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POLICY INSIGHT

What Is 'Food Is Medicine,' Really? Policy Considerations On The Road To Health Care Coverage

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ABSTRACT **Food Is Medicine interventions are increasingly gaining attention from policy makers, payers, and health care professionals as a promising approach to addressing diet-related chronic health conditions in the health care setting, given the increasing burden and cost of these conditions. The American Heart Association defines Food Is Medicine 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. Importantly, Food Is Medicine is distinct from, yet complementary to, food and nutrition assistance programs and population-level healthy food policies and programs. In this article, we discuss the importance of this distinction and the prerequisites for successfully integrating Food Is Medicine interventions within the health care system: a standard definition of Food Is Medicine focused on medically tailored meals, medically tailored groceries, and produce prescriptions; a research base showing clinical effectiveness and cost-effectiveness; and implementation that ensures fidelity and quality.**

After a long history of Food Is Medicine initiatives showing promise to improve health outcomes, policy makers, payers, and health care professionals are considering Food Is Medicine as a clinically effective and cost-effective way to address diet-related chronic health conditions in the health care setting. This interest is largely driven by rising health care costs and poor health outcomes. An estimated 90 percent of the $4.5 trillion annual cost of health care in the United States is spent on medical care for chronic conditions, and for many of these conditions, diet is a major risk factor.[1] Despite spending the most on health care when compared with other high-income countries, the US ranks last on key health care outcomes.[2] Unhealthy diets are linked to poor health outcomes, which is concerning, as more than nine in ten people in the US eat less than the recommended amounts of fruit and vegetables and consume too much sodium, saturated fat, and calories.[3–5] There is also growing recognition that diet-related chronic conditions disproportionately affect historically underserved populations, with reduced access to healthy, safe, and affordable food playing an important role.[6]

Recognizing the inextricable link between nutrition and health, stakeholders and policy makers are considering future health care coverage of clinically effective and cost-effective food-based interventions as an approach to improving the treatment and management of chronic conditions. An inherent challenge is that Food Is Medicine as a health care intervention does not have a standard definition. Indeed, with its rise in popularity as a concept, we have observed stakeholders defining Food Is Medicine broadly, such as any food- or nutrition-related activity or intervention that promotes health and well-being.

To successfully take Food Is Medicine to scale and fully integrate it into the health care delivery system, policy makers and stakeholders must establish a standardized and targeted definition for Food Is Medicine interventions. In this Policy Insight, we suggest policy factors that stakeholders should consider in defining Food Is Medicine at this stage of the movement. We examine the value of Food Is Medicine as complementary to, yet distinct from, food and nutrition assistance programs and population-level healthy food policies and programs. Federal food and nutrition assistance programs in the US are largely designed to address food insecurity (that is, the household-level social or economic condition of limited access to sufficient food).[7] In contrast, Food Is Medicine interventions are intended to address diet-related chronic conditions for specific individuals in a health care setting. Food Is Medicine should work in tandem with food and nutrition assistance programs and population-level food policies to support a healthier population overall. Advocates must work to ensure that policy makers understand these dual goals and the need for robust government investment in both.

Several other policy factors must be considered when defining Food Is Medicine for the purpose of health care coverage. For instance, a Food Is Medicine intervention must meet certain parameters for Medicare and Medicaid coverage. Further, although cost-effectiveness of a health care service is not required by Medicare and Medicaid statute, policy makers are more likely to support broader coverage of Food Is Medicine if they see strong evidence of its efficacy and effectiveness, particularly with respect to its potential to reduce the use of more costly medical services. We describe these factors in detail and conclude with a call to action.

Background On Food Is Medicine

The American Heart Association defines Food Is Medicine 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 heath care sector (see online appendix A for a description of Food Is Medicine components).[8]

The roots of Food Is Medicine go back to the 1960s, when H. Jack Geiger's community health clinic offered food prescriptions to families with malnourished children in Mississippi, and the 1980s, when organizations began providing medically tailored meals to people living with HIV/AIDS who had insufficient food to meet their nutritional needs.[3] Today, stakeholders ranging from community-based organizations to health systems and plans provide Food Is Medicine.

To strengthen the evidence base around Food Is Medicine for the purpose of health care coverage, the American Heart Association and the Rockefeller Foundation, with support from other stakeholders, launched the Health Care by Food initiative in 2022.[9] The initiative has since funded more than twenty research studies testing how to equitably increase enrollment and engagement in Food Is Medicine interventions, the results of which will inform future studies.

Innovation is also occurring at the state and federal levels. The Centers for Medicare and Medicaid Services (CMS) is encouraging states to use flexibilities within Medicaid to provide nutrition supports of limited duration for specific populations as a medically appropriate way to address their health-related social needs, defined as a person's unmet, adverse social conditions that contribute to poor health outcomes.[10] A growing number of state Medicaid programs now use one or more of the following mechanisms to provide Food Is Medicine interventions: Section 1115 demonstration waivers, which advance experimental, pilot, or demonstration projects that further the objectives of the Medicaid program; Section 1915(b) waivers, which address implementation of managed care delivery systems; Section 1915(c, i, j, and k) waivers, which provide home and community-based services; and managed care in lieu of services and settings authority, which allows Medicaid managed care plans to offer medically appropriate and cost-effective alternatives to state Medicaid benefits. These programs vary from state to state, and evaluations of these programs are in progress. Similarly, Congress and CMS have taken steps to allow and encourage Medicare Advantage (MA) plans to offer supplemental benefits beyond those covered under traditional Medicare and in the Special Supplemental Benefits for the Chronically Ill program for eligible enrollees with chronic conditions.[11,12] These benefits can include food, produce, and meals to meet nutritional needs. Although these are now the most common benefits provided by MA plans, with more than three-quarters of MA enrollees in a plan that offers food benefits,[13] approaches vary and might not, in all cases, be medically tailored meals, medically tailored groceries, or produce prescriptions. For instance, some MA plans offer prefunded debit cards for groceries.

Collectively, these efforts inform and lay the groundwork for potential health care coverage of Food Is Medicine. As practitioners and advocates work toward this goal, it is critical that policy makers recognize the value of Food Is Medicine

as complementary to, yet distinct from, food and nutrition assistance programs.

Differentiating Programs And Potential Complementarities

It is important to recognize that the goals of food and nutrition assistance programs and Food Is Medicine programs are distinct from one another, while also complementary, to support a healthier population (see exhibit 1).

US food assistance programs are designed to address food insecurity, and eligibility is based on income and other factors, depending on the program. The largest of these programs, in terms of participation and cost, is the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), which supports households with food assistance and does not consider the nutritional quality of food. The charitable food system, including food banks and food pantries, similarly provides households with food assistance and is not required to consider the nutritional quality of food. Federal nutrition assistance programs, including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the National School Lunch Program and School Breakfast Program, and the Older Americans Act Nutrition Programs, among others, are designed to address both food insecurity and nutrition insecurity (that is, lack of equitable access to and stable availability, access, affordability, and use of foods and beverages that promote well-being and prevent and treat disease).[14] Eligibility is generally based on income. These programs address the nutritional quality of food but are not designed to address specific clinical conditions.

In contrast to US food and nutrition assistance programs, Food Is Medicine is designed to improve an individual's health through the provision of healthy food tailored to meet the needs of their medical condition or conditions, prescribed through the health care system. Food Is Medicine interventions can also support improved nutrition security, but the main goal is to treat or manage specific clinical conditions. Eligibility is based on health criteria, rather than primarily on income. Finally, Food Is Medicine programs are both integrated with and paid for by the health sector. Some of these differences are highlighted in exhibit 1 and appendix B.[8]

There is some evidence showing that participation in nutrition assistance programs is associated with improved health outcomes. The most robust evidence, from WIC, has been shown to lower infant mortality, increase birthweight, raise beneficiaries' diet quality, and reduce childhood anemia.[15–17] WIC is a particularly important precursor of Food Is Medicine programs that are now being developed and refined. For the purpose of health care coverage, we distinguish WIC as a nutrition assistance program rather than as Food Is Medicine, as eligibility for WIC is based on income, nutritional risk, and life stages, as opposed to a clinical diagnosis. Further, WIC is not paid for through the health care system and is instead funded through federal appropriations.

For the millions of people who are food insecure, food and nutrition assistance programs are a vital lifeline to afford and obtain food. In fiscal year 2023, approximately 42.1 million people participated in SNAP and 6.6 million people participated in WIC each month.[18] For those who have a diet-related chronic condition, a Food Is

EXHIBIT 1

Differentiating Food Is Medicine from other US food and nutrition programs and policies

	Food Is Medicine as a health care intervention	Food and nutrition assistance programs	Population-level healthy food policies and programs
Purpose	Improve an individual's health	Improve an individual's food or nutrition security	Improve public health
Target population	Patients with specific clinical conditions	Income-eligible people, may have other qualifying factors such as life stage	All populations
Example	Medically tailored meals, medically tailored groceries, produce prescriptions	Food assistance programs: Supplemental Nutrition Assistance Program (SNAP), the charitable food system Nutrition assistance programs: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child nutrition programs; nutrition programs for seniors	Dietary Guidelines for Americans, sodium reduction, menu labeling, healthy restaurant meals, SNAP nutrition education (SNAP-Ed)
Funding	Public and private health insurance	Federal appropriations, additional private donations for the charitable food system	Varies depending on the policy or program

SOURCE Authors' analysis. **NOTES** Food and nutrition security are defined in the text. Child nutrition programs include the National School Lunch Program and School Breakfast Program. Nutrition programs for seniors include the Older Americans Act Nutrition Programs.

It is essential that Food Is Medicine programs be understood as complementing and not supplanting existing food and nutrition assistance programs.

Medicine intervention serves a different purpose: treating their chronic condition. Roughly 127.9 million people in the US (48.6 percent) older than age twenty have cardiovascular disease, including coronary heart disease, heart failure, stroke, and hypertension.[19] Nearly two-thirds of people in in the US older than age twenty have cardiovascular-kidney-metabolic syndrome stage 2 or higher.[20] This includes metabolic risk factors or moderate- or high-risk chronic kidney disease (stage 2), very high risk chronic kidney disease or high predicted ten-year cardiovascular disease risk (stage 3), and established cardiovascular disease such as coronary artery disease (stage 4).[21] Many of these people would benefit from healthier diets, and Food Is Medicine research should determine the subset of these patients for which the programs are most clinically effective and cost-effective.

In some cases, these programs reach distinct populations with distinct needs, and in others, they overlap. Many people with chronic conditions are not eligible for food and nutrition assistance programs. Conversely, many people eligible for food and nutrition assistance programs do not have a chronic condition. However, some people will be eligible for both a food and nutrition assistance program and a Food Is Medicine intervention because of income and clinical condition. An estimated 47.3 percent of people in the US older than age eighteen with hypertension (a risk factor for cardiovascular disease) were eligible for food and nutrition assistance programs such as SNAP or WIC, based on income, between 2017 and 2020.[22] Food Is Medicine and food and nutrition assistance programs can work together to meet these people's needs. This complementarity highlights that health care may have an important role to play in addressing both clinical conditions (through a Food Is Medicine intervention) and food insecurity (through screening, referral, and navigation to food and nutrition assistance programs).

The distinctions discussed above are important to highlight for policy makers in differentiating funding for these programs for the purpose of health care coverage. Classifying Food Is Medicine as a safety-net program similar to WIC or SNAP may inadvertently undermine public support for these programs; it is essential that Food Is Medicine programs be understood as complementing and not supplanting existing food and nutrition assistance programs. This is particularly important given recent attempts to limit eligibility for and access to SNAP (for example, the draft Farm Bill proposed in 2024 by the House of Representatives in the 118th Congress)[23] and weaken evidence-based nutrition standards in school meals programs and WIC (for example, the Consolidated Appropriations Act, 2024 and accompanying report language).[24,25] If policy makers perceive WIC or SNAP to be Food Is Medicine, questions may be raised about why health care should pay for Food Is Medicine or, conversely, why WIC or SNAP funding should be independently maintained if health care would fund them.

Duplication of services has been, is, and will continue to be a concern of policy makers trying to responsibly spend taxpayer dollars. Accordingly, funding for Medicare and Medicaid Food Is Medicine interventions should be understood as intended to supplement existing nutrition services, not supplant or duplicate them.[10]

Parameters For Public Health Insurance Coverage

At this time, Food Is Medicine interventions are not covered under traditional Medicare, as there is no statutorily defined benefit category for food and meals. Because federal legislation will likely be required to gain coverage, a robust evidence base for Food Is Medicine will be required. Here we highlight the path for Food Is Medicine coverage in traditional Medicare. Covered services must fall within at least one benefit category established in Section 1861 of the Social Security Act, not be specifically excluded by this act, and be "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member [Section 1862(a)(1)(A) of the Social Security Act].[26]

Medical nutrition therapy provides a potential road map of how coverage could be obtained for Food Is Medicine interventions through legislation. A 2000 Institute of Medicine report[27] found

that medical nutrition therapy was beneficial for maintaining health and managing disease of Medicare beneficiaries with certain conditions (diabetes, for example). Congress enacted the report's coverage recommendation and added medical nutrition therapy services as a benefit category to the Social Security Act, providing coverage for beneficiaries with specific clinical conditions as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional."[28] A national coverage determination by CMS further defines the frequency and scope of this benefit.[29] Specifically, Medicare Part B covers medical nutrition therapy for only patients diagnosed with diabetes or nondialysis kidney disease or patients within thirty-six months after kidney transplant, when furnished by a registered dietitian or nutrition professional and referred by a physician. Medicare covers only three hours of medical nutrition therapy in the first year and up to two hours for each subsequent year, and does not cover food consistent with the dietary recommendations of the patient's medical nutrition therapy.

As demonstrated by the medical nutrition therapy example, a more robust evidence base for Food Is Medicine interventions could provide a foundation for coverage through legislation and subsequent development of a national coverage determination. Legislation or subsequent regulations will need to create parameters for these interventions. Using medically tailored meals as an example, this will include the frequency and duration of meal provision, specific clinical conditions and context (for example, congestive heart failure after a hospital discharge), how the service is provided, and the entity providing the service (for example, referred by a health professional and provided by vendors). CMS will also need to determine how these services will be coded and paid for, which may require a separate fee schedule for payment. Many Food Is Medicine interventions include nutrition education or counseling, culinary training and skills, or other wraparound services that will also need to be sufficiently evidence based and well defined to be covered. Finally, implementation will also need to be well defined.

Ensuring Fidelity And Quality

Another need for specifically defining Food Is Medicine for coverage purposes is to ensure fidelity and quality. A loose definition would create the possibility that some programs would not improve health. This could take the form of a food company selling unhealthy meals that are high in fat or sodium and labeled medically tailored meals[30] or of programs providing Food Is Medicine interventions that are too limited in scope or duration to achieve the effects measured in the research. Some efforts are under way to address fidelity and quality.[31] Evidence-based standards for accreditation and nutritional quality would help mitigate the risks above and are necessary for Food Is Medicine interventions to consistently improve health.

Clinicians, advocates, researchers, and policy makers should adopt a standard definition of Food Is Medicine that is focused on medically tailored meals, medically tailored groceries, and produce prescriptions.

Given the lack of a standard, specific definition in determining what is covered, there is significant variability in what stakeholders consider to be Food Is Medicine. A food company may define it as the provision of its "better-for-you" granola bars. Other stakeholders may consider population-level food policies (as shown in exhibit 1), such as public health department work on food and nutrition or dissemination of the Dietary Guidelines for Americans, as Food Is Medicine. We acknowledge that stakeholders will have different definitions, but this range of definitions is too broad to satisfy the purpose of health care coverage. That said, efforts that improve the broader food environment remain an invaluable public health tool and may also support the scalability, implementation, and sustainability of Food Is Medicine.

Cost Considerations

Policy makers are generally hesitant to pass legislation adding to government spending without

a compelling reason for doing so. At the federal level, the nonpartisan Congressional Budget Office (CBO) will estimate the increased cost of Medicare covering Food Is Medicine interventions and any decreased cost in health care spending in other areas as a result of the coverage (for example, reduced hospitalizations and emergency department visits), typically for a ten-year period, although the CBO can have longer budget projections.[32] A CBO budget score for Food Is Medicine would include its effects not only on traditional Medicare spending but also on Medicare Advantage. A standard, specific definition of Food Is Medicine is necessary in this context; an overly broad definition could include interventions that are costly or minimally effective. The scope of the covered beneficiary population would also need to be well defined to ensure that the cost is not too prohibitive for passage of the legislation.

Recommendations

Clinicians, advocates, researchers, and policy makers working toward health care coverage of clinically effective and cost-effective Food Is Medicine interventions within the health care sector should adopt a standard definition of Food Is Medicine that is focused on medically tailored meals, medically tailored groceries, and produce prescriptions and that considers the policy factors discussed in this analysis. Funders and researchers should undertake comparative effectiveness and cost-effectiveness studies of Food Is Medicine programs and systematic assessments of intervention models with strong research designs, such as randomized controlled trials and quasi-experimental designs. Research should be patient centered and take into account the lived experience of patients, which will be essential to the success of Food Is Medicine, given that food has important social and cultural connotations. In addition, research should consider nutrition-related health disparities, using the Nutrition Health Disparities Research Framework as appropriate.[33] At the same time, a sustained focus on federal-, state-, and community-level efforts to protect, strengthen, expand, and improve existing food programs and policies that support food and nutrition security will complement Food Is Medicine implementation. Together, these strategies can help improve the US ranking of first in health care spending[2] and forty-eighth in life expectancy.[34,35] ■

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