The Honorable Xavier Becerra
Secretary U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

March 29, 2021

RE: Medically Tailored Meal Policy Recommendations

Dear Secretary Becerra:

As a national coalition of nonprofits focused on the intersection of nutrition and healthcare, we want to congratulate you on your appointment as Secretary of the Department of Health and Human Services. We acknowledge the great challenges ahead for your Department and humbly offer our expertise and support as food and nutrition professionals working at this increasingly important intersection of practice. As you embark on your efforts, we hope you will consider our recommendations for improving health outcomes and reducing healthcare costs below. What follows is an Executive Summary and then the full discussion of each policy recommendation.

Executive Summary

The Food Is Medicine Coalition is a national coalition of providers who deliver medically tailored meals and nutrition counseling and education to people in communities across the country who are too sick to shop or cook for themselves. FIMC respectfully offers the policy recommendations below to the Biden Administration.

As medically tailored meal (MTMs) providers who serve people in communities across the country who are too sick to shop or cook for themselves, we recognize Nutrition as a Key Social Determinant of Health and that MTMs are an Innovative and Low-Cost Response to Disease and High Costs Driven by Food Insecurity and Malnutrition. There is robust research Evidence that when MTMs are included as part of a treatment plan for the highest risk in our communities, the service results in lower healthcare costs, higher patient satisfaction and better health outcomes. Receipt of MTMs (as compared to a group of comparable individuals who did not receive MTMs) is associated with:

- Reduction in emergency department visits of dually eligible individuals by 70%
- Reduction in inpatient hospital admissions by 52%
- Reduction in admission to skilled nursing facilities by 72%
- 16% net decrease in health care costs for over 800 individuals receiving the service over a 5-year period[1]

And yet, despite this evidence, there is a Lack of Federal Support for MTMs. To correct this service gap, over the past decade and more, FIMC agencies have participated in Healthcare Innovation through Medicaid, Medicare and other healthcare funding streams, further demonstrating the efficacy of the MTM intervention.

[1] Berkowitz SA, Terranova J, Randall L, Craston K, Waters DB, Hsu J. Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. JAMA. 2019;179(6):786-793.

Further, FIMC addresses Racial Equity in Health by rebalancing health in favor of our clients through the services we provide. COVID-19 only highlighted The Urgent Need for MTM, as FIMC agencies remained open throughout the pandemic to continue to serve our clients and provide increased services to those newly needing medically tailored nutrition at home.

The time has come to acknowledge the efficacy of administering MTMs on a broader scale and to implement policies that make that provision a reality. In the full paper, we lay out our recommendations for both First Year and Administration Opportunities.

Opportunities for the First Year

While making MTMs a fully reimbursable benefit for all who could benefit in Medicare and Medicaid should be the ultimate goal of this Administration, we recommend expanding on existing successful programs that incorporate MTMs during the first year.

Our recommendations include:

- Fully fund and implement pilot MTM programs in the Medicare and Medicaid programs;
- Expand funding and programmatic opportunities for medically tailored meals within Title III of the Older Americans Act;
- Increase Ryan White HIV/AIDS Program funding to support all People Living With HIV/AIDS (PWH) that come to FIMC agencies in need;
- Research Funding for MTM.

Opportunities for the Administration

For the Administration, we turn to broader systemic changes that integrate MTM into the clinical structure of healthcare delivery and support recovery and health for high-risk populations.

Our recommendations include:

- Modernize Medicare and Medicaid to Make MTMs a Fully Reimbursable Benefit for People Living with Severe Illness;
- Increase Funding and Institutional Support for New Research on MTMs and other Food Is Medicine Interventions;
- Improve Quality Standards for Nutrition Interventions;
- Connect Clinical Systems to the Social Services Safety Net:
    1. Implement universal screening for food insecurity and malnutrition;
    2. Increase nutrition education among health care providers:
    3. Improve coordination of referrals to the MTM intervention;
    4. Further build medical coding of food insecurity, malnutrition, and their treatments;
    5. Clarify regulation around data sharing between the clinical field and community-based organizations providing social services.

Early and reliable access to medically tailored meals helps individuals live healthy and productive lives, produces better overall health outcomes and reduces health care costs. It is a solution that improves population and individual health, improves the experience of care, and has been proven to reduce costs substantially. Americans have gone through a very tough time, and the agencies of FIMC have strived to represent the best of our country during the pandemic. We are ready to continue serving and working alongside you to bring our life-saving service to all those in need across the country.

~The Food Is Medicine Coalition Advisory Board

Medically Tailored Meal Policy Recommendations

The Food Is Medicine Coalition (FIMC) is a national coalition of nonprofits focused on the intersection of nutrition and healthcare, delivering medically tailored meals and nutrition counseling and education to people in communities across the country who are too sick to shop or cook for themselves. Most FIMC agencies began 35 years ago at the height of the AIDS pandemic, serving people with HIV. In the years since, all have expanded their missions to serve all people living with severe illnesses. **Medically tailored meals (MTMs)** are delivered to individuals living with severe illness through a referral from a medical professional or healthcare plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction. MTMs are delivered to an individual's home. The Clinical Committee of FIMC, made up of credentialled RDNs from across the country, establishes and regularly updates the FIMC Medically Tailored Meal Nutrition Standards, which catalogue the nutrition quality of this evidence-based intervention.[2]

Collectively, in the last year, FIMC MTM providers served over 11 million meals to over 48,000 people across multiple states and the District of Columbia. Clients living with a primary diagnosis of HIV, cancer or diabetes made up the majority of those that received meals from FIMC agencies in the last year, however, the plurality of clients live with multiple diagnoses at once. Because of their complicated medical situations, most of our clients are unable to shop or cook for themselves and often require the assistance of family or caregivers. FIMC clients have complex dietary restrictions because of their medical conditions, and also may experience limitations on activities of daily living, and hence cannot take advantage of the traditional emergency food support systems.

MTMs meet a critical need that is not addressed by the current food safety net. As you will see in the Evidence section below, when added to a care plan, receipt of MTMs (as compared to a group of comparable individuals who did not receive MTMs) is associated with:

- Reduction in emergency department visits of dually eligible individuals by 70%
- Reduction in inpatient hospital admissions by 52%
- Reduction in admission to skilled nursing facilities by 72%
- 16% net decrease in health care costs for over 800 individuals receiving the service over a 5-year period[3]

To continue to build the evidence base for the efficacy of medically tailored meals, FIMC is currently engaged in 15 different research projects across the country including statewide demonstration and clinical trials funded by the National Institute of Health. Health care organizations and insurers want to provide MTMs to their patients and members, but current regulations restrict their ability to provide MTMs to all who need this benefit.

[2] http://www.fimcoalition.org/our-model

[3] Berkowitz SA, Terranova J, Randall L, Craston K, Waters DB, Hsu J. Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. JAMA. 2019;179(6):786-793.

Nutrition as a Key Social Determinant of Health

Only a small proportion of health outcomes are attributable to care provided in a clinical setting: 80% of a patient's health is driven by what happens before or after the patient leaves the hospital or clinic. Adequately addressing the root causes of illness and poor health outcomes – or the social determinants of health (SDH) – will advance the goal of realizing an outcomes-driven, cost-effective health care system. It is widely understood and well-researched that effective systems change to address the social determinants of health must encompass far more than the healthcare sector.

One of the most significant barriers to more effective prevention and delayed progression of chronic health conditions in the US is lack of access to healthy and affordable food, resulting in population-level incidence of food insecurity and malnutrition. Food insecurity is a household-level economic and social condition of limited or uncertain access to adequate food.[4] Malnutrition is an acute, subacute or chronic state of nutrition, in which a combination of varying degrees of overnutrition or undernutrition with or without inflammatory activity have led to a change in body composition and diminished function.[5] Both have been strongly associated with poor health outcomes and higher health care costs. Summarized findings of select scientific literature on malnutrition, food insecurity, and health outcomes are below. These data suggest that incorporating access to disease-specific, nutritious food is a necessary component of improving health outcomes in the population.

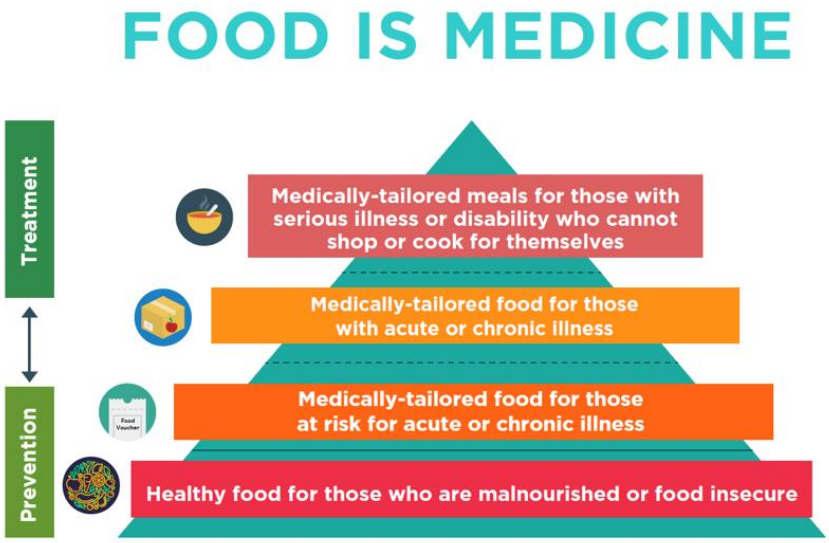
- Malnutrition is a factor in almost two million hospital stays annually.[6]
- Hospital stays for malnourished patients are up to three times longer than hospital stays for properly nourished patients.[7]
- Average inpatient hospitalization costs are 24% higher and readmission within 15 days almost twice as likely for malnourished patients as compared to properly nourished patients.[8]
- Food insecurity is also associated with increased use of health services in primary care networks.[9]
- Total healthcare costs, including inpatient care, emergency care, surgeries, and drug costs, increase as food insecurity severity increases. [2],[10]
- Hospitalizations for low-income, diabetic patients increase at the end of the month when nutrition benefits, finances, and food are in short supply, while they remain stable for middle class and upper-class households.[11]
- The odds of poor diabetes control and increased use of health services are doubled with food insecurity. [12]

[4] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx
[5] https://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Toolkits/Malnutrition_Toolkit/Definitions/
[6] Weiss, AJ, et al. Characteristics of Hospital Stays Involving Malnutrition, 2013. HCUP Statistical Brief #210. September 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb210-Malnutrition-Hospital-Stays-2013.pdf.
[7] Corkins, M.R., Guenter, P., DiMaria-Ghalili, R.A., Jensen, G.L., Malone, A., Miller, S., Patel, V., Plogsted, S., Resnick, H.E. and American Society for Parenteral and Enteral Nutrition, 2014. Malnutrition diagnoses in hospitalized patients: United States, 2010. *Journal of Parenteral and Enteral Nutrition*, *38*(2), pp.186-195.
[8] Lim, S.L., Ong, K.C.B., Chan, Y.H., Loke, W.C., Ferguson, M. and Daniels, L., 2012. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. *Clinical Nutrition*, *31*(3), pp.345-350.
[9] Tarasuk, V., Cheng, J., De Oliveira, C., Dachner, N., Gundersen, C. and Kurdyak, P., 2015. Association between household food insecurity and annual health care costs. *Cmaj*, *187*(14), pp.E429-E436.
[10] Berkowitz, S.A., Seligman, H.K., Meigs, J.B. and Basu, S., 2018. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. *The American Journal of Managed Care*, *24*(9), p.399.
[11] Seligman, H.K., Bolger, A.F., Guzman, D., López, A. and Bibbins-Domingo, K., 2014. Exhaustion of food budgets at month's end and hospital admissions for hypoglycemia. *Health Affairs*, *33*(1), pp.116-123.
[12] Berkowitz, S.A., Meigs, J.B., DeWalt, D., Seligman, H.K., Barnard, L.S., Bright, O.J.M., Schow, M., Atlas, S.J. and Wexler, D.J., 2015. Material need insecurities, control of diabetes mellitus, and use of health care resources: results of the Measuring Economic Insecurity in Diabetes study. *JAMA Internal Medicine*, *175*(2), pp.257-265.

- Food insecurity is associated with nearly twice the odds of HIV treatment non-adherence,[13] and connecting HIV patients to medically tailored meals has been found to increase medication adherence by 50%.[14]

MTMs are a Low-Cost Innovative Response to Disease and High Costs Driven by Food Insecurity and Malnutrition

It has been demonstrated that access to healthy and affordable food is key to improved health outcomes. Below, you will see a common framework to conceptualize where the MTM intervention fits in the broader scope of nutrition interventions:



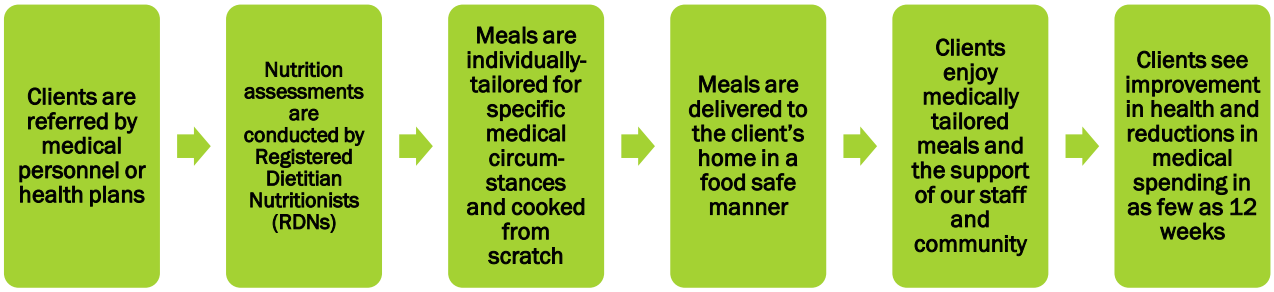
The Food is Medicine pyramid describes the density of the population in need of each intervention and sets up a continuum from prevention to treatment on the left-hand side. The taxonomy of all Food is Medicine interventions is based upon their purpose and reach. Interventions primarily aimed at reducing food insecurity and improving the dietary intake of Americans –including SNAP, WIC, and others– are located at the base of the pyramid. These programs achieve broad reach and provide more general support that evidence demonstrates is effective prevention for certain illnesses or illness progression that are affected by food insecurity. As we move up the pyramid, the specialization of the intervention increases while the population in need of the intervention decreases.

FIMC focuses our services on the top of the pyramid, where we find the smallest population, but the most acute: individuals with multiple conditions who need specialized nutrition – the highest risk in our communities who also account for disproportionately high medical spending. MTMs are designed primarily as a treatment, rather than a prevention measure, though they do accomplish tertiary prevention. The strategic implementation of targeted interventions, like MTMs, which are designed to support and stabilize this population and bridge the clinical and community space, are an effective prevention and treatment strategy.

A growing body of evidence shows that MTMs are an extremely effective response for individuals with complex health profiles, generating rapid and significant impacts on both health outcomes and costs. Medically tailored meals can support treatment of an acute health episode, such as a round of

[13] Singer AW., Weiser SD., McCoy SI. (2014) Does Food Insecurity Undermine Adherence to Antiretroviral Therapy? A Systematic Review. AIDS and Behavior. August 2014.
[14] Palar, K., Napoles, T., Hufstedler, L.L., Seligman, H., Hecht, F.M., Madsen, K., Ryle, M., Pitchford, S., Frongillo, E.A. and Weiser, S.D., 2017. Comprehensive and medically appropriate food support is associated with improved HIV and diabetes health. *Journal of Urban Health*, *94*(1), pp.87-99.

chemotherapy and radiation, or be part of chronic disease management. They are designed with the expertise of Registered Dietitian Nutritionists (RDNs), recommended in partnership with the patient's health care provider as part of the beneficiary's treatment plan, and are customized to meet complex dietary and medical conditions. The MTM intervention includes rigorous dietary assessment and individualized medical nutrition therapy to ensure that individuals understand what they should be eating, how to manage/augment often-complex medication regimens with proper nutrition, and how to continue making meals that conform to their recommended medical diet once they no longer receive prepared meals. Conditions commonly addressed by MTM interventions include diabetes, renal disease, chronic obstructive pulmonary disease (COPD), heart disease, congestive heart failure, cancer, and HIV. Below is a descriptive diagram of the continuity of the MTM intervention.



Medically Tailored Meals: The Evidence

Recent research has demonstrated significant improvements in health outcomes and associated cost savings for Medicare and Medicaid beneficiaries. In an article published in *Health Affairs* in 2018, researchers analyzed claims data and found providing MTMs for patients dually eligible for Medicaid and Medicare resulted in fewer emergency department visits, emergency transportation services, and inpatient admissions as compared to dually eligible patients not enrolled in the meal program. Compared to matched controls, dually eligible patients receiving MTMs experienced a 70% reduction in emergency department visits, a 52% reduction in inpatient admissions, and a 72% reduction in emergency transportation events. The MTM intervention resulted in a 16% net reduction in health care costs, and the net savings after factoring in the cost of the meals was $220 per month per patient. [15]

These results were validated in a much larger scale study, conducted in partnership with the Massachusetts Department of Public Health and published in *JAMA* in 2019, which found that the provision of MTMs was associated with 49% fewer inpatient admissions, 72% fewer admissions into skilled nursing facilities, and a 16% net decrease in healthcare costs for over 800 individuals receiving the service over a 5-year period.[16]

A similar MTM program deployed in a Medicaid managed care population in Philadelphia saw 28% lower health care costs for Medicaid patients receiving MTMs as compared to a similar group of Medicaid patients. Researchers found that individuals who received MTMs had hospital stays that were 37% shorter, visited the hospital 50% less, and were 20% more likely to be discharged to their homes than a matched control group.[17] A MTM program in Denver similarly recorded a 24% decrease in health care costs for patients enrolled in their services in a retrospective cohort analysis

[15] Berkowitz, S.A., Terranova, J., Hill, C., Ajayi, T., Linsky, T., Tishler, L.W. and DeWalt, D.A., 2018. Meal delivery programs reduce the use of costly health care in dually eligible Medicare and Medicaid beneficiaries. *Health Affairs*, *37*(4), pp.535-542.

[16] Berkowitz SA, Terranova J, Randall L, Craston K, Waters DB, Hsu J. Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. JAMA. 2019;179(6):786-793.

[17] Gurvey, J., Rand, K., Daugherty, S., Dinger, C., Schmeling, J. and Laverty, N., 2013. Examining health care costs among MANNA clients and a comparison group. *Journal of Primary Care & Community Health*, *4*(4), pp.311-317.

and found a 13% decrease in all cause, 30-day readmission rate.[18] Finally, another study conducted in San Francisco found that for HIV patients with diabetes connected to MTM, adherence to antiretroviral therapy increased from 47% to 70%, and perceived diabetes self-management significantly increased for diabetic patients. The same study also found reduction of diabetes-related distress and recorded improved depressive symptoms and decreased binge drinking. [19]

These studies show that access to MTMs not only improves an individual's health outcomes but can also reduce total health care costs, especially for our country's most ill individuals. Furthermore, this research demonstrates the preventive nature of MTMs when it comes to future healthcare utilization. Expanding coverage of MTM in public health insurance systems would improve that access, thereby strengthening our ability to address the burden of chronic and acute illness in the United States.

In addition to the research, multiple public payers have incorporated the MTM intervention into their services for high-risk populations across the country and preliminary outcomes demonstrate both improved health and decreased costs. For example, a Pennsylvania Medicaid Managed Care Organization incorporated MTM into their management of high-need/high-cost members. More than 25% of diabetic members who received the service were able to lower their hemoglobin A1C levels, and in-patient hospitalizations were reduced by more than 27%.[20] A similar partnership resulted in a 30% decrease in hospitalizations and a nearly 25% reduction in overall medical costs. Pilots such as these demonstrate real world benefits to inclusion of MTM in management of high-risk populations.[21]

Lack of Federal Support for MTM

Despite research proving the efficacy of the MTM intervention, there are system-wide gaps in provision of this lifesaving, cost-saving service. The only dedicated federal funding stream for any population living with severe or chronic illness that can include MTM as an intervention is the Ryan White HIV/AIDS Program (RWHAP) for people living with HIV (PWH). Yet even this critical funding stream does not cover all those who come to FIMC agencies for service. Even when individuals receive low-cost and clinically effective interventions through RWHAP[22], they are often not enough[23]. Access to MTMs is largely funded through private philanthropy across the country with most FIMC agencies raising the majority of their budgets each year.

MTMs are not generally a reimbursable benefit for enrollees in state Medicaid programs unless the state has elected to cover them through a waiver or special program. In fact, HRSA noted in 2014[24] and 2015[25] that nutrition was not covered in any comprehensive way even in States that allowed for Medicaid expansion. Similarly, while Medicare Advantage plans have the option to cover meals as a supplemental benefit for certain populations, Medicare Parts A and B provide no such coverage. As a result, most Medicare beneficiaries—approximately 38 million people—are not eligible for this cost-effective benefit.[26] Innovative pilot programs made possible through the Affordable Care Act have created opportunities to fund hospitals for referrals to social services agencies[27], but do not pay these agencies to deliver services, like meals and nutrition counseling.

Healthcare Innovation

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[18] Small Intervention, Big Impact: Health Care Cost Reductions Related to Medically Tailored Nutrition. Project Angel Heart. June 2018. Accessed online at: https://view.publitas.com/project-angel-heart/whitepaper-small-intervention-big-impact/page/8

[19] Palar, K., Napoles, T., Hufstedler, L.L., Seligman, H., Hecht, F.M., Madsen, K., Ryle, M., Pitchford, S., Frongillo, E.A. and Weiser, S.D., 2017. Comprehensive and medically appropriate food support is associated with improved HIV and diabetes health. *Journal of Urban Health*, *94*(1), pp.87-99.

[20] https://www.healthpartnersplans.com/media/100225194/food-as-medicine-model.pdf

[21] https://www.nytimes.com/2019/10/22/opinion/chronic-illness-diet.html

[22] http://www.nyhiv.org/pdfs/chain/CHAIN_2013_5a_Service_Needs_and_Utilization_Report_NYC_Final.pdf

[23] Anema A, Weiser SD, Fernandes KA, Ding E, Brandson EK, Palmer A, Montaner JS, Hogg RS. High prevalence of food insecurity among HIV-infected individuals receiving HAART in a resource-rich settings. AIDS Care. 2011 Feb;23(2):221-30.

[24] https://www.abtassociates.com/insights/publications/presentation/the-future-of-ryan-white-services-snapshot-of-outpatient

[25] https://hab.hrsa.gov/sites/default/files/hab/Global/medicaidwaivers.pdf

[26] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/

[27] https://innovation.cms.gov/initiatives/AHCM

Because of the compelling research results, some individual states and Medicaid and Medicare managed care plans have begun to use waivers and regulatory flexibilities to pilot coverage of MTMs. While much success has been seen in these pilots, largely in states and localities that have expanded Medicaid (e.g., in New York, California, Washington, DC, Colorado, and Pennsylvania), they remain on the margins of innovation and fall short of establishing the widespread coverage needed to ensure equitable access to these critical services across the U.S. Changing healthcare policy to fund, deliver and explicitly evaluate the MTM intervention in Medicare and Medicaid would solve this issue. In Appendix A. please find a listing of our extensive State-based Medicaid partnerships.

Racial Equity in Health

An outsized portion of adverse health outcomes find their root in lack of access to good nutrition, and that lack of access is predicated on healthcare inequities – both racial and socioeconomic. FIMC agencies serve those adversely affected by the epidemic of serious and chronic illness in our country, which disproportionately affects communities of color. Our experience of service has shown us the deep disparities in health outcomes that our communities face and demonstrates that good nutrition is part of the solution.

While there is no singular action that will create health equity in America because racism is systemic, FIMC seeks to address the inequity that already exists and to rebalance health in favor of our clients through the services we provide. By ensuring that when an individual is living with severe or chronic illness, they get access to the right kind of food to produce better health outcomes, we enable our clients to have a similar opportunity to use diet to their advantage when addressing their medical condition. Right now, whether a person has access to medically tailored meals depends on where they live and if their insurance provider offers this service – a situation that must change.

Medically tailored meals are one of the least expensive and most effective ways to improve our healthcare system in an equitable way, and each policy recommendation in this document is offered through the lens of correcting racial inequity in health.

COVID-19: The Urgent Need for MTM

The specific need for medically tailored meals exponentially increased with the onset of COVID-19. Not only did the pandemic exacerbate current needs for medically tailored meals, but almost overnight it created new populations – the medically vulnerable, older Americans with chronic illness who were now required to isolate at home, and others – needing nutrition-specific and home-delivered interventions. As providers with many years of experience serving high-risk populations, MTM organizations across the country stepped into the gap and saw referrals skyrocket.[28] To respond to the influx, many MTM organizations completely changed their model(s) of operation almost overnight, significantly increasing costs.[29]

Furthermore, the COVID-19 pandemic has disproportionately negatively affected communities of color. For examples: "Non-Hispanic American Indian or Alaska Native, non-Hispanic Black, and Hispanic or Latino people have higher hospitalization rates compared with non-Hispanic Asian or Pacific Islander and non-Hispanic White people."[30] It is communities of color that FIMC primarily serves through our programs nationwide.

As a result of necessary social distancing policies and inevitable economic disruption, the rate of food insecurity has significantly increased during the pandemic. Research shows that COVID-19 will have a long-term effect on food insecurity well beyond the end of the pandemic, contributing to an

[28] Food is Medicine Massachusetts (2020). "Medically Tailored Meal Services are Critical to Covid-19 Response Efforts, Yet Most Lack Adequate Support" *Food is Medicine Massachusetts*, 4 May. Available at: https://foodismedicinema.org/blog/2020/5/11/medically-tailored-meal-services-are-critical-to-covid-19-response-efforts-yet-most-lack-adequate-support

[29] https://www.chlpi.org/health_library/bringing-food-home-during-covid-19-medically-tailored-meal-nonprofits-respond-to-a-new-epidemic/

[30] https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-hospitalization.html

increased burden of chronic disease in the United States and globally, highlighting the ongoing need for MTM programs.[31]

While MTM organizations have been a crucial part of COVID response, the pandemic has once again highlighted the policy and structural barriers that limit MTM program capacity and reach. The MTM intervention has not been incorporated into federal funding streams which limits providers' ability to scale up to meet the need. Because of this exclusion, local and federal emergency management planning systems also do not include access to MTM in their planning.

In such a fragmented landscape, we lack effective technologies and systems to reliably refer patients exiting the hospital to sources of food and nutrition. FIMC agencies have been working to connect healthcare and community care systems for years and have innovated through technology partnerships, referral tool creation and data exchange[32] to create systems of care that help people stay healthy and in their homes. But it has been an uphill battle and the need for acceleration in resourcing these systems is ever more apparent in the face of the pandemic and must continue as we move into a post-COVID world.

MTM clients are typically at the highest risk for serious complications or death from COVID-19. MTMs have been shown to reduce inpatient hospital admissions and emergency department visits, which is exactly what we want for this population right now and into the future. Reliable and safe home delivery of medically tailored meals has become more critical than ever before.

There is no better time to acknowledge the efficacy of administering MTMs on a broader scale and to implement policies that make that provision a reality. Below please find our recommendations for both First Year and Administration Opportunities.

Opportunities for the First Year

Fully fund and implement pilot MTM programs in the Medicare and Medicaid programs

While often not a long-term solution, pilot programs can be a first step towards filling gaps in access to MTM. State and federal pilots provide an opportunity to improve the health of Medicaid and Medicare patients in the short term, build program capacity, and inform broader efforts to establish MTMs as a covered benefit within both Medicaid and Medicare. This recommendation is directed at CMS:

1. **Medicare**: The Administration and Congress should advance efforts to pilot coverage of MTMs for Medicare enrollees with chronic illnesses through legislation, such as H.R. 6774, the Medically Tailored Home Delivered Meals Demonstration Pilot Act of 2020,[33] or through direct action through the Center for Medicare and Medicaid Innovation.

2. **Medicaid:** The Administration and Congress should specifically promote state-based efforts to cover clinical nutrition services and nutrition-based interventions for individuals participating in Medicaid, such as 1915(c) waivers, 1115 waivers and the In Lieu of Services option, which have been used to provide medically tailored home-delivered meals to targeted populations in certain states. FIMC agencies have been engaged in these innovation projects for years, as can be seen in the successful examples below. Furthermore, a brief from CMS released in early 2021 catalogues the many ways that states can take advantage of flexibilities to provide MTM and other services through Medicaid.[34] The brief does not appear

[31] Leddy, A.M., Weiser, S.D., Palar, K. and Seligman, H., 2020. A conceptual model for understanding the rapid COVID-19–related increase in food insecurity and its impact on health and healthcare. *The American Journal of Clinical Nutrition*, *112*(5), pp.1162-1169.
[32] https://www.glwd.org/blog/success-the-final-report-from-year-1-of-the-food-and-nutrition-services-bundle/
[33] https://www.congress.gov/bill/116th-congress/house-bill/6774?s=1&r=1
[34] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

to add anything new to our understanding of how states can leverage current flexibilities, but the support symbolized is important and encouraging. In Appendix A. please find a listing of our extensive State-based Medicaid partnerships, as examples.

While we support these innovation efforts in the short term, we note that allowing states to experiment on their own requires each state to use resources and time to develop protocols independently resulting in a patchwork system of access and provision across the country that will remain insufficient to the need for MTM. Piecemeal implementation of access efforts will inevitably result in growing inequity. Below you will find our recommendations for changing Medicaid and Medicare policy to make MTM a reimbursable service for qualifying individuals, so that access is not dependent on a client's residence.

Expand funding and programmatic opportunities for medically tailored meals within Title III of the Older Americans Act

Chronic illness is on the rise for older adults: approximately 92% of older adults have at least one chronic disease, and 77% have at least two.[35] Individuals with chronic health conditions account for approximately 86% of all health care spending.[36] Combined with the fact that 75% of seniors were unable to shop for food on their own and 58% were unable to prepare their own food, means risk factors align for malnutrition.[37] Furthermore, data show significant unmet need, despite participation in Older Americans Act (OAA) programs being associated with better health outcomes and even reduced mortality.[38,39,40] This recommendation is directed both at Congress (appropriation) and at the Administration for Community Living (implementation).

1. The Administration and Congress should continue to increase funding for Older Americans Act programs and enhance opportunities to support implementation of MTMs in OAA programs (such as Amendment 268 to H.R. 2740, which allowed a percentage of OAA funds to be used for implementation of evidence-based practices including MTMs).[41]

Increase Ryan White HIV/AIDS Program funding to support all People Living With HIV/AIDS (PWH) that come to FIMC agencies in need

As mentioned above, food insecurity is associated with significant adverse outcomes and substance use among people living with HIV. In contrast, receipt of nutrition services is associated with better viral suppression and health for people living with HIV.[42] This recommendation is directed at Congress (appropriation) and HHS, more specifically HRSA (implementation).

1. Congress and the Administration should expand the nutrition assistance programs in the Ryan White Care Act, specifically medical nutrition therapy, medically tailored meals, and food bank services.

Research Funding for MTM

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[35] According to the National Council on Aging. Available at https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts/. Accessed July 24, 2017).

[36] According to 2010 data. *Chronic Disease Overview*, CTRS. FOR DISEASE CONTROL & PREVENTION. Available at https://www.cdc.gov/chronicdisease/overview/. Accessed Mar. 28, 2017.

[37] Phipps EJ, Singletary SB, Cooblall CA, Hares HD, Braitman LE. Food Insecurity in Patients with High Hospital Utilization. Popul Health Manag. 2016;19(6):414-420.

[38] Lepore, M.J. and Rochford, H., 2019. Addressing food insecurity and malnourishment among older adults: the critical role of Older Americans Act Nutrition Programs. *Public Policy & Aging Report*, *29*(2), pp.56-61.

[39] Kowlessar, N., Robinson, K. and Schur, C., 2015. Older Americans benefit from Older Americans Act nutrition programs. *Administration on Aging*. https://nutritionandaging.org/wp-content/uploads/2015/10/2015_0928_AoA_Brief_September.pdf

[40] Gum, A.M., Green, O., Schonfeld, L., Conner, K., Rigg, K.K., Wagoner, F., Melling, K.A. and Parkinson, K., 2020. Longitudinal Analysis of Mortality for Older Adults Receiving or Waiting for Aging Network Services. *Journal of the American Geriatrics Society*, *68*(3), pp.519-525.

[41] https://www.congress.gov/bill/116th-congress/house-bill/2740/amendments?q={%22search%22:[%22hr+2740%22]}&page=2&searchResultViewType=expanded

[42] Alexy, E., Feldman, M., Thomas, J. and Irvine, M., 2013. Food insecurity and viral suppression in a cross-sectional study of people living with HIV accessing Ryan White food and nutrition services in New York City. *The Lancet*, *382*, p.S15.

Making nutrition research central to all of NIH begins with a mandate from the top. We were pleased to see that NIH has begun the official transfer of the Office of Nutrition Research (ONR) to the Division of Program Coordination, Planning, and Strategic Initiatives within the Office of the Director. This reorganization signals to us that all NIH Institutes and Centers will be focusing on implementing the 2020-2030 Strategic Plan for NIH Nutrition Research and coordinating nutrition research across Institutes. Medically tailored meals were specifically mentioned as a priority for research in *Objective 4-1. Identify Interactions Between Drugs, Disease States, and Nutrition to Improve Clinical Care and Test Strategies to Improve Clinical Outcomes* of the Strategic Plan.[43] With this focus, NIH is in a unique position to expand upon the MTM research questions.

1. NIH should establish a Steering Committee of MTM experts and advisors to guide this aspect of their nutrition research development. For this effort, NIH should work directly with community providers of nutrition interventions and the clients they serve, as well as with CDC and HHS on research methods and approach, population selection, implications for healthcare policy and study design.

Opportunities for the First Administration

Modernize Medicare and Medicaid to Make MTMs a Fully Reimbursable Benefit for People Living with Severe Illness

While the various authorities mentioned above in our First-Year recommendations do provide piecemeal options for improving MTM implementation, they will never be enough. Without widespread access to this cost-saving clinical service, our nation will not reap the benefits. Supporting medically tailored meals as a benefit for the sickest of the sick in the Medicaid statute would prevent the uneven access currently available through the use of state-based waivers. Similarly, building access to MTMs into Medicare Parts A or B would address enormous gaps in coverage, ensuring that MTMs are available to all Medicare enrollees who need them, rather than only to individual enrolled in certain Medicare Advantage plans. Many FIMC agencies have done feasibility testing that scales the MTM model through shipping and the expansion of Medicare/Medicaid coverage would ensure that the reach of meals can be extended across the country. A fix to the statute (legislative) or a reinterpretation of existing statute (administrative) could accomplish the following:

1. Establish coverage for medically tailored meals in Medicaid
    a. Include “medically-tailored nutrition” in the definitions of the mandatory “home health care services” benefit category.
    b. Include “medically-tailored nutrition” in the optional “other diagnostic, screening, preventive, and rehabilitative services” category.
2. Establish coverage for medically tailored meals in Medicare
    a. Add “medically tailored meals” to the definition of “medical and other health services” in the Medicare statute for Medicare Part B.

Increase Funding and Institutional Support for New Research on MTMs and other Food Is Medicine Interventions

While there is a rigorous evidence base for the efficacy of MTMs, larger, multi-site studies are the next step in more fully understanding the effects of the intervention in certain populations, dosages and densities of service. There is also no data on the impact of providing MTMs to a household versus solely to an individual with a qualifying medical condition, although many of our member organizations use philanthropic dollars to feed the household of a qualifying individual. They recognize that food provided to adults with chronic illness will be shared or foregone entirely in a food insecure household, limiting the intervention’s efficacy. Community-based organizations that deliver MTM services are further challenged in evaluating the effect of their own services by barriers

[43] https://dpcpsi.nih.gov/onr/strategic-plan

to data access, as health and cost outcomes data rests with either clinical or plan partners. Operationalizing studies on a larger scale with robust investment by the National Institutes of Health would address these issues and allow larger sample sizes.

A recent brief, *Strengthening national nutrition research: rationale and options for a new coordinated federal research effort and authority*,[44] identifies key nutritional challenges and the strains they take on productivity, health care costs, health disparities, government budgets, US economic competitiveness, and military readiness, and how the COVID-19 pandemic has further exacerbated these strains. The rationale posits that a greater harmonization and expansion of federal investment in nutrition science and research has tremendous potential to generate new discoveries to improve and sustain the health of all Americans. We support the recommendations in this brief, including the establishment of a new authority for robust cross-governmental coordination of nutrition research and other nutrition-related policy and strengthened authority, investment, and coordination for nutrition research within the NIH.

Improve Quality Standards for Nutrition Interventions

As nutrition has begun to be incorporated into healthcare delivery, the need for rigorous quality and definitional standards has become apparent, especially as it relates to consistently achieving the results evidenced in research. To answer this need and to ensure that where and when the MTM intervention is implemented that it is of the highest quality, the FIMC Clinical Committee, composed of Registered Dietitian Nutritionists from agencies across the country, issued the FIMC Medically Tailored Meal Nutrition Standards.[45] These detail the rigorous, evidence-based nutrition standards expected for a high-quality MTM service. The standards have received much attention and were recently adopted by the NYC Eligible Metropolitan Area (EMA) Health and Human Services HIV Planning Council, as the benchmark for all Ryan White nutrition programming in the largest EMA in the country. In addition, newer Medicaid pilots, like the Healthy Opportunities Pilots in NC,[46] are pointing to these rigorous standards as a base for the MTM delivered in program. We ask that the FIMC Medically Tailored Meal Nutrition Standards be adopted wherever MTM are delivered within the HHS portfolio.

Connect Clinical Systems to the Social Services Safety Net

1. Implement universal screening for food insecurity and malnutrition

Given the above research, identifying food insecurity and malnutrition in clinical settings is an urgent priority. Screening for patient food insecurity and connecting patients to food resources has been strongly supported in official statements by the Centers for Medicare and Medicaid Services, the American Academy of Pediatrics, the American Diabetes Association, the Academy of Nutrition and Dietetics and AARP. A more sophisticated malnutrition risk screen is more appropriate to identifying high-risk patients that would need a more rigorous intervention like MTM.[47] Including these assessments in routine patient care is a critical first step in laying the groundwork for implementing nutrition interventions, identifying patients in need, and referring them to appropriate services.[48] We commend HHS and CMS for the steps they have taken to ensure that social needs screening becomes a widespread practice within the health care system, such as initiating the Accountable Health Communities model,[49] but these changes could be made universal through administrative action.

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[44]Fleischhacker, S.E., Woteki, C.E., Coates, P.M., Hubbard, V.S., Flaherty, G.E., Glickman, D.R., Harkin, T.R., Kessler, D., Li, W.W., Loscalzo, J. and Parekh, A., 2020. Strengthening national nutrition research: rationale and options for a new coordinated federal research effort and authority. The American journal of clinical nutrition, 112(3), pp.721-769.

[45] http://www.fimcoalition.org/our-model

[46] https://files.nc.gov/ncdhhs/medicaid/20191223-HO-LPE-RFP-Addendum-7-Revisions-to-the-RFP-TO-POST.pdf

[47] Skipper, A., Coltman, A., Tomesko, J., Charney, P., Porcari, J., Piemonte, T.A., Handu, D. and Cheng, F.W., 2020. Position of the academy of nutrition and dietetics: malnutrition (undernutrition) screening tools for all adults. *Journal of the Academy of Nutrition and Dietetics*, *120*(4), pp.709-713.

[48] Reber, E., Gomes, F., Vasiloglou, M.F., Schuetz, P. and Stanga, Z., 2019. Nutritional risk screening and assessment. *Journal of clinical medicine*, *8*(7), p.1065.

[49] https://innovation.cms.gov/innovation-models/ahcm

2. Increase nutrition education among health care providers

Doctors are often the most important voice in an individual's health. Yet, doctors are not trained adequately on nutrition science in medical school. "Nutrition plays a critical role in the prevention and treatment of many chronic diseases, and diet is one of the most significant risk factors for disability and premature death in the United States. Leading causes of death include heart disease, cancer, stroke, and diabetes—all of which have a high correlation to poor diet and nutrition. Yet despite the overwhelming evidence linking food with health, nutrition receives little attention in medical school and throughout the education of physicians." A recent brief, *Doctoring our Diet: Policy Tools to Include Nutrition in U.S. Medical Training*, written by the Center for Health Law and Policy Innovation of Harvard Law School[1], takes stock of this problem and offers viable solutions to make sure our most important assets in identifying malnutrition and food insecurity are properly trained. We request that in areas where HHS has purview, they implement recommendations around increased nutrition training for medical personnel.

3. Improve coordination of referrals to the MTM intervention

A key challenge with the implementation of better connection to MTM interventions in the community has been establishing a coordinated data system that accurately assesses need and eligibility for the MTM intervention in clinical settings and then refers patients to appropriate providers in the community in a closed-loop fashion, so individuals do not fall through the treatment gaps. Creation of these data systems have happened piecemeal. Fewer patients receive the care that they need when providers are unsure of where to refer their patients, community-based organizations receive improper referrals that drain capacity, and patients are referred to services for which they are ineligible. This is a key area of opportunity and learning, and several pilot projects have innovated solutions with great effect, most notably the *Food and Nutrition Services Bundle* in New York City.[50] We respectfully ask that a federal workgroup be established that offers best practices for screening, risk-stratifying and referring to nutrition interventions from clinical settings to the community, so there is a unified system nationwide.

4. Further build medical coding of food insecurity, malnutrition, and their treatments

The healthcare system is becoming more involved in addressing whole-person care and playing a more prominent role in assessing and addressing social risk factors. These facts underscore the need to design and implement social determinants of health (SDH) coding within the clinical setting. While not complete, much progress has been made on this front by the *Gravity Project*,[51] which aims to gain consensus on the definitions of SDH interventions, identify gaps in coding of SDH, emphasize uniform collection of SDH data in electronic health and medical records and point out inconsistencies in guidelines and incentives around SDH to endeavor to create a more uniform set of principles for data recording and sharing. Many agencies, including CMS and CDC, are already involved in the *Gravity project* and we support their continued focus in this area.

5. Clarify regulation around data sharing between the clinical field and community-based organizations providing social services.

Necessary privacy regulations add complexity to partnerships between community-based organizations and payers. Lack of clarity around consent, HIPAA, and other data sharing issues between clinical providers and the community has meant that the creation of an innovative, coordinated referral and treatment system has stagnated in many localities. Clarity and specificity in this area, from HHS, could catalyze invention and implementation.

[50] https://1ijrim370iz22k1owzbmpcx1-wpengine.netdna-ssl.com/wp-content/uploads/2019/11/Food-and-Nutrition-Services-Bundle-Report.pdf
[51] https://www.hl7.org/gravity/

Conclusion

A person's diet often has life and death consequences. When people are severely ill, good nutrition is one of the first things to deteriorate, making recovery and stabilization that much harder, if not impossible. Early and reliable access to medically tailored meals helps individuals live healthy and productive lives, produces better overall health outcomes and reduces health care costs. It is a solution that improves population and individual health, improves the experience of care, and has been proven to reduce costs.

Americans have gone through a very tough time, and the agencies of FIMC have strived to represent the best of our country during the pandemic. We are ready to continue serving and working alongside you to bring our life-saving service to all those in need across the country.

We welcome follow up and questions. Please contact Alissa Wassung (awassung@glwd.org), Senior Director of Policy & Planning at God's Love We Deliver in New York City and Policy Committee Chair of the Food is Medicine Coalition if we can be of assistance. Thank you for the opportunity to offer our recommendations and perspective.

Sincerely,

Karen Pearl, Chair, Food is Medicine Coalition and President & CEO, God's Love We Deliver

Food Is Medicine Coalition Advisory Board

Matthew Pieper, Vice Chair, Food is Medicine Coalition and Executive Director, Open Hand Atlanta, Atlanta, GA
Susan Daugherty, RDN, LDN, Vice Chair, Food is Medicine Coalition and CEO, MANNA, Philadelphia, PA

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Carrie Stoltzfus, Executive Director, Food & Friends, Washington, DC
Claire Neal. CEO, Lifelong, Seattle, WA
Alberto Cortes, CEO, Mama's Kitchen, San Diego, CA
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Jessica Schubel, Director of ACA and Health Care for the Domestic Policy Council at Executive Office of the President
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Liz Richter, Acting Administrator for the Centers for Medicare and Medicaid Services
Alison Barkoff, Acting Administrator and Assistant Secretary for Aging for the Administration for Community Living

Senator Patty Murray (WA), Chair, Senate Committee on Health, Education, Labor and Pensions

Senator Richard Burr (NC), Burr, Ranking Member, Senate Committee on Health, Education, Labor and Pensions
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Senator Steve Daines (MT), Ranking Member, Senate Committee on Finance
Senator Patrick Leahy (VT), Chair, Senate Committee on Appropriations
Senator Roy Blunt (MO), Ranking Member, Senate Committee on Appropriations
Senator Bob Casey (PA), Chair, Senate Special Committee on Aging
Senator Tim Scott (SC), Ranking Member, Senate Special Committee on Aging
Representative Jim McGovern (MA-2), Chair, House Committee on Rules and Co-Chair, House Hunger Caucus
Representative Jackie Walorski (IN-2), Co-Chair, House Hunger Caucus
Representative Rosa DeLauro (CT-03), Chair, House Committee on Appropriations
Representative Kay Granger (TX-12), Ranking Member, House Committee on Appropriations
Representative Frank Pallone (NJ-06), Chair, House Committee on Energy and Commerce
Representative Cathy McMorris Rodgers (WA-05), Ranking Member, House Committee on Energy and Commerce
Representative Richard Neal (MA-01), Chair, House Ways and Means Committee
Representative Kevin Brady (TX-08), Ranking Member, House Ways and Means Committee
Representative Chellie Pingree (ME-1), Member, House Hunger Caucus

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Appendix A: FIMC MTM State-based Innovation
In addition to the Medicaid partnerships below, many FIMC agencies also have partnerships with **Medicare Advantage** plans, supplying post-discharge meals and ongoing nutrition support.

State	Description	FIMC Provider(s)
CA	California's Medi-Cal Medically Tailored Meals Pilot Program is an evaluated Medicaid pilot that provides medically tailored meals and medical nutrition therapy to people living with congestive heart failure. are all providers through this program.	California Food Is Medicine Coalition (CA)
CO	The Colorado Choice Transitions (CCT) demonstration project was a money follows the person initiative to provide wrap around services to Medicaid members who were transitioning from a long-term care facility to independent living. As a result of the success of CCT, Transitions Services was created. Medically tailored meals are one of 4 services covered under home and community-based services waivers for the Transitions Services program.	Project Angel Heart (Denver, CO)
GA	Georgia's Elderly and Disabled Program helps frail and disabled Medicaid enrollees who otherwise would be eligible for a nursing home stay healthy and at home with the provision of medically tailored meals and other in-home support services.	Open Hand Atlanta (Atlanta, GA)
MA	Launched in March 2020, The Massachusetts Medicaid Demonstration Flexible Services Pilot reimburses for the provision of social services,	Community Servings (Boston, MA)

	including nutrition services and medically tailored meals, referred through Accountable Care Organizations.	
MD	Maryland offers MTM through the Community First Choice Option and a 1915(k) waiver to older adults and people with disabilities.	Moveable Feast (Baltimore, MD)
MN	The Minnesota Medicaid Community Access for Disability Inclusion Waiver and the Elderly Waiver support MTM for populations covered as beneficiaries.	Open Arms Minnesota (Minneapolis, MN)
NY	The New York State Value-Based Payment Roadmap, which incorporates social determinant of health interventions, like medically tailored meals, in risk bearing Medicaid arrangements. Find preliminary outcomes here from God's Love We Deliver's provision of MTM through this program, presented at the NYS Medicaid Population Health Symposium.	God's Love We Deliver, Inc. (New York, NY)
NY	New York's 1115 Waiver Medicaid Managed Long Term Care program has included MTM for vulnerable individuals for nearly 15 years.	God's Love We Deliver, Inc. (New York, NY)
NY	New York State became the first in the nation to approve medically tailored meals as a NYS Medicaid In Lieu of Services benefit for personal care aide hours used to prepare meals. A groundbreaking provision, this would allow Medicaid managed care plans to offer MTMs as a benefit to enrollees with serious illness.	God's Love We Deliver, Inc. (New York, NY)
PA	Pilot programs within Medicaid Managed Care in Pennsylvania have promoted provision of medically tailored meals within a high need/high risk population as a success story within value-based care. Find preliminary outcomes here from MANNA's provision of MTM through this program.	MANNA (Philadelphia, PA)