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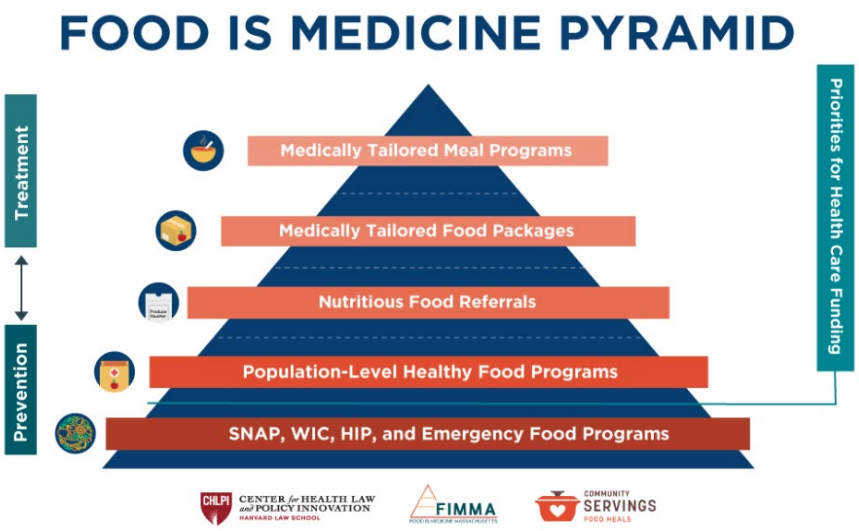
BRIEF

Expanding and Sustaining Food is Medicine in Illinois Using 1115 Waivers

The purpose of this brief is to offer the state of Illinois and Medicaid managed care organizations tangible approaches for implementation of the Illinois Healthcare Transformation Section 1115 Demonstration Extension. Many states have leveraged the 2022 CMS policy change to implement 1115 waivers to cover health-related social needs (HRSN), such as food and nutrition benefits. This brief describes how two states have structured eligibility, authorized services and provider types, service codes and referral platforms, and fee services and billing guides to provide Food is Medicine programs within their 1115 waiver food and nutrition benefits. The final section explores how Illinois partners can leverage these lessons learned and take a step further to implement the 1115 waiver in ways that build health equity and local food system resiliency.

What is Food is Medicine?

The Aspen Institute defines Food is Medicine as "a spectrum of programs and services that respond to the critical link between nutrition and health" which include "the provision of foods that support health, such as medically tailored meals or groceries, or food assistance, such as vouchers for produce...a nexus to the healthcare system". Food is Medicine programs, like those depicted in the Food is Medicine Pyramid, can treat illnesses like hypertension and diabetes while addressing food and nutrition insecurity among patients and families, reducing the probability of poor health (USDA). These interventions have the potential to save healthcare systems and insurers millions of dollars annually and significantly reduce hospitalizations (Hager, et al. 2022).



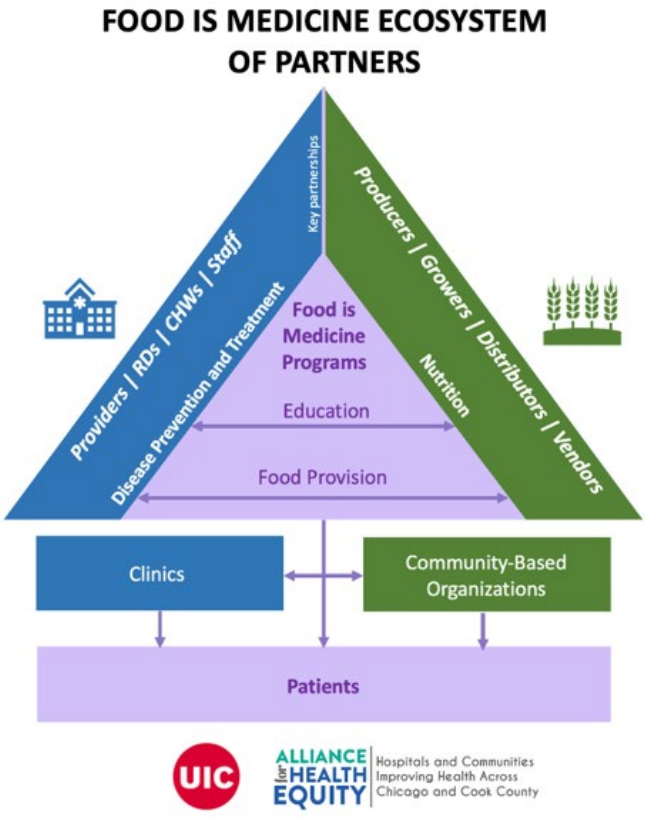
Food is Medicine in Practice

Food and nutrition insecurity most often affect communities of color and communities experiencing disinvestment. Programs that respond to these inequities by leveraging local resources and community-driven approaches more effectively improve health outcomes (*Chicago Sun Times*). In the Illinois context, Food is Medicine: Healing Together provides an innovative example of the promise of this local, community-driven model to address health equity. This 12-week program utilized cooking classes guided by the interests of participants, nutrition education, and produce bags prepared by local growers and vendors to improve blood pressure and other health outcomes for Black women experiencing hypertension on the South Side of Chicago.

An Opportunity to Sustain Food is Medicine Initiatives

One of the greatest barriers to scaling and sustaining Food is Medicine programs in both community-based and healthcare settings is access to ample resources. To address this concern, many states have been exploring policy mechanisms that would build pathways for Medicaid reimbursement of providers. Under this model, participating providers who screen for food insecurity, enroll patients in Food is Medicine programs, and/or provide services (e.g., medically tailored meals, produce prescriptions, SNAP/WIC enrollment, etc.) directly to patients would be compensated by insurers.

Many states have turned to 1115 waivers to build reimbursement pathways between health plans, healthcare systems,



and direct service providers to address HRSN for eligible Medicaid enrollees, like food and nutrition benefits. Thus 1115 waivers provide an excellent opportunity to marshal reimbursement mechanisms toward expanding successful Food is Medicine programs that could be included as part of broader food and nutrition benefits.

1115 Waivers in Practice: Lessons from Other States

North Carolina and California (among other states) have used 1115 waivers to create Food is Medicine benefits for eligible Medicaid enrollees:

California (2021-2026)

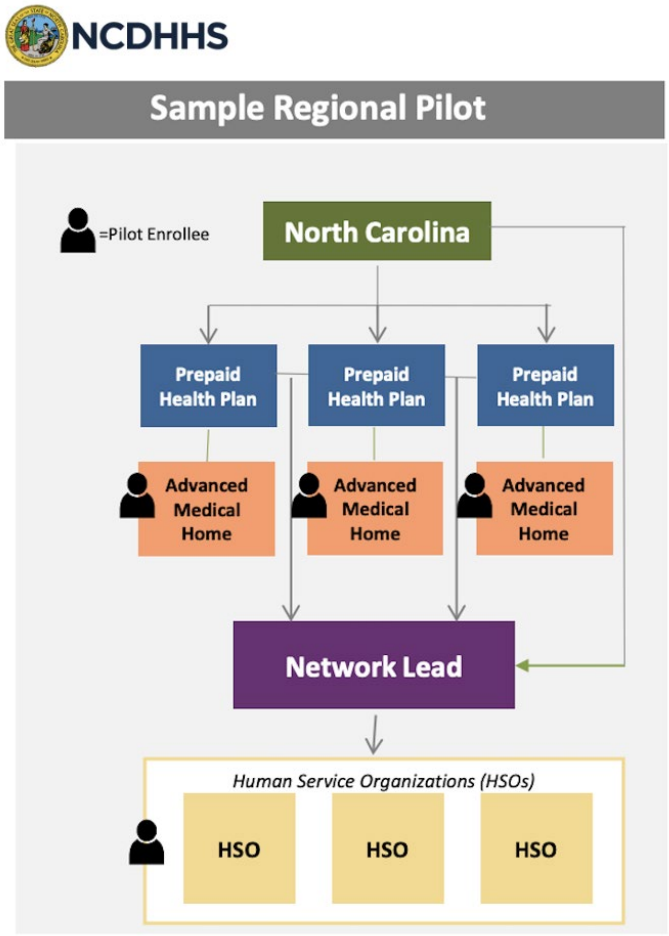
As part of CalAIM, 14 HRSN benefits—otherwise known as "community supports" or in lieu of services (ILOS)—are offered to any eligible Medicaid enrollee by participating Managed Care Plans (MCPs). Medically proven interventions that can reduce backend healthcare expenditures, such as medically tailored meals, are considered ILOS. MCPs partner with community support providers (i.e., community-based Food is Medicine providers), many of which are also part of the Medically Supportive Food and Nutrition Network, a collaborative that has guided implementation of CalAIM. Harvard published a series of case studies examining successes and challenges during the first year of implementation of CalAIM.

North Carolina (2019-2024)

As part of the Healthy Opportunities Pilot, Medicaid Prepaid Health Plans (PHPs) partner with Advanced Medical Homes and Human Service Organizations (HSOs) to screen, refer (via NCCARE360, a statewide platform), and provide up to 29 different HRSN interventions to eligible Medicaid enrollees in three pilot regions. Additional network leads (i.e., lead pilot entities for a particular region) help to bridge the gap between PHPs and HSOs so that services like produce prescriptions and nutrition classes could be effectively provided. This pilot is being rigorously evaluated in partnership with the University of North Carolina and the first rapid cycle assessment is available for review.

Implementation of an 1115 waiver in Illinois can certainly seem daunting, but looking to other states for guidance and leveraging the expertise of Illinois-based providers will help our Medicaid MCOs succeed. Emerging best practices that could guide implementation in Illinois include:

- **Eligibility** Although the 1115 demonstration application that was submitted by IL-HFS includes eligibility criteria for managed care enrollees (Illinois 1115 Demonstration Extension Application[1]), it is important for IL MCOs to understand how other state health plans have more narrowly defined eligibility during their implementation processes. The California Department of Healthcare Services (MediCal Community Supports Policy Guide[2]) and the North Carolina Department of Health and Human Services (Healthy Opportunities Pilots) determined eligibility in those states, and health plans were then allowed to more narrowly define their own criteria based on these guidelines and the services they are able to provide. In many instances, Medicaid health plans prioritized populations that were most at-risk for severe illness (e.g., food insecure adults with one or more chronic diseases, pregnant people, etc.) Many health plans opted to provide food and nutrition interventions to entire households when one adult screened positive, recognizing that households with children are more likely to be food insecure (USDA, 2020) and therefore are more likely to share food and nutrition benefits across household members (White et. al, 2020; Feinberg et. al, 2018).
- **Authorized Services and Provider Types** In California, MCPs have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members. These services were originally outlined by the California Department of Healthcare Services. PHPs in North Carolina have similar discretion and follow service definitions laid out by the North Carolina Department of Health and Human Services. In both states, health plans are encouraged



1 See page 18 for food and nutrition benefits criteria.

2 See page 54.

to offer as many services as possible, recognizing that providing a greater suite of benefits enables them to address different needs and levels of care across their target population.

Notably, the North Carolina language describing authorized benefits has been vague, putting the responsibility of clearly defining each type of service on the HSO. With respect to authorized provider types, North Carolina has carefully laid out a system of care coordination which includes care management teams (i.e., providers from care management delegate programs, local health departments, and PHPs that interact with beneficiaries), PHPs, network leads, and HSOs. Under the state's waiver, each provider is authorized to carry out a specific role intended to minimize barriers to patient enrollment and retention, and simplify reimbursement pathways and payment to HSOs (Pilot Overview and Care Management Team Roles and Responsibilities[3]).

- **Service Codes and Referral Platforms** Through work led by the Gravity Project and UCSF Siren, medical coding for food insecurity screening, treatment, and billing is becoming more accessible and easily understood (An Overview of Food Insecurity Coding in Healthcare Settings). Although many healthcare systems are using similar coding procedures (most commonly, the Hunger Vital Signs Tool and LOINC codes followed by ICD-10-CM and SNOMED CT codes), new ICD-10-CM, SNOMED intervention codes, and billing related ICD-10-CM, CPTII, and HCPCS codes are currently being explored to better capture the wide range of food insecurity interventions healthcare systems and community-based partners provide. California has put out guidance lists for HCPCS codes that are to be used by both providers, which can be found in the Enhanced Care Management and Community Supports Coding Options. Major strides have also been made in referral platforms, as seen with NCCARE360, which plays a critical role in the North Carolina Healthy Opportunities Pilot. This is a closed-loop referral platform that connects healthcare services to a statewide resource database of community-based and social service organizations, and has additional features that support eligibility, enrollment, and invoicing processes specific to the pilots.
- **Fee Schedules and Billing Guides** Both California and North Carolina have developed detailed billing guidance for their respective pilots. North Carolina has described units of service or payments and rates or caps in their fee schedule. With respect to food and nutrition interventions, they've also built in additional cost if the benefit requires delivery—$89.29 for one small healthy food box for pick up, vs. $96.79 for one small healthy food box for delivery, for example. These fees are intended to cover staff time, materials, and delivery (where applicable) and are regularly updated by the North Carolina Department of Health and Human Services based on recommendations from Federal CMS. Because of their success in developing a fee schedule, coordinating with providers, assigning dedicated medical coding and billing specialists to each regional Network Lead, and building invoicing into their statewide referral platform, 89% of North Carolina's invoices are currently paid. However, HSOs providing food and nutrition benefits have noted that although the process of submitting invoices is straightforward, reimbursement rates are so marginally thin that they must apply for grants to support staff time, forgo local purchasing and provide only shelf stable foods, and/or greatly limit their service area.

  In California providers are expected to submit claims to MCPs, although if barriers arise they can instead submit invoices with data elements defined by the California Department of Healthcare Services (detailed information on requirements can be found in the CalAim Data Guidance: Billing and Invoicing). MCPs are also **required to train community support providers** on how to submit a clean claim and assist with troubleshooting. Like other MediCal services, community support providers are subject to the same reimbursement timelines: MCPs must pay 90% of all clean claims within 30 days of receipt and 99% of all clean claims within 90 days; MCPs must reimburse claims as soon as practicable, but no later than 30 days after receipt of the claim. To support partnerships between community support providers and MCPs, the California Department of Healthcare Services has prepared non-binding community support pricing guidance which is found in the Community Supports Reference Guide.

3 See slide 7.

Envisioning Implementation of Illinois' 1115 Waiver

In Illinois groups like the Alliance for Health Equity Food is Medicine Subcommittee are mapping Food is Medicine providers to share with the state, easing the burden of creating new MCO-provider partnerships. The expertise of historically disadvantaged growers, producers, and vendors who have been engaged with the Local Food Purchasing Agreement (LFPA) process and through the Lt. Governor's Agriculture Equity and Food Insecurity Advisory Council could also be leveraged to ensure local procurement is easy and accessible for MCOs who are providing food and nutrition benefits. Additionally, the Illinois Department of Healthcare and Family Services and MCOs could partner with academic institutions to ensure robust evaluation of implementation and appropriately measure health outcomes. In summary, providers are ready to support the state to succeed.

Beyond what can be leveraged as lessons learned from other states, Illinois could take a step further during implementation by incorporating the following considerations:

- **Coordinating and collaborating across a spectrum of partners** Instead of taking a top-down approach, 1115 waiver implementation should leverage thoughtful engagement of healthcare systems, community-based providers (including growers, producers, and vendors and emergency food system providers), and potential beneficiaries. By working together from the outset, these partners can best inform approaches to building implementation infrastructure and rolling out benefits in a coordinated and sustainable way.
- **Creating partnerships with local food systems** Local food systems can provide fresh and nutrient dense produce, shelf-stable food items, and prepared meals and should be considered a critical component of a successful Food is Medicine program. Providing food purchased from historically disadvantaged farmers, producers, and vendors also creates investments in local communities and builds food system resiliency. Ample reimbursement rates must also be offered if these partners are to be equitably engaged in work with the state and managed care organizations (MCOs).
- **Providing culturally responsive food and nutrition education** Illinois' diverse population encompasses a multitude of cultural backgrounds, each with unique dietary preferences and traditions. Recognizing and respecting these cultural nuances through tailored programming ensures that interventions are not only relevant but also effective for all participants.

Successful implementation in Illinois will involve a coordinated approach among state agencies and MCOs in addition to the creation of several new systems and many new partnerships. Illinois-based partners are primed to support the state to succeed, recognizing this waiver poses an immense opportunity to improve the health of Illinois Medicaid beneficiaries who are most affected by inequity.

This brief was prepared by Dr. Saria Lofton and Ty Green, University of Illinois Chicago, and Lucy Peterson, Alliance for Health Equity, Illinois Public Health Institute, in partnership with the Scholars Strategy Network.

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