New York
FOOD AS MEDICINE
State Project

Executive Summary and Recommendations

October 2023

New York State Food as Medicine Project
Executive Summary
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We envision a healthcare system in which all New Yorkers who are food insecure or at risk of or suffering from a medical condition impacted by food and nutrition have access to Food as Medicine interventions to improve their health and quality of life.

- New York State Food as Medicine Project Vision

A National Call to Action

Poor diet and food insecurity – the limited or uncertain availability of nutritionally adequate and safe foods – are leading drivers of poor health outcomes and preventable healthcare costs in the U.S. and globally. People who are food insecure are at a greater risk of developing ten of the deadliest chronic conditions, including hypertension, coronary heart disease, stroke, cancer, and diabetes.[1] These diet-related chronic conditions and food insecurity cost the U.S. an estimated $1.1 trillion per year in healthcare spending and lost productivity.[2] These burdens disproportionately affect communities of color, those with lower incomes, rural populations, and individuals with disabilities.[3,4,5]

A growing body of evidence demonstrates the ability of certain nutrition interventions to address the connection between food and health, improving health outcomes and preventing unnecessary healthcare spending and utilization.[6,7,8] These Food as Medicine interventions, also known as Food is Medicine interventions, include a spectrum of services that respond to the critical link between nutrition and health through:

1. The provision of foods that support health; and

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[1] Christian A. Gregory & Alisha Coleman-Jensen, U.S. DEP'T OF AGRIC., *Food Insecurity, Chronic Disease, and Health Among Working-age Adults* (2017), https:// www.ers.usda.gov/webdocs/publications/84467/err-235.pdf.

[2] *True Cost of Food Measuring What Matters to Transform the U.S. Food System*, THE ROCKEFELLER FOUND. (July 2021), https://www.rockefellerfoundation.org/wp-content/uploads/2021/07/True-Cost-of-Food-Full-Report-Final.pdf.

[3] THE US BURDEN OF DISEASE COLLABORATORS, *The State of US Health, 1990–2016: Burden of Diseases, Injuries, and Risk Factors Among US States*, 319 JAMA 1444 (2018), https://jamanetwork.com/journals/jama/fullarticle/2678018 (doi:10.1001/Jama.2018.0158).

[4] Alisha Coleman-Jensen et al., U.S. DEP'T OF AGRIC., *Household Food Security in the United States in 2020* (Sept. 2021), https://www.ers.usda.gov/webdocs/publications/102076/err-298.pdf.

[5] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals* (updated Feb. 9, 2023), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html.

[6] SARAH DOWNER ET AL., CTR. FOR HEALTH L. & POL'Y INNOVATION AND ASPEN INSTITUTE, FOOD IS MEDICINE RESEARCH ACTION PLAN (2022) (hereinafter "RESEARCH ACTION PLAN"), https://www.aspeninstitute.org/wp-content/uploads/2022/01/Food-is-Medicine-Action-Plan-Final_012722.pdf.

[7] Kurt Hager et al., *Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated hospitalizations and Health Care Expenditures in the US*, 5 JAMA NETW. OPEN e2236898 (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797397 (doi:10.1001/jamanetworkopen.2022.36898).

[8] Lu Wang et al. *Health and economic impacts of implementing produce prescription programs for diabetes in the United States: a microsimulation study*, 12 J. AM. HEART ASSOC. e029215 (2023), https://doi.org/10.1161/JAHA.122.029215.

2. A nexus to the healthcare system.[9]

Food as Medicine (FAM) interventions include the direct provision of food, such as through medically tailored meals and medically tailored groceries, or the provision of food assistance, such as through produce prescriptions.[10] Interventions are often provided in combination with nutrition education. Services are generally tailored to meet an individual's specific food insecurity and/or nutrition needs for those with or at risk of diet-related disease. Frequently, clinicians or other health system staff, including registered dietitian nutritionists, social workers, and community health workers, screen and refer eligible patients for appropriate services.[11]

Historically, FAM programs have operated on smaller scales with support from grants and charitable donations. However, leaders in the U.S. healthcare and food systems are increasingly working to expand access to and sustainable funding for Food as Medicine interventions through systems-level change. These efforts have been particularly robust in Medicaid – the U.S.'s safety net health insurance program that operates as a partnership between the federal and state governments – where beneficiaries may be more likely to face challenges to accessing healthy foods due to income and other structural barriers.[12,13] In September 2022, the White House convened the second-ever White House Conference on Hunger, Nutrition, and Health – over 50 years after the first. The White House's top policy priorities to end hunger, improve nutrition, and reduce health disparities, released in conjunction with the Conference, included expanding public health insurance beneficiaries' access to FAM interventions.[14]

As support for FAM grows, stakeholders – including state agencies, healthcare payers, and providers – have become increasingly cognizant of their role in the food system and the impact of food production choices on the health of local communities. Many programs are implementing innovative food purchasing models that prioritize local sourcing and values-based procurement. Although various features influence how programs define local and values-based procurement, a common thread throughout is the consideration of factors other than costs during the contract or bid solicitation process. Values that are commonly reflected in state or other good food purchasing programs include impacts on local economies, environmental sustainability, valued workforce, animal welfare, and nutrition,[15] but can also include other values such as equity and diversity, and support for small, medium, and family farms.

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[9] RESEARCH ACTION PLAN, *supra* note 6.

[10] RESEARCH ACTION PLAN, *supra* note 6.

[11] Dariush Mozaffarian et al., *A Food is Medicine approach to achieve nutrition security and improve health*, 28 NAT. MED. 2238 (2022), https://doi.org/10.1038/s41591-022-02027-3.

[12] See KATIE GARFIELD ET AL., ADDRESSING NUTRITION AND FOOD ACCESS IN MEDICAID (Jan. 2022), https://populationhealthalliance.org/wp-content/uploads/2022/01/addressing_nutrition_foodaccess_Jan2022.pdf.

[13] KRISTIN SUKYS ET AL., CENTER FOR HEALTH LAW AND POLICY INNOVATION, MAINSTREAMING PRODUCE PRESCRIPTIONS IN MEDICAID MANAGED CARE: A POLICY TOOLKIT AND RESOURCE LIBRARY (June 2023), https://chlpi.org/wp-content/uploads/2023/06/Mainstreaming-Produce-Prescriptions-in-Medicaid-Managed-Care-V6.pdf.

[14] WHITE HOUSE, *Biden-Harris Administration National Strategy on Hunger, Nutrition, and Health* (2022), https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf.

[15] THE CITY OF NEW YORK OFFICE OF THE MAYOR, EXECUTIVE ORDER NO. 8, COMMITMENT TO HEALTH AND NUTRITION FOOD STANDARDS AND GOOD FOOD PURCHASING (Feb. 10, 2022), https://www.nyc.gov/assets/home/downloads/pdf/executive-orders/2022/eo-8.pdf; NEW YORK STATE OFFICE OF GENERAL SRVS., *GreenNY Specification: State Funded Food*, HEALTH CARE WITHOUT HARM, THE REAL FOOD CHALLENGE and CENTER FOR GOOD FOOD PURCHASING, *Anchors in Action: Connecting Food*

Seizing the Momentum in New York State

In 2021, over 2.26 million New Yorkers, or 1 in 9 people, were food insecure,[16] and more than 40% of adults suffered from a chronic condition, resulting in 6 out of 10 deaths and 23% of all hospitalizations in the state.[17] The devastating consequences of food insecurity and diet-related chronic conditions were underscored by the COVID-19 pandemic, during which food insecurity disparities by race and ethnicity increased and diet-related conditions like diabetes and cardiovascular diseases were leading risk factors of COVID-19 hospitalization and death.[18,19,20] The pandemic hit New York particularly hard, with disproportionate impacts on low-wage workers and people of color, reflecting long standing health disparities and inequities in healthcare in the state.[21,22]

In April 2022, New York released a proposal for an amendment to its Section 1115 Medicaid demonstration waiver with the aim of addressing health disparities exacerbated by the pandemic.[23] Section 1115 demonstration waivers require federal approval and allow states to pilot non-traditional service coverage, payment models, and eligibility criteria in their Medicaid programs for up to five years.[24] A key aspect of New York's proposal would allow Medicaid to pay for services, such as Food as Medicine interventions, that respond to the health-related social needs of beneficiaries.[25] Health-related social needs (HRSN) are the social and economic conditions that affect an individual's ability to maintain their health and well-being. Unmet HRSN include conditions such as housing instability, food insecurity,

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Work Across Sectors https://ogs.ny.gov/greenny/statefunded-food; https://noharm-uscanada.org/sites/default/files/documents-files/5795/Anchors%20in%20Action%20Backgrounder_April%203%202019.pdf

[16] MONICA HAKE ET AL., FEEDING AMERICA, MAP THE MEAL GAP 2023: AN ANALYSIS OF COUNTY AND CONGRESSIONAL DISTRICT FOOD INSECURITY AND COUNTY FOOD COST IN THE UNITED STATES IN 2021 (2023), *available for download at* https://www.feedingamerica.org/research/map-the-meal-gap/overall-executive-summary.

[17] NEW YORK STATE DEP'T OF HEALTH, *Chronic Diseases and Conditions* (last revised Nov. 2021), https://www.health.ny.gov/diseases/chronic/.

[18] Alisha Coleman-Jensen et al., U.S. DEP'T OF AGRIC., *Household Food Security in the United States in 2020* (Sept. 2021), https://www.ers.usda.gov/webdocs/publications/102076/err-298.pdf.;

[19] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals* (updated Feb. 9, 2023), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html

[20] Meghan O'Hearn et al., *Coronavirus disease 2019 hospitalizations attributable to cardiometabolic conditions in the United States: a comparative risk assessment analysis*, 10 J. AM. HEART ASSOC. e019259 (2021), https://doi.org/10.1161/JAHA.120.019259.

[21] Gbenga Ogedegbe et al., *Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients with COVID in New York City*, 2 JAMA NETW. OPEN e2026881(2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773538 (doi:10.1001/jamanetworkopen.2020.26881).

[22] Benjamin D. Renelus et al., *Racial Disparities in COVID-19 Hospitalization and In-Hospital Mortality at the Height of the New York City Pandemic*, 8 J. RACIAL AND ETHNIC HEALTH DISPARITIES 1161 (2020), https://doi.org/10.1007/s40615-020-00872-x.

[23] NEW YORK STATE DEP'T OF HEALTH, *Full Public Notice: Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidenced-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic* (Apr. 13, 2022), https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-04-13_1115_waiver_public_notice.pdf

[24] 42 USC § 1315(a) (2023).

[25] NEW YORK STATE DEP'T OF HEALTH, *Medicaid in New York 2023 Conference (Presentation)* (July 2023), https://uhfnyc.org/media/filer_public/2f/dc/2fdc1a24-e4ff-4568-87f8-0db242222ef3/uhf_2023_medicaid_conference_slides_for_publication.pdf.

personal safety, and lack of transportation.[26] New York submitted its proposal to the Centers for Medicare & Medicaid Services (CMS) for approval in September 2022.[27]

The New York State Food as Medicine Project was convened in June 2022 to harness these policy opportunities and develop a set of recommendations to serve as a "blueprint" for the sustainable and equitable integration of Food as Medicine services into New York Medicaid. The 18-month Project was led by The Food Pantries for the Capital District ("The Food Pantries") – a coalition of more than 70 New York food pantries in Albany, Rensselaer, Saratoga, and Schenectady Counties – and The Alliance for a Hunger Free New York ("The Alliance") – a collaborative effort of community-based food assistance providers and stakeholders advocating to reduce food insecurity in New York State – with funding from the New York Health Foundation and technical assistance support from the Center for Health Law and Policy Innovation of Harvard Law School.

For the first time, the statewide Project brought together representatives from every region of the state and key stakeholder groups including healthcare providers and payers, government, academic institutions, advocacy organizations, community-based nutrition providers, retail, FAM program participants, agriculture, and more. The New York State Food as Medicine Project developed 15 policy recommendations to help guide New York State towards successful integration of Food as Medicine interventions into Medicaid and the broader healthcare system. Implementation of the Recommendations is being driven by the newly formed New York State Food as Medicine Coalition.

New York State Plan Project Accomplishments

Establishment of shared language and framework for Food as Medicine within the State.

Collection of statewide data on the availability of Food as Medicine services, funding and staffing of programs, and other program details for layering onto an existing statewide Food Connect Map, which maps availability of food and nutrition services, such as food pantries and SNAP/WIC assistance, as well as other health-related social needs services, such as housing assistance and period supply pantries.

Creation of statewide connections and collaborations between diverse stakeholders to advance Food as Medicine, including healthcare providers, CBOs, healthcare payers, government agencies, advocacy groups, food system reformers, directly impacted community members, academic researchers, and more.

Publication of a blueprint for scaled integration of food and nutrition interventions into New York Medicaid and the broader healthcare system through 15 targeted policy recommendations.

[26] OREGON HEALTH AUTHORITY, *Health-Related Social Needs vs The Social Determinants of Health* (accessed Aug. 4, 2023), https://www.oregon.gov/oha/HPA/dsi-pcpch/AdditionalResources/Health-related%20Social%20Needs%20vs%20the%20Social%20Determinants%20of%20Health.pdf.

[27] NEW YORK STATE DEP'T OF HEALTH, NEW YORK STATE MEDICAID REDESIGN TEAM (MRT) WAIVER AMENDMENT (Sept. 2, 2022), https://www.medicaid.gov/sites/default/files/2022-09/ny-medicaid-rdsgn-team-pa-09152022_updated.pdf.

Development of the New York Food as Medicine Project

The development of the New York Food as Medicine Project and Recommendations proceeded through five key stages: (1) statewide landscaping analysis; (2) steering committee convening; (3) workgroup formation; (4) recommendation drafting; and (5) solicitation and incorporation of feedback.

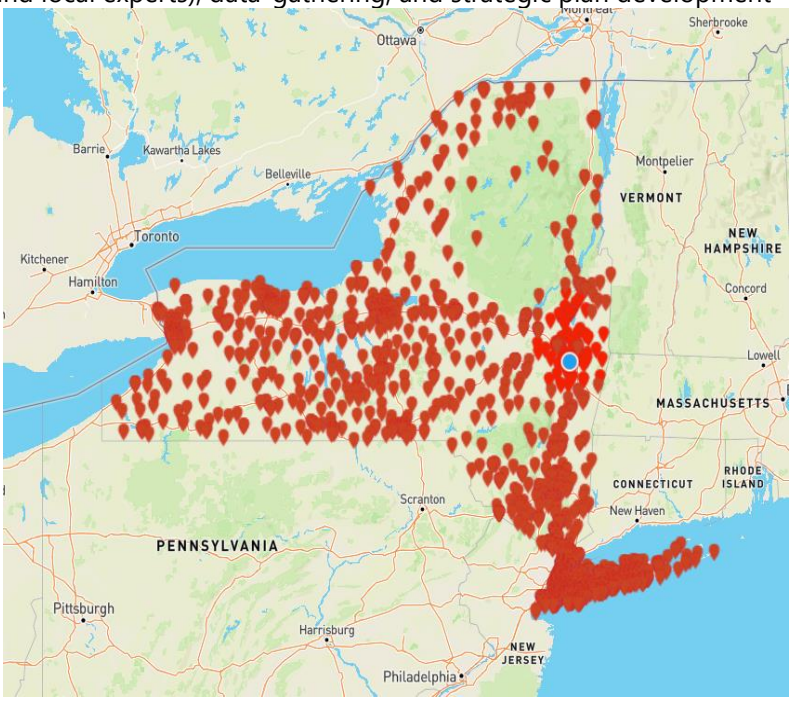
At every stage of the process, the convenors and stakeholders were focused on creating a shared knowledge base, building a strong coalition that incorporated perspectives of individuals with lived experience relevant to the Project's policy goals, creating ample opportunities for stakeholder and decision-making engagement, offering guidance and technical assistance to stakeholders and the broader community regarding the upcoming demonstration waiver opportunity and other food access initiatives, and planning for the sustainability for FAM services.

1. ***Statewide Landscaping***: Beginning with a statewide Project kickoff meeting in June 2022 with 133 individuals representing every New York region and various sectors, The Food Pantries surveyed participants and other relevant stakeholders to understand the landscape of FAM in the state as well as the desired scope of the Project. For example, the survey asked respondents which services should be included in the Project's definition of FAM and gauged respondents' familiarity with various payment pathways for FAM. The Food Pantries also collected statewide data on the availability of Food as Medicine services, funding and staffing of programs, and other program details. The Food Pantries, The Alliance, and the newly formed New York State Food as Medicine Coalition are seeking funding to layer this data onto an existing statewide Food Connect Map, which maps availability of food and nutrition services, such as food pantries and SNAP/WIC assistance, as well as other HRSN services. With the addition of the FAM services data, the Food Connect Map can be a one-stop referral reference for Medicaid providers and others in need of food and nutrition services. Finally, The Food Pantries, in partnership with the Figueroa Interdisciplinary Group (FIG) Research Lab in the Division of Nutrition Sciences at Cornell University, gathered aggregate data from de-identified patient surveys, focus group transcripts, and grant reports from five New York State

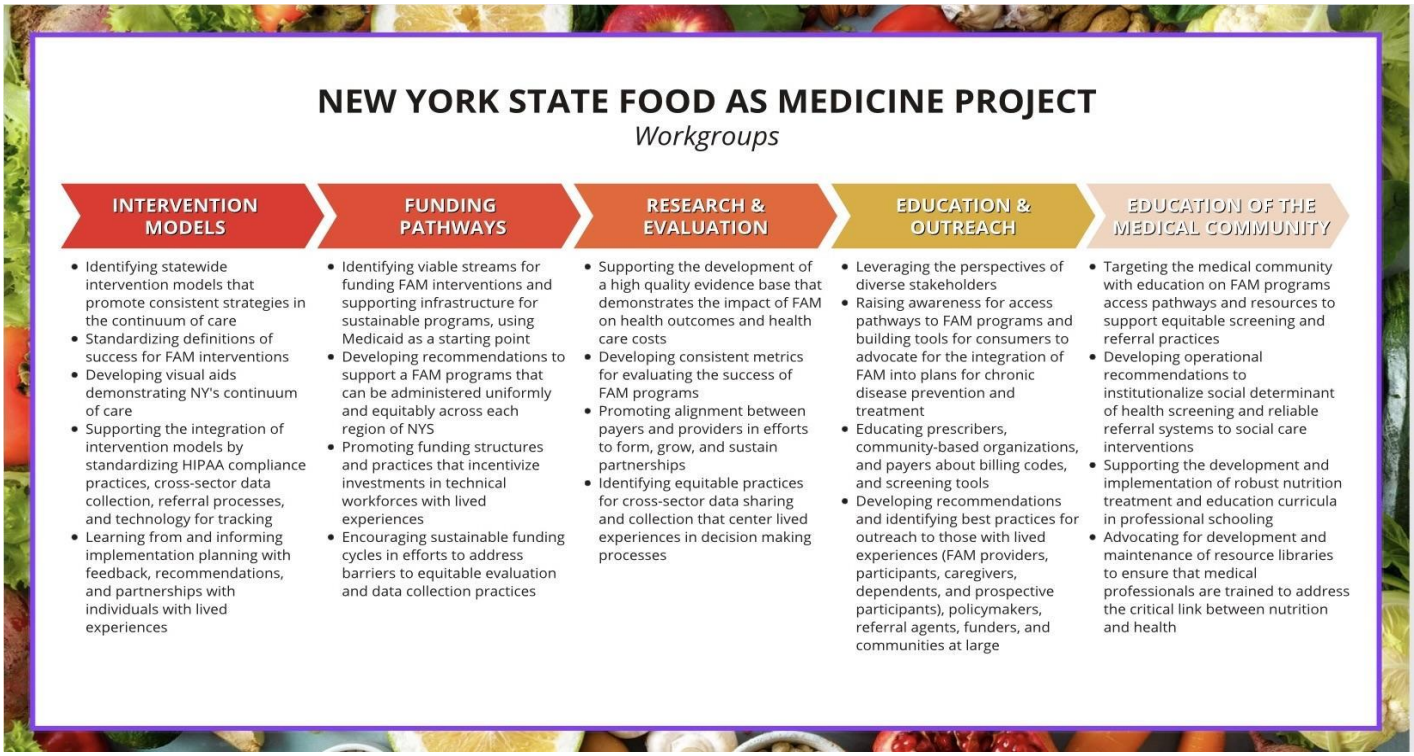
FAM programs to further inform the Project from the perspective of FAM services beneficiaries.

2. ***Steering Committee***: Essential to the development of the Project was the establishment of a multi-sector Steering Committee, which consisted of over 50 individuals from healthcare systems, health insurers, community-based organizations, academic programs, government agencies, and more. Members were identified as organizations and entities necessary to ensure statewide geographic inclusion and a diversity of deep substantive knowledge and experience to inform the Project. Once established in October 2022, the Steering Committee met monthly to guide the creation of a shared knowledge base (for example, through various presentations by national and local experts), data-gathering, and strategic plan development to ensure that each step of the Food as Medicine Project stayed grounded in its mission and vision.

3. ***Workgroups***: To develop a comprehensive "blueprint" for the successful integration of FAM interventions into New York Medicaid and the broader healthcare system, the Steering Committee formed five Workgroups to develop a set of policy and practice recommendations. The five groups each focused on a substantive area of expertise and were tasked with developing three recommendations in their area: (1) intervention models; (2) funding pathways; (3) research & evaluation; (4) education & outreach; and (5) education of the medical community. The Steering Committee recruited individuals from every region of the state and a wide array of lived experience and expertise to serve on the Workgroups. First convened in January 2023, over 60 representatives from over 40 organizations comprised the five Workgroups.

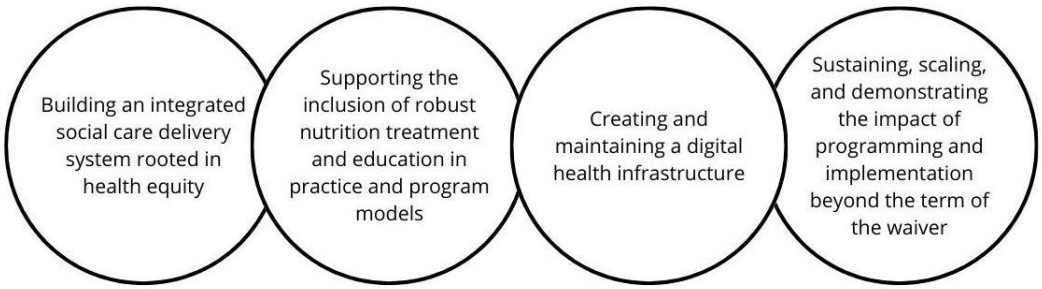


Food Connect Map showing food pantries available in New York State. Data collected by the New York Food as Medicine Project regarding available Food as Medicine services could be layered onto this map.



4. ***Recommendation Drafting***: While each Workgroup developed recommendations in their own substantive areas of expertise, all the Project's recommendations were framed to support four focus areas. These focus areas aligned with the goals of New York's proposed Medicaid demonstration waiver and allowed the Workgroup participants to envision a future for FAM beyond the term of the waiver.

Four Focus Areas



To develop the recommendations, each Workgroup compiled resources and research from states with existing Medicaid demonstrations similar to New York's proposal (e.g., Massachusetts, North Carolina, California), academic institutions, policy labs, state agencies, research bodies, and the experiences of community partners. Members then identified priority areas that advanced the goals of the four focus areas within their substantive topic area, adapting and developing language to address the challenges and opportunities specific

to the landscape and infrastructure in New York State. Central to the iterative process in each Workgroup was uniting diverse perspectives around a shared goal of building an equitable and sustainable plan for FAM in New York State.

5. ***Feedback Process***: The Project Workgroups compiled their draft recommendations and solicited feedback from the Steering Committee and the public through two web-based public forums as well as through an online form.

The New York Food as Medicine Project Recommendations

As a result of the statewide landscaping, convening of stakeholders and strategic planning, resource and research compilation and analysis, and iterative drafting processes, **the New York State Food as Medicine Project identified 15 actionable policy and practice recommendations** for New York State to integrate Food as Medicine interventions equitably and sustainably into New York Medicaid and the healthcare system broadly. The New York Food as Medicine Coalition will work with the NYS DOH to assist with the implementation of the Recommendations.

The Future of Food as Medicine in New York State and Beyond

As the support for Food as Medicine interventions as a cost-effective response to food insecurity, chronic illness, and health disparities continues to grow, the New York Food as Medicine Project and Recommendations can serve as a model for how stakeholders can leverage policy opportunities to build healthcare and food systems that reliably connect individuals in need to meaningful interventions, and sustainably fund and support those services.

The New York Food as Medicine Coalition and the participants in the New York State Food as Medicine Project will continue to strive for a healthcare system in which all New Yorkers who are food insecure or at risk of or suffering from a medical condition impacted by food and nutrition have access to Food as Medicine interventions to improve their health and quality of life.

FOR MORE INFORMATION

The full New York State Food as Medicine Project Recommendations and resources can be found online at: thefoodpantries.org/home/new-york-state-food-as-medicine-project/

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NEW YORK FOOD AS MEDICINE TEAM

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NYS FOOD AS MEDICINE PROJECT

POLICY AND PRACTICE RECOMMENDATIONS

Fifteen New York State Food as Medicine Project Policy and Practice Recommendations were developed by a statewide coalition of representatives from every region of the state with diverse and deep expertise in healthcare, food systems, policy, government, research, and more. The Recommendations are framed around four goals:

1. **Building an integrated social care delivery system rooted in health equity.**
2. **Supporting the inclusion of robust nutrition treatment and education in practice and program models.**
3. **Creating and maintaining a digital health infrastructure.**
4. **Sustaining, scaling, and demonstrating the impact of programming and implementation beyond the term of the New York Health Equity Reform 1115 Waiver Amendment.**

To support the sustainable and equitable integration of Food as Medicine interventions into New York Medicaid and the broader healthcare system, the New York Food as Medicine Project recommends that New York State:

1. **Provide infrastructure funding, technical assistance, and guidance for the full menu of Food as Medicine (FAM) interventions covered under the New York Health Equity Reform (NYHER) 1115 Waiver Amendment[1] to support:**
    a. Design and implementation of FAM programs (e.g., scope, eligibility criteria, dose, frequency, duration, and delivery);
    b. Administrative costs, capital investments, and incentives for the production, procurement, storage, handling, and transportation of food that supports local sourcing and values-based procurement (i.e., a purchasing approach that emphasizes values other than cost during the bidding or contract solicitation process. These values may be related to the types of products FAM programs seek to procure, for example organic foods, or the characteristics of food

[1] CENTERS FOR MEDICARE & MEDICAID SERVICES, *New York Medicaid Redesign Team* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82656; NYS DEPT OF HEALTH, *New York State Medicaid Redesign Team Waiver Amendment.* (Proposal, submitted Sept. 2022), https://www.google.com/url?q=https://www.medicaid.gov/sites/default/files/2022-09/ny-medicaid-rdsgn-team-pa-09152022_updated.pdf&sa=D&source=docs&ust=1695739969085561&usg=AOvVaw2u8meh7X6mdPvkrsi0UnFW

producers and vendors, such as local or socially disadvantaged producers[2].);
c. Capacity building to scale and continually support digital and telehealth infrastructure;
d. Language services and program education in accessible formats;
e. FAM program evaluation, inclusive of process and outcome assessments, that are developed concurrently with program design and implemented to demonstrate return on investment, health impact, and patient satisfaction.

2. **Implement a comprehensive, statewide digital health system that includes a standardized payment model, closed-loop referral processes, and interoperable data sharing by prioritizing:**
    a. The development and implementation of user-friendly digital health platforms for healthcare providers, social care providers, and patients;
    b. Commitments to bidirectional information sharing between community based organizations (CBOs), healthcare clinicians, managed care organizations (MCOs) and other health plans, healthcare systems, data sharing platforms and other entities providing services;
    c. Technology that is accessible and compatible with Health Insurance Portability and Accountability Act (HIPAA) requirements to maintain data security and privacy;
    d. Technology and referral systems that enhance the coordination and delivery of services for individuals facing one or more health-related social needs;
    e. Education and training for healthcare clinicians on best practices for using digital health platforms and conducting virtual consultations;
    f. Equitable reimbursement rates to incentivize providers to spend sufficient time educating eligible patients about FAM interventions, thereby increasing access and reach to vulnerable populations;
    g. A plan to evaluate the statewide referral platform(s) for:
        i. Consistency of data collected and assessment of the allocation of funding and technical assistance to CBOs to ensure that all communities have equal access to platform customization and features;
        ii. Utilization of the platform (e.g., barriers to and facilitators of optimal use).

3. **Provide guidance and technical assistance to the 1115 Waiver Amendment Social Care Networks to promote collaborative, equitable, and diverse vendor networks to foster partnerships between FAM providers, CBOs and healthcare providers.**

[2] This purchasing approach is consistent with New York State Executive Order 32, issued by Governor Kathy Hochul in August 2023. NY Executive Order No. 32 (2023). https://www.governor.ny.gov/executive-order/no-32-establishing-state-agency-food-purchasing-goals-new-york-state-agricultural

4. **Develop appropriate reimbursement rates to support the inclusion of a continuum of FAM services with minimal access barriers by:**
    a. Reimbursing the full cost of services, infrastructure, operations and administration;
    b. Embedding FAM service and administrative costs into standard payment systems (e.g., capitation and fee-for-service) and emerging funding streams;
    c. Conducting a statewide FAM provider cost and rate survey to establish standard rates that are reflective of regional need;
    d. Continuing to guide private and public payers to incorporate the value-based payment roadmap and incentive structures for case management teams who incorporate FAM interventions into the delivery of care.

5. **Identify a standardized nutrition security assessment to supplement the Accountable Health Communities Health Related Social Needs Screening Tool[3] when food insecurity is indicated. Provide onboarding and culturally responsive training guidance for Qualified Health Providers and Community Health Workers to implement best practices in their use of both screening tools to identify and connect vulnerable populations to services addressing social needs.**

6. **Support the Statewide Health Equity Regional Organization (HERO)[4] in their provision of guidance on best practices for compliance, promotion of health equity, data collection and reporting, implementation and evaluation strategies, and the use of enrollment data across social care programs to enhance the impact of the provision of FAM for eligible populations.**

7. **Direct the Statewide HERO under the 1115 Waiver Amendment to promote inclusive and expansive service guidelines when designing value-based payment models with health and social service partners.**

8. **Fund a robust, required, and standardized monitoring and evaluation plan**

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[3] CENTERS FOR MEDICARE & MEDICAID SERVICES, *The Accountable Health Communities Health-Related Social Needs Screening Tool*, https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.

[4] NEW YORK STATE DEP'T OF HEALTH, *Medicaid in New York 2023 Conference (Presentation)* (July 2023), https://uhfnyc.org/media/filer_public/2f/dc/2fdc1a24-e4ff-4568-87f8-0db242222ef3/uhf_2023_medicaid_conference_slides_for_publication.pdf; NYS DEPT OF HEALTH, *New York State Medicaid Redesign Team Waiver Amendment*. (Proposal, submitted Sept. 2022), https://www.google.com/url?q=https://www.medicaid.gov/sites/default/files/2022-09/ny-medicaid-rdsgn-team-pa-09152022_updated.pdf&sa=D&source=docs&ust=1695739969085561&usg=AOvVaw2u8meh7X6mdPvkrsi0UnFW

of the New York Health Equity Reform 1115 Waiver Amendment, led by the Statewide HERO, to assess the implementation process, evaluate the health and cost impacts of FAM interventions, and inform the ongoing development of the delivery systems where FAM is provided. Contract with research entities with the vision and capacity to develop and conduct evaluations of the FAM interventions included under the Waiver Amendment, with input from stakeholders, including the NYS FAM Coalition.

9. **Embed Medicaid coverage in value-based payment arrangements for social determinant of health (SDOH) screening and referrals (including FAM interventions) provided by Community Health Workers, registered dietitians and nutritionists, and food access navigators employed by non-Medicaid billing entities.**

10. **Support the continued education of Qualified Health Providers who are practicing within Medicare and Medicaid by:**
    a. Requiring periodic coursework or training in nutrition, social determinants of health and health related social needs;
    b. Working with expert entities, including but not limited to the Accreditation Council for Education in Nutrition and Dietetics (ACEND)[5] and the American College of Lifestyle Medicine[6] to develop continuing education (CE) courses specific to medical providers who screen for food/nutrition security;
    c. Working with expert entities such as the Academy of Nutrition and Dietetics[7] on the development and maintenance of a resource library related to nutrition CEs and training opportunities on topics that include but are not limited to:
        i. Food as medicine approaches
        ii. Food and nutrition security
        iii. Diet related chronic illnesses
        iv. Prioritizing cultural, religious, and trauma informed best practices
        v. Utilizing nutrition as a prevention strategy
        vi. Bio/psycho/social factors/determinants of nutrition choices and habits.

11. **Direct health and social service partners to adopt flexible program guidelines that will maximize the impact of FAM interventions by:**
    a. Creating pilot programs and alternative payment methods to extend FAM services for up to 12 months with reauthorizations/extensions granted upon medical necessity;

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[5] ACADEMY OF NUTRITION AND DIETETICS, *Acend Mission and Values*, (2023), https://www.eatrightpro.org/acend/about-acend/acend-mission-and-vision

[6] AMERICAN COLLEGE OF LIFESTYLE MEDICINE, https://lifestylemedicine.org/

[7] ACADEMY OF NUTRITION AND DIETETICS, *About Us*, https://www.eatrightpro.org/about-us

b. Providing additional nutrition support to the household of primary recipients in the form of meal support with deliveries of up to 3 meals a day for prepared meals or sufficient groceries (via home delivery, pick-up, or voucher/card) to create a minimum of 10 meals a week (follow Hunger Prevention and Nutrition Assistance Program (HPNAP) guidelines), for a minimum of 6 months or as long as the primary recipient is enrolled in a program;
c. Prioritizing trauma informed care;
d. Including all diagnoses that are impacted by nutrition support services, including but not limited to: cardiovascular disease, prediabetes/diabetes, kidney disease, cancer, HIV/AIDS, substance abuse, mental and behavioral health, gastrointestinal conditions, high risk pregnancy, diet related autoimmune diseases, obesity, and malnutrition;
e. Adopting incentives for values-based food procurement that:
    i. Ensure food provided meets quality, quantity, clinical nutrition, and safety standards as developed by the Food is Medicine Coalition (FIMC)[8];
    ii. Offer culturally and personally preferred food options to patients;
    iii. When possible, prioritizes seasonal food sourced from New York producers or within a 400-mile radius;
    iv. Support and prioritize good food purchasing values, including positive impact on local economies, environmental sustainability (e.g., seasonal, vegetarian, organic, or regeneratively produced foods), valued workforce, animal welfare, nutrition, equity and diversity (e.g., socially disadvantaged producers), and support for small, medium, and family farms;
    v. Establishes clear goals and/or financial incentives as well as mechanisms for tracking outcomes and impacts of values-based food procurement;
f. Allowing for and providing guidance on best practices for referrals to step-down or step-up interventions on the FAM continuum that address the changing needs of participants.

12. **Ensure that individuals receiving FAM interventions have access to an appropriate level of medical nutrition therapy and education services from a registered dietitian nutritionist (RDN) to best address medical and nutrition needs. Specifically, in the provision of medically tailored meals, RDNs should be integrated into the entire intervention process, from menu design to intake, assessment, ongoing medical nutrition therapy, nutrition counseling, and nutrition education based on the assessment of eligible participant needs.**

13. **Enable Medicaid Managed Care and encourage Medicare Advantage plans to reimburse for SDOH screening and FAM eligibility referrals as a part of care coordination and case management programs.**

[8] FOOD IS MEDICINE COALITION, https://www.fimcoalition.org/

14. **Broaden the scope and depth of FAM evaluation by partnering with the philanthropic community and private payers to fund research extending beyond the required statewide 1115 Waiver Amendment monitoring and evaluation plan to inform future FAM policies by generating evidence regarding:**
    a. The dose, frequency, and duration of services sufficient to meet health impact and cost saving goals;
    b. Which FAM benefits and program activities contribute to improved health outcomes for the Medicaid population and at what cost ratios;
    c. A sustainable financial plan for FAM providers to provide and continue programming for vulnerable populations beyond the term of the Waiver Amendment.

15. **Partner with the NYS FAM Coalition to regularly review and integrate evidence from monitoring and evaluation activities—including recommendations from FAM stakeholders and program participants—to regularly update implementation policies and to inform best practices for the delivery of FAM services.**

10/16/23

NEW YORK STATE FOOD AS MEDICINE STEERING COMMITTEE

Name	Position	Affiliation	Industry
Alex Adam El Din-Meeks	Former Special Initiatives Director	The Food Pantries	FAM Provider, FAM Program, Policy
Amaka Anekwe	Director of Strategic Nutrition Initiatives	NYC Department of Health and Mental Hygiene	Policy, Government
Nicole Anderson	Director of Nutrition Incentives and Food Access	NYC Department of Health and Mental Hygiene	Policy, Government
Rachel Atcheson	Deputy Director	NYS Mayor's Office of Food Policy	Policy, Government
Brenda Ayers	Physician, Medical Director of Health Equity	Nuvance Health	Healthcare
Keith-Thomas Ayoob	NYSAND, Associate Clinical Professor Emeritus	Department of Pediatrics, Albert Einstien College of Medicine	Research and Evaluation, Policy, RDN, Education
Nate Bernstein	Executive VP, Healthcare Partnerships & Business Development	Tangelo	Distribution
Nicole Borchard	Communications & Partnerships Manager	Field and Fork Network	FAM Provider
Morgan Black	Director of Advancing Healthcare Excellence and Inclusion	Healthcare Association of NYS (HANYS)	Policy
Betsy Bray	Director of Health Affairs	NYS Dental Association	Policy
Jessica Chait	Managing Director, Food Programs	MET Council	Policy
Emma Clippinger	Senior Healthcare and Justice Attorney	NYC Department of Health and Mental Hygiene	Policy, Government
Sophia Conroy	Physician	Saratoga Community Health Center	Healthcare
Wendy DeMarco	Director of Food and Nutrition Policy	NYS Office of Temporary and Disibility Assistance	Policy, Government
Beth Dollinger	Physician	Arnot Ogden Medical Center	Healthcare
Patti Cuartas	Executive Director and Associate CIMO	New York State Society of PA's (NYSSPA), Mount Sinai Health System	Policy, Education
Jill Dunkel	Director, Division of Nutrition at New York State Department of Health	New York State Department of Health	Government, Policy

NEW YORK STATE FOOD AS MEDICINE STEERING COMMITTEE

Name	Position	Affiliation	Industry
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Roger Figueroa	Assistant Professor	Division of Nutritional Sciences, Cornell University	Policy, Education
Renee Fillette	Executive Director	Dutchess Outreach	FAM Provider, FAM Program
Ashley Fitch	Senior Director	Social Determinants of Health & Community Partnerships at Mount Sinai Health Partners	Healthcare, Policy
Lisa A. Frisch	Consultant	The Food Pantries	Policy, Research, Government
Amelia Gelnett	Special Initiatives Manager	The Food Pantries	FAM Provider, FAM Program, Policy
Marla Guarino	RDN, Director of Programming	Buffalo Go Green, Inc.	RDN, Policy, Education
Renee Rodriguez-Goodemote	Chair, Department of Ambulatory Medicine	Saratoga Hospital	Healthcare Policy
Kathryn Gordon	Director of Government & Public Affairs	Freedom Care LLC	Healthcare, Policy
Mitch Gruber	Chief Programs Officer	Foodlink	FAM Provider
*Erika Hanson**	*Clinical Instructor*	*Harvard Law School's Center for Health Law and Policy Innovation (CHLPI)*	*Policy, Education*
Tammy Holmes	Program Recipient	Community Member	Lived Experience
Nellie T. Kapur	Senior Director of Social Services (Food Programming)	Office of Ambulatory Care and Population Health at NYC Health & Hospitals	Policy, Government
Kimberly Kessler	Assistant Commissioner	Bureau of Chronic Disease Prevention, Center for Health Equity & Community Wellness, NYC Health	Policy, Government
Nikki Kmicinski	Executive Director	Western New York Integrated Care Collaborative, Inc.	FAM Provider, Policy
Pam Koch	Faculty Director	Laurie M. Tisch Center for Food, Education & Policy, Columbia Teachers College	Policy, Education
Anne Lally	Assistant Director of Research and Evaluation	Community Health Interventions Lab	Research
Lucia Leone	Director of the Community Health Interventions Lab	University of Buffalo	Research

**Project Partner*

NEW YORK STATE FOOD AS MEDICINE STEERING COMMITTEE

Name	Position	Affiliation	Industry
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*Julia McCarthy**	*Senior Program Officer*	*New York State Health Foundation*	*Grantor*
Mireille Mclean	Managing Director, Neighborhood Health Services	Public Health Solutions	FAM Provider
Katie Mednick	Manager, Healthcare Partnerships	Mom's Meals	FAM Provider
Kathy Messer	VP State Programs	Independent Health	MCO/Insurance
Colleen Miller	Manager of Healthcare Partnerships	Mom's Meals	FAM Provider
Lisa Neff	Senior Community Impact Director	American Heart Association, Eastern States	Healthcare, Policy
Carla K. Nelson	Associate VP Ambulatory Care & Population Health	Greater New York Hospital Association	Healthcare, Policy
Annette Nielson	Executive Director	Food Policy Center at Hunter College	Policy, Education, Research
NYS Vegetable Growers Association			Policy
Elizabeth (Baz) Perry	Associate Director, FIG Lab, Division of Nutrition Sciences	Cornell University	Education, FAM Provider, Evaluation & Research
Natasha Pernicka	Executive Director	The Food Pantries, The Alliance for a Hunger Free New York	FAM Provider, Policy
Charles Platkin	Executive Director	Center for Food as Medicine	FAM Policy
Alyson Rosenthal	Chief Program Officer	West Side Campaign Against Hunger	FAM Provider, Policy

**Project Partner*

NEW YORK STATE FOOD AS MEDICINE STEERING COMMITTEE

Name	Position	Affiliation	Industry
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Allyson Schiff	Business Development Association	God's Love We Deliver	FAM Provider
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Elizabeth Solomon	Director, Nutrition Policy & Programs	NYC Department of Health and Mental Hygiene	Policy, Government
Linda Spokane	VP Population Health Management	Hudson Headwaters	Healthcare
Mary Springston	Clinical Associate Professor and Director of Clinical Advancement	Le Moyne College	Healthcare
Erin Summerlee	Director	Rural Health Network of South Central New York	FAM Provider
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Ellie Wilson	Manager of Lifestyles and Wellness, Food Policy Council	Price Chopper, Market 32	Retail, RDN/CDN
Damali Wynter	Assistant Commissioner	New York Department of Agriculture and Markets	Government, Policy
Susan Zimet	New York State Food & Anti-Hunger Policy Coordinator	Office of Temporary & Disability Assistance (OTDA)	Government, Policy

In addition to convening a NYS FAM Steering Committee, five workgroups were developed and tasked with compiling research data, and relevant lived experience to inform policy and practice recommendations

THANK YOU TO OUR WORKGROUP LEADERS

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Roopa Kalyanaraman Marcello

Carla Nelson

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FOOD AS MEDICINE

GLOSSARY

Accountable Health Communities Health Related Social Needs Screening Tools: Assessment tools used to identify individuals' social needs that impact their health and well-being.

Best Practice: A method, process, or approach that is recognized as the most effective and efficient way to achieve desired outcomes in a given field.

Capitation: Fixed amount of money per patient per unit of time, paid in advance to a physician, community-based organization or other service provider for the delivery of health care services.

Closed Loop Referral: A referral process in which the progress and outcomes of a referral are tracked and communicated back to the referring party, ensuring continuity of care.

Community Health Worker: A trained professional who provides health education, support, and advocacy to individuals and communities, especially in underserved or vulnerable populations.

Dietitian: A licensed professional with expertise in nutrition and dietetics who provides evidence-based nutritional guidance and support.

Digital Health Infrastructure: Technological tools, systems, and platforms that support healthcare services, including telehealth, electronic health records, and health information exchange.

Fee-for-service: A health care payment model in which a provider is paid for each service provided**.**

Food Access Navigator: A guide who assists individuals and communities in accessing affordable and nutritious food options.

Food as Medicine: A concept that emphasizes the role of nutritious food in preventing, managing, and treating health conditions. It involves using medically tailored diets and other interventions to improve health outcomes and overall well-being.

Food System: The entire process of producing, processing, distributing, consuming, and disposing of food, along with the associated economic, environmental, and social aspects.

Health Equity: The principle of ensuring that everyone has the opportunity to attain their highest level of health, in the context of systemic social and economic injustices.

HIPAA: Health Insurance Portability and Accountability Act, a federal law governing the protection and disclosure of patient health information.

Integrated Social Care Delivery System: A comprehensive approach that combines medical and social services to address both traditional healthcare needs and social determinants of health.

Interoperable Data Sharing: The ability of different healthcare systems and providers to exchange and use health-related information seamlessly and effectively.

Managed Care Organization: A group of providers that contract with insurers to provide care.

Medicaid: A state and federally funded program in the United States that provides health coverage to eligible low-income individuals and families.

Medicaid Managed Care: A system in which Medicaid beneficiaries receive healthcare services through managed care organizations.

Medical Nutrition Therapy: Nutritional interventions provided by a registered dietitian to manage or prevent health conditions.

Medicare Advantage Plan: A private insurance plan that provides Medicare benefits, often including additional coverage beyond the original, basic Medicare plan.

Nutritionist: An individual with expertise in nutrition who provides advice on healthy eating and dietary habits.

Nutrition Security: Consistent access to foods that promote well-being and prevent and/or treat disease.

Nutrition Treatment: The use of dietary interventions, such as specific diets or nutritional supplements, to manage or improve health conditions.

NY Health Equity Reform (NYHER) 1115 Waiver Amendment: A program in New York State that seeks to address health disparities and promote health equity by using a federal waiver to modify Medicaid programs.

NYS Plan Amendment: Changes or modifications made to the state's official plan, often related to healthcare programs or policies.

Qualified Health Providers: Licensed medical professionals who are authorized to provide healthcare services to patients.

SDOH (Social Determinants of Health): Non-medical factors such as socioeconomic status, education, environment, and access to resources, which impact health outcomes.

Social Care Networks: Collaborative networks of social care providers working together to offer comprehensive support to individuals in need.

Social Care Providers: Organizations or individuals that offer social services and support to individuals and families, addressing non-medical needs that impact health.

Standardized Monitoring and Evaluation: Consistent methods and measures used to assess the effectiveness and outcomes of programs or interventions.

Standardized Payment Model: A consistent approach to reimbursing healthcare services based on predetermined criteria, promoting fairness and transparency.

Statewide Health Equity Regional Organization (HERO): One organization that works on health equity initiatives within a state.

Value-Based Payment Models: Reimbursement models in healthcare where payment is based on the quality and value of services provided rather than the volume of services.

Vulnerable Populations: Groups of people who are at a higher risk of experiencing health disparities due to various factors such as socioeconomic status, age, race, or health conditions.