The Medically Tailored Meal Sustainability Blueprint

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Food is Medicine Coalition (FIMC)

The Food is Medicine Coalition (FIMC) is the national coalition of nonprofit organizations that provide medically tailored meals (MTMs) and medically tailored groceries (MTGs), medical nutrition therapy, and nutrition counseling and education to people in communities across the country who are living with severe, complex, and chronic conditions. We advance access to these life-saving interventions through service, policy change, research and evaluation, and best practices. FIMC agencies created the medically tailored meal intervention as a response to community need over forty years ago and maintain the nutrition standards for the intervention. FIMC offers a community of learning for existing practitioners, equips new organizations to launch medically tailored meal programs, and accredits agencies against our fieldwide standard for MTM.

Center for Health Law and Policy Innovation

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy. CHLPI is comprised of the Harvard Law School Health Law and Policy Clinic and the Harvard Law School Food Law and Policy Clinic.

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The Medically Tailored Meal Sustainability Blueprint Subject Matter Experts and Advisory Group

The authors gratefully acknowledge the valuable insights and feedback provided by the subject matter experts and advisory group below. Their expertise and thoughtful contributions helped to sharpen the Blueprint throughout its development, as well as improve the overall applicability and rigor of the work. However, the views, interpretations, and conclusions expressed in this brief are solely those of the authors and do not reflect those of the subject matter experts, advisory group, or their affiliated institutions.

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Disclaimer

This report provides information and technical assistance on issues related to health reform, public health, and food law. It does not provide legal representation or advice. This document should not be considered legal advice. For specific legal questions, consult an attorney.

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Introduction

Diet-related chronic health conditions, including diabetes, heart disease, and cancer are the leading cause of mortality and morbidity in the United States, contributing to the deaths of nearly 1.5 million people each year and accounting for approximately 85% of our $4.5 trillion in annual healthcare expenditures.[1] Food is Medicine (FIM) interventions have emerged as an important component of state and federal strategies to prevent and respond to the root causes of chronic disease and complications of severe and complex conditions, as well as rising healthcare costs and other multifaceted priorities.[2] FIM is defined as the provision of healthy food such as medically tailored meals, medically tailored groceries, and produce prescriptions to treat or manage specific clinical conditions in a way that is integrated with and paid for by the health care sector.[3]

A Need for Sustainability, Standardization, and Clarity

While a growing body of evidence demonstrates that FIM interventions can be a cost-effective approach to treating, managing, and/or preventing diet-related chronic disease, funding to support these services has historically been provided on a limited or pilot basis through public and private grant funding. Programs in several federal agencies, such as the Ryan White HIV/AIDS Program, the Older Americans Act Nutrition Program, and the Center for Medicare and Medicaid Innovation Value-Based Insurance Design Model, all housed within the U.S. Department of Health and Human Services (HHS); the U.S. Department of Agriculture's Gus Schumacher Nutrition Incentive Program Produce Prescription Program; and the Indian Health Service's Produce Prescription Pilot Program, have or do provide vital pilot and grant funding to seed and build capacity for programs providing FIM interventions.[4] Still, pilot and grant funding can limit the availability, reach, and sustainability of these life-saving and preventive healthcare services.

Project Angel Food

As the burden of diet-related chronic disease has grown and our healthcare system has begun to shift towards value-based care, insurers and healthcare systems are increasingly integrating food- and nutrition-related benefits into healthcare delivery and insurance coverage.[5] Healthcare payment provides greater promise of service availability for patients, program sustainability for providers, and cost efficiencies for the system.

However, as a natural consequence of this evolution, regulators, payers, and FIM providers have faced challenges in defining coverage requirements, credentialing providers, and appropriately pricing services across jurisdictions.[6] In sum, stakeholders have faced roadblocks in successfully transitioning FIM interventions from pilot- and grant-funded programs to healthcare reimbursement structures.[7] This has led to potential variation in service and provider quality across and within jurisdictions and systems. Lack of standardization across varied grant programs, and lack of clarity regarding standards in healthcare systems has also led to inefficiencies as stakeholders must repeatedly invest time and funds to develop answers to common questions (e.g., target populations, nutrition standards, screening and assessment, and appropriate providers) across different partnerships, threatening sustainability.

The Sustainability Blueprint: A Starting Place for Fieldwide Success

Open Arms Minnesota

The purpose of the Sustainability Blueprint is to outline a pathway to sustainable access and quality standardization for FIM interventions, starting with the medically tailored meal intervention (MTM). Specifically, the Blueprint starts with the legal framework that federal and state agencies use to define quality for all Medicaid covered benefits and uses these legal concepts to articulate guardrails for program design that can better ensure program quality and sustainability over time. The idea is that if we start with this consistency in current innovation projects, we will be better able to incorporate the services into the requirements of healthcare in the future.

The Sustainability Blueprint Process

The development of this Blueprint followed a rigorous and inclusive process to ensure that it reflects expert input, the latest clinical research, and on-the-ground perspectives.

Open Hand Atlanta

Phase I - Scoping: This project began with outlining the MTM intervention, the current evidence base, and policy implementation considerations, with assistance from subject matter experts. The Food is Medicine Coalition (FIMC)—the national coalition of nonprofits that created the MTM intervention[8]—has already made significant progress creating guardrails for quality service. FIMC released the first-ever accreditation standard for MTMs, the Food Is Medicine Coalition Medically Tailored Meal Intervention Accreditation Criteria and Requirements (FIMC MTM ACR), which fully defines the MTM intervention and ensures non-profit providers who are accredited under the standard provide a high-quality MTM intervention suitable for patients' conditions.[9]

Phase II - Advisory Group: The authors partnered with a diverse Advisory Group—including FIM practitioners, healthcare payers, healthcare providers, researchers, coding and terminology experts, actuaries, consumer advocacy groups, and others—to provide critical guidance and review throughout the drafting process.

Phase III - Public Comment: A public comment phase was conducted to invite feedback from stakeholders, practitioners, and community members, allowing for broader input and transparency.

Phase IV – Final Blueprint: Insights from all phases were carefully considered in producing this final brief.

Next Steps: The authors will continue to refine the Blueprint process, update this document as needed, and outline the legal frameworks that regulators use to define quality for covered benefits in other insurance systems—including Medicare and commercial insurance—and use these legal concepts to articulate guardrails for MTM program design that can better ensure program quality, integrity, and sustainability over time.

We acknowledge that there are related fields, interventions, and providers implicated by the topics raised in the Blueprint. While the narrow focus of this iteration of the Blueprint is the MTM intervention, the goal of the Blueprint is to create a framework that other FIM interventions can use to outline a similar pathway for sustainable access.[10] Likewise, the Blueprint is using Medicaid as a starting legal framework because the program has been a prominent space for large-scale healthcare integration of MTM and FIM, and the federal/state partnership aspect of the program is useful in outlining layers of fiscal and regulatory responsibility.[11] However, again, the goal of the Blueprint is to create a framework adaptable to other healthcare funding pathways, including Medicare and commercial insurance.

Defining the Medically Tailored Meal Intervention

The Medically Tailored Meal (MTM) intervention is the comprehensive process of delivering meals to individuals living with severe, complex or chronic condition(s) using therapeutic, evidence-based dietary specifications for condition(s), based on an assessment of the individual's nutrition needs by a Registered Dietitian Nutritionist (RDN) or other nutrition professional, as defined by applicable state law.

Patient referrals to MTM providers originate from a variety of sources, however, client eligibility is verified through the involvement of healthcare personnel via confirmation of medical diagnoses using the most current International Classification of Diseases (ICD) diagnosis codes or medical necessity as determined by healthcare authorization. Once the eligibility assessment is complete, an intake and nutrition risk screening is conducted by the MTM provider. After onboarding, an RDN or other nutrition professional conducts a nutrition assessment, which leads to the determination of the meal and care plan tailored for the circumstances of the client. Meals are prepared according to therapeutic, evidence-based nutrition guidelines for specific medical conditions, such as FIMC's publicly issued Medically Tailored Meal Nutrition Standards.[12] Meals are home-delivered, shipped, or available for pick-up. Patients may receive meal services prior to completion of the nutrition assessment when needed to address acuity, with the subsequent assessment adjusting the meal service. The patient has ongoing access to medical nutrition therapy (MNT), nutrition counseling, and nutrition education throughout the term of service and is reassessed for eligibility and nutrition need at least annually.

For use in healthcare billing and coding, the Food is Medicine Coalition recommends the following description of an MTM: a meal, providing an estimated 1⁄3 of the recommended dietary intake(s), per therapeutic, evidence-based dietary specifications for conditions, assigned based on an assessment of the individual's nutritional needs by a RDN or other nutrition professional, intended for use in non-facility/home settings. This description is consistent with the MTM code submission from the Coding4Food (C4F) project, a community-informed initiative aiming to create new Healthcare Common Procedural Coding System (HCPCS) codes to define a spectrum of FIM interventions in a consensus-building process with experts from across the country, facilitated by the Gravity Project.[13] The individualized assessment by an RDN, subsequent care plan and ongoing management may constitute the provision of MNT, nutrition counseling, or nutrition education as defined by applicable state law.[14]

Project Angel Food

MTMs, and other FIM interventions, are distinct from, but complementary to, efforts to support enrollment or participation in federal and state safety net programs, as well as programs that address social determinants of health (e.g., housing, education, transportation, social services). FIM directly responds to challenges with accessing and consuming foods that are indicated for conditions, which are a major barrier to population adherence to dietary recommendations. FIM interventions also respond to public demand for participating in programs that provide healthy foods to prevent, manage, and treat many diseases.[15]

The Need for the Medically Tailored Meal Sustainability Blueprint

Despite a growing body of evidence demonstrating that the MTM intervention is a cost-effective approach to treating, managing, and/or preventing severe, complex and chronic diseases, with limited exceptions, the Centers for Medicare & Medicaid Services (CMS) has not explicitly allowed states to cover the direct provision of food under any established Medicaid benefit category. States have been able to provide Medicaid coverage for MTMs and other FIM services through waivers and other legal flexibilities.[16] Although these legal flexibilities create only temporary access, they have historically laid the groundwork for integrating innovative services into standard coverage pathways.

Past experience has also shown that if the legal frameworks governing covered benefits are not considered at these early stages, interventions may find themselves struggling to evolve and meet the requirements of sustainable healthcare funding streams. Healthcare delivery and financing are heavily regulated, and existing law, regulation, and guidance establish quality standards to which all healthcare services and providers are subject.

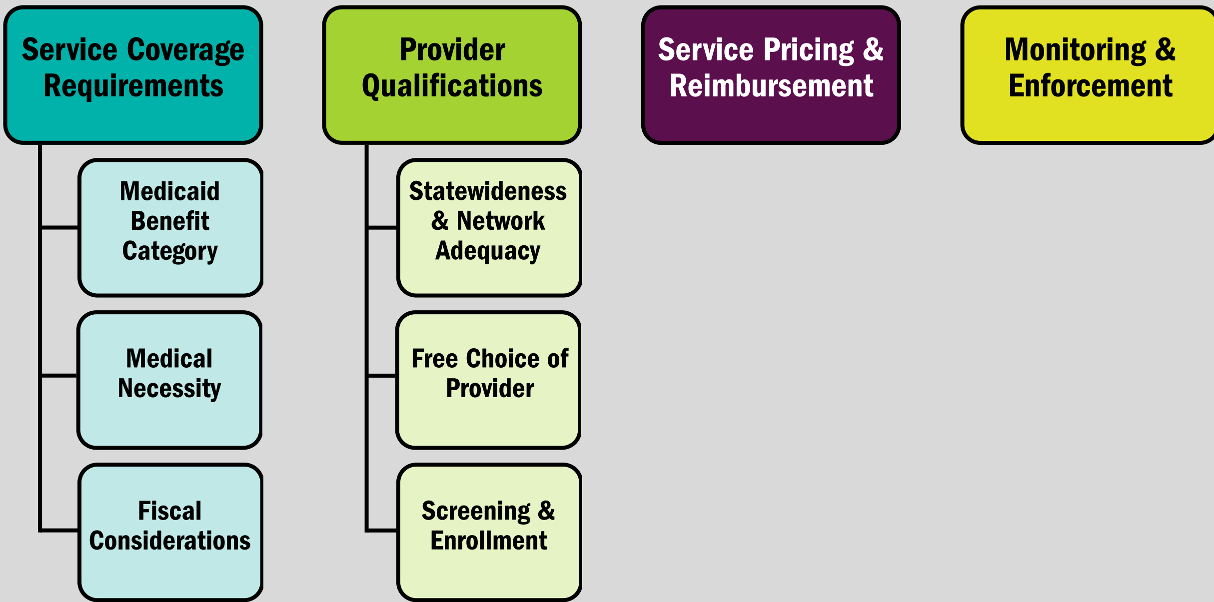
By outlining these standards from the outset, FIM providers, regardless of funding source, can operate under more uniform standards across programs and jurisdictions, with the goal of using resources efficiently should these providers choose to pursue sustainable healthcare funding and coverage in the long term.

Food & Friends

The purpose of the Food is Medicine Coalition Medically Tailored Meal Sustainability Blueprint is to outline a pathway to sustainable access and quality standardization for FIM interventions by defining the necessary elements for the MTM intervention to transition from grant, pilot, and waiver funded services to sustainable healthcare funding and coverage pathways.

The Blueprint outlines the necessary elements for MTMs to chart this course over time. Through the four main sections of this Blueprint, we assess the baseline legal requirements in four categories that Medicaid programs apply to covered benefits and their associated delivery systems:

(1) Service Coverage Requirements
(2) Provider Qualifications and Requirements
(3) Service Pricing and Reimbursement
(4) Monitoring and Enforcement

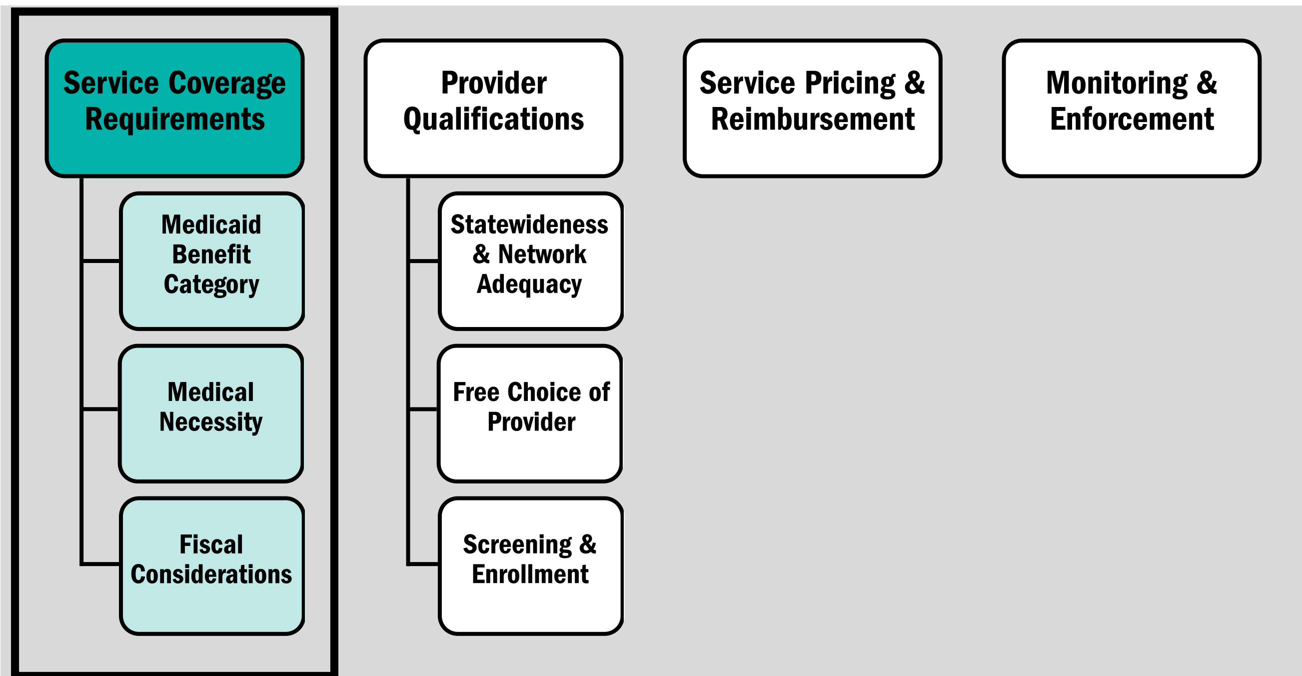


We then apply these requirements to the MTM intervention, taking into account current evidence and practice, to identify and recommend approaches to benefit design, service delivery eligibility, and other elements of program development. In doing so, we aim to assist stakeholders at any stage of implementation—from pilot, to large-scale research, to plan or state-level coverage—in thinking through how programs being designed *now* can better prepare to meet *future* requirements as they launch, scale, and move towards coverage over time.

Section 1:
Service Coverage Requirements

Federal law requires states to provide Medicaid coverage for certain mandatory benefits and allows states to cover other optional benefits through the state plan process. States then determine the type, amount, duration, and scope of services within federal guidelines.[17]

The Blueprint examines three concepts that help to define the bounds of how a state and other relevant stakeholders shape service coverage via these determinations: (A) Medicaid benefit category; (B) Medical necessity, and; (C) Fiscal considerations.



A) Medicaid Benefit Category

To be covered, a service must fall within 17 enumerated mandatory benefit categories, 27 enumerated optional benefit categories, and/or be approved by the Secretary of Health and Human Services.[18] Within each of these categories, services must be delivered in accordance with existing eligibility criteria and processes.

New benefits can be added if:

Advocate with Congress

(1) Congress amends the Social Security Act to add a service to an existing mandatory or optional benefit category, or to add a new benefit category (or by directing the Secretary of HHS to do so),

Advocate with CMS

(2) CMS interprets an existing mandatory or optional benefit category to include a new service through administrative rulemaking, and/or

Advocate with a State

(3) a state submits a state plan amendment (SPA) and CMS approves the state to cover a new service within an existing mandatory or optional benefit category.[19] Unless otherwise prescribed by Congress or CMS, states do not need to choose the same benefit category under which to add a new service benefit via a state plan amendment.[20]

How to Apply This Section of the Blueprint: As states, plans, and other stakeholders develop MTM programming, it can be useful to consider how MTMs could fit within these categories at the outset. By doing so, stakeholders can better account for the specific regulatory parameters of the category (e.g., eligibility, service delivery) when developing strategies for overall service coverage requirements and benefit design.

The Blueprint identifies three existing Medicaid benefit categories into which MTMs may fall (subject to potential need for regulatory amendment), including the "catchall" provision allowing for coverage of services approved by the Secretary of HHS:

I. Home Health Services, Mandatory Benefit Category, 42 U.S.C. 1396d(a)(7), 42 C.F.R. 440.70, 441.15

II. Other Diagnostic, Screening, Preventive, and Rehabilitative Services, Optional Benefit Category, 42 U.S.C. 1396d(a)(13), 42 C.F.R. 440.130

III. Any Other Medical Care, And Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary, Optional Benefit Category, 42 U.S.C. 1396d(a)(30), 42 C.F.R. 440.170

More information on each of these categories is included below.

(I) Home Health Services, Mandatory Benefit Category:

Mandatory benefits for home health services include nursing, home health aide, and medical supplies, equipment, and appliances suitable for use at home. States also have the option to include benefits for physical therapy, occupational therapy or speech pathology, and audiology services.[21]

Home health services must be prescribed by a physician and reviewed every 60 days. State Medicaid plans must cover these services for all individuals 21 years of age or over in the categorically needy eligibility group, for individuals under 21 years of age in the categorically needy eligibility group if the state plan provides nursing facility services for that group, and for all medically needy individuals for whom skilled nursing facility services are provided under the state plan. These services must be provided at the recipient's place of residence and the eligibility of a beneficiary to receive home health services cannot depend on their need for or discharge from institutional care.

While MTMs could be considered "medical supplies" under existing regulations and guidance,[22] allowing potential coverage with a state SPA submission and CMS approval, the home health services regulations may need to be amended by CMS to require coverage of MTMs as a mandatory benefit within this category more broadly.[23]

Open Arms Minnesota

(II) Other Diagnostic, Screening, Preventive, and Rehabilitative Services, Optional Benefit Category:

Relevant here, optional benefits for diagnostic, screening, preventive, and rehabilitative services include (a) clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;[24] and (b) any medical or remedial services recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[25]

Within this category, **preventive services** are further defined as those that are provided to (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and mental health and efficiency.[26]

- Preventive services must directly involve patient care for the express purpose of addressing physical or mental health. CMS takes care to note that "[w]hile a social service, in the course of addressing an individual's basic life needs (adequate food, housing, income, etc.), may indirectly affect the individual's health as well, it would not be covered under Medicaid because it is not in itself directly and primarily concerned with the individual's health."[27] Thus, it is important to note that MTMs (and other FIM interventions) are distinct from the general provision of food and the social services that provide for such, even though it is well-understood that access to food can improve individual and community health. MTMs, by contrast, are a generally limited-duration nutritional service administered to severely ill individuals at the direction of a medical provider. They are directly tied to an explicit health condition and need. As a result, the question of whether MTM services can be covered by Medicaid requires a distinct analysis from the question of whether regular social service provision could be similarly encompassed within this benefit category.
- As noted in The State Medicaid Manual, there is currently no uniformly accepted nationwide standard that specifies a single set of preventive services, or a particular schedule for their delivery. However, CMS has delineated general criteria for evaluating proposed state plan amendments for preventive services coverage. For example, CMS notes that the proposed services must "[n]ot entail an additional payment for a service which is logically an inherent part of otherwise paid-for services" such as a physician providing counseling of a preventive nature, which is already included in the physician services benefit.[28]

Rehabilitative services are further defined as services that are provided for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.[29] This is a flexible benefit category that has been widely used in state plan amendments, including to provide services to beneficiaries living with cancer and HIV.[30]

States could submit a SPA to cover MTMs as optional other diagnostic, screening, preventive, and rehabilitative services without regulatory amendment.

(III) Any Other Medical Care, And Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary, Optional Benefit Category:

For maximum flexibility and tailoring, the Secretary of the Department of Health and Human Services can specify that MTMs be covered by Medicaid as an optional benefit, and/or states could submit a state plan amendment to cover MTMs as an optional benefit.[31] This provision has been used to allow coverage for a variety of services such as transportation and costs associated with participation in a clinical trial.[32]

As shown through these summaries, the options for MTM coverage vary in their scope and flexibility. Stakeholders should therefore consider whether a particular approach may be most likely in their state in the long-term, as some benefit categories may impact program eligibility (e.g., home health services) or goals (e.g., preventive services), while others (e.g., other care specified by the Secretary) may have less impact on program design.

(B) Medical Necessity

To further refine the reach of an MTM benefit, stakeholders can look to the concept of **medical necessity.** Federal law does not explicitly define the eligibility, scope, or the target population(s) for each Medicaid-covered service. Rather, states must establish reasonable standards that are comparable across all Medicaid groups, with some additional limitations. A service must be provided so that it is "sufficient in amount, duration, and scope to reasonably achieve its purpose."[33]

To date, MTMs and other FIM services have been covered under experimental, pilot, and temporary legal flexibilities, such as Medicaid 1115 demonstrations and 'in lieu of services and settings,' and have not yet been subjected to medical necessity standards for fully covered Medicaid services. For a service to be incorporated into a state's Medicaid program as a permanent, fully covered benefit, a SPA must specify the amount, duration, and scope of each service provided for each covered Medicaid group.[34] Generally, this requirement is understood to mean that states must cover medically necessary treatment in an amount sufficient to adequately meet the needs of the Medicaid population of the state, interpreted as most individuals who are eligible for Medicaid,[35] and particular conditions cannot be singled out for coverage or restriction.[36] Because state Medicaid programs must generally cover all medically necessary treatment for all eligible Medicaid beneficiaries for designated services, with limited controls, this requirement often carries significant budgetary implications.

Instructive here, the American Medical Association defines medical necessity as "health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

C. Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider."[37]

States can place additional "appropriate limits" on covered services based on **utilization control procedures** "as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan".[38] Common utilization control procedures include prior authorization, concurrent review, retrospective review, step therapy, and decision support tools. In contrast to medical necessity criteria, utilization control procedures, may limit the provision of services.[39] However, any limiting criteria must ultimately "assur[e] that individuals will receive necessary medical care."[40]

Project Angel Food

How to Apply This Section of the Blueprint: As a starting point for defining service **eligibility**, **scope**, and/or the **target populations** for MTM programs, stakeholders should consider current clinical evidence to determine where provision of MTMs may be medically necessary for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms. By beginning with definitions grounded in current clinical evidence, stakeholders can build MTM interventions and programs that can be logically integrated into healthcare frameworks, which utilize these medical necessity standards. However, stakeholders should recognize that the concept of medical necessity is flexible and clinical evidence is evolving,[41] allowing decisions on issues such as target populations to adapt as the evidence evolves. Stakeholders can therefore also see this section of the Blueprint as a useful tool to identify where they may be able to contribute to the research base to fill gaps where more evidence is needed to deepen the understanding of medical necessity for MTMs. Finally, while both the Blueprint and service eligibility, scope, and target population definitions may appear exhaustive, they are not: patient-centered clinical judgement is key to informing patient-level medical necessity and eligibility for healthcare services, including MTMs.

To recommend the evidence-based circumstances under which MTMs may be considered medically necessary for treatment or prevention, the Blueprint process focused on the strongest current clinical evidence—large randomized controlled trials (RCTs) and quasi-experimental studies—in order to align medical necessity recommendations with the current "generally accepted standards of medical practice." To identify the conditions for which there is currently clinical evidence and/or generally accepted standards supporting MTMs as medically necessary, we first relied on large RCTs (i.e., trials adequately powered to detect change in outcomes; excluding small, feasibility, or pilot trials) published in peer-reviewed journals in the United States that found improvements in clinical outcomes or healthcare utilization.[42] Randomized trials are the gold standard in medical care and are typically required for approving new treatments and therapies. Additionally, evidence from clinical trials aligns with the decision-making of a prudent physician.[43] The Blueprint identified patient populations from these RCTs as *priority populations* for MTM benefit eligibility.

There is also strong and meaningful evidence from quasi-experimental studies to guide medical necessity recommendations. These studies tend to be larger, offer MTMs for longer time periods, enroll a wide range of patients, and are more generalizable. Importantly, several have been conducted in Medicaid. For example, Medicaid 1115 demonstration waiver evaluations from Massachusetts and North Carolina have shown significant improvements in healthcare utilization and costs among FIM recipients. Findings from these studies, which were conducted in major state-level Medicaid demonstrations that transformed clinical care, support a finding of "generally accepted standards."[44] Findings from these quasi-experimental studies identified patient populations that are *likely to benefit* from MTMs. A state could reasonably choose to include these patient populations in MTM benefit eligibility.

God's Love We Deliver

As of June 2025, 14 peer-reviewed studies conducted in the United States evaluated changes in health outcomes and healthcare utilization among MTM recipients and compared those changes to a control/comparison group.[45] These studies include RCTs—which offered a range of MTM program dose and duration, typically for a single diagnosis of interest within a highly focused clinical population—and quasi-experimental studies—which tended to offer longer, more robust MTM programs across multiple diagnoses. Five studies evaluated condition-specific clinical outcomes, and nearly all (13 out of 14) assessed changes in healthcare utilization or costs.[46] All studies were conducted in the United States and published in peer-reviewed, scientific journals. MTM studies that did not include a comparison group or evaluated impacts only on diet, food insecurity, or other patient-reported outcomes were excluded.

The current clinical evidence is outlined in *Annex A: Evidence for Health Benefits in Peer-Reviewed Medically Tailored Meal Studies.*

Medical Necessity Recommendation for Medically Tailored Meals

MTMs are a healthcare service, and as such, must be recommended by a physician or other licensed or certified practitioner of the healing arts (e.g., RDNs, nurses, licensed social workers, or community health workers) acting within their scope of practice under state law[47] to be eligible for Medicaid reimbursement.

Acknowledging that it can be challenging to align clinical evidence within the legal framework of medical necessity, the Blueprint selected a conservative approach in describing the conditions with the current strongest clinical evidence for medical necessity as determined by RCTs.

Based on the current state of clinical evidence and legal framework for medical necessity, Medicaid programs should cover MTM services for beneficiaries who:

1. Have a diagnosis of heart failure, **or** human immunodeficiency virus (HIV); **and**
2. Are at risk for nutritional deficiency, as measured by having food insecurity or nutrition insecurity (e.g., screen positive for food insecurity using the validated 2-item Hunger Vital sign or validated 1-item nutrition insecurity screener),[48] **or** are clinically diagnosed for malnutrition.

The following conditions are very likely to benefit from provision of MTMs given their inclusion in quasi-experimental studies that found improvements in healthcare utilization. The clinical evidence for the conditions in this secondary category, and others, is growing. As mentioned above, states and payers have the ability to expand their definitions of medical necessity as evidence and standards of practice evolve.

Based on the current state of clinical evidence and legal framework for medical necessity, Medicaid programs should consider covering MTM services for additional beneficiaries who are likely to benefit, including those who:

1. Have a diagnosis of uncontrolled diabetes, **or** stage 3-5 chronic kidney disease, **or** cardiovascular disease, **or** cirrhosis, **or** high-risk pregnancies, in particular gestational diabetes and pre-eclampsia; **and**
2. Are at risk for nutritional deficiency, as measured by having food insecurity or nutrition insecurity (e.g., screen positive for food insecurity using the validated 2-item Hunger Vital sign or validated 1-item nutrition insecurity screener),[49] **or** are clinically diagnosed for malnutrition, **or**
3. Are clinically diagnosed for malnutrition, **and** are experiencing food insecurity (e.g., screen positive for food insecurity using the validated 2-item Hunger Vital sign).[50]

Additionally, in the current clinical studies, many, but not all, MTM participants were living with activities of daily living (ADL) and/or instrumental activities of daily living (IADL) limitations. Medicaid programs could consider including this factor in designing eligibility criteria or utilization control procedures, which may allow states to focus on high-need populations (e.g., eligible individuals who cannot shop or cook independently) where necessary, with caution not to unduly limit access for other populations for whom MTM is indicated but for whom ADL/IADL limitations are less common (e.g., eligible individuals living with high-risk pregnancies).

Finally, we recommend that stakeholders look to this same evidence base in establishing the appropriate dose and duration for the MTM service. Based on the current state of clinical evidence, Medicaid programs should cover MTM services:

I. For a minimum of 6 months with at least 10 meals per week and tailored by an RDN, or other nutrition professional, to meet the diagnosis-specific nutrition guidelines.

II. The beneficiary's physician or other licensed or certified practitioner of the healing arts should reassess the beneficiary for continued medical necessity/eligibility for MTM receipt and renewal.

III. Home delivery is preferred to assist those with ADL/IADL limitations.

(C) Fiscal Considerations

One way that a state can add coverage of a new service to its Medicaid program is with submission of a SPA and CMS approval to cover the service within an existing mandatory or optional benefit category.[51] SPAs can be used to amend the Medicaid state plan—the agreement between a state and the federal government outlining how the state will administer its Medicaid program.[52] Proposed changes, including proposals to add or modify covered benefits, must comply with federal requirements.[53] The addition of new Medicaid benefits is not contingent on any federal budgetary requirements or cost analyses. However, when submitting a SPA to add a new covered service, states are required to indicate the expected federal financial impact.[54]

Generally, actuaries are engaged to assist state Medicaid agencies in calculating the expected federal financial impact of a proposed new or modified Medicaid benefit, as well as expected state financial impact and other cost projections, policy analyses, and risk assessments that may impact decision-making.[55] Actuaries utilize mathematical, statistical, economic, and financial approaches to create projection models about a program or policy's expected impact based on historical information, expected future changes, and assumptions about how the program works. Actuaries developing these analyses consider many data inputs and factors. The actuarial standards of practice (ASOPs) are key resources guiding actuaries' decision-making, including risk classification, data quality and credibility, as well as communication of the work to intended users and the development and use of models.[56]

How to Apply This Section of the Blueprint: As states, funders, program implementers, and other stakeholders develop MTM programming, it can be useful to consider ways to design the intervention and program evaluation to collect the data needed to **measure, model, and predict expected financial impact**. This type of planning at early stages can allow MTM programs, regardless of funding source, to operate under more uniform standards and use resources more efficiently in the short term, while developing the data needed to ultimately support sustainable healthcare funding and coverage in the long term.

There are several main categories of information states, actuaries, and other stakeholders need in order to make calculations regarding financial impact:[57]

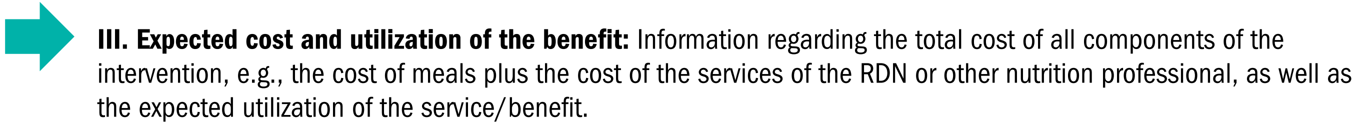
I. Information about the target population: A description of the service/benefit target population(s), including basic demographics such as age, gender, and geographic area; and any key social factors such as income, education, or working status.

II. Expected benefit impacts: A description of how the service/benefit is expected to impact the utilization of existing healthcare services. For example:

a. Is the proposed MTM service/benefit expected to increase or decrease other healthcare services, such as primary care visits, specialty visits, emergency department visits, inpatient hospitalization, or drug utilization?

b. What is the expected timeframe for these impacts to occur? For example, is the change in utilization expected to happen in weeks, months, or years?

The analysis will utilize any literature-based evidence or results from demonstrations of similar programs, including from other states, to support the expected impacts. Actuaries will evaluate whether that evidence is from a comparable population or if adjustments are needed. This information should be provided at a level of detail that is sufficient to demonstrate evidence for the service/benefit for the covered population. For a SPA, the covered population includes all Medicaid recipients in that state.

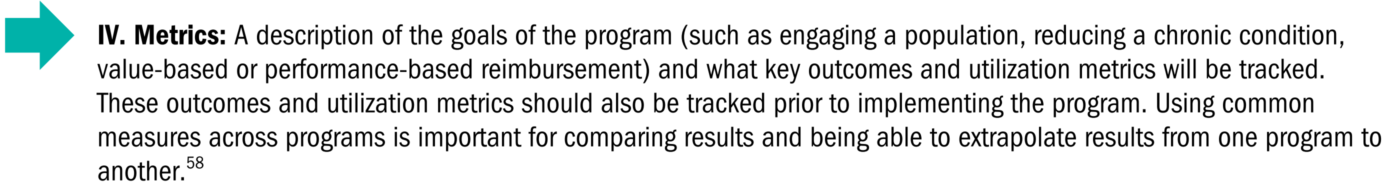


III. Expected cost and utilization of the benefit: Information regarding the total cost of all components of the intervention, e.g., the cost of meals plus the cost of the services of the RDN or other nutrition professional, as well as the expected utilization of the service/benefit.

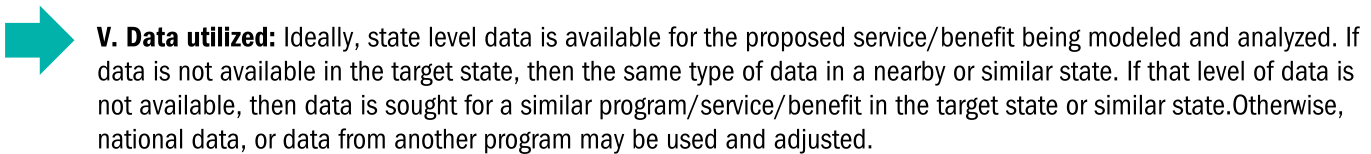
a. Are all individuals in the targeted population expected to join and be eligible for services or only a certain percentage?

b. Are all eligible individuals expected to utilize the service/benefit for the full length of the program or are some people expected to drop out of the program?

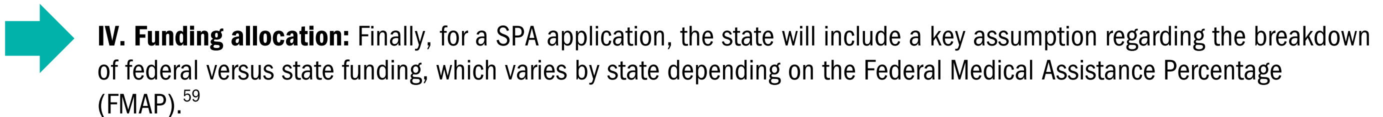
c. Which populations are expected to benefit the most from the service/benefit?



IV. Metrics: A description of the goals of the program (such as engaging a population, reducing a chronic condition, value-based or performance-based reimbursement) and what key outcomes and utilization metrics will be tracked. These outcomes and utilization metrics should also be tracked prior to implementing the program. Using common measures across programs is important for comparing results and being able to extrapolate results from one program to another.[58]



V. Data utilized: Ideally, state level data is available for the proposed service/benefit being modeled and analyzed. If data is not available in the target state, then the same type of data in a nearby or similar state. If that level of data is not available, then data is sought for a similar program/service/benefit in the target state or similar state.Otherwise, national data, or data from another program may be used and adjusted.



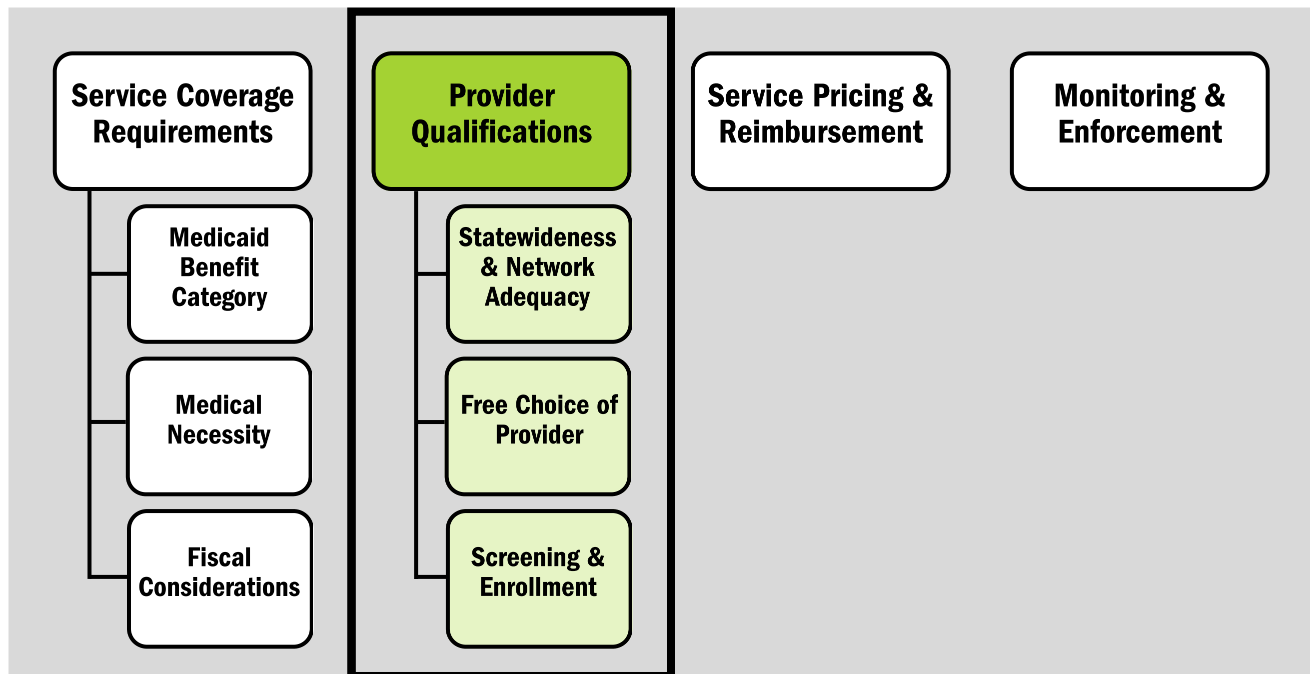
IV. Funding allocation: Finally, for a SPA application, the state will include a key assumption regarding the breakdown of federal versus state funding, which varies by state depending on the Federal Medical Assistance Percentage (FMAP).[59]

As noted in an American Academy of Actuaries issue brief: “Pricing new health benefits can be challenging”, with the sources of data relied upon in making assumptions having potential significant effects on projections.[60] External structural, industry, and policy factors can also affect projections. For example, most health insurance policies renew—and thus actuarial calculations are made—on a yearly basis and do not incorporate expected future costs or savings. This means that even though some benefits, such as preventive care, could reduce health costs in future years, those savings may not be used in calculations to predict the financial impact of the benefit. Additionally, because beneficiaries tend to change insurance and plan enrollment over time, future savings could accrue to different payers in a managed care context, creating a further barrier to using future savings to offset current spending.[61] While actuarial modeling can sometimes account for such externalities, in these cases, it can be useful to broaden the focus of “program impact” to note areas of offsetting costs and benefits not accounted for in traditional modeling—for example, future year cost savings, quality of life improvements, workforce productivity gains, economic multipliers, and savings in other areas of state budgets.[62]

Section 2: Provider Qualifications and Requirements

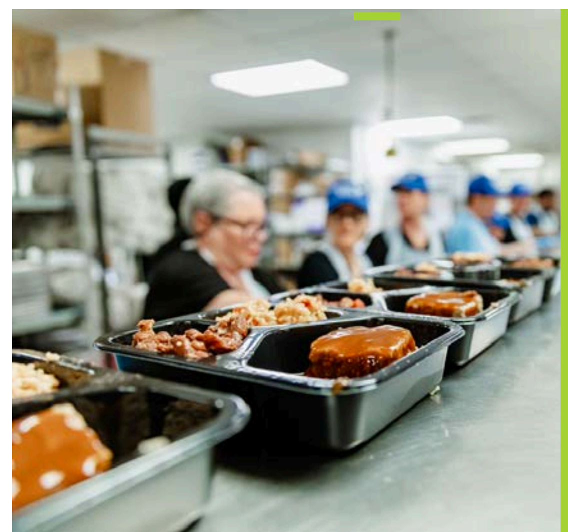
For every covered Medicaid service, federal law requires that an adequate network of screened, verified, and properly enrolled Medicaid providers be able to provide sufficient access to services throughout the state.

The Blueprint examines three concepts that help to define and shape provider qualifications and requirements in Medicaid: (A) Statewideness and Network Adequacy; (B) Free Choice of Provider; and (C) Provider screening and enrollment.



(A) Statewideness and Network Adequacy

Federal law requires the Medicaid state plan to be "in effect in all subdivisions of the state" and "continuously in operation" throughout the state.[63] This means services must be available to all beneficiaries, regardless of where they live in the state. Importantly, this does not mean that every Medicaid provider must offer services statewide, rather that the network of Medicaid providers must be able to reach throughout the state and the state cannot place limits on services based on geography. Relatedly, federal law requires that Medicaid managed care plans ensure provider network adequacy and availability. This means that health plan provider networks must be sufficient to provide adequate access to all covered services, taking into account the number, type, and geographic distribution of providers.[64]



Project Angel Food

How to Apply This Section of the Blueprint: Historically, MTM services have been provided by a range of providers, including community-based organizations, some Older Americans Act nutrition network providers, and more. As stakeholders develop a framework for MTM benefit coverage, investigating whether a network of MTM providers can adequately provide services on a statewide basis to the Medicaid population is an important question. This section of the Blueprint can help stakeholders **understand the details of Medicaid's network requirements** and the flexible ways states, payers, and MTM providers are already meeting patient need, as well as areas for growth and investment. MTM providers—both community-based and commercial—may lack experience navigating complex Medicaid or managed care requirements to fulfill statewide delivery, but an understanding of these requirements at the outset can help stakeholders develop infrastructure, such as contracting and other guidance, training, IT infrastructure, and hub models that can support provider network requirements and scale.

States have a variety of options to meet the statewideness requirement using methods that support geographically complete service delivery. In some cases, statewideness can be accomplished by nonprofit agencies or commercial entities that can individually provide statewide service. For example, MTM providers may leverage telemedicine for the initial intake, eligibility assessment, nutrition risk screening, and nutrition assessment with an RDN. To reach geographies that are further afield, providers have developed sophisticated, food-safe MTM shipping programs in addition to delivery.

Open Hand Atlanta

More often, statewideness is fulfilled by establishing a network of MTM providers that can collectively provide service to people living across the state. To ensure compliance with these standards, the state Medicaid agency may require managed care plans to guarantee they are contracted with a threshold number of providers to cover the state. For example, in New York State's Medicaid Managed Long Term Care (MLTC) program, the state requires that its managed care plans contract with at least two (2) different providers of meals (or other services) within a given county, "unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department."[65]

Likewise, states can use a variety of methods to comply with network adequacy requirements, including travel time or distance standards, minimum provider ratios, and appointment wait-time standards.[66] Similar requirements have already been applied to MTM and like providers under Medicaid 1115 demonstrations. In Massachusetts, Accountable Care Organizations (ACOs) contract with health-related social needs (HRSN) providers for the delivery of nutrition supports. For each service, the Medicaid agency sets a variety of network adequacy requirements, including that ACOs must contract with at least one provider located in Massachusetts, though they may need to contract with additional providers to guarantee service.[67] In California, the state requires managed care plans to report information on MTM and similar providers quarterly to monitor network adequacy.[68]

Other innovative FIM models have achieved statewideness and network adequacy through the establishment of hub contracting models. The current New York Medicaid 1115 demonstration established Social Care Networks (SCNs), which are responsible for coordinating systems of HRSN providers in given geographies. The SCN Lead Entity handles contracting between managed care organizations and care providers in the community.[69] Specific state requirements ensure that SCNs create networks that are diverse in size and scope, prioritize the inclusion of community-based organizations, and ensure timely patient access to service.[70]

Implementation Resources: For state and program implementation examples to illustrate recent approaches and geographic variations in strategy to address patient nutrition needs in Medicaid and Children's Health Insurance Program (CHIP) programs, see Food is Medicine: A State Medicaid Policy Toolkit (July 2024).

(B) Free Choice of Provider

Under federal law, Medicaid beneficiaries are allowed to obtain Medicaid services from "any institution, agency, community pharmacy, or person, qualified to perform the service or services required" that is willing to provide the services.[71] There are exceptions for enrollees in Medicaid managed care and other Medicaid flexibilities, who can be limited to the managed care plan's provider network, except regarding family planning providers.[72] The provider must meet, and the state can limit participation according to, Medicaid qualifications and standards set by the state.[73] However, because the free choice of provider provision guarantees Medicaid beneficiaries the right to see any willing and qualified provider of their choice, the state's authority to establish qualification standards or take certain actions against a provider is limited, unless those standards or actions are related to the fitness of the provider to perform covered medical services.[74] In other words, state action against a provider that affects beneficiary access must be supported by evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them.[75] Even in delivery systems in which free choice of provider has been waived to require enrollees to receive certain services via a network of providers—e.g., managed care—these networks must be sufficient to provide adequate access to all covered services.[76]

How to Apply This Section of the Blueprint: As stakeholders consider how to define providers of MTM services in their own programs, it can be helpful to consider the free choice of provider requirement. For example, stakeholders can first focus on provider fitness to perform the covered service and then consider how additional qualification criteria may be added in contexts where free choice of provider has been waived (e.g., in managed care delivery systems). For more on potentially allowable state action regarding provider qualification and enforcement, see **"2.C Provider Qualifications and Requirements, Screening and Enrollment"** and **"4. Monitoring and Enforcement."**

(C) Screening and Enrollment

Federal regulations require all "ordering or referring physicians or other professionals" providing services under the Medicaid state plan to be enrolled as participating providers and to be screened using risk-based criteria.[77] This includes license verification, disclosures, and federal database checks, and may include site visits and criminal background checks. Screening and enrollment procedures ensure that providers meet state qualification standards to deliver Medicaid services, including educational, training, and professional standards of conduct. Many of these screening and verification requirements are enforced via program integrity actions. For more, see **"4. Monitoring and Enforcement."**

While specifics vary by state, generally, individual and organizational provider eligibility requirements include, but are not limited to:

Individual Providers:
(1) State-granted Licensure, Certification, or Registration
(2) Relevant Degree/Education
(3) Board/Specialty Certification (if applicable to provider type)
(4) Not on the "Excluded" lists
(5) National Provider Identifier (NPI) registration

Organizational Providers:
(1) Facility License
(2) Accreditation (if applicable to provider type – e.g., Hospital Joint Commission)
(3) Provider Credentialing
(4) Technology (if applicable to provider type – e.g., specialty facility)
(5) National Provider Identifier (NPI) registration
(6) Organizations must ensure individual provider staff meet their requirements

How to Apply This Section of the Blueprint: There are currently no mandatory licensure or credentialing requirements for MTM organizations to deliver services in the United States. As stakeholders begin to develop MTM programming, they should proactively consider the screening and enrollment methods and frameworks that can address this gap. State Medicaid qualifications and standards should balance the assurance of quality care delivery with ensuring that community providers who have been successfully delivering MTMs to Medicaid beneficiaries are not prevented from doing so by novel requirements.

While many MTM models are interdisciplinary—comprising RDNs, chefs, and logistics professionals to deliver effective, patient-centered care—typically, the MTM organization itself will need to be credentialed as the billing provider (in addition to any employees with their own credentialing and licensing requirements as noted above). Most MTM providers can be assessed under eligibility requirements for “organizational providers,” similar to providers of home delivered meals and transportation services.[78] However, as with many community-based services, the prospect of Medicaid screening and enrollment of MTM providers may also raise new questions for states, particularly with respect to licensure/credentialing.[79] The integration of other community-based or non-traditional providers into Medicaid can offer insights into how states and federal regulators can approach screening and enrollment of MTM providers.

Doulas are non-medical professionals who provide emotional, physical, and informational support and guidance before, during, and after labor and birth. As of April 2024, thirteen states provided Medicaid coverage for doula services via SPA.[80] Like for MTM providers, there are no uniform and mandatory licensure or credentialing requirements for doulas to practice in the United States. However, in order to participate in and receive reimbursement from these state Medicaid programs, doulas must be screened and enrolled in the program, which includes meeting state qualifications. States have taken a variety of approaches to doula credentialing requirements, with most states relying on independent organizations whose certification, accreditation, or programming is approved by the state. Fewer states—three—offer multiple pathways to licensure that include both a formalized training pathway and an experience pathway in which doulas with experience in the field can prove their competence through attestation, recommendations, testimonials, or other evidence.[81]

States have taken similar approaches to the screening and enrollment of community health workers (CHWs), frontline public health workers who serve as intermediaries between health and social services and communities, and whose practice likewise lacks mandatory licensure or credentialing. As of April 2025, 20 states covered CHW services via SPA, while many more covered these services via Medicaid flexibilities such as 1115 demonstrations and Home and Community Based Services (HCBS) authorities.[82] Like with doula certification requirements, state CHW credentialing requirements often include certification or accreditation from a list of state-approved entities, completion of specific training programs or curricula, and/or completion of a specified number of training or supervised practice hours. Some states exempt CHWs with prior experience.[83] The selection and establishment of credentialing pathways should be conducted with guidance and input from the service providers.[84]

Finally, the federal government can also impose provider qualification standards when defining a covered benefit. For example, when Congress added non-emergency medical transportation (NEMT) as a statutorily covered Medicaid benefit in 2020, it also established uniform provider and driver requirements. These requirements include ensuring drivers have valid driver’s licenses and that providers have processes to address violations of state drug laws and disclose pertinent driver histories to the state.[85]

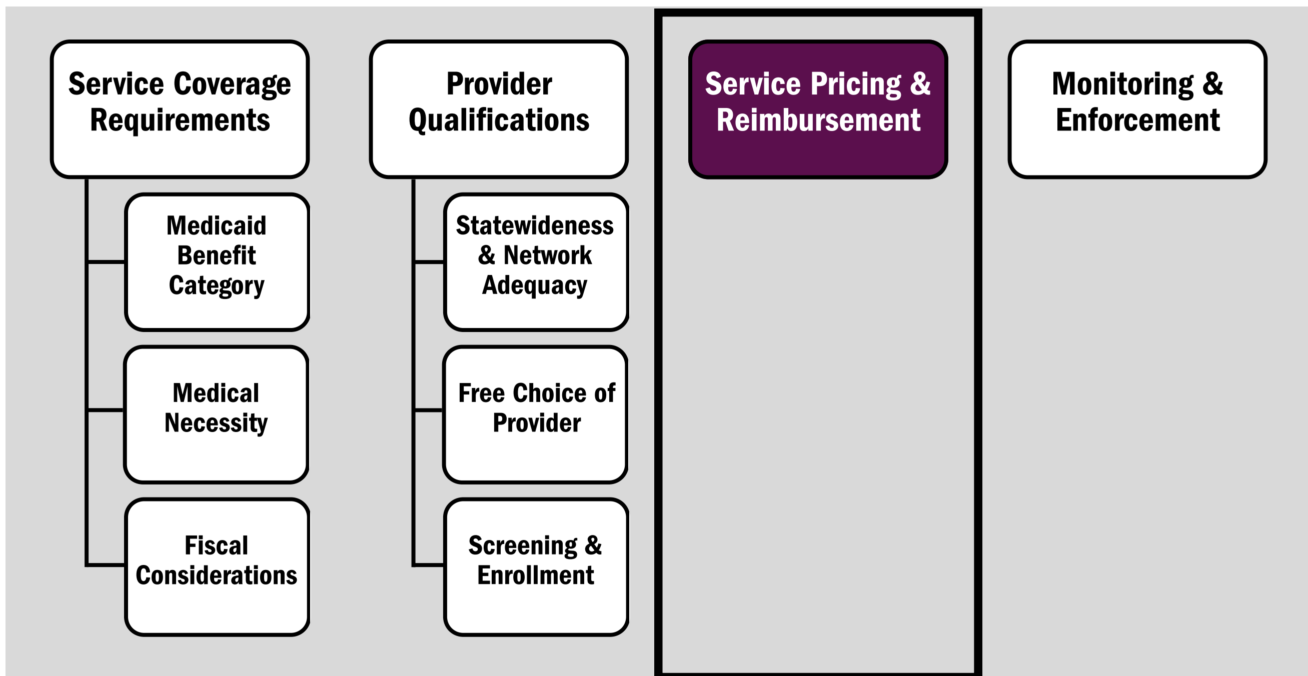
Open Arms Minnesota

We have already seen application of some individual and organizational provider eligibility requirements and credentialing frameworks to MTM providers. As in the doula and CHW contexts, states have adopted "experience" pathways for credentialing. For example, under Massachusetts' 1115 demonstration, among staffing individuals with required qualifications, organizations providing MTMs must have "at least one year of experience providing medically tailored meals to persons experiencing Food Insecurity with applicable health conditions".[86] While states have not fully embraced the more popular "training" pathway for MTM providers, in which licensure/credentialing is based upon training and credentialing from approved, independent organizations, some states require MTMs provided under Medicaid authorities to comply with the nutritional guideline portion of the Food Is Medicine Coalition Medically Tailored Meal Intervention Accreditation Criteria and Requirements (FIMC MTM ACR), the first-ever accreditation standard for MTMs.[87] Embrace of the nutrition standards—evidence-based nutrition requirements for meal quality and menu development that are designed to evolve with generally accepted medical standards—could be a first step in adoption of the full accreditation standard and a more robust training pathway for MTM provider credentialing. Requirements within the FIMC MTM ACR are publicly available and could be adopted by states as a way to manage and adjudicate provider qualifications, thereby serving as the licensure/credentialing framework for state agencies.

Project Angel Food

Additionally, because MTMs can be delivered to beneficiaries from a remote provider—i.e., face-to-face interaction with a provider is not necessarily required for service provision—state approaches to licensure of similar providers may offer useful insight. For example, some states have limited licensure of telehealth and durable medical equipment providers to those with physical locations within the state or a border state/community.[88] However, these requirements appear to be rare and potentially disfavored. In enacting its in-state licensure law in 2014, the Colorado General Assembly noted, that "Access to vital durable medical equipment is being jeopardized by suppliers outside the borders of Colorado that win contracts but do not have a physical location in Colorado, do not have inventory available, and do not have Colorado employees to run the businesses."[89] Yet the state amended the requirement just one year later and now requires applicants for licensure to have "at least one accredited physical facility that is staffed during reasonable business hours and is within one hundred miles of any Colorado resident [M]edicare beneficiary being served by the applicant."[90] In 2023, Tennessee similarly repealed its in-state provider requirement that "a provider of home medical equipment services that has a principal place of business outside this state must maintain an office or place of business within this state."[91]

Section 3: Service Pricing and Reimbursement



In Medicaid managed care, federal statute and regulation require a qualified actuary to certify that capitation rates—the periodic payments state Medicaid programs pay to Medicaid managed care organizations (MCOs) to cover the benefit package—are actuarially sound, meaning rates must be calculated to cover anticipated healthcare costs, be appropriate for the populations to be covered and the services to be furnished under the contract, and appropriately balance profit and risk (i.e., the medical loss ratio must be at least 85%).[92] Actuaries are often engaged not only for certification purposes, but also for preparing, reviewing, and advising on capitation (or other value-based payment) rate development.[93] Payment rates are typically established prospectively for a 12-month rating period based on anticipated healthcare costs of covered services for covered enrollees, and costs of plan administration, reserves, and profit.[94] Actuaries may also assist MCOs in developing and assessing rates. States, CMS, and MCOs have implemented annual rate development and certification processes and tools to ensure that capitation payments support access, quality, and efficiency. This includes flexibilities to prioritize and balance cost savings, health systems investments, or population health initiatives, for example.[95]

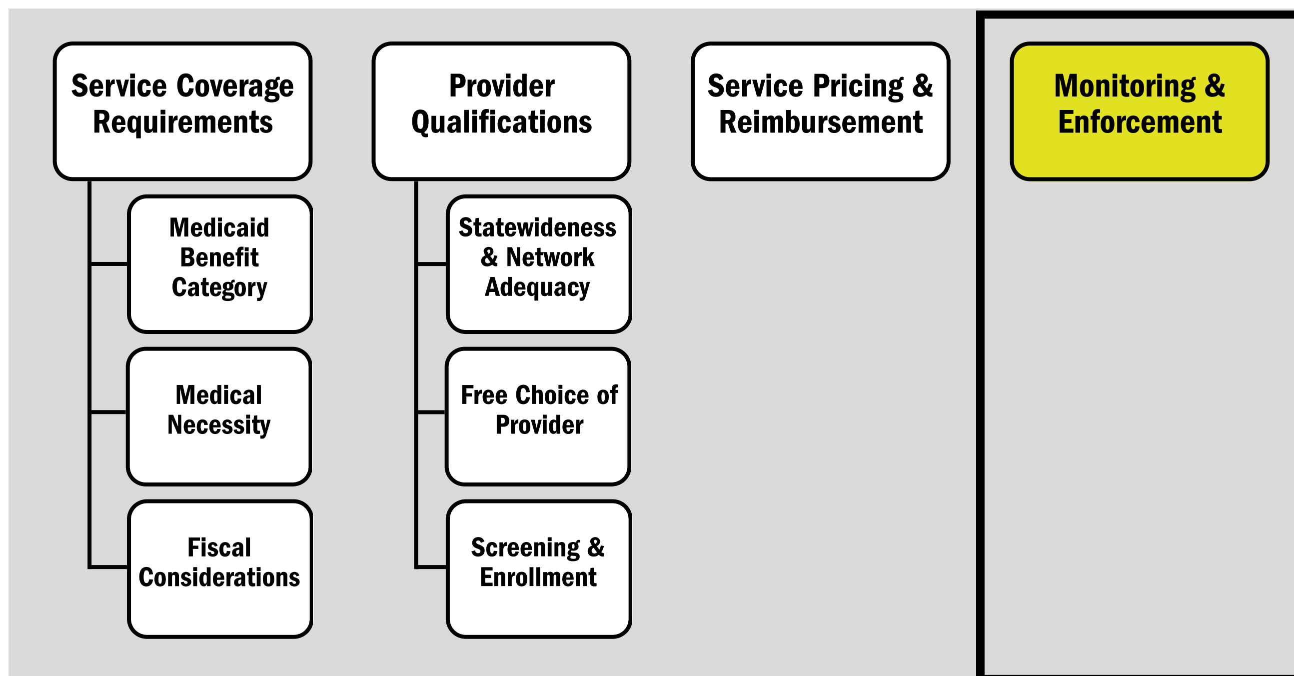
Food & Friends

How to Apply This Section of the Blueprint: Payment rates influence many aspects of a state Medicaid program, including the solvency of MCOs and state budgets, whether providers are adequately reimbursed for services provided, and beneficiary access to and quality of care. States typically seek to develop payment rates that are adequate but also efficient, while MCOs seek to contract at capitated rates that are anticipated to cover required costs with a reasonable expectation of profit or surplus.[96] As states, funders, program implementers, and other stakeholders develop MTM programming, it can be useful to consider how adoption of a Medicaid MTM benefit may impact capitation rates and what types of data may be needed to make this assessment. This type of planning can assist implementers and decisionmakers in developing programming that can more easily integrate into annual processes and calculations.

While capitation rate development and certification would not necessarily include benefit level data, program level information would potentially contribute to the overall rate, as well as to calculations regarding service pricing and reimbursement.[97] States, actuaries, and other stakeholders need the same categories of information identified in **"1.C Service Coverage Requirements, Fiscal Considerations"** in order to make these calculations: information about the target population, expected benefit impacts, expected cost and utilization of the benefit, program metrics, and state versus federal funding using the FMAP. Again, ideally, state level data is available for the proposed service/benefit being modeled and analyzed. If data is not available in the target state, then the same type of data in a nearby or similar state should be used. If that level of data is not available, then data is sought for a similar program/service/benefit in the target state or similar state. Otherwise, national data, or data from another program may be used and adjusted.

In determining service valuation and reimbursement rates at the benefit level, states should consider all components of the service and the ways in which these components impact cost. For MTMs, this includes nutrition assessment with an RDN or nutrition professional, meal design, meal preparation with high-quality ingredients, meal delivery, and administrative costs—including factors such as delivery costs based on the geography served—for example. Additionally, the MTM intervention is more complex than standard home delivered meal services, due to the patient-centered, tailored nature of the service, and this should be considered. Some peer reviewed national modeling studies have reported on average pricing across a cohort of MTM programs, and some states have set fee schedules in their Medicaid programs that reflect historic data on MTM costs.[98]

Section 4: Monitoring and Enforcement



States proactively institute policies and infrastructure to establish quality standards and monitor program integrity. Myriad requirements ensure payers, providers, beneficiaries, and other stakeholders are complying with proper administration of benefits in line with the legal requirements outlined above: service coverage requirements, provider qualifications, service pricing and reimbursement, and others, such as beneficiary and provider rights.[99]

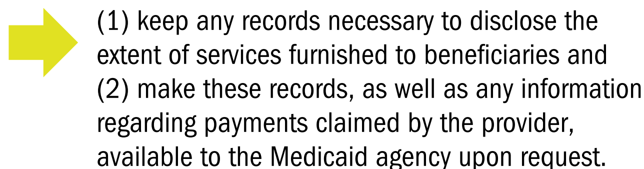
How to Apply This Section of the Blueprint: As states, plans, and other stakeholders begin to develop MTM programming, it is helpful to consider the legal requirements described in this document, not only for sustainable benefit design, but also to uphold quality standard and program integrity requirements enforced by states and the federal government.

Project Angel Food

Many of these requirements have already been applied to MTM services through statewide Medicaid demonstrations, pilots, and other programs. For example, in authorizing coverage of MTMs and other nutrition supports via Medicaid managed care in lieu of services, Michigan clarifies in its Medicaid managed care contract and policy guide that enrollees are entitled to federal grievance and appeal rights, and managed care plans are responsible for monitoring grievances and appeals, provider network capacity, service authorization and medical appropriateness, referrals, and expenditures, among other areas.[100]

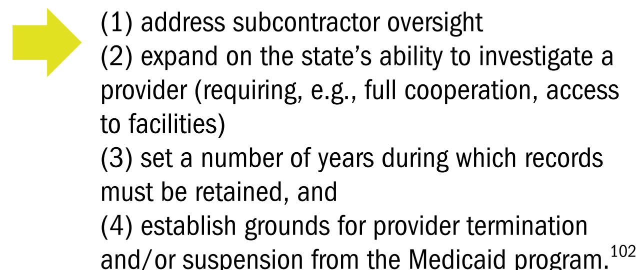
Medicaid agencies use a variety of strategies to monitor and enforce provider compliance with applicable regulatory requirements.The provider agreement is a key source of these oversight capabilities. Federal law requires Medicaid agencies to enter into provider agreements with each provider or organization furnishing services under the state's Medicaid plan.[101]

Minimum required provisions include that the provider will:



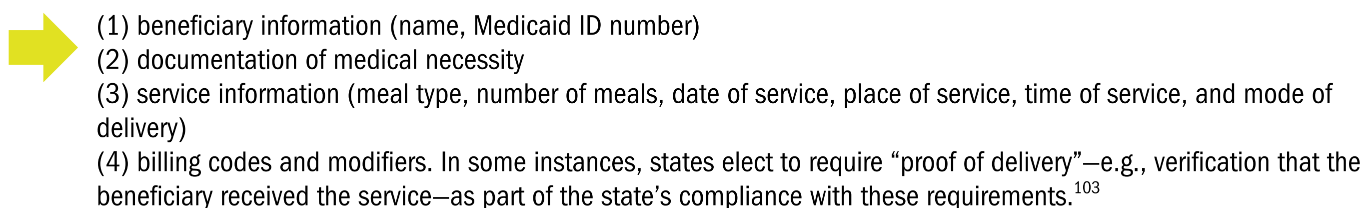
(1) keep any records necessary to disclose the extent of services furnished to beneficiaries and
(2) make these records, as well as any information regarding payments claimed by the provider, available to the Medicaid agency upon request.

It is also common for provider agreements to:



(1) address subcontractor oversight
(2) expand on the state's ability to investigate a provider (requiring, e.g., full cooperation, access to facilities)
(3) set a number of years during which records must be retained, and
(4) establish grounds for provider termination and/or suspension from the Medicaid program.[102]

The main goal of provider agreement record and documentation requirements is to show that submitted claims represent medically necessary services furnished to beneficiaries. Coupled with record retention requirements, documentation allows for post-payment audit, appeals, overpayment investigations, and program integrity enforcement. Relevant data points for MTM provider compliance with record requirements may include:



(1) beneficiary information (name, Medicaid ID number)
(2) documentation of medical necessity
(3) service information (meal type, number of meals, date of service, place of service, time of service, and mode of delivery)
(4) billing codes and modifiers. In some instances, states elect to require "proof of delivery"—e.g., verification that the beneficiary received the service—as part of the state's compliance with these requirements.[103]

Implementation Resources: Community care integration with health care can pose several practical challenges for providers, payers, and regulators. In particular, community providers who have been successfully delivering MTM services in other payment models may need additional support to comply with health care regulations. For examples of supportive structures that can promote sustainable and transformative success—such as policy guidance, model practices, technical assistance, funding support, and flexibility to allow gradual compliance with health care procedures and payer innovation—see Promising Practices from the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

Finally, federal law requires and authorizes investigation and auditing for the enforcement of quality standards and program integrity. Bad actors can be administratively sanctioned via payment withhold for a credible fraud allegation and terminated from the program for cause in line with state law.[104] State-based, jointly funded Medicaid Fraud Control Units (MFCUs) are primarily responsible for detecting, investigating, and prosecuting fraud, waste, and abuse.[105] The federal government also retains authority to bring criminal, civil, or administrative legal actions.[106]

Notably, not all of the most common healthcare "schemes" require intent to defraud. Some of the most common intentional and accidental fraud, waste, and abuse Medicaid provider schemes include issues with billing practices.[107] There are currently no universally utilized codes to accurately describe, bill, and track MTMs, complicating integration with healthcare delivery and payment. The creation of common billing codes for MTM and other FIM services are vital for the consistent monitoring and evaluation of services, enabling accurate data collection, performance analysis, and informed decision-making across providers and systems. Supporting this need, consensus-based applications have been submitted to CMS for new Healthcare Common Procedural Coding System (HCPCS) codes to describe a spectrum of nutrition services. Additionally, states have taken steps in current Medicaid pilots and demonstrations to help MTM providers understand and gain the necessary capabilities to properly submit claims and bill.[108]

Conclusion

The Food is Medicine Coalition Medically Tailored Meal Sustainability Blueprint establishes a foundation for integrating the MTM intervention into the broader healthcare ecosystem. By outlining regulatory expectations and setting forth resulting options for program design, this Blueprint provides MTM and other nutrition supports providers, policymakers, and stakeholders with a roadmap for achieving sustainability and high-quality service delivery across diverse settings.

Stakeholders can next focus on collaboration and engagement with state and federal agencies, payers, and beneficiaries to validate and refine these legal and regulatory pathways to ensure alignment with emerging healthcare priorities. In parallel, the continued research and analysis of outcome and utilization data will be critical to demonstrate the value of these interventions and to inform further policy development.

Implementing MTM provision now in accordance with the legal and regulatory framework outlined in this document will allow stakeholders to build on existing foundations and avoid inefficient, duplicative, and/or conflicting efforts to redesign promising programs as the field moves toward comprehensive benefits coverage.

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Within this supportive system, stakeholders can continue building the evidence base and infrastructure necessary for broader coverage adoption, including by using the Blueprint to map MTM provision against legal standards in Medicare and commercial insurance, ensuring that MTMs become a lasting component of comprehensive, cost-effective healthcare solutions for people who need them.

Annex A

Evidence for Health Benefits in Peer-Reviewed Medically Tailored Meal Studies

This table outlines MTM studies with comparison groups that evaluated clinical outcomes and healthcare utilization. These include randomized trials and quasi-experimental studies. All studies were conducted in the United States and published in peer-reviewed, scientific journals. MTM studies that did not include a comparison group or evaluated impacts only on diet, food insecurity, or other patient-reported outcomes were excluded.*

Several studies included multiple diagnoses as eligibility criteria, thus the effects should be interpreted as pooled effects across multiple conditions. Other studies focused exclusively on a single medical condition. Diagnoses included in previous MTM studies that assessed changes in health outcomes and healthcare utilization are below:

1. High healthcare utilization (recent hospitalization or high ED visits)[1-5]
2. Diabetes[2,5-8]
3. Need for assistance with instrumental activities of daily living[5,7,8,13]
4. Heart failure[2,3,9]
5. HIV[10,13]
6. Cirrhosis[11]
7. High-risk pregnancy[5,12]
8. Depression[14^]

See table on next page.

*Additional MTM studies not included in this table have found improvements in dietary quality, food insecurity, medication adherence, and mental health (Kelly 2023, Belak 2022, Sakr-Ashour 2021, Berkowitz 2020, Berkowitz 2019, Palar 2017, DiMaria-Ghalili 2015).

^ Although this study found greater reductions in healthcare costs among participants with depression, 59% of the group with depression in this study also had a diagnosis of at least one major diet-related condition: diabetes, chronic kidney disease, or cardiovascular disease. When additionally considering comorbid hypertension, the percentage increases 73% of the group with depression. This suggests that a coexisting diagnosis of depression likely makes MTM services more impactful for patients with diet-related illness, but the study cannot confirm that a depression diagnosis alone, without additional diet-relates illness, is a medically necessary reason for MTMs. The role of MTMs on mental health will be an important area for future research, and medical necessity standards may be updated with new evidence.

Food is Medicine Intervention	Strength of Evidence	Intervention Duration	Intervention Dose	Foods Selected	Nutrition Education
Medically Tailored Meals (MTM)	Several quasi-experimental studies on medically tailored meals, which are often prioritized for medically complex patients with activity limitations and provided meals for 6 months -2 years, have found reductions in hospitalizations, ED visits, and healthcare costs.[7,8,13] Trials seeking to confirm these findings have had mixed results. A 6-month program for HIV patients found an 80% reduction in hospitalizations,[10] a 6-month trial for heart failure patients found a 50% reduction in hospitalizations, and 10-week program found a 50% reduction in hospitalizations among heart failure patients only, but not patients with diabetes or kidney disease.[2] MTM programs of very short duration (2 and 4 weeks), have not found any impact on healthcare utilization and costs in trials.[4] There is evidence that programs implemented during the COVID-19 emergency period were less effective.[5] For HIV patients, MTMs reduced hospitalizations by 80% and improved mental health, but had no impact on viral suppression.[10] For patients with cirrhosis with ascites, MTMs for 12-weeks in a small pilot study (sample size =40 people) reduced the number of paracenteses and reduced mortality.[11] In a large quasi-experimental, state-level Medicaid policy evaluation, MTM recipients with greater comorbidity scores experienced the largest reductions in healthcare costs. Net cost savings were observed for MTM recipients with diabetes, chronic kidney disease, cardiovascular disease, or depression.^[14]	Studies that provided meals for longer durations found reduced healthcare utilization. Receiving meals for at least 6 months has the strongest evidence in both large quasi-experimental studies and trials.[5,7,8,10, 13] Very short meal programs of 2-4 weeks did not reduce healthcare utilization,[4] and a 10-week program for patients with diabetes and chronic kidney disease also did not reduce healthcare utilization (actual average meal time was 7 weeks).[11] A 3-month meal program for Medicaid members with diabetes did not find an impact on HbA1c at 6-months after randomization (ie, 3-months after meals ended during a 3-month meal program).[6] The exception is for heart failure patients, wherein three RCTs have found ~ 50% fewer hospitalizations among heart failure patients receiving MTMs, 2 of which were for shorter durations of4-10 weeks after hospital discharge, while a third provided meals for 6 months.[1,2,9]	Studies that provided 10-21 meals per week found greater benefits.[3,5,7,8,10] Programs that provided only 1 meal per day for 5 days per week (half the dose included in other studies), found less or no impact.[2,4]	Meals are designed by registered dietitians to meet nutritional needs of specific diagnoses and vary across heart failure, kidney disease, cirrhosis, etc.	Several programs had optional nutrition counseling with 1-3 sessions with a RDN.
MTM Pooled Effects With Medically Tailored Groceries (MTG) & Produce Prescriptions	Two recent studies on Medicaid 1115 Waivers in MA and NC pooled 20,000 and 14,000 patients receiving a range of Food is Medicine programs for analysis. Most of the programs were either MTGs or produce prescriptions, with some MTMs. In MA, 20,000 Medicaid members enrolled in the Flexible Services nutrition program experienced 23% fewer hospitalizations and 13% fewer emergency department admissions.[5] Significant healthcare cost reductions were observed after the height of the COVID-19 pandemic in years 2022-23 (offsetting 75% of the program costs) and among adults enrolled for 3 months or longer across all study years (2020-2023), resulting in cost savings.[5] In NC, 14,000 Medicaid members enrolled in the Healthy Opportunities Pilots experienced fewer ED visits and lower medical spending. The program resulted in cost savings to NC Medicaid after 8 months of HOP receipt (very few HOP participants received MTMs however; most received medically tailored groceries). In NC, HOP recipients had fewer ED visits, but there was no change in hospitalizations.	Most programs were designed to be 6-months, with an opportunity to re-enroll based on physician recommendation. Some participants received food for over 2 years. In the MA study, longer enrollments were associated with greater reductions in healthcare utilization and costs.[5] In NC, cost savings occurred 8 months after referral to the Healthy Opportunities Pilot program.[12]	Varied widely, but in general MTG and MTMs provided 10 meals / week, produce prescriptions and food vouchers provided ~ $100/month.	Varied, but in general foods were fruits and vegetables or meals / groceries designed by RDNs to meet medical needs.	Varied widely. Some programs offered nutritional education but it was not a requirement in either 1115 Waiver.

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[7] Similar issues have arisen for other nontraditional services and providers that have and are making these transitions, such as doula care and community health worker/patient navigator/peer support services. See, e.g., Cassondra Marshall et al., Facilitators and Barriers to Medicaid Doula Benefit Implementation in California: Perspectives from Managed Care Plans and Risk-Bearing Organizations, 34(5) WOMEN’S HEALTH ISSUES 465 (2024), https://doi.org/10.1016/j.whi.2024.05.006; Anoosha Hasan, National Academy for State Health Policy, State Medicaid Approaches to Doula Service Benefits (updated April 16, 2024), https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits; Rory Peters and Alexis Robles-Fradet, National Health Law Program, 2024 Update: Medicaid Coverage for Doula Care Requires Sustainable and Equitable Reimbursement to be Successful (Jan. 23, 2025), https://healthlaw.org/2024-update-medicaid-coverage-for-doula-care-requires-sustainable-and-equitable-reimbursement-to-be-successful/; Leticia Boughton Price et al., Illinois Community Health Workers Assoc. and Center for Health Law and Policy Innovation, Illinois Community Health Worker Roundtables: Recommendations for the Community Health Worker Certification and Reimbursement Act (July 2022), https://chlpi.org/wp-content/uploads/2022/07/Illinois-Community-Health-Worker-Roundtables.pdf; Kathryn Garfield et al., Evaluating the Sustainability of Patient Navigation Programs in Oncology by Length of Existence, Funding, and Payment Model Participation, 128 Suppl. 13 CANCER 2578 (2022), https://doi.org/10.1002/cncr.33932.

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[13] See Gravity Project, Coding4Food HCPCS (May 27, 2025), https://confluence.hl7.org/spaces/GRAV/pages/184932452/Coding4Food+HCPCS.

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[20] See, e.g., Anoosha Hasan, State Medicaid Approaches to Doula Service Benefits (updated Apr. 16, 2024), https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/. States have selected different benefit categories under which to classify their state plan amendments for coverage of doula services.
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[78] Ctrs. for Medicare & Medicaid Servs., The National Provider Identifier (NPI) Fact Sheet (Dec. 2024), https://www.cms.gov/files/document/npi-fact-sheet.pdf; National Uniform Claim Committee, Health Care Provider Taxonomy Code Set, Version 25.1 (July 2025), https://taxonomy.nucc.org/.
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*Additional MTM studies not included in this table have found improvements in dietary quality, food insecurity, medication adherence, and mental health (Kelly 2023, Belak 2022, Sakr-Ashour 2021, Berkowitz 2020, Berkowitz 2019, Palar 2017, DiMaria-Ghalili 2015).

^ Although this study found greater reductions in healthcare costs among participants with depression, 59% of the group with depression in this study also had a diagnosis of at least one major diet-related condition: diabetes, chronic kidney disease, or cardiovascular disease. When additionally considering comorbid hypertension, the percentage increases 73% of the group with depression. This suggests that a coexisting diagnosis of depression likely makes MTM services more impactful for patients with diet-related illness, but the study cannot confirm that a depression diagnosis alone, without additional diet-relates illness, is a medically necessary reason for MTMs. The role of MTMs on mental health will be an important area for future research, and medical necessity standards may be updated with new evidence.

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