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Combating Diet-Related Disease in Oklahoma Through Food is Medicine in Medicaid Managed Care



OKLAHOMA

.....Food is Medicine

Poor diet is the **leading cause of death** in the US,¹ and people experiencing food insecurity are at a greater risk of developing chronic conditions including cancer, coronary heart disease, hypertension, and diabetes.² These diet-related conditions cost the US economy over **\$1.1 trillion each year**.³ Food is Medicine (FIM) interventions respond to these problems by providing food or food assistance that supports health to patients or communities in connection with the health care system.⁴ FIM interventions aim to prevent and treat poor health outcomes resulting from diet-related chronic conditions and food insecurity.

FIM interventions build upon existing nutrition security programs (e.g., the Supplemental Nutrition Assistance Program) **and healthy food policies but are further designed to target various patient populations based on the acuity of patients' medical conditions**.⁵ For example, medically tailored meals are designed for patients with severe chronic illnesses that limit daily activities and cause high healthcare utilization (e.g., heart failure or kidney failure). They involve the delivery of fully prepared meals designed by a registered dietitian, through a referral from a medical professional. Medically tailored groceries are targeted towards patients who have diet-related health risks or conditions that are less severe (e.g., diabetes or obesity) and who can still prepare and cook their own meals. They prioritize patients with low incomes and involve the provision of healthy food items in combination with nutrition education. Produce prescriptions also target patients with diet-related health risks and prioritize patients with low incomes. They involve the provision of discounted or free produce at retail settings (such as grocery stores and farmers' markets), at a health care setting or home delivered, in combination with nutrition education.⁶

FIM interventions have been shown to **reduce health care costs** and **improve health outcomes** including improved hemoglobin A1c (a measure of blood sugar), body mass index, blood pressure, and fruit and vegetable consumption as well as reduced depression scores and hospital and emergency room utilization.⁷ For example, the adoption of medically tailored meals across the US has the potential to prevent approximately 1.6 million hospitalizations and save payers a net \$13.6 billion in the first year.⁸ Additionally, FIM can boost state and local economies by supporting farmers and agriculture, food retailers such as supermarkets, farmers markets, and CSAs; and community-based organizations.⁹ **Each food dollar spent locally in Oklahoma has an estimated multiplier effect of 1.41 to 1.78**.¹⁰ Considering these benefits of FIM programs, state governments are increasingly adopting them to improve public health outcomes.¹¹

.....Existing Efforts to Integrate Nutrition Support into Medicaid in Oklahoma

Food access and nutrition are consistently top barriers to health in Oklahoma.¹² The prevalence of food insecurity in Oklahoma is 14.3%, the 6th highest in the US.¹³ Oklahoma also has the highest prevalence of death from heart disease in the US.¹⁴ Hunger costs Oklahoma over \$1.4 billion each year through increased illness and decreased academic achievement.¹⁵

Oklahoma's current transition to Medicaid managed care (MMC) presents an optimal opportunity to ensure that Medicaid reflects Oklahomans' food and nutrition needs.

Oklahoma has already taken steps to be a leader in the use of MMC to address the social determinants of health (SDOH). In 2020, Oklahoma completed its first **MMC procurement**, with an aim to "improve health outcomes, increase access to care, and increase accountability in the State's Medicaid program."¹⁶ Oklahoma required prospective plans to **describe how they will support services addressing the SDOH** and to **provide examples** of innovative policies they undertook to address the SDOH. Oklahoma's **model contract** also stipulated that plans must **enact strategies addressing the SDOH**, develop a **health risk screening tool** that includes questions about the SDOH, and **document referrals to social services**. Oklahoma's procurement effort was designed in response to

“extensive feedback... from a broad array of stakeholders” including provider groups, community organizations, tribal partners, advocacy groups, and managed care organizations (MCOs). Stakeholder recommendations included encouraging MCOs to “address Social Determinants of Health” and to “track and report on outcomes of Social Determinants of Health referrals”.¹⁷ The stakeholders’ emphasis on the SDOH underscores the importance of Oklahoma’s efforts to address the SDOH.

By contracting with plans that are committed to addressing the SDOH, Oklahoma has positioned itself to successfully improve Oklahomans’ health and to reduce costs: investments in the SDOH have been shown to improve health and well-being and generate substantial cost savings.¹⁸

Oklahoma can build upon this momentum to reduce diet-related chronic illness and nutrition insecurity by integrating food and nutrition supports into the SoonerSelect MMC program. This issue brief offers strategies for Oklahoma to incentivize plans to provide and further incorporate these supports into Oklahoma’s Medicaid managed care.

North Carolina Case Study

North Carolina provides an instructive example of capitalizing on the transition from fee-for-service to MMC to address health-related social needs. In 2015, North Carolina’s Republican legislature passed legislation that required the state Medicaid program to move from a fee-for-service to a managed care program.¹⁹ As part of the transition, North Carolina sought to “measurably improve health through tailored plans for certain individuals with complex needs, maximize value to ensure sustainability of the program and to increase access to care.”²⁰ And in 2018, CMS approved a §1115 waiver, which included the Healthy Opportunities Pilot Program. The pilot required all plans to implement screening questions to address enrollees’ health-related social needs relating to food, housing, transportation, and interpersonal safety.²¹ North Carolina provided enrollees with access to a statewide tool to identify community resources and track referrals. CMS also authorized the use of Medicaid funds to pay for support services for high-risk enrollees in the pilot through the §1115 Waiver.²²

Pathways to Integrate Food and Nutrition Supports into Medicaid Managed Care

Opportunities to further address the food and nutrition needs of Oklahomans through MMC can be divided into three categories: (1) procurement, (2) contracting, and (3) oversight.

Procurement

Oklahoma can build upon its recent procurement effort by incorporating food and nutrition-specific goals, questions, and scoring criteria in its subsequent procurements. Additionally, the state can use these tools to gauge how plans will support community health and local food systems (though it cannot provide a preference to in-state bidders or products). This will allow Oklahoma to select plans that prioritize addressing the food and nutrition needs of Oklahomans and ensure that selected plans have the resources and expertise to implement food and nutrition interventions.²³

Ohio, in its MMC procurement, indicated that it will require plans to address food access and nutrition for individual plan participants, and support health at the community level. Plans must work with community organizations and “contribute to solutions addressing SDOH-related needs” including “lack of access to nutritious food,” provide up-to-date community resources lists to patients and health care providers, reimburse SDOH diagnostic codes, and contribute 3% of the plan’s annual profits to community reinvestment in support of population health strategies.²⁴

Notably, in Oklahoma, state agencies generally cannot discriminate against out-of-state bidders or products.²⁵ If the price, suitability, availability, and quality of in-state and out-of-state products or services are equal, state agencies must give preference to in-state bids.²⁶ Within these confines, Oklahoma could explore the extent to which it may be able to ask plans how they intend to support local food systems or provide access to seasonal products, foods with short harvest-to-delivery times, or culturally appropriate product varieties and grade vendors based on their ability to accommodate those criteria.²⁷ Because procurement is highly specialized area of the law, state agencies should consult with counsel to obtain tailored legal advice on their proposed procurement process and requirements.²⁸

Contracting

MMC contracts allow Oklahoma to influence the services and supports that MMC plans provide to Medicaid enrollees. Oklahoma can include contract provisions relating to food and nutrition and encourage plans to take advantage of flexibilities such as In Lieu of Services and value-added services.

Contracting Requirements

Within baseline federal requirements, states have wide flexibility in structuring and developing contracts with managed care plans.²⁹ Oklahoma’s existing SDOH contract requirements can be modified to incorporate requirements specific to food and nutrition. These requirements may include requiring plans to screen enrollees for nutrition security, establish partnerships with community organizations, and reinvest profits in community organizations.

Kansas’ scope of work requires MMC plans to partner with community organizations to provide service coordination that addresses the SDOH, including nutrition.³⁰

Texas’ scope of work requires MMC plans to use an evidence-based screening tool to assess enrollees’ health-related social needs, organize referrals to community organizations for social services, and provide healthcare staff with information about relevant resources available in the community.³¹

In addition to its contract language, Oklahoma could also adjust MMC plan capitation rates in its contracts to account for social risk factors in a way that provides incentives for plans to address social needs of patients.³² For example, Oklahoma could pay higher capitation rates for patients who are food insecure to encourage the adoption of interventions to address food insecurity in these populations. By paying higher capitation rates for patients who are food insecure, Oklahoma could increase incentives for plans to serve this population and increase the feasibility of implementing food and nutrition interventions.

Minnesota is a leader in risk adjusting Medicaid payment methodologies using social risk factors.³³ The state adjusted population-based payments to accountable care organizations (ACOs) to account for social risk factors such as homelessness, substance use disorder, and past incarceration.³⁴ Minnesota's approach encourages ACOs to serve patients with greater social needs because the costs of addressing these social needs are accounted for in their capitated payment.³⁵ Minnesota also requires ACOs to develop equity measures that target health related social needs and report their progress towards these measures.³⁶

In Lieu of Services (ILOS)

Through In Lieu of Services (ILOS), states can enable MMC plans to substitute state plan-covered services with medically appropriate and cost-effective services that address health-related social needs.³⁷ For example, medically tailored meals can be provided in lieu of more costly hospitalizations and emergency room visits, as medically tailored meals can prevent the need for these services.³⁸ Oklahoma can authorize ILOS relating to food and nutrition, including case management services that support access to nutritious food, nutrition counseling, medically tailored meals or groceries, and food prescriptions.³⁹ The costs of ILOS are included in the plan's capitation rate and the numerator of the plan's medical-loss ratio.⁴⁰

For a service to be substituted through ILOS, it must meet the following requirements:

- it must be medically appropriate and cost-effective;
- it must be identified in the managed care plan contract;
- it must be offered to enrollees at the at the option of the managed care plan;
- it must not be required for enrollees; and
- its cost must be included in capitation rates.⁴¹

Oklahoma can ensure that these requirements are met by identifying relevant research on food and nutrition interventions to demonstrate their impact on health outcomes and health care costs and clearly specifying authorized ILOS in the managed care contract.

Rhode Island has approved services from Meals on Wheels as an ILOS.⁴²

New York has pre-approved medically tailored meals as an ILOS.⁴³

California uses ILOS authority to allow plans to provide a full spectrum of “medically-supportive food and nutrition services,” in lieu of more intensive services (e.g., hospitalizations and Emergency Department visits) that would be needed in their absence.⁴⁴

Florida's model MMC plan contract provides a list of pre-approved ILOS that plans could provide without agency approval (including nursing facility services in lieu of inpatient hospital services and addiction facilities in lieu of inpatient detoxification hospital care) as well as a list of services that would require agency approval (including self-help or peer services in lieu of psychosocial rehabilitation services and behavioral health services in lieu of inpatient psychiatric programs).⁴⁵

Michigan recently released a request for information that sought public input on a proposed definition for ILOS services that would require meal and healthy food pack providers to “have experience and expertise with providing these unique services and be locally-based and participate in the local food economy.”⁴⁶

Value-Added Services

In addition to services that the state designates as ILOS, plans can voluntarily choose to offer additional services that the state plan does not cover, termed value-added services.⁴⁷ These services do not need to be state approved as medically appropriate or cost-effective substitutes for existing covered services. Oklahoma could include provisions in their MMC contracts that encourage plans to use value-added services. This can build upon existing value-added services that are already offered in SoonerSelect.⁴⁸ Examples of existing value-added services offered in Oklahoma contracting plans include fresh produce boxes for food insecure enrollees (Humana), medically tailored meals (Oklahoma Complete Health), and a Diabetes Care Program including a healthy food budget (Aetna).⁴⁹

Unlike ILOS, the costs of value-added services are not included in plans' capitation rates,⁵⁰ which may reduce plans' incentive to provide these services. However, value-added services can count towards the numerator of a plan's medical-loss ratio as long as they meet the definition of "activities that improve health care quality" as defined at 45 C.F.R. §158.150).⁵¹ Offering value-added services relating to the SDOH can be a way for plans to fulfil contractual requirements relating to the SDOH that Oklahoma has already established. Oklahoma can remind plans of this to encourage plans to adopt value-added services. Several states have successfully used value-added services to address the SDOH.

Hawaii has required MMC plans to develop a work plan outlining how they will provide value-added services to address the SDOH of their enrollees.⁵²

Nevada's scope of work encourages the use of care coordination with community health workers as a value-added service.⁵³

Value-Based Payment

Oklahoma has shown a strong commitment to value-based care in its shift from a fee-for-service model to managed care. Oklahoma can leverage the value-based care model to incentivize plans to offer food and nutrition services by creating value-based payment schemes. These payment schemes can base payments to plans on metrics relating to nutrition security and diet-related diseases.⁵⁴

Michigan's Pay for Performance program allows plans to earn bonuses for implementing programs addressing food insecurity.⁵⁵

Pennsylvania's model MMC plan contract specifies that MMC plans must incorporate partnerships with community organization into value-based payment schemes.⁵⁶

Oversight

After MMC contracts are developed, Oklahoma can continue to encourage the implementation of food and nutrition projects through the oversight of managed care plans. States are required to develop quality strategies to assess the quality of managed care plans and to identify targets for improvement.⁵⁷ Oklahoma's MMC procurement model contract in 2020 established SDOH-related requirements for plans,⁵⁸ therefore oversight will be important to evaluate plans' fulfillment of these requirements. Oversight will also be valuable to determine how Oklahomans' access to food and health outcomes have changed with the implementation of any nutrition interventions.

Oklahoma can further include food and nutrition-related metrics in quality assessments. These metrics can include reporting requirements and performance measures regarding SDOH, food insecurity, and/or diet-related

diseases. This could also include measures to identify impacts on community health and local food systems, such as identification of the types of organizations involved in providing nutrition services (e.g., non-profits, farms, farmers markets, food hubs, and retailers), the size of those organizations, changes in their capacity such as foods or services offered, and the geographic locations served.

Michigan's model contract requires plans to comply with state reporting requirements and to gather data regarding the SDOH.⁵⁹ The state uses this data to prepare a Quality Strategy Report, which tracks metrics related to the SDOH including food insecurity and evaluates MMC Plans' incorporation of the SDOH into their quality assessment processes.⁶⁰

Additionally, to tie incentives to the quality improvement process, Oklahoma can connect oversight metrics with financial incentive policies like bonuses, withholds and value-based payment.⁶¹ For instance, the state could reward plans for high performance in nutrition-related metrics.

Conclusion

Given Oklahoma's MMC transition and shift towards value-based care, it is well positioned to integrate food and nutrition into Medicaid. Oklahoma can build upon its existing innovations in using MMC to address the SDOH and implement new pathways to improve access to food and nutrition supports for Medicaid enrollees. By incorporating food and nutrition as a focus in procurement, contracting and oversight, Oklahoma can work towards addressing poor health outcomes resulting from diet-related chronic conditions and food insecurity.

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