
MEDICAID FOOD
SECURITY NETWORK
Medicaid Food
Security Network Summit
MAY 7-8, 2025
WASHINGTON, DC
SHARE
OUR
STRENGTH
HEALTH
BEGINS

Medicaid Managed Care Organization food security screening and navigation to SNAP, WIC, and more

May 8th, 2025

Medicaid Food Security Network Summit 2025

Session Goals

- Demonstrate how MCO procurement drives transformative change
- Provide insights from both Medicaid agencies and MCOs
- Share successes and lessons learned
- Support Medicaid Food Security Network's goal to develop template contract language

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Session Speakers

SHARE OUR STRENGTH™

Rich Sheward
Director of System Implementation Strategies, Children's HealthWatch at Boston Medical Center

Katie Commey
Manager, Strategic Engagement & Planning Section, Health Services, MI DHHS

Aaron Canfield
Manager, Plan Management Section, Health Services, MI DHHS

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Session Speakers

Jennifer Park
National Social Health Lead, Kaiser Permanente

Leah Pryor-Lease
Director of Community and External Relations, Colorado Access

SHARE OUR STRENGTH™

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The Hunger Vital Sign™: A Foundation for Change

- Validated two-question screening tool
- Gold standard for identifying food insecurity in healthcare settings
- Catalyzes healthcare delivery transformation
- Connects patients to SNAP, WIC, and other resources
- Improves long-term health outcomes

The Hunger Vital Sign™ identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

> **" Within the past 12 months we worried whether our food would run out before we got money to buy more."**

> **" Within the past 12 months the food we bought just didn't last and we didn't have money to get more."**

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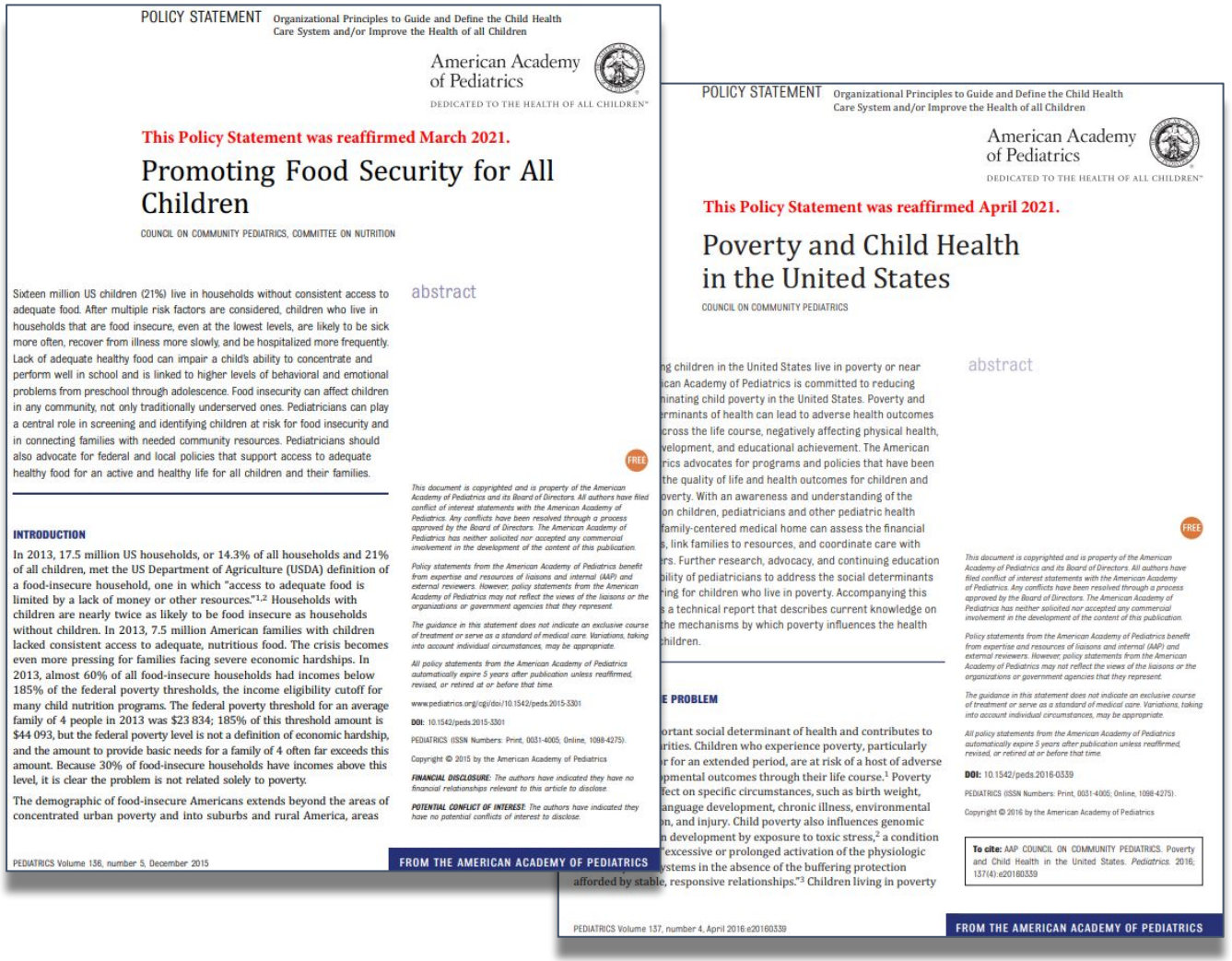
The Evolution of Food Security in Healthcare

- Predates 1115 waivers and In Lieu of Services provisions
- American Academy of Pediatrics:

  "The early detection and management of poverty-related disorders is an important, emerging component of pediatric scope of practice."

- Significant progress since 2016 when we first discussed CMS paying for screenings



POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

This Policy Statement was reaffirmed March 2021.

Promoting Food Security for All Children

COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON NUTRITION

abstract

Sixteen million US children (21%) live in households without consistent access to adequate food. After multiple risk factors are considered, children who live in households that are food insecure, even at the lowest levels, are likely to be sick more often, recover from illness more slowly, and be hospitalized more frequently. Lack of adequate healthy food can impair a child's ability to concentrate and perform well in school and is linked to higher levels of behavioral and emotional problems from preschool through adolescence. Food insecurity can affect children in any community, not only traditionally underserved ones. Pediatricians can play a central role in screening and identifying children at risk for food insecurity and in connecting families with needed community resources. Pediatricians should also advocate for federal and local policies that support access to adequate healthy food for an active and healthy life for all children and their families.

FREE

www.pediatrics.org/cgi/doi/10.1542/peds.2015-3301

DOI: 10.1542/peds.2015-3301

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

INTRODUCTION

In 2013, 17.5 million US households, or 14.3% of all households and 21% of all children, met the US Department of Agriculture (USDA) definition of a food-insecure household, one in which "access to adequate food is limited by a lack of money or other resources."[1,2] Households with children are nearly twice as likely to be food insecure as households without children. In 2013, 7.5 million American families with children lacked consistent access to adequate, nutritious food. The crisis becomes even more pressing for families facing severe economic hardships. In 2013, almost 60% of all food-insecure households had incomes below 185% of the federal poverty thresholds, the income eligibility cutoff for many child nutrition programs. The federal poverty threshold for an average family of 4 people in 2013 was $23 834; 185% of this threshold amount is $44 093, but the federal poverty level is not a definition of economic hardship, and the amount to provide basic needs for a family of 4 often far exceeds this amount. Because 30% of food-insecure households have incomes above this level, it is clear the problem is not related solely to poverty.

The demographic of food-insecure Americans extends beyond the areas of concentrated urban poverty and into suburbs and rural America, areas

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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DEDICATED TO THE HEALTH OF ALL CHILDREN™

This Policy Statement was reaffirmed April 2021.

Poverty and Child Health in the United States

COUNCIL ON COMMUNITY PEDIATRICS

abstract

ng children in the United States live in poverty or near
ican Academy of Pediatrics is committed to reducing
minating child poverty in the United States. Poverty and
rminants of health can lead to adverse health outcomes
cross the life course, negatively affecting physical health,
velopment, and educational achievement. The American
ics advocates for programs and policies that have been
the quality of life and health outcomes for children and
overty. With an awareness and understanding of the
on children, pediatricians and other pediatric health
family-centered medical home can assess the financial
s, link families to resources, and coordinate care with
rs. Further research, advocacy, and continuing education
bility of pediatricians to address the social determinants
ing for children who live in poverty. Accompanying this
s a technical report that describes current knowledge on
the mechanisms by which poverty influences the health
children.

FREE

DOI: 10.1542/peds.2016-0339

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

To cite: AAP COUNCIL ON COMMUNITY PEDIATRICS. Poverty and Child Health in the United States. *Pediatrics*. 2016; 137(4):e20160339

E PROBLEM

ortant social determinant of health and contributes to
rities. Children who experience poverty, particularly
r for an extended period, are at risk of a host of adverse
pmental outcomes through their life course.[1] Poverty
fect on specific circumstances, such as birth weight,
anguage development, chronic illness, environmental
n, and injury. Child poverty also influences genomic
n development by exposure to toxic stress,[2] a condition
excessive or prolonged activation of the physiologic
ystems in the absence of the buffering protection
afforded by stable, responsive relationships."[3] Children living in poverty

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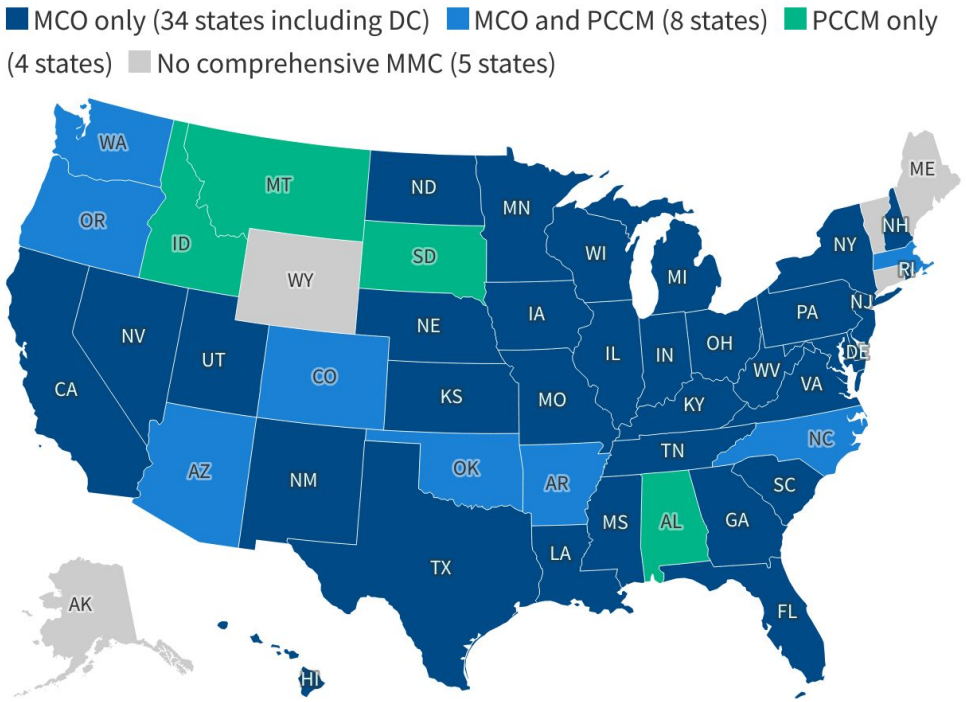
Medicaid MCO Procurement: A Transformative Policy Vehicle

Figure 1

As of July 2024, 42 States Used Capitated Managed Care Models to Deliver Services in Medicaid.



Note: MMC: Medicaid managed care. FL did not respond to the 2024 survey; publicly available data used to verify status. ID's Medicaid-Medicare Coordinated Plan and Medicaid Plus programs have been recategorized by CMS as MCO programs but are not counted here as such since they are secondary to Medicare. CT and SC use PCCMs but are not counted here as such.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024

KFF

What is Medicaid MCO Procurement?

- Process by which state Medicaid agencies select MCOs
- Powerful lever for systemic change at the state level
- Opportunity to establish requirements affecting millions of Medicaid members
- Viable pathway even in the current policy landscape

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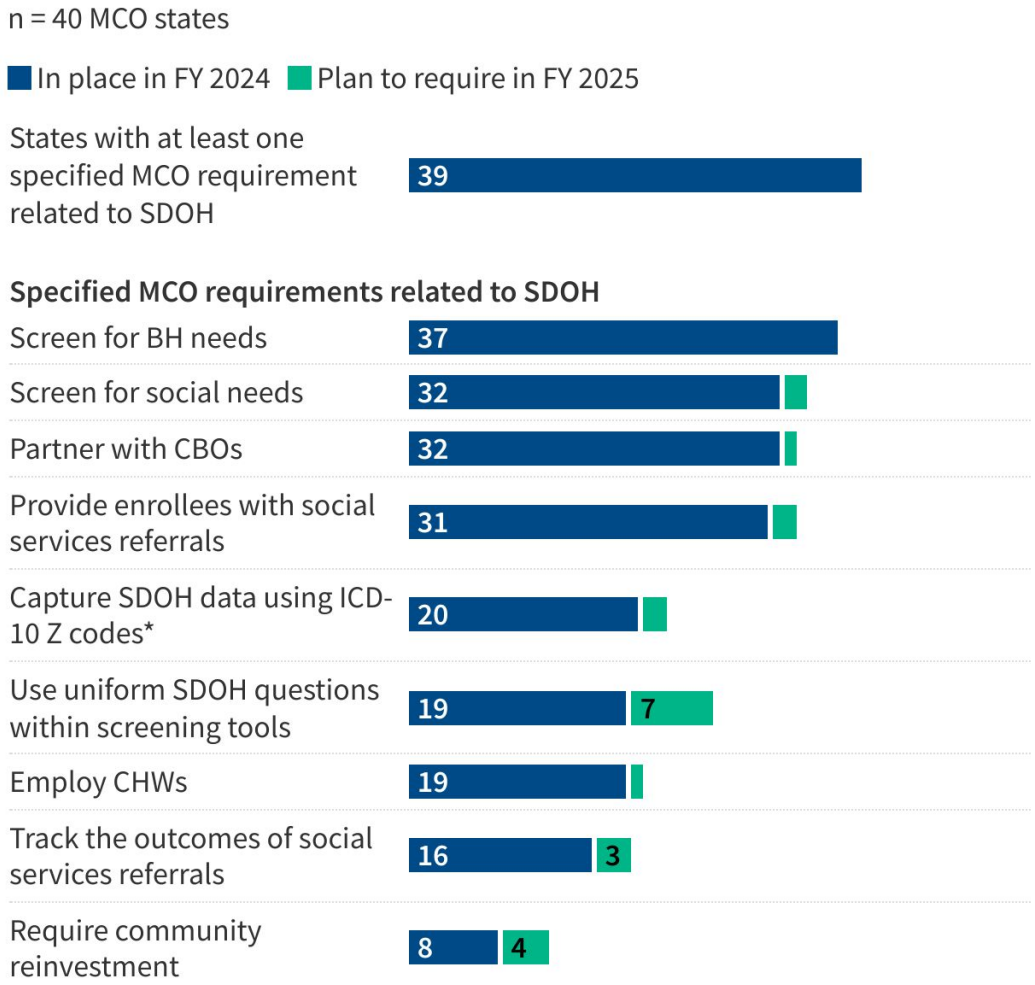
Figure 11

In FY 2024, Most MCO States Had at Least One MCO Contract Requirement Related to Social Determinants of Health.



Note: FL did not respond to the 2024 survey, and GA did not provide a response to this survey question. BH: behavioral health. CBOs: community-based organizations. CHWs: community health workers. *ICD-10 Z codes are a subset of the ICD-10 diagnosis codes that reflect patient social characteristics.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024

KFF

The Through-Line: From Requirements to Implementation

- Contract compliance → Innovation pipeline
- Risk stratification → Value-based care
- Minimum requirements → Comprehensive referral networks
- Data integration across systems

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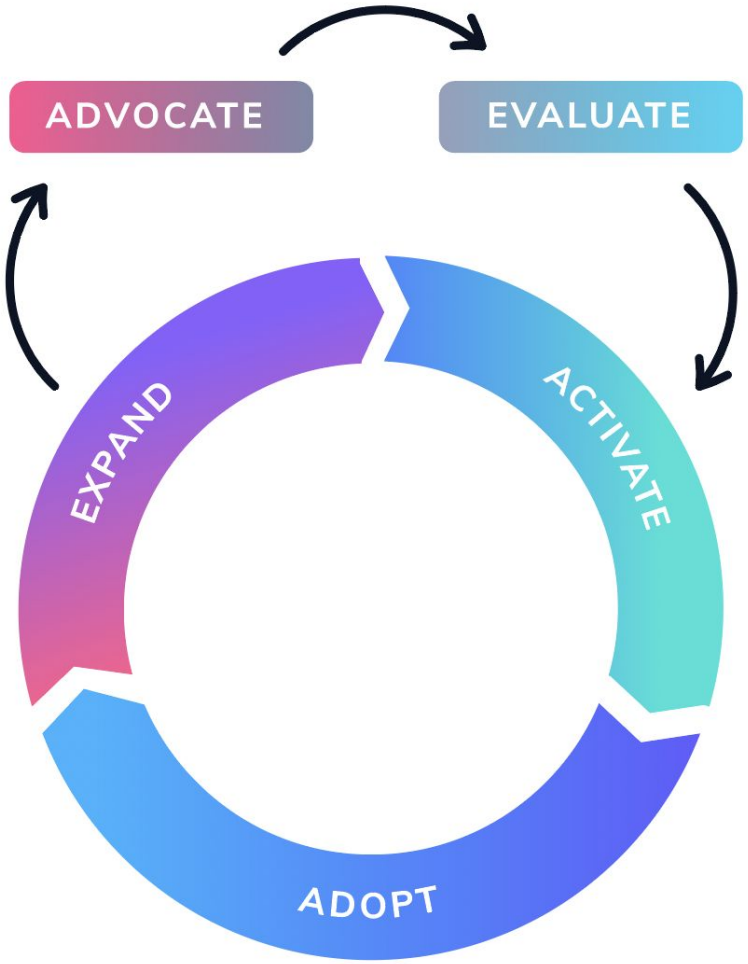
First-Movers and Best Practices



- Advantages of early adoption:
  - Infrastructure development ahead of competitors
  - Stronger community partnerships
  - Valuable ROI data
  - Pilot programs that scale
- Michigan's example of systemic change through procurement

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Medicaid Contracts as a Tool for Food Access

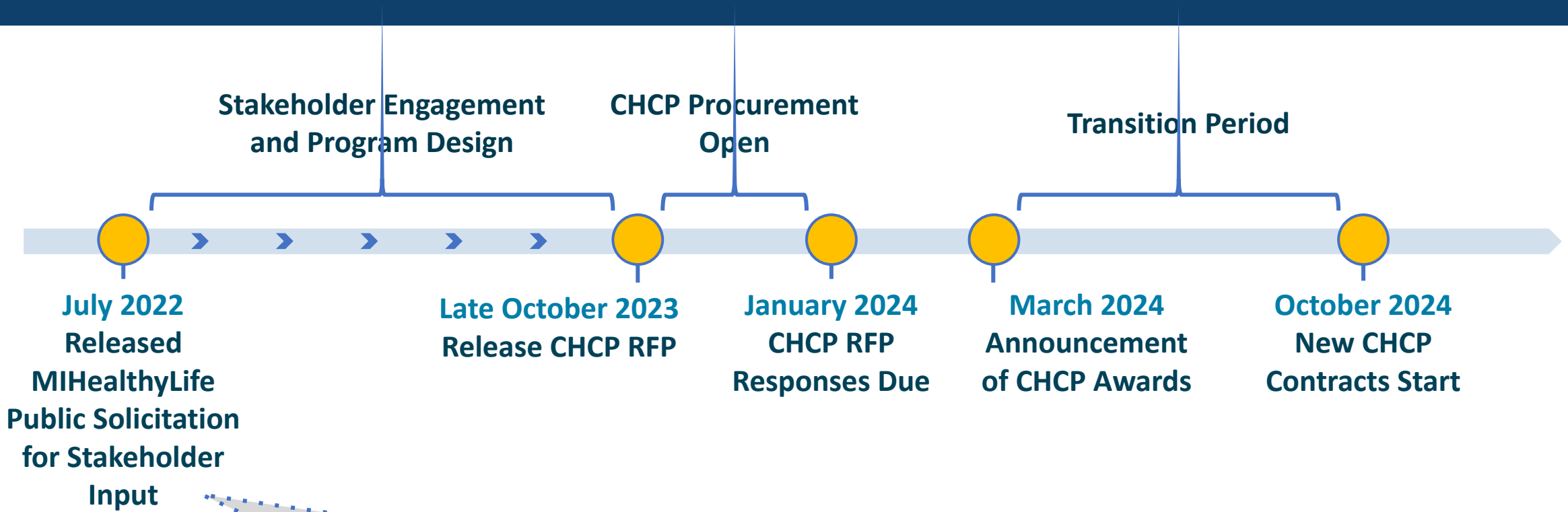
Medicaid Food Security Network Summit

May 8, 2025

MDHHS

Michigan Department of Health & Human Services

MIHealthyLife Milestones



MDHHS received nearly 10,000 responses to its public solicitation; these responses informed the MIHealthyLife pillars and design process

Framework for Addressing SDOH Through Medicaid Managed Care

Key Requirements:

- Screen Medicaid Enrollees for unmet social needs.
- Monitor whether Medicaid Enrollees receive services to address their needs.

Screening and Reporting Requirements

Identifying Enrollee's unmet social needs is an important step in addressing the major causes of poor health and health care outcomes. The state established new requirements that Medicaid Health Plans screen for health-related social needs among Enrollees.

- **Identifying Social Need Among Enrollees**: Medicaid Health Plans are required to screen Enrollees for needs, including food, housing, and transportation needs within 90 days of plan enrollment, at annual redetermination and during transitions of care, following up at least twice if needed to complete the screening.
  - **Reporting Screening Rates:** Medicaid Health Plans must submit quarterly reports showing how many members were screened, how many could not be reached, and how many declined to participate.
  - **Using Standardized Screening Tools**: To ensure consistency, the state requires all Medicaid Health Plans to use MDHHS-approved screening instruments to assess needs related to food, housing, and transportation.
- **Connecting Performance to Payment (Quality Withhold):**The state strengthened the SDOH-related benchmarks that Medicaid Health Plans must meet in order earn back the part of their funding that is contingent on performance and quality.

Goal: Ensure that Medicaid Health Plans are accountable for identifying unmet needs among Enrollees and help to address health-related factors.

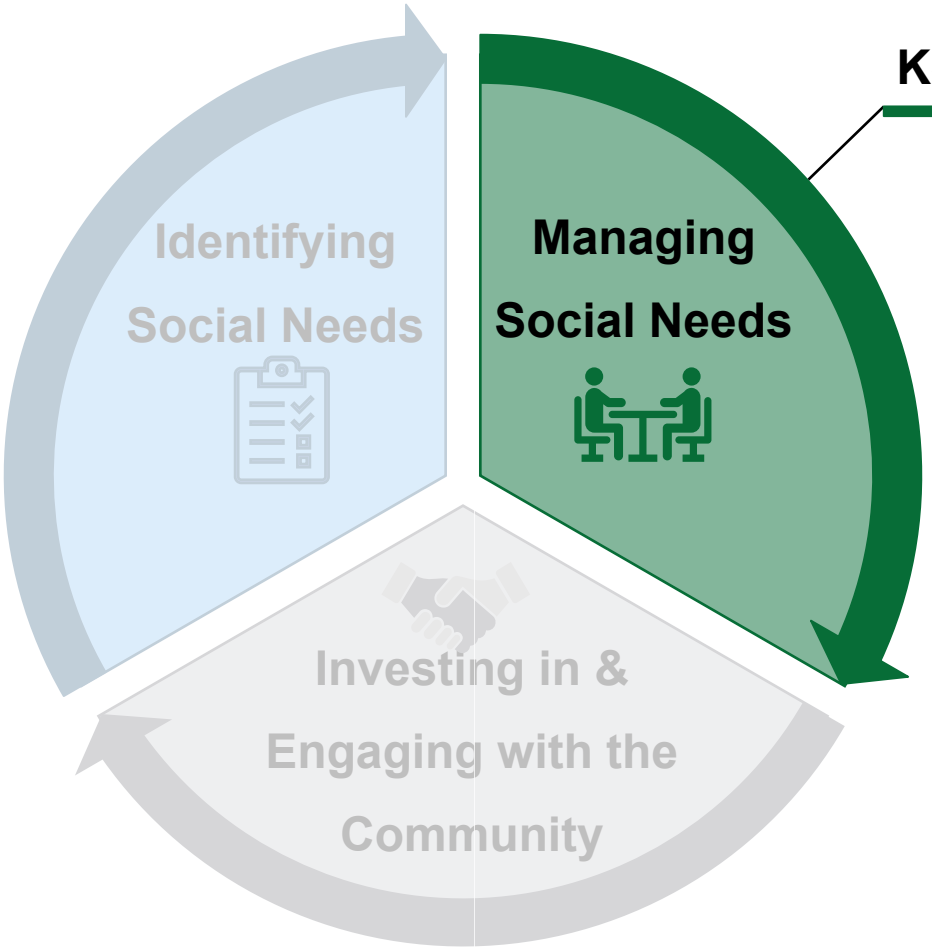
Source: Comprehensive Health Care Program for the Michigan Department of Health and Human Services (FY2025). Contract Sections:
1.1. Contractor Requirements, V. Access and Availability of Providers and Services, S. Care Coordination
Appendix 5. Performance Bonus (Quality Withhold)

CHCP Quality Withhold and SDOH

Features	New for Fiscal Year 2025 & 2026
Key HEDIS® measure performance	✔ Medicaid Health Plans report the HEDIS® *Social Needs Screening and Intervention (SNS-E*) measure, which assesses: • The percentage of Enrollees who were screened for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Michigan-specific custom quality measures and priority projects	✔ *Social Determinants of Health - Screening Rates*, requires Medicaid Health Plans to report unmet social need screening rates. Medicaid Health Plans earn points based on: • Meeting screening thresholds • Showing statistically significant improvement in screening rate over the previous year
	✔ *Social Determinants of Health –SDoH Referrals,* requires Medicaid Health Plans to report a comprehensive list of resources to meet members' SDOH-related needs for each Region they serve.

Source: Comprehensive Health Care Program for the Michigan Department of Health and Human Services (FY2025). Appendix 5. Performance Bonus (Quality Withhold)

Framework for Addressing SDOH Through Medicaid Managed Care



Key Requirements:

- **Support Enrollees** by addressing unmet social needs as part of Population Health Management Program
- Send all members information on **public benefits**
- Factor **SDOH** when **assessing** and **providing care management**
- Ensure **workforce** is equipped to **support unmet social** needs
  - Encourage use of **Community Health Workers** (CHWs)
  - Require **contracting** with community-based organizations (CBOs) **to address SDOH**

Population Health Management Requirements

For all Enrollees, the Medicaid Health Plan must….

- ✔ **Consider SDOH when designing population health improvement interventions**
- ✔ **Provide Enrollees information about the availability of other public benefit programs** and support them in applying for, and promote the use of, the state's centralized portal (MI Bridges).

For Enrollees receiving care management, the Medicaid Health Plan must….

…help Enrollees obtain Social Services to address unmet needs. To extent possible, the following activities must be offered by or coordinated with the Enrollee's care team:

- ✔ Conduct assessments to identify any unmet needs
- ✔ Address unmet social needs when an Enrollee screens positive.
- ✔ Refer Enrollees to community-based Social Services and other resources to address unmet needs not covered under contract
- ✔ Track referrals to ensure Enrollees receive all necessary services
- ✔ Coordinate health and Social Services between settings of care, delivery systems, and programs
- ✔ Assist members in applying for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and using MI Bridges

Source: Comprehensive Health Care Program for the Michigan Department of Health and Human Services (FY2025). 1.1. Contractor Requirements, X. Population Health

Framework for Addressing SDOH Through Medicaid Managed Care

Key Requirements:

- Invest a portion of Medicaid profits in CBOs.
- Encourage Medicaid Health Plans to offer ILOS.

In Lieu of Services

Medicaid Health Plans are strongly encouraged to provide one or more of the MDHHS pre-approved ILOS

- **Medicaid Health Plans that elect to offer ILOS must adhere to MDHHS requirements,** including:
  - ✔ MDHHS established service definitions
  - ✔ MDHHS defined eligible populations
  - ✔ Use of standard code sets

- **Medicaid Health Plans that elect to offer ILOS must:**
  - ✔ Utilize a consistent process for determining medically appropriateness
  - ✔ Maintain Enrollee right to receive Covered Services (cannot require ILOS utilization)
  - ✔ Submit policies and procedures for MDHHS approval prior to implementation

Priority SDOH Domain

Food and Nutrition

Food Insecurity in MI is Rising

In 2020, nearly two million people in Michigan experienced hunger. 1 in 7 children in Michigan were estimated to be food insecure.

ILOS Service Definitions Development

- Evidence indicates these ILOS can improve Enrollee health outcomes and can reduce how often a person must use more serious levels of medical care.
- Input from community partners and learnings from other states.

Source: Comprehensive Health Care Program for the Michigan Department of Health and Human Services (FY2025). 1.1. Contractor Requirements, X. Population Health

Community Reinvestment

MDHHS Michigan Department of Health & Human Services

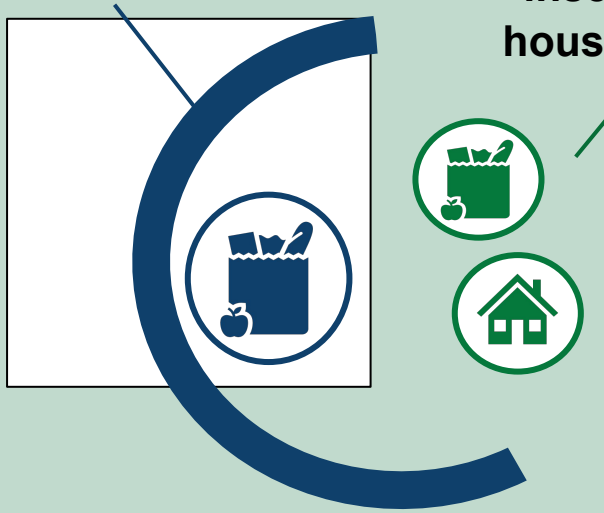
Under new requirements, Medicaid Health Plans must invest 5% of profits in their communities.

OBJECTIVES OF COMMUNITY REINVESTMENT:

- Formalize longstanding reinvestment efforts by Medicaid Health Plans.
- Increase funding in communities to address Medicaid members' SDOH, to ultimately improve health.
- Provide funding to support new and expanded partnerships between CBOs and Medicaid Health Plans, including to build CBO capacity to provide in lieu of services (ILOS).

60% must address food insecurity.

The remaining 40% can address food insecurity and/or housing instability.



The Community Reinvestment Obligation *cannot* pay for services that Medicaid Health Plans are required to pay for or to meet other contract requirements.

CHCP Contract in Action

Thank You

Katie Commey, MPH
Manager, Strategic Engagement & Planning

Aaron Canfield
Manager, Plan Management

Contact:
MDHHS-ENGAGEMedicaid@michigan.gov

Resources:

- MIHealthyLife
- CHCP Sample Contract
- In-Lieu of Services
- Community Reinvestment

Kaiser Permanente Community Support Hub™

Jennifer Park
Social Health Practice

KAISER PERMANENTE®

Hub Call Center Caring Moment

Maria's* care provider sent in a referral to the Hub Call Center after finding out she needed help with her **finances, food and utilities**

Maria shared that she did not have enough income to cover all her monthly expenses. She especially struggled with having enough food to eat and paying her utility bills. The Hub Call Center provided Maria several resources that could offer support

When the call center followed up with Maria, she was able to get her utility bill lowered and received food from two different organizations. She also said she was going to explore the employment resources that the agent sent her to look for a higher paying job. Maria was extremely grateful for the help and resources she received.

Region: SCAL
Timeframe: Oct 2024
Community Organizations:
- CA Public Utilities Commission
- St. Margaret's Center
- Turning Point

Campaign: Centralized Referral Model

*Maria is a pseudonym

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Social Health at Kaiser Permanente

The Social Health Practice at Kaiser Permanente is **integrating social health with physical and mental health** by focusing on establishing scaled systems, tools, and interventions required to **support KP members across the enterprise** in a sustained way.

We are addressing social factors that impact the health of our members by systematically and proactively **identifying social needs**, **connecting members to resources**, and **establishing support and follow-up.**

Kaiser Permanente Community Support Hub™

KP's shared service infrastructure with the tools and capabilities needed to identify when members have social needs, connect to support, follow-up and track outcomes

KAISER PERMANENTE®

Member Journey Utilizing the Hub Call Center

Identify Needs

Care delivery has a social health conversation

Member completes a standard social health screener

Member finds the Hub Call Center number through an after-visit summary, kp.org, flyer, etc.

Assistance Desired

Member expresses a desire for support for social need(s)

Ways to Engage

Care team member transfers the call to Hub Call Center

Member provides information to contact Hub Call Center

Hub Call Center receives a list via KPHC or secure file for proactive outreach

Support & Follow Up

- Hub Call Center Specialist confirms social needs
- Provides resources or makes referral
- Follows up to confirm resource connection and/or provides coordination until social needs are met

Member Experience and Follow Up Workflows

Member Experience Survey

- **Day 0** — Sends Aftercall Survey
- **Day 3** — If no response: Sends 1st reminder email
- **Day 5** — If no response: Sends 2nd reminder email
- **Day 7** — If no response: Survey link expires

Members select manual or digital follow up:

Telephonic (live follow up)

- **Day 3-7** — Agent calls member at scheduled time
- If no response: Will make 3 attempts
- If members request additional support: Ongoing follow up calls
- **Days 7-30+**

Digital

- **Day 14** — Sends Follow-up Survey
- **Day 16** — If no response: Sends 1st reminder email
- **Day 18** — If no response: Sends 2nd reminder email
- **Day 20** — If no response: Survey link expires
- **Day 22-30** — Final Telephonic attempt to reach member

Member Follow Up Survey

(if applicable) Community Resource Platform referrals to CBOs

Community Organization Follow Up

- **Day 0** — Referral to CBO made
- **Days 2-7** — CBO accepts or rejects referral
- **Days 7+14** — CBO indicates outcome of referral

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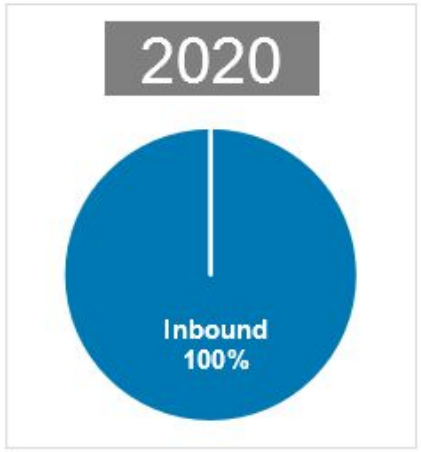
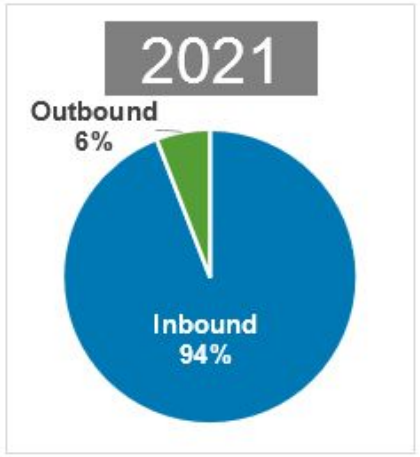
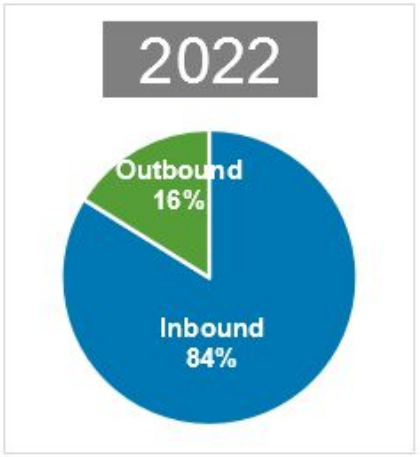
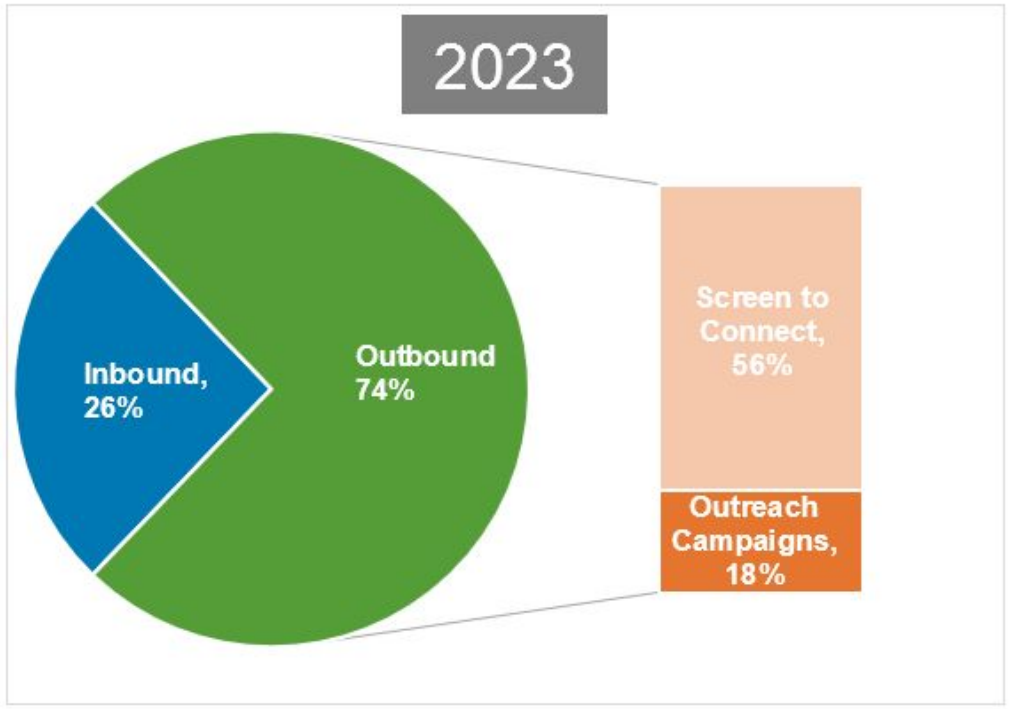
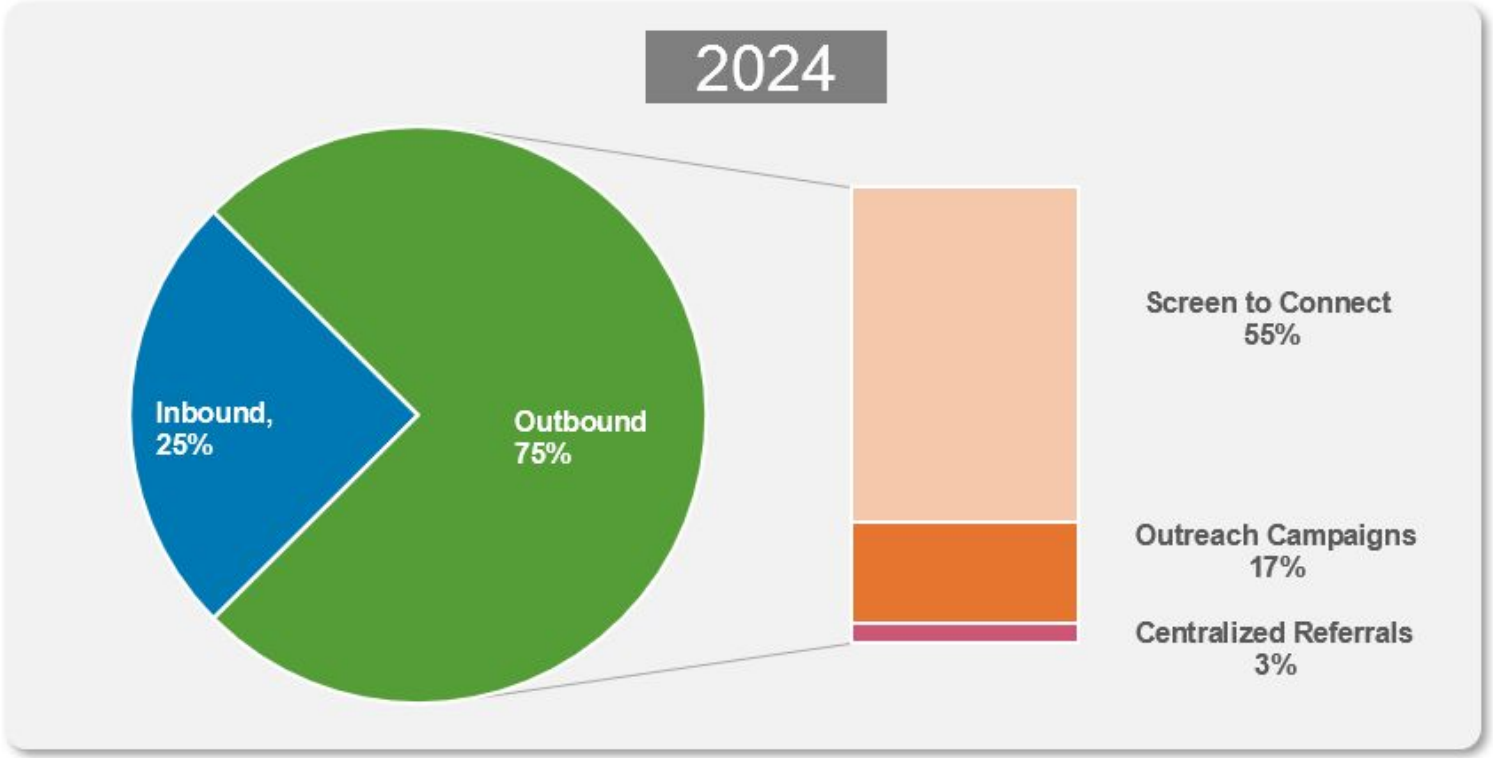
Evolution of the Hub Call Center Operational Model











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Increasing Access and Support for Members

Automation of Positive Screenings

Positive social needs from standard social health screenings either have a daily file sent to HCC or automatically uploaded into a call directive that offers efficiency features.

Outreach Modality

HCC operational model evolved to incorporate more outreach efforts to support our members rather than only relying on inbound calls through screening workflows and targeted outreaches (climate care, Medicare, high risk scores).

Centralized Referrals

Care delivery can send electronic referrals to HCC through the EMR or the Unite Us platform as a central place to send electronic social health referrals.

Data Integration

HCC has direct access to the EMR or established technology solutioning built out to automate documentation of interventions in progress notes and to update screening needs.

KAISER PERMANENTE®

Colorado Access
SDOH & Food as Medicine

Leah Pryor-Lease

Director of Community & External Relations

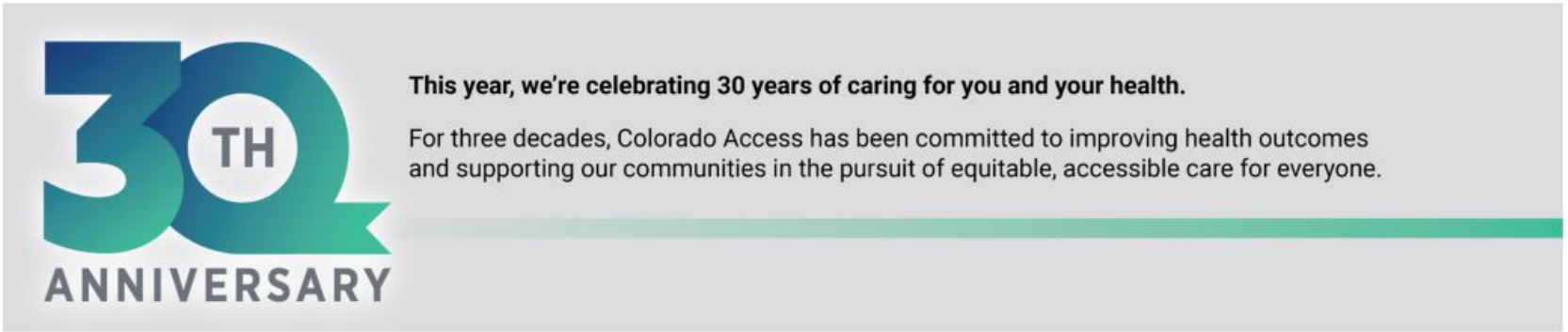
colorado access

Colorado Access – Who we are

Colorado Access is a local, nonprofit health care company that has been caring for the health of Coloradans for 30 years.

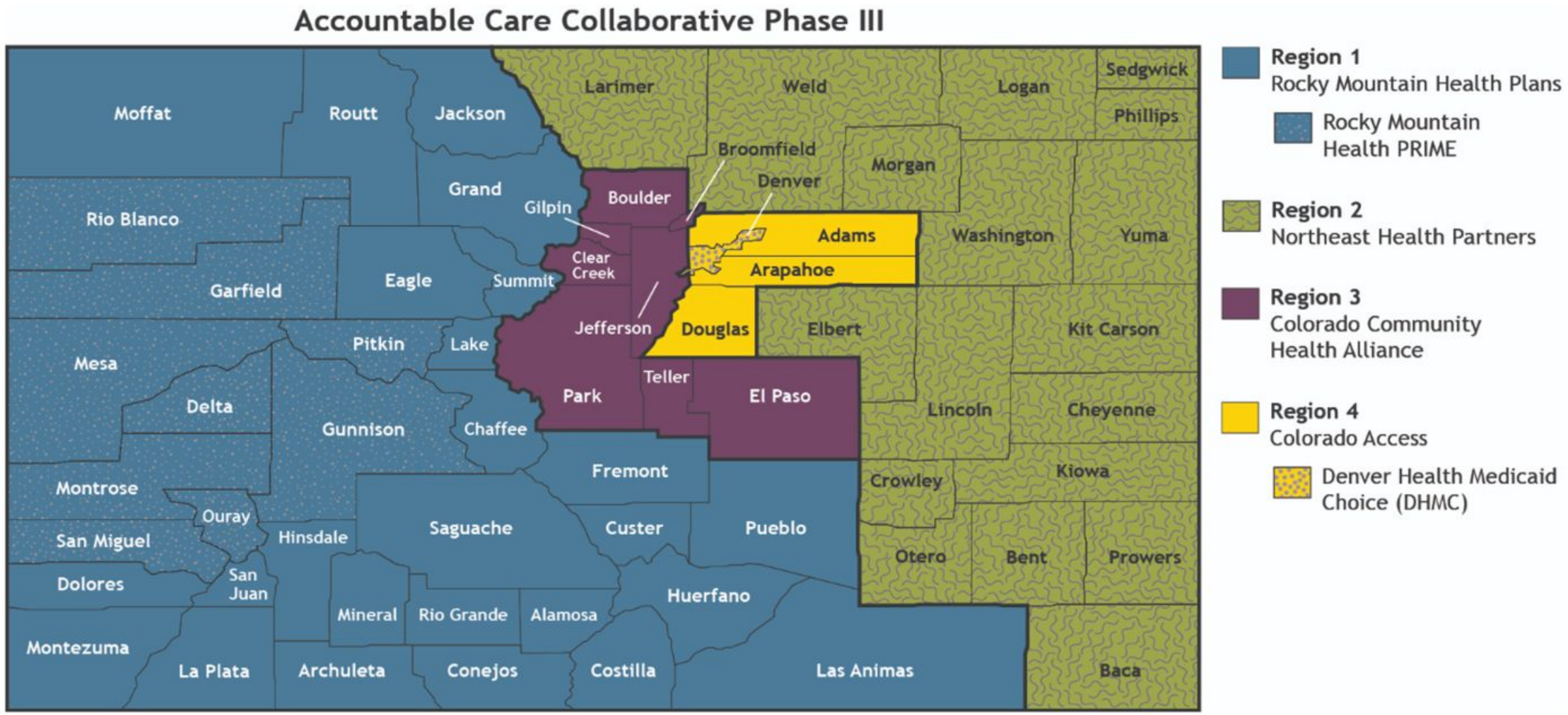
Vision: Partner with communities and empower people through access to quality, equitable, and affordable care.

Mission: Healthy communities transformed by the care that people want at a cost we can all afford.



colorado access

Colorado Regional Accountable Care Collaborative



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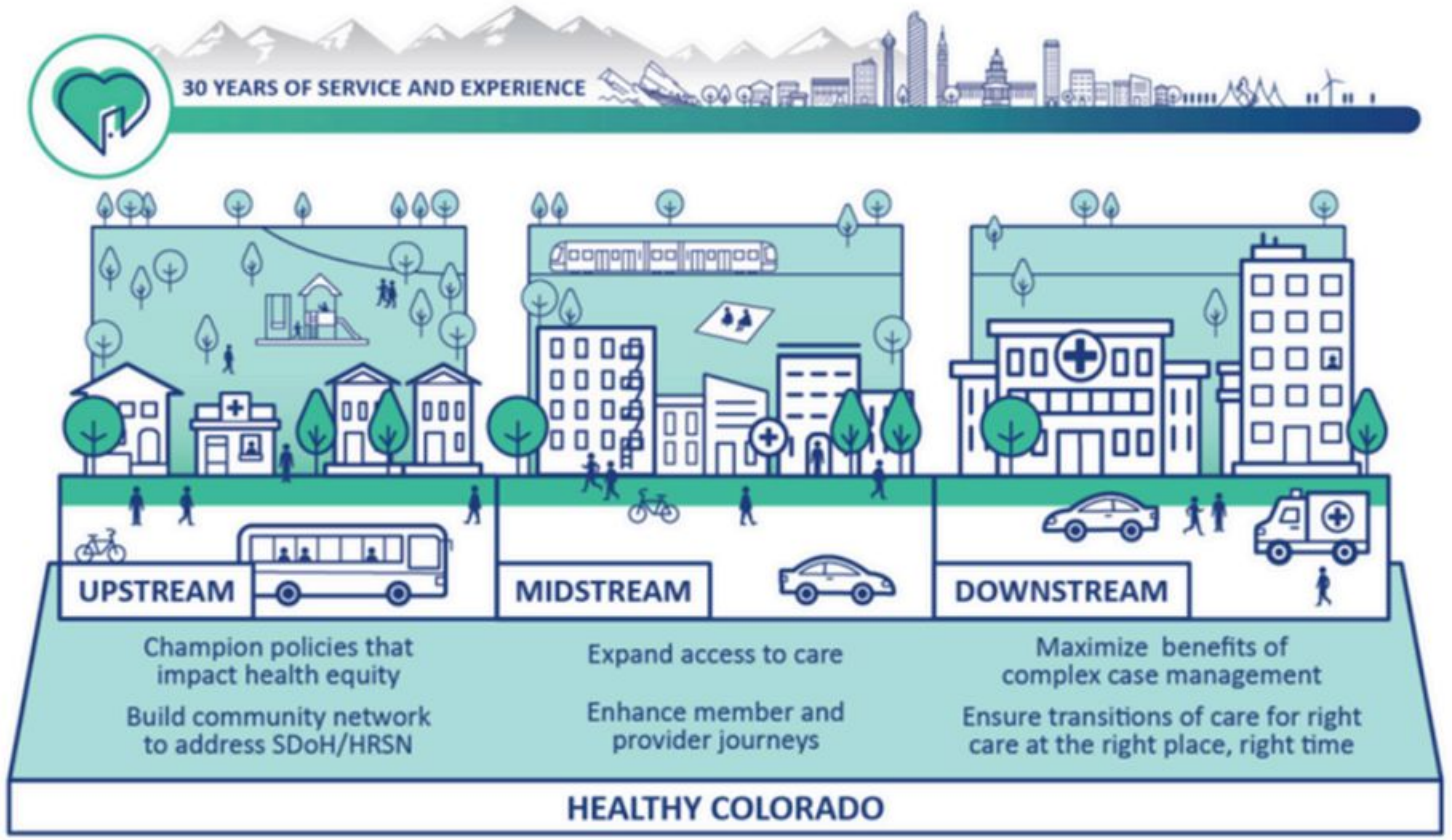
COA Health Neighborhood

Guiding Principles

Demonstrate Health Plan Excellence	Become a Member & Person Centered Organization	Promote Social Justice



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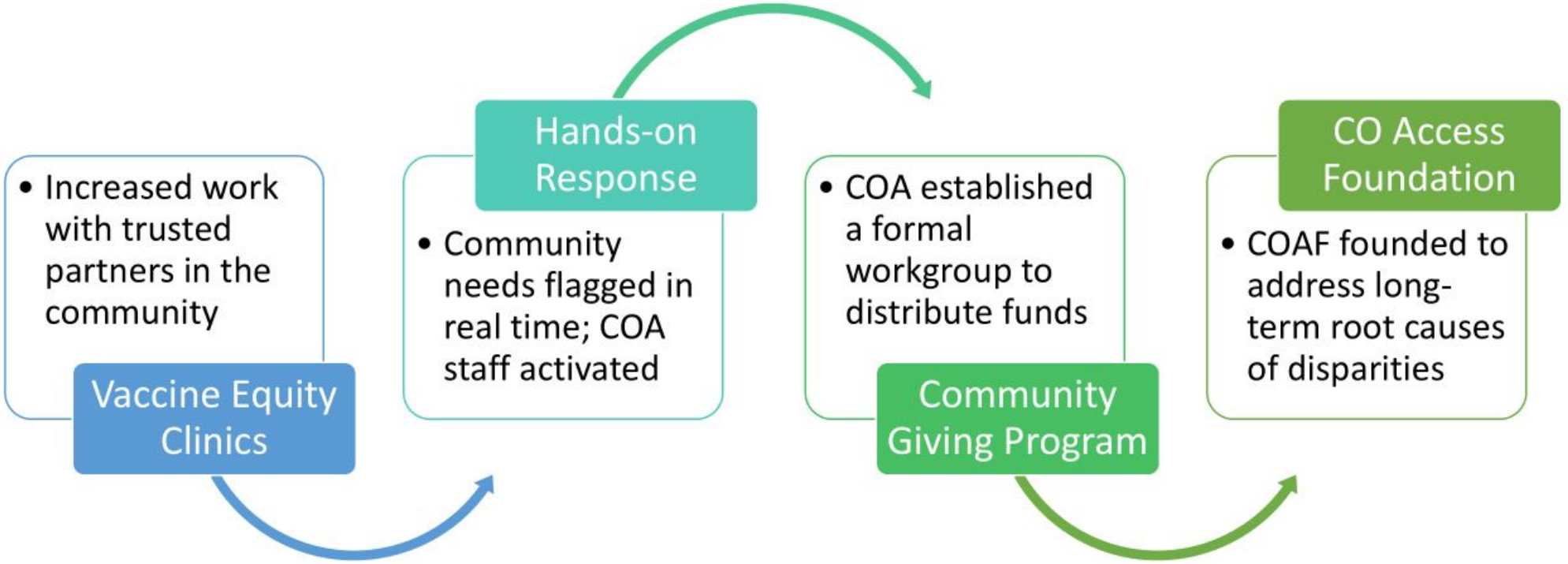
Community Engagement & Public Health Emergency



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Food Insecurity Rates Among Overall Population by County

ADAMS COUNTY

FOOD INSECURE POPULATION: 60,200

FOOD INSECURITY RATE

AVERAGE MEAL COST
$ 4.12

ADDITIONAL MONEY REQUIRED TO MEET FOOD NEEDS
$ 46,580,000

ARAPAHOE COUNTY

FOOD INSECURE POPULATION: 67,430

FOOD INSECURITY RATE

AVERAGE MEAL COST
$ 4.38

ADDITIONAL MONEY REQUIRED TO MEET FOOD NEEDS
$ 55,505,000

DENVER COUNTY

FOOD INSECURE POPULATION: 88,660

FOOD INSECURITY RATE

AVERAGE MEAL COST
$ 4.65

ADDITIONAL MONEY REQUIRED TO MEET FOOD NEEDS
$ 77,455,000

DOUGLAS COUNTY

FOOD INSECURE POPULATION: 27,270

FOOD INSECURITY RATE

AVERAGE MEAL COST
$ 4.70

ADDITIONAL MONEY REQUIRED TO MEET FOOD NEEDS
$ 24,085,000

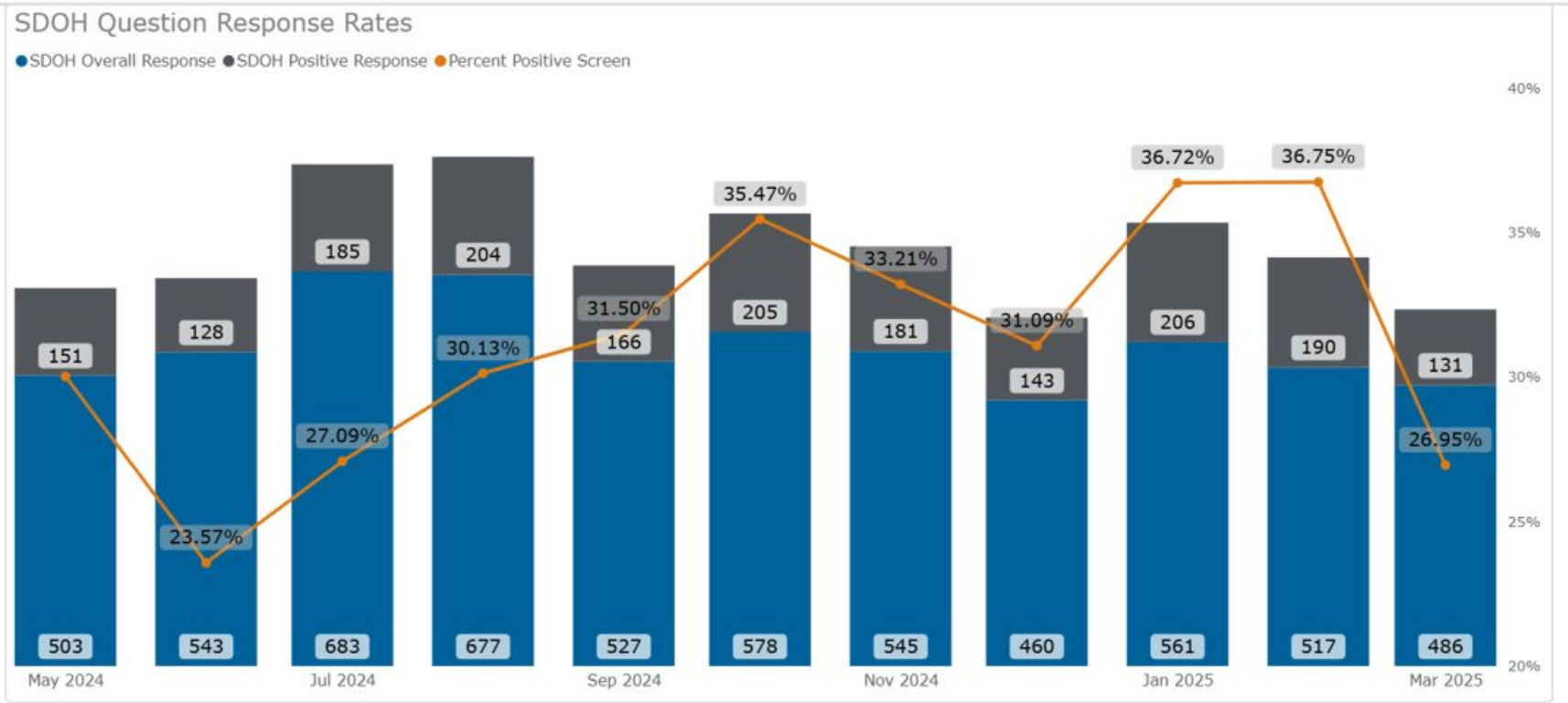
colorado access

Source: Feeding America, Mind the Meal Gap

CORE 5 Screening Tool

CORE 5 validated screening tool for Food, Housing, Utilities and Transportation questions.

1. Do you/your family worry about whether your food will run out and you won't be able to get more?
2. Are you worried about losing your housing, or are you experiencing homelessness?
3. Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?
4. Has a lack of transportation kept you from attending medical appointments or from work, or from getting things you need for daily living?



colorado access

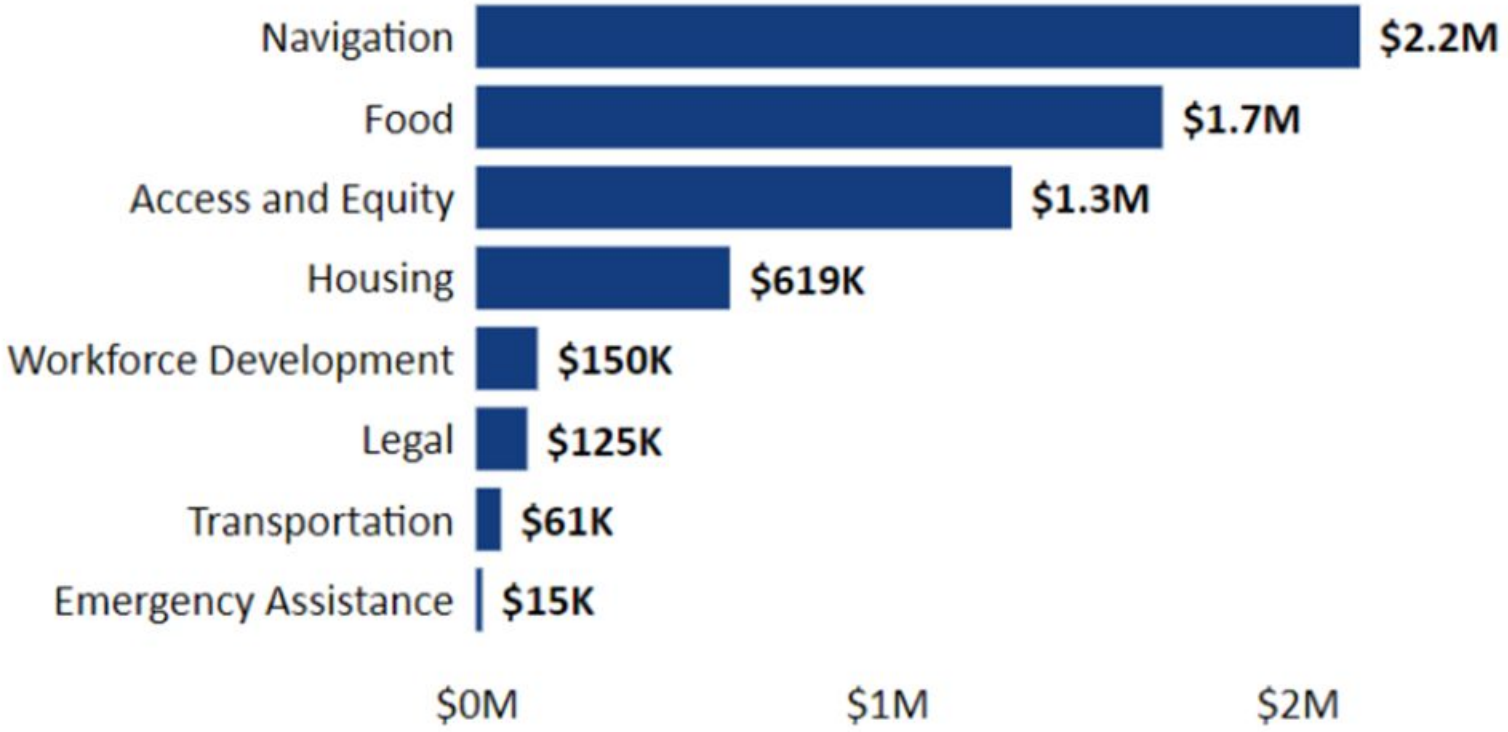
SDOH Strategy – Year 1

Food	• Expand access to SNAP & WIC • Decrease food insecurity • Medically tailored meals
Other Priority Areas	• Housing Stability & Support • Resource Linkages

colorado access

COA Community Giving

(HRSNs) in the areas of resource navigation, food, accessibility, housing, workforce development, and legal services.



"Food as Medicine" related investments = approx. $2M

- Food Pantries
- "Food for Health" grocery boxes
- Medically Tailored Meals
- 1115 Waiver related preparation

Figure 11-05. *Community Giving Program Social Determinants of Health Funding 2020 to 2024*

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Applied Integrated Health Strategy

Project Angel Heart

HUNGER FREE COLORADO

FOOD BANK OF THE ROCKIES

Benefits in Action

RE:VISION

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be well™

THANK YOU

Your feedback is important to us, please take a moment to fill out our survey. The first 10 respondents get a $10 e-gift card, and you can submit the survey multiple times if you think of more to share.

SHARE OUR STRENGTH™