Food is Medicine: A State Medicaid Policy Toolkit

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CHLPI CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

FOOD IS MEDICINE COALITION

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About the Authors

This report was written by the following staff and students at the Center for Health Law and Policy Innovation of Harvard Law School: Erika Hanson, Sara Raza, Katie Garfield, Erin Mizraki, Hannah Rahim, Jessica Samuels, Carmel Shachar, and Emily Broad Leib.

Additional authors from the Food is Medicine Coalition include: Alissa Wassung and Cate Hensley.

Center for Health Law and Policy Innovation

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 healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare 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.

Food is Medicine Coalition (FIMC)

The Food is Medicine Coalition (FIMC) is the national coalition of nonprofit organizations that provide medically tailored meals (MTMs) and groceries (MTGs), medical nutrition therapy, and nutrition counseling and education to people in communities across the country who are living with severe, complex, and chronic illnesses. We advance equitable access to these life-saving interventions through policy change, research and evaluation, and best practices. FIMC agencies created the medically tailored meal intervention as a response to community need nearly 40 years ago and maintain the nutrition standards for the intervention. FIMC offers a diverse community of learning for existing practitioners and equips new organizations to launch medically tailored meal programs.

Acknowledgement

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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.

I. Introduction

Poor diets are the leading cause of death in the United States, costing the economy roughly $1.1 trillion each year and accounting for 85% of healthcare spending.[1] Food is Medicine (FIM) interventions have emerged as an important component of state and federal strategies to respond to these troubling trends.[2] A recent consensus-based document defined these FIM interventions as including two core components: (1) "the provision of food that supports health," and (2) "a nexus to the healthcare system." [3] Under this definition, FIM interventions encompass a spectrum of nutrition services—ranging from medically tailored meals, to medically tailored groceries, and produce prescriptions—all of which are tailored to patient needs and integrated into the healthcare system through referrals from medical providers.

Notably, these interventions are primarily designed to provide access to specific foods as part of medical treatment. While FIM interventions can also help to address social determinants of health (SDOH) and health related social needs (HRSNs) such as food insecurity, the primary intent behind these programs is to meet the medical nutrition needs of individual patients. In doing so, FIM interventions build upon broader nutrition security programs such as the Supplemental Nutritional Assistance Program (SNAP) and population-level healthy food policies and programs to provide access to nutritious food as part of a patient's treatment plan.[4]

A growing body of evidence demonstrates that FIM interventions can be a cost-effective—and in some cases even cost-saving—approach to treating, managing, and/or preventing diet-related chronic disease.[5] ***This is due in large part to their ability to reduce the downstream need for more intensive healthcare services. For example, studies have shown that the medically tailored meal intervention [6] can lead to reductions in: emergency department visits (70%), inpatient hospital admissions (52%), admissions to skilled nursing facilities (72%), and net healthcare costs (16%).[7] As a result, a 2022 study projected that if all eligible patients in Medicaid, Medicare, and private insurance received medically tailored meals, the U.S. healthcare system could avert 1.6 million hospitalizations and $13.6 billion in healthcare costs each year, even after accounting for the cost of the programs.[8]*** Similar research has begun to emerge across the spectrum of FIM interventions, showing that these services have the potential to improve disease management (e.g., diabetes control) and avert long-term negative health outcomes, such as cardiovascular events.[9] Additionally, FIM programs can help state and local economies by supporting food retail, local and regional agriculture systems, and encouraging the growth of community-based organizations.[10]

Over the past decade, several policy pathways have emerged to integrate nutrition interventions into two of the United States' most critical public health insurance programs for low-income families: **Medicaid** and the **Children's Health Insurance Program (CHIP)**. To support these efforts, the Centers for Medicare & Medicaid Services (CMS) has released numerous regulations and guidance documents.[11] In November 2023, CMS consolidated these policy documents into a comprehensive Informational Bulletin and Coverage Framework.[12] The November 2023 guidance details coverage pathways for "allowable" health-related social need (HRSN) services and supports based on "robust evidence" that the interventions "have proven to strengthen coverage and improve downstream health outcomes, cost, and/or equity."[13]

The following 5 nutrition interventions are included in this guidance:

1. **Case management services** for access to food/nutrition, including outreach and education and linkages to state and federal benefit programs, benefit program application assistance, and benefit program application fees.
2. **Nutrition counseling and instruction**, including guidance on selecting healthy food and healthy meal preparation.

I. Introduction

3. **Home delivered meals or pantry stocking** tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals. For example, medically tailored meals for high-risk expectant individuals at risk of or diagnosed with diabetes.
4. **Nutrition prescriptions** tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including fruit and vegetable prescriptions, protein boxes, food pharmacies, and healthy food vouchers.
5. **Grocery provisions** for high-risk individuals to avoid unnecessary acute care admission or institutionalization.[14]

Under the guidance, CMS explains that states have the option to use any of the following Medicaid/CHIP authorities to pay for and deliver these services:

1. **Section 1115 Demonstration Waivers**
2. **Section 1915 Home and Community-Based Services Waivers and State Plan Options**
3. **Managed Care In Lieu Of Services and Settings (ILOS)**
4. **CHIP Health Services Initiatives (HSIs)**

Toolkit Purpose

The purpose of this Toolkit is to build upon CMS's 2023 guidance by providing a roadmap by which state officials can identify the most feasible and impactful approaches to address patient nutrition needs in their state Medicaid and CHIP programs.

- ***Sections II - V detail each of the four authorities listed above. In each section, we summarize the legal underpinnings of the authority and describe the nutrition services allowed, beneficiaries targeted, additional requirements, and application/approval processes.***
- ***Section VI then provides an overview of practical considerations that have implications across these policy pathways.***

Throughout the analysis, we offer state and program implementation examples to illustrate current approaches and geographic variations in strategy. In providing this information, we aim to enable readers to find the information needed to advance a FIM strategy appropriate to their individual landscape, creating more widespread access to these crucial nutrition services across the nation.

II. Section 1115 Demonstration Waivers

Medicaid section 1115 demonstration waivers authorize states to temporarily modify Medicaid programs through experimental, pilot, or demonstration projects that promote Medicaid's objectives.[15] States can use section 1115 demonstrations to expand eligibility, test new service delivery systems, and incorporate services not traditionally covered by Medicaid, such as housing and nutrition supports.[16] State interest in this pathway has accelerated in the wake of the COVID-19 pandemic, which laid bare the need to improve healthcare delivery, care for people who are ill in their homes, and better address high rates of diet-related chronic conditions.[17] Today, more than 49 million people receive Medicaid coverage from a state that provides access to nutrition services via an 1115 demonstration. These waivers, operating in states such as Arkansas, Oregon, and Massachusetts, are designed to address HRSN, improve health outcomes, and drive down healthcare costs.[18]

PATHWAY SUMMARY **Section 1115 Health Related Social Need Demonstrations**	
Nutrition Services Allowed	1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – *up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods* 4. Nutrition Prescriptions – *up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods* 5. Grocery Provisions – *up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods*
Populations Reached	Requirements That May Be Waived: • Statewideness • Comparability HRSN services must be medically appropriate according to state-defined clinical and social criteria Beneficiary needs must be documented in care plan or medical record
Initial Approval Period	5 years
Fiscal Requirements	Budget Neutrality with ***flexibility for HRSN expenditures*** 3% Spending Cap on Total HRSN (of total state Medicaid spend) 15% Spending Cap on HRSN Infrastructure (of HRSN spend) Primary care, behavioral health, and OB/GYN provider reimbursement rate requirements

II. Section 1115 Demonstration Waivers

A. Law and Policy

a. Nutrition Services Allowed

In September 2022, the White House announced a National Strategy on Hunger, Nutrition, and Health which explicitly supported the piloting of FIM interventions through Medicaid 1115 demonstrations.[19] Section 1115 offers states broad flexibilities in tailoring the services provided under demonstrations. However, CMS has published a framework for states seeking to leverage 1115 demonstrations specifically to provide HRSN services, articulating 5 nutrition supports as "allowable" under section 1115 authority: (1) case management services, (2) nutrition counseling and instruction, (3) home-delivered meals (including medically tailored meals) or pantry stocking, up to 3 meals/day (4) nutrition prescriptions, up to 3 meals/day, and (5) grocery provisions, up to 3 meals/day. The direct provision of food (e.g., meals, nutrition prescriptions) can be covered for up to 6 months with the possibility of renewal for additional 6-month periods.[20] States have the option to offer some or all of these services.

Implementation Examples:

As of July 1, 2024, there are 21 states with approved or pending(*) section 1115 demonstrations that provide coverage for nutrition interventions: **Arkansas**, **California**, **Washington D.C.**,* **Delaware**, **Florida**, **Georgia**, **Hawaii,*** **Illinois**, **Maine**, **Maryland**, **Massachusetts**, **Michigan**, **North Carolina**, **New Mexico**,* **New York**, **Oregon**, **Pennsylvania**,* **Rhode Island**,* **Utah**, **Virginia**, and **Washington**.[21] The scope and coverage of these demonstrations vary. For example, 14 include coverage for the direct provision of food, while the rest support the provision of nutrition education or screening for food insecurity only.[22] Of the states with coverage for the direct provision of food, the majority include coverage of medically tailored meals, medically supportive meals, produce prescriptions, and/or medically tailored groceries.[23]

b. Beneficiaries Reached

1115 demonstrations can reach a wide range of beneficiaries. Under section 1115, states are allowed to waive statewideness (i.e., the requirement that Medicaid services reach all parts of the state) and comparability (i.e., the requirement that Medicaid services must be provided in the same amount, duration, and scope to all beneficiaries) in order to target services.[24] For example, states can choose to target groups according to age, defined risk factors, geographic locale, and/or individual characteristics. Oregon has leveraged this flexibility to provide HRSN benefits to those experiencing critical life transitions among other characteristics [25] and North Carolina has targeted its demonstration to three regions, which encompass rural and racially diverse communities.[26] More commonly, states have tailored nutrition support services in 1115 demonstrations to populations who are pregnant or postpartum, living with diet-sensitive conditions, or experiencing substance use disorder and/or mental illness.[27] CMS guidance also permits expanded nutrition support to include the households of pregnant individuals or children identified as high risk.[28] Importantly, coverage of HRSN services must qualify as "medically appropriate" according to state-defined clinical and social criteria (typically set out in state guidance), and beneficiaries must have their needs documented in their care plan or medical record.[29]

c. Other Requirements

1. Duplication of Benefits

HRSN services supported by 1115 authority must "supplement, not supplant" existing supports at the local, state, and federal level.[30] State Medicaid agencies must partner with existing state agencies and social service providers to connect beneficiaries experiencing food insecurity with programs such as SNAP, WIC, and TANF.[31] Any services covered by 1115 demonstrations may not overlap with those covered by sections 1915(c), (i), or (k) (described in more detail in **Section III** below) unless a state is willing to conform to independent programming requirements for those sections.[32]

2. Fiscal Requirements

To determine federal-state cost-sharing in the Medicaid program, the federal government calculates a Federal Medicaid Assistance Percentage (FMAP) for each state, which establishes the percentage of state Medicaid service costs the federal government will reimburse or "match."[33] Section 1115 allows states to receive federal matching funds for demonstration costs that would not typically qualify under the FMAP cost sharing, such as workforce training.[34]

Additionally, 1115 demonstrations must be "budget neutral" to the federal government, meaning changes proposed must cost the same or less than existing federal spending on the state's Medicaid program.[35] CMS recognizes that evidence-based HRSN services are likely to reduce downstream costs of medical care and improve beneficiary health. However, it notes that predicting these downstream effects on the overall Medicaid program and the resulting budget neutrality calculations is "extremely difficult."[36] Therefore, CMS has enabled flexibility in budget neutrality calculations for HRSN demonstrations. For example, CMS considers certain HRSN expenditures, including HRSN services and infrastructure expenditures (described in **Section VI**), as "hypothetical" or "without waiver" expenditures, meaning states are not obligated to offset these costs with budget neutrality savings.[37]

Still, to maintain fiscal integrity of the Medicaid program, CMS limits HRSN spending to 3% of the state's total Medicaid spend and infrastructure expenditures to 15% of the state's total spending on HRSN services.[38] A recent analysis shows that states have kept HRSN expenditures well below these caps.[39] Finally, as a condition of approval for HRSN 1115 demonstrations, states are subject to threshold requirements for provider payment rates for primary care, obstetrics, and care for mental health and substance use disorders – a condition designed to target the relationship between payment rates and access to quality care for beneficiaries.[40]

II. Section 1115 Demonstration Waivers

B. Application and Approval Process

As an initial matter, states must comply with state-level laws that may constrain revisions to Medicaid services, such as state laws that require legislative approval for Medicaid waivers. [41]

Application Process for 1115 Demonstration Waivers

States must then meet federal 1115 waiver requirements. Application, monitoring, and evaluation requirements for 1115 demonstrations are rigorous. CMS provides resources to support states across each of these steps on the 1115 waiver section of Medicaid.gov. All proposed 1115 demonstrations must promote the objectives of the Medicaid program, meaning the proposed program must furnish medical assistance to those who lack access to necessary care and provide services designed to help individuals achieve or maintain the capacity for self-care.[42] Before submitting a formal application, a state can confer with CMS regarding its intent to seek a demonstration and submit a pre-application concept paper to CMS for discussion.[43]

States must then provide the public with a minimum of 30 days for notice and comment on its proposal.[44] The public notice must provide the demonstration proposal; location, date, and time of at least two public hearings; and channels for comment. The state is also required to engage in Tribal consultations.[45] In its application to CMS, the state must report issues raised by the public during the comment period and discuss how they were addressed.[46] Upon completing these steps, a state may submit its application to CMS.

Once CMS determines an application is complete, the agency initiates a 30-day federal public comment window. After a waiting period of at least 15 days after the conclusion of the federal comment period, CMS will approve or reject the application, or issue Special Terms and Conditions.[47] Notably, though, this CMS review can take up to 15 months or longer, during which negotiation with the state continues. CMS typically approves 1115 demonstrations for a 5-year period.

Once the application is approved, the demonstration will be subject to review and evaluation. Within 30 days of CMS approval, states must submit an evaluation design plan.[48] States can select among a range of evaluation strategies. At minimum, a state's evaluation design plan must include an independent evaluator, qualitative research designs, measures to protect beneficiary privacy and reduce burdens, hypothesis and progress monitoring, prospective data and collection methods, and an explanation of how the state will address confounding factors in assessing implementation (evaluation requirements and resources further described in **Section VI**).[49] States must submit annual reports no later than 90 days after the conclusion of each demonstration year.[50] States also must hold annual public forums to solicit comments on demonstration implementation.[51] After the initial term, demonstrations can then be extended for additional 3-5 year periods.[52]

III. Home and Community-Based Services Authorities

Home and Community-Based Services (HCBS) provide opportunities for eligible individuals to receive services in their home or community rather than through institutional settings. Several different HCBS authorities are available. The most common HCBS authorities used to provide food and nutrition services to Medicaid beneficiaries are section 1915(c) Home and Community-Based waivers and section 1915(i) State Plan Home and Community-Based Services amendments. This resource will address 1915(c) and 1915(i) in detail. Other HCBS authorities include section 1915(j) Self-Directed Personal Assistance Services and section 1915(k) Community First Choice state plan amendment (SPA) options, which will be briefly covered.

HCBS authorities differ in their structure and target populations. However, all allow states to offer a variety of acute medical care and long-term services. Eligible populations under each authority and in each state's program vary, but generally, programs serve individuals with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.[53]

PATHWAY SUMMARY
Home and Community-Based Services Authorities

	Section 1915(c) Home and Community-Based Waivers	Section 1915(i) State Plan Home and Community-Based Services Amendments
Nutrition Services Allowed	1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – *up to 2 meals per day or less than a full nutritional regimen* 4. Nutrition Prescriptions – *up to 2 meals per day or less than a full nutritional regimen* 5. Grocery Provisions – *up to 2 meals per day or less than a full nutritional regimen*	
Populations Reached	Requirements That May Be Waived: • Statewideness • Comparability • Community income rules for medically needy population Individuals must meet institutional level of care	Requirements That May Be Waived: • Comparability • Community income rules for medically needy population Individuals must meet state-defined needs-based criteria that are less stringent than institutional level of care criteria
Initial Approval Period	3 years	One-time approval unless targeting, then 5 years
Fiscal Requirements	Cost Neutrality	None

III. Home and Community-Based Services Authorities

A. Law and Policy

a. Nutrition Services Allowed

State programs under 1915(c) waivers and 1915(i) SPAs can cover state-proposed nutrition services and education that are approved by CMS.[54] This includes all 5 nutrition services articulated in CMS's November 2023 guidance.[55] However, HCBS nutrition coverage is limited under the "room and board" exclusion under sections 1915(c)(1) and 1915(i)(1) of the Social Security Act. Therefore, nutrition services provided under these authorities are limited to less than a full nutritional regimen (i.e., less than 3 meals per day).[56] This means beneficiaries receiving nutrition services under HCBS authorities can only receive up to 2 meals per day, or if receiving supports that do not come in the form of meals, such as a nutrition prescription in the form of a healthy food voucher, they cannot receive a voucher that provides for a full nutritional regimen.

Many states have historically provided access to home-delivered meals as part of HCBS authorities. However, CMS's 2023 guidance makes clear that there is significant opportunity to go further, using these authorities to provide access to more tailored FIM interventions.

b. Beneficiaries Reached

Section 1915(c) waivers allow states to offer long-term services and supports as an alternative to institutional care.[57] The goal of these waivers is to provide home benefits to populations who would otherwise require institutional services in a hospital, nursing facility, or Intermediate Care Facility for Intellectual Disabilities.[58] Although states cannot adjust this institutional care requirement, they are permitted to tailor programs within this group by waiving Medicaid statewideness, comparability, and community income rules (i.e., Medicaid income eligibility requirements) in some cases.[59] Therefore, a state may direct 1915(c) nutrition supports towards communities based on age, diagnosis, or disability.[60] For example, states have used this authority to target older adults, individuals with autism or HIV/AIDs, and those suffering from brain or spinal cord injuries.[61] States can also design programs that target geographic areas where need is greatest or where certain types of providers are available to provide approved services.

Section 1915(i) SPAs allow states to target individuals along the same criteria permitted under section 1915(c) waivers. However, states can cast a wider net by targeting populations with less stringent requirements.[62] A state may establish its own needs-based criteria to provide services to those "at risk of institutional care" and may define these criteria to include, among other things, a risk of homelessness, food insecurity for those living with diabetes, or social isolation for older individuals with chronic conditions.[63] This breadth of potential target populations under Section 1915(i) contrasts with the inflexible institutional care requirement of section 1915(c). States may further choose to "target" 1915(i) services on the basis of age, diagnosis, disability, and/or Medicaid eligibility group by waiving comparability requirements.[64] Should the state choose to target its HCBS SPA in this way, the SPA does not enact a permanent change to the state's Medicaid program, rather, CMS will approve the 1915(i) program for 5 years, subject to renewal.[65] States can also waive the community income rules, allowing the state to provide community Medicaid services to individuals with incomes that would otherwise make them ineligible for Medicaid services outside an institutional setting.[66] Unlike under 1915(c) waivers, states cannot waive the statewideness

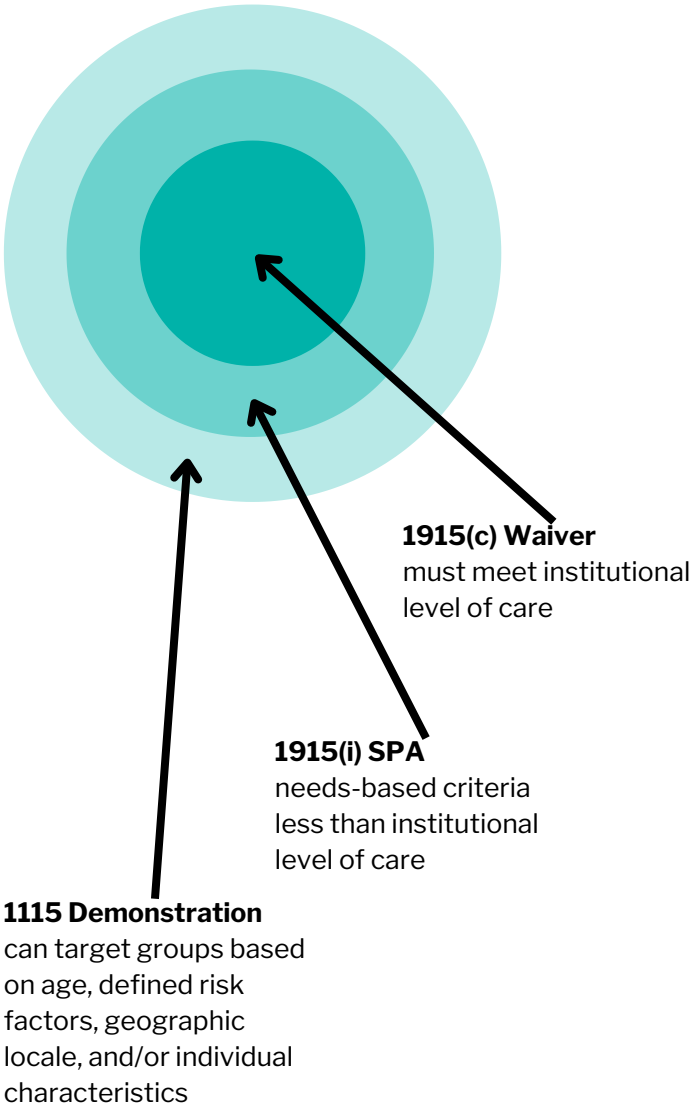
requirement in a 1915(i) SPA, meaning programs implemented through this authority cannot target populations based on geography. States should consider this limitation when analyzing which authority to pursue. For example, this pathway could limit the state's ability to target individuals who live in areas with limited access to nutritious foods or medical services that address diet-related disease.

When determining whether a 1915(c) waiver or 1915(i) SPA is a better pathway to provide nutrition coverage to Medicaid beneficiaries, states should consider their population composition and needs. For example:

- **If the goal is to serve a population that meets an institutional level of care, a 1915(c) waiver may be the best pathway.**
- **If the goal is to reach a broader population to prevent institutionalization, a 1915(i) SPA may be a better option.**

Finally, CMS has offered potential target populations and risk factors that can be used to tailor nutrition services in 1915(c) waivers and 1915(i) SPAs.[67] For example, nutrition counseling may be tailored to target populations defined by health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement. Waivers or SPAs that include medically tailored meals may tailor subgroups by health risk and further narrow eligibility criteria by nutrition-sensitive health condition, age (e.g., children), or pregnancy status. For example, eligibility for receiving medically tailored meals may be tailored to high-risk expectant individuals at risk of or diagnosed with diabetes.

Comparing Breadth of Target Populations



Implementation Examples:

Michigan's Choice 1915(c) waiver provides services to individuals ages 65 or older and individuals with physical disabilities aged 18-64 years who meet a nursing facility level of care. Services offered include home delivered meals, defined as the provision of "one to two nutritionally sound meals per day" to a waiver participant otherwise unable to care for their nutritional needs.[68] Meal delivery kits and service or membership fees for grocery delivery services are also included. To be eligible for meal delivery kits, the participant must be the target recipient of the meal, be able to prepare or have someone available to prepare the meal, and have the capacity to properly store the meal components. Grocery delivery services do not include payment for the food, and the participant must have difficulty getting to the grocery store, selecting groceries, transporting groceries, or quarantining due to illness or public health emergency.[69]

Implementation Examples continued:

Connecticut's Home Care Program for Elders 1915(i) SPA provides HCBS services to individuals who are 65 years of age or older, Connecticut residents, at risk of nursing home placement, and meet the program's financial eligibility criteria. The SPA provides home-delivered meals for individuals who are unable to prepare or obtain nourishing meals on their own.[70] Special diet meals are available including diabetic, cardiac, low sodium, and renal. Culturally appropriate meals such as Hispanic and Kosher meals are also available. Home-delivered meals cannot constitute a full nutritional regimen.

c. Other Requirements

1. Health and Welfare

In general, programs offered under both 1915(c) waivers and 1915(i) SPAs must ensure the protection of individuals' health and welfare. To do so, both authorities require that provider and facility standards, licensure, and certification requirements are adequate and reasonable to meet the needs of target populations.[71]

2. Fiscal Requirements

Section 1915(c) waiver programs must be cost-neutral. Specifically, these programs must ensure that the average annual cost of waiver services is less than the average institutional costs for each waiver participant.[72] States have noted that it is generally not difficult to meet these cost neutrality prerequisites because institutional costs are often high compared to the cost of waiver services. However, calculating the costs of institutional care to demonstrate cost neutrality can be complex.[73] In implementing 1915(c) waivers, states must also promote financial accountability by imposing independent audits and providing appropriate financial records to HHS.[74]

In contrast, there is no cost neutrality requirement for 1915(i) SPAs. However, states must still submit an estimated fiscal year impact on the federal budget with its state plan materials.[75] States should consider this difference in fiscal requirements and resulting administrative burden when determining which HCBS pathway to pursue.

B. Application and Approval Process

a. Section 1915(c) Waivers

Application Process for 1915(c) Waivers

States submit 1915(c) waiver applications to CMS electronically.[76] CMS provides detailed information to support applications on its 1915 Waiver Toolkit page on Medicaid.gov, including an electronic application, a technical guide, and FAQs regarding waiver processing.

In the application, states must provide the purpose of the waiver program and a brief description. States must also include a detailed process for developing individualized "person-centered service plans" for each waiver participant, also called a plan of care.[77] The plan of care must be based on an independent assessment of the individual and reflect the services and supports that are important for that individual to meet their needs related to health, welfare, and financial accountability identified through an assessment of function need.[78]

States must provide public notice and comment for new 1915(c) waivers as well as for any proposed changes to an existing waiver's services or operation.[79] A sufficient public input process requires states to share the entire waiver and include at least two statements of public notice and public input procedures (one must be web-based and one must be non-electronic). The comment period must be at least 30 days and be completed prior to submission to CMS. The state's waiver application must include a summary of the public comments received during the public input process, the reasons why any comments were not adopted, and a summary of modifications made as a result of the process.[80] In the event of an emergency or natural disaster, states may amend their 1915(c) waivers by submitting an Appendix K form.[81] Many states utilized the Appendix K amendment process during the COVID-19 public health emergency to expand HCBS, including to expand meal coverage.[82] States may continue to use this amendment process to address food and nutrition needs during times of emergency. Once in place, these programs may be implemented through other HCBS authorities.

CMS has 90 days from the date of submission to review a 1915(c) application.[83] Initial applications are approved for 3 years and can be renewed for 5-year periods.[84] If the program serves individuals eligible for both Medicare and Medicaid (i.e., dual eligibles), initial applications can be approved for 5 years.[85] The State must submit annual reports on the number of people who receive 1915(c) waiver program services and Medicaid expenditures.[86] CMS has recently clarified and streamlined the reporting requirements for all Medicaid HCBS services (whether authorized and administered via 1915(c), 1915(i), 1115, or any other authority). These requirements will go into effect in 2027-28 and dictate annual, biannual, and other reporting to CMS on topics such as the results of an incident management system assessment; information regarding critical incidents; person-centered planning metrics; the waiver's impact on the type, amount, and cost of services provided under the State plan; the Home and Community-Based Services Quality Measure Set; access and waiting lists; and payment adequacy.[87] Prior to renewal, the waiver goes through an evidence-based review[88] (further described in **Section VI**).

b. Section 1915(i) State Option

States must submit a State Plan Amendment to CMS to establish a 1915(i) program. To assist in this process, CMS provides helpful materials including a pre-print.[89] State 1915(i) SPAs must meet the same person-centered plan requirements as a 1915(c) waiver.[90] Additionally, a Medical Care Advisory Committee must advise the Medicaid agency director about the proposed health and medical care services and have the opportunity to participate in policy development and administration.[91]

Notice and comment is required for needs-based criteria changes and changes in payment methodology. States seeking to modify needs-based criteria must provide at least 60 days' notice of the proposed modification to CMS, the public, and each individual enrolled in the SPA HCBS benefit.[92] If these modifications affect beneficiary services, they also require fair hearing rights.[93] Modifications to the payment methodology require a separate notice and publication scheme.[94]

The SPA is subject to a one-time approval unless a state chooses to "target" the SPA to certain groups, as detailed above, in which case the initial approval period is for 5 years and can be renewed with CMS approval for additional 5-year periods. CMS requires annual reporting regarding 1915(i) metrics, however, beginning in 2027-28, as noted above, this reporting process will be streamlined.[95] Thirty-nine months after the SPA effective date, the State must begin an evidence-based review process[96] (further described in **Section VI**).

c. Additional HCBS Authorities

Section 1915(k) Community First Choice and 1915(j) Self-Directed Personal Assistance Services SPAs are sometimes overlooked authorities that can be utilized to provide home and community-based services and supports, like nutrition services, to select Medicaid beneficiaries.

1. Section 1915(k) Community First Choice SPA

Section 1915(k) SPAs allow states to provide personal attendant services and supports in a home and community-based setting to individuals meeting an institutional level of care.[97] States may also offer services that substitute for human assistance under this option, including assistance in preparing meals.[98] For example, Maryland uses the 1915(k) pathway to provide coverage of home-delivered meals for qualified applicants.[99] 1915(k) SPAs can be submitted to CMS via pre-print.[100] Notably, 1915(k) provides a 6-percentage point increase in federal matching payments to states for services provided under this option.[101] The SPA is subject to a one-time approval. Changes must also be submitted to CMS and approved.[102]

2. Section 1915(j) Self-Directed Personal Assistance Services SPA

Section 1915(j) SPAs allow states to provide self-directed personal assistance services under the Medicaid State Plan and/or section 1915(c) waivers that the state already has in place.[103] SPA beneficiaries manage a cash disbursement and purchase goods, supports, or supplies that increase their independence or substitute for human help to the extent the individual would otherwise rely on and pay for human assistance. The SPA can be submitted to CMS via pre-print.[104] The SPA is subject to a one-time approval. Changes must be submitted to CMS and approved.[105] Although it appears that 1915(j) SPAs have not yet been used to provide food or nutrition services, CMS has presented the authority as a possible pathway to cover the same types of services currently allowed under 1915(c), 1915(i), and 1915(k) options.[106]

IV. Medicaid Managed Care: In Lieu of Services (ILOS)

In lieu of services (ILOS) is a payment pathway that enables states to authorize Medicaid managed care organizations (MCOs) to provide medically appropriate and cost-effective substitutes for traditional state plan-covered services.[107]

PATHWAY SUMMARY In Lieu of Services	
Nutrition Services Allowed	1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – *up to 2 meals per day or less than a full nutritional regimen* 4. Nutrition Prescriptions – *up to 2 meals per day or less than a full nutritional regimen* 5. Grocery Provisions – *up to 2 meals per day or less than a full nutritional regimen*
Populations Reached	Requirements That May Be Waived: None Medicaid managed care enrollees only; services are offered at the option of each managed care plan State develops and CMS approves clinically oriented definitions for the target population(s) for which the state has determined each ILOS to be a medically appropriate and cost-effective substitute
Initial Approval Period	Annual review as part of rate certification
Fiscal Requirements	Cost Effectiveness

A. Law and Policy

a. Nutrition Services Allowed

ILOS can be provided in lieu of state plan-covered services that can be accessed at the current point in time or in lieu of future state plan services (e.g., for the prevention of the need for future hospitalizations).[108] Since the enactment of ILOS in 2016, states have traditionally used ILOS to address behavioral health, such as providing mental health services in lieu of inpatient psychiatric care.[109] Under CMS's most recent ILOS guidance, states can use ILOS to address health-related social needs and reduce the need for future medical care.[110]

CMS considers the following services that address nutrition "allowable" under ILOS authority: (1) case management services, (2) nutrition counseling, (3) home delivered meals or pantry stocking tailored to health conditions, (4) nutrition prescriptions, and (5) grocery provisions.[111] These interventions must be for less than 3 meals a day and cannot cover all of an enrollee's nutritional needs.[112] This limitation is due to a CMS requirement (described below) that services provided as ILOS must be approvable as services under a SPA or HCBS 1915(c) waiver (which limit nutrition benefits to less than a full nutritional regimen).[113]

IV. Medicaid Managed Care: In Lieu of Services (ILOS)

b. Beneficiaries Reached

The ILOS coverage pathway is only available through Medicaid managed care.[114] Within the state's Medicaid managed care program, the state must give each MCO the option of whether to offer an ILOS service to their enrollees.[115] Therefore, ILOS can be accessed by eligible enrollees of any MCO that offers ILOS. However, because ILOS is not available in fee-for-service Medicaid, these services cannot be accessed by individuals who are enrolled in fee-for-service-based programs unless otherwise offered by the state Medicaid program. As of 2021 (the most recent year for which data is available), 74% of the United States' Medicaid population was enrolled in comprehensive managed care.[116] However, ten states had no comprehensive Medicaid managed care program (Alabama, Alaska, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, Vermont, and Wyoming).[117] Oklahoma implemented comprehensive Medicaid managed care in April 2024.[118]

c. Other Requirements

States and plans utilizing ILOS must adhere to several requirements:

1. ILOS must be (a) medically appropriate and (b) cost-effective substitutes for services covered under the state plan.[119]
    a. States must submit to CMS the name and definition of each ILOS, the covered services for which they substitute, the clinically oriented definitions for each ILOS target population, and a contractual requirement for plans to use a consistent process to ensure that a provider determines that the ILOS is medically appropriate for the specific enrollee.[120]
    b. CMS imposes a limit on the expenditures for ILOS: the ILOS Cost Percentage (calculated as the total capitation payments attributable to ILOS divided by the total costs for the specific managed care program) should not exceed 5%.[121]
2. States must consider the cost of ILOS in developing capitation rates.[122]
3. States must authorize and identify ILOS in the managed care contract and give plans the option of whether to offer ILOS to enrollees.[123]
4. Plans cannot require Medicaid enrollees to use ILOS. Enrollee handbooks must contain information on enrollee rights with respect to ILOS in accordance with 42 CFR § 438.3(a).[124]
5. States must establish a system to monitor performance of their managed care programs, and when ILOS are included, they must be part of monitoring activities and subject to retrospective evaluation.[125]
6. ILOS must advance the objectives of the Medicaid program and cannot violate any applicable federal requirements. ILOS must be approvable through a state plan amendment authorized through the Social Security Act, including sections 1905(a), 1915(i), or 1915(k) of the Social Security Act, or a waiver under section 1915(c) of the Social Security Act.[126] This means that ILOS can cover home and community-based services but not room and board (i.e., not a full nutritional regimen). [127]

CMS provides additional information and resource regarding these requirements in the In Lieu of Services and Settings section of Medicaid.gov.

IV. Medicaid Managed Care: In Lieu of Services (ILOS)

Implementation Examples:

Several states have implemented ILOS to offer nutrition services, generally substituting for state plan-covered services such emergency department visits, hospital care, and home care that may be required for the treatment of diet-related chronic conditions. For example:

- **Rhode Island** has approved home-delivered meals (described as "Meals on Wheels" in the state's model contract documents) for persons who are in danger of malnutrition and/or have limited mobility or access to transportation, and nutritional education programs.[128]
- **New York** has approved medically tailored meals for adults living with severe illness and the Brook+ Diabetes Prevention Program for adults with overweight and prediabetes.[129]
- **Kansas** has authorized medical nutrition therapy and diabetes self-management training.[130]
- **Oregon** offers diabetes self-management programs, including online training and services from the National Diabetes Prevention Program Services.[131]
- **California** uses ILOS 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).[132] Plans can pair these ILOS with behavioral, cooking or nutrition education.[133]
- The **Michigan** Department of Health and Human Services has indicated that its health plans will be encouraged to offer approved ILOS that address enrollees' nutrition needs (including medically tailored meals, healthy home delivered meals, healthy food packs, and produce prescriptions).[134] In March 2024, the state issued a request for information that it will use to refine its ILOS definitions and implementation plan.

States have also issued various guidance documents to help plans and other stakeholders with the implementation of ILOS, including:

1. Lists of ILOS that have been pre-approved by the state (e.g., New York,[135] Oregon,[136] Kansas[137])
2. Procedures and processes for ILOS submission and approval (e.g., Rhode Island,[138] New York,[139] California[140])
3. Mechanisms for tracking and reporting ILOS-related information (e.g., California[141])
4. Billing guidance (e.g., Oregon,[142] California[143])
5. Information on terminating ILOS (e.g., Rhode Island[144])

B. Approval Process

CMS conducts a risk-based process for its review of state-approved ILOS, which occurs as part of the Medicaid managed care rate certification process.[145] Section 1903(m)(2) of Social Security Act and 42 C.F.R. § 438.4 require that capitation rates (i.e., the upfront and set amount, typically per-member per-month rate, that MCOs receive for delivering Medicaid services)[146] be actuarially sound. This means that rates must be calculated to cover anticipated healthcare costs of enrollees and appropriately balance profit and risk. States must consider the utilization and unit costs of ILOS when determining the projected benefit costs of the covered services in rate development.[147] Additionally, capitation rates must be developed in such a way that the medical loss ratio (i.e., the proportion of state payments MCOs spend on clinical services and quality improvement versus administrative costs and profits) is at least 85%.[148] CMS has the authority to deny approval for an ILOS if it does not meet the requirements outlined in the previous section, including medically appropriateness and cost effectiveness.[149]

The documentation required of states will vary based on a state's ILOS Cost Percentage.[150] States must annually submit a projected ILOS Cost Percentage to CMS, as part of the rate certification documentation process.[151] No later than 2 years after the completion of the contract year that includes the ILOS, states must submit an actuarial report with a final ILOS Cost Percentage and the actual managed care plan costs for delivering ILOS. States must also submit monitoring information to CMS including an actuarial report, a notice of termination of ILOS (if applicable), and an audit effort. States with an ILOS Cost Percentage above 1.5% must conduct a retrospective evaluation of ILOS.[152]

Some states also conduct their own evaluation of interventions provided by ILOS. For example, New Hampshire requires plans using ILOS to provide annual updates highlighting the use and expenditures of ILOS to show cost effectiveness within a given year.[153] In Oregon, plans must monitor efficacy of ILOS by tracking their uptake.[154]

ILOS offers several unique advantages as compared to other coverage pathways. By addressing diet-related conditions and reducing hospitalization costs, nutrition services provided as ILOS can generate a good return on investment. At the same time, ILOS offers flexibility by allowing states to determine which services they would like to authorize as ILOS and by allowing MCOs to decide whether to offer the authorized services. ILOS also has a quicker process for approval than other Medicaid pathways. Finally, the costs of ILOS are included in MCO capitation rates and MCO medical-loss ratio numerators, creating financial benefits for plans.[155]

C. Additional Medicaid Managed Care Pathways

In addition to ILOS, other Medicaid managed care pathways, such as value-added services and contracting, can be used to integrate medically tailored meals and other nutrition services into Medicaid managed care.

a. Value-Added Services

MCOs can voluntarily choose to offer services that the state plan does not cover, termed value-added services.[156] Unlike ILOS, these services do not need to be state approved as medically appropriate or cost-effective substitutes for existing covered services. Many plans voluntarily offer value-added services.

IV. Medicaid Managed Care: In Lieu of Services (ILOS)

Implementation Examples:

Oklahoma plans offer several value-added services, including 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).[157]

Unlike ILOS, the costs of value-added services are not included in MCO capitation rates,[158] which may reduce plans' incentive to provide these services. However, value-added services can count towards the MCO's medical loss ratio (MLR) numerator as long as the services meet the definition of "activities that improve healthcare quality" as defined at 45 C.F.R. § 158.150.[159] Services meet this definition if they are evidenced-based and improve health quality to the individual or population in a way that is measurable.[160]

States can incorporate provisions into their Medicaid managed care scope of work or contracts to encourage MCOs to adopt value-added services.

Implementation Examples:

Hawaii required MCOs to develop a work plan outlining how they will provide value-added services to address the SDOH of their enrollees.[161]

Nevada's scope of work encouraged the use of care coordination with community health workers as a value-added service.[162]

b. Contracting

States have flexibility in structuring and developing managed care contracts,[163] which provides the opportunity for states to incorporate specific provisions to address food and nutrition into these agreements. These terms may include requirements for plans to screen enrollees for nutrition security, establish partnerships with community organizations, and reinvest profits in the community.

Implementation Examples:

Texas' MCO scope of work for its Medicaid managed care program for adults who have disabilities or are age 65 or older requires 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.[164]

Oklahoma's Medicaid MCO request for proposals required prospective plans to describe how they would support services addressing the SDOH and to provide examples of innovative policies they undertook to address the SDOH.[165]

V. CHIP Health Services Intiatives (HSI)

Children's Health Insurance Program (CHIP) health services initiatives (HSIs) are activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children.[166] An HSI must directly improve the health of low-income children aged 19 and below who are eligible for CHIP and/or Medicaid, however, it may serve children regardless of income.[167]

PATHWAY SUMMARY CHIP Health Services Initiatives	
Nutrition Services Allowed	1. Case Management - *Not Previously Approved* 2. Nutrition Counseling 3. Meals or Pantry Stocking – *Not Previously Approved* 4. Nutrition Prescriptions – *Not Previously Approved* 5. Grocery Provisions – *Not Previously Approved*
Populations Reached	Must benefit low-income children aged 19 and below who are eligible for CHIP and/or Medicaid but may serve children regardless of income
Initial Approval Period	One time approval
Fiscal Requirements	Funding Cap (included in the CHIP 10% administrative funding cap)

A. Law and Policy

Under HSI authority, states are permitted to provide direct services and develop public health initiatives.[168] States are granted wide flexibility in designing CHIP HSIs.[169] CMS has encouraged states to consider the Medicaid and CHIP Children's Health Care Quality Measures[170] data when determining which needs to address via HSIs. For example, data from measures addressing maternal and perinatal health can help states develop responsive HSIs.

Implementation Examples:

Illinois' Postpartum Services HSI allows the state to cover the costs of uncompensated postpartum care for mothers of Medicaid-eligible newborns and provides services during the twelve-month postpartum period for women who are ineligible for Medicaid for non-financial reasons.[171]

States have traditionally implemented HSIs to address an ongoing need for the community or acute public health issues for specific populations.[172] While apart from nutrition counseling, none of the nutrition services addressed in CMS's November 2023 guidance have been previously approved under CHIP HSI authority,[173] these and other nutrition interventions could be approved in the future.

V. CHIP Health Services Initiatives (HSI)

B. Application and Approval Process

States must submit a CHIP State Plan Amendment to CMS to request implementation of an HSI.[174] The submission must include a detailed description of the HSI program; the populations served by the HSI, including the proportion of low-income children served; and how the HSI aims to improve the health of children.[175] States may use part of their annual allotments and receive the federal CHIP matching rate for expenditures associated with HSIs, subject to the CHIP 10 percent administrative cap. This means states may use up to 10 percent of total CHIP spending for HSIs and other allowable activities (such as outreach), after covering CHIP state plan administrative expenses.[176] States are required to submit annual reports to CMS that include the number of children served by HSIs, other population demographics, and state-defined metrics for measuring each HSI's effect on the health of low-income children and the corresponding outcomes.[177] CMS provides additional information regarding the application process for HSIs via an FAQ on the CHIP Financing section of Medicaid.gov.

Implementation Examples:

New York's Hunger Prevention and Nutrition Assistance Program HSI provides emergency food relief and nutrition services to food-insecure children under the age of 18.[178] For FY 2017, the program served around 9,407,669 children, improving the nutrition and health status of low-income children at risk for nutrition-related diseases.

One of **Massachusetts**' HSIs helps to support a School Breakfast Program under which the state provides students in kindergarten through 12th grade in qualifying schools with nutritious breakfasts on school days and during summer vacation.[179] In FY 2018, 167,206 students received nutritious breakfast. Another Massachusetts's HSI provides the same services as the federally funded WIC program to pregnant women and mothers with children under age 5 who are enrolled in the state-funded WIC program.[180] The program uses peer counseling and professional medical staff to provide breastfeeding support, dietary assessments, nutrition education and counseling, immunization screening, and referrals to other health and social services.

VI. Considerations

Lessons from long-standing FIM programs, as well as from stakeholders implementing large-scale projects like HCBS programs and HRSN 1115 demonstrations, show that in order to be successful, programs seeking to address nutrition in Medicaid must be reflective of the clinical and practical experiences of service delivery and utilization. In particular, common implementation challenges often arise in the areas of **(1) state fiscal considerations, (2) program criteria, (3) healthcare infrastructure coordination, and (4) service delivery**. This section therefore briefly details these cross-cutting considerations and potential approaches to addressing them.

Several of the recommendations in this section are drawn from feedback regarding section 1115 demonstrations piloting nutrition interventions delivered to CMS in April 2023 by CHLPI, FIMC, and other experts in research, law, and implementation of Medicaid and other healthcare food and nutrition policies. This feedback was informed by a survey of on-the-ground implementers, participants, and evaluators of these demonstrations. [181] Overall, to ensure patient access to services, return on investment, and general chances of success, program design—under any of the pathways described in this Toolkit—should strive to reflect these realities on the ground.

A. State Fiscal Considerations

a. Cost of Care Estimates

Recent policy changes have striven to make many of the most difficult fiscal requirements of complying with various payment authorities more manageable (e.g., flexibilities for budget neutrality under 1115 authority).[182] Despite these changes, states determining whether to submit an 1115 demonstration application, HCBS application, approve an ILOS, or otherwise take action to allow Medicaid coverage of nutrition services still must typically estimate the current cost of care for target populations and possible return on investment for proposed new or expanded Medicaid services. To help with these policy decisions, several states have developed analyses using their existing Medicaid data.

Implementation Examples:

Alaska examined the prevalence of six diet-related chronic conditions in its Medicaid population via Medicaid claims data – cancer, cardiovascular disease, diabetes, obesity, renal disease, and stroke – and compared average Medicaid spending on these populations to Medicaid populations with one or more non-diet-related chronic condition (in FY2023, average spending for Medicaid beneficiaries with at least one diet-sensitive chronic condition was $28,667 compared with $21,914 for recipients with one or more chronic conditions that did not include a diet-sensitive condition).[183] Through this process, Alaska was better able to understand the cost of diet-related disease for the state as well as the potential impact of improving access to nutrition services.

b. Capitation Rates

States and other stakeholders may also weigh the financial implications of each potential pathway on capitation rates (i.e., the upfront, set amount paid to healthcare providers or MCOs to cover the predicted cost of all or some of the healthcare services for a specific patient over a certain period of time).[184] Each pathway can have a different effect on these payments and states can also thoughtfully design policy to account for various capitation considerations.

VI. Considerations

States can adjust capitation rates via waivers or MCO contracting to account for social risk factors in a way that provides incentives for providers, programs, and MCOs to address the social needs of patients.[185] For example, states can 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, states can increase incentives for plans to serve this population and increase the feasibility of implementing food and nutrition interventions.

Implementation Examples:

Minnesota has adjusted population-based payments to accountable care organizations (ACOs) to account for social risk factors such as homelessness, substance use disorder, and past incarceration.[186] 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.

Likewise, states developing actuarially sound capitation rates for ILOS should consider that although ILOS are cost-effective substitutes for state plan-covered services, they often involve up-front costs to prevent the need for future expenses. In other words, some ILOS may not produce returns on investment immediately. In the first year of implementation of ILOS, there may be little data on which to base utilization and cost determinations. States can take these factors into account to ensure that rates adequately support the projected costs of providing ILOS, particularly in the first years of implementation. Doing so can incentivize plans to adopt ILOS and help to ensure program sustainability and adequate reach to intended beneficiaries. While states cannot require MCOs to implement ILOS, incentivizing plans to adopt the services can help ensure services are offered to Medicaid enrollees statewide.

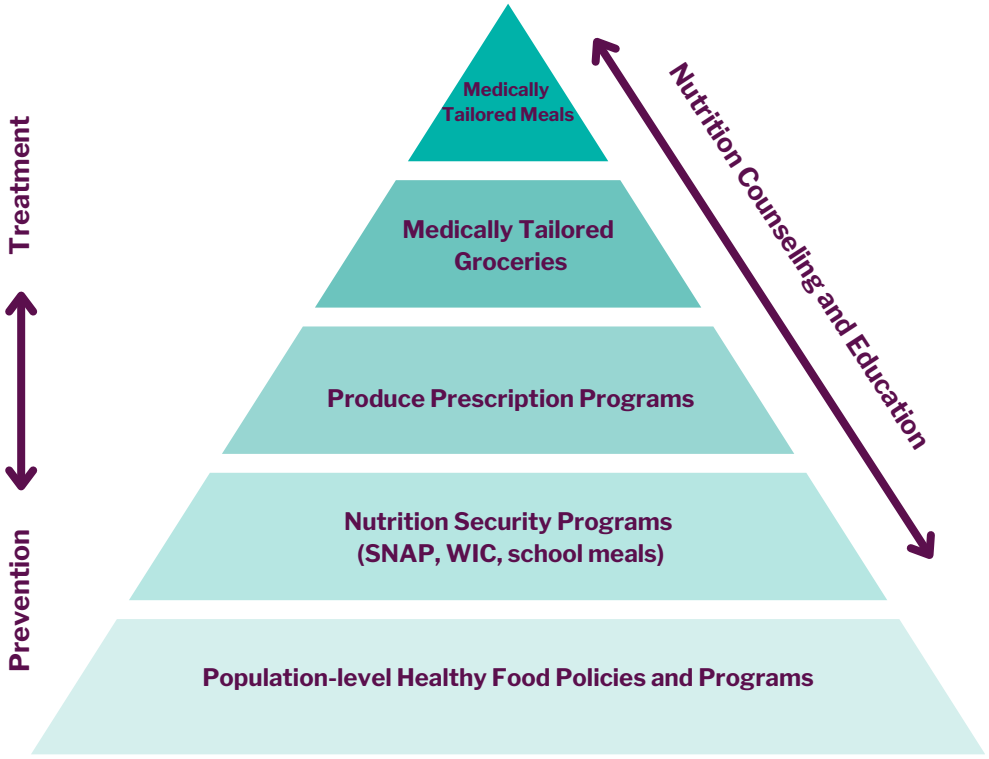
Implementation Examples:

To increase incentives for MCOs to adopt ILOS, **Michigan**'s Governor has proposed a $10 million ILOS incentive pool, which would be made available to Medicaid health plans to improve food security for enrollees with diet-related chronic health conditions.[187] These types of incentives can also assist MCOs and stakeholders with the year-one and initial start-up costs associated with some preventive interventions that may not see returns on investment immediately.

B. Program Criteria

a. Service Definitions

States developing nutrition programs will need to implement these supports through an understanding of the context in which FIM services are provided. While all FIM interventions consist of healthy foods that are tailored to meet the needs of individuals living with or at risk for serious diet-related health conditions, each allowable service varies in scope, purpose, and format. The FIM pyramid provides one way of describing this spectrum of services—ranging from medically tailored meals for the most intensive/acute health needs to medically tailored groceries and produce prescriptions for individuals with diet-related conditions who are still able to shop and cook for themselves. These services then rest on the foundation of broader policies and programs that exist outside of the healthcare system, such as SNAP and population-level healthy food policies, which serve as the basis for society-wide access to healthy foods.



Source: Adapted from Dariush Mozaffarian et al., A Food is Medicine approach to achieve nutrition security and improve health, 28 Nature Medicine 2238 (Nov. 2022), https://doi.org/10.1038/s41591-022-02027-3

As states implement the pathways described in this Toolkit, it is critical to establish and maintain clear definitions for the FIM services provided. Doing so can help to ensure that medically appropriate interventions are reaching the correct beneficiaries and that policies regarding payment and evaluation accurately reflect the differences between interventions.

VI. Considerations

The following chart provides definitions developed by national entities experienced in providing FIM services:

Nutrition Service	Defintiion
Medically Tailored Meals (MTMs) [188]	The MTM intervention is the comprehensive process of delivering MTMs to individuals of all ages living with severe, complex or chronic illness(es), and often living with activities of daily living (ADLs) limitations. Clients are referred to an MTM agency with the involvement of healthcare personnel. An intake and eligibility assessment are conducted as well as a nutrition risk assessment, if appropriate. Then the client goes through a nutrition assessment with a Registered Dietitian Nutritionist (RDN) and a meal and care plan is tailored for the specific medical circumstances of the client. Meals are prepared by the agency and home-delivered, shipped or available for pick-up for the client and the client is reassessed for eligibility and nutrition need at regular intervals. The client experiences the ongoing Nutrition Care Process (NCP), including nutrition education/counseling, medical nutrition therapy if indicated, and reassessment of their needs throughout the course of their intervention. Recently, the Food Is Medicine Coalition – the national coalition of nonprofits that created the medically tailored meal (MTM) intervention – released the first-ever standard for MTMs, which contains recommended service density, duration and nutrition standards for the intervention.[189]
Medically Tailored Groceries (MTGs)[190]	MTGs include distributions of unprepared or lightly processed foods that recipients are meant to prepare for consumption at home; the contents are sufficient to prepare nutritionally complete meals or provide a significant portion of the ingredients for such meals, including produce, whole grains and legumes, and lean proteins. Food items are approved by an RDN as appropriate for certain medical diets and health conditions, such as a diabetes-appropriate food box. Recipients should have access to nutrition counseling and education as well as medical nutrition therapy, if indicated.
Produce Prescription Programs [191]	A medical treatment or preventative service for eligible patients due to diet-related health risks or conditions, food insecurity, or other documented challenges in access to nutritious foods. Patients are referred by a healthcare provider or health insurance plan. These prescriptions are fulfilled through a food retail location or direct delivery and enable patients to access healthy produce with no added fats, sugars, or salt, at low or no cost to the patient.

Using specific definitions such as these can help to promote clarity within program policies. For example, many states and plans have historically provided coverage of "home-delivered meals" (e.g., as part of HCBS services). However, not all home-delivered meals are unique to a patient's dietary needs or tailored to their medical condition. As a result, use of this broad category to describe all meals blurs the distinctions between medically tailored meals and other meals—distinctions which may be critical to patient eligibility, evaluation outcomes and accurate reimbursement rates. In some cases, states are beginning to apply more specific definitions to reflect these distinctions.

Implementation Examples:

Massachusetts has proposed to distinguish between 'medically tailored meals' and 'nutritionally appropriate home delivered meals,' as well as between 'medically tailored food boxes' and 'nutritionally appropriate food boxes,' primarily on the basis of the intended recipients.[192]

California uses the terms 'medically tailored' and 'medically-supportive' to distinguish between these categories.[193] Such differences in terminology, when paired with clear definitions, standards, and rates, can help with service targeting and ensure that program evaluations reflect the impact of each individual service provided.

b. Eligibility Criteria

In the April 2023 survey of on-the-ground implementers, participants and evaluators of 1115 demonstrations (described above), respondents identified eligibility criteria for FIM services as a top regulatory barrier to uptake of nutrition interventions.[194] Specifically, respondents noted that complex and conflicting eligibility criteria and processes presented a barrier to participant access. Moreover, respondents noted that, in some cases, eligibility criteria varied by geography or MCO, creating disparities in access across a single state. When designing eligibility criteria, states should keep these issues in mind and be careful to appropriately balance flexibility with consistency and access. In doing so, states can better ensure that eligibility is not so cumbersome as to exclude beneficiaries, making it challenging to generate referrals for nutrition services as well as generate and evaluate cost-savings and effectiveness.

Similarly, many respondents warned against imposing strict time limits on service eligibility. When CMS initially announced its framework for HRSN 1115 demonstrations, it indicated that eligibility for services would be limited to 6 months.[195] Respondents noted that a 6-month duration may be sufficient for many patient populations, but based on clinical evidence and experience, some diagnoses (e.g., high-risk pregnancy) and/or individual patients may require longer treatment. Further, they noted that such time limits conflict with current research[196] and create the risk for reduced impact on health outcomes and healthcare costs. CMS therefore clarified in its November 2023 guidance that while services such as home delivered meals, nutrition prescriptions, and grocery provisions should initially be provided for up to 6 months, interventions may be renewed for additional 6-month periods if the beneficiary continues to meet eligibility criteria.[197] Notably, CMS applied no such duration guidance to the other policy pathways in the guidance. However, these same concerns and principles apply. Across all policy pathways, states should seek to give healthcare providers the flexibility to apply their clinical judgment regarding the duration of services most appropriate each patient's treatment plan.

c. Evaluation

As discussed in **Sections II-V** above, CMS requires some type of evaluation under Medicaid section 1115, HCBS sections 1915(c) and (i), ILOS, and CHIP HSI pathways:

CMS EVALUATION REQUIREMENTS	
Section 1115	**Independent evaluation required:** states must submit an evaluation design plan to CMS within 30 days of CMS approval of the demonstration. The plan must include qualitative research designs, measures to protect beneficiary privacy and reduce burdens, hypothesis and progress monitoring, prospective data and collection methods, and an explanation of how the state will address confounding factors in assessing implementation.[198]
HCBS Section 1915(c)	**Evidence-based review required for renewal:** states submit evidence-based review to CMS about two years before the waiver is set to expire.[199] Among other requirements, the state must demonstrate that the waiver has been cost-neutral and provide information on the quality of services.[200]
HCBS Section 1915(i)	**Evidence-based review required**: 39 months after the SPA effective date, states must begin the evidence-based review process.[201] States have noted that section 1915(i) reporting and evaluation requirements are ambiguous given lack of technical guidance.[202]
ILOS	**Actuarial report required, retrospective evaluation may be required:** states must submit an actuarial report with a final ILOS cost percentage and the actual managed care plan costs for delivering ILOS within 2 years of the contract year that includes the ILOS. States with an ILOS cost percentage above 1.5% must conduct a retrospective evaluation.[203]
CHIP HSI	**Annual reporting required:** states must report on outcomes of each HSI's effect on the health of low-income children as measured by state-defined metrics in annual CHIP reporting.[204]

VI. Considerations

Nutrition interventions have a strong evidence base, with great potential to address nutrition insecurity, chronic illness, and high healthcare costs and utilization at scale.[205] States and stakeholders should ensure robust and appropriate evaluation of programs in order to yield significant and actionable information. While many statewide demonstrations are fairly new, CMS guidance, along with teachings from early implementation states, can be instructive for states developing evaluation plans. Additionally, several initiatives—led by the Department of Health and Human Services (HHS) and the American Heart Association—are currently underway to develop common metrics for FIM research, which may be useful to states in developing evaluation and reporting plans specific to evaluation of nutrition services. Similarly, the above service definition and eligibility criteria best practices are critical for effective evaluation of FIM interventions.

For example, CMS conducts robust federal reviews to monitor 1115 demonstration impact and implementation.[206] While no full evaluations of HRSN 1115 demonstrations have yet been completed, in December 2022, CMS released a framework in which it clarified that evaluations should test whether HRSN services (1) effectively address unmet HRSN, (2) reduce potentially avoidable, high-cost services, and (3) improve beneficiaries' physical and mental health outcomes.[207] States must also submit reporting on HRSN-specific metrics including (1) service implementation, (2) service utilization, (3) quality of services, (4) health outcomes for individuals receiving HRSN services, and (5) CMS health equity metrics, stratified where possible by language, geography, disability status, sexual orientation, and/or gender identity.[208] Moreover, CMS has published a suite of evaluation resources online, including a guide to building an outline for the design plan, best practices for making causal inferences, and recommendations for implementation research.[209]

States can also refer to evaluation design plans and interim evaluations from other states such as California, Massachusetts, and North Carolina for guidance.[210] These evaluation plans follow best practices[211] such as emphasizing both qualitative and quantitative measures, assessing metrics beyond cost and utilization, and evaluating infrastructure implementation. A key challenge to accurate evaluation is connecting the various data systems involved in service delivery, which is fully discussed in the next section and should be one of the primary considerations in planning.

Implementation Examples:

North Carolina's evaluation design plan, approved in early 2020, relies on a wide range of qualitative and quantitative measures to evaluate (1) health outcomes, (2) utilization, and (3) costs.[212] To assess strengths and weaknesses of early implementation, North Carolina relies on mixed-methods qualitative evaluation which incorporates claims, surveys, and perspectives from primary care providers, state health agency officials, and health plans. In April 2024, North Carolina submitted its Interim Evaluation Report, covering roughly the first 19 months of service implementation.[213] Of the outcomes that were measurable at the time, the Report found that (1) participation in the pilot reduced enrollees' total number of social needs, (2) participation was associated with decreased emergency department utilization by an estimated 6 emergency department visits per 1000 member months and reduced inpatient hospitalizations for non-pregnant adults by 2 admissions per month per 1000 beneficiaries, and (3) estimated service spending (spending for medical care and pilot services) was on average $85 dollars less per pilot participant per month and longer pilot participation was associated with greater reductions in direct service spending.[214]

Implementation Examples continued:

Approved in January 2024, **Massachusetts**' Evaluation Design Plan similarly includes a wide range of data sources and metrics such as food insecurity and self-reported health status, HbA1c and blood pressure, and detailed information on program type (medically tailored meal, produce prescription, etc.).[215] Other strengths of the plan include its mixed methods approach and a comparison group of members who did not receive covered services. Massachusetts developed these features based, in part, on lessons learned from its first design plan submitted in 2018. The design plan also includes several research questions and hypotheses specifically designed to assess implementation. For example, one research question asks "[w]hat actions did MassHealth and Key Stakeholders take to implement, operate, integrate, and coordinate HRSN initiatives?" [216]

C. Healthcare Infrastructure Coordination

A common goal of Medicaid/CHIP nutrition policies is for providers to be able to sustain delivery of high value services over the long term. Often, this requires nontraditional healthcare providers, such as community-based organizations (CBOs), to coordinate with healthcare infrastructure and develop related technical competencies. These organizations may have deep expertise delivering services, such as medically tailored meals and produce prescriptions, in their communities and states, but may have little experience with service delivery in the healthcare system. Service provider coordination with healthcare infrastructure has proven particularly difficult with respect to **referral communication, privacy and data requirements, and coding, billing, and reimbursement**. These barriers can exacerbate existing inequalities in service access, as obstacles are more difficult to overcome in rural and underfunded communities and/or where local CBOs respond to otherwise unmet needs. However, states designing and implementing programs can take several steps to address these concerns, including strategically utilizing available **funding** to support infrastructure and service delivery.

a. Infrastructure Funding

Critical to addressing patient nutrition needs is the collaboration of a variety of stakeholders to build the capacity to administer new or expanded services.[217] Integrating new entities—such as the CBOs that have historically provided FIM interventions in their communities—into the Medicaid system represents a major operational shift that requires changes for all parties in the ecosystem. To successfully navigate this change, states will need to prioritize providing support—in the form of funding, guidance, and supportive structures—to ensure that these new entities can effectively share data; coordinate with agencies, MCOs, and healthcare providers; and deliver care.

The availability of infrastructure funding with federal match is a unique feature of HRSN section 1115 demonstrations that can help support those goals. This funding helps facilitate implementation of services by providing states, MCOs, healthcare providers, and other stakeholders with critical resources beyond reimbursement for service provision. This support can be particularly critical to integrating new partners into Medicaid delivery and financing. CMS permits infrastructure investment in four areas: (1) technology, (2) business development, (3) workforce development, and (4) outreach, education, and stakeholder convening.[218] CMS enables broad flexibility for states in allocating, investing, and distributing these infrastructure and capacity-building funds.

Implementation Examples:

Infrastructure funding has proved to be an asset for states implementing HRSN 1115 demonstrations:

- In 2018, **North Carolina** received approval for $100 million in capacity building funds for its Healthy Opportunities Pilots, which the state has used for a statewide referral platform through its "211" system, as well as for food banks, meal delivery services, and other community-based meal programs to build capacity to deliver services under the pilots.[219]
- **Massachusetts** received authorization to use infrastructure funding for the establishment of a Social Service Organization (SSO) Preparation Fund (reapproved as the SSO Integration Fund in its waiver extension).
- **California** was approved for $1.85 billion to fund capacity building and technical support for community providers.[220]

While no other Medicaid/CHIP pathways offer federal match funds for infrastructure or capacity building, additional funding such as grants from agencies like the United States Department of Agriculture (USDA) and the Centers for Disease Control and Prevention (CDC), as well as private contributions, can support similar activities.

Implementation Examples:

The **USDA Gus Schumacher Nutrition Incentive Program** (GusNIP) provides grants to state and local agencies and organizations that aim to improve access to fresh fruits and vegetables for low-income consumers. This includes grants to support programs such as the Nutrition Incentive Program, which encourages the purchase of fruits and vegetables by providing incentives at the point of sale, and the Produce Prescription Program, which funds projects demonstrating the impact of prescribing fresh fruits and vegetables on dietary health, food insecurity, and healthcare costs.[221]

The **CDC** funds states to implement evidence-based strategies aimed at improving nutrition, physical activity, and obesity under its State Physical Activity and Nutrition (SPAN) grants. The agency funded 17 states under this program for 2023-28.[222]

b. Referral Communication

Ensuring communication across the entities coordinating and delivering HRSN services can present obstacles to program implementation. Varying institutional norms and cultures, distinct business practices, and reliance on different technologies can delay service at any number of points in the delivery chain: patient referral, diagnosis and eligibility determinations, treatment authorization, treatment reauthorization and resolution, through to claims and reimbursement. Ineffective and inefficient infrastructure can also alienate important stakeholders, such as the CBOs that have historically provided FIM services.

VI. Considerations

In the April 2023 survey (described above), respondents across states with section 1115 demonstrations identified referral infrastructure (i.e., the communication of patient information between stakeholders for the purposes of service delivery) as a top barrier to successful implementation.[223] Respondents urged states to focus on integrating, rather than removing, CBOs from the healthcare delivery system to promote continuity in the administration and delivery of services.[224] States can release guidance to support the successful integration of CBOs. For example, states can issue standard clauses for provider contracts;[225] model contracts for health plans, CBO network leads, and CBOs;[226] and guidance clarifying credentialing requirements, data sharing standards, and billing and invoicing procedures.[227]

Implementation Examples:

In **California**, several CBOs and MCOs have integrated their practices to successfully communicate referrals. Medically tailored meal providers, Project Angel Food and Project Open Hand, have standardized application forms available on their websites for their services offered under the state's section 1115/1915(b) demonstration.[228] Project Open Hand applicants that are members of Contra Costa Health Plan can submit their application directly through the plan's provider portal, available through a link on Project Open Hand's website. This sort of referral infrastructure has helped integrate the CBOs into the state's Medicaid system.[229] This integration was made possible through flexibility and an open line of communication between the CBOs and partnering MCOs as well as infrastructure funding through the state's 1115 demonstration.

Infrastructure hubs are another possible solution to referral and coordination challenges. Also known as networked service delivery systems, infrastructure hubs typically constitute coalitions of governmental and non-governmental organizations that can help organizations delivering HRSN services by centralizing administrative functions and operational infrastructure, such as by coordinating contracting, service delivery, managing referrals and payment, sharing data, ensuring compliance with regulatory standards, and incorporating a diverse array of perspectives in establishing local community goals.[230] Hubs have proliferated across states to support service delivery for HRSN 1115 demonstrations.[231]

Implementation Examples:

As part of its section 1115 demonstration, **North Carolina**'s Healthy Opportunities Pilots (HOPs), includes three regional hubs across the state called "Network Leads" that develop, coordinate, and oversee a network of CBOs that deliver HRSN services.[232] Network Leads contract with Medicaid MCOs, support CBOs with capacity building funds, and assist CBOs with payment, invoicing, and technical support. HOPs also includes a third-party statewide resource and referral platform, NCCARE360, which enables healthcare providers and insurers to electronically identify and refer patients to CBOs.[233] Notably, though, in recent evaluations of the program, North Carolina reported some initial challenges with operating NCCARE360 (e.g., a need to make the site more user friendly to improve efficiency).[234]

New York's 1115 demonstration similarly establishes regional hubs, known as Social Care Networks (SCN) to coordinate screening, referral, and delivery of HRSN services.[235] Unlike HOPs, SCNs are not accompanied by a statewide referral platform but will utilize the state's existing heath electronic information exchange, Statewide Health Information Network for New York (SHIN-NY).[236]

Outside of state-established hubs, organizations have formed CBO Networks, which generally constitute contracted organizations led by a network lead entity (NLE) that contracts with a healthcare organization(s) on behalf of a group of CBOs. By shouldering the burden of contracting, the NLE helps to coordinate services, increase efficiency, ensure uniform service delivery, and provide administrative oversight of CBOs within the Network. In doing so, the NLE can make it possible for smaller CBOs that may provide critical services in a community to enter into the healthcare ecosystem without having to build all necessary administrative capacity internally.

Implementation Examples:

In **Oregon**, a local organization, Project Access NOW (PANOW), coordinates a network of CBOs to connect patients who are transitioning out of hospitals with HRSN services.[237] PANOW's program is operated with the support of six local hospital systems and two Coordinated Care Organizations, in partnership with over 200 CBOs. PANOW also collaborated with a software company to develop a customizable digital screening portal which supports patient screening, direct entry of service requests, data collection and reporting, utilization tracking, and information sharing across providers. The program, which is funded through transaction and administrative fees, helps save an estimated $2.78 million in hospital stays each year.[238]

Ultimately, whether stakeholders view hubs and statewide referral platforms as a "help or hindrance" depends on their "design and implementation,"[239] suggesting that thoughtfully crafted and carefully implemented hubs and referral platforms can overcome referral infrastructure challenges.

c. Patient Privacy and Data Security Compliance

While healthcare is one of the most regulated sectors in the country, there is little tailored guidance for community partners concerning compliance with patient privacy and data security requirements, such as HIPAA.[240] This often leads to inefficient, costly, and repeated investments in legal and other compliance support needed to establish infrastructure across various partnerships. Additionally, HIPAA-covered entities often refrain from sharing pertinent information with CBOs or impose barriers to sharing information (such as requiring a business associate agreement where a business associate relationship does not exist). As a result, meaningful CBO-healthcare partnerships are regularly stymied. States can assist nontraditional healthcare providers in coordinating with healthcare by advocating for federal clarification and guidance regarding the application of federal laws to community partners providing services to Medicaid beneficiaries.[241] At the state level, agencies can issue guidance explaining how community providers can communicate and receive patient information while complying with state and federal privacy laws, and/or design consent and authorization mechanisms that comply with these requirements.[242]

d. Coding, Billing, and Reimbursement

Coordination between community service providers and healthcare to effectuate service reimbursement, particularly coding and billing of services, has also been a challenge in many Medicaid nutrition programs. Complicated billing codes and reimbursement processes threaten the timely delivery of services and payments. States and other stakeholders can and have taken several steps to address these challenges, such as collaborating with and supporting efforts in the field to establish medical billing and coding infrastructure that accurately describes Food is Medicine interventions in clinical care. One project, Coding4Food, is a community-informed effort working with the Gravity Project to create Healthcare Common Procedural Coding System (HCPCS) codes for a range of nutrition interventions, beginning with medically tailored meals, medically tailored groceries, and produce prescriptions.[243] States have also created on-ramps for community providers to establish claims and billing competency. For example, California allows CBOs to invoice, rather than requiring integrated claims billing in its 1115/1915(b) HRSN demonstration.[244] Several MCO-CBO partnerships have noted that this policy has allowed for successful initial operationalization of the program, with partners moving towards integrated billing once the program is more established.[245] While coding and billing for HRSN services is an evolving area of Medicaid reimbursement policy, it is critical to prioritize this mechanism in any program that includes coverage of nutrition interventions to allow for minimal administrative waste and timely reimbursement for service delivery.

D. Service Delivery

Successful delivery of HRSN services through Medicaid requires coordination with trusted and experienced service providers. Often, these providers are nonprofit, community partners who have been embedded in their communities for years and whose partnership can offer many advantages to Medicaid members and stakeholders.[246] For example, the medically tailored meal intervention began as a community response to hunger and illness, and provision of this lifesaving service continues to be provided by many nonprofit organizations that are deeply rooted in and responsive to their communities.[247] FIMC agencies – which make up many of the nonprofit medically tailored meal providers in the country – maintain nutrition standards for the intervention,[248] using high quality ingredients and tailoring diets to the needs of each community member with severe, complex and/or chronic illnesses. These organizations are embedded in the local healthcare ecosystem, with long-term relationships to community health centers and other healthcare providers, enabling coordination of care for members. Through volunteerism, donations, community co-design of culturally competent programs and the creation of value to local economies, CBOs remain tied to the needs of neighborhoods, responsive to them, and most importantly, trusted.

States and stakeholders can design programs to foster successful partnerships with experienced community providers through various pathways, such as commitments in waiver documents, directives in policy guidance, requirements in procurement/contracting, and design of service reimbursement rates. These mechanisms can also be used to support other priorities of the state, such as local/regional agriculture or food systems.

VI. Considerations

Implementation Examples:

In its request to renew its 1115 demonstration to include nutrition supports, **Hawaii** emphasizes that the state will encourage the inclusion of local growers and community-based organizations to bolster the purchase of locally grown food to strengthen the state's food system.[249]

States also encourage the prioritization of contracting with local CBOs through policy guidance. In its 1115 demonstration implementation guidance, **Massachusetts** encourages Accountable Care Organizations (ACOs) to strategically partner with CBOs that "leverage existing community-based expertise and capacity."[250] Although ACOs have autonomy in selecting entities to deliver HRSN services, they are required to consider an organization's experience and success in serving target populations as well as the organization's cultural competency, among other factors.[251]

In its demonstration, **California** has encouraged MCOs to contract with "nontraditional" providers that offer services which have historically suffered from poor integration into the healthcare delivery system, such as nutrition services.[252]

Procurement can also serve as a valuable tool to further state values. In connection with its recent MCO procurement process, **Michigan** released a request for information that sought public input on proposed definitions for nutrition ILOS 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."[253]

Kansas' procurement scope of work for MCOs requires plans that contract with the state to partner with community-based organizations and provide service coordination that addresses social determinants of health, including nutrition.[254]

Finally, states can ensure that service reimbursement rates are adequate for providers to deliver quality services to beneficiaries. In the April 2023 implementation survey (described above), respondents identified service payment and reimbursement rates as a top barrier to successful provision of nutrition services in 1115 demonstrations.[255] In California, respondents reported that the state's initial rate guidance for medically tailored meals was developed without adequate consultation of California medically tailored meal providers and instead relied on outside sources (e.g., fee schedules for other states and other sources). This process led to rates which failed to reflect the relevant treatment and cost of living. Respondents also highlighted that rates were insufficient to cover efforts to provide services in rural geographies where providers are looking to fill unmet needs. To avoid similar challenges, states developing rate guidance should do so in consultation with relevant service providers and ensure it is reflective of the state and local cost of living. Additionally, rate guidance can allow for increased rates for rural areas and local providers seeking to address expanded geographies, populations, or other unmet needs, or offering higher quality or locally sourced/produced services in line with the state's priorities.

VII. Conclusion

Incorporating Food is Medicine interventions into healthcare delivery and financing can be an effective strategy to combat the costly consequences of diet-related disease. Thanks to recent guidance and regulations from CMS, states have more options than ever to pursue policy pathways to make access to Food is Medicine services a reality for the Medicaid and CHIP beneficiaries who need them most. However, state approaches will be highly dependent on their individual policy landscapes, infrastructure, and health profiles. This Toolkit therefore strives to provide a starting point for states as they each begin to chart their individual course to Food is Medicine coverage. If you would like to learn more about the interventions or policies described in this Toolkit, please visit www.fimcoalition.org and www.healthlawlab.org.

Appendix 1: Summary of Policy Pathways

last updated: July 2024

	PATHWAY SUMMARY	PATHWAY SUMMARY		PATHWAY SUMMARY	PATHWAY SUMMARY
	Section 1115 Health-Related Social Need Demonstrations	**Home and Community-Based Services Authorities**		**In Lieu of Services**	**CHIP Health Services Initiatives**
		Section 1915(c) Home and Community-Based Waivers	Section 1915(i) State Plan Home and Community-Based Services Amendments		
Nutrition Services Allowed	1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods 4. Nutrition Prescriptions – up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods 5. Grocery Provisions – up to 3 meals/day for up to 6 months with possibility of renewal for additional six-month periods	1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – up to 2 meals per day or less than a full nutritional regimen 4. Nutrition Prescriptions – up to 2 meals per day or less than a full nutritional regimen 5. Grocery Provisions – up to 2 meals per day or less than a full nutritional regimen		1. Case Management 2. Nutrition Counseling 3. Meals or Pantry Stocking – up to 2 meals per day or less than a full nutritional regimen 4. Nutrition Prescriptions – up to 2 meals per day or less than a full nutritional regimen 5. Grocery Provisions – up to 2 meals per day or less than a full nutritional regimen	1. Case Management – Not Previously Approved 2. Nutrition Counseling 3. Meals or Pantry Stocking – Not Previously Approved 4. Nutrition Prescriptions – Not Previously Approved 5. Grocery Provisions – Not Previously Approved
Populations Reached	Requirements That May Be Waived: • Statewideness • Comparability HRSN services must be medically appropriate according to state-defined clinical and social criteria Beneficiary needs must be documented in care plan or medical record	Requirements That May Be Waived: • Statewideness • Comparability • Community income rules for medically needy population Individuals must meet institutional level of care Benefits provided in accordance with a person-centered plan of care	Requirements That May Be Waived: • Comparability • Community income rules for medically needy population Individuals must meet state-defined needs-based criteria that are less stringent than institutional level of care criteria Benefits provided in accordance with a person-centered plan of care	Requirements That May Be Waived: None Medicaid managed care enrollees only; services are offered at the option of each managed care plan State develops and CMS approves clinically oriented definitions for the target population(s) for which the state has determined each ILOS to be a medically appropriate and cost-effective substitute Healthcare provider must determine and document that the ILOS is medically appropriate for the specific enrollee	Must benefit low-income children aged 19 and below who are eligible for CHIP and/or Medicaid but may serve children regardless of income
Initial Approval Period	5 years	3 years	One-time approval unless targeting, then 5 years	Annual review as part of rate certification	One time approval
Fiscal Requirements	Budget Neutrality with flexibility for HRSN expenditures 3% Spending Cap on Total HRSN (of total state Medicaid spend) 15% Spending Cap on HRSN Infrastructure (of HRSN spend) Primary care, behavioral health, and OB/GYN provider reimbursement rate requirements	Cost Neutrality	None	Cost Effectiveness	Funding Cap (included in the CHIP 10% administrative funding cap)
CMS Evaluation Requirements	Independent evaluation required: states must submit an evaluation design plan to CMS within 30 days of CMS approval of the demonstration. The plan must include qualitative research designs, measures to protect beneficiary privacy and reduce burdens, hypothesis and progress monitoring, prospective data and collection methods, and an explanation of how the state will address confounding factors in assessing implementation.	Evidence-based review required for renewal: states submit evidence-based review to CMS about two years before the waiver is set to expire. Among other requirements, the state must demonstrate that the waiver has been cost-neutral and provide information on the quality of services.	Evidence-based review required: 39 months after the SPA effective date, states must begin the evidence-based review process. States have noted that section 1915(i) reporting and evaluation requirements are ambiguous given lack of technical guidance.	Actuarial report required, retrospective evaluation may be required: states must submit an actuarial report with a final ILOS cost percentage and the actual managed care plan costs for delivering ILOS within 2 years of the contract year that includes the ILOS. States with an ILOS cost percentage above 1.5% must conduct a retrospective evaluation.	Annual reporting required: states must report on outcomes of each HSI's effect on the health of low-income children as measured by state-defined metrics in annual CHIP reporting.

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CENTER *for* HEALTH LAW
and POLICY INNOVATION
HARVARD LAW SCHOOL

chlpi@harvard.law.edu

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info@fimcoalition.org