RESEARCH BRIEF

SNAP and Medicaid Work Together to Address Social Determinants of Health

Food Research & Action Center

The Supplemental Nutrition Assistance Program (SNAP) and Medicaid are two of the most effective entitlement programs for fighting poverty in the U.S. Medicaid provides health insurance to eligible households and individuals, with specific coverage differing based on each state's regulations and contracts. SNAP provides eligible households with benefits to purchase food from grocery stores, farmers' markets, and convenience stores using an Electronic Benefit Transfer (EBT) card. Nearly 80 million people are enrolled in Medicaid each month, while over 40 million people are enrolled in SNAP.[1] Both programs are administered on the state level using federal guidance and regulations — and there are significant opportunities for the programs to work together to meet the nutritional and health needs of people in America struggling with poverty.

SNAP's Impact on Health

Significant research has demonstrated a link between positive health outcomes and SNAP participation. Food insecurity is associated strongly with adverse health outcomes, including increased incidence of diseases, such as a higher likelihood for children to have asthma.[2] Recognizing the influence of food insecurity on health has led the Department of Health and Human Services (HHS) to deem food insecurity one of the social determinants of health (SDOH) — the social conditions that influence health outcomes.[3] Food insecurity is differently experienced along different identity categories, including disability and race/ethnicity, with Black non-Hispanic households disproportionately impacted compared to White households. Black non-Hispanic households are more than two times as likely to experience food insecurity as compared to their White counterparts.[4] SNAP empowers its participants each month to purchase food appropriate to their nutritional and cultural needs. And when adults participate in SNAP, they have an average $1,400 less in medical care costs than adults with low incomes who do not receive SNAP.[5]

SNAP and Medicaid Data Sharing

States are increasingly linking data between SNAP and Medicaid to connect potentially eligible populations and to simplify recertification processes by reducing the number of contacts needed with households, with 43 states adopting some kind of data-sharing practice between their state SNAP and Medicaid administrations.[6] Data sharing can help reduce administrative burdens, increase access, and enhance racial equity.[7] SNAP administrators may accept telephonic signatures when the state records the signature and links the recording with a case, a technology which not all states have implemented.[8] Since 2014, Centers for Medicare & Medicaid Services (CMS) requires that states accept telephonically recorded signatures.[9] For states with capabilities to record signatures, aligning SNAP and Medicaid telephonic signatures to collect recertification information is important to facilitating a more efficient and less burdensome recertification process for households and for administrators.

SNAP, Nutrition, and Medicaid Contracts

States are beginning to mandate that Medicaid providers conduct food insecurity screenings and connect patients to federal programs that combat food insecurity, including SNAP. Thirty states require some kind of SDOH screening, while 33 states mandate that providers maintain partnerships with social services organizations that can help enrollees address SDOH.[10] Supporting Medicaid's work on SDOH are flexible service demonstrations, commonly called 1115 waivers because they are authorized under Section 1115 of the Social Security Act. Under 1115 authority, HHS may approve experimental approaches to meeting the objectives of Medicaid. Every state has a state plan to administer Medicaid that is approved by CMS, and the 1115 waiver allows states to include options that are not typically included in state plans, which typically are reserved for things like covering drug costs. The 1115 authority is very broad, with the major stipulation being that the plan must be cost-neutral compared to state Medicaid costs without the waiver. Since 2010, with Georgia's initial waiver to support nutrition to reduce maternal mortality, states have integrated nutrition into their waivers, including food insecurity screenings, nutrition education, and a variety of Food Is Medicine approaches, including produce prescriptions and medically tailored meals.[11]

In 2022, HHS released guidance to expand what is allowable under section 1115 — states could begin to more explicitly use Medicaid funding for housing and nutrition supports. Food insecurity is defined as one of several "health related social needs" (HRSN), which are the individual experiences of SDOH. Social service delivery is an allowable use of 1115 authority so long as it is integrated with existing social services, including SNAP and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[12] Other provisions also encourage SNAP assistance — states that have 1115 authority to address HRSN must track SNAP enrollment among Medicaid beneficiaries. States addressing HRSN must also maintain sufficient provider rates for access to Medicaid for beneficiaries.

States' Medicaid Nutrition Screening Supports

Several states, both before and after the CMS expansion of acceptable nutrition supports for HRSN, require that Medicaid vendors screen for food insecurity and connect patients with crucial nutrition supports. In Minnesota, for example, the model managed care contract calls for prenatal risk screenings for pregnant women with providers required to refer patients who are potentially eligible for WIC.[13] Massachusetts' standard accountable care contract contains several provisions that mandate integration between Medicaid managed care and SNAP. Massachusetts calls for providers serving patients under age 21 to offer on-site SNAP application assistance. Additionally, when a provider finds that a patient is experiencing HRSN like food insecurity, the provider must refer the patient to social services, and the provider must maintain a relationship with an organization that offers SNAP application assistance.[14]

North Carolina is designing a model system for the rest of the country in their work to modernize their Medicaid system as they transition from a fee-for-service to a managed care model. The state Department of Health and Human Services, starting in 2017, designed a set of SDOH screening questions, which focus, in part, on food insecurity, and while use by managed care organizations is not mandatory, some providers are nevertheless adopting the screening with the knowledge that SDOH have a key impact on health outcomes.[15] The screening is integrated with the state's coordinated care network, NCCARE360, to refer patients to resources that address SDOH, including SNAP.[16] Patients experiencing food insecurity in certain high-risk regions are eligible for Healthy Opportunities Pilots that include more intensive support like meal delivery.

SNAP and HRSN Flexible Services Waivers

The 2022 expansion of HRSN-related 1115 waivers contains significant promise for SNAP to support the health of people experiencing poverty. Several states, including Oregon, Arkansas, and Massachusetts, have already integrated the new guidance into their 1115 waivers with approval from CMS.[17] Oregon's waiver allows for Medicaid enrollees who are undergoing "life challenges or transitions," including release from incarceration or an Institution for Mental Disease, past involvement with the child welfare system, Medicare/Medicaid dual enrollment, or homelessness, to access a variety of HRSN supports, including referrals to SNAP outreach support.[18] Arkansas' 1115 waiver, approved in 2022, includes support for HRSN, including connections to nutrition supports, for populations identified as high-risk, including young adults, rural people with substance abuse/mental illness, and pregnant women, through hospitals designated as a Life360 Health and Opportunity for Me (HOME) center that includes case management. However, in 2023, the state requested an amendment to the waiver, which would provide case management including food insecurity screenings to those at 20 percent of the federal poverty level, but enrollment in the plan is predicated on engagement with the case management, including employment, effectively imposing a work requirement for enrollees in deep poverty to maintain their current coverage.[19] Work requirements for Medicaid increase administrative costs and make health care more difficult to access — putting in jeopardy enrollees' crucial link to SNAP and forcing more difficult decisions between food and medicine.[20]

Given the many examples of states leveraging Medicaid funds to support nutrition, including connections to SNAP, states should continue to support Medicaid enrollees in navigating SNAP enrollment and recertification through implementing data-sharing practices and streamlining applications, and states should standardize and adopt practices for providers to screen and intervene through Medicaid and 1115 waivers to address HRSN. Increasing access to food through connecting SNAP to Medicaid will reduce medical costs, including Medicaid costs, while improving health outcomes.

Endnotes

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