

Combating Food Insecurity during the COVID-19 Pandemic and Beyond: MCO Efforts and Initiatives

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The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and health equity and health care transformation. We encourage you to share your experiences with us and welcome your feedback on future MCO Learning Hub work to better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The changes that COVID-19 have forced on our society underscore the importance of both protecting and strengthening core social determinants of health (SDOH). Programs and policies that address SDOH and work to align health care and social services play a central role in alleviating the impacts of this virus on individuals' health and well-being. Services and supports for individuals whose needs go beyond the traditional health care landscape are already precarious; lack of access to them has been further exacerbated by the daily restrictions placed on us all to fight the virus.

A critical area in addressing SDOH is individuals' access to nutrients and their dietary practices. When individuals or families have limited ability or resources to attain proper nutrients—to have low food security—the consequences ripple through numerous physical and mental health issues. In light of the COVID-19 pandemic, school closures, and social distancing restrictions, many populations who were already food insecure have had increased difficulty in accessing food, and many more vulnerable groups have become food insecure because of loss of work and/or income. The following brief summarizes how food insecurity impacts health outcomes, how the COVID-19 pandemic has exacerbated this issue, and what strategies MCOs have used and can use to address the issue and support their communities.

This brief is intended to support the Robert Wood Johnson Foundation, Robert Wood Johnson Foundation funded-organizations, MCOs, and other organizations to advance health equity by presenting timely topics and providing examples of leading organizations and their efforts in these topic areas.

Food Insecurity and COVID-19

The impact of COVID-19 on social determinants of health (SDOH) such as food insecurity has put many health equity safety net programs to the test and illuminated deficiencies in our health equity infrastructures. A greater number of households are faced with food insecurity as a result of the pandemic, with household food insecurity increasing from 11 percent to nearly 23 percent between 2018 and April 2020.¹

FOOD INSECURITY ISSUES PRIOR TO COVID-19

The lack of adequate and consistent nutrients can have severe consequences for an individual's health and mortality. Those who experience food insecurity are more likely to suffer from chronic diseases including obesity, diabetes, hypertension, and obstructive airways diseases.^{2,3} The lack of nutrients and distress from experiencing food insecurity are also associated with lower levels of physical activity,⁴ further perpetuating physical harm. People who struggle from food insecurity are more likely to suffer from mental and behavioral health issues such as smoking,

drinking, and substance use disorder (SUD) in certain populations, all of which are associated with higher health care costs.^{5,6,7}

Like many health issues, food insecurity does not equally impact all populations. Marginalized racial and ethnic groups experience food insecurity at a much higher rate:

- More than 20 percent of Black households and 19 percent of Latinx households reported experiencing food insecurity, compared to 10 percent of White households.⁸
- Immigrants who identify as Black are nearly twice as likely to experience food insecurity as White immigrants.⁹
- Hispanic and Latinx immigrants are 2.5-3 times more likely to experience food insecurity than White immigrants.¹⁰

In general, Medicaid serves a much higher proportion of marginalized groups as compared to the overall population, with beneficiaries at a heightened risk of food insecurity.¹¹ Thirty-two percent of Medicaid beneficiaries often purchase less healthy food options due to lack of financial resources; purchase less food overall (28 percent); worry about running out of food more often (27 percent); and skip at least one meal a day more frequently than the general population (43 percent).¹²

FOOD INSECURITY ISSUES IN LIGHT OF COVID-19

The issues impacting food insecure populations have been exacerbated as a result of the pandemic, increasing the suffering of vulnerable populations.¹³ As many people around the country have been furloughed, become unemployed, or had reductions in pay and household income, the consequences of the economic downturn as a result of COVID-19 have dramatically impacted the ability of millions of Americans to afford enough nutritious food to feed themselves and their families.

This brief lays out the regulatory landscape of this issue, how food insecurity has increased as a result of the COVID-19 pandemic, what MCOs are doing to respond, and which potential improvements or opportunities can address food insecurities and serve food insecure communities. This information is crucial for MCOs and health plans as they structure programs to provide resources to food insecure populations.

The Impact of COVID-19 on Food Insecurity

While efforts to combat food insecurity predated the COVID-19 pandemic, the public health emergency has intensified the need to address food insecurity. An April survey from NORC and the Data Foundation found that 28 percent of respondents have worried about not having enough money to buy food at least at some time during the pandemic.¹⁴

IMPACTS ON MARGINALIZED GROUPS

COVID-19 has disproportionately impacted marginalized racial and ethnic groups. Individuals with low food security are more likely to be Black and Hispanic than any other racial or ethnic group, and 29 percent of Black households and 24 percent of Hispanic households reported their children did not have enough to eat at home, compared to 9 percent of White households as of March 2020.^{15,16} Citizenship status is also associated with low levels of food security; one in four adults in family units with individuals without citizenship status reported struggling with food insecurity during the pandemic, compared to 16.8 percent of families with individuals without citizenship status in the family.¹⁷ Food insecurity among individuals without citizenship status and households is especially difficult to combat due to the fear of repercussions that they may face when reaching out for public assistance. For example, in the wake of the Trump administration's announcement of the public charge rule in 2019, more than one in four adults in low-income immigrant families reported that they avoided government benefits including Medicaid and SNAP for fear of risking green card status.¹⁸

Additionally, neighborhoods with high proportions of low-income and minority residents are more likely to be in "food deserts,"¹⁹ places with limited access to healthy food sources, or "food swamps,"²⁰ places with both a dearth of supermarkets or grocery stores and an overabundance of unhealthy food options, such as fast food and convenience stores. Residents of these neighborhoods often need to travel farther to access healthy foods, and many rely on public transportation to make these trips. The COVID-19 pandemic has made the use of public transportation risky in all cases and impossible in some places where these services have been cut or limited to reduce disease spread.^{21,22} The restrictions on gathering and social distancing have also impacted the availability of some programs aimed at combating food insecurity in food deserts, such as farmers markets or mobile markets.^{23,24}

Furthermore, food hoarding, especially at the beginning of the pandemic, has been widely documented across the country, which puts low-income and food insecure families at increased risk of food insecurity when they come across empty shelves for everyday nutritional needs.²⁵

PHYSICAL HEALTH IMPACTS

School-aged children are directly impacted by COVID-19 response safety measures and the closing of schools. As of April 2020, food insecurity in households with children had risen to 34.5 percent, an increase of 130 percent from pre-COVID.²⁶ More than 30 million students annually rely on free or subsidized school lunches. Within the city of Philadelphia, officials predict that just three days of school closure could result in more than 405,000 missed meals for students.²⁷ School lunches are a crucial stopgap to child hunger and the lack of access to this daily food source can be devastating for households that are already food insecure.

The closing of schools in response to the pandemic has also heightened the risk of obesity that children experience during the typical summer recess, which accrues year-to-year and has long-term consequences.²⁸ During the pandemic, sedentary lifestyles and screen time have increased. Many families are understandably wary to bring their children to public parks for exercise due to the inability to keep such areas properly sanitized. Black and Hispanic children are already at a heightened risk for obesity and summer recess weight gain, and the pandemic only increases the disparities between those who can and cannot safely be physically active outdoors.^{29,30}

MENTAL HEALTH IMPACTS

The implications of the global pandemic is likely to increase chronic stress, especially for families experiencing food insecurity. The coping strategies that food insecure groups have become accustomed to are more difficult to maintain and access due to pandemic conditions. Pre-pandemic, many food insecure households relied on meal-sharing with families and neighbors; however, social distancing guidelines make gathering in these settings difficult and unattainable for some families. Congregating meals in soup kitchens and churches are often nearly impossible to offer unless curb-side accommodations can be made for recipients and social distancing standards put in place for volunteers. Additionally, recipients cannot use Supplemental Nutrition Assistance Program (SNAP) benefits to purchase food online, meaning that they must shop for food in person, putting themselves and their families at risk.³¹

Regulatory Landscape

Understanding the regulatory landscape prior to COVID-19 is essential to developing mitigation strategies during the current pandemic. Because of the impact of food insecurity on the health of Medicaid beneficiaries, state and federal governments have implemented policy mechanisms and programs to help ensure access to healthy food.

FEDERAL ACTION

The Centers for Medicare & Medicaid Services (CMS) specifies two categories of food insecurity-related services that are reimbursable with Medicaid funds:

1. **Food delivery or pickup programs** are services whereby Medicaid beneficiaries receive prepared meals or meal packages with the necessary ingredients to cook meals.³² A 2019 study found that medically tailored meals (MTMs) were associated with fewer hospital admissions.³³
 - California's MTM program is a \$6 million pilot program that delivers three medically tailored free meals per day for 12 weeks to beneficiaries of the California Medicaid program.³⁴
 - New York's MTM program coordinates community-based organizations (CBOs) to deliver MTMs to the critically ill. The program is associated with a 28 percent reduction in health care costs for recipients when compared to the critically ill who did not receive MTMs.³⁵
 - Legislation proposed in Massachusetts would establish the Food and Health Pilot Program, which would allow MCOs to participate and provide healthy food subsidies and MTM to Medicaid beneficiaries.³⁶
 - Meals-on-Wheels is a private-public partnership that works with Medicare and Medicaid to support more than 5,000 CBOs across the United States to deliver free or low-cost meals to senior citizens.³⁷
2. **Purchasing assistance programs**, which can be paid for using Medicaid dollars, enable Medicaid beneficiaries to buy healthy foods, including fruits and vegetables at participating food retail locations.³⁸
 - The Accountable Health Communities Model is a five-year program that operates across 22 states and aims to remove the gap between clinical care and community services to address health-related social needs including food insecurity.³⁹
 - The Fruit and Vegetable Prescription Program (FVRx) creates networks in five cities in the Northeast among health care providers and participating food retailers to serve populations that are at-risk for nutritional deficiencies who cannot afford produce.⁴⁰

In addition to Medicaid programs, the federal government also funds other food and nutrition services under the Department of Agriculture (USDA), Food and Nutrition Service including SNAP,⁴¹ and the Special Supplemental Nutrition Program from Women, Infants, and Children (WIC).⁴² Both programs aim to assist food insecure households with monthly issued coupons that are used to purchase food.

Finally, it's worth noting that Medicare Advantage (MA) supplemental benefits can now cover meal delivery, and that dual-eligible beneficiaries, those who qualify for both Medicaid and Medicare, may have access to this benefit through their MA plan.^{43,44}

STATE ACTION

In the current framework, most state Medicaid programs do not offer beneficiaries assistance with purchasing healthy food as a health care benefit.⁴⁵

Some states have enacted legislation to combat food insecurity. For example, Washington State enacted legislation to create a fruit and vegetable prescription program that gives members produce vouchers at participating food retail locations.⁴⁶ Washington, D.C., established the Produce Plus program that offers participants \$20 per week in credit to spend at local farmers markets.⁴⁷ Some states, including New Mexico, California, and Virginia, have passed legislation that would prohibit schools from withholding meals from students who cannot afford to pay for them.⁴⁸

Waivers: States can expand access to healthy food supplies among their Medicaid beneficiaries by applying for waivers (i.e., Home and Community-Based Services 1915(c) waiver and Section 1115 Demonstration waiver). North Carolina's Section 1115 waiver, the Healthy Opportunities pilot, covers populations at risk for adverse outcomes from SDOH, including food insecurity, and provides food support and meal delivery to effected recipients.⁴⁹ Several states have existing meal delivery services under Home and Community Based Services (HCBS) waivers to deliver meals to eligible senior citizens and people with disabilities.

Contracts: Partnerships between states and MCOs also allow states flexibility in offering benefits and services to improve access to healthy food for beneficiaries and therefore increase food security. Medicaid MCOs in Virginia are required to address access to healthy foods; one of the Virginia health plans covers meal delivery for patients and family members for a limited time after a hospital visit. Michigan requires its Medicaid MCOs to match beneficiaries to community services and make referrals for individuals experiencing food insecurity.⁵⁰ In Florida and Nebraska,

MCOs are required to offer WIC program services as well as other community services.⁵¹

Addressing Food Insecurity amid COVID-19

To address the compounded effects of food insecurity during the COVID-19 pandemic, governments are taking additional steps to mitigate the health impacts on Medicaid beneficiaries. Some states are building on existing programs to provide access to healthy food for their Medicaid populations (see Regulatory Landscape above) prior to the pandemic, and others are accessing additional funding and flexibility available as a result of the COVID-19 pandemic.

FEDERAL, STATE, AND LOCAL GOVERNMENT

Funding for new and expanded federal, state, and local-level programs, services, and policies has aimed to address food insecurity. These programs and services provide a lifeline to many during the pandemic and the ensuing economic crisis.

At the federal level, the Coronavirus Aid, Relief, and Economic Security (CARES) Act and Families First Coronavirus Response Act (FFCRA) allocated \$850 million in additional funding for the Emergency Food Assistance Program.⁵² Under this program, the USDA purchases surplus agricultural products and sends them to state agencies to distribute to emergency feeding organizations, such as food banks. Further, through funding from the CARES Act, USDA will spend up to \$3 billion on the Farmers to Families Food Box Program within the Coronavirus Food Assistance Program, purchasing agricultural products from U.S. farmers and delivering boxes of produce, dairy, and cooked meat to nonprofits, including food banks.⁵³

The federal government has also increased flexibilities and waivers to expand SNAP and WIC benefits.⁵⁴ For example, USDA authorized a Pandemic Electronic Benefit Transfer (EBT) in Michigan and Rhode Island, a supplemental food purchasing benefit to current SNAP participants to offset the cost of meals that would have otherwise been consumed at school.⁵⁵ USDA also expanded a SNAP online grocery purchase pilot program in 45 states including Arizona; California; Florida; Idaho; Washington, D.C.; and North Carolina, including expanding relief to families with kids in school lunch programs.⁵⁶ USDA has partnered with the Baylor Collaborative on Hunger and Poverty, McLane Global, PepsiCo, and others to deliver meals to students who attend rural schools affected by COVID-19 closures.⁵⁷

The Commonwealth of Massachusetts is taking action to combat food insecurity exacerbated by the COVID-19 pandemic. In line with recommendations from the Commonwealth's Food Security Task Force, Massachusetts invested \$56 million to combat food insecurity.⁵⁸ In addition, a total of 15 states have added home-delivered meals to HCBS through Medicaid.⁵⁹

MCO Mechanisms for Addressing Food Insecurity

In addition to federal, state, and local efforts, MCOs—through their own efforts, within Medicaid managed care and/or CBO partnerships—have opportunities to meet Medicaid members' food insecurity needs.

MCO-LED EXAMPLES

Many health care organizations are also starting or expanding existing efforts to combat food insecurity among Medicaid members. Numerous health plans have donated money to food-related nonprofits. For example, UnitedHealth has committed \$5 million to address food insecurity in light of the COVID-19 pandemic, allocating \$2.5 million to the National Health Care for the Homeless Council to support needs for local homeless programs, \$1.5 million to the Feeding America network of member food banks, and \$1 million to Meals on Wheels America to support local programs.⁶⁰ Another example includes Amerigroup's \$100,000 donation to the Food Bank of Iowa.⁶¹ In addition to financial donations, health plans have set up innovative ways to distribute food. For example, the L.A. Care health plan has committed \$172,400 to set up 30 drive-through food pantries and one Produce Pop-Up.⁶²

MEDICAID MANAGED CARE EXAMPLES

Some state Medicaid programs are supporting MCOs in addressing food insecurity of their members by tailoring coverage of meals and nutrition support for people who meet eligibility criteria or by expanding waiver services, including New York, California, and Massachusetts.^{63, 64, 65} The state of New York submitted an 1135 waiver requesting the extension of coverage of nutritional services to families who may not have access to meals during periods of social distancing.^{66, 67} Massachusetts has added nutrition sustaining supports as a Medicaid-allowable service under the state's Delivery System Reform Incentive Payment (DSRIP) program, including covering kitchen cleaning and sanitation supplies. Expanding coverage of these services enables MCOs to empower providers to directly address food insecurity with their patients. Prior to the pandemic, a majority of MCOs reported working with CBOs to link

members to social services. MCOs can build on their partnerships with CBOs to help directly link patients to food resources, where state Medicaid waivers and programs allow flexibility in this area.⁶⁸

In addition, health care systems are continuing and intensifying efforts to screen, identify, and refer food insecure patients to community organizations that can help. For example, the Cambridge Health Alliance, a Boston-based community health system, has screened COVID-19-positive patients and their family members for food insecurity and connected them to nonprofits to provide two weeks of free food assistance for the quarantine period.⁶⁹

MCO-CBO PARTNERSHIP EXAMPLE

MCO and CBO partnerships also offer opportunities to meet the food insecurity needs of Medicaid members. The [FOODRx program](#) partners with health plans and providers through value-based payment (VBP) arrangements to engage at-risk patients through culturally effective food security services. FOODRx was launched in 2016 by Second Harvest Heartland—one of the largest food banks in the nation whose majority of recipients are Medicaid beneficiaries. Currently integrated into both health plans and providers, FOODRx is a food insecurity intervention receiving national attention.⁷⁰ Amid COVID-19, FOODRx has had to pivot to meet the demands of a growing population of Medicaid beneficiaries with food security challenges, including engaging more intensively with established partners, identifying new populations and partnerships to expand the reach of the program, and adapting to quickly respond to changing needs among vulnerable populations.

CHALLENGES TO ADDRESSING FOOD INSECURITY IN MEDICAID MANAGED CARE

While some Medicaid MCOs have found creative and innovative ways to address the food security needs of their beneficiaries, challenges still exist. Identifying how large the issue is among a certain beneficiary population can be difficult. The data collection tools that assess food insecurity at the patient and population levels are not standardized. Further, data sharing between government agencies is minimal, and increased information sharing is necessary to gain a full picture of food insecurity in a given state or area.⁷¹ The lack of clarity on the prevalence of food insecurity in a state's Medicaid beneficiary population can lead to an incomplete understanding of the size and scope of the problem on behalf of the MCOs.

Additionally, there are various CBOs of different sizes focused on addressing this issue, from small local food banks to large national organizations and in between. MCOs have reported that coordinating across these multiple

entities to best serve all of their members can be a challenge. The structure of services and approaches to addressing food insecurity also varies greatly from federal nutrition programs to statewide, regional, and local programs, making it difficult for MCOs to determine how they can best intervene in a way that is complementary rather than duplicative.

Finally, in any VBP arrangement, quality metrics must be aligned to incentivize MCOs' action on SDOH. Most quality metrics used in VBP strategies focus on process or specific clinical outcomes, such as inpatient utilization, readmission rates, diabetes and asthma management, and delivery of preventive services (e.g., immunization rates, well-child visits). Though some of these metrics do likely incentivize investments in social interventions, states interested in encouraging plans and providers to address social issues should explore whether there are additional or alternative metrics aimed more explicitly at these objectives.⁷²

Future Directions for Sustainably Addressing Food Insecurity

In addition to studying the measures taken by government and health care organizations to address food insecurity amid the pandemic, it is also important to consider what can be done to address this problem in the future and reduce the amount of food insecure households and individuals in the long term. While health plans and health systems play some role in addressing food insecurity during the pandemic, federal programs such as SNAP are seen as the first-line defense against food insecurity—for every meal served by America's largest food coalition, Feeding America, SNAP provides nine.⁷³

Food insecurity coping strategies have become significantly more challenging in light of social distancing guidelines.⁷⁴ According to suggestions from the Brookings Institution, the Hamilton Project, and Food Is Medicine Coalition, the federal government could work with state and local entities to:

- Increase the maximum and minimum SNAP benefits
 - Authorize SNAP emergency allotments under the Families First Act to eligible households
- Extend Pandemic-EBT through the summer and at least through the end of the 2021 school year
 - Gives eligible families grocery vouchers when schools are closed

- Support families with children ages 5 and under through an additional SNAP multiplier or by broadening eligibility for Pandemic-EBT
 - Reverse recent rule changes for eligibility, legal immigration determinations, and strengthen the program's recession-fighting power⁷⁵
- Suspend SNAP work requirements for students and sustain able-bodied adults without dependents (ABAWD) SNAP work requirement suspension⁷⁶
 - Work requirements weaken SNAP's ability to be effective during an economic crisis and periods of high unemployment⁷⁷
- Establish coverage for MTMs under Medicare and Medicaid
 - Add MTMs to the definition of "medical and other health services" within the Medicare statute for Medicare Part B⁷⁸

MCOs should continue to address members' food insecurity, in tandem with a broader push for addressing SDOH. Strong links between communities and health systems are needed to address food insecurity, and cross-sector partnership requires investment and time.⁷⁹ Investment of resources by partnering MCOs is key to this strategy, as CBOs are already stretched thin trying to address the needs of their existing service population. Alternative payment models and VBP arrangements that incorporate CBOs that are working to serve the food insecurity needs of the population can help to advance health equity, improve patient outcomes, and reduce costs.

Working with state Medicaid programs to determine the most effective approaches, using Medicaid dollars, can help MCOs more directly address barriers to healthy food. MCOs also need to find ways to stay current with updated policies and infrastructure at the state and federal level to ensure they have good information that can be provided to members, including which food banks and organizations are receiving additional resources and how SNAP benefits are changing in states based on waivers and federal policies to help support families.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support MCOs in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at MCOLearningHub@norc.org to start the conversation or join our distribution list.

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