Starting the Conversation: Nutrition Supports

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- **ATI's Starting the Conversation series offers state policymakers Medicaid innovation ideas alongside top considerations to inform state decision making.**
- In this resource, we highlight provisions of and pose considerations for **nutrition supports.**

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Key Questions

- What are nutrition supports?
- Do nutrition supports make sense for my state?
- What authorities can states use to pursue nutrition supports?
- What challenges should our state be aware of when implementing nutrition supports?

What are nutrition supports?

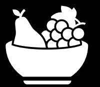
Nutrition supports provide individuals with nutritional knowledge and access to foods. Nutrition supports are intended to mitigate the effects of food insecurity and help manage or prevent diet-related diseases. There are four primary types of services within this benefit category:

→ **Case Management, Screenings, and Referrals.** Screenings for food insecurity and referrals to resources, such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

→ **Nutrition Counseling and Education.** Includes nutritional counseling from a qualified professional and broader education classes to teach food-related skills, such as nutritious cooking, affordable grocery shopping, and other topics.

→ **Food Provisions.** Provides individuals with food supplies through groceries pick-up and delivery programs, pre-made meal delivery and pick-ups, and/or vouchers for individuals to purchase food supplies.

→ **Investment in Infrastructure.** Medicaid funding can be used to strengthen community food infrastructure, including farmer’s markets, public gardens, non-medical transportation to food sources, and more.



2 Do nutrition supports make sense for my state?

Nutrition supports are intended to augment existing food programs (e.g., SNAP) and address persistent gaps in food security. Policymakers considering nutrition supports can explore:

Factors	Key Questions
Magnitude	• How severe are current rates of food insecurity in the state? Are there geographic areas that are disproportionately affected? • What is the magnitude and impact of diet-related chronic diseases among Medicaid beneficiaries (e.g., diabetes)? • To what extent might nutrition supports prevent avoidable utilization of care, such as emergency care?
Populations	• Which populations are most impacted by food insecurity or diet-related health outcomes? • Which health conditions may be most positively impacted by nutrition supports?
Community Perspectives	• How might perspectives differ among key stakeholders (e.g., Medicaid-enrolled individuals, providers, health plans, state legislators, community-based organizations, etc.)?

What authorities can states use to pursue nutrition supports? *(1 of 2)*

Many factors—including the specific services to be provided, the desired populations to be served, and state financial and administrative considerations—influence which Medicaid authority pathways are most appropriate to pursue. However, states use some combination of the following:

State Plan	Sections 1915(c) and 1915(i) HCBS	Section 1115 Demonstration	In Lieu of Services (ILOS)	CHIP Health Services Initiatives (HSIs)
Nutrition counseling is covered through the State Plan. States may need to explore whether updates are required to existing benefit policies to meet the state's intended benefit scope.	Sections 1915(c) and 1915(i) options allow states to cover food provisions and preparation for individuals receiving home- and community-based services (HCBS).	Section 1115 Demonstrations allow states to provide nutrition supports to a broad range of individuals, beyond the scope of benefits and eligibility allowed through other authorities.	ILOS allows states to approve managed care plans to cover otherwise non-covered services as medically appropriate, cost-effective substitutes for services covered under the state plan.	Children's Health Insurance Program (CHIP) HSIs allow states to provide services focused on improving children's health by using a limited amount of unspent CHIP allotment, at the CHIP federal matching rate.
Hawaii. *(Under review)* Will leverage state plan nutrition counseling benefits to complement other nutrition supports via the Section 1115 Demonstration.	**Texas.** Uses 1915(i) authority to provide home-delivered meals for eligible HCBS recipients.	**Massachusetts.** Provides nutrition counseling and education, home-delivered meals, medically-tailored food, and cooking supplies.	**California.** Medi-Cal (Medicaid) plans are allowed to provide medically-tailored meals and medically supportive foods through ILOS.	**New York.** Provides emergency food relief to food-insecure children through its Hunger Prevention Nutrition Assistance Program.

What authorities can states use to pursue nutrition supports? *(2 of 2)*

Each Medicaid authority has varying guidelines and restrictions regarding spending, scope of services, and evaluations. States should consider the following when designing nutrition supports:

Health Related Social Needs (HRSN) Section 1115 Guardrails	ILOS Guardrails	Supplanting Existing Social Services & Funding
▪ Expenditures on HRSN services cannot exceed 3% of total Medicaid spending. ▪ Infrastructure costs cannot exceed 15% of total HRSN spending. ▪ State spending on related social services must be maintained or increased. ▪ States must meet minimum thresholds for or commit to improving provider payment rates.	▪ Must advance the objectives of Medicaid. ▪ Must be cost effective. ▪ Must be medically appropriate. ▪ Must be provided in a manner that preserves enrollee rights and protections. ▪ Must be appropriately monitored and overseen. ▪ Must be subject to retrospective evaluation.	▪ Medicaid-covered services and supports to address access to nutritious foods cannot supplant existing social services and non-Medicaid funded programs, such as SNAP or WIC. ▪ Instead, Medicaid services must complement the scope and financing of existing services.

What challenges might states face when implementing nutrition supports?

States considering nutrition supports should evaluate their own capacity for implementation and oversight. Additionally, states should evaluate gaps in the level of existing community infrastructure required to ensure that individuals can access nutrition benefits (e.g., provider capacity).

Factors	Key Questions
Finances	• Does the State have a source of funding to cover the non-federal share associated with nutrition supports? • Does the State already offer other HRSN services approved through a Section 1115 Demonstration? If so, how much room is under the HRSN expenditure cap based on current HRSN service utilization?
Operations	• How significant is the administrative burden to the State in implementing and managing nutrition supports? • Does the State Medicaid agency have sufficient capacity to apply for and negotiate federal authorities to implement nutrition supports? If not, do resources exist to outsource these efforts?
Infrastructure	• What is the landscape of existing nutrition supports providers in the State? Is there a robust network of community-based organizations operating in this space, or will network capacity be a challenge at launch? • What level of infrastructure updates will be needed for the State, providers, health plans, and community organizations to effectively implement and manage services (e.g., billing, data sharing, referrals, etc.)?

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