention to address rising rates of chronic illness and food insecurity across our nation. The voices of these individuals and the lessons learned from their experiences have played a critical role in shaping the recommendations laid out in the report. The recommendations seek to expand access to Produce Prescription Programs and integrate them into health care delivery and financing and existing food system infrastructure.

Report design by Najeema Holas-Huggins, based upon *Produce Prescriptions: A U.S. Policy Scan* designed by lvl.agency.

What are Produce Prescriptions?

Produce Prescription Programs are a promising strategy to improve health outcomes, reduce food insecurity, and decrease long-term health care costs. The term "produce prescription" is typically used to describe benefits distributed by health care providers (i.e., physicians, nurses, dietitians) to address a recipient's diet-affected health condition such as diabetes, prediabetes, or hypertension. Such "prescriptions" are redeemed for produce at food retailers such as grocers, corner stores or *bodegas*, farmers markets, or within Community Supported Agriculture (CSA) programs. Often, non-profit community-based organizations or local health departments act as facilitators for these Programs by ensuring adequate funding; managing administrative duties; overseeing technological infrastructure; and coordinating health care provider, retail partner, and patient relationships.

Defining Produce Prescription Programs: The definition of a Produce Prescription Program has varied over time. The National Produce Prescription Collaborative, a coalition of produce prescription practitioners, researchers, and advocates, currently defines a Produce Prescription Program as: "a medical treatment or preventative service for patients who are eligible due to a diet-related health risk or condition, food insecurity or other documented challenges in access to nutritious foods, and are referred by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy produce with no added fats, sugars, or salt, at low or no cost to the patient. When appropriately dosed, Produce Prescription Programs are designed to improve healthcare outcomes, optimize medical spend, and increase patient engagement and satisfaction."[1]

Impact of Produce Prescriptions

A growing body of research illustrates the significant, cost-effective[2] impact that produce prescriptions can have on patient health. Most notably, Produce Prescription Programs have been shown to improve nutrition-related outcomes including fruit and vegetable consumption,[3] Healthy Eating Index scores,[4] and adherence to the Dietary Guidelines for Americans.[5]

Participation in Produce Prescription Programs has also been shown to:

- Improve blood pressure;[6]
- Reduce hemoglobin A1c levels in individuals with diabetes;[7]
- Decrease food insecurity;[8]
- Decrease depressive symptoms and improve overall health management;[9]
- Reduce body mass index (BMI) scores;[10] and
- Improve patient-provider relationships.[11]

Current Landscape and Goals of the Policy Strategy Report

Despite our growing understanding of their potential, access to produce prescriptions remains limited across the United States. Now, as the United States battles the short and long-term health impacts of the COVID-19 crisis while continuing to transition to value-based care,[12] new opportunities are emerging in U.S. health care and food systems that could provide the funding, infrastructure, and political will needed to truly mainstream access to produce prescriptions. *Mainstreaming Produce Prescriptions: A Policy Strategy Report* seeks to respond to this moment by:

1. **Identifying key challenges that currently inhibit the growth of Produce Prescription Programs; and**
2. **Providing recommendations for policies at the federal, state, and institutional level that could support their expansion.**

While we recognize the potential for Produce Prescription Programs to improve the health of all populations, the recommendations in the Policy Strategy Report have the specific goal of improving access for populations most in need: low-income individuals living with or at risk for diet-affected health conditions.

Key Terms: Throughout the Policy Strategy Report, we use the terms "scaling," "expansion," or "growth" to mean expanding access to produce prescriptions to new geographies and populations. We use these terms to mean *both* the growth of existing Programs and the proliferation of new Programs across the country, as both strategies will be necessary to establish widespread, equitable access.

Methodology and Results

Policy Scan

From March to August 2020, CHLPI staff reviewed laws, regulations, and guidance related to federal health insurance and food assistance programs. Through this process, we identified both existing opportunities and policy gaps that must be addressed to grow and sustain Produce Prescription Programs in the long term. CHLPI published the initial findings from this scan in October 2020 as: *Produce Prescriptions: A U.S. Policy Scan*.

Stakeholder Feedback

From June to October 2020, CHLPI staff conducted 62 stakeholder interviews.[13] In the fall of 2020, CHLPI used information gathered through the Policy Scan and stakeholder interviews to develop initial recommendations for the Policy Strategy Report. In November 2020, CHLPI conducted a feedback session—with both interviewees and non-interviewees—to review and refine these recommendations. The final recommendations respond to the five core challenges identified in our data gathering:

- **Funding**: Stakeholders identified lack of sustainable funding as the single largest barrier to maintaining and expanding Produce Prescription Programs in the United States.[14] Stakeholders expressed support for funding produce prescriptions via the health care system, and noted the need to expand and improve enrollment in federal food assistance programs to address broader population health.
- **Research**: Stakeholders called for additional research regarding Program outcomes (e.g., health outcomes and cost-effectiveness) and design (e.g., duration and target health conditions) to promote integration into health care delivery and financing. Stakeholders also highlighted the role that structural and systemic barriers can play in Program participation—indicating a need to better understand the relationship between Program design and health equity.
- **Patient Data and Privacy**: Stakeholders noted tensions between the need for data; the desire to protect participant privacy; and the legal, financial, and administrative burdens associated with navigating state and federal privacy laws—especially in the absence of clear guidance from government officials.
- **Infrastructure**: Stakeholders noted the need for improved infrastructure to support access to produce prescriptions, including: health care providers who understand the value of referring patients to Produce Prescription Programs; accessible food retailers where participants can redeem produce prescription benefits; and support for different types of retailers in accessing and implementing redemption technology advancements.
- **Advancing the Field**: Stakeholders highlighted the lack of guidance available to facilitate creation of or participation in Produce Prescription Programs.

Vision for the Future

We believe it is possible to establish widespread, affordable access to produce prescriptions to improve the health of low-income individuals living with or at risk for diet-affected disease and to increase access to produce more broadly to better support population health. More specifically, we believe in a future where:

- Low-income individuals living with or at risk for diet-affected health conditions have access to produce prescriptions mediated through their health care provider(s) and sustainably funded through the health care system.
- Federal food assistance programs provide a sufficient supplement to household budgets to enable recipients to purchase produce to prevent many diet-affected health conditions and assist individuals transitioning off of produce prescription services.
- A robust body of high-quality research grounded in equity principles clearly establishes the value of produce prescriptions for a range of stakeholders—including Program participants, retailers, and health care payers.
- Produce Prescription Programs are able to effectively exchange data with health care payers, providers, and retailers.
- Cost-effective infrastructure is in place to support participation in Produce Prescription Programs by a diverse range of participants, retailers, and health care partners.
- Guidance is available to facilitate the implementation and scaling of effective, equitable Produce Prescription Programs.

Overview of Recommendations

The recommendations discussed in the Policy Strategy Report seek to realize the vision outlined above by responding to the core challenges and values uncovered through our research, expert interviews, and feedback session. These recommendations are outlined in the table below, organized by the challenge to which they respond.

Critically, our research and conversations with stakeholders stressed the role that broader societal issues, including systemic racism, have played in shaping U.S. federal health care and food assistance programs.[15] Produce Prescription Programs cannot, on their own, resolve these issues. Produce Prescription Programs can, however, be shaped to respond to—rather than exacerbate—the health inequities resulting from these historic biases. To advance this goal, the recommendations in the Policy Strategy Report strive to call out specific opportunities to expand our understanding of racial disparities in the produce prescription space and promote equitable access to services.

Challenge	Recommendation	Recommended Actions	Potential Actor(s)
Funding	**Recommendation 1**	Broaden coverage of produce prescriptions within Medicaid and Medicare via: · Guidance or regulations authorizing coverage within existing benefit categories; · Amendment to the Medicaid and Medicare statutes to establish coverage; or · The implementation and scaling of a demonstration project administered by the Center for Medicare and Medicaid Innovation (CMMI).	· Centers for Medicare & Medicaid Services (CMS) · Congress · CMMI
	Recommendation 2	Authorize coverage of produce prescriptions within the Veterans Affairs medical benefits package via: · Addition of produce prescriptions to the statutory medical benefit package for the VHA health care system; or · The implementation and scaling of a demonstration project administered by the Center for Innovation for Care and Payment.	· Congress · Center for Innovation for Care and Payment
	Recommendation 3	Provide guidance and technical assistance on current opportunities to fund produce prescriptions within Medicaid and Medicare.	· CMS
	Recommendation 4	Utilize existing opportunities to fund produce prescriptions in State Medicaid Programs. · Use Medicaid Waiver authorities (e.g., Section 1115 Waivers) to fund/cover produce prescriptions. · Use managed care contracting to incentivize Medicaid Managed Care Organizations (MCOs) to provide coverage for produce prescriptions.	· State Medicaid Agencies

Challenge	Recommendation	Recommended Actions	Potential Actor(s)
Funding	**Recommendation 5**	Utilize existing opportunities to fund produce prescriptions in individual health plans and health care systems. · Cover produce prescriptions in Medicaid Managed Care plans (e.g., as an "in lieu of" service or value-added service). · Cover produce prescriptions in Medicare Advantage plans (e.g., as a Special Supplemental Benefit for the Chronically Ill or as part of a Value-Based Insurance Design (VBID) model). · Use institutional funding (e.g., community benefits) to support community access to produce prescriptions.	· Medicaid MCOs · Medicare Advantage Plans · Health Care Providers
	Recommendation 6	Utilize public health funding streams to support produce prescriptions. · Use public health grant funding to support Produce Prescription Programs in the short term. · Use public health-focused funding streams (e.g., sugar sweetened beverage taxes) to support Produce Prescription Programs in the long term.	· Federal, state, and local public health agencies
	Recommendation 7	Increase the value of the WIC cash value benefit for the purchase of fruits and vegetables.	· Food and Nutrition Service (FNS), USDA · Congress
	Recommendation 8	Expand support for the GusNIP Produce Prescription Grant Program as a critical accelerator of Produce Prescription Programs. · Increase funding for GusNIP and the proportion dedicated to Produce Prescription Programs. · Increase the funding cap for grant awards. · Set aside portions of funding for Programs that (1) advance research, and (2) expand patient reach.	· Congress · National Institute of Food and Agriculture, USDA
	Recommendation 9	Establish a Produce Prescription Preparation Program to expand capacity to partner with the health care sector via: · Planning grants; and · Technical assistance.	· Department of Health and Human Services (HHS) · Congress
	Recommendation 10	Ensure that households enrolled in SNAP can readily afford the produce they seek by: · Increasing monthly SNAP benefits; and · Expanding produce-specific benefits.	· Center for Nutrition Policy & Promotion, USDA · FNS, USDA · Congress

Challenge	Recommendation	Recommended Actions	Potential Actor(s)
Research	**Recommendation 11**	Design produce prescription research to promote health equity by ensuring that all research: · Includes equitable evaluation practices; and · Investigates the experience of communities of color.	· Researchers · Research funders · Produce Prescription Programs
	Recommendation 12	Support high-quality research regarding the impact of produce prescriptions on health outcomes, utilization, and costs.	· National Institutes of Health (NIH) · CMS · Philanthropic Funders
	Recommendation 13	Strive to track key patient-reported and participant experience outcomes.	· Produce Prescription Programs
	Recommendation 14	Study key elements of Program design that may impact outcomes, participant experience, and implementation costs such as: · Program duration, dose, scope, and redemption mechanisms.	· Researchers · Research Funders · Produce Prescription Programs
Patient Data and Privacy	**Recommendation 15**	Clearly articulate how social service providers, including Produce Prescription Programs, fit within legal landscapes governing patient privacy. · Provide guidance regarding application of privacy laws to partnerships between health care entities and social service organizations. · Where guidance cannot address current barriers, create new express parameters for partnerships between health care entities and social service organizations.	· HHS · State Health Departments · Legal experts
	Recommendation 16	Identify best practices and principles to protect patient privacy in Produce Prescription Programs that do not implicate patient privacy laws.	· Produce Prescription Programs
Infrastructure	**Recommendation 17**	Require or incentivize improved nutrition education in undergraduate, graduate, and continuing education for health care providers through: · Accreditation and funding; · Licensing exam content; · Continuing education requirements; and · Advocacy from professional associations.	· Accreditation Bodies · Licensing Exam Bodies · State Boards of Licensure · Professional Associations
	Recommendation 18	Expand and enhance programs that support the viability of healthy food retailers, especially in low-income or historically marginalized communities.	· Federal executive and agencies · State and local governments

Challenge	Recommendation	Recommended Actions	Potential Actor(s)
Infrastructure	**Recommendation 19**	Provide funding and coordination for the implementation and maintenance of technology solutions for produce prescription transactions.	· Federal executive · USDA · HHS · Congress
Advancing the Field	**Recommendation 20**	Establish a task force to develop strategic guidance on Program design, research, and future directions for the field.	· HHS · USDA · Produce Prescription Programs · Health Care Providers and Payers · Retailers · Researchers

Conclusion

The recommendations outlined above provide a framework for building the system needed to truly mainstream produce prescriptions, making our health care, public health, and food systems better equipped to connect individuals across the United States to the foods they need to be healthy and thrive. For more information on these recommendations, access the full report available at www.chlpi.org.

Endnotes

[1] E-mail from Christa Drew, DAISA, NPPC Co-convenor, to author (Mar.16, 2021) (on file with author). NPPC defines "healthy produce" in accordance with section 10010 of the Agricultural Act of 2014, Public Law 113-79.

[2] Yujin Lee et al., *Cost-effectiveness of Financial Incentives for Improving Diet and Health through Medicare and Medicaid: A Microsimulation Study*, 16 PLoS MED. e1002761 (2019), https://doi.org/10.1371/journal.pmed.1002761.

[3] Jessica Marcinkevage, Alyssa Auvinen, & Susmitha Nambuthiri, *Washington State's Fruit and Vegetable Prescription Program: Improving Affordability of Healthy Foods for Low-Income Patients*, 16 PREV. CHRONIC DIS. E91 (2019), http://dx.doi.org/10.5888/pcd16.180617; Ashley Chrisinger & A. Wetter, *Fruit and Vegetable Prescription Program: Design and Evaluation of a Program for Families of Varying Socioeconomic Status*, 48 J. NUTR. EDUC. & BEHAV. 557 (2016), https://doi.org/10.1016/j.jneb.2016.04.153; Alicia J. Cohen et al., *Increasing Use of a Healthy Food Incentive: A Waiting Room Intervention Among Low-Income Patients*, 52 AM. J. PREVENTATIVE MED. 154 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5444808/ (doi: 10.1016/j.amepre.2016.11.008).

[4] Seth A. Berkowitz et al., *Health Center–Based Community-Supported Agriculture: An RCT*, 57 AM. J. PREVENTIVE MED. S55 (2019), https://doi.org/10.1016/j.amepre.2019.07.015.

[5] Ronit A. Ridberg et al., *Effect of a Fruit and Vegetable Prescription Program on Children's Fruit and Vegetable Consumption*, 16 Prev. Chronic Dis. E73 (2019), http://dx.doi.org/10.5888/pcd16.180555.

[6] Benjamin Emmert-Aronson et al., *Group Medical Visits 2.0: The Open Source Wellness Behavioral Pharmacy Model*, 25 J. ALTERNATIVE & COMPLEMENTARY MED. 1026 (2019), https://pubmed.ncbi.nlm.nih.gov/31460769/ (doi: 10.1089/acm.2019.0079).

[7] Richard Bryce et al., *Participation in a Farmers' Market Fruit and Vegetable Prescription Program at a Federally Qualified Health Center Improves Hemoglobin A1C in Low Income Uncontrolled Diabetics*, 7 PREVENTIVE MED. REP.176 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5496208/#__ffn_sectitle (doi: 10.1016/j.pmedr.2017.06.006).

[8] Jennifer N. Aiyer et al., *A Pilot Food Prescription Program Promotes Produce Intake and Decreases Food Insecurity*, 9 TRANSLATIONAL BEHAV. MED. 922 (2019), https://doi.org/10.1093/tbm/ibz112; Seth A. Berkowitz et al., *Health Center–Based Community-Supported Agriculture: An RCT*, 57 AM. J. PREVENTIVE MED. S55 (2019), https://doi.org/10.1016/j.amepre.2019.07.015.

[9] Toni Terling Watt et al., *A Primary Care-Based Early Childhood Nutrition Intervention: Evaluation of a Pilot Program Serving Low-Income Hispanic Women*, 2 J. RACIAL & ETHNIC HEALTH DISPARITIES 537 (2015) https://doi.org/10.1007/s40615-015-0102-2; Jessica Marcinkevage, Alyssa Auvinen, & Susmitha Nambuthiri, *supra* note 2.

[10] Michelle Cavanagh et al., *Veggie Rx: An Outcome Evaluation of a Healthy Food Incentive Program*, 20 PUB. HEALTH NUTR. 2636 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5743436/pdf/nihms866976.pdf (doi:10.1017/S1368980016002081).

[11] Marcinkevage, Auvinen, & Nambuthiri, *supra* note 2; Allison V. Schlosser et al., *"The coupons and stuff just made it possible": economic constraints and patient experiences of a produce prescription program*, 9 TRANSLATIONAL BEHAV. MED. 875 (2019), https://doi.org/10.1093/tbm/ibz086.

[12] CMS describes value-based care models as ones in which "[health care] providers are rewarded—based on specific evidence of performance on quality measures—for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives, as part of a larger healthcare system effort." CTRS. FOR MEDICARE & MEDICAID SERVS., SMD# 20-004 RE: VALUE-BASED CARE OPPORTUNITIES IN MEDICAID (Sept. 15, 2020), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.

[13] In order to encourage candor, CHLPI told all interviewees that they would remain anonymous in this final report.

[14] *See also* Anne Cafer et al., Examining Program Context, Logistics, and Outcomes: A Scoping Review of Food Prescription Programs, at 12-13 (unpublished manuscript) (on file with author) (noting reliance on outside dollars, e.g., grants, as main barrier to sustainability for food Rx programs).

[15] *See, e.g.*, Joe Feagin & Zinobia Bennefield, *Systemic Racism and U.S. Health Care*, 103 SOC. SCI. & MED. 7 (2014), https://doi.org/10.1016/j.socscimed.2013.09.006; Caryn N. Bell, Jordan Kerr & Jessica L. Young, *Associations between Obesity, Obesogenic Environments, and Structural Racism Vary by County-Level Racial Composition*, 16(5) INT. J. ENVIRON. RES. PUBLIC HEALTH 861 (2019), https://doi.org/10.3390/ijerph16050861; RICH PIROG ET AL., MICHIGAN STATE UNIVERSITY CTR. FOR REG. FOOD SYSTEMS, AN ANNOTATED BIBLIOGRAPHY ON STRUCTURAL RACISM PRESENT IN THE U.S. FOOD SYSTEM (8TH ED.) (2021), https://www.canr.msu.edu/foodsystems/uploads/files/Annotated-Bibliography-on-Structural-Racism-Present-in-the-US-Food-System-Eighth-Edition.pdf.

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