NATIONAL PRODUCE PRESCRIPTION COLLABORATIVE

CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

State Policy Options:
Leveraging Produce Prescriptions (PRx) to Treat and Prevent Diet-Related Illness

Policymakers have various options to leverage the Produce Prescription model as a powerful response to healthcare's increasing focus on addressing the social drivers of health, improving health outcomes, and decreasing long-term health care costs.

Why Produce Prescriptions?

A Produce Prescription is a medical treatment or preventive service for patients who are eligible due to (1) diet-related health risk or condition, (2) food insecurity or other documented challenges in access to nutritious foods, and (3) referral by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy fruits and vegetables with no added fats, sugars, or salt, at low or no cost to the patient.

Food insecurity has vast health and financial costs

- Food insecurity is associated with 10 of the costliest and most deadly preventable diseases.[1]
- Diet-affected chronic health conditions cost the U.S. over a trillion dollars in direct medical expenses each year.[2]

Produce Prescription programs are health- and cost-effective

- Produce Prescription programs have been shown to:
  - ✓ Improve household food security[3]
  - ✓ Increase fruit and vegetable consumption[4] and nutrition and cooking knowledge[5]
  - ✓ Improve blood pressure,[6] body mass index (BMI) scores,[7] and hemoglobin A1c levels in individuals with diabetes, the primary indicator for managing the disease[8]
- Modeling estimates that providing Medicaid and Medicare enrollees with a 30% subsidy for the purchase of fruits and vegetables would save $39.7 billion in formal healthcare costs over a lifetime if enacted on a national level, and remains cost-effective even when considering the program and implementation costs[9]

State Policy Opportunities to Leverage Produce Prescriptions

Each of these options are being utilized in different states and municipalities across the country.

Medicaid

- 1115 Demonstration Waivers (best opportunity for large-scale delivery): with CMS approval, state Medicaid plans can cover services, such as PRx, and populations that may not normally be allowed under federal rules.[10] California, Massachusetts, North Carolina, and Oregon are among the states that have used 1115 waivers to address food access and nutrition.

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Medicaid (continued)

- 1915(b)(3) Managed Care Waivers: with CMS approval, states are allowed to enroll a broader segment of their Medicaid population in managed care than otherwise allowed and then use savings from their managed care program to provide coverage for services that would other wise not be covered under the State Plan, such as PRx.[11]
- In Lieu of Services (ILOS): states can approve Medicaid managed care plans to cover otherwise non-covered services as a medically appropriate, cost-effective substitute for services covered under the State Plan (e.g., produce prescriptions covered in lieu of hospitalizations and emergency department visits). ILOS services are attractive to plans because they may be included in a plan's Medical Loss Ratio and capitation rate.[12]
- Value-Added Services: services not covered under the State Plan, but voluntarily offered by a Medicaid managed care plan.[13] Value-added services that are "activities that improve healthcare quality"[14] may be included in a plan's Medical Loss Ratio but generally cannot be included in capitation.[15] States can also make value-added services like PRx, more attractive by including costs associated with these services in capitation through an 1115 waiver.[16]
- State Medicaid Managed Care Procurement/Contracting: states can incentivize or require plans to cover PRx services through their Medicaid managed care procurement and contract processes. For example, states can use federal regulations requiring plans to assess the needs of new patients and coordinate care to require plans to screen for and respond to food insecurity,[17] or use contract provisions regarding reporting/incentive arrangements or value-based payment model requirements[18] (i.e., incorporating metrics related to food insecurity and diet-related diseases into reporting and incentive arrangements at the plan or provider level).

Medicare

- Medicare Advantage: the state can engage with Medicare Advantage plans in the state to encourage utilization of Special Supplemental Benefits for the Chronically Ill (SSBCI), which allows Medicare Advantage plans to cover an expanded range of supplemental benefits, including food and produce, for enrollees living with chronic illness.[19]

Pilots

- States have and continue to initiate numerous grants/pilots alone and with the assistance of the federal government (e.g., HHS and USDA), healthcare entities, and philanthropic funders to provide critical resources for launching, evaluating, and/or expanding access to nutrition interventions, including produce prescriptions.

[1] Christian A. Gregory & Alisha Coleman-Jensen, U.S. DEP'T OF AGRIC., Food Insecurity, Chronic Disease, and Health Among Working-age Adults (2017), https://www.ers.usda.gov/webdocs/publications/84467/err-235_summary.pdf?v=2983.5.
[2] Hugh Waters & Marlon Graf, MILKEN INST., Costs of Chronic Disease in the U.S. (2018), https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL.pdf
[3] Jennifer N. Aiyer et al., A Pilot Food Prescription Program Promotes Produce Intake and Decreases Food Insecurity, 9 TRANSLATIONAL BEHAV. MED. 922 (2019), https://doi.org/10.1093/tbm/ibz112.
[4] Jessica Marcinkevage, Alyssa Auvinen, & Susmitha Nambuthiri, Washington State's Fruit and Vegetable Prescription Program: Improving Affordability of Healthy Foods for Low-Income Patients, 16 PREV. CHRONIC DIS. E91 (2019), http://dx.doi.org/10.5888/pcd16.180617.
[5] Christine M. Burrington et al., A Pilot Study of an Online Produce Market Combined with a Fruit and Vegetable Prescription Program for Rural Families, 17 PREVENTIVE MED. REP. 101035 (2020), https://pubmed.ncbi.nlm.nih.gov/32021759/.
[6] Benjamin Emmert-Aronson et al., Group Medical Visits 2.0: The Open Source Wellness Behavioral Pharmacy Model, 25 J. ALTERNATIVE & COMPLEMENTARY MED. 1026 (2019), https://pubmed.ncbi.nlm.nih.gov/31460769/.
[7] Michelle Cavanagh et al., Veggie Rx: An Outcome Evaluation of a Healthy Food Incentive Program, 20 PUB. HEALTH NUTR. 2636 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5743436/pdf/nihms866976.pdf.
[8] Richard Bryce et al., Participation in a Farmers' Market Fruit and Vegetable Prescription Program at a Federally Qualified Health Center Improves Hemoglobin A1C in Low Income Uncontrolled Diabetics, 7 PREVENTIVE MED. REP.176 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5496208/#__ffn_sectitle.
[9] Yujin Lee et al., Cost-effectiveness of Financial Incentives for Improving Diet and Health through Medicare and Medicaid: A Microsimulation Study, 16 PLOS MED. e1002761 (2019), https://doi.org/10.1371/journal.pmed.1002761.
[10] 42 U.S.C. § 1315(a)(2)(A).
[11] 42 U.S.C. § 1396n(b).
[12] 42 C.F.R. § 438.3(e)(2).
[13] 42 C.F.R. § 438.3(e)(1)(i).
[14] 45 C.F.R. § 158.150.
[15] 42 C.F.R. §§ 438.8(e)(2)(i)(A); 438.3(e)(1)(i).
[16] See OR. HEALTH AUTH., Health-Related Services Brief (Nov. 2021), https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf.
[17] 42 C.F.R. § 438.208(b).
[18] 42 C.F.R § 438.6(b), (c).
[19] CTRS. FOR MEDICARE & MEDICAID SERVS., Implementing Supplemental Benefits for Chronically Ill Enrollees (2019), https://www.cms.gov/-Medicare/Health-Plans/HealthPlansGenInfo Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

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