AMPL INSTITUTE

A VIEW OF THE FIELD

THE EVOLVING LANDSCAPE OF MEDICALLY TAILORED NUTRITION IN 2025

Foreword by United States Representative Jim McGovern

COMMUNITY SERVINGS FOOD HEALS

Acknowledgments

The AMPL Institute Advisory Committee

Nora Moreno Cargie, President, Point32Health Foundation
Kevin Cranston, Senior Policy Advisor, Bulfinch Strategies Group
Aretha Delight Davis, CEO, ACP Decisions
Thomas Dehner, Executive Director of Medicaid Accountable Care Organizations, Boston Medical Center Health System
Jason Evans, Dean of the College of Food Innovation and Technology, Johnson & Wales University
David Farwell, Head of Specialty Finance, Eastern Bank
Jack Shonkoff, Founding Director, Center on the Developing Child, Harvard University
Methodius Tuuli, Chief of Obstetrics and Gynecology, Women & Infants Hospital & Chair of Obstetrics and Gynecology, Brown University
Priscilla Wang, Associate Medical Director, Primary Care Health Equity, Massachusetts General Hospital
Debra J. Williams, International Healthcare Executive

This report was written by the following Community Servings staff members:

James Flaherty, Senior Manager of Communications
Liz Hatzenbuehler, Senior Manager of Food and Health Policy
Ryan Levasseur, Director of Communications
Jean Terranova, Senior Director of Policy and Research
David B. Waters, Chief Executive Officer

The designer of this report was Anna Zaharewicz, Multimedia Design and Social Media Specialist, Community Servings.

The AMPL Institute thanks Takeda for contributing to the development of this report.
We also thank the following individuals for their time and expertise:

Nancy Brumbaugh, Chief Food Service Officer, Second Harvest Food Bank of Central Florida
Erin DiBacco, Senior Director of Strategy and Business Development, Community Servings
Katie Ettman, Deputy Director, Fullwell
Katie Garfield, Director of Whole Person Care, the Center for Health Law and Policy Innovation, Harvard Law School
Jody Grant, Senior Director of Operations, Meals on Wheels People
Hannah Griswold, Food as Medicine Director, La Soupe
Brian Hillmer, Chief Culinary Officer, Community Servings
Leigh Kalbacker, Senior Director of Programs, Community Servings
Dawn Koffarnus, Chief Health Systems & Financial Officer, Second Harvest Food Bank of Central Florida
Tim Leahy, Chief Development Officer, Community Servings
Tobin Scipione, Director of Strategic Partnerships, Community Servings
Silifa Wallace, Chief Financial Officer, Community Servings
Dorella Walters, Chief Business Development Officer, God's Love We Deliver
Suzanne Washington, Chief Executive Officer, Meals on Wheels People
Alissa Wassung, Executive Director, the Food is Medicine Coalition
Leah Hebert Welles, Chief Executive Officer, Open Arms of Minnesota
Renata Wilson, Chief Operations Officer, Meals on Wheels People

The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of any other organization, including partners or funders.

Table of Contents

Foreword

Thanks to the amazing work of advocates across the country and the 2022 White House Conference on Hunger, Nutrition, and Health, the Food is Medicine movement is gaining momentum like never before.

Its bold vision asks: What if everyone had access to the nutritious food they needed for health and well-being? What if access to nutritious food really helped us live healthier, more independent lives? If so, what would society be like? What would the healthcare system be like?

Thanks to Community Servings' research, we know the answers: People with chronic illnesses would be healthier and healthcare would be more efficient. Through medically tailored meals (MTM), people with severe, complex illnesses have better health outcomes. They use the emergency room less often. They require less frequent inpatient admissions. By expanding access to MTM, millions of hospitalizations could be averted and healthcare spending could decline across the country. It's not an exaggeration to say the future of our country depends on our good health. That's why I have teamed up with a group of bipartisan members of Congress to advance legislation that would pilot the coverage of MTM in Medicare.

For decades, nonprofits like Community Servings have kept alive the vision of Food is Medicine while the rest of society catches up. In Congress, there is now more bipartisan interest than ever in expanding successful Food is Medicine interventions like MTMs. I am excited to continue working with experts on the ground – like the incredible visionaries who run Community Servings and the Food is Medicine Coalition – and both Republicans and Democrats in Congress to save lives and improve health.

My friends at Community Servings are uniquely dedicated to serving their communities and advancing this field. With you, I'm celebrating the launch of the AMPL Institute, this evolution of Community Servings' work in support of access to medically tailored nutrition. I couldn't be more grateful to partner with an organization so highly qualified and dedicated. I hope you will join me in doing so.

REPRESENTATIVE JIM MCGOVERN (D-MA)

Introduction from David B. Waters, CEO

Thirty-five years ago, it was the height of the HIV crisis. People in the community who were living with HIV/AIDS — cherished friends, family members, and neighbors — were isolated and lacked care. Federal supports like the Ryan White HIV/AIDS Program were just beginning to emerge. However, the term medically tailored meals (MTM) didn't exist yet. Neither did Medicare or Medicaid funding for the provision of social services. It was a challenging time. Today much has changed, but the challenges seem just as daunting.

Community Servings and other nonprofit organizations around the country were founded to take action. Preparing and home-delivering healthy meals, we drew from our love of food and our commitment to meet the needs of loved ones. In the process, this nonprofit coalition invented a creative intervention. Philanthropy, grants, and the Ryan White HIV/AIDS Program made the work possible, but we soon realized that to serve all of the people who needed MTM, regardless of their illness, we needed more resources. Even more consequentially, we realized that many of our goals — such as improving health outcomes and empowering people to live healthier lives independently — were beginning to match those of an evolving healthcare system. That's why, 10 years ago, Community Servings and our peers began to align our efforts with innovative healthcare payment and delivery initiatives happening in Massachusetts.

Partnering With Healthcare

The emotional benefits of MTM were obvious — feelings of vitality, for example, and the connection with a caring delivery driver. Could we prove the clinical and economic benefits, as well? Alongside dedicated funders and leading researchers, we embarked on a new initiative to measure MTM's impact. And it worked. Community Servings' research proved that MTM accomplishes a unique feat in healthcare. It improves dietary quality, reduces healthcare utilization, and reduces healthcare costs. It improves health outcomes for people with severe, complex, and chronic illnesses and reduces their reliance on costly healthcare services.

Fast-forward to 2025 and a new field is emerging. It's growing with a speed that we never could have imagined. Central to that growth is Community Servings' rigorous research, including one of the nation's largest MTM studies, which has catalyzed efforts across sectors to address the historically overlooked connection between nutrition and health. The Food is Medicine concept originated in the social services space. Today it reaches much further. Food is Medicine has become a movement. It has gained passionate advocates among elected officials, government agencies, food-based nonprofits, and leaders in the healthcare system. The results have been rapid and extraordinary. Medically tailored nutrition, little understood 10 years ago, is becoming a valued clinical tool. And there's more work to be done.

Introducing the AMPL Institute

In this important moment, Community Servings is launching the **AMPL Institute for Access to Medically Tailored Nutrition through Policy and Leadership**. The mission is to transform the healthcare system so that medically tailored nutrition becomes a universally accessible standard of comprehensive, person-centered care. The AMPL Institute will pursue this goal through research, policy advocacy, and provider education, strengthening the provision of medically tailored nutrition within healthcare in the coming years.

The first installment of a regular publication, the *View of the Field* report is AMPL's commentary on current access to medically tailored nutrition in the United States.

It surveys the evolving landscape, summarizing recent progress and identifying opportunities for further advancement. It was written to achieve many purposes: to inform policymakers, to guide healthcare and nutrition service providers, and to give new and dedicated partners an on-ramp to the field. By design, however, the report is one organization's point of view. It provides a thoughtful summary, but it leaves much of the story for others to tell. Many important services exist under Food is Medicine. Our focus here is medically tailored nutrition.

I want to emphasize that the work of the AMPL Institute is inseparable from 35 years of providing MTM in Massachusetts and Rhode Island. As MTM advances into healthcare, we remain dedicated, first and foremost, to helping people in the community live healthier, stronger lives. MTM works. It should be a reimbursed health benefit anywhere in America. That's the goal we're working toward.

DAVID B. WATERS, CEO

Selected Policy Advancements in Medically Tailored Nutrition

1990	Congress passes the Ryan White CARE Act, creating the Ryan White HIV/AIDS Program to fund treatment and care services, including nutrition services, for low-income people living with HIV. Community Servings is founded to serve 30 people living with AIDS in Boston.
1994	The AIDS Nutrition Services Association (ANSA) holds its first annual conference.
1997	New York begins to create access to home-delivered meal services through its Managed Long-Term Care system for people dually eligible for Medicare and Medicaid.
2010	Congress passes the Patient Protection and Affordable Care Act. The Food is Medicine Coalition is founded. Community Servings is a founding partner and advisory board member.
2012	In partnership with the Congressional Hunger Center, Community Servings publishes its first white paper on MTM's benefits.
2013-2014	Massachusetts begins the One Care demonstration for Medicare-Medicaid dually eligible individuals who are ages 18-64 and have a disability. Community Servings contracts with a health plan to provide MTM to One Care enrollees.
2014	Community Servings creates a dedicated team to advance policy initiatives for reimbursing medically tailored meals through healthcare.
2016	The Centers for Medicare & Medicaid Services (CMS) launches the Accountable Health Communities model to test addressing health-related social needs.
2016-2018	CMS approves Medicaid Section 1115 Demonstration Waivers in Massachusetts, North Carolina, and Oregon, funding health-related social needs services for qualifying individuals.
2017	Community Servings partners with Dr. Seth Berkowitz on scientific evaluation of the outcomes of MTM.
2018	California pilots an MTM program for Medicaid-enrolled individuals with heart failure in partnership with CalFIMC member organizations.

2018-2019	CMS allows Medicare Advantage plans to cover nutrition services for certain groups as supplemental covered benefits.
2019	Food Is Medicine Massachusetts (FIMMA) publishes the FIMMA State Plan, including analysis and recommendations to expand access to services. *JAMA Internal Medicine* publishes a peer-reviewed study in which medically tailored meals are proven to reduce healthcare utilization and costs.
2020	In Massachusetts, the Flexible Services Program launches through an innovative Section 1115 Medicaid Waiver, the first to cover food-based services.
2022	New York creates access to MTM through its Medicaid Managed Care In Lieu of Service authority. A bipartisan U.S. Congressional resolution calls on medical schools and residency and fellowship programs to strengthen nutrition education for physicians. Medi-Cal, California's Medicaid program, creates access to MTM through its Managed Care In Lieu of Services authority. The White House convenes the historic Conference on Hunger, Nutrition, and Health.
2023	The American Heart Association launches the Food is Medicine Initiative in partnership with the Rockefeller Foundation. The Medically Tailored Home-Delivered Meals Demonstration Pilot Act is introduced in the U.S. Congress.
2024-Jan. 2025	CMS approves 1115 waivers allowing for MTM coverage in Colorado, Hawaii, Illinois, and Pennsylvania.
2025	Michigan's participating Medicaid health plans can offer MTM as In Lieu of Services.

The Connection Between Nutrition and Health

Nutrition is more than a social determinant of health. Nutrition determines health directly.[1]

Poor nutrition is a leading cause of illness, preventable healthcare spending, and lost productivity.[2] It is directly related to heart disease, diabetes, and kidney disease — several of the leading causes of death in the United States.[3] It exacerbates health disparities. It is estimated to be responsible for $50 billion in healthcare costs each year.[4] Food insecurity (i.e., a limited or uncertain level of access to adequate food) is associated with a higher risk of chronic disease and healthcare utilization.[5]

Over the last decade, healthcare has begun to address the critical relationship between access to nutritious food, health outcomes, and health disparities.[6] Food is Medicine interventions have emerged as a cost-effective and innovative response. Research shows that Food is Medicine interventions can reduce the need for more intensive healthcare services.[7]

Food is Medicine

Food is Medicine is the provision of food resources to prevent, manage, or treat specific illnesses.

Food is Medicine interventions are designed to address a patient's specific medical nutrition needs and are integrated into healthcare through referrals from healthcare providers.

Food is Medicine pyramid[8]

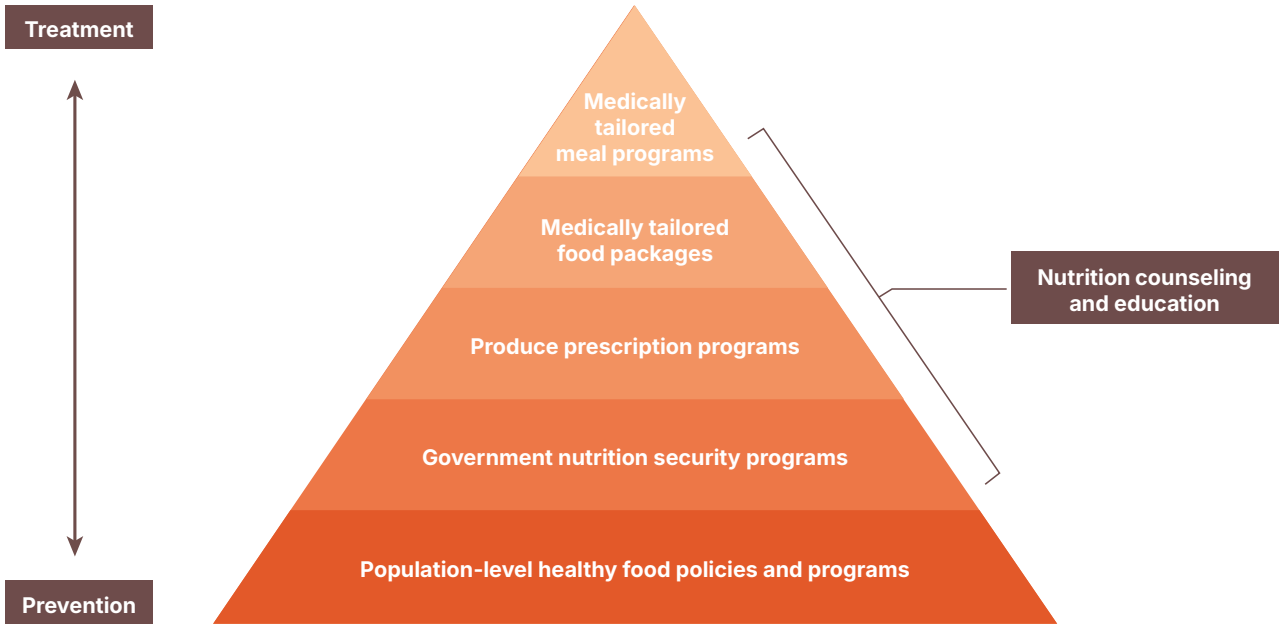


Image credit: *Nature*, see citation.

Medically Tailored Meals and Groceries

Medically tailored meals (MTM) and medically tailored groceries (MTG) are designed by a registered dietitian nutritionist (RDN) based on practice guidelines and an individual's medical diagnosis. Both MTM and MTG are provided in combination with nutrition counseling and education. These services benefit people with severe, chronic, or complex health needs.

Medically tailored nutrition can be part of an individual's treatment plan, just like any other medication prescribed by a doctor. MTM, in particular, can benefit people with limitations in instrumental activities of daily living (e.g., difficulty going shopping or preparing foods independently).

Community Servings' Clients, FY2024

Primary Diagnosis

- 18% - Diabetes
- 18% - Cardiac Illness
- 16% - Other Illness
- 10% - HIV/AIDS
- 8% - Cancer
- 7% - Renal Illness
- 6% - Obesity/ Overweight
- 5% - Behavioral Health
- 4% - Lung Disease
- 3% - Joint Replacement Surgery
- 2% - High Risk Pregnancy
- 2% - GI Illness
- 1% - Liver Disease

Race/Ethnicity

- 37% - White
- 26% - Unknown/Not Disclosed
- 17% - Black/African American
- 10% - Hispanic, Latino/a, or Spanish
- 6% - Multiple Races/Ethnicities
- 2% - Unknown

Primary Language

- 85% - English
- 10% - Spanish
- 4% - Other

Age

- 41% - 65 and older
- 35% - 45 to 64
- 17% - 19 to 44
- 5% - 18 and younger
- 1% - Unknown

90% of clients are living under 200% of the Federal Poverty Level.

10% are experiencing unstable housing.

Community Servings' Programs

Medically Tailored Nutrition & Nutrition Support Services

Community Servings offers 16 medical diets designed to improve health outcomes through the provision of medically appropriate food. Diets can be customized with soft, mild, vegetarian, pescetarian, low-fiber, low-lactose, high-calorie and high-protein, and fish-free foods.
The culinary team produces all entrees, soups, stews, and protein salads on-site in Boston, using seasonal, high-quality, and locally sourced ingredients. Chefs design the Community Servings menu to reflect a variety of culinary traditions.

Medical diets are prescribed by an RDN based on a healthcare provider referral and nutrition assessment. RDNs identify medical diagnosis, co-occurring conditions, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

Core Diets

Community Servings' diets include delicious, medically appropriate entrees, soups or stews, protein salads, fresh fruit, snacks, milk, and house-made baked goods.

Wellness, Diabetic, and Cardiac Diets

Emphasize whole grains and lower-glycemic carbohydrates; limited sodium, carbs, and saturated fat

Pregnancy Health Diet

To address maternal health outcomes, features protein-rich breakfasts; high-protein, high-calorie snacks; no fish; limited sugar, sodium, and saturated fats

Renal Health Diet

Emphasizes adequate protein plus limited fluids, sodium, potassium, and phosphorous

Pediatric Health Diet

Features kid-friendly breakfasts, entrees, snacks, and house-made desserts

---

Meals are:

- Scratch-made from fresh, whole ingredients in Boston
- Delivered weekly to clients' homes
- Modified for the restrictions and needs of each individual

New in 2025: Medically Tailored Groceries

Medically tailored groceries (MTG) provide a delivery of ingredients every two weeks to individuals who have the ability to prepare food independently and have a medical need for a medically tailored diet. Grocery deliveries are designed by an RDN and tailored to the client's medical diagnosis. The MTG service educates clients so they can prepare medically tailored meals at home. The intervention features produce grown by local suppliers in Central Massachusetts.

This new offering launched in January 2025 in parallel with Massachusetts' Health-Related Social Needs Supplemental Services Program. Community Servings' Accountable Care Organization healthcare partners are referring patients to the program. Through a grant from the Health Foundation of Central Massachusetts, Community Servings is also piloting MTG for individuals residing in Central Massachusetts.

Community Servings' Healthcare Partners

The AMPL Institute firmly believes that the healthcare system is the appropriate space for the provision of Food is Medicine interventions. Simply put, Food is Medicine shares many of healthcare's core goals: improving health outcomes, reducing cost of care, and reducing rates of chronic, diet-related illness. MTM should be a covered benefit in Medicare and Medicaid. For that reason, Community Servings partners with healthcare in Massachusetts and Rhode Island, contracting with health plans and healthcare providers to reimburse for MTM. Within each contract, healthcare professionals submit client referrals to Community Servings.

As of January 2025, Community Servings contracts with:

- 12 Medicaid (MassHealth) Accountable Care Organizations (ACOs)
- 2 home hospital programs
- 2 dual-eligible Medicare-Medicaid contracts
- 1 community health center
- 2 Medicare Advantage plans
- 1 commercial health plan
- 1 hospital-based maternal health partner

Client Experiences

Lashaya

Lashaya, age 37, lives with her daughter in Dedham. Lashaya's doctor referred her to Community Servings with a medical diagnosis of hypertension. She has experienced improvements in blood pressure, quality of diet, weight management, and motivation due to medically tailored meals.

"It makes me want to do more," she says. "The mental state is like you're down and depressed. But here is something that's helping you change something you've been wanting to change. It's like my mental state just went from 50 to 90."

Lashaya enjoys the food, even when she isn't familiar with the ingredients. "They have these amazing soups," Lashaya says. "I just can't believe how you can make soups with these vegetables and flavors." Lashaya was initially skeptical of leeks but gave them a try. The Potato Leek Soup has become a favorite.

A Community Servings RDN provides helpful counseling for Lashaya's periodic sugar cravings. On one occasion, Lashaya's RDN guided her toward healthy snack options that are included in the weekly delivery. "She just broke that down for me, and it's been working," Lashaya says.

Chuck

Three years ago, Chuck, who is living with diabetes, had an A1C of 13. He was taking 14 medications every day. He had cardiovascular issues, stage 2 chronic kidney disease, and a diabetic foot wound that, doctors said, would require foot amputation.

But Chuck was resolute. He believed that with healthier diet and regular exercise, he could better his health. That is why Chuck enrolled in Community Servings' medically tailored meal program. Three years later, the results have been remarkable. His A1C is now 4.1. He takes fewer medications daily, only four. His foot wound healed without surgery. "I'm proof," Chuck says. "I'm convinced 100 percent. I didn't have my foot amputated because I was eating the right things and doing the right things."

Food has always been central for Chuck. He spent part of his childhood on a farm in rural California, where he learned how important food is for health. "I always felt that what I put inside myself was key. Food can correct a lot of things."

A View of the Field

2025 finds the field of medically tailored nutrition entering a period of major transition. Long-awaited milestones have finally arrived. The integration of medically tailored meals into healthcare is well underway. There is much to celebrate. However, there is also a sense of concern.

Two policy examples, one at the state level, another at the federal level, illustrate the remarkable yet uncertain nature of the current moment.

1. Across the country, Medicaid Section 1115 demonstration waivers are creating access to medically tailored meals (MTM) and other health-related social needs services in order to improve the efficiency and quality of care. In Massachusetts, for example, the Health-Related Social Needs Supplemental Services Program, which launched in January 2025 through an 1115 waiver, now requires contracting providers to offer MTM to all eligible individuals who meet clinical and social risk criteria. As of this writing, 1115 demonstrations in 13 states are approved with meal services.[9]

2. The bipartisan Medically Tailored Home-Delivered Meals Demonstration Pilot Act could be passed in the 119th U.S. Congress and become law. It would provide MTM to qualifying Medicare-enrolled seniors and individuals with disabilities in diverse geographic regions, urban and rural, throughout the country.[10]

These two policy opportunities have the potential to establish long-term pathways for the provision of MTM. Both require evaluation, the findings of which could support the case for MTM as a healthcare service in Medicaid and Medicare, powerfully advancing one of the AMPL Institute's core objectives. However, both opportunities could face policy setbacks, setbacks that could put at risk the progress of recent years.

2025 marks the start of a new era of health policy, one that may introduce new opportunities. Created through an Executive Order in February 2025, the Make America Healthy Again Commission tasks its members, which include as chair Secretary of Health and Human Services Robert F. Kennedy Jr., with understanding and lowering chronic disease rates and ending childhood chronic disease.[11] The AMPL Institute shares these goals and is eager to participate in new policy initiatives to address chronic diseases with evidence-based interventions.

However, this new era is also a time of upheaval. Federal agencies and programs that provide children, older adults, people with disabilities, and lower-income adults with access to healthcare and social services are facing funding cuts, actual and threatened. It is thanks to programs like Medicaid, the Ryan White HIV/AIDS Program, and the Older Americans Act that community-based organizations in this field have progressed over the years. If these programs are significantly reduced, how exactly will the federal government advance MTM access moving forward? What does the future hold for the approval — or the possible withdrawal — of Medicaid Section 1115 waivers, which have proven so important in creating state-level access? How will MTM providers navigate the funding challenges of such a rapidly changing landscape?

The sense of concern has other sources, as well. Among them is the need for the consistent definition, provision, and quality standardization of MTM. The field faces a tremendous risk if MTM is provided at varying levels of quality and quantity — and then evaluated. According to Food is Medicine Coalition Executive Director Alissa Wassung, a failure to define the MTM intervention robustly could derail years of research and advocacy, and further delay more widespread access to MTM. “If we implement interventions that don’t meet standards, evaluate them, and get sub-par outcomes, we might, as a nation, abandon the whole concept of Food is Medicine as part of healthcare,” Wassung says.

Maintaining Momentum for MTM

Throughout the country, nonprofit MTM providers are navigating the challenges of integration with the healthcare system. Surveying their experiences, key themes stand out:

Scientific evidence supporting the health benefits and cost-effectiveness of MTM continues to drive adoption in policy and healthcare. In the years to come, researchers are poised to evaluate the impact of MTM at even larger scales. This is the result of new policy opportunities, major investments from organizations like the American Heart Association and The Rockefeller Foundation, and emerging guidelines for accurate service coding for Food is Medicine interventions.

The structural framework of MTM coverage — the regulatory work of making MTM a healthcare benefit — continues to evolve. Those evolutions can pose formidable administrative and financial challenges to community-based organizations. To make those challenges clear and concrete, this report provides a detailed look at Community Servings' partnership with Medicaid-contracted providers in Massachusetts.

The need for philanthropic support is growing among community-based organizations. Under the new Administration, longstanding federal funding, such as the Ryan White Program, the Older Americans Act, and FEMA's Emergency Food and Shelter Program, are facing significant uncertainty. Historically, philanthropy was the primary funder of community-based Food is Medicine services. In the coming years, private philanthropic support may play an increasingly important role in sustaining momentum and mitigating the impact to direct services.

With approval from the Centers for Medicare and Medicaid Services (CMS), new standard service codes for MTM and medically tailored groceries would endorse national concepts for medically tailored nutrition. This would be a huge step forward for the standardization of medically tailored nutrition interventions. (See the "Coding and Billing for Food is Medicine" section.)

The field's nonprofit pioneers have produced the first-ever quality standard for MTM through the new FIMC Accreditation program. These criteria and requirements comprehensively define and guide MTM service provision — a tremendous milestone for MTM's integration within the heavily regulated healthcare system. (See the "Need for Quality Standards" section.)

A Historic Milestone

In the report that follows, readers will encounter several references to a historic milestone, the significance of which cannot be overstated. In September 2022, the White House Conference on Hunger, Nutrition, and Health was a call to action on behalf of Americans living with food insecurity and diet-related diseases. It was truly a catalyzing event. Investments in Food is Medicine services, across government and healthcare, underwent a surge:

- $8 billion in public and private commitments were announced September 2022[12], including a $250 million commitment from the American Heart Association and The Rockefeller Foundation to support scientific evidence of Food is Medicine[13]
- $1.7 billion in new public and private commitments were announced February 2024[14]
- Since 2022, CMS has approved renewals or amendments to Medicaid Section 1115 demonstration waivers in several states (e.g., Oregon, Massachusetts, Arkansas, and Arizona) and released new policy frameworks regarding health-related social needs (HRSN)[15]

Food is Medicine, an emerging concept a decade ago, suddenly became a widely recognized term. But as this report will demonstrate, MTM is still not a term that is uniformly understood. It is a term that urgently requires definition and standardization in a moment when, across the country, MTM service provision varies. For MTM to hold a secure place within healthcare, it is critical that stakeholders establish standards and definitions that are evidence-based and medically appropriate.

Community Servings' Commitments

As part of the White House Conference, Community Servings made a public commitment to achieve ambitious goals by 2030:

1	Provide 10 million medically tailored meals
2	Co-lead the national Food is Medicine Coalition's Accelerator program to incubate 15 new medically tailored home-delivered meals programs in states that are unserved or underserved by existing programs
3	Expand workforce development training programs for individuals experiencing barriers to employment and provide resources to help trainees become employed in food service

In the years since the Conference, Community Servings has made significant progress and remains dedicated to its commitments.

In March 2024, Community Servings expanded its reach with the opening of a new satellite distribution center in Mansfield, Massachusetts. This new facility enables Community Servings to better deliver and ship meals to clients living in Cape Cod, Rhode Island, and southeastern Massachusetts.

October 2022 through the end of 2024, Community Servings accomplished the following:

2,765,364	**total medically tailored meals provided**
12,103	**unique clients served**
8	**graduated organizations of the Food is Medicine Coalition Accelerator program**
109	**graduates of the Teaching Kitchen food service job-training program**

Enduring Momentum

Amid uncertainty, there are reasons to hope for enduring momentum. Two reasons are bipartisan enthusiasm for Food is Medicine and a growing evidence base.

In May 2024, Representatives James P. McGovern (D-MA) and Vern Buchanan (R-FL) submitted a bipartisan letter to the House Committee on Appropriations, co-signed with 35 members of the U.S. House of Representatives, requesting greater federal investment in Food is Medicine and expansion of access to MTM.[16]

> Let's Make America Healthy Again – and I think that starts with food as medicine. It starts with a healthy diet, it starts with declaring war on chronic diseases.
>
> — SENATOR ROGER MARSHALL (R-KS)[17]

"It remains to be seen how the Trump Administration plans to lower chronic disease rates," says Community Servings' Senior Director of Policy and Research Jean Terranova. "What AMPL wants stakeholders to understand is that Food is Medicine interventions are strongly complementary of the MAHA Commission's stated purpose. Medically tailored meals should figure prominently in any strategy to lower the country's healthcare spending and improve health outcomes among people with chronic illnesses. We can change lives and achieve billions in savings through this intervention. We should continue investing in MTM so that more people across the country can stay out of the hospital and, if possible, manage their health independently."

Research will shed new light on how effectively MTM achieves those goals in the coming years. The AMPL Institute is collaborating with the Tufts University Food is Medicine Institute and UMass Chan Medical School on a claims-data study that is evaluating the impact of MTM in Massachusetts Medicaid. The findings may be especially important during challenging times for state Medicaid budgets. "I think this is a moment to be doubling down on evaluation," says Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School. "Seeing the Evaluation Consortium findings could play a huge role in the renewal of Massachusetts' 1115 waiver, which is set to occur in 2027."

On the Cusp

Two years after the White House Conference, Senior Chief Business Development Officer Dorella Walters of God's Love We Deliver observes that the impact of the Conference is still unfolding. "Great things have happened. We're on the cusp. And now the question is, are we as FIMC agencies prepared for what the cusp will bring?"

This report explores that question, looking closely at areas where the healthcare system and nonprofit community-based organizations are coming together, or preparing to more effectively come together, to support their shared goals.

Research

In 2015, Community Servings convened a summit at the Blue Cross Blue Shield of Massachusetts Foundation to introduce health plans, healthcare providers, and policy leaders to the idea that medically tailored meals (MTM) should be viewed as a reimbursable intervention to treat acute, diet-related chronic disease.

Dr. Seth Berkowitz, a clinician and researcher then with Massachusetts General Hospital, presented on the link between food insecurity and advanced diabetes, hypothesizing that MTM would disrupt this cycle by improving health outcomes and lowering healthcare costs for people with diabetes and food insecurity.

Robert Greenwald, then Director of the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), made a case for insurance coverage of medically tailored food under the Affordable Care Act (ACA). Greenwald explained MTM had the potential to meet the ACA's triple aim:

Improving health at the population level	Improving individual health outcomes	Reducing spending on acute care services

Given the ACA's focus on delivering value of care over volume of services, Greenwald pointed to ACA provisions allowing for reimbursement of MTM for those experiencing serious or chronic illness.

Community Servings' CEO David B. Waters gave an overview of the MTM intervention and the results of the agency's first white paper, which included surveys of healthcare providers who had referred individuals to the program:

96% of referral partners surveyed stated that MTM improved health outcomes
65% believed MTM reduced hospitalizations
96% stated that MTM improved access to healthy food[18]

After highlighting published research demonstrating the connection between malnutrition, poor health outcomes, and high healthcare costs,[19] Waters asked a pointed question: "What would it take for the healthcare system to begin reimbursing for MTM?"

The response was overwhelming: more research. *Stronger* research.

The Impact of Research

With support from Blue Cross Blue Shield of Massachusetts and BNY Mellon, and in partnership with Dr. Berkowitz, Community Servings piloted its first research study in 2018, a randomized control trial examining the impact of MTM on individuals with advanced diabetes and food insecurity.

To date, Community Servings has published four peer-reviewed journal articles, all in partnership with Dr. Berkowitz. These studies found that for individuals with complex chronic illnesses and food insecurity, MTM:

- Improves dietary quality
- Improves mental health
- Reduces healthcare utilization
- Reduces costs

People who received MTM demonstrated:

16%	**Monthly net reduction in healthcare costs**[20]	**70%**	**Reduction in ED visits**[21]
49%	**Reduction in inpatient admissions**[22]	**72%**	**Reduction in skilled nursing facility admissions**[23]

People with diabetes who received MTM demonstrated:

31.4-point	**Increase in Healthy Eating Index (HEI) score**[24]
17%	**Fewer reports of hypoglycemia**
20%	**Fewer reports of food insecurity** compared with study participants who did not receive meals[25]
41%	**Fewer reports of mental health interfering with daily life** compared with study participants who did not receive meals[26]

As research findings have proven MTM's effectiveness, enthusiasm for MTM has grown among policymakers and healthcare leaders. A prominent example: The Biden Administration cited Community Servings' research in its endorsement of expanding access to Food is Medicine interventions for Medicaid and Medicare enrollees.[27] "MTM research and ROI are extremely important to healthcare partners," reports Community Servings' Senior Director of Strategy and Business Development Erin DiBacco. "Our partners are impressed and reassured that we are at the forefront of research nationally, and [they] will often work with us to evaluate our individual partnerships as well."

A recent economic evaluation study, published in *JAMA Network Open* in 2022, was built upon the MTM research of Community Servings and contributions from other member organizations of the Food is Medicine Coalition. Researchers forecasted the impact on hospitalizations and healthcare costs if the MTM model were to scale and reach all individuals in the United States who qualified based on illness and limitations on activities of daily living. According to the study:

> National implementation of MTMs for patients with diet-sensitive conditions and activity limitations could potentially be associated with **1.6 million** averted hospitalizations and net cost savings of **$13.6 billion annually** from an insurer perspective.[28]

These findings, which project net cost savings for Medicare, Medicaid, and commercial insurance types, are incredibly important to policymakers and healthcare leaders.

Given the current policy climate and ongoing interest in improving the healthcare system, research will remain vital to policy advocacy. "The more we can grow the evidence, the better," says Katie Garfield, Director of Whole Person Care at CHLPI. "In a tight budgetary space, the state will do what works. We just have to show that it works."

It is worth noting that the evaluation of MTM outcomes from state-level demonstrations and waivers is an emerging opportunity for the field. A large-scale analysis could measure the effectiveness of MTM across geographies and among populations. However, evaluation at this scale remains aspirational for the time being. It is dependent on infrastructure, coding, and data standardization — topics which are discussed later in this report.

Current Research Projects

The AMPL Institute continues to invest in research that will advance the integration of medically tailored nutrition into healthcare. Active projects include:

Food is Medicine: A Randomized Clinical Trial of Medically Tailored Meals For Individuals with Type 2 Diabetes Mellitus and Food Insecurity (FAME-D)

SUMMARY

Examining the impacts of increased food access on improving health outcomes for individuals with Type 2 diabetes and food insecurity.

- Participants are randomized to receive: Community Servings meals with 12 lifestyle coaching sessions over the course of six months OR $40 food subsidy in the form of a grocery store gift card once a month for six months with usual care

STATUS

Completed recruitment goal of 200 participants

TIMELINE

Study activities will continue through January 2026.
Anticipate publication in the spring of 2026.

FUNDERS AND PARTNERS

Funder: NIH
Partners: Berkowitz (University of North Carolina School of Medicine); Delahanty (Massachusetts General Hospital)

Food as Medicine for HIV: A Randomized Trial of Medically Tailored Meals and Lifestyle Intervention (FAME-H)

SUMMARY

Examining the impact of increased food access and a lifestyle intervention on improving health outcomes and quality of life for individuals with HIV, Type 2 diabetes, prediabetes, high risk of developing diabetes, and food insecurity

- Participants are randomized to receive Community Servings meals with 20 lifestyle coaching sessions over the course of twelve months OR Community Servings meals only

STATUS

Recruitment goal: 100 participants by 8/1/25

TIMELINE

Study activities will continue through February 2027.
Anticipate publication in the spring of 2027.

FUNDERS AND PARTNERS

Funders: NIH
Partners: Berkowitz (UNC School of Medicine); Delahanty and Lo (Massachusetts General Hospital)

Impact of Medically Tailored Meals on Obesity, Other Health Outcomes, and Healthcare Utilization under Medicaid Flexible Services (Evaluation Consortium)

SUMMARY

Claims and clinical data analysis to assess the impacts of MTMs delivered as part of the MassHealth Flexible Services Program on health outcomes and healthcare utilization.

STATUS

Data collection and analysis complete. Manuscripts drafted.

TIMELINE

Anticipate publication in the spring of 2026

FUNDERS AND PARTNERS

Funder: NIH
Partners: Mozaffarian, Zhang, Folta (Tufts Food is Medicine Institute); Hager, Alcusky (UMass Chan Medical School)

Food as Medicine for Families (FAME-F)

SUMMARY
Recruiting 100 individuals with a chronic cardiometabolic condition to test the "target" of the intervention (individual v. household) and the delivery mechanism (shipped v. delivered by a Community Servings driver). All individuals will receive the MTM intervention for 12 weeks.

STATUS
Recruitment completed.

TIMELINE
Anticipate publication in the fall of 2025.

FUNDERS AND PARTNERS
Funder: The American Heart Association
Partner: Berkowitz (UNC School of Medicine)

FIM+ Case Study

SUMMARY
Developing a report and supporting evaluation and educational tools documenting Community Servings' practices of sourcing foods from local farms, fisheries, and other producers.

STATUS
Project launched in November 2024.

TIMELINE
Report and supporting materials to be released in the fall of 2027.

FUNDERS AND PARTNERS
Funder: The Rockefeller Foundation
Partners: Long (The Center for Nutrition & Health Impact); Broad Leib, Latino (The Center for Health Law and Policy Innovation of Harvard Law School); Evans (Johnson & Wales University)

Community Servings' Senior Director of Policy and Research Jean Terranova served on the Aspen Institute's Food is Medicine Research Action Plan, a comprehensive report of existing research on Food is Medicine interventions (MTM, medically tailored groceries, and produce prescriptions) through 2023. A comprehensive resource, the Action Plan includes recommendations for future research and best practices in the field.[29]

National Trends in Research

NIH Nutrition Research

Released in May 2020, the 2020-2030 Strategic Plan for NIH Nutrition Research included four strategic goals leading toward "Precision Nutrition" for optimal health.[30] Precision Nutrition is:

> A holistic approach to developing comprehensive and dynamic nutritional recommendations relevant to both individual and population health. To that end, Precision Nutrition is a framework canvassing a wide array of features including genetics, dietary habits and eating patterns, circadian rhythms, health status, socioeconomic and psychosocial characteristics, food environments, physical activity, and the microbiome."[31]

Expanding Food is Medicine research is one of the four strategic goals underpinning this ambitious vision.[32] Progress on the 2020-2030 Strategic Plan for NIH Research is reported annually in NIH's *Nutrition Research Report*.

Scaling Food is Medicine

As part of the 2022 White House Conference on Hunger, Nutrition, and Health, The Rockefeller Foundation and the American Heart Association committed to investing $250M to build a national Food is Medicine research initiative to generate the tools and evidence necessary to help build and scale Food is Medicine programs that can be adapted into healthcare payment and delivery models.

Community Servings is included in the first cohort of the American Heart Association's 10-year commitment to invest in research. As referenced in the above table, Community Servings has recruited 100 individuals with a chronic cardiometabolic condition to test the "target" of the intervention (individual v. household) and the delivery mechanism (shipped v. delivered by a Community Servings driver).

Future Research Agenda

In alignment with the work of The Rockefeller Foundation, Community Servings is launching a pilot of its medically tailored groceries program (MTG), in partnership with the Health Foundation of Central Massachusetts. The MTG intervention includes produce grown in Central Massachusetts, delivered to 55 residents in the region. Dr. Kurt Hager of UMass Chan Medical School serves as the project evaluator. Key goals include demonstrating that the MTG model improves or maintains client food security, improves client confidence to meet nutrition goals, and supports healthier food purchasing outside of the intervention.

Good Food Sourcing

One emerging trend is the connection between Food is Medicine and the food system. The Rockefeller Foundation is a leader in this area, advocating that, in addition to improving health outcomes, Food is Medicine's integration with healthcare may also benefit local economies and good food purchasing practices.

In 2022, The Rockefeller Foundation announced its commitment of $105M to its Good Food Strategy, which aims to increase access to healthy food, reduce greenhouse gas emissions in the food system, and expand economic opportunity for small- and mid-size food producers.[33] About the Strategy, Sara Farley, Managing Director, Global Food Portfolio, The Rockefeller Foundation, said, "Local food system stakeholders should be protagonists in their own future."[34]

One such protagonist is Community Servings.

Food is Medicine+ Case Study, 2024–2027

Through a three-year grant from The Rockefeller Foundation, Community Servings' Medically Tailored Meal FIM+ Case Study will measure the outcomes and benefits of FIM+, the Food is Medicine meets Good Food Systems approach.

The Case Study evaluation is designed to educate stakeholders, including community-based organizations, healthcare payers, providers, policy leaders, and local foods growers and producers, on best practices based on Community Servings' approach to sourcing. The project will explore Community Servings' good food sourcing as well as challenges and opportunities. Through its extensive experience as a trainer and convener, the organization will engage the Food is Medicine community to advance sourcing practices among providers.

Project Components
Evaluation partners: The Center for Nutrition & Health Impact, Duke World Food Policy Center, the Center for Health Law and Policy Innovation of Harvard Law School, Johnson & Wales University
Geography: Massachusetts and Rhode Island
Value Chain Partners: Local farms, fisheries, and other New England producers
Clients and Referrers: Messaging and stakeholder communications and effectiveness

Sourcing at Community Servings

Community Servings invests in New England-based food suppliers and high-quality products to support the health of clients and communities. Of its total food purchasing in FY2024, 21% were purchases of local foods (i.e., foods grown, harvested, and fished in New England).

“When we buy from New England suppliers, we have a multiplier effect,” says Community Servings’ Chief Culinary Officer Brian Hillmer. “We support our local economy, directing our purchasing toward smaller New England businesses, many of which are nonprofit and share our mission. By doing business with these farmers and fisheries, we invest in suppliers that produce less greenhouse gas emissions than conventional sources. In exchange, we get the most nutrient-dense, high-quality product for clients who are living with diet-related illnesses.”

Community Servings evaluates its food suppliers based on values that include but are not limited to quality, cost and availability, local sources, environmental value (e.g., organic, regenerative, sustainable), social value (e.g., supplier affiliation; owned by women, people of color, or family; worker-centric), and cultural appropriateness.

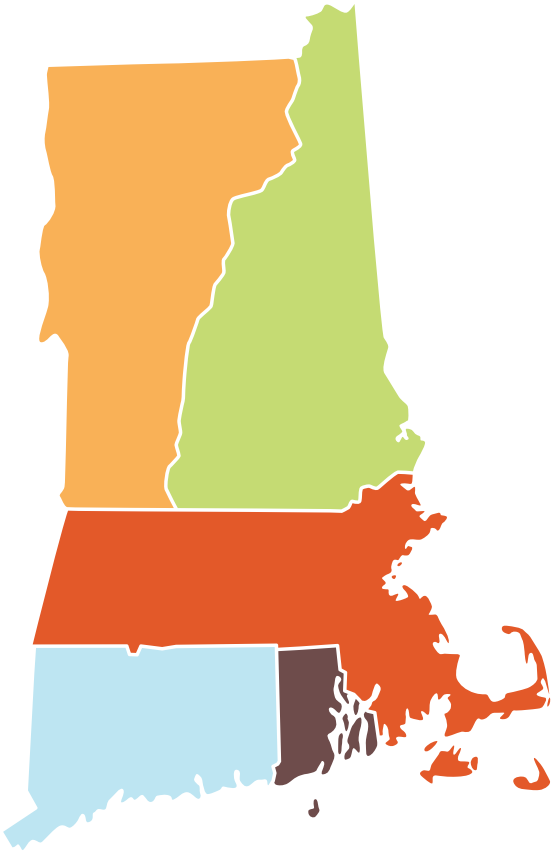
Community Servings' Estimated Food Purchasing by State, Planned for FY25

MASSACHUSETTS
109,000 lbs. / $250,000

NEW HAMPSHIRE
19,200 lbs. / $144,000

RHODE ISLAND
30,000 lbs. / $30,000

VERMONT
46,800 lbs. / $137,000



Local Sourcing in Medicaid Policy

In recent years, state Medicaid programs have begun to call out the value of local food sourcing in policy and guidance.

Hawaii's Section 1115 demonstration waiver encourages medically tailored meal and grocery service providers to include local growers, with the goals of supporting local food purchasing and strengthening Hawaii's food system.[35]

Michigan's In Lieu of Services policy guide has the stated goal of supporting local organizations, including medically tailored meal providers, that participate in Michigan's local food economy.[36]

Policy Landscape

The AMPL Institute advocates for policy change that will make medically tailored nutrition available to any person living with a severe, complex, or chronic illness, regardless of their condition, geography, or ability to pay. As such, the organization supports making medically tailored meals (MTM) an established benefit in Medicaid and Medicare. This is AMPL's central policy objective.

Recent years have seen rapid progress toward that objective. At the federal level, promising signs include the introduction of bipartisan and bicameral bills in Congress as well as unprecedented endorsement of Food is Medicine among federal agencies and programs. With respect to concrete policy change, much (though not all) of the progress has played out at the state level, through Medicaid pathways such as Managed Care In Lieu of Services, Home- and Community-based Services, and Section 1115 demonstrations. However, as the following pages will show, state-level progress is still relatively new. Policy continues to evolve. In the view of the AMPL Institute, the direction of the evolution is positive, with guidance requiring that services be clearly defined and standardized and that eligibility be based on health need and social risk factors. The evolution has been driven by the goals of improving healthcare and health outcomes among populations disproportionately affected by severe, complex illnesses. The speed and scale of the evolution, however, present major challenges for community-based organizations as they attempt to build sustainable partnerships with the healthcare system.

The present section summarizes the policy landscape, highlighting noteworthy state and federal opportunities that are supporting access to MTM. (The focus is MTM; in the interest of brevity, policy opportunities related to other Food is Medicine services are not explored.) Some of the concrete impacts of policy evolution on healthcare partnership will be examined in the next section, "MTM Access Through MassHealth," which offers a detailed look at Community Servings' partnership with Medicaid-contracted accountable care providers in Massachusetts.

One final but necessary note of introduction: Given the political transitions of 2025, it is difficult to offer definitive views on the national policy landscape. Nonetheless, this report offers a few words on potential changes under the Trump Administration and 119th Congress. This much is clear: 2025 is likely to bring seismic shifts in national health and nutrition policy.

A Snapshot of Federal Government Agencies That Support Nutrition and Health

U.S. Department of Health and Human Services

Supports America's health and well-being through health and human services programs and the research of medicine, public health, and social services. Below are some but not all HHS agencies.

Centers for Disease Control and Prevention (CDC)

Centers for Medicare and Medicaid Services (CMS)
Oversees Medicare, Medicaid, State Children's Health Insurance Program, and the Health Insurance Marketplace.

Regulates and approves state-level Medicaid demonstration waivers (e.g., 1115, Home- and Community-Based Services, and Managed Care In Lieu of Services).

Food and Drug Administration (FDA)

Health Resources and Services Administration (HRSA)
Administers the Ryan White HIV/AIDS Program.

National Institutes of Health (NIH)
Advances the nation's medical research agenda, including the connection between nutrition and health.

U.S. Department of Agriculture

Supports America's food production and safety, agriculture, natural resources, rural development, nutrition, and related issues. Below is one but not all USDA agencies.

Food and Nutrition Service
Administers the Dietary Guidelines for Americans, SNAP, and WIC.

Food is Medicine is supported by many government agencies, including many that are not listed above. For the purpose of this report, the U.S. Department of Health and Human Services (HHS) will be discussed primarily.

To learn more about federal support of Food is Medicine more broadly, please see the HHS virtual toolkit at **odphp.health.gov/foodismedicine**.

An Ongoing Crisis

Hunger remains a known and ongoing crisis in America. In 2022, 13 percent of households were food insecure,[37] a risk factor associated with certain chronic health conditions.[38] In the same year, the White House Conference on Hunger, Nutrition, and Health issued a call to action to the public and private sectors to reduce hunger and address the connection between nutrition and health. A corresponding National Strategy directed federal agencies to take action:[39]

> The Department of Health & Human Services, the Centers for Medicare and Medicaid Services, and the Centers for Disease Control and Prevention were directed to coordinate efforts to increase access to nutrition services.

> The National Institutes of Health was directed to enhance research on food and nutrition security.

> State Medicaid programs were directed toward innovative solutions to increase access in nutrition services, such as Section 1115 demonstration waivers.

While the Conference had a substantial impact on health and nutrition policy, important work remains. Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), observes that full equity of access to Food is Medicine interventions remains a distant goal. So does the full integration of Food is Medicine into healthcare. “If healthcare is a house, Food is Medicine is not yet making it through the front door. It is just getting in through the windows. If our big goal is to create equity of access regardless of geography or ability to pay, the best way to achieve that is to create coverage of medically tailored meals in federal healthcare programs such as Medicare, Medicaid, the Indian Health Service, and the Department of Veterans Affairs. We haven’t reached that goal yet.” If equity of access remains elusive, it now faces the added complexity of recent changes in Washington.

The Possibility of Federal Funding Cuts

It is uncertain how the Trump Administration and 119th Congress will prioritize the connection between nutrition and health. Hunger remains prevalent, even showing signs of worsening. (In 2023, the rate of food insecurity grew, by a statistically significant percentage, to 14 percent.[40]) Yet it is unlikely, in this policy climate and given actions taken by the previous Trump Administration, that programs like SNAP and WIC, which are foundational for addressing hunger nationwide, will receive improvements or expansions.[41] It is more likely that the United States Department of Agriculture (USDA), the federal agency that administers both programs, will pursue structural reforms or funding reductions to both programs.

There is also the possibility of policies that would cut funding to the Medicaid program writ large, which would represent a significant setback to MTM access in many states.

A joint federal-state program, Medicaid provides healthcare coverage to a wide and varied cross-section of society: eligible people with low income, children, people who are pregnant, older adults, and people with disabilities. Of the total U.S. population, 35% of Black Americans are enrolled in Medicaid; 31% of Hispanic Americans are enrolled in Medicaid; and 40% of Native Americans are enrolled in Medicaid.[42]

The federal government provides a Federal Medical Assistance Percentage (FMAP) reimbursement for a state's total Medicaid spending. In Massachusetts, for example, 50% of MassHealth spending is matched by the federal government.[43] But that could change. The Trump Administration may revisit policies that were intended to control Medicaid costs through funding cuts. "These include, for example, proposals to cap Medicaid funding through per capita caps or block grants and proposals to cut the portion of Medicaid costs paid by the federal government," Garfield says. "These policies generally require legislative change. If passed in Congress, they would have serious consequences for state Medicaid programs and the individuals they serve."

Medicaid budgets are already challenged, given the ending of enhanced federal Medicaid reimbursements from the COVID-19 pandemic.[44] "If we see this Administration and Congress go through with cuts to Medicaid funding, that would mean even tighter Medicaid budgets and it would probably mean program cuts in some way," Garfield reports. In such a scenario, states would face difficult budgeting choices. In Massachusetts, maintaining near-universal healthcare coverage is paramount, and a constrained scenario could leave fewer resources available for health-related social needs services.

State Policy Opportunities

Over the last decade, states have been experimenting with Medicaid demonstration waivers to address drivers of poor health, health disparities, and preventable healthcare spending.[45] Subject to approval by the Centers for Medicare & Medicaid Services (CMS), states can take advantage of various Medicaid waivers to fund nontraditional services to achieve Medicaid's core objectives. Each Medicaid funding pathway is intended to achieve slightly different aims and comes with different guidelines and restrictions. They have varying eligibility criteria and require varying levels of complexity for state administrators. The following paragraphs will primarily focus on Section 1115 demonstration waivers, but for broader context, a few words will be given first to other Medicaid opportunities.

Section 1915 Home- and Community-Based Services

Historically, states have provided access to home-delivered meals for people who meet (or almost meet) an institutional level of care through Home- and Community-based Services (HCBS) pathways, most commonly through section 1915(c) and 1915 (i) waivers.[46] Compared to 1115 demonstrations, HCBS waivers focus on a narrow population. However, policy advocates in states with more constrained budgets may find this waiver type to be more feasible, or even a helpful funding pathway for a pilot program.

Managed Care Opportunities

The same is true of Managed Care In Lieu of Services (ILOS), another Medicaid pathway. States can use ILOS to fund medically appropriate and cost-effective substitutions for covered services, such as emergency department visits and hospital care for the treatment of diet-related chronic illnesses. Enacted in 2016, ILOS is only available to eligible individuals in states with Medicaid managed care and through participating managed care organizations (MCOs). That said, many states have created access to MTM through ILOS. For example, since 2022:[47]

- New York has MTM coverage for adults living with severe illnesses through ILOS.[48]
- California allows participating MCOs to provide MTM in lieu of more intensive services, such as hospitalization and emergency department visits.[49]

Other ways to create access to nutrition services within Medicaid managed care include:

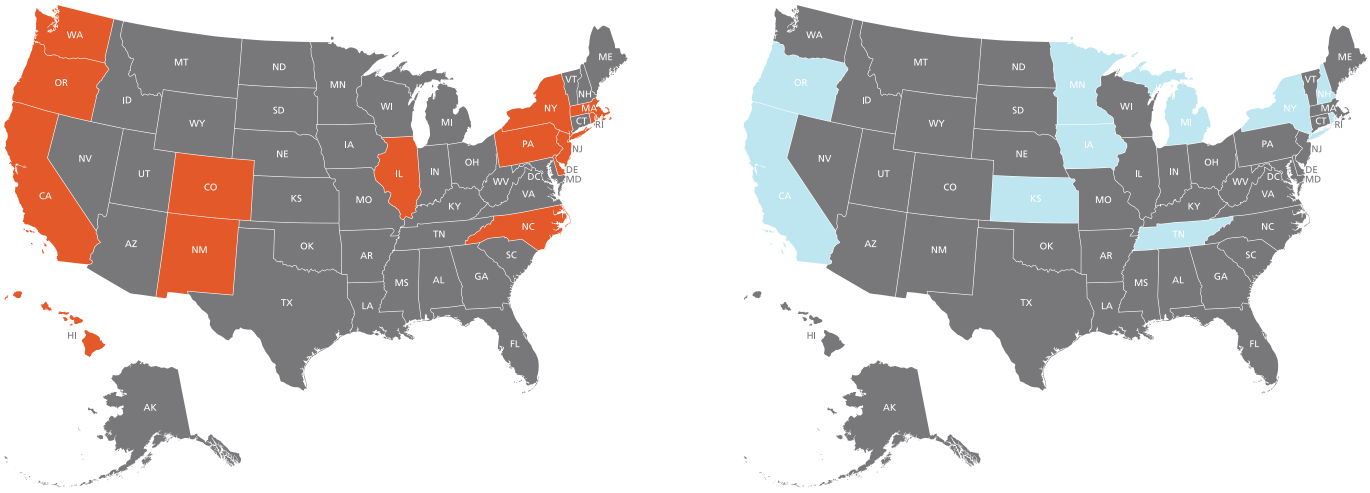
- **Value-added services**, which are typically funded through an MCO's administrative budget. Medicaid MCOs in Oklahoma and Nevada have used this pathway to offer meals and care coordination with community health workers.[50]
- **Quality improvement activities**, wherein MCOs improve performance metrics related to quality of care. MCOs may focus their quality improvement activities on health-related social needs.

Section 1115 Demonstration Waivers

Section 1115 waivers allow states to temporarily modify Medicaid programs to test new services that traditionally are not covered, provided the services are budget-neutral to the federal government and supportive of the goals of Medicaid.[51] Compared to other Medicaid pathways, 1115 waivers have important benefits. They have an initial approval period of five years and give states breadth and flexibility to define their target population based on medically appropriate clinical and social criteria, subject to CMS approval. They require independent evaluation of the impact of services. They can authorize federal Medicaid matching funds to support health-related social needs infrastructure, such as technology, operations, and workforce development.

As of late January 2025, 13 states were approved to offer food-based services through 1115 waivers.[52]

Approved Section 1115 and ILOS Waivers with Meal Services, as of January 2025



Approved HRSN 1115 waivers with meal services

Approved ILOS waivers with meals services

Overall, waivers have created only a patchwork of access to nutrition services nationally.

> The reality of access to MTM in our country is that it depends heavily on what state you are in. Did that state actually implement and leverage some of these policy flexibilities? Were those flexibilities leveraged in a widespread fashion?
>
> — ALISSA WASSUNG, EXECUTIVE DIRECTOR, FOOD IS MEDICINE COALITION

There are promising indications that diverse states across the country – and across the political spectrum – will continue to pursue funding for MTM through Medicaid. Garfield observes that states such as Alaska, Minnesota, and Colorado are showing interest in using Medicaid waivers to create access to food-based nutrition services (or expand access already available under existing state policies). "We continue to think it's really important that Food is Medicine is and should be a bipartisan issue," Garfield says. "It has a lot of things going for it that are appealing across political lines — namely, addressing chronic illness and containing costs."

In the coming years, however, CMS approval of Medicaid waivers will hinge on the priorities of the new Administration, which are likely to diverge from the prior.[53] It is possible that CMS will not continue to approve 1115 waivers at the same rate or on the basis of the same priorities. In creating a strategy for policy advocacy, CBOs should carefully assess the existing priorities of local policymakers and weigh CMS requirements for each type of waiver against their state's administrative capacity. While there are good reasons for CBOs to strive for 1115 waivers, they come with requirements that may be untenable for states with more limited capacities. In such states, ILOS and HCBS waivers may be more feasible.

Produced by CHLPI and FIMC, *Food Is Medicine: A State Medicaid Policy Toolkit* is an excellent resource for policy advocates. It is available on FIMC's website.

Case Study: La Soupe in Ohio

A FIMC organization based in Ohio, La Soupe rescues food and transforms it into fully prepared meals for community members that need access to healthy food. Recognizing that food insecurity can entail a high disease burden, La Soupe started an MTM program in 2021. It is a graduate of the FIMC Accelerator Program. Today the organization offers MTM for people with diabetes and heart disease.

While there is interest in Food is Medicine among Ohio's policymakers and healthcare organizations, funding is challenging. "There aren't many opportunities for healthcare reimbursement," says Hannah Griswold, Food as Medicine Director at La Soupe. "The Ohio Department of Health and the Ohio Association of Foodbanks have been working toward covering nutrition services through an 1115 waiver. They presented the case recently but were told there was a low probability of success in the next few years. They need local data to support the benefit. So, we are working with researchers to get that data to show that MTM works and advocate for policy change, whether it's In Lieu of Services or 1115."

To that end, La Soupe recently partnered with a local healthcare provider on an MTM pilot program. With Cincinnati Children's Hospital Medical Center, La Soupe provided 10 meals a week for children who are overweight or obese. Cincinnati Children's was enthusiastic about Food is Medicine, familiar with MTM research findings, and prepared to finance the pilot. Their researchers are evaluating the outcomes of program participants. While the pilot was only three months, Griswold is hopeful that the formal evaluation will unlock future opportunities.

Image credit: lasoupe.org

Federal Policy Opportunity: Medicare

Compared to state-level progress, federal support for MTM has been slow. However, this may change during the 119th U.S. Congress. To support progress toward establishing MTM as a permanent benefit in Medicare and advance access to MTM nationally, the AMPL Institute is advocating for the Medically Tailored Home-Delivered Meals Demonstration Pilot Act (the MTM Bill). It is the best current opportunity to create access to MTM through the Medicare program.

Soon to be re-introduced in Congress, the MTM Bill was unanimously passed out of the House Committee on Ways and Means in 2024 as a bipartisan, cost-neutral bill.[54] (A Senate version of the MTM Bill, i.e., S. 2133, was introduced in 2023 by Senators Debbie Stabenow (D-MI), Roger Marshall (R-KS), Cory Booker (D-NJ), and Bill Cassidy (R-LA).)

Authored by Representative James P. McGovern (D-MA), who introduced it alongside a bipartisan coalition, including Representatives Nicole Malliotakis (R-NY), Chellie Pingree (D-ME), Dwight Evans (D-PA), and Brian Fitzpatrick (R-PA), the MTM Bill establishes a four-year Medicare pilot to address the link between diet, chronic illness, and the health of older adults and individuals with disabilities. The pilot would take place in 40 hospitals in geographically diverse communities across the country (rural, urban, and frontier) and provide participants with at least two medically tailored meals every day for 12 weeks. The bill contains a strong evaluation component, which would provide evidence for policymakers and health systems to determine whether MTM should become a national benefit.

As of now, Original Medicare does not include coverage for meals. In Medicare Advantage, certain individuals can access meals in narrow circumstances if their health plan opts to cover meals as a supplemental benefit. However, successful implementation of the MTM Bill, and evaluation of its outcomes, could provide evidence to support MTM becoming a covered benefit in Medicare.

> We have a success story related to a member who had cardiac disease. This member was an older gentleman. He lived alone. . . We introduced the Community Servings meals to him, and he loved them. He would write down, 'This is what they gave me. This is what I loved. This is what I need to move forward, better myself, get stronger, recover, and prevent myself from going back to the hospital.'
>
> — SARAH NICKLEY, NURSE MANAGER, MEDICARE ADVANTAGE, BLUE CROSS BLUE SHIELD

Learn more about Community Servings' partnership with Blue Cross Blue Shield.

Federal Policy Opportunity: Veterans Affairs

Introduced in the U.S. Congress by Representative Vern Buchanan (R-FL), the Veterans Nutrition and Wellness Act of 2025 would establish an MTM and medically tailored groceries (MTG) program for eligible veterans through the Department of Veterans Affairs.[55] The bipartisan bill, co-sponsored by Representatives Gwen Moore (D-WI) and Greg Murphy (R-NC), would allow veterans to access MTM and MTG as part of their healthcare. Compared to the average U.S. population, veterans experience obesity and associated chronic conditions, such as diabetes, chronic obstructive pulmonary disease, and heart disease, at significantly higher levels.[56]

Federal Agencies and Programs

With a new Administration and Congress, the AMPL Institute will be closely monitoring support for MTM across federal agencies. As shown below, many agencies have played – and should continue to play – instrumental roles in advancing MTM access.

U.S. Department of Health and Human Services

Food is Medicine Initiative

Following the White House Conference in 2022, the Department of Health and Human Services (HHS) and the federal agencies under its oversight have made coordinated efforts to address social determinants of health as a means of enhancing the health and well-being of Americans.[57] Food is Medicine policy and practice has played an important role in those efforts.[58]

- In 2024, HHS convened the Food is Medicine Summit, which announced new private-public partnerships with Instacart, The Rockefeller Foundation, and Feeding America.[59]
- Also in 2024, HHS published a virtual toolkit to encourage the integration of Food is Medicine interventions across communities and health systems. The toolkit can be accessed at **odphp.health.gov/foodismedicine.**

The AMPL Institute is advocating for HHS to continue its coordination of efforts across the federal government, which has fostered an unprecedented and helpful resourcing of the field. HHS strategy under the new Administration continues to emerge. Secretary of HHS Robert F. Kennedy, Jr. is the chair of the Make America Healthy Again Commission. The intention of the new commission is to understand and lower chronic disease rates, an objective that is closely aligned with Food is Medicine. As of this writing, HHS is undergoing a workforce reduction and reorganization, including the creation of a new Administration for a Healthy America, which will include HRSA, the agency that administers the Ryan White HIV/AIDS Program.

The Ryan White HIV/AIDS Program

Operating under the federal Health Resources & Services Administration, the Ryan White HIV/AIDS Program (RWHAP) funds HIV care and treatment services, including nutrition supports, for people with low income and diagnosed HIV. Ryan White funding provides important support to many FIMC organizations, including Community Servings and Open Arms of Minnesota. “Given the changes in politics and concerns around federal funding, we’re very worried,” said Open Arms CEO Leah Hebert Welles, during an interview in December 2024. The worry was well founded. Due to a state budget deficit in Minnesota, Open Arms was notified of cuts to its government funding early in 2025. Open Arms made the decision to immediately stop new client intake in February 2025. The organization continues to serve 1,300 people weekly. However, it anticipates suspending services for some individuals at least temporarily.[60]

As of this writing, RWHAP is operating as it has been, without amendment, since 2009. The AMPL Institute has joined with FIMC in recommending that Congress increase funding to RWHAP through its standard appropriations process. More robust funding would enhance efforts to end the HIV epidemic by 2030 and allow program recipients to access services, such as transportation, food and nutrition, linguistic services, case management, and housing services.[61]

According to FIMC, RWHAP remains one of the only federal health funding streams that addresses nutrition and other structural interventions to support individuals who are critically ill. RWHAP set an important precedent in recognizing that healthcare is not the only determinant of health.

Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990, the same year Community Servings was founded to deliver meals to 30 people living with HIV.

National Institutes of Health (NIH) Food is Medicine Centers of Excellence

In 2022, the Office of Nutrition Research (ONR) at the NIH proposed to establish Centers of Excellence in Food is Medicine.[62] These centers would advance research, education, patient care, and community outreach on the role of nutrition in preventing and treating diet-related chronic disease. Alongside the Aspen Institute, FIMC, and the Tufts Food is Medicine Institute, the AMPL Institute recommends that Congress provide the NIH with significant funding dedicated to Food is Medicine research and the establishment of FIM Centers of Excellence.[63]

Recent disruption at the NIH makes its future difficult to predict. Under the new Administration, the NIH has reduced staff members, frozen grants (later resuming them), and issued guidance — currently subject to litigation — to cap the reimbursement rates for indirect costs of medical research.

Nonetheless, Community Servings is committed to continuing to advance research through the launch of the AMPL Institute. AMPL is closely monitoring developments at the NIH. More broadly, AMPL continues to invest in MTM research and celebrates that organizations such as the Rockefeller Foundation and the American Heart Association are doing the same. To date, Community Servings has received three NIH R01 grants for MTM intervention studies, which will help healthcare providers, health plans, and policymakers better understand the impact of MTM. Study findings are anticipated to be published in the fall of 2025, the spring of 2026, and the spring of 2027.

A Closer Look: MTM Access Through MassHealth

In 2016, the Centers for Medicare and Medicaid Services approved Massachusetts' innovative 1115 waiver, the first in the country to provide direct food-based services such as medically tailored meals (MTM) for eligible individuals enrolled in MassHealth, the state's Medicaid program.[64] MassHealth covered these and other health-related social needs services through the Flexible Services Program. To be eligible, individuals had to be enrolled in a MassHealth Accountable Care Organization (ACO), meet health-needs criteria, and demonstrate social risk factors. ACOs were responsible for working within the state's health-needs criteria to select their target population. ACOs had to do so in alignment with overall program goals of reducing total cost of care, improving health outcomes, and reducing health disparities for MassHealth members.[65]

What Is an Accountable Care Organization (ACO)?

ACOs are healthcare providers that coordinate care and enhance the role of primary care. They are paid based on health outcomes instead of service volume. In Massachusetts, ACOs can refer their patients to community-based organizations (CBOs) for nutrition and housing services.[66]

The Flexible Services Program is a strong example of state policy creating access to MTM. Within the first two years of the program, all 17 ACOs referred their patients for nutrition services;[67] 11 ACOs partnered with Community Servings as their MTM provider. Community Servings has participated in the Flexible Services Program since it launched in 2020. As a result, the organization has enhanced its operations and programs in meaningful ways.

Operations Enhancement: Shipping

Prior to Flexible Services, Community Servings explored the possibility of a shipping program to supplement its existing delivery operations. As the organization prepared to partner with ACOs who served patients outside of its established delivery routes, Community Servings rapidly operationalized a shipping option.

Since 2020, the program has scaled dramatically and is now based in the organization's satellite distribution center in southeastern Massachusetts, where it supports individuals referred to Community Servings through various pathways. In FY2024, Community Servings' shipping program supported 19% of the organization's total meal distribution.

Service Enhancements for Pediatric and Pregnancy Health

With Flexible Services, Community Servings began to serve more pregnant and pediatric individuals. High-risk pregnancy was a health needs-based criteria of the program. The program also indicated that children could receive services.[68] Thirty-six percent of MassHealth enrollees are children under the age of 21.[69]

With the shift in client population, Community Servings re-evaluated its services. “We evolved and added service offerings to make sure we met the unique nutrition needs and preferences of children and pregnant individuals,” says Community Servings’ Senior Director of Strategy and Business Development Erin DiBacco. “There was a significant influx in these two populations coming to us through Flexible Services, coupled with interest from other potential new healthcare partnerships and funders. So, we enhanced our program in order to serve clients better.”

Consulting with pediatric hospitalist and trained chef Dr. Emma Steinberg of Mass General Brigham – Newton-Wellesley Hospital, Community Servings’ registered dietitian nutritionists ensured meals include ingredients that are high in fiber and iron and low in sodium and added sugar. The team also ensured meals are tailored to the nutritional needs of individuals who have risk factors such as gestational diabetes, prediabetes, overweight, iron-deficiency anemia, preeclampsia, and hyperemesis gravidarum.

Learn more about Community Servings’ partnership with Dr. Steinberg.

Pregnancy Health Program: Client Experience

Jennitha

Jennitha, 25, lives in Lowell with her daughter, Izzariyah. She was early in her first pregnancy when she enrolled with Community Servings' Pregnancy Health Program, which she received for seven months. She had prenatal depression and was at risk for gestational diabetes. But Jennitha reports that, thanks to MTM and nutrition counseling, she was able to successfully manage her diabetes risk factors.

"When I was pregnant with Izzariyah, they did say I was close to having diabetes," Jennitha shares. "Because of my weight and my high risk, I was probably supposed to get diabetes. But because of the meals, I did not become a diabetic, which was great. I'm so thankful for that!"

Caring for a newborn and learning to breastfeed were challenging for Jennitha. She works as an administrator in the medical field and is a caregiver for her mother. "This resource helped a lot," Jennitha says, referring to MTM. "I had prenatal depression and then postpartum depression. The meals helped a lot when it came to dealing with my mental health issues."

Nutrition counseling sessions gave Jennitha personalized support in applying her primary care provider's suggestions to real life. A Community Servings registered dietitian nutritionist would reach out by phone. "Every single time she called to talk to me it was helpful," Jennitha recalls. "She shed light on [the issue of] my weight, and my doctor sending me to weight management. She gave me advice and helped me feel better. I gained weight during pregnancy, but I didn't gain weight that bad."

Today, Jennitha is pregnant once again and feeling hopeful. She is also taking classes and progressing toward her professional goal of working as a clinician.

The Impact of the Flexible Services Program

From January 2020 through March 2023, Flexible Services supported the provision of nutrition services to over 23,000 individuals across Massachusetts.[70] In addition to MTM, nutrition services included food prescriptions, nutrition education and counseling, and kitchen supplies.

One ACO observed that individuals who received nutrition supports in CY2020 saw[71]:

- $11,309 reduction in total cost of care (n=839), compared to a $345 reduction in total cost of care among a comparison group that qualified for the services but did not participate (n=162)
- Only 8% required 4+ visits to the emergency department, compared to 31% in the comparison group

In 2026, an independent evaluation of Flexible Services will be published, providing a comprehensive assessment of the program's health outcomes. As a continuation of that research, the Evaluation Consortium will examine MTM provision. This subproject is funded by the National Institutes of Health and includes research partners from Community Servings, the Tufts University Food is Medicine Institute, and UMass Chan Medical School.

Community Servings' MTM Services Through Flexible Services, 2020–2024

1,301,429 meals

6,339 individuals

4,737 nutrition counseling sessions

Primary Diagnosis

34% - Diabetes	4% - Lung disease
20% - Other	2% - Cancer
14% - Cardiac illness	2% - GI Illness
11% - Behavioral Heath	1% - Renal Illness
6% - Obesity/Overweight	1% - Liver Disease
4% - High risk pregnancy	1% - HIV/AIDS

To build on the success of Flexible Services and advance efforts to address health disparities and improve health outcomes, in 2025 MassHealth introduced policy changes that were intended to support greater access to health-related social needs services in a sustainable construct.

Health-Related Social Needs Supplemental Services Program

On January 1, 2025, MassHealth's coverage of nutrition services changed from a grant-based model to a covered services framework.[72] The Flexible Services Program was sunsetted on December 31, 2024. It was replaced by the **Health-Related Social Needs Supplemental Services Program (HRSN)**.

Under the new structure, people who are eligible for MTM must screen positive for very low food security and have a diagnosis of HIV, cardiovascular disease, diabetes, renal disease, lung disease, liver disease, cancer, or high-risk pregnancy; people diagnosed with these conditions meet MassHealth's health needs-based criteria (HNBC) for MTM.[73] In a departure from prior policy guidance, ACOs cannot limit the provision of nutrition services to specific patient populations.[74] Eligible individuals who have very low food security and a primary diagnosis that is not one of the conditions listed above may qualify for "nutritionally appropriate meals," a new service type. According to MassHealth policy, nutritionally appropriate meals are healthy, well-balanced meals.

Overall, the policy changes of the HRSN Program signal two important intentions. One intention is to make health-related social needs services more accessible to medically appropriate individuals. However, there have been initial concerns that ACO providers may lose their ability to reach all populations that could benefit from meals.

Notably, the final guidance from MassHealth required ACOs to offer *only one* of the two fully prepared meal services— either MTM or nutritionally appropriate meals, but not both. Consequently, ACOs could not provide a fully prepared meal service for people with any and all diagnoses. A public meeting deck from September 2024 offers a general explanation of the new guidance: "MassHealth made some changes to HRSN Supplemental Services to better match eligibility and program size to available budget so that members can receive services throughout 2025."[75]

According to DiBacco, Community Servings' ACO partners all navigated this requirement in the same manner: "They all chose medically tailored meals. The diagnoses that qualify for MTM are the ones that have been most closely studied for outcomes. But now the downside is that it's potentially cutting out whole populations of people with behavioral health, GI, or neurological primary diagnoses that will no longer have access to medically tailored meals."

Efforts have been taken to prevent people from losing access to medically tailored nutrition because of their primary diagnosis. As of this writing, five of Community Servings' 12 ACO partners are able to serve individuals that do have an HNBC condition as well as individuals that do not have a HNBC condition. These five ACOs have contracted with Community Servings to offer MTM to one population and nutritionally appropriate grocery boxes to the other.

The second intention behind the policy changes of HRSN is to establish a more permanent funding mechanism for health-related social needs services. However, a permanent funding mechanism can still entail financial hurdles for CBOs. Historically, changes to MassHealth's coverage of nutrition services create temporary reductions in service volume.

Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation, places this trend – policy evolution followed by service-level drops – in a larger context: the process of configuring a social service like MTM within a healthcare benefits framework. "The Medicaid program is very interested in the Food is Medicine concept, but we're going through an evolutionary process as the healthcare system makes decisions about the right scope and role of Food is Medicine in Medicaid," Garfield explains. "That has involved a lot of experimentation to figure out where we see the best outcomes for the best populations. It has meant adjustments over time. Hopefully, this is a trajectory toward more solidly fitting Food is Medicine within the scope of covered services."

Community Servings and partner ACOs will closely monitor the HRSN Program in 2025. Indeed, as of late January 2025, Community Servings' service levels have declined, though they are gradually rising back. DiBacco advises other CBOs in the field to anticipate declines in health-care service volume anytime there are structural changes to policy. Fluctuations in client volume mean fluctuations in revenue, which are difficult for nonprofit organizations to sustain.

Policy evolution has brought about other financial challenges for CBOs, as well: In the case of the HRSN Program, it has required new and sizeable investments in operations and technology.

Administrative Adjustments

Starting January 1, 2025, the HRSN Program requires all nutrition services providers, including CBOs, to be credentialed and enrolled as health plan network providers.[76] Credentialing is how health plans ensure a potential provider meets state and federal qualifications. Generally speaking, becoming a network provider means doing business with the healthcare system like any other healthcare provider. However, there are administrative ramifications to the transition. For 2025, Community Servings is exploring the use of an intermediary clearinghouse for data exchange processes, such as claims billing and verifying MassHealth member eligibility in advance of each delivery or shipment — two new 2025 requirements. Furthermore, in order to track billing units for meals, shipments of groceries, and nutrition counseling sessions as required by the HRSN Program, Community Servings has updated its internal client tracking system (Salesforce). Taken together, these adjustments have required a significant investment for Community Servings. With funding authorized through its 1115 waiver, MassHealth created the HRSN Integration Fund to support CBOs through such transitions, supporting potentially burdensome technology and systems enhancements. The fund was opened to applicants in August 2024, and Community Servings was awarded an HRSN Integration grant of $250,000, the maximum available, in late December 2024.[77] However, Community Servings invested significantly in advance of the grant in order to be ready for the transition on January 1.

“I imagine that the level of investments that we have made would not have been possible for many CBOs,” observed Community Servings’ Senior Director of Programs Leigh Kalbacker. “We committed to enhancing our systems. We worked with a vendor to complete the labor on time over a few short months. This project took place before the HRSN Integration grant came through, but it’s what we had to do to be ready on January 1.”

Community Servings continues to navigate the operational challenges of the HRSN Program transition, as service volumes fluctuate and, simultaneously, system enhancements are implemented. The organization is hopeful that philanthropic giving will meet or exceed plans, providing support during a time of significant administrative investment. Also in the mix, however, are potential cuts to federal funding. “This is a wait-and-see year,” observes Community Servings’ Chief Financial Officer Silifa Wallace. “You need to be prepared for the possibility of losing your government funding. Federal funding is a large portion of our revenue. So, in a year like 2025, you only want to pay for what you must have to fulfill your core services.”

Summary of Operational Changes Impacting MTM HRSN Providers in 2025		
	Before 1/1/2025	As of 1/1/2025
MassHealth Eligibility Verification	MassHealth eligibility verification was required at the time of referral and every 90 days following (could be done by either ACO or social services organization).	HRSN providers must verify MassHealth eligibility prior to each service delivery in order to ensure payment of claims.
Eligibility Criteria for Medically Tailored Meals	Eligible individuals were required to meet one health-needs based criteria (HNBC) and one risk factor.	Eligible individuals must meet medical necessity criteria, which includes narrower HNBC, risk factors, and other programmatic criteria as required.
Health Needs Based Criteria (HNBC)	To receive any Flexible Service, individuals had to meet at least 1 of 5 HNBC: 1) Behavioral health need; 2) Complex physical health need; 3) ADL/Instrumental ADL Needs; 4) Repeated ED utilization; 5) High-risk pregnancy.	To receive MTM specifically, individuals must have one of the following HNBC conditions: HIV, cardiovascular disease, diabetes, renal disease, lung disease, liver disease, cancer, or high-risk pregnancy.
Risk Factor	Food insecurity was an eligible risk factor.	Eligible individuals must screen positive for very low food security every 6 months.
Household Referrals	ACOs could refer household members of an eligible individual for services.	ACOs can only refer eligible individuals for services (no household members).

Summary of Operational Changes Impacting MTM HRSN Providers in 2025		
	Before 1/1/2025	As of 1/1/2025
Nutrition Counseling	Social services organizations could bundle nutrition counseling with meals or grocery boxes, or provide nutrition counseling as a stand-alone service.	Nutrition counseling is a separate billable service. Offering nutrition counseling is left to the discretion of the ACO and can only be provided to individuals also receiving meals, grocery boxes, or food vouchers.
Billing	Social service organizations could invoice ACOs for payment.	HRSN providers are required to submit claims for billing.
Service Duration	Individuals were referred for a maximum of 6 months. In limited cases, the member could be extended for another 6 months of meals based on clinical judgement of RDN.	Individuals need to be rescreened every 6 months. As long as the member remains eligible with health insurance coverage, HNBC, very low food security, and inability to prepare meals, the member may remain on service.

Stakeholders anticipate the implementation of the HRSN Program will reach stability over the course of 2025. In the meantime, Community Servings is focused on ensuring seamless service for its clients. “The people we serve expect to keep getting food every week,” Kalbacker says. “So we can’t take a year to get up and running. We have to be ready to go day one.”

Fundraising in 2025

As the Trump Administration continues to reshape the federal government, many in the field are bracing for a more challenging funding landscape. Philanthropic funding, which has been so important to medically tailored meals (MTM) historically, remains important today and will become even more competitive as federal programs face possible cuts.

It is largely thanks to decades of philanthropic support that the Food is Medicine movement has persisted. During the HIV/AIDS epidemic of the late 1980s and early 1990s, nutritious food was one of the few tools available to address AIDS wasting syndrome. Nonprofit community-based organizations (CBOs) stepped up to support the unmet health needs of people experiencing severe, complex illnesses long before the healthcare system recognized the importance of social determinants of health. Today CBOs rely on individual donations, fundraising events, and corporate and foundation grants. Federal and local government grants are another funding source. Only in the last ten years, organizations such as God's Love We Deliver in New York City, MANNA in Philadelphia, Project Angel Food in Los Angeles, and Community Servings in Boston have contracted with healthcare providers and health plans to create access to MTM. However, opportunities for healthcare partnerships vary widely based on a region's local entities and policy pathways. Securing partnerships may require a CBO to undertake years of persistent policy advocacy, discussion with prospective partners, and pilot programming and evaluation to demonstrate impact.

> "Philanthropy is really the backbone of the Food is Medicine movement, now more than ever.
>
> — TIM LEAHY, CHIEF DEVELOPMENT OFFICER, COMMUNITY SERVINGS

"Philanthropy provides the stability to scale services over time," Leahy says. "While we've seen progress through healthcare, it's still a percentage of total revenue and it can fluctuate drastically year to year. If that wasn't challenging enough, government funding is now subject to change with the new Administration's shifting policies. Government funding is never guaranteed. It's through private philanthropy that a CBO can ensure that direct services continue without interruption, regardless of the political climate. As we look at the next few years, we believe the philanthropic community will be instrumental in supporting a sustainable future for MTM."

The Need for Quality Standards

What distinguishes medically tailored meals (MTM) from a home-delivered meal service? When and why is the provision of MTM medically appropriate? How do we know that MTM providers, with differing scales of operations, are delivering the same service?

Questions like these, though complex, have a simple point. They ensure quality, consistency, and measurability. And when it comes to MTM — a service that reduces healthcare costs, inpatient admissions, emergency department visits, and skilled nursing facility admissions — quality, consistency, and measurability matter.[78]

Over the past three years, Medicaid and Medicare, which provide health insurance coverage to over 145 million Americans combined,[79] [80] have been creating access to MTM through demonstrations, waivers, and pilots. Yet, across these coverage opportunities, MTM's standard definition remains a work in progress. This is a significant issue. Any service that is available within the heavily regulated ecosystem that is healthcare must be defined and standardized. From a regulatory perspective, all stakeholders — policymakers, healthcare providers, health plans, and MTM providers — should align on an overarching definition. Absent such a definition, services and practices vary widely. Quality varies widely.

A recent article in *Health Affairs*, authored by the Center for Health Law and Policy Innovation of Harvard Law School and the Food is Medicine Coalition (FIMC), argues that the principle of "medical necessity," which health plans use within coverage guidelines, is the logical place to start in determining when and how MTM is appropriate for prevention or treatment.[81] Existing legal, regulatory, and quality standards in the healthcare system can and should also be applied to MTM.

To that end, the field celebrated an extraordinary milestone in 2024 as FIMC, the national coalition of nonprofit MTM providers, published its first practice standard.

Standardizing a Model of Care

In March 2024, FIMC released the MTM Intervention Accreditation Criteria and Requirements (ACR) along with the announcement of FIMC's first accredited organizations. The ACR is the first time that FIMC's guiding ethic – "meals made with love and care," in the words of Executive Director Alissa Wassung – has been standardized in a specific, auditable manner. The ACR "fully describes what it means to be an MTM provider," Wassung says. It also defines the MTM intervention comprehensively, including the integrated role of a registered dietitian nutritionist (RDN), whose responsibilities include client assessment, meal plan design, and nutrition counseling and education.[82]

> The release of the new MTM accreditation standard is the most significant milestone in the field of medically tailored nutrition in the last year.
>
> — DAVID B. WATERS, CEO, COMMUNITY SERVINGS

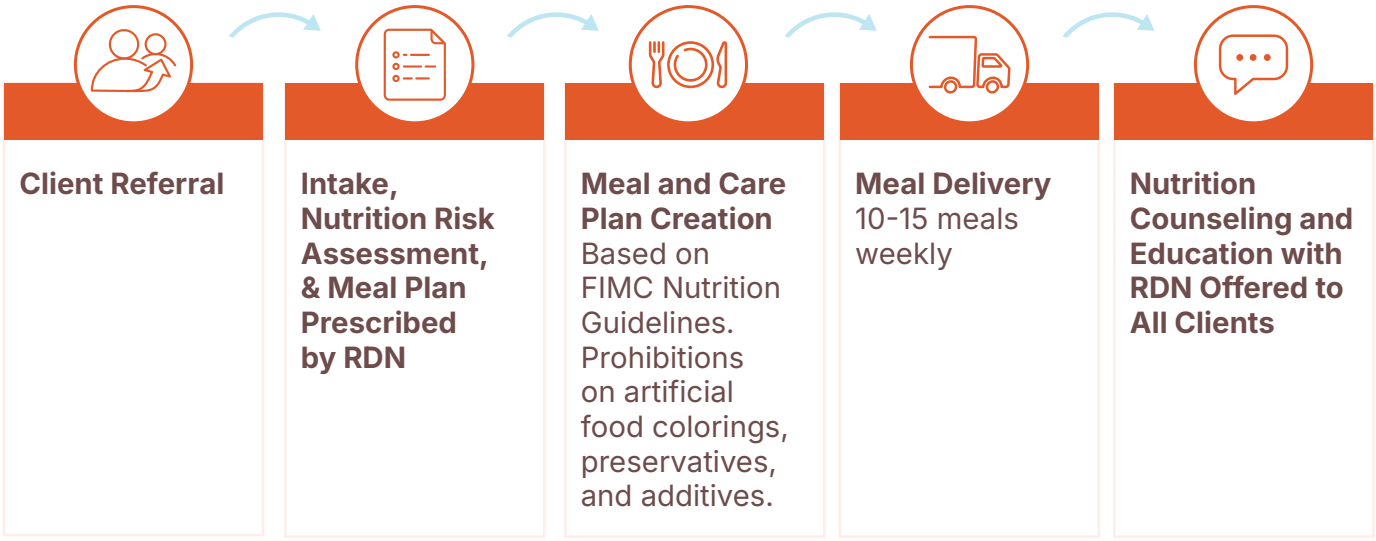
As of this writing, Community Servings and ten other FIMC organizations have been audited and accredited. Accredited organizations comply with FIMC's rigorous guidelines. Accredited organizations, no matter their operational scale or geography, provide the same high-quality MTM intervention, one that meets the needs of clients living with severe, complex, or chronic health conditions. Health plans or hospital systems that operate in multiple markets now have, in any FIMC accredited organization, a partner that offers a standard MTM intervention.

While the ACR currently focuses on nonprofit providers, it is intended to be a universally accessible resource, a guidebook to meet community need.

To become accredited, organizations must undergo an on-site audit. When organizations have gaps in conformity with the ACR, organizations can take corrective action to close gaps within an alloted time frame and fully comply with the ACR. Final accreditation decisions are reviewed and voted on by the FIMC Membership and Accreditation Committee.

FIMC created the ACR in partnership with SCS Standards, a nonprofit standards development body, and with input from diverse FIMC organizations across the country. In the future, the ACR will be reviewed and updated as new considerations in the practice and provision of MTM arise through policy change, community input, and research.

FIMC MTM Intervention Model



The 8 Pillars of the ACR

1. General Requirements
   (i.e., training, 501(c)(3) status, quality improvement program, client experience)
2. Fully Integrated RDNs
3. Client Referrals, Eligibility, Intake, and Disenrollment
4. Nutrition Care Process Intervention
   (i.e., nutrition therapy, counseling, and education)
5. Medical Tailoring Following FIMC Clinical Committee Guidelines
6. Food Safety
7. Community-Based Volunteer-Supported Services
8. HIPAA Compliance

Example Requirements:

- Artificial food coloring, artificial sweeteners, preservatives, trans fats, and ultra processed foods are prohibited from use in most cases.
- Meals must be prepared using fresh ingredients and in a manner that preserves the nutrient value of the food.
- RDNs tailor menus to the medical needs of clients.
- RDNs conduct nutrition risk screenings and nutrition assessments for each new client.
- RDNs lead nutrition counseling and education.

Because of the limited access to MTM through healthcare reimbursement, Wassung believes it is important to focus on nonprofits' provision of MTM across the country: "We support sophisticated agencies that can both partner with healthcare and feed people for free when necessary." In the first-ever standard, it was important to FIMC to recognize the community connections that are part of the success of the MTM model: dedication to mission, cultural competency, and community trust.

A Threat to Decades of Progress

In July 2024, *STAT* reported on a for-profit meal provider whose "diabetic friendly" and "renal friendly" menu included a commercially processed Jimmy Dean Ham, Egg, and Cheese Croissant Sandwich.[83] (On the basis of the ingredients list, which includes high-fructose corn syrup, this entree does not conform with FIMC's Nutrition Guidelines.) This meal provider, which is not part of FIMC, receives Medicaid reimbursement for MTM services in several states. How, one might ask, does unhealthy food advance the goals of Medicaid?

> If we implement interventions that don't meet standards, evaluate them, and get sub-par outcomes, we might, as a nation, abandon the whole concept of Food is Medicine as part of healthcare. That would be a tragedy for our current and future clients and the health of our nation, just when we are all agreeing that Food is Medicine is important and necessary.
>
> — ALISSA WASSUNG, EXECUTIVE DIRECTOR, FOOD IS MEDICINE COALITION

There is also, of course, the negative effect of lower-quality food on the health of consumers. "Clients will individually suffer," says Community Servings' Chief Culinary Officer Brian Hillmer. "But it will also undermine the belief in the work we have been doing and cause the public to question its validity."

Policy Guardrails

FIMC is not the only stakeholder placing guardrails around the provision of MTM. The Centers for Medicare and Medicaid Services (CMS) and state Medicaid programs also have important roles in standardizing MTM eligibility and services in Medicaid demonstrations.

CMS's recent approvals of 1115 waivers generally require health-need criteria and social risk factors for eligibility. Another general trend is that MTM must be tailored to the individual's health condition. It is noteworthy, however, that these definitions leave room for each state to apply criteria in different ways, subject to CMS approval. As a result, guidelines vary across state Medicaid demonstrations. For example, California's Community Supports Program[84] and the 1115 waivers in Massachusetts[85], New York[86], and Pennsylvania[87] require that an RDN approve meals (or "meal plans"). However, the 1115 waivers recently approved for Illinois[88], North Carolina[89], and Washington[90] require that an RDN or another qualified provider conduct an initial assessment and reassessment of MTM recipients.

In some cases, the coverage of MTM within Medicaid demonstrations explicitly references FIMC guidelines. For example:

- Michigan's Managed Care In Lieu of Services authority explicitly requires that MTM be tailored in accordance with FIMC Nutrition Guidelines.[91]
- Rhode Island's 1115 waiver extension, pending as of this writing, and North Carolina's Healthy Opportunities Pilot Program both cite FIMC Nutrition Guidelines. [92] [93]

Reception to Date

For Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation, the ACR is an important milestone "in terms of guaranteeing health outcomes and making sure we're comparing apples to apples in any research we're doing, and creating consistency in the space" among providers and health plans. Given the concern about quality, Garfield anticipates that more requirements will come forward in the future. "What we haven't seen yet is a national, consistent framework lifted up around what MTM should look like. I think that's where we're headed. Hopefully, we will see more consistent above-the-state-level articulation of quality about MTM."

Such a framework may prove critical for MTM's long-term role in the healthcare system. "Quality intersects with other potential liabilities in healthcare, such as fraud, waste, and abuse." Garfield emphasizes that, "Because of this, clear guidelines are in the best interest of patients but also nutrition organizations and our federal healthcare programs."

For Community Servings' Senior Director of Strategy and Business Development Erin DiBacco, FIMC accreditation is, in the short term, a "game-changer" for MTM's integration into healthcare.

> To be able to point to a clear set of established guidelines for accreditation will differentiate accredited agencies when discussing potential partnerships within healthcare. That's a very powerful distinction that will resonate with healthcare and policy leaders.
>
> — ERIN DIBACCO, SENIOR DIRECTOR OF STRATEGY AND BUSINESS DEVELOPMENT, COMMUNITY SERVINGS

Accelerating Access Nationally

For decades, nonprofit community-based organizations (CBOs) have provided access to high-quality medically tailored meals (MTM) free of charge to the people who need them, regardless of their ability to pay. Possessing knowledge of their region and ties to the communities served, CBOs are well equipped to serve their communities – better equipped than national companies.

The national association of nonprofit MTM providers, the Food is Medicine Coalition (FIMC) creates learning and training opportunities in the provision of MTM for CBOs across the country. FIMC's Accelerator Program was launched in early 2020 to replicate and expand MTM programs nationwide. "We envision a future where these critical services are available to everyone who needs them—at the highest quality," says FIMC Executive Director Alissa Wassung.

A joint program of FIMC, Community Servings, God's Love We Deliver, the Nonprofit Finance Fund, and the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), the Accelerator provides CBOs with:

- Training in the preparation and delivery of MTM, in compliance with rigorous standards
- Support in creating funding models that include Medicaid and Medicare reimbursement
- Guidance on healthcare partnerships to integrate MTM into patient care

Since its launch, the Accelerator has graduated 17 nonprofit organizations, including Meals on Wheels People and Second Harvest Food Bank of Central Florida.

Case Study: Meals on Wheels People

Based in Portland, Oregon, Meals on Wheels People (MOWP) has long provided home-delivered meals to older adults. MOWP sees life-changing results for its clients. "We had a client whose kidney function was down in the 20s and nearing dialysis," says MOWP Chief Executive Officer Suzanne Washington. "The client had diabetes. They started getting renal meals, and their kidney GFR [glomerular filtration rate] measurements went from the 20s to the 60s [indicating normal waste filtering function.] They were no longer worried about dialysis."

MOWP joined the Accelerator in order to diversify its income through MTM and expand their services to people who are too sick to shop or cook for themselves. Participation in the program helped MOWP build out and position its MTM program for prospective healthcare partners. Effective January 1, 2025, a Medicaid Section 1115 demonstration waiver in Oregon is funding access to MTM for Oregon Health Plan enrollees.[94]

Partnering with CareOregon, a nonprofit Medicaid insurer, was a breakthrough for MOWP. "CareOregon wanted to do special diets for wound care. That was one of the earliest," says Washington. "We needed to figure out a way to medically customize what a client gets." Through MTM, MOWP supported improved health outcomes for CareOregon's target population.

Washington credits the Accelerator for broadening her understanding of potential healthcare contracts and informing MOWP's business strategy: "It helped us answer big questions. How do we find the partners to contract with? What could contract negotiations look like? What are the funding sources? Where do we go to build the business relationships?"

"The Accelerator really helped with, for lack of a better term, the jargon of healthcare," says MOWP Senior Director of Operations Jody Grant. "How do you speak to a healthcare provider? What words are they looking to hear? Developing the pitch deck was key. It really opened our eyes."

Yet barriers remain in working with healthcare. The biggest one for MOWP is long-term, sustainable funding. "We have two healthcare partners. We've had them for years. They're great to work with," Washington shares. "The challenge is none of them have funding for meals as a line item in their budget. It's coming through other sources. Oregon's Medicaid waiver provides a funding source starting this year. We'll see how that goes. But our partners do not yet have the costs or cost-savings of Food is Medicine worked into their budget."

Image credit: mowp.org

Case Study: Second Harvest Food Bank of Central Florida

Located in Orlando, Second Harvest Food Bank of Central Florida has addressed food insecurity for over 40 years. The organization collects and donates food to over 750 partners in seven Central Florida counties. It was through the Accelerator Program that Second Harvest learned how to scale its burgeoning MTM program, which allows it to meet even more nutritional needs across the community.

"Our medically tailored meals are all from scratch," says Second Harvest's Chief Foodservice Officer Nancy Brumbaugh. "The Accelerator gave us the framework for what an MTM operation would look like. Before we even went into the program, we had to make changes — switching from foodservice employees to a chef-brigade structure, ensuring we had the expertise to do from-scratch cooking, and bringing in a registered dietitian nutritionist to guide our work."

> We're still in a pilot phase, so it's incredibly helpful to learn from programs that are more established as we plan for the future.
>
> — NANCY BRUMBAUGH, CHIEF FOODSERVICE OFFICER, SECOND HARVEST FOOD BANK OF CENTRAL FLORIDA

While Second Harvest has made significant investments to operationalize MTM, the program faces funding challenges.

"Our MTM program is solely funded through grants and pilot funding," says Dawn Koffarnus, Chief Financial Officer and Chief Health Systems Officer at Second Harvest. A grant from the DaVita Giving Foundation, for example, helped Second Harvest jumpstart a renal health pilot program. "We have not been able to contract with a health plan, particularly related to a Medicaid Managed Care Organization or a Medicare Advantage plan. We don't have an 1115 waiver in Florida and we don't have Medicaid Expansion. So, we have to work within those parameters. However, the state of Florida recently made a requirement where MCOs had to support four different social determinants of health, food security being one of them. It's the first time we've had a requirement like this in Florida's Medicaid program. And MCOs are required to work with a community-based organization. So, we're teed up to have some success in that area, but I think we're a good year away from signing a contract with an MCO."

Second Harvest sees growing interest in MTM from healthcare providers. “The hospital systems recognize that their patients with diet-related illnesses are being discharged and readmitted,” Koffarnus says. “They’re starting to see the cost of readmissions is higher than what it would be to provide MTM. We are in conversations about the long-term financial benefits of integrating MTM into patient care.”

Through the Accelerator, CHLPI provided Second Harvest with guidance on policy opportunities in Florida. Today, Second Harvest advocates for local policy change. The organization is not alone in the effort. Funders, health plans, and healthcare providers are working with Second Harvest to plan future access to MTM. “I have a lot of optimism about these conversations,” Koffarnus shares. “We have a lot of opportunity to co-create solutions with MCOs. This work is new for MCOs, too. We’ve never had the ability to have this kind of collective impact. We’ve never met and planned with MCOs like we are now. There’s momentum, but we still have work ahead of us when it comes to financial sustainability for MTM.”

The Path Forward

The momentum behind medically tailored nutrition is undeniable, but scaling its impact nationwide requires continued capacity-building, workforce development, and policy advocacy.

“Access to these services is a challenge, particularly in geographically underserved areas,” says Wassung.

As new policy opportunities create access to MTM, new geographies will require local, community-based MTM providers that can offer MTM at the highest standard. While FIMC member organizations are uniquely qualified to provide MTM, currently just under half of states are home to FIMC organizations.

“We have a model that works,” Wassung says. “Now, the challenge is reaching as many people as possible—and urgently.”

Nutrition in Medical Education

Surprisingly, one of the barriers preventing more people from accessing nutrition interventions is located within the healthcare system itself. Physicians — the healthcare providers that can directly advise patients on healthy behaviors like diet — historically receive inadequate training in nutrition and are unequipped to advise patients about diet.[95]

To understand why, it is helpful to examine medical education in America. Medical schools (or undergraduate medical education, UME) have no nationally required nutrition competencies, meaning the basic skills that trainees are required to demonstrate. Medical students generally receive little nutrition education — less than 20 hours over four years of medical school.[96] While a growing number of medical schools have begun to offer elective courses in nutrition in recent years, the impact of diet on health demands stronger requirements. Nutrition education is inadequately incorporated into graduate medical education (GME, or the residency/fellowship stage of medical education), as well. Nutrition competencies are limited or absent from most GME program requirements, even in cases where nutrition is highly relevant to the medical specialty (such as internal medicine and cardiovascular medicine).

Research shows that physicians with training in nutrition are significantly more confident in providing nutrition counseling to patients and referring them to registered dietitian nutritionists.[97] In contrast, physicians without any nutrition training are less likely to refer patients to registered dietitian nutritionists. For Hannah Griswold, Food as Medicine Director at La Soupe and a registered dietitian nutritionist herself, nutrition education for providers would address two problems: It would give physicians the knowledge that patients expect from them, and it would inform physicians about the tremendous value of dietitians. "Most people take what their physician says as 'the word.' If a physician says you need to eat more fruits and vegetables, patients will really listen to that. I wish I could say patients would give dietitians the same level of trust. Dietitians are the true experts on nutrition and health."

> Physicians need to understand what dietitians do, their role and their value. We're not just in hospitals calculating formulas. Physicians can refer patients to see dietitians for education and counseling. That's going to help physicians, as well, since physicians can be incentivized through value-based programs for improving patients' values, such as keeping A1C within normal limits. Dietitians can help with that.
>
> — HANNAH GRISWOLD, LDN, RDN, FOOD AS MEDICINE DIRECTOR, LA SOUPE

For healthcare to realize the benefits of nutrition, medical professionals need training that will help them understand both why nutrition matters and how to share that expertise with patients.

Recent Milestones

Awareness of medical professionals' lack of nutrition education is growing.
So is consensus among stakeholders regarding the need for change.

The federal government is the largest source of GME funding in the country.[98] Through Medicare alone, Congress allocates $16.2 billion annually for medical trainees.[99] On those grounds, the U.S. House of Representatives in 2022 passed a bipartisan resolution, House Resolution 1118, introduced by Representatives James P. McGovern (D-MA) and Michael Burgess (R-TX).[100] Resolution 1118 urges medical schools, residencies, and fellowship programs to incorporate meaningful nutrition education into curricula. Such education should, the resolution states, demonstrate the connection between nutrition and disease and develop in students the skills necessary to initiate meaningful nutrition interventions and referrals. Later that year, the White House Conference on Hunger, Nutrition, and Health sent the same message, recommending that schools and licensing boards expand nutrition education in GME curricula, board exams, and post-graduate training.[101]

The medical field took notice. Motivated both by House Resolution 1118 and the White House Conference, the governing bodies of medical education, including the Accreditation Council for Graduate Medical Education (ACGME), the American Association of Osteopathic Medicine (AACOM), and the Association of American Medical Colleges (AAMC), collaborated in 2023 on a summit devoted to the role of nutrition within medical education.[102] In 2024, following a literature review conducted by academic researchers, an expert panel reached consensus to recommend 36 nutrition competencies for UME and GME.[103] This is an extraordinary milestone. The panel agreed that these competencies should be included in licensing and board certification examinations. Example competencies include, but are not limited to, skills to:

- Screen for food and nutrition insecurity and make appropriate referrals for those identified at risk
- Provide evidence-based and culturally sensitive nutrition and food recommendations for the prevention and treatment of disease
- Start a sensitive, nonjudgmental conversation about food and lifestyle within a primary care setting
- Demonstrate empathy and sensitivity when counseling patients on obesity and eating disorders

“Nutrition Education for Physicians Is Overdue”

First published by the Harvard Law School Food Law and Policy Clinic (FLPC) in 2019, the Doctoring Our Diet report advocates for nutrition education for physicians and offers policy recommendations to improve nutrition education at each level of medical training.[104] In a 2024 update, FLPC highlighted timely policy recommendations to advance nutrition education for medical professionals across federal, state, and accreditation bodies.

Federal	
FLPC Recommendation to Advance Nutrition Education	**Decisionmakers**
Require federally employed doctors to complete nutrition continuing medical education course or training program	• Congress • President • Secretary of Health and Human Services
Make nutrition education a condition of Medicare funding for GME	• Congress
Adapt existing grant programs or create new grant programs to accelerate inclusion of nutrition education within UME and GME	• Congress

State	
FLPC Recommendation to Advance Nutrition Education	**Decisionmakers**
Implement nutrition education in continuing medical education requirements for continued licensure and develop nutrition education resources for medical professionals	• State medical boards • State legislatures
Require or incentivize a baseline level of nutrition education for GME through funding mechanisms (e.g., Medicaid funding, other state-level mechanisms)	• State Medicaid programs • State legislatures

Accreditation Bodies	
FLPC Recommendation to Advance Nutrition Education	**Decisionmakers**
Incorporate nutrition education into GME accreditation standards, required competencies, and reporting requirements	• Accreditation bodies (e.g., LCME, ACGME)

Culinary Medicine at the AMPL Institute

The AMPL Institute is working to support the incorporation of nutrition into medical education. The organization believes that increasing the knowledge of nutrition among healthcare providers is key to improving patients' access to nutrition services. To that end, the AMPL Institute launched a Culinary Medicine Program in 2025.

What Is Culinary Medicine?

Culinary medicine is a relatively new evidence-based field in medicine that blends the art of food and cooking with the science of medicine.[105] Its goal is to support future physicians to empower all people to make healthy personal decisions to access and eat nutritious meals that prevent and treat disease and restore well-being. In culinary medicine, food and beverage are primary care techniques, and individuals can care for themselves safely and effectively.

Building on Community Servings' decades of expertise and national leadership in the provision of medically tailored meals, the AMPL Institute's Culinary Medicine Program teaches graduate students in the healthcare field how to educate patients about and prepare meals for the prevention and treatment of diet-related illnesses. At the same time, this program addresses the numerous barriers to accessing and affording food through carefully selected discussion activities and recipes. The program represents the evolution of the organization's work to integrate nutrition into existing healthcare systems.

Target Audience

The program is ideal for third- or fourth-year medical students, residents, and other healthcare professionals interested in gaining empathy and skills to share recommendations with patients experiencing nutrition insecurity and chronic illnesses related to diet.

Curriculum and Structure

- Up to 14 90-minute modules that combine evidence-based nutrition education with basic cooking skills and recipes
- Divided between coursework (reading materials, activities, discussions) and hands-on cooking in Community Servings' Learning Kitchen

Participants learn about topics such as:

- Food safety and preparation
- The intersection between public health and nutrition
- Grocery budgeting and meal planning
- Motivational interviewing and cultural competence
- Medically tailored nutrition
- Nutrition guidelines
- Nutrition for pregnancy, children, and older adults

Looking Ahead

The AMPL Institute celebrates the recent progress toward a future in which more physicians provide food-based care that is practical, evidence-based, accessible, and culturally sensitive. However, the organization also recognizes the challenges that primary care is undergoing. Primary care physicians, of course, play an indispensable role in directing patients to necessary interventions, food-based and otherwise. Yet the percentage of Massachusetts residents having difficulty obtaining necessary healthcare is currently growing due to a workforce shortage.[106] According to a recent survey, ease of access to care is declining.[107] Nationally and in Massachusetts, there is a growing percentage of primary care providers who are leaving primary care.[108] Projections from the Association of American Medical Colleges indicate the shortage of physicians will continue, with demand outpacing supply.[109] It may prove difficult to enhance primary care when the current state is struggling. The AMPL Institute will continue to thoughtfully monitor opportunities to advance the integration of nutrition into healthcare and will remain committed to addressing gaps in nutrition education.


COMMUNITY
SERVINGS
LEARNING KITCHEN LIVE


COMMUNITY
SERVINGS

Coding and Billing for Food is Medicine

Healthcare and social services share the goal of improving health and well-being. Historically, however, these sectors have operated with very different administrative models. As the two begin to work together – as community-based organizations (CBOs) begin to bill health plans for services, for instance – the significance of these differences is becoming more apparent. The operational integration of MTM into healthcare has been a recurring theme throughout this report, but it is perhaps nowhere more immediate than in service billing and reimbursement.

Background

According to 2023's White House Social Determinants of Health (SDOH) Playbook, one of the challenges in partnership between healthcare and social services is the lack of SDOH data standards.[110] Investment in data standards "will help to enable and improve the *quality of referrals* between social care services and health care delivery organizations" (emphasis added).

What exactly are the issues affecting referrals? In early 2024, the Gravity Project – a collaborative initiative that develops consensus-based data standards – convened a discovery committee to answer that question. The committee corroborated the White House's assessment. It also went further. Gravity's findings locate structural barriers across several use cases; claims submission and billing and remittance are two of them.[111] According to Gravity, if health-related social needs (HRSN) reimbursement programs are going to succeed, all of the stakeholders involved – states, healthcare providers, CBOs, and health plans – need uniform data standards. Without them, CBOs face financial and operational burdens. More concerningly, HRSN reimbursement programs may be prevented from reaching their full potential in implementation.

In parallel, another Gravity initiative, Coding4Food, is working to support CBOs as they partner with healthcare.[112] The workgroup is comprised of for-profit and nonprofit Food is Medicine providers as well as the Food is Medicine Coalition (FIMC) and the Center for Health Law and Policy Innovation of Harvard Law School.

The primary objective of Coding4Food is addressing the lack of standard service codes for Food is Medicine interventions — an important infrastructure gap between healthcare and social services. Coding4Food has the potential to alleviate significant operational challenges. It also has the potential to advance long-term goals for the field, such as evaluating HRSN policy implementations and researching the outcomes of Food is Medicine interventions.

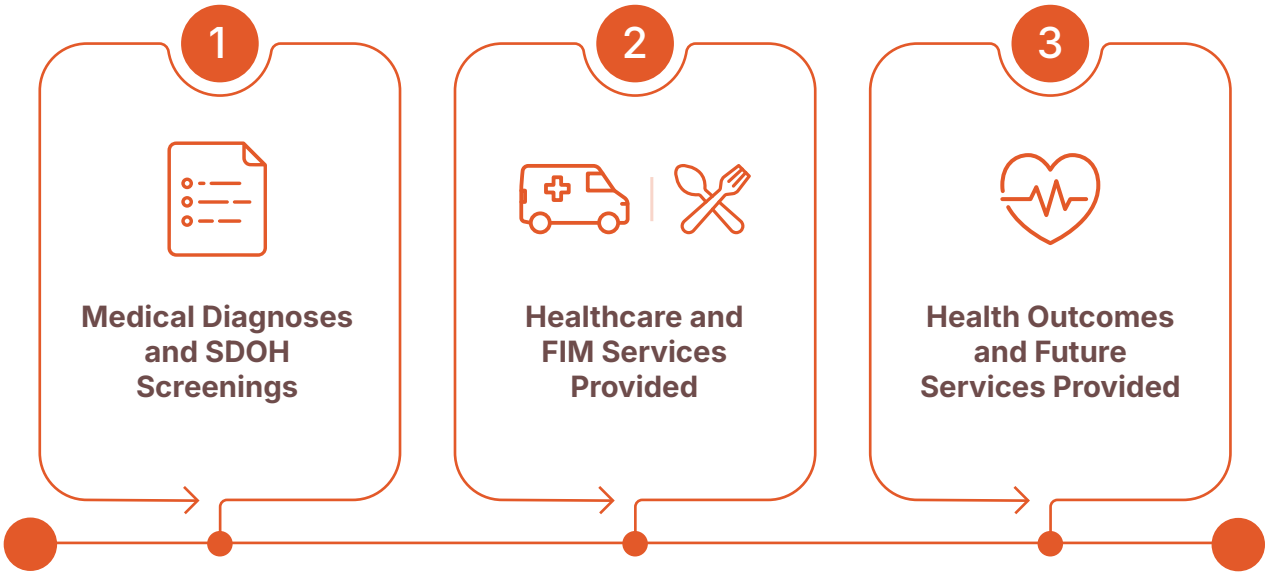
What Is a Code?

Codes are how the healthcare system records key information for administrative use. Medical diagnoses are captured with ICD codes. Standard services and procedures are captured with CPT codes. Nontraditional services are captured with Level II HCPCS codes. HCPCS, short for the Healthcare Common Procedure Coding System, is a national standard data set that the federal government manages through the Centers for Medicare and Medicaid Services (CMS).

For service reimbursements, healthcare providers submit claims to health plans. A claim uses standard codes to identify furnished services. Submitting a claim for the provision of MTM, for example, would require a standard code, but as of this writing, no such term exists in any national data set. MTM providers can bypass this gap and bypass having to submit claims by contracting with healthcare organizations as vendors and submitting invoices. However, as has happened in Massachusetts, Medicaid programs can require HRSN service providers to contract as network providers.

Regarding billing and coding, some state policies are directing MTM providers to use codes that, according to FIMC, are close but only partial descriptors of MTM.[113] California, Massachusetts, and New York, which otherwise define MTM in generally the same manner, require contracting providers to bill for MTM using HCPCS code S5170.[114] [115] [116] S5170 is a code for home-delivered meals, a service that is typically used to address food insecurity for seniors or adults with disabilities. Alissa Wassung, Executive Director of FIMC, says, "S5170 does not encapsulate the details that make MTM unique, such as assessment by an RDN, tailoring according to therapeutic, evidence-based guidelines, and more." MTM is a distinct service that needs a code to describe it accurately.

Standardized FIM Codes Would Offer Insight Into



> When researchers aggregate and study all of these data points, we can better understand patient experiences so that the services that work become more accessible for the people who need them.

According to FIMC standards, as well as policy guidance from the three states listed above, MTM must be approved by a registered dietitian nutritionist (RDN) and tailored to the health needs of the individual client. There is strong evidence to defend this. A peer-reviewed study that compared the outcomes of Community Servings' MTM service and the outcomes of a home-delivered meal service that was not RDN-approved or medically tailored found that MTM "may be particularly useful for those who are sicker and disabled." In contrast, home-delivered meals may be a useful way to "improve health care use for people who are older but otherwise relatively healthy." [117]

Some CBOs in the field may ask, "Why bill through claims when it's easier to invoice?"

Community Servings' Chief Financial Officer Silifa Wallace often fields this question from emerging Food is Medicine providers. The answer: It depends on your client volume and your internal capacity for administrative complexity. Partnering with a clearinghouse solution is a costly proposition, but so is managing multiple billing processes for multiple partners. "If you hit a certain threshold in terms of volume and revenue, it can be worth it to invest in a claims-based system," Wallace says. "There are varying thresholds and options to consider that might make sense for your organization."

In the long-term, however, healthcare partnership in general warrants moving to a claims-based process, if feasible. Community Servings' Senior Director of Strategy and Business Development Erin DiBacco says that CBOs have to operate like healthcare providers if they want to do business in healthcare. "It feels uncomfortable at times, but if we want to continue to advance our mission, we must evolve and align ourselves more closely with how healthcare operates – and submitting claims is an example of that."

Another reason to move toward a claims-based system: As long as HRSN service data exists outside of healthcare's standard operational systems, administrative challenges to the measurement and evaluation of those services will remain, posing obvious challenges to the field as a whole.

Achieving Consensus

Coding4Food's preliminary goals are submitting new HCPCS code requests to CMS for three Food is Medicine interventions: MTM, medically tailored groceries, and produce prescriptions. Using a consensus-based methodology and with input from diverse subject matter experts in the field, the workgroup reached agreement on definitions for each intervention throughout the latter part of 2024. A vote in November approved the definitions. These definitions, or concepts, were the basis for Gravity's terminology build, which was formally submitted to CMS in January 2025. The timeline and outcome of CMS's review are not known, but the project team is hopeful that CMS will issue approved HCPCS codes later in 2025.

Coding4Food's Consensus-Based Medically Tailored Meals Service Description Proposal[118]

A meal providing an estimated 1/3 of the recommended dietary intake per therapeutic, evidence-based dietary specifications for conditions, prepared using natural foods*, assigned based on an assessment of the individual's nutritional needs by a Registered Dietitian (RD) or other nutrition professional, intended for use in non-facility/home settings

* Natural means nothing artificial or synthetic (including all color additives regardless of source) has been included in, or has been added to, a food that would not normally be expected to be in that food. (USDA)

According to Dorella Walters, a member of the Coding4Food workgroup and Chief Business Development Officer at God's Love We Deliver, CMS's potential approval of the new MTM HCPCS code would be "model-change all the way through."

What Comes Next?

A bipartisan proposal, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act would create access to MTM for individuals with diet-related illnesses across the country. If the bill becomes law, Medicare would reimburse for MTM services. It may do so through claims-based billing. That means there could be claims data available to offer insight into the patient journey across a more diverse geography. Consider separately the states that have approved 1115 demonstration waivers with food-based services. The provision of services in some of these states has generated, or could eventually generate, claims data. Both of these examples, the federal demonstration and the state-level policies, represent a powerful opportunity for large-scale evaluation. But whether or not CMS can utilize the totality of available data to evaluate MTM depends on the standardization of the data. "CMS and states should have this data," argues Wassung, who serves on the Coding4Food advisory committee and workgroup. "They should be able to do these evaluations. They should be able to cross compare. They should have the facility and the power to look at efficacy. That will move this conversation so far forward." In the meantime, however, CMS is unable to evaluate what is "not helpfully homogenized."

Katie Ettman, Coding4Food's project lead and Deputy Director of Fullwell, joins Wassung in pointing to measurement as an exciting use case of standard Food is Medicine service codes. She hopes that, years from now, new HCPCS codes for Food is Medicine interventions "will lead to some sort of incredibly large-scale analysis about the health outcomes and/or cost-savings associated with these programs. For example, a partnership with a university where we can finally talk about thousands and thousands of patients instead of the current struggle that is using a single organization's data. That would be an absolute gold-star outcome."

Conclusion

Addressing chronic illnesses and lowering healthcare costs can transcend today's divisive politics. Regardless of the potential challenges, access to medically tailored nutrition is likely to grow in the coming years. As of this writing, one of the largest challenges is the turbulence currently playing out in the federal government and the resulting uncertainty about funding and policy opportunities. It is unknown how drastically federal programs such as Medicaid will change. It is unclear how the healthcare system at large may adjust its approach to making healthcare more efficient and effective. However, the evidence base and the case for making medically tailored nutrition a fully reimbursable healthcare service continue to grow. It is less a question of *if* and more a question of *at what scale* and *with what funding* will access increase? Medically tailored nutrition has advocates across the political spectrum and spanning the public and the private sectors. Stakeholders in the field continue to achieve highly significant milestones in bringing medically tailored nutrition more fully into the healthcare system, through recent and ongoing advancements in policy, billing and coding, and standardization and accreditation.

Most importantly, community-based organizations across the country remain committed to serving people who are living with severe, complex, or chronic illnesses and who are unable to prepare meals independently. These organizations are steadfastly committed to meeting unmet health needs in their communities and delivering services at the highest standard of quality. "Many nonprofit organizations might view this as a time to scale back. But in Food is Medicine, that's not the case," argues Community Servings' Chief Executive Officer David B. Waters. "First, everyone in the field should remember that we have persevered through hard times in the past. If access to social services or certain funding sources are about to shrink, we will shift our approach, but we will never quit. If need be, we will be twice as vocal. We will do what our communities deserve. This is not the time to go silent. This is the time to keep serving the people who need help. This is the time to keep delivering the excellent interventions that keep people healthy, strong, and living their best lives."

In spite of recent funding challenges in Minnesota, Leah Hebert Welles, Chief Executive Officer of Open Arms, is resolute. "Our critically ill clients share how life-changing these meals are. Their stories inspire us to keep pushing forward. As we navigate the evolving landscape, one thing remains clear: access to medically tailored meals is not just an act of compassion—it's a necessity. We will continue to advocate for policies that recognize food as a cornerstone of care. Every person facing a serious illness deserves access to appropriate nutrition."

Hannah Griswold, Food as Medicine Director of La Soupe, remains motivated for deeply personal reasons. “I got into nutrition because my grandfather passed away from diabetes at a young age,” Griswold says. “He didn’t take care of himself because he didn’t know how. Today my father has the same struggles. My dad is my world, but he can’t afford good food, lacks knowledge, and has multiple health issues. Medically tailored meals could improve his quality of life tremendously and by extension the lives of everyone who loves him. I want more people to experience that, to experience another Christmas, another holiday, another trip. Food has the power to make that happen.”

Dorella Walters, Chief Business Development Officer at God’s Love We Deliver, is hopeful, because the long-standing objective of the Food is Medicine movement is as pressing as ever. “We have fought too hard for too long,” Walters says. “Every person in the country who is dealing with a serious, life-altering illness should have access to food and nutrition, the way they merit it, the way they should get it for that moment in time. Policy needs to transform in order to honor that phenomenon. That’s what we’re working toward.”

Among community-based organizations, the commitment to the people we serve is unwavering. It will adapt to a changing ecosystem. It will continue to provide the evidence-based services and the dedicated advocacy that the community needs.

Resources

The Food is Medicine Field

2024 Food is Medicine Research Action Plan
Kurt Hager, Corby Kummer, Alexandra Lewin-Zwerdling, Zhongyu Li
Food & Society at the Aspen Institute (2024)
aspenfood.org/food-is-medicine/

Health Care by Food Initiative
American Heart Association
healthcarexfood.org

Food is Medicine Coalition
fimcoalition.org

Food Is Medicine Federal Resource Hub
Office of Disease Prevention and Health Promotion, U.S. Department of Health & Human Services
odphp.health.gov/foodismedicine

Food is Medicine Massachusetts
foodismedicinema.org/

The Rockefeller Foundation Food is Medicine Initiative
rockefellerfoundation.org/initiative/food-is-medicine/

True Cost of Food: Food is Medicine Case Study
Kirsten A. Deuman, Emily A. Callahan, Lu Wang, Dariush Mozaffarian
Tufts Food is Medicine Institute, Tufts University (2023)
tuftsfoodismedicine.org/resources/

Tufts Food is Medicine Institute
tuftsfoodismedicine.org

Medically Tailored Meal Studies Co-investigated by Community Servings

"Association Between Receipt of a Medically Tailored Meal Program and Health Care Use"
Berkowitz S, et al. JAMA Internal Medicine (2019)
doi.org/10.1001/jamainternmed.2019.0198

"Association of National Expansion of Insurance Coverage of Medically Tailored Meals with Estimated Hospitalizations and Health Care Expenditures in the US."
Hager, K et al. JAMA Network Open (2022)
doi.org/10.1001/jamanetworkopen.2022.36898

"Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries."
Berkowitz S, et al. Health Affairs (2018)
doi.org/10.1377/hlthaff.2017.0999

"Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: A Randomized Cross-over Trial." Berkowitz S, et al. Journal of General Internal Medicine (2019) doi.org/10.1007/s11606-018-4716-z

"'I Was Able to Eat What I Am Supposed to Eat' "-- Patient Reflections on a Medically Tailored Meal Intervention: A Qualitative Analysis." Berkowitz S, et al. BMC Endocrine Disorders (2020) doi.org/10.1186/s12902-020-0491-z

Nutrition Education

Doctoring Our Diet II: Nutrition Education for Physicians Is Overdue
Food Law and Policy Clinic, Harvard Law School (2024)
chlpi.org/FLPC

"Proposed Nutrition Competencies for Medical Students and Physician Trainees: A Consensus Statement" Eisenberg, D et al. JAMA Network Open (2024) doi.org/10.1001/jamanetworkopen.2024.35425

Policy

"Applying Legal and Clinical Quality Standards to 'Food Is Medicine'"
Hanson E et al. Health Affairs Forefront (2024)
doi.org/10.1377/forefront.20241121.83832

Center for Health Law and Policy Innovation of Harvard Law School
chlpi.org

"The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A US Survey" Hanson, E et al. Health Affairs Scholar (2024) doi.org/10.1093/haschl/qxae013

"Food is Medicine: A State Medicaid Policy Toolkit"
Center for Health Law and Policy Innovation & the Food is Medicine Coalition (2024)
fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf

"Massachusetts Food is Medicine State Plan"
Center for Health Law and Policy Innovation of Harvard Law School & Community Servings (2019)
foodismedicinema.org/wp-content/uploads/2024/09/MA-FIM-State-Plan-Executive-Summary.pdf

Medicaid Federal Policy Guidance
Centers for Medicare & Medicaid Services.
medicaid.gov/federal-policy-guidance/index.html

References

[1] Nutrition and Obesity Policy Research and Evaluation Network (NOPREN). 2023. Supporting Food & Nutrition Security through Healthcare: A Resource for Healthcare Systems and their Public Health and Community Partners. San Francisco, CA: University of California, San Francisco.

[2] Id.

[3] Xu J, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2021. 12/22/2022. NCHS Data Briefs. https://stacks.cdc.gov/view/cdc/122516. Accessed 1/21/2025.

[4] Jardim TV, Mozaffarian D, Abrahams-Gessel S, et al. Cardiometabolic disease costs associated with suboptimal diet in the United States: A cost analysis based on a microsimulation model. PLoS Med. 2019;16(12):e1002981. Published 2019 Dec 17. doi:10.1371/journal.pmed.1002981

[5] Nutrition and Obesity Policy Research and Evaluation Network (NOPREN). 2023. Supporting Food & Nutrition Security through Healthcare: A Resource for Healthcare Systems and their Public Health and Community Partners. San Francisco, CA: University of California, San Francisco.

[6] Hanson E, Albert-Rozenberg D, Garfield KM, Leib EM, Ridberg RA, Hager K, Mozaffarian D. "The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey." Health Affairs Scholar, Volume 2, Issue 2, February 2024, qxae013, https://doi.org/10.1093/haschl/qxae013

[7] Hanson E, et al. "Food is Medicine: A State Medicaid Policy Toolkit." (July 2024). Food is Medicine Coalition & Center for Health Law and Policy Innovation, Harvard Law School. https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf Accessed 1/23/2025.

[8] Mozaffarian D, et al. "A Food is Medicine approach to achieve nutrition security and improve health." Nature Medicine (Nov 2022). https://pubmed.ncbi.nlm.nih.gov/36202998/

[9] Kaiser Family Foundation. Section 1115 SDOH & Other DSR Changes - Approved SDOH Provisions. (Jan. 2025), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state. Accessed 1/21/2025.

[10] Food is Medicine Coalition. FIMC Info Sheet Oct 2024 Medically Tailored Home-Delivered Meals Demonstration Act. https://fimcoalition.org/wp-content/uploads/2024/11/FIMC-Info-Sheet-Oct-2024_MEDICALLY-TAILORED-HOME-DELIVERED-MEALS-DEMONSTRATION-ACT.pdf. Accessed 1/21/2025.

[11] Executive Order 14212 of February 13, 2025. "Establishing the President's Make America Healthy Again Commission." National Archives, Feb. 19, 2025. Federalregister.gov/documents/2025/02/19/2025-02871/establishing-the-presidents-make-america-healthy-again-commission.

[12] White House, Biden-Harris Administration National Strategy on Hunger, Nutrition and Health. (Sept.2022). https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy- on-Hunger-Nutritionand-Health-FI NAL.pdf. Accessed 1/18/2025.

[13] American Heart Association. Statement by Dr. Rajiv J. Shah, President of The Rockefeller Foundation,and Nancy Brown, CEO of the American Heart Association, on New Food Is Medicine Research InitiativeSept. 2022. https://newsroom.heart.org/news/statement-by-dr-rajiv-j-shah-president- of-the-rockefeller-foundation-and-nancy-brown-ceo-of-the-american-heart-association- on-new-food-is- medicine-research-initiative. Accessed 1/21/2025.

[14] Superville, D. "Emhoff announces $1.7B in pledges to help President Biden meet goal of ending hungerby 2030." AP News. Feb. 27, 2024. https://apnews.com/article/biden-emhoff-hunger-nutrition-health-pledge-15b29bbddc8da0896b7b914002f0da79. Accessed 1/27/2025.

[15] Centers for Medicare & Medicaid Services. Medicaid.gov. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

[16] Buchanan V, McGovern JP, May 2024, https://fimcoalition.org/wp-content/uploads/2024/05/FY25-Food-is-Medicine-Initiatives.pdf. Accessed 1/21/2025.

[17] Sen. Marshall, Newsroom, Dec, 20, 2024. https://www.marshall.senate.gov/newsroom/press-releases/senator-marshall- on-fox-news-lets-make-america-healthy-again/. Accessed 1/31/2025.

[18] Cohn, D.J. & Waters, D. Food as Medicine. White paper (2013).

[19] Jensen GL, et al. Recognizing Malnutrition in Adults: Definitions and Characteristics, Screening,Assessment, and Team Approach, J. Parenteral and Enteral Nutrition (2013); Corkins MR et al. MalnutritionDiagnosis in Hospitalized Patients: United States 2010. Parenteral and Enteral Nutrition (2013).

[20] Berkowitz SA, Terranova J, Hill C, et al. "Meal Delivery Programs Reduce the Use of Costly Health Carein Dually Eligible Medicare and Medicaid Beneficiaries." Health Affairs. 2018; 37 (4): 535-542.Doi.org/10.1377/hlthaff.2017.0999

[21] Id.

[22] Berkowitz SA, Terranova J, Randall L, Cranston K, Waters DB, Hsu J. Association between receipt of amedically tailored meal program and healthcare use. JAMA Intern Med. 2019;179(6):786-793. doi:10.1001/jamainternmed.2019.0198

[23] Id.

[24] Berkowitz SA, Delahanty LH, Terranova J, Steiner B, Ruazol MP, Singh R, Shahid NN, Wexler DJ.Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity. Journal of General InternalMedicine. 2019 Mar;34(3):396-404.doi:10.1007/s11606-018-4716- z

[25] Id.

[26] Id.; see also Berkowitz et al. I was able to eat what I am supposed to eat. BMC Endocrine Disorders.2020 https://doi.org/10.1186/s12902-020-0491-z

[27] White House, Biden-Harris Administration National Strategy on Hunger, Nutrition and Health. (Sept.2022). https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy- on-Hunger-Nutritionand-Health-FI NAL.pdf. Accessed 1/18/2025.

[28] Hager K, Cudhea FP, Wong JD. Association of National Expansion of Insurance Coverage of MedicallyTailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA NetwOpen. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

[29] Aspen Institute. Food is Medicine Research Action Plan (2024).

[30] Strategic Plan for NIH Nutrition Research (2020)

[31] Id.

[32] Id.

[33] The Rockefeller Foundation. "The Rockefeller Foundation Commits USD 105M to Making Healthy andSustainable Foods More Accessible Around the World" (March 2022).https://www.rockefellerfoundation.org/news/the-rockefeller-foundation-commits-usd-105m-to-making-healthy-and-sustainable-foods-more-accessible-around-the-world/

[34] Food Tank, April 2022. https://foodtank.com/news/2022/04/rockefeller-foundation-new-good-food-strategy/. Accessed 1/30/2025.

[35] State of Hawaii Section 1115 Demonstration Extension Application. Nov 2023.https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf . Accessed on1/22/2025

[36] Michigan Department of Health and Human Services. "Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide." Sept. 2024. https://www.michigan.gov/mdhhs/mihealthylife/michigan-in-lieu-of-services. Accessed 1/27/2025

[37] Rabbitt MP, Reed-Jones M, Hales LJ, Burke MP. U.S. Department of Agriculture, Economic ResearchService. "Household Food Security in the United States in 2023." September 4, 2024. https://www.ers.usda.gov/publications/pub-details?pubid=109895. Accessed 1/27/2025.

[38] Seligman HK, Laraia BA, Kushel MB. "Food insecurity is associated with chronic disease among low-income NHANES participants." The Journal of Nutrition. February 2010.https://doi.org/10.3945/jn.109.112573. Accessed 1/27/2025.

[39] U.S. Department of Health and Human Services. White House Conference on Hunger, Nutrition, andHealth. Nov. 2024. https://odphp.health.gov/our-work/nutrition- physical-activity/white-house-conference-hunger-nutrition-and-health/implementing-national-strategy. Accessed on 1/27/2025

[40] U.S. Department of Agriculture, Economic Research Service. Food Security in the U.S. – Key Statistics &Graphics. Jan. 2025. https://www.ers.usda.gov/topics/f ood-nutrition-assistance/f oodsecurity-in-the-us/key-statistics-graphics. Accessed 1/27/2025

[41] Rosenbaum D and Neuberger Z. "President's 2021 Budget Would Cut Food Assistance for Millions andRadically Restructure SNAP." Center on Budget and Policy Priorities. Feb. 2020. https://www.cbpp.org/research/presidents-2021-budget-would-cut-food-assistance-for-millions-and-radically-restructure. Accessed 1/27/2025

[42] Burns A, et al. "10 Things to Know About Medicaid." Kaiser Family Foundation, Feb. 18, 2025. kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

[43] Blue Cross Blue Shield of MA Foundation. "What Is the Actual State Cost of MassHealth in State Fiscal Year 2025?" May 2024. https://www.bluecrossmafoundation.org/sites/g/files/csphws2506/files/2024-05/BCBSF-ActualCostOfMassHealth-FINAL.pdf. Accessed 1/27/2025.

[44] Williams E, Burns A, Rudowitz R. Kaiser Family Foundation. "Fiscal Implications for Medicaid of Enhanced Federal Funding and Continuous Enrollment" June 16, 2023. https://www.kff.org/medicaid/issue-brief/fiscal-implications-for-medicaid-of-enhanced-federal-funding-and-continuous-enrollment/

[45] Hanson E, Albert-Rozenberg D, Garfield KM, Leib EM, Ridberg RA, Hager K, Mozaffarian D. "The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey." Health Affairs Scholar, Volume 2, Issue 2, February 2024, qxae013, https://doi.org/10.1093/haschl/qxae013

[46] Hanson E, et al. "Food is Medicine: A State Medicaid Policy Toolkit." (July 2024). Food is Medicine Coalition & Center for Health Law and Policy Innovation, Harvard Law School. https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf Accessed 1/23/2025.

[47] Id.

[48] New York State Department of Health. Rev. Jan 2025. https://www.health.ny.gov/health_care/managed_care/app_in_lieu_of_svs_mmc.htm. Accessed on 1/23/2025.

[49] Centers for Medicare & Medicaid Services, California Advancing & Innovating Medi-Cal Approval. (Dec. 2021). https://www.medicaid.gov/sites/default/files/2021-12/ca-calaim-ca-17-appvl-ltr.pdf. Accessed 1/23/2025.

[50] Hanson E, et al. "Food is Medicine: A State Medicaid Policy Toolkit." (July 2024). Food is Medicine Coalition & Center for Health Law and Policy Innovation, Harvard Law School. https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf Accessed 1/23/2025.

[51] U.S. Department of Health and Human Services. Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and CHIP. Dec. 2024. https://www.hhs.gov/guidance/document/coverage-services-and-supports-address-health-related-social-needs-medicaid-and-chip. Accessed on 1/27/2025.

[52] Centers for Medicare & Medicaid Services. Medicaid.gov. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

[53] Hinton E, Diana A. "Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs." Kaiser Family Foundation (March 2024). https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiverwatch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/ Accessed 1/23/2025.

[54] FIMC Coalition. MTM Pilot Act. https://fimcoalition.org/policy/policy-priorities/mtm-pilot-act/. Accessed 1/27/2025.

[55] Press Release, "Buchanan Leads Legislation to Strengthen Veterans' Physical and Mental Health," Feb. 13, 2025. buchanan.house.gov/2025/2/buchanan-leads-legislation-to-strengthen-veterans-physical-and-mental-health.

[56] Betancourt JA, et all. Healthcare 2021, 9(5), 604. Doi.org/10.3390/healthcare9050604

[57] Darby B, Mirchandani H, and Moss S. Summary of The U.S. Playbook to Address Social Determinants of Health. Milliman. https://www.milliman.com/en/insight/summary-of-the-us-playbook-to-address-social-determinants-of-health. Accessed 1/27/2025.

[58] Hager K, Kummer C, Lewin-Zwerdling A, Zhongyu L. 2024 Food is Medicine Research Action Plan. Published April 2024.

[59] U.S. Department of Health and Human Services. "HHS Hosts First-Ever Food is Medicine Summit, Launches Three Public-Private Partnerships." Feb. 2024. https://www.hhs.gov/about/news/2024/02/02/hhs-hosts-first-ever-food-medicine-summit-launches-three-public-private-partnerships.html. Accessed 1/27/2025.

[60] Open Arms, "Message from Leah Hebert Welles." Feb. 11. 2025. Openarmsmn.org/feb-11-2025-open-arms-program-update/.

[61] FIMC Coalition. "Increase Funding for the Ryan White HIV/AIDS Program." March 2024. https://fimcoalition.org/wp-content/uploads/2024/03/FIMCRyanWhiteInfoSheet.pdf. Accessed 1/27/2024.

[62] National Institutes of Health. https://dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf

[63] Hager K, Kummer C, Lewin-Zwerdling A, Zhongyu L. 2024 Food is Medicine Research Action Plan. Published April 2024.

[64] Hanson E, Albert-Rozenberg D, Garfield KM, Leib EB, Ridberg RA, Hager K, Mozaffarian D. "The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey." Health Affairs Scholar. Feb 2024. https://doi.org/10.1093/haschl/qxae013

[65] Commonwealth of Massachusetts, EOHHS. Contract Year 2023-2024 Flexible Services Program Guidance Document. Version 1.0. December 2022. https://www.mass.gov/doc/contract-year-2023-2024-flexible-services-program-guidance-document/download. Accessed 1/24/2025.

[66] Commonwealth of Massachusetts. MassHealth Innovations. https://www.mass.gov/masshealth-innovations. Accessed on 1/24/2025.

[67] MassHealth Section 1115 Quarterly Report Q4 and Demonstration Year 25. Sept 2022. https://www.mass.gov/doc/section-1115-demonstration-waiver-annual-report-fy22/download. Accessed 1/24/25.

[68] Commonwealth of Massachusetts, EOHHS. Contract Year 2023-2024 Flexible Services Program Guidance Document. Version 1.0. December 2022. https://www.mass.gov/doc/contract-year-2023-2024-flexible-services-program-guidance-document/download. Accessed 1/24/2025.

[69] Commonwealth of Massachusetts. MassHealth Enrollment Snapshot for August 2024. Aug 2024. https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-august-2024/download. Accessed 1/28/2025.

[70] Commonwealth of Massachusetts. HRSN November Stakeholder Meeting. Nov 2023. https://www.mass.gov/doc/health-related-social-needs-hrsn-november-stakeholder-meeting-november-2023-1/download. Accessed 1/28/2025.

[71] Commonwealth of Massachusetts. MassHealth Section 1115 Demonstration Extension Request, Attachment 2. Dec. 27, 2021. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82006. Accessed on 1/28/2025.

[72] Commonwealth of Massachusetts. HRSN November Stakeholder Meeting. Nov. 2023. https://www.mass.gov/doc/health-related-social-needs-hrsn-november-stakeholder-meeting-november-2023-0/download. Accessed on 1/24/2025.

[73] Commonwealth of Massachusetts. HRSN Service Manual – HRSN Supplemental Nutrition Services. Dec. 2024. https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/download. Accessed on 1/24/2025.

[74] Commonwealth of Massachusetts. HRSN July Stakeholder Meeting. July 2024. https://www.mass.gov/info-details/masshealth-health-related-social-needs-services-meeting-materials#july-18,-2024-. Accessed 1/24/2025.

[75] Commonwealth of Massachusetts. HRSN November Stakeholder Meeting. Sept 2024. https://www.mass.gov/info-details/masshealth-health-related-social-needs-services-archived-meeting-materials

[76] Commonwealth of Massachusetts. HRSN July Stakeholder Meeting. July 2024. https://www.mass.gov/info-details/masshealth-health-related-social-needs-services-meeting-materials#july-18,-2024-. Accessed 1/24/2025.

[77] Commonwealth of Massachusetts. Healey-Driscoll Administration Awards $10 Million to Community-Based Housing and Nutrition Organizations. Jan 2025. https://www.mass.gov/news/healey-driscoll-administration-awards-10-million-to-community-based-housing-and-nutrition-organizations. Accessed 1/28/2025.

[78] Berkowitz S, et al. Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. Health Affairs (April 2018). https://doi.org/10.1377/hlthaff.2017.0999. Accessed 1/28/2025.

[79] Department of Health and Human Services. October 2024 Medicaid & Chip Enrollment Data Highlights. Oct 2024. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed 1/28/2025.

[80] U.S. Department of Health and Human Services. Medicare.gov. https://www.medicare.gov/about-us. Accessed 1/28/2025.

[81] Hanson E, et al. "Applying Legal and Clinical Quality Standards to 'Food Is Medicine.'" Health Affairs Forefront (Nov 2024). https://www.doi.org/10.1377/forefront.20241121.83832.

[82] FIMC Coalition. "FIMC Accreditation" (March 2024). https://fimcoalition.org/programs/fimc-accreditation/. Accessed 1/28/2025.

[83] Florko, N. STAT. "Medicaid is paying millions for salty, fat-laden 'medically tailored' cheeseburgers and sandwiches" (July 2024). https://www.statnews.com/2024/07/11/medicaid-food-is-medicine-medically-tailored-meals-quality-questioned/. Accessed 1/28/2025.

[84] California Department of Health Care Services, Medi-Cal Community Supports or In Lieu of Services (ILOS) Policy Guide. July 2023. https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

[85] Commonwealth of Massachusetts. HRSN Service Manual – HRSN Supplemental Nutrition Services. Dec. 2024. https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/download. Accessed on 1/24/2025.

[86] Centers for Medicare and Medicaid Services, New York State Health Related Social Need Services Protocol, Dec. 18, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-proto-appvl-ltr-12162024.pdf

[87] Centers for Medicare and Medicaid Services, Pennsylvania Keystones of Health Section 1115 Demonstration, Dec. 30, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/pa-keystones-of-health-dmntn-aprvl-atchmnt-12302024.pdf

[88] Centers for Medicare and Medicaid Services, Illinois Draft HRSN Protocol, Sept. 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-continuity-care-admin-protocol-approval-letter.pdf

[89] Centers for Medicare and Medicaid Services, North Carolina Medicaid Reform Section 1115(a) Demonstration, Dec. 10, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nc-technical-correction-ltr-01162025.pdf

[90] Centers for Medicare and Medicaid Services, Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration, Nov. 22, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medcaid-transfmtn-hrsn-implementation-plan-approval-letter-12022024.pdf

[91] Michigan Department of Health and Human Services. "Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide." Sept. 2024. https://www.michigan.gov/mdhhs/mihealthylife/michigan-in-lieu-of-services. Accessed 1/27/2025.

[92] Rhode Island Executive Office of Health and Human Services. RI 1115 Extension Request Addendum. May 2024. https://eohhs.ri.gov/reference-center/medicaid-state-plan-and-1115-waiver/waiver-extension. Accessed 1/28/2024.

[93] North Carolina Department of Health and Human Services. Healthy Opportunities Pilots Fee Schedule. July 2024. https://www.ncdhhs.gov/healthy-opportunities-pilot-fee-schedule-and-service-definitions/open. Accessed 1/28/2025.

[94] Oregon Health Authority, "Oregon Health Plan (OHP) Nutrition Benefits." Oregon.gov/OHA/HSD/OHP/Pages/Nutrition.aspx. Accessed 3/21/2025.

[95] Vetter ML, et al. What Do Resident Physicians Know about Nutrition? An Evaluation of Attitudes, Self-Perceived Proficiency and Knowledge. Journal of the American College of Nutrition (April 2008). https://pmc.ncbi.nlm.nih.gov/articles/PMC2779722/pdf/nihms-105054.pdf. Accessed 1/28/2025.

[96] Adams KM, et al. The State of Nutrition Education at US Medical Schools. Journal of Biomedical Education (Jan. 2015). https://doi.org/10.1155/2015/357627. Accessed 1/28/2025.

[97] Pojednic R, et al. Physician Nutrition Advice and Referrals to Registered Dietitians. American Journal of Lifestyle Medicine (May 2022). Accessed 1/28/2025.

[98] Eisenberg DM, et al. Proposed Nutrition Competencies for Medical Students and Physician Trainees: A Consensus Statement. JAMA Network Open (Sept. 2024). https://www.doi.org/10.1001/jamanetworkopen.2024.35425

[99] Congressional Research Service. Medicare Graduate Medical Education Payments: An Overview (Sept. 2022). https://crsreports.congress.gov/product/pdf/IF/IF10960. Accessed 1/28/2025. 117 U.S. Congress. H.Res. 1118. https://www.congress.gov/bill/117th-congress/house-resolution/1118/text.

[100] 117 U.S. Congress. H.Res. 1118. https://www.congress.gov/bill/117th-congress/house-resolution/1118/text.

[101] U.S. Department of Health and Human Services. White House Conference on Hunger, Nutrition, and Health (Sept. 2022). https://odphp.health.gov/our-work/nutrition-physical-activity/white-house-conference-hunger-nutrition-and-health/conference-details. Accessed 1/28/2025.

[102] Accreditation Council for Graduate Medical Education. "Proceedings of the Summit on Medical Education in Nutrition" (2023). https://www.acgme.org/globalassets/pdfs/nutritionsummit/nutrition-summit-proceedings.pdf. Accessed 1/28/2025.

[103] Eisenberg DM, et al. Proposed Nutrition Competencies for Medical Students and Physician Trainees: A Consensus Statement. JAMA Network Open (Sept. 2024). https://www.doi.org/10.1001/jamanetworkopen.2024.35425

[104] Food Law and Policy Clinic of Harvard Law School. "Doctoring Our Diet II: Nutrition Education for Physicians Is Overdue" (June 2024). https://chlpi.org/wp-content/uploads/2024/06/Doctoring-Our-Diet-II_FINAL_6.10.24.pdf.

[105] La Puma J. What Is Culinary Medicine and What Does It Do? Population Health Management (2016). https://www.liebertpub.com/doi/abs/10.1089/pop.2015.0003

[106] Massachusetts Health Quality Partners. "Primary Care in Massachusetts" (2023). https://www.chiamass.gov/assets/docs/r/pubs/2023/MA-PC-Dashboard-2023.pdf. Accessed 1/28/2025.

[107] Massachusetts Health Quality Partners. "Patient Experience Scores for Adults Improve Since Before the Pandemic, Except in One Key Area: Access" (Feb. 2024). https://www.mhqp.org/2024/02/13/patient-experience-scores-for-adults-improve-since-before-the-pandemic-except-in-one-key-area-access/. Accessed 1/28/2025.

[108] Id.

[109] Association of American Medical Colleges. The Complexities of Physician Supply and Demand. March 2024. https://www.aamc.org/media/75231/download?attachment.

[110] Darby B, Mirchandani H, and Moss S. Summary of The U.S. Playbook to Address Social Determinants of Health. Milliman. https://www.milliman.com/en/insight/summary-of-the-us-playbook-to-address-social-determinants-of-health. Accessed 1/27/2025.

[111] Gravity Project. "Payment & Reporting Standards: Gravity Project Discovery Findings" (April 2024). https://confluence.hl7.org/download/attachments/91996855/Payment%20%26%20Reporting%20Standards_%20Gravity%20Project%20Discovery%20Findings%20April%202024%20FINAL.docx.pdf?version=1&modificationDate=1731075850750&api=v2. Accessed 1/28/2025.

[112] Gravity Project. Coding4Food HCPCS, 2023. https://confluence.hl7.org/pages/viewpage.action?pageId=184932452

[113] See Gravity Project Community Meeting, September 28, 2023. https://confluence.hl7.org/pages/viewpage.action?pageId=184932452

[114] California Department of Health Care Services, "ECM AND COMMUNITY SUPPORTS HCPCS CODING GUIDANCE" (June 2024). https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf. Accessed 1/28/2024.

[115] Commonwealth of Massachusetts, HRSN Supplemental Services Fee Schedule 2024. https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download. Accessed 1/28/2025. New York Department of Health. Social Care Network: Program, Billing, and Data Governance Operations Manual (August 9, 2024).

[116] New York Department of Health. Social Care Network: Program, Billing, and Data Governance Operations Manual (August 9, 2024).

[117] Berkowitz SA, Terranova J, Hill C, et al. "Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries." Health Affairs. 2018; 37 (4): 535-542. Doi.org/10.1377/hlthaff.2017.0999

[118] Coding4Food HCPCS, March 7, 2025. Confluence.hl7.org/spaces/GRAV/pages/184932452/Coding4Food+HCPCS. Accessed 3/21/2025.

AMPL INSTITUTE