Produce Prescriptions:
A U.S. Policy Scan

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CHLPI
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About the Authors

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Introduction

Produce prescription programs are a promising low-cost strategy to address food insecurity, improve health outcomes, and potentially decrease long-term health care costs. The term "produce prescription" is typically used to describe vouchers for free or discounted produce, distributed by health care providers to address a recipient's diet-affected health condition such as diabetes, prediabetes, or hypertension. These vouchers are then redeemed at retail grocers, farmers markets, or for purchases made from Community Supported Agriculture (CSA) programs.

Produce prescription programs have been shown to improve health outcomes by reducing financial burden and promoting the consumption of nutrient-rich foods.[1] Studies have found produce prescription programs to be associated with:

- Reductions in household food insecurity,[2,3]
- Increased fruit and vegetable consumption,[4]
- Lowered body mass index (BMI),[5] and
- Decreased hemoglobin A1C levels.[6]

Additionally, by lowering the cost of healthy food and thus reducing overall financial burden, produce prescription programs have the potential to diminish the use of harmful coping strategies that food insecure individuals often adopt to mitigate limited financial resources, such as delaying or forgoing medical care;[7,8] engaging in cost-related medication underuse;[9,10,11] choosing between food and other basic needs such as utilities;[12,13] opting to consume low-cost, energy dense foods;[14,15,16] and/or forgoing foods needed to address specific medical conditions.[17]

Benefits of produce prescription programs can also extend beyond the recipients of the intervention. As many produce prescription programs involve an educational component (e.g., counseling or role modeling from health care professionals), these interventions create opportunities to enhance provider communication skills and improve provider-patient relationships.[18] Further, because produce prescriptions are often redeemed at farmers markets, participating farmers are likely to experience an increase in customer base and revenue.[19] Produce prescriptions are also increasingly redeemed in brick-and-mortar retail settings such as grocery stores,[20] creating similar potential for these retailers and for the local economies in which they operate.[21]

Despite these benefits, access to produce prescriptions remains limited across the United States. Historically, funding to support the growth of and research surrounding these interventions has been provided on a limited or pilot basis by community-based organizations, research institutions, or through private, local, or state grants.[22] As a result, produce prescription programs have often been small, narrowly targeted, or time-limited, making it difficult to scale

up to meet the need for these services.

Faced with mounting pressure to control health care costs and improve health outcomes, health care payers (i.e., insurers), providers (i.e., physicians and health care institutions), and policymakers are increasingly interested in the role that nutrition interventions can play in addressing the burden of diet-affected chronic disease. Simultaneously, supporting local, sustainable production continues to be a priority for food systems practitioners and agricultural-focused policymakers to enhance the social, economic, and ecological vitality of their regions. As a result, new opportunities are emerging in the U.S. health care and food systems that could provide the funding and infrastructure needed to mainstream access to produce prescriptions.

Purpose of this Document

The tables below provide an overview of opportunities to support produce prescription programs, as well as ongoing gaps that must be addressed to create the policy environment needed to sustainably fund and scale-up produce prescriptions for the populations that need them most, including low-income populations living with or at risk for diet-affected disease. In doing so, this Policy Scan lays the groundwork for a broader **National Produce Prescription Policy Strategy Report** to be published in 2021 that will provide a strategic roadmap for action in this space.

Table I provides an overview of opportunities and policy gaps for supporting and scaling produce prescriptions via the U.S. health care system. **Table II** provides an overview of similar opportunities and gaps within the U.S. food system, with a particular eye to programs that provide funding or infrastructure that could be leveraged to support produce prescriptions. **These Tables are living documents that will be updated over time as federal legislation, regulations, and guidance evolve to better support produce prescription programs across the nation.**

I. Health Care System Opportunities and Gaps

The U.S. health care system has not historically provided funding to support food access. However, recent research has highlighted the critical role that food security and overall nutrition play in driving patient health outcomes and costs. As a result, new policies are emerging that allow nutrition interventions, such as produce prescriptions, to be funded via health care payment streams. **Table I** provides a high-level summary of these opportunities, as well as funding gaps, in two of the most critical health insurance payment systems for food-insecure populations: Medicare and Medicaid.

Table I: Health Care System Opportunities and Gaps

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Medicare			
Original Medicare (Medicare Parts A & B)	**Part A:** 42 U.S.C. §§ 1395c - 1395i-5, 1395x 42 C.F.R. § 409 **Part B:** 42 U.S.C. §§ 1395j – 1395w-6, 1395x 42 C.F.R. § 410		Medicare provides health insurance coverage for individuals aged 65 and older, some individuals with disabilities, and individuals living with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS). Roughly two thirds of Medicare beneficiaries receive their Medicare coverage directly from the federal government through the Original Medicare program (a/k/a Medicare Parts A & B). Original Medicare currently does not provide coverage for produce prescriptions. Original Medicare therefore presents a policy gap—rather than an opportunity—for scaling produce prescriptions.
Medicare Advantage (Medicare Part C) Supplemental Benefits	42 U.S.C. § 1395w-22(a)(3) 42 C.F.R. § 422.102	Medicare Managed Care Manual Ch. 4 § 30 (2016) Medicare Advantage 2020 Final Call Letter CMS Letter to MAOs, Implementing Special Supplemental Benefits for Chronically Ill Enrollees (Apr. 24, 2019)	Roughly one third of Medicare enrollees receive their Medicare coverage from private insurers through the Medicare Advantage program (a/k/a Medicare Part C). Medicare Advantage plans must generally cover all services covered in Original Medicare. However, Medicare Advantage plans also have some flexibility to go beyond Original Medicare to cover additional services as "supplemental benefits." These supplemental benefits must typically be "primarily health related." Historically, CMS has allowed coverage for meals (e.g., medically tailored meals or meals provided by Meals on Wheels organizations) as a Medicare Advantage supplemental benefit under certain limited circumstances. However, current guidance suggests that CMS would likely not allow produce prescriptions to be covered as a general supplemental benefit because it does not consider the provision of unprepared food—as opposed to meals—to be primarily health related.
Medicare Advantage (Medicare Part C) Special Supplemental Benefits for the Chronically Ill (SSBCI)	42 U.S.C. § 1395w-22(a)(3)(D) 42 C.F.R. § 422.102(f)	85 Fed. Reg. 33800-05 (June 2, 2020) Medicare Advantage 2020 Final Call Letter CMS Letter to MAOs, Implementing Special Supplemental Benefits for Chronically Ill Enrollees (Apr. 24, 2019)	As of 2020, Medicare Advantage plans may offer a new category of supplemental benefits known as Special Supplemental Benefits for the Chronically Ill (SSBCI). Under this new category, Medicare Advantage plans may provide additional supplemental benefits to individuals who are chronically ill, including benefits which are not primarily health related. CMS guidance has indicated that SSBCI may include food and produce. Medicare Advantage plans may therefore cover produce prescriptions under this option.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Medicare			
Medicare Advantage (Medicare Part C) Value-Based Insurance Design Model (VBID)	42 U.S.C. § 1315a (creating the Center for Medicare and Medicaid Innovation (CMMI)) 42 U.S.C. § 1395w-28(h) (extending the VBID model to all states)	CMS, Value-Based Insurance Design Model Request for Applications for CY 2021	The VBID Model is a demonstration project operated by the Center for Medicare and Medicaid Innovation (CMMI). Medicare Advantage plans from all 50 states may apply to participate in this demonstration project. The VBID model gives participating plans the flexibility to use cost-sharing and health plan design to encourage patients to "use the services that can benefit them the most." As part of this flexibility, participating plans may provide additional supplemental benefits to target populations based upon chronic illness, socioeconomic status, or both. These supplemental benefits do not need to be primarily health related. CMS guidance has indicated that non-primarily health related supplemental benefits provided via the VBID program may include a variety of food items (meals, food, groceries). Participating Medicare Advantage plans may therefore cover produce prescriptions under this option.
Medicaid			
Standard Medicaid	42 U.S.C §§ 1396d (covered benefits), 1396a (mandatory services) 42 C.F.R. §§ 440.1 – 185 (service definitions), 440.210 – 225 (mandatory and optional services)		Traditionally, Medicaid has provided health insurance coverage to certain categories of low-income individuals, such as children, pregnant women, older adults, and people with disabilities. Under the Affordable Care Act, states now also have the option to provide coverage to the Medicaid expansion population, which includes all adults with incomes up to 138% of the federal poverty level (FPL). Federal law and regulations establish a baseline of mandatory benefits that all states must cover for their traditional Medicaid population as well as a series of optional benefits. Federal law and regulations also establish ten categories of Essential Health Benefits (EHBs) that states must cover for their Medicaid expansion population. Medicaid does not currently provide coverage for food within any of its mandatory or optional benefit categories or EHBs. The statutory and regulatory definitions of certain categories of benefits, such as home health services and rehabilitative services, appear broad enough to include food, but CMS has not explicitly interpreted them to do so up to this point. States therefore generally cannot cover produce prescriptions as part of their standard Medicaid State Plan.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Medicaid			
Medicaid Managed Care	**In lieu of services:** 42 C.F.R. §§ 438.3(e)(2); 438.8(e)(2)(i)(A) **Value-added services:** 42 C.F.R. §§ 438.3(e)(1)(i); 438.8(e)(2)(i)(A) **Quality improvement activities:** 42 C.F.R. § 438.8(e)(1), (3); 45 C.F.R. § 158.150(b), (c)		As of 2017, roughly two-thirds of Medicaid enrollees received Medicaid coverage through private insurers known as Medicaid Managed Care Organizations (MCOs). MCOs must generally provide coverage of all benefits in their Medicaid State Plan, but have historically had some flexibility to go further, providing coverage of additional items and services including food. These flexibilities include regulatory provisions regarding "in lieu of" services, value-added services, and, potentially, quality improvement activities. • **In lieu of services:** Services provided as a cost-effective substitute to a service covered under the State Plan. • **Value-added services:** Services not otherwise covered in the State Plan but voluntarily provided by the MCO. • **Quality Improvement Activities:** Activities conducted by the MCO designed to improve health quality and outcomes. MCOs can likely cover produce prescriptions under these options. However, depending on the category used, plans may not be able to include the costs of these services in their capitation rate (i.e., the amount the plan receives per member per month to deliver care). In lieu of services and quality improvement activities may be included in capitation (as covered benefits and administrative services, respectively). Value-added services may not be included in capitation.
Section 1115 Demonstration Waiver	42 U.S.C. § 1315 42 C.F.R. §§ 431.400 – 431.428		State Medicaid agencies may apply for a Section 1115 Demonstration Waiver to waive elements of the Medicaid statute to test new approaches that promote the objectives of the Medicaid program. As part of this process, states may request CMS approval to provide additional benefits to Medicaid enrollees. Several states (e.g., MA, NC) have used Section 1115 Waivers to provide coverage of produce prescriptions or similar services.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Medicaid			
1915(c) Waiver	42 U.S.C. § 1396n(c) 42 C.F.R. §§ 440.180 (benefits), 441.300-310 (with 441.310(a)(2) discussing meals)	CMS, Application for a 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide, and Review Criteria (Jan. 2019)	State Medicaid agencies may apply for a Section 1915(c) Waiver to waive elements of the Medicaid statute to provide home and community-based services to individuals who would otherwise require an institutional level of care. CMS has historically allowed states to use Section 1915(c) Waivers to cover meals but not "board," with board defined as "3 meals a day or any other full nutritional regimen." Given the past use of Section 1915(c) Waivers to cover meals, states may be able to cover produce prescriptions under this type of waiver. However, some individuals who receive home and community-based services may experience mobility issues and be unable to shop and cook for themselves. As a result, the impact of covering produce prescriptions under this type of waiver may be limited.
1915(i) State Plan Amendment/Waiver	42 U.S.C. § 1396n(i) 42 C.F.R. §§ 440.182(c) (benefits), 441.700-745		State Medicaid agencies may submit a State Plan Amendment (SPA) to provide home and community-based services to individuals with incomes below 150% of the federal poverty level (FPL) who meet certain needs-based criteria but do not yet require an institutional level of care. States who use this SPA option may also submit a waiver to provide home and community-based services to individuals who: (1) are eligible for home and community-based services under a 1915(c), 1915(d), 1915(e), or 1115 Waiver in the state and (2) have incomes that do not exceed 300% of the supplemental security income benefit rate. In both cases, these services may not include "board," defined as "3 meals a day or any other full nutritional regimen." However, CMS has historically allowed some coverage of meals under this option. Given past coverage of meals, states may be able to cover produce prescriptions under this type of amendment/waiver. As with 1915(c) Waivers, the impact of this opportunity may depend upon the level of mobility in this population. While individuals served under 1915(i) SPAs/waivers may not yet require an institutional level of care, some may still have difficulty shopping or cooking for themselves, limiting their ability to participate in a produce prescription program.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Medicaid			
1915(k) State Plan Amendment	42 U.S.C. § 1396n(k) 42 C.F.R. §§ 441.500 – 590	CMS, Community First Choice State Plan Option Technical Guide (2019) CMS, State Medicaid Director Letter, Community First Choice State Plan Option (Dec. 2016)	States may submit a State Plan Amendment (SPA) to provide home and community-based attendant services and supports to individuals who qualify for Medicaid, require an institutional level of care, and are either in a Medicaid eligibility category that has access to nursing facility services or have an income under 150% FPL. States receive a 6% increase in federal funds for services and supports offered via this type of SPA (i.e., a 6% increase in their Federal Medical Assistance Percentage). Under this option, states may cover expenditures that substitute for human assistance. States have used the 1915(k) SPA option to cover meals, but may not cover "board," defined as "3 meals a day or any other full nutritional regimen." Given past coverage of meals, states may be able to cover produce prescriptions under this type of amendment. However, as with 1915(c) Waivers, individuals served under 1915(k) SPAs may have mobility issues, limiting their ability to participate in a produce prescription program.
Dual Eligible Programs			
Dual Eligible Special Needs Plans (D-SNPs)	42 U.S.C. §§ 1395w-28(b)(6)(defining SNPs), 1395w-22(a)(3) (supplemental benefits) 42 C.F.R. § 422.102(e) (Dual SNP supplemental benefits)	Medicare Managed Care Manual, Ch. 16-B § 20.2 (2016)	Dual eligibles are individuals who are eligible for both Medicare and Medicaid coverage. D-SNPs are Medicare Advantage plans that specifically serve dual eligible populations. As Medicare Advantage plans, D-SNPs may cover produce prescriptions as Special Supplemental Benefits for the Chronically Ill (SSBCI) (described in more detail in the rows above). Additionally, D-SNPs that meet certain requirements may offer standard supplemental benefits that exceed those allowed in typical Medicare Advantage plans. These additional benefits must be provided at no cost to enrollees, and CMS must find that these benefits will improve integration of care for enrollees. CMS has provided guidance allowing D-SNPs greater flexibility to cover meals as a standard supplemental benefit, but has not addressed covering other types of food. Given this flexibility regarding meals, D-SNPs may be able to cover produce prescriptions as both SSBCI and standard supplemental benefits.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Dual Eligible Programs			
Dual Demonstrations	42 U.S.C §§ 1315a(b)(2)(B)(x) (establishing CMMI and its authority to conduct dual demonstration projects), 1315b (creating the Federal Coordinated Health Care Office)	CMS, Financial Alignment Initiative CMMI, Financial Alignment Initiative for Medicare-Medicaid Enrollees CMS, State Medicaid Director Letter 11-008 (July 2011)	A number of states currently participate in the Center for Medicare and Medicaid Innovation's (CMMI) State Demonstrations to Integrate Care for Dual Eligible Individuals. Under this demonstration model, states may seek CMS approval to provide services not currently covered under their State Plan. This demonstration model is highly flexible and states have used the model to provide coverage for meals. Given this history of flexibility, states can likely cover produce prescriptions under this option.

II. Food System Opportunities and Gaps

The federal food system provides various funding mechanisms to support food access for low-income households. These programs also provide infrastructure for deploying nutrition benefits—such as existing technology, retailer networks, administrative support systems—that could be leveraged in varying degrees to support produce prescription expansion. While the principal method of providing nutrition benefits continues to be the Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, the U.S. Department of Agriculture oversees a number of other programs intended to supplement or build upon SNAP benefits.[23] **Table II** provides a high-level summary of opportunities and gaps in the current federal food system.

Table II: Food System Opportunities and Gaps

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Supplemental Nutrition Assistance Program (SNAP)			
Original SNAP	7 U.S.C. §§ 2011 – 2036d 7 C.F.R. §§ 271.1 – 285.5		SNAP provides important nutritional support for low-income households in the form of monetary benefits that may be spent on eligible food items at participating retailers or vendors. SNAP reached about 37 million individuals, or 19 million households, in the months prior to COVID-19. SNAP benefits are loaded onto an electronic benefit transfer (EBT) card, which functions like a debit card, that participants can use to purchase eligible food items. The recent expansion of SNAP's Online Purchasing Pilot creates new opportunities to redeem public benefits through online vendors and may provide future avenues for redeeming produce prescriptions. The SNAP EBT system could provide an existing payment infrastructure to support the addition of a new cash benefit that supports produce purchasing as part of a produce prescription program. This opportunity is limited, however, by the technological challenges of building out a produce-specific benefit in the EBT system and SNAP data-sharing restrictions that could inhibit some elements of program tracking and evaluation. SNAP oversight responsibilities are divided between federal, state, and local agencies. The U.S. Department of Agriculture's Food and Nutrition Service issues guidance and regulations that govern the program generally—subject to state waivers and flexibilities—and approves and monitors the retailers accepting SNAP benefits. State and local agencies administer most other aspects of the program—e.g., individual applications and participation—in their respective jurisdictions. State and local agencies administering SNAP could provide a home for produce prescription program oversight if provided with additional funding and resources.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Supplemental Nutrition Assistance Program (SNAP)			
Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed)	7 U.S.C. § 2036a 7 C.F.R. § 272.2(d)(2)	FY2020 SNAP-Ed Plan Guidance	SNAP-Ed funds state sponsored nutrition education and obesity prevention programs for low-income individuals. While SNAP-Ed may provide an avenue for promoting produce prescription participation, it does not directly support food purchases.
Disaster SNAP (D-SNAP)	42 U.S.C. §§ 5170a, 5179	Disaster SNAP Guidance (July 2014)	D-SNAP provides short-term SNAP assistance for households impacted by a declared disaster. Given the temporary, ad-hoc nature of the program, D-SNAP does not provide opportunities to support scaling up produce prescription programs.
Gus Schumacher Nutrition Incentive Program (GusNIP)			
SNAP Incentives[24]	7 U.S.C. § 7517(b) 7 C.F.R. §§ 3430.1100 – 1108	GusNIP Request for Application (RFA) 2020, NIFA (2020) GusNIP 2019 FAQs, NIFA (2019) State Flexibilities Promoting FINI Grants, FNS (2018)	The SNAP Incentives program provides pilot funding for programs that supplement existing SNAP benefits with additional support for specific food items, such as produce. In 2019, USDA awarded $41.4 million to support GusNIP grants, including support for the produce prescription programs and the technical assistance services described below. SNAP Incentive grantees must match federal funds on a dollar-for-dollar basis with cash and/or in-kind contributions, with some limited exceptions. Existing grantee programs provide systems and infrastructure for redeeming produce-specific benefits, though these elements vary by project. GusNIP funding for SNAP Incentive projects can support less-formal produce prescription programs that do not meet the parameters of, or otherwise receive funding through, the GusNIP Produce Prescription Program.
Produce Prescription Program	7 U.S.C. § 7517(c) 7 C.F.R. §§ 3430.1100 – 1108	GusNIP Request for Application (RFA) 2020, NIFA (2020)	Up to 10% of funding available under GusNIP is set aside to provide grants for produce prescription projects. Under the program, a government agency or nonprofit organization, in partnership with a health care provider, can apply for pilot funds to conduct a produce prescription project that demonstrates and evaluates the impact of the project on the improvement of dietary health through increased consumption of fruits and vegetables; the reduction of individual and household food insecurity; and the reduction in health care use and associated costs. Program grantees are not required to match the federal grant award. The program is the most direct federal support for produce prescription projects, but funding streams are time-limited due to the grant structure of the program.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Gus Schumacher Nutrition Incentive Program (GusNIP)			
Training, Technical Assistance, Evaluation, and Information Centers (The Centers)	7 U.S.C. § 7517(e) 7 C.F.R. § 3430.1100 – 1108	GusNIP 2019 Request for Applications (RFA), NIFA (2019)	A new component of GusNIP, the Centers are expected to provide training and technical assistance to GusNIP applicants and grantees, as well as compile and evaluate data sets from eligible entities. GusNIP produce prescription grantees are also required to communicate core data to the Centers for collection and evaluation. While the Centers do not directly provide produce prescription services, their creation has built useful infrastructure that may enhance the capacity of produce prescription programs moving forward.
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)			
WIC	42 U.S.C. § 1786 7 C.F.R. § 246.1 – 246.29	WIC Income Eligibility Guidance, (May 2019) WIC EBT Technical Implementation Guide & Operating Rules (2018) WIC Food Package Policy & Guidance (2018) WIC Nutrition Services Standards (2013)	WIC provides supplemental nutritious food, nutrition education and counseling, and referral services to support low-income pregnant and postpartum women and children. The program reached approximately 6.4 million individuals in 2019, though that number likely reflects just over half of those eligible to receive WIC benefits. WIC employs a clinical model similar to that of produce prescription programs, making it a ready analogue for produce prescription expansion nationwide. A WIC participant's benefits reflect one of seven available "food packages"; benefits may then be redeemed at authorized retailers to purchase the approved items. WIC prescribes the type and quantity of most food items that may be purchased with WIC benefits. For fruit and vegetables, however, WIC provides a cash-value benefit that may be used to purchase fruits and vegetables up to the cash-value amount. This benefit is currently set at $11 a month for women and $8 a month for children.[25] States have spent the last several years transitioning WIC from a voucher system to an EBT system (eWIC), with most states fully transitioned or in an "implementation phase" as of August 2020. With integration of the cash-value benefit into the electronic benefit system already underway, eWIC may provide a mechanism for issuing additional cash benefits to support more fruit and vegetable purchases. This opportunity faces challenges in that WIC currently reaches a relatively small and narrowly defined segment of the population and has much fewer approved vendors than SNAP. Similar to SNAP, WIC imposes confidentiality rules and data-sharing restrictions that may also pose challenges.

Sub-Program	Law(s)/ Regulations	Guidance	Summary
Farmers Market Nutrition Program (FMNP)			
WIC FMNP	42 U.S.C. § 1786(m) 7 C.F.R. §§ 248.1 – 248.26	Questions from the National Association of Farmers' Market Nutrition Programs (NAFMNP) State Plan Session (Nov. 2000) WIC and WIC FMNP Cost Allocation (Aug. 2002)	WIC FMNP participants receive checks or coupons to purchase fruits and vegetables at state-approved, participating farms, farmers markets, and farm stands. Farmers then submit the checks or coupons to banks or state agencies for reimbursement. This straightforward, existing redemption infrastructure offers an opportunity for produce prescription programs to build out partnerships with local agricultural producers, as well as with the state and local agencies administering the programs. The program also models a methodology for the federal government to distribute supplemental benefits limited to fruit and vegetable purchases. The opportunity may be restrained by current capacity, as the annual benefit amount is capped at $30 (min. $10) and reaches only a portion (around 25% in 2018) of WIC households. Additionally, the program is, by definition, limited to farm-vendors and does not provide a connection to brick-and-mortar retail. The current paper-based system also lacks the efficiency and tracking capabilities an electronic system might provide.
Senior FMNP (SFMNP)	7 U.S.C. § 3007 7 C.F.R. §§ 249.1 – 249.27	SFMNP Income Guidelines (Nov. 2017)	SFMNP participants receive checks or coupons to purchase fruits and vegetables at state-approved, participating farms, farmers markets, farm stands, and community supported agriculture (CSA) programs. Farmers then submit the checks or coupons to banks or state agencies for reimbursement. As with WIC FMNP, produce prescription programs could take advantage of the existing redemption infrastructure and build out partnerships with local agricultural producers. Program capacity is currently limited as, similar to WIC FMNP, benefits are limited at $20–$50 per household annually. The current paper-based system also lacks the efficiency and tracking capabilities an electronic system might provide. Additionally, while WIC FMNP's integration with WIC means that participants meet with a health care provider in order to participate in the program, SFMNP does not incorporate an intersection with the health care system. Expanding and redesigning the program to incorporate such an intervention (i.e., employing a produce prescription model) could provide an additional opportunity to evaluate the health impacts of increased access to produce on older adults.

Conclusion

As shown in the tables above, policy pathways are emerging within the U.S. health care and food systems to scale access to produce prescriptions. Within the health care system, the most promising of these pathways include new Special Supplemental Benefits for the Chronically Ill within Medicare Advantage plans, Medicaid Section 1115 Demonstration Waivers, and the range of options that allow Medicaid Managed Care Organizations to provide new and innovative benefits.

While these policies present significant opportunities to fund produce prescriptions, several challenges may prevent progress in this space. First, federal laws and regulations do not mandate coverage of nutrition interventions in Medicaid or Medicare. As a result, it is up to individual states and health plans to decide whether or not to use these levers to cover produce prescriptions. This leaves coverage inconsistent and subject to change as priorities shift over time. Second, federal guidance regarding some of these opportunities—especially those within Medicaid—is limited or vague. Without clear guidance, states and plans may hesitate to act, passing up opportunities to support produce prescriptions. Finally, and perhaps most importantly, these changes still leave out large segments of the population. For example, Original Medicare (i.e., Medicare Parts A & B), which covers two-thirds of Medicare enrollees, still provides no option to cover produce prescriptions.

Similarly, within the food system, federally-supported nutrition programs provide opportunities to leverage existing investments and benefit-administration models to support the expansion of produce prescription programs. Currently, the federal government directly supports produce prescription programs through USDA grants issued under GusNIP. Growth opportunities are limited, however, due to the time-restricted nature of the grant program and the amount of funding available relative to program costs. Beyond direct funding, federal programs like SNAP, WIC, and FMNP offer state and federal infrastructure that could be built out further to incorporate produce prescription benefits. However, integration into any one of these systems would require time, resources, and careful coordination to expand the technological and administrative capacity to operate an additional benefit. Finally, federal investments in sustaining the GusNIP SNAP Incentives grants and creating the new Training, Technical Assistance, Evaluation, and Information Centers should yield important insights and innovations to better support both nutrition incentive and produce prescription programs, which may provide alternative, scalable mechanisms for more mainstream produce prescription programming without necessarily relying on the SNAP or WIC EBT systems.

While U.S. policymakers have laid a promising foundation for scaling produce prescription programs, significant change is still needed to truly mainstream access to these services. The **National Produce Prescription Policy Strategy Report** will examine potential approaches to such change, and we will continue to update this document to reflect the evolving policy landscape.

Note on Future Updates: As stated above, this is a living document. We aim to provide a comprehensive overview of opportunities for produce prescriptions in relevant programs in the U.S. health care and food systems. We therefore welcome suggested additions to this document. If you have recommended additions, please contact Katie Garfield and Emma Scott at kgarfield@law.harvard.edu and escott@law.harvard.edu.

Endnotes

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[16] Kathryn Edin et al., U.S. Dep't of Agric., SNAP Food Security In-Depth Interview Study (2013).

[17] Hilary K. Seligman et al., Food Insecurity and Glycemic Control Among Low-Income Patients with Type 2 Diabetes, 35 Diabetes Care 233 (2012).

[18] Swartz, supra note 1.

[19] Id.

[20] See, e.g., Produce Prescriptions, Reinvestment Partners, https://reinvestmentpartners.org/what-we-do/produce-prescriptions/ (last visited Aug. 18, 2020) (describing Reinvestment Partners' partnership with Food Lion for its produce prescription program);Food as Medicine: North Carolina Commits $2.5 Million to Prescription Produce Program, Am. Heart Ass'n Voices for Healthy Kids (Aug. 10, 2020), https://voices-forhealthykids.org/impact/success-stories/food-as-medicine-north-carolina-commits-usd2-5-million-to-prescription-produce-program (describing North Carolina's recent investment of $2.5 million to expand access to Reinvestment Partners' produce prescription program).

[21] Produce prescriptions, which provide additional dollars for individuals to spend on produce, have the potential to have a similar economic impact to other food assistance programs such as SNAP. Research indicates that spending SNAP dollars results in a broader economic benefit (e.g., $1 billion in SNAP spending could result in $1.54 billion increase in GDP). See, e.g., Patrick Canning & Rosanna Mentzer Morrison, Quantifying the Impact of SNAP Benefits on the U.S. Economy and Jobs, U.S. Dep't of Agric., Econ. Rsch. Serv (Jul. 18, 2019), https://www.ers.usda.gov/amber-waves/2019/july/quantifying-the-impact-of-snap-benefits-on-the-us-economy-and-jobs/.

[22] Swartz, supra note 1. .

[23] While other federal programs—like school feedings programs—provide nutritional support in certain settings, this analysis focused on those providing supplemental assistance outside of such institutional settings.

[24] For purposes of these tables, "SNAP Incentives" collectively refers to the GusNIP Pilot Projects, GusNIP Projects, and GusNIP Large Scale Projects.

[25] Food packages for infants include a quantity-specific portion of infant fruits and vegetables instead of a cash-value benefit, with some flexibility for states to permit issuance cash-value benefits on an individualized basis for infants 9 months through 11 months.