



President Joseph R. Biden
The White House
1600 Pennsylvania Ave NW
Washington, D.C. 20500

May 2, 2022

RE: Recommendations for the White House Conference on Food, Nutrition, Hunger, and Health

Dear President Biden:

On behalf of the Food is Medicine Coalition, I would like to thank you for this opportunity to provide recommendations regarding challenges and policy opportunities that we hope will be considered as you plan for the upcoming White House Conference on Food, Nutrition Hunger and Health. We, as medically tailored meal providers, are thrilled that the Biden Administration will be holding this event to examine the critical connections between food access, nutrition, and health. Given the goals of the event, we believe that medically tailored meals – which respond directly to these connections – should be a core topic of discussion and of any resulting policy recommendations.

Background

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 people living with other serious and chronic 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-informed intervention.¹

As medically tailored meal (MTM) 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. Though most FIMC clients may be eligible to receive food from anti-hunger providers, the complexity of their medical condition requires a specialized diet that only MTM agencies can provide. We serve people of all ages and most of our clients are living with multiple illnesses at once.

¹ <http://www.fimcoalition.org/our-model>

Specifically, we recognize that the United States faces an epidemic of diet-related chronic disease. Sixty percent of US adults are living with at least one chronic illness, many of which are diet-related (e.g., hypertension: 27 percent of US adults; diabetes: 12 percent of US adults). As a result, diet quality is now the number one risk factor for death in the United States, and diet-related health conditions cost the United States trillions of dollars each year in direct health care spending and lost productivity. Malnutrition and food insecurity are key drivers of this epidemic. Experts have long understood the direct link between nutrition and health, with diets rich in fruits, vegetables, whole grains, and lean protein associated with lower risk of disease. However, access to such foods is often limited by a variety of factors, including costs and availability of healthy foods, the need to make difficult choices between purchasing healthy food and meeting other basic needs (e.g., housing, medical care, etc.), and medical conditions that may limit an individual's ability to shop or cook. Addressing the epidemic of diet-related disease thus requires strengthening every individual's ability to consistently consume foods that support health. This underscores the critical importance of services such as MTMs.

MTMs are an innovative and low-cost response to disease and high healthcare 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 healthcare costs for over 800 individuals receiving the service over a 5-year period^{2,3}

Ongoing research continues to prove the efficacy of the medically tailored meal model in populations living with serious illnesses such as HIV/AIDS, cancer, cardiovascular disease, renal failure and many more.⁴ In addition, the model is beginning to be utilized in other contexts with encouraging results: as a support for people with gestational diabetes during pregnancy and through the first months of a child's life; as part of a treatment plan for children who are severely ill; as targeted support for people living with behavioral health issues or serious mental illnesses and more. Most FIMC providers also support the families of our clients by feeding the children and caregivers of severely ill people, which has positive implications for supporting caregiving networks in our country.

Despite research proving the efficacy of the MTM intervention, there are system-wide gaps in provision of this lifesaving, cost-saving service. 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. Similarly, while Medicare Advantage plans have the option to cover meals as a supplemental benefit for certain populations, Medicare Parts A and B provides no such coverage. As a result, most Medicare beneficiaries—approximately 38 million people—are not eligible for this cost-effective benefit.⁵ Innovative pilot programs made possible through the Affordable Care Act have

² 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.

³ Berkowitz SA, Terranova J, Hill C, Ajayi T, Linsky T, Tishler LW, DeWalt DA. Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. Health Aff (Millwood). 2018 Apr;37(4):535-542. doi: 10.1377/hlthaff.2017.0999

⁴ <https://www.fimcoalition.org/research1>

⁵ <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>

created opportunities to fund hospitals for referrals to social services agencies,⁶ but do not pay these agencies to deliver services, including meals and nutrition counseling.

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 people adversely affected by the epidemic of serious and chronic illness in our country, which disproportionately affects people 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. 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.

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 recommendations below, we identify a range of policy opportunities that we hope the DPC will consider and highlight in the upcoming White House Conference.

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

While the pilot and large-scale research recommendations described above provide important first steps in expanding access to MTM across the United States, they are not, alone, sufficient. Ultimately, to create widespread, equitable access, coverage of MTM services must be built into baseline benefits for healthcare programs such as Medicaid and Medicare. Supporting MTMs in the Medicaid statute as a benefit for people who are severely or chronically ill 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 permanently address enormous gaps in coverage, ensuring that MTMs are available to all Medicare enrollees who need them, rather than only to individuals 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. We therefore recommend that policymakers also begin to examine potential pathways for establishing widespread coverage. For example, federal legislators and agency officials should consider the following clarifications (legislative) or reinterpretations (administrative) to the sections of the Social Security Act governing Medicaid and Medicare benefits.

- **Establish coverage for medically tailored meals in Medicaid**
 - a. Include “medically-tailored nutrition” in the definitions of the mandatory “home healthcare services” benefit category.
 - b. Include “medically-tailored nutrition” in the optional “other diagnostic, screening, preventive, and rehabilitative services” category.
- **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.

⁶ <https://innovation.cms.gov/initiatives/AHCM>

2. Fully fund and implement large-scale MTM pilots in the Medicare and Medicaid programs

In line with the recommendation above, we also urge the Administration to proactively fund and implement large-scale MTM pilots in key healthcare programs such as Medicaid and Medicare. While not a long-term solution, large-scale pilot programs can be an important first step towards broader integration into healthcare delivery and payment systems. 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 Medicaid and Medicare. We therefore recommend the following:

- **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. 5370, the Medically Tailored Home Delivered Meals Demonstration Pilot Act of 2021,⁷ or through direct action through the Center for Medicare and Medicaid Innovation. Such a pilot would begin to address one of the largest access gaps for MTMs – Medicare Parts A and B.
- **Medicaid:** The Administration and Congress should provide technical assistance and guidance to promote state-based efforts to pilot coverage of nutrition-based interventions in the Medicaid program (e.g., through options such as 1915(c) Home and Community-Based Services Waivers, 1115 Demonstration Waivers, and Medicaid Managed Care pathways). In particular, we recommend that CMS publish formal guidance regarding the utilization of Medicaid Managed Care pathways, such as “in lieu of services” and value-based purchasing requirements, to promote access to and payment for MTMs. While these pathways are gaining traction in states such as California, New York, and Pennsylvania, they are underutilized nationwide, presenting an important opportunity to prompt action through clarification and technical assistance.

3. Expand Research on MTMs

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. Such studies would go far in advancing the case for expanding access to MTMs via both existing coverage opportunities and long-term policy change. We therefore recommend that the White House Conference consider recommendations that would create new funding and opportunities for multi-site MTM studies. Specifically, we recommend that (1) the National Institutes of Health (NIH) invest significantly more in multi-site MTM research and (2) CMS work with state Medicaid agencies to capture data on MTMs from ongoing large-scale natural experiments generated by program policy changes (e.g., Medicaid Section 1115 Demonstration Waivers). Finally, we also recognize that multiple federal agencies are currently engaged—or could be engaged—in MTM research (e.g., NIH, CMS, VA). To maximize alignment and coordination of these efforts, we recommend that the Biden Administration appoint a federal agency or entity to coordinate efforts across federal agencies to explore the impact of Food is Medicine interventions, including MTMs. (For more info on these recommendations, see the [Food is Medicine Research Action Plan](#) at pages 100-102).

4. Promote universal screening for food insecurity and malnutrition

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

⁷ <https://www.congress.gov/bill/117th-congress/house-bill/5370>

would need a more rigorous intervention like MTM.⁸ 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.⁹ We commend HHS and CMS for the steps they have taken to ensure that social needs screening becomes a widespread practice within the healthcare system, such as initiating the Accountable Health Communities model,¹⁰ but these changes could be made more universal through additional administrative action. In particular, we recommend that CMS:

- Finalize its proposed rulemaking that would require standardized food insecurity screening within all Medicare Advantage Special Needs Plans;
- Implement its recent proposal to include metrics related to screening for social risks (including food insecurity) and referral to services in Medicare Advantage Star Ratings;
- And identify further opportunities to expand screening for nutrition and food insecurity, such as through further clarification of Medicaid Managed Care regulations regarding care coordination requirements.

5. Increase nutrition education among healthcare providers

Doctors are often the most important voice in an individual's health and can be important gatekeepers/connectors to Food is Medicine interventions such as MTM. 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, 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 recommend that Congress and HHS consider the strategies outlined in this report and take concrete steps to improve nutrition education for physicians and other health professionals, including:

- Implementing the recently passed H. Res. 784,¹¹ to express the sense of Congress that medical schools and other health professional training programs should provide meaningful education on nutrition and diet; and
- Establishing grant funding for medical and other health professional schools to create or expand nutrition curricula, as proposed in previous Congresses through policies such as the Expanding Nutrition's Role in Curricula and Healthcare Act (ENRICH Act).¹²

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

As noted above, we are seeing some important progress towards the integration of MTM into healthcare delivery and financing through initial opportunities such as Medicaid Waivers and managed care flexibilities. However, as these efforts move forward, they have highlighted important gaps in healthcare infrastructure that must be addressed to allow organizations to properly bill and code for nutrition interventions. Some initial progress has been made on this front by the *Gravity*

⁸ 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.

⁹ 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.

¹⁰ <https://innovation.cms.gov/innovation-models/ahcm>

¹¹ <https://www.congress.gov/bill/117th-congress/house-resolution/784?r=73&s=1>

¹² Expanding Nutrition's Role in Curricula and Healthcare Act (ENRICH Act), H.R. 1888, 116th Cong. (2019).

Project,¹³ 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. However, there are still key steps that must be taken to truly allow information around the delivery and payment for nutrition interventions to be accurately represented in healthcare data systems. For example, no HCPCS or CPT billing codes currently exist to properly differentiate MTM from broader meal interventions. Furthermore, there are no codes to properly represent many other nutrition interventions—such as produce prescriptions and medically tailored groceries. We therefore recommend CMS and the American Medical Association develop specific, appropriate billing codes for these services.

7. Modernize Healthcare Regulation

Finally, we urge the DPC to bring attention through the White House Conference to the need to continue recent efforts to modernize regulations implementing federal healthcare laws such as HIPAA and the Civil Monetary Penalties Law provisions on beneficiary inducements. FIMC agencies have seen firsthand the way that uncertainties around the application of these healthcare regulations to community-clinical partnerships can create barriers to delivering MTM to individuals who need them most. For example, 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. The prior Administration's regulatory sprint to coordinated care initiative sought to ease barriers to social supports. However, finalization and expansion of these efforts to provide additional clarity, flexibility, and support is necessary to truly resolve barriers to innovation. Setting aside funding for technology infrastructure and capacity building so that community-based providers can steward data appropriately and participate meaningfully in clinical partnerships would be a concrete step toward true integrated systems change.

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 healthcare 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 the DPC, Congress, and federal agencies to bring our life-saving service to all those in need across the country. We hope that the White House Conference can be a catalyst to expanding this important work.

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.

¹³ <https://www.hl7.org/gravity/>

Sincerely,



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

Food Is Medicine Coalition Advisory Board

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cc:

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Representative Jim McGovern (MA-2), Chair, House Committee on Rules and Co-Chair, House Hunger Caucus

Senator Cory Booker (NJ), Member, Committee on Agriculture, Nutrition, and Forestry