CALCULATING THE COST OF MEDICAID FOOD IS MEDICINE INTERVENTIONS

A GUIDE FOR POLICYMAKERS, STATE AGENCIES, AND ADVOCATES

MEDICAID FOOD SECURITY NETWORK

SHARE OUR STRENGTH

HEALTH BEGINS

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ABOUT THE MEDICAID FOOD SECURITY NETWORK

The Medicaid Food Security Network is a group of healthcare and food security stakeholders, mobilizing Medicaid systems to become a key partner in addressing food and nutrition insecurity. Our mission is to support anti-hunger advocates to engage, influence, and partner with state Medicaid programs and managed care organizations in adopting and implementing effective strategies to connect Medicaid-enrolled children and families proactively to Food is Medicine services, with an emphasis on closing the enrollment gaps in SNAP and WIC.

ABOUT SHARE OUR STRENGTH

At Share Our Strength, we're ending hunger and poverty—in the United States and abroad. Through proven, effective campaigns and programs like No Kid Hungry, we connect people who care to ideas that work.

ABOUT HEALTHBEGINS

HealthBegins partners with and trains courageous leaders to improve the social drivers of health and equity at all levels: individual social needs, community-level social determinants of health, and deeper structural determinants of health equity.

Learn more:

Website: medicaidfoodsecuritynetwork.org
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INTRODUCTION

Medicaid programs are increasingly turning to Food is Medicine (FIM) strategies to manage and treat diet-sensitive conditions. However, unrealistic estimates of uptake, cost, and savings often hinder policy adoption, cause programs to be underfunded, and/or lead implementers to restrict eligibility beyond what is necessary for cost control. While FIM cost savings evidence is growing, the practice of applying this evidence to health insurance cost-effectiveness evaluation is nascent1,2,. This paper helps policymakers and advocates apply established methods from actuarial science to conduct balanced analyses of the predicted costs and potential savings from FIM grocery programs. Higher-quality cost assessments will support states in making informed decisions about whether and how to implement FIM programs.

At the heart of this paper is a step-by-step guide to using a spreadsheet calculator to estimate a FIM program's impact on Medicaid capitation rates. This step-by-step process supports users in more accurately predicting utilization of a FIM intervention in a Medicaid context. Since studies about FIM grocery programs are ongoing, **this tool is currently limited in how precise it can be** and should be used primarily to guide program design and policy decision making conversations. The calculator supports readers in assessing whether a FIM program's cost is reasonable within a state's annual managed care budget—not to formally evaluate (either prospectively or retrospectively) first-year savings. Once these studies become available, they can be combined with detailed population-level healthcare utilization data and known capitation rates to enable even more rigorous and reliable estimates with the calculator. Nonetheless, even without detailed state- and population-specific data, **the calculator will provide a deeper understanding of how FIM costs relate to broader healthcare costs.** In turn, policymakers, advocates, and other stakeholders can develop more realistic proposals and have the ability to provide feedback on state-driven fiscal analysis.

For the purposes of this paper, we use "FIM grocery programs" to refer to produce prescriptions, medically tailored groceries, and healthy groceries. This paper focuses on **FIM grocery programs** because:

- FIM grocery programs are considered to have intermediate intervention intensity; i.e., less intensive than medically tailored meals (MTM). Historically, Medicaid programs have been less likely to include these interventions, instead focusing on higher-acuity Medically Tailored Meals for populations requiring long-term care.
- The Medicaid Food Security Network focuses on children and families and FIM grocery programs are likely appropriate for perinatal populations, parents, and youth with diet-sensitive conditions and nutrition insecurity who may have the ability and desire to prepare food for themselves and their families.
- There is evidence for the effectiveness of FIM grocery programs in increasing fruit and vegetable intake and improving health indicators such as HbA1c, but less evidence directly linking FIM grocery programs to healthcare cost and utilization impacts.[3]

Federal rules require Medicaid-funded FIM services to supplement—not replace—other governmental programs like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Assistance Program

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1 Hanson, E., Albert-Rozenberg, D., Garfield, K. M., Leib, E. B., Ridberg, R. A., Hager, K., & Mozaffarian, D. (2024). The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey. Health affairs scholar, 2(2), qxae013. https://doi.org/10.1093/haschl/qxae013

2 Berkowitz SA, Archibald J, Yu Z, LaPoint M, Ali S, Vu MB, Dave G, Flower KB, Domino ME. Medicaid Spending and Health-Related Social Needs in the North Carolina Healthy Opportunities Pilots Program. JAMA. 2025 Feb 27;333(12):1041–50. doi: 10.1001/jama.2025.1042. Epub ahead of print. PMID: 40014313; PMCID: PMC11869083.

3 Social Needs Investment Lab (2025). Medically Tailored Food Packages Retrieved December 8, 2025 from https://www.socialneedsinvestmentlab.com/assessment/medically-tailored-food-packages

for Women, Infants and Children (WIC)[4]. The primary way states ensure that FIM strategies are not duplicative is by ensuring that Medicaid enrollees are either already enrolled in those programs or receive navigation assistance to enroll in them. As a result, this paper assumes that intervention costs include navigation assistance to access SNAP and WIC. Navigation assistance can include education about these programs, preliminary eligibility screening, referral, and/or direct application assistance. Therefore, **we include projected savings attributable to enrollment in SNAP and WIC, as well as FIM programs, among eligible but not enrolled Medicaid members.**

This paper focuses on predicting costs for FIM grocery programs delivered through Medicaid managed care authorities, such as In Lieu of Services (ILOS). ILOS allows states to embed FIM as a covered service in Medicaid managed care contracts alongside conventional medical benefits. ILOS can support long-term sustainability of new covered benefits like FIM if they are cost-effective.

1115 waivers have also been a common Medicaid policy pathway for FIM coverage, and many of the same considerations apply. However, this paper does not address 1115-specific issues such as the Centers for Medicare & Medicaid Services (CMS) budget neutrality requirements or separate funding for up-front infrastructure costs.

Readers who are new to this content may want to begin by reviewing the Appendix A Definitions and Appendix B Policy Levers for Food Is Medicine.

4 Bank, A. Jantz, K. Xie, J. Rees, E and Scott, K. (2025) Food is Medicine is complementary with SNAP & WIC: A brief on comprehensive nutrition supports for Medicaid enrollees. MFSN Website. Retrieved December 8, 2025 from https://medicaidfoodsecuritynetwork.org/food-is-medicine-complementary-snap-wic/

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ASSUMPTIONS AND LIMITATIONS

Only captures healthcare savings: This paper focuses solely on healthcare benefits and costs and does not account for food system benefits that may result from FIM, such as local multiplier effects on the food economy from local food procurement. The GusNIP Nutrition Incentive Hub has created an economic impact estimator focused on PRx and nutrition incentive programs that can support such calculations. Other downstream benefits from FIM programs may also be realized and are not considered here.

Does not capture cost of SNAP and WIC: While our analysis includes the costs of additional SNAP and WIC navigation assistance, our paper does not account for the cost states incur to administer the SNAP and WIC programs. This is consistent with how most states approach budgeting, considering solely primary impacts and not downstream impacts to other agencies (e.g., how reduced mental healthcare access may increase criminal justice costs). In addition, the incremental cost to states of processing SNAP applications and any SNAP benefit cost-sharing would be relatively small relative to the cost of chronic disease healthcare in Medicaid. This analysis also does not account for administrative savings as a result of FIM-based SNAP and WIC navigation assistance reducing benefits churn. Inappropriate churn in SNAP (being removed from the SNAP program due to procedural reasons and then re-applying) can cost states $82 per person[5]. The cost and benefit ratio for SNAP enrollment may shift as the O.B.B.A is implemented. Hence, our calculator encourages users to include the healthcare savings and to cost of FIM program-provided SNAP and WIC navigation assistance, but there are other state costs and benefits from additional SNAP and WIC navigation enrollments not captured in our calculator.

Focuses on one-year budget impacts: This paper is grounded in the realities of state budgets and In Lieu of Services, and therefore focuses on the one-year cycle of Medicaid managed care rate setting. However, some FIM interventions—particularly grocery programs—may require multiple years to show measurable fiscal benefit. For example, the Tufts Institute for Food is Medicine estimates long-term savings over ten years from nationwide implementation of Produce Prescriptions and Medically Tailored Meals. The short-term estimates generated through this calculator will not align with that type of long-term modeling (especially in lower-risk patient populations), and any advocacy strategy should emphasize the potential for long-run cost curve improvement.

Assumes participation from all MCOs: Given that the primary driver for developing this paper was fiscal impact analyses that occur at a state level, the workbook assumes that all MCOs participate because states need estimated costs for that scenario. The calculator can be used for smaller geographic areas as well.

Does not account for Medicaid Agency Costs: This guide does not account for Medicaid agency staff time or overhead costs. Some states have been able to administer without additional staff, others may request additional capacity through other processes and some may choose to include workforce costs in their ILOS budget analysis.

Not intended to prove savings: The calculator presented in this paper is designed to support readers in assessing whether a FIM program's cost is reasonable within a state's annual rate-setting environment—not to formally evaluate (either prospectively or retrospectively) first-year savings. Expecting immediate return risks underfunding programs to the point that they cannot achieve their intended impact.

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5 Mills, Gregory, Tracy Vericker, Heather Koball, Kye Lippold, Laura Wheaton, Sam Elkin. Understanding the Rates, Causes, and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP) - Final Report. Prepared by Urban Institute for the US Department of Agriculture, Food and Nutrition Service, November 2014. Retrieved December 8, 2025 from https://fns-prod.azureedge.us/sites/default/files/ops/Sinin,anotherNAPChurning.pdf#page=102

BACKGROUND AND CONTEXT

There are multiple policy levers that state Medicaid agencies can use to finance FIM interventions (read about them in the Toolkit created by the Harvard Law School Center for Health Law Policy Innovation [CHLPI] and Food is Medicine Coalition). This paper focuses on In Lieu of Services (ILOS), which is a managed care authority that enables managed care organizations (MCOs) to offer a service that is not a Medicaid benefit "in lieu of" a Medicaid benefit. This flexibility is intended to allow MCOs to provide innovative and cost-effective care and is a promising pathway for FIM policy innovation. In 2025, CHLPI identified ten states that were already using In Lieu of Services to address food security and nutrition[6].

OVERVIEW OF IN LIEU OF SERVICES

ILOS must meet several key requirements:

- **Medically Appropriate and Cost-Effective**: Each ILOS must be medically appropriate and cost-effective, meaning it provides a suitable alternative to standard Medicaid medical services.
- **Optional for enrollees**: Participation in an ILOS must be optional for enrollees—members cannot be required to use an ILOS or be denied access to the standard Medicaid-covered service it intends to replace.
- **Optional for MCOs**: states also cannot require that MCOs offer ILOS services, though they can encourage or incentivize it.
- **State Approval**: For plans that opt in, ILOS must be authorized and clearly identified in the Medicaid managed care contract with the state.
- **Under 5% of Total Capitation for Each Managed Care Program**: ILOS spending for all ILOS is capped at 5% of the total capitation rate for each managed care program, excluding the costs of Institutes for Mental Disease (IMD)

Calculating the Percentage of the Total Capitation Rate for ILOS

Total cost of all ILOS for a specific managed care contract / Total cost of the capitation for that same managed care program. "Managed care program" refers to a specific managed care contract, not the entire managed care system[7]. For example, if a state operates separate behavioral health and physical health contracts and the physical health capitation program includes five MCOs, the ILOS denominator would be the total capitation premiums for one MCO's physical health contracts, not the combined capitation payments across all five physical health contracts[8].

The costs associated with ILOS services must be incorporated into the capitation rate and calculated in a way that is actuarially sound, ensuring financial stability and fairness in rate-setting. This means that the cost and savings for an ILOS offering would be incorporated into the overall assessment of the average cost per person.

Although states are responsible for the calculation and payment of capitation premium rates, CMS reviews and approves MCO contracts and capitation rates to ensure compliance with federal regulations. As of August

6 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01349

7 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438#p-438.2(Managed%20care%20program)

8 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.16

2025, new CMS documentation[9] requires states to provide CMS with detailed documentation and obtain a certification from the state's actuary. This includes reporting both projected and actual ILOS costs as a share of the total capitation rate, along with summaries of the actual costs to deliver each ILOS. These summaries must draw from claims and encounter data, including enrollment by rate cell, data sources, and methods and assumptions for each ILOS. If projected ILOS spending for all ILOS combined exceeds 1.5% of total capitation, states must also provide additional documentation showing that the services are cost-effective, including a retrospective evaluation of actual performance.[10]

> 💡 **Tip:** Some states may make capitation premium rates publicly available, or they may be able to be requested through open records acts. Obtaining this information and identifying whether the state has other ILOS offerings will allow advocates to better assess potential allowable amounts for ILOS (to stay within the 5% limit described amount) and to estimate whether or not the ILOS is likely to have a net impact on the capitation.

The key for advocates is to understand that cost-effectiveness needs to be calculated for each ILOS separately, but that overall compliance processes examine all ILOS jointly. In other words, readers of this report should **calculate costs and savings individually for each specific intervention, but also be aware of how these add to other existing or proposed ILOS programs.**

9 https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf

10 https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

HOW AND WHEN TO ENGAGE WITH POLICYMAKERS AND REGULATORY ENTITIES

The cost of a FIM intervention will impact a state's decision to pursue a program and the success of the program's implementation. The table below describes three key instances when a FIM program cost might be estimated, who to engage to improve the accuracy of that estimation, and when to engage. Close alignment and collaboration between FIM experts and stakeholders and the Medicaid agency will be critical, as the agency typically plays a significant role in estimating costs.

Budget Estimation Activity	Activity Description	Who to engage	When to engage
Legislators initiate a FIM bill	In some states, legislators are passing legislation mandating, incentivizing, or authorizing the Medicaid agency to pursue a FIM strategy. During the process of evaluating a bill, most state legislatures have a process to assess the cost impact of a bill. In many states these cost estimates are prepared by a non-partisan entity and may include consultation with the affected agency. These "fiscal notes" are typically focused solely on how the bill will impact state revenue and state costs including agency and staff time, infrastructure costs and other expenditures.	Medicaid Agency staff leading the budget process and FIM strategy.	Review your state's budget setting timeline. Consider engaging your Medicaid agency six months prior to legislative review of the budget
Medicaid agency incorporates FIM into annual budget	In some states, the Medicaid agency will act within their authority to propose the addition of a FIM program and any additional expenditures will be approved through the state budget process. Within this process, the Medicaid agency would propose to the legislature the cost of the FIM program as part of their overall package of Medicaid funding.	Medicaid Agency staff leading the budget process and FIM strategy.	Review your state's budget setting timeline. Consider engaging your Medicaid agency six months prior to legislative review of the budget.
Medicaid agencies sets MCO rates to include FIM ILOS	Medicaid actuaries typically set capitation rates annually. Capitation rates are typically based on adjustments of historical data and assumptions about future costs. For standard Medicaid benefits, the state will rely heavily on utilization data of past years. However, for FIM, actuaries may not have the necessary data or the insights around reasonable assumptions. Given challenges in predicting costs, some states are proposing to adjust capitation rates retroactively which can lead MCOs to prefer a slower or more narrow roll-out.	Medicaid agency staff including FIM program staff and the actuary calculating the capitation rates.	3-6 months before the fiscal year for which the rates are being calculated.

USING THE CALCULATOR: COST ASSUMPTIONS

This section will review the key assumptions that should be defined in order to calculate the costs of a FIM intervention program. These assumptions are also outlined in the accompanying workbook, which can be used to track and input the variables to calculate costs and offsetting savings. While your state actuaries and analysts will use more sophisticated methodologies, conducting this analysis as part of your advocacy effort can help you advocate for a feasible program within state budget parameters and provide meaningful information to state staff conducting the analysis. This high-level analysis may also help with proposing FIM program partnerships to Medicaid Managed Care Organizations. To ensure your numbers and analysis carry credibility, track your sources and rationale for each estimated number that you input in the documentation column of the workbook.

Each subsection below outlines the specific areas that contribute to the final program cost. Italicized terms below are also outlined in the workbook. This guide will describe three types of data entries:

- **Text Entry:** These are narrative fields where you will describe what you are doing.
- **Numeric Entry:** This is where you will enter a number estimate.
- **Calculated Field:** These fields will be calculated based on the otherwise collected data.

FOOD IS MEDICINE COST AND IMPACT CALCULATOR ACCOMPANYING WORKBOOK INTERFACE

Step 1: Program Description		Calculations	Documentation	Calculations
a) Program Name				
b) Program Description				
c) Program Duration (months)		12		
Step 2: Population Projection				
a) Target Population				
b) Geographic Scope				
c) Maximum Number of Months of Benefit (up to one year)		6		
d) Expected Number of Months of Utilization of the Benefit		6		
e) Total Number of Eligible Members in the Target Population				
f) Percent of Eligible Members Successfully Outreached				
g) Percent of Members Reached Who Accept Intervention and Enroll				
h) Expected Number of Participants		0		0
i) Ramp-up for Months 1-6: Percent of Expected Participants Enrolled Each Month				
j) Ramp-up for Months 7+: Percent of Expected Participants Enrolled Each Month				
k) Total Expected Participants Factoring in Ramp-up		0		0
k) Total Benefit Months		**0**		
Step 3: Unit Costs				
a) Unit Description				
b) Average cost per participant per month				
c) Total program costs		**$0**		**$0**
Step 4: Estimated Medical Outcomes Offsets				
a) Estimated average annual per capita health care costs for the Target		$7,200		$0
FIM Intervention-related Savings				
b) Estimated Annual Savings Due to FIM Intervention		$720		
c) Estimated Annual Intervention Savings as a Percent of Cost		10.0%		0.0%
d) Total Annual Savings Due to FIM Intervention		$0		$0

Source: https://medicaidfoodsecuritynetwork.org/wp-content/uploads/2026/02/FIM-cost-and-impact-calculator-Feb-2026-REVISED.xlsx

PROGRAM DESCRIPTION AND TARGET POPULATION

BACKGROUND AND CONSIDERATIONS

As discussed above, it is critical to outline the definition of the specific program or programs, as well as the target population or populations, including combinations of programs and populations. This involves thinking through a number of considerations, which will inform the program's cost estimate scenarios. These considerations in program and population definitions include the following:

- **Highest benefit.** What are the populations most likely to benefit from the service? Narrowing the population can reduce total program cost, improve potential medical cost offsets, and increase impact (e.g., focusing a perinatal program on people with food insecurity and gestational diabetes). Combining clinical need with food and/or nutrition insecurity is one way to prioritize the population of highest need. For example, in Massachusetts, to be eligible for Medically Tailored Food Boxes, you must have HIV, cardiovascular disease, diabetes, renal disease, lung disease, liver disease, cancer or high-risk pregnancy and be experiencing very low food security.[11]
- **Population needs.** Determine which population characteristics may increase program costs, such as the need for longer or more intensive interventions, enhanced care coordination, or tailored dietary supports for different participant preferences or needs. Populations with high medical or social needs may need additional support such as nutrition education, cooking training, and kitchen implements to effectively participate.

ASSUMPTIONS

Below are the program and population assumptions that feed the Cost and Impact Calculator. Review the text below as you input the corresponding assumptions into the Calculator.

PROGRAM DESCRIPTION

Text Entry: 1a) and 1b) *Program name and description.* This is the name and brief description of the FIM program for which you are calculating the cost. Use different scenarios to outline different programs or populations.

> 💡 **Tip:** If you change one element of each of your scenarios (cost of intervention, population acuity, etc.), You will be able to see how marginal differences in costs or savings can make a significant difference in program viability at scale. You can copy/paste an entire column and only change the items that you wish to test.

POPULATION PROJECTION

Text Entry: 2a) *Target population. Describe the Target Population.* Scenarios can be used to estimate the impact on various subpopulations.

> 💡 **Tip:** Make this as specific as possible and include both the clinical requirements and, if applicable, food insecurity requirements. This will allow you to create better numeric estimates below. A narrow target population would be pregnant individuals with either gestational diabetes or pre-eclampsia and food insecurity.

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11 Health Related Social Needs (HRSN) Service Manual – HRSN Supplemental Nutrition Services (2026). Massachusetts Medicaid. Retrieved December 8, 2025 from https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/

Text Entry: 2b) *Geographic scope.* In what geographic area will the program operate? Will it be statewide, limited to a few counties or metropolitan areas?

> 💡 **Tip:** If you want to use this calculator to model an ILOS for each of the MCOs in your state, you can note the MCO and its catchment area here.

Numeric Entry: 2c) *Maximum Number of Months of Benefit.* What is the program's maximum number of allowable months that an individual enrollee can receive the benefit?

> 💡 **Tip:** Six months is typically the longest period of time before a renewal is required, although there is no federal limit on ILOS duration. Some states, like California ,only authorize for three months but allow for renewal if medically necessary. This calculator is built on the assumption that the state is projecting one year of costs. While some states create their budgets at a longer interval, MCO rates and Medicaid budget projections are more likely to occur for one year. If you would like to model multiple years, you can complete a scenario for each year and sum the anticipated costs.

Numeric Entry: 2d) *Expected Number of Months of Utilization of the Benefit.* Some programs may see a drop over time of people utilizing the program. In addition, some programs may have an initial benefit period with an additional opt-in for extension of services. These attrition and extension assumptions should be factored into the expected number of months of utilization.

> 💡 **Tip:** For grocery programs, participation may be dependent on ease of access, with vouchers or other cash-type programs having very minimal drop off in utilization prior to using the maximum benefit from the program. Programs that require a person to go pick up a box or other barriers, like having to be home for a delivery, may have a higher rate of program attrition. In the Massachusetts 1115 waiver, there was a significant range in length of participation in the nutrition services. The average enrollment was 138 days (almost four and a half months), and the range was 3-1,004 days.

Takeup: The Expected Number of Program Participants.

The number of eligible people in a target population is the (2e) Total Number of Eligible Members minus the (2f) Percent of Eligible Members Unable to be Outreached minus the (2g) Members outreached who do not wish to enroll:

Numeric Entry: 2e) *Total Number of Eligible Members in the Target Population.* This is the estimated number of people who meet all eligible criteria.

> 💡 **Tip:** The eligible members can be estimated in partnership with your state agency, your local MCOs or through publicly available data. Most states have publicly available Medicaid enrollment data that is broken out by eligibility category. You can use publicly available public health data (i.e., the percent of pregnant individuals with gestational diabetes) to estimate the rate of eligibility in that population. For perinatal populations, this KFF dashboard provides insight into the percentage of births in your state financed by Medicaid. For narrowing perinatal populations to a specific chronic condition, you can use state-specific data or use national rates such as this data, which indicates that of female beneficiaries: 21% have been told they have high blood pressure, 12% have ever been told they have diabetes, and 17% have reported postpartum depression. For other conditions, the MACStats Medicaid and CHIP Data Book 2024 provides some information about condition prevalence nationally.

Numeric Entry: 2f) *Percent of Eligible Members Successfully Outreached:* This is the number of people within the eligible population who are offered the program. Outreach is an important step that can be difficult and complex. Not every person in the target population will be reachable. Many people may not respond to phone outreach because they are working, caring for children, lack reliable phone access, or have other reasons.

> 💡 **Tip:** The type of outreach can significantly impact the success rate, whether it is a "cold outreach" (where a Medicaid enrollee receives a cold call) or a "warm handoff" (where a Medicaid enrollee who was already identified as potentially eligible by a healthcare provider or MCO care manager, and is told to expect outreach). Warm handoffs may have a success rate of 50-70% depending on factors like the ability to text, outreach after-hours and on weekends, and the recognizability of the organization conducting outreach. For example, one Michigan study found that with primary care provider encouragement, 50% of recipients completed the MCO Health Risk Assessment[12]. Illinois reports similar numbers for Health Risk Assessments[13]. According to a sales industry report, cold calling, on the other hand, may have outreach success rates below 10%[14]. It may also take multiple encounters before a member is willing to engage and enroll in the benefit. Patience and multiple attempted contacts is important for organizations conducting outreach.

Numeric Entry: 2g) *Percent of Members Reached Who Accept Intervention and Enroll.* Not every person reached will want to engage in the program.

> 💡 **Tip:** The percentage of people who accept the resource depends on the ease of access to the resource. For example, delivered food may have fewer barriers to participation, unless it requires someone to be home to accept the delivery. Anecdotally, Medicaid Food Security Network members report that enrollees are more likely to accept groceries than meals. Participant choice in delivery method may further enhance participant-specific participation.

Calculated Field: *2h) Expected Number of Participants.* This refers to the number of people who agreed to accept the FIM intervention and is calculated based on Eligible Members, adjusted for successful outreach and opting into the program. Expected Number of Participants is further adjusted for ramp-up as outlined below.

Ramp-up: Total Expected Participants in the Program Duration.

Program ramp-up takes time. Once individuals are identified and engaged in the program, it will generally take some time to assess and enroll those individuals and get all the information needed to receive the FIM service (e.g., delivery address and time). Also, staff bandwidth and resources will likely be such that it will only be possible to enroll a limited number of members each month.

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12 Kelley, A. T., Goold, S. D., Ayanian, J. Z., Patel, M., Zhang, E., Beathard, E., Chang, T., Solway, E., & Tipirneni, R. (2020). Engagement with Health Risk Assessments and Commitment to Healthy Behaviors in Michigan's Medicaid Expansion Program. Journal of general internal medicine, 35(2), 514–522. https://doi.org/10.1007/s11606-019-05562-x

13 Q1 2023 Illinois Quarterly Business Report. Retrieved December 8, 2025 from https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/q12023report.pdf

14 The State of Cold Calling in 2025. Retrieved December 8, 2025 from https://www.cognism.com/cold-calling-report-2025

This ramp-up time should be factored into the cost calculation. If it is not considered, it can result in an overestimate of program costs, which can potentially be detrimental to approval of the program.

As this calculator focuses on calculating costs for one year, users are able to enter different ramp-up projections for the first six months and the second six months. It may take multiple years for program outreach to achieve its intended scale. The following assumptions can be used.

Numeric Entry: 2i) *Ramp-up: Percent Enrolled in Months 1-6.* This is the percent of Total Eligible Members that will be added to the Program in the first six months of the program.

Numeric Entry: 2j) *Ramp-up: Percent Enrolled in Month 7+.* This is the percent of Total Eligible Members that will be added to the Program each month, after the first month.

> 💡 **Tip:** California's ramp up data is a good example of what might be expected. The chart below shows the ramp up for all of California's Community Supports ILOS program, which includes various non-food HRSN supports and Medically Tailored or Medically Supportive Food. Note that even over three years into a program with fairly broad eligibility[15], only 2.9%[16] of the Medicaid-enrolled population are receiving any of the broad array of services. At the end of year one, only 0.2% of the enrolled Medicaid population was receiving any Community Supports services. While no data is readily available on what percent of the total eligible population received Community Supports, the enrollment at the end of year one was 9% of the enrollment at the beginning of year four. In other words, if we assume 100% of the eligible population was enrolled in year 4, then at most, 10% of the eligible population received services in the program's first year. In reality, that number is even smaller since even in the fourth year, it is unlikely that every eligible enrollee participated in Community Supports.

The percentages in the workbook are meant to be the percentage of the Total Number of Eligible Members who enroll each month. The Calculator will not allow the Total Participants to exceed the Expected Number of Participants.

Calculated Field: 2k) Total Benefit Months is the total number of recipients multiplied by the total number of months that they are enrolled.

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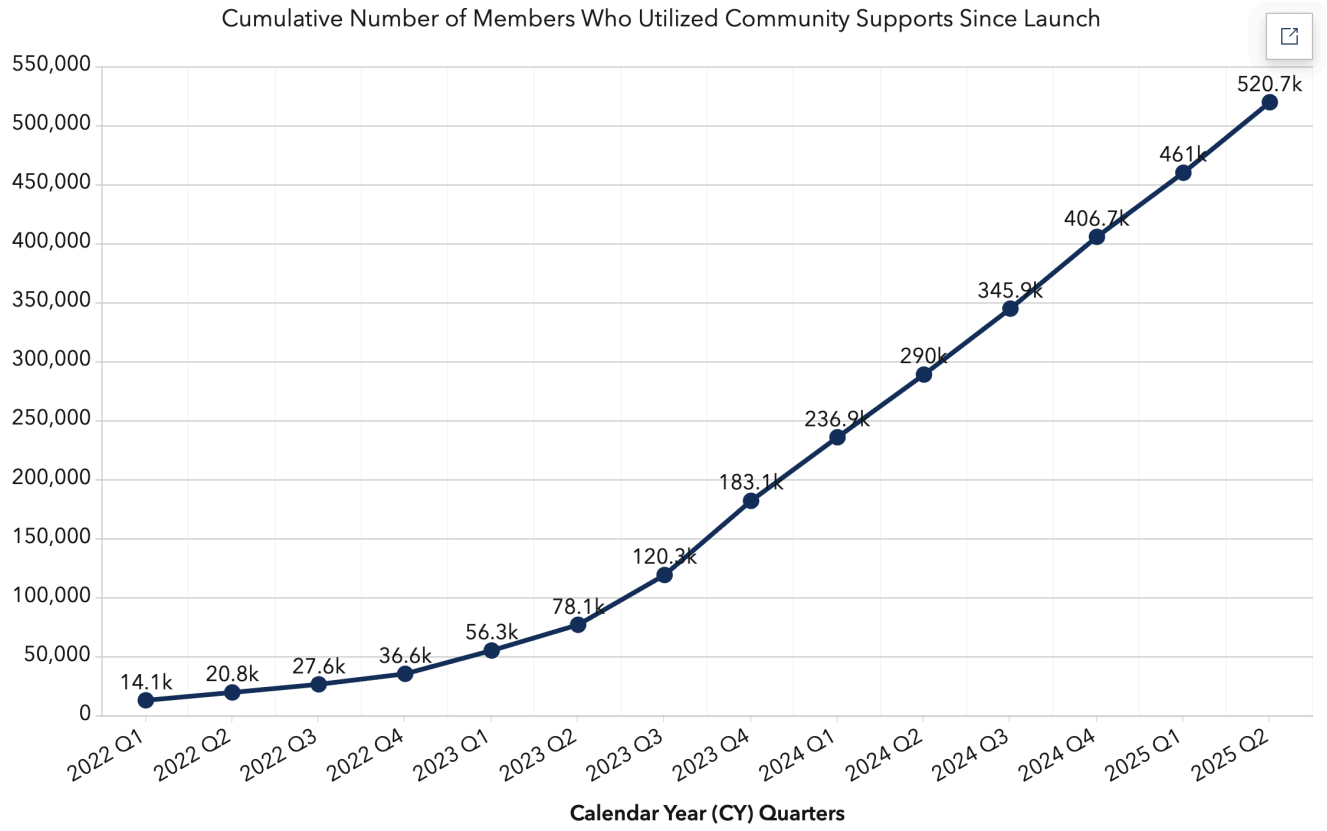
15 Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders. (source: Community Supports Policy Guide)

16 Calculated by dividing the total number of Community Supports & ECM participants (as noted in graph below) by the total Medicaid enrollment in Q1 2025. Referenced here: https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Medi-Cal-Enrollment-and-Renewals-Dashboard-March2025.aspx

CUMULATIVE NUMBER OF MEMBERS WHO UTILIZED COMMUNITY SUPPORTS SINCE LAUNCH



Source: ECM and Community Supports Quarterly Implementation Report

Massachusetts Flexible Services Program showed a similarly slow ramp up. Three-quarters of a year after ramp up, only about 0.3% of the total ACO-enrolled population had received either housing or nutritional support.

UNIT COSTS

BACKGROUND AND CONSIDERATIONS

Federal regulations do not allow ILOS interventions to include room and board. Section 4442.3.B.12 of the State Medicaid Manual defines board as "three meals a day or any other full nutrition regime[17]." Therefore, a food ILOS must provide less than three meals a day (which has often been interpreted as two meals per day or less). This is consistent with many FIM services that cover up to two meals per day. In addition, CMS requires that these programs are not duplicative to SNAP and WIC programs[18], which should be factored into cost estimates.

Nutrition programs can be organized in different ways, but the benefit is often provided on a weekly basis.

Availability of food and delivery costs will vary from state to state and region to region. In developing assumptions for unit costs for food programs, the following characteristics of the target program and population should be factored into unit cost assumptions:

- Rural vs. urban.
- Meal/box delivery vs. pickup: Delivery will require an additional cost, which may vary depending on urban/rural setting. Pick-up meals and boxes may be underutilized due to lack of transportation.
- Food content.
- Size of the unit.
- Other costs, such as wraparound services like SNAP and WIC navigation.

Appendix 1 includes references and tables to provide a range of reasonable unit cost or monthly cost assumptions. These assumptions should be used only as a guide, and not a replacement for research on costs in a particular region or state.

ASSUMPTIONS

The Unit Cost for each unit (e.g., meal, box or other) can be calculated based on the direct cost of the food benefit, adjusted for the considerations outlined above. Specific variables include the following:

Text Entry: 3a) *Unit description.* The unit of delivery of the benefit, such as "week of medically tailored groceries" or "weekly grocery box".

> 💡 **Tip:** To keep track of changes, you may want to note whether you are including other costs such as care coordination, nutrition assessments or other costs. SNAP and WIC navigation assistance is a best practice to better address whole-person care, and should be incorporated into the average monthly costs.

Numeric Entry: 3b) *Average cost per participant per month.* This should be inclusive of all fixed and incremental costs with assumptions of volume and utilization that are consistent with the rest of your model.

> 💡 **Tip:** Ensure that your cost estimate includes all of the following:
>
> - Start-up costs such as legal counsel to negotiate contracts, purchasing of new hardware or software, and infrastructure investments such as vehicles, refrigerators or storage spaces
> - Delivery costs for the percentage of the population receiving delivery
> - Registered dietitian initial assessments, consultations, and care planning
> - Care coordination, including SNAP and WIC application assistance
> - Administrative costs for the CBO, such as staff or overhead
> - Administrative costs for the MCO to administer the program

17 The State Medicaid Manual https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms02192

18 CMCS Information Bulletin (December 10, 2024). Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program https://www.medicaid.gov/federal-policy-guidance/downloads/cib12102024.pdf

Consider comparing your cost estimates to other Medicaid Nutrition program costs shown below.

State	Pricing guidance
Michigan's ILOS pricing guidance document (April, 2025)	◦ MTM (14/wk): est $698 Per Member Per Month ◦ Healthy Home delivered meal (14/wk): est $632 Per Member Per Month ◦ Health Food pack (weekly): est $396 Per Member Per Month ◦ Produce Rx (weekly): $225 Per Member Per Month
From North Carolina's Healthy Opportunities Fee Schedule (July, 2024)	◦ Fruit and Vegetable Prescription: $248 Per Member Per Month ◦ Healthy Food Box: $97 - $177 per box (depending on box size and pickup vs delivery) ◦ Healthy Meal: $7.10-$7.70 per meal (depending on pickup vs delivery ◦ Medically tailored home-delivered meal: $7.92 per meal
California's Non-Binding Pricing Guidance (December 2025)	◦ Delivered Meal: $7-$12 per meal ◦ Weekly Grocery Box: $52 - $81

Calculated Field: 3c) Total Program Costs is the Average Cost per Participant Per Month multiplied by 2l) Total Benefit Months. This is the total cost of the intervention.

USING THE CALCULATOR: ACCOUNTING FOR MEDICAL OUTCOMES OFFSETS AND RETURN-ON-INVESTMENT

ESTIMATED MEDICAL OUTCOMES OFFSETS

BACKGROUND AND CONSIDERATIONS

The impact of Medicaid FIM investments includes healthcare savings related to the FIM intervention and increased Medicaid enrollee participation in federal nutrition benefits (SNAP and WIC). This paper and model assume that FIM interventions will include enrollment in benefits as a necessary strategy to ensure the FIM Intervention is additive to other nutrition benefits, rather than replacing them. SNAP and WIC enrollment are clearly linked to reduced healthcare costs and improved health outcomes. Many FIM organizations include SNAP and WIC navigation at some level, particularly to assist participants in continuing to receive nutrition support even after a FIM intervention has ended. Therefore, linking the benefits from both the FIM intervention (i.e. grocery program) and SNAP/WIC enrollment is critical for capturing the full healthcare cost effectiveness impact of FIM. Navigation includes "referral and enrollment support" that helps provide access to food and information on making healthy food choices.

Some of the population considerations noted above for costs have corollary considerations for cost offsets.

- **Highest Benefit.** Narrowing a population receiving a service to the population that will benefit most can result in higher medical savings for the resources spent. Children with low healthcare costs may not be able to demonstrate savings within that population as you would not want to reduce use of critical preventive services. However, it may be possible to reduce healthcare costs and improve health outcomes for children with higher baseline healthcare utilization and needs such as children with complex needs, like children experiencing diet-related illnesses or living in the foster care system.
- **Population needs.** Populations with higher needs may require a longer duration or a more intensive intervention to see better health outcomes.

This resource does not offer specific recommendations for potential savings because such estimates are dependent on the specifics of population and program design. In addition, for many interventions, the data is nascent, and the potential savings rely heavily on assumptions that may be different for each state.

ASSUMPTIONS

The variables that drive the medical outcomes offsets can be entered into the Workbook.

Numeric Entry: 4a) Estimated average annual per capita health care costs for the Target Population are the average annual costs specific to the target population. Since we are calculating the medical offsets for the population receiving the intervention, we want to use the costs specific to that target population. For example, a pediatric population would have lower annual health care costs than the general adult population, while a population of people with disabilities would have higher annual health care costs.

> **Tip:** If you are not able to find actual expenditures for the population, you can use the capitation rate for the population less the medical loss ratio as a proxy.

FIM INTERVENTION-RELATED SAVINGS

Numeric Entry: 4b) Estimated Annual Savings Due to FIM Intervention should be based on any available evidence regarding savings for the particular intervention, and will depend on the Target Population.

> **Tip:** Appendix B: Predicting Cost Savings provides a number of resources for creating a reasonable estimate of potential savings. For many populations and programs, the evidence is incomplete, and these data points will need to be leveraged to make a reasonable assumption. Document and share these assumptions.

Calculated Field: 4c) Estimated Annual Intervention Savings as a Percent of Cost. This converts the savings in 5i) into a percentage and can be a reasonableness check.

Calculated Field: 4d) Total Annual Savings Due to FIM Intervention provides the savings estimate for the entire population.

SNAP/WIC-RELATED SAVINGS

For this section, you should either enter savings as a result of WIC enrollment or as a result of SNAP enrollment. As there has been limited data showing the effect of enrollment in both programs compared to just one, adding savings from both risks over-estimating the impact of being enrolled in SNAP and WIC.

Numeric Entry: 4e) Percent of Target Population Who Are Eligible for SNAP or WIC should be based on the estimate of the Target Population who are currently ELIGIBLE for SNAP and/or WIC.

> **Tip: WIC.** Medicaid enrollees who are pregnant, postpartum, or under the age of 5 are automatically eligible for WIC, so if your program is solely focused on this population, you can enter 100%.

> 💡 **Tip: SNAP.** The overlap between SNAP and Medicaid eligibility is dependent on state eligibility rules, but there is significant overlap in all states. Review the income eligibility parameters for your target population and compare these to SNAP eligibility income limits to estimate the degree of overlap.

Numeric Entry: 4f) Current Utilization of SNAP or WIC for the Target Population is the number who are actually currently using SNAP or WIC. The national SNAP participation gap is 12%, though the USDA has acknowledged that their estimation methods can sometimes yield participation rates over 100% in specific states, which should not imply true full participation among eligible individuals. The national WIC participation gap is 46.5%. Among Medicaid enrollees, the participation gap among all eligible individuals is 61%[19].

> 💡 **Tip: WIC.** Figure Six WIC eligibility and Participation by State Over Time on the National and State Level Estimates of WIC Eligibility and Program Reach will provide state-level estimates of WIC Participation. The Center for Budget and Policy Priorities provides WIC participation data by age group and race/ethnicity that may be more accurate for more narrow target populations.

> 💡 **Tip: SNAP.** SNAP Participation rates can be found in the Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2022.

Calculated Field: Then, 4g) Gap in SNAP/WIC Takeup is the difference between those eligible and those using SNAP/WIC. This gap is the opportunity that the FIM intervention can have to enroll new members into SNAP or WIC.

Numeric Entry: 4h) Portion of Gap that Will Be Newly Enrolled in SNAP/WIC Because of FIM Intervention is the portion that will be enrolled. Despite the gap and opportunity, not every un-enrolled member will be enrolled.

> 💡 **Tip:** If your organization already provides SNAP and WIC navigation assistance, use internal estimates of what percentage of people you offer SNAP and WIC enrollment assistance to are actually enrolled. If you don't have internal data, you may want to consider a more conservative estimate (10%), knowing that stigma, barriers to enrollment, fear of public charge, and other factors may impede enrollment. This meta-analysis of strategies to increase WIC participation rate found that successful strategies increased participation by about 9%[20]. A study on SNAP outreach and navigation assistance found that mail outreach led to 11% of individuals getting newly enrolled, and outreach plus application assistance led to 18% of individuals newly enrolling. Hence, you could assume a higher enrollment rate if the FIM intervention includes more intensive navigation assistance.

Numeric Entry: 4i) Estimated Annual Savings per person in Healthcare Cost Due to Enrollment in SNAP/WIC should be based on any available evidence, and will depend on the Target Population. As discussed above in the Background and Considerations section, the evidence around medical cost savings and SNAP/WIC enrollment is strong.

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19 Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2022. Retrieved December 8, 2025 from https://fns-prod.azureedge.us/sites/default/files/resource-files/ear-snap-Reaching-Those-in-Need-2022.pdf

20 Davis RA, Leavitt HB, Chau M. A Review of Interventions to Increase WIC Enrollment and Participation. J Community Health. 2022 Dec;47(6):990-1000. doi: 10.1007/s10900-022-01131-2. Epub 2022 Aug 13. PMID: 35962868; PMCID: PMC9375084.

Tip:

- SNAP is associated with healthcare savings ranging from $1,400 per adult Medicaid participant ($4,100 for those with heart disease) to $2,360 per dual-eligible adult enrolled in Medicare and Medicaid.
- WIC is linked to reduced risk of preterm birth and infant mortality, preeclampsia, excessive gestational weight gain, and improvements to infant gestational age and birthweight (across multiple studies in California and South Carolina). Food assistance in the form of SNAP or WIC participation was associated with reductions in pregnancy complications, including gestational diabetes, gestational hypertension, preterm birth, optimal birthweight, NICU, and adverse pregnancy outcomes.
    - WIC participants have 13% lower odds of preterm birth[21].
    - WIC participants have an average of 0.41 fewer hospital days in the first year of life[22].

Calculated Field: 4j) Estimated Annual SNAP/WIC Savings as a Percent of Cost converts the total savings to a percent of costs.

Tip: An effective FIM program may decrease potentially preventable healthcare costs such as Emergency Room visits and hospitalizations. For children and perinatal populations, most healthcare costs are necessary expenses like primary care visits and labor and delivery. However, diet-related conditions in pregnancy can lead to birth complications and costly hospital care. Use this field to assess whether your savings projections are reasonable. In populations with overall low costs, the percentage of avoidable costs will be quite low.

Calculated Field: 4k) Total Annual Savings Due to SNAP/WIC Enrollment. This provides the savings for the entire population for WIC or SNAP Enrollment

TOTAL SAVINGS

Calculated Field: 4l) Total Savings From Intervention and SNAP/WIC combines total savings for SNAP and WIC enrollment, as well as the FIM intervention.

Calculated Field: 4m) Net Program Costs After Savings. This is essentially the number that will end up being the focus of a fiscal note. It is the net impact of the program on state costs. As a food upstream and preventive service, it is likely that there will be some cost impact.

21 Soneji S, Beltrán-Sánchez H. Association of Special Supplemental Nutrition Program for Women, Infants, and Children With Preterm Birth and Infant Mortality. JAMA Netw Open. 2019;2(12):e1916722. doi:10.1001/jamanetworkopen.2019.16722

22 Bersak T, Sonchak L. The Impact of WIC on Infant Immunizations and Health Care Utilization. Health Serv Res. 2018 Aug;53 Suppl 1(Suppl Suppl 1):2952-2969. doi: 10.1111/1475-6773.12810. Epub 2017 Dec 1.

USING THE CALCULATOR: COST LIMIT TEST

COST LIMIT TEST

BACKGROUND AND CONSIDERATIONS

The costs calculated above should be tested for two CMS thresholds. First, CMS requires additional documentation if ILOS costs exceed 1.5% of capitation for the managed care program that includes the ILOS[23]. This additional documentation includes a description of processes for determining that each ILOS is cost-effective, including a description of the key factors and data included in this analysis.

Second, CMS imposes a limit on the cost of ILOS, such that the cost of the ILOS cannot exceed 5% of the total capitation specific to the Medicaid managed care program that includes the ILOS[24].

ASSUMPTIONS

Numeric Entry: 5a) Total Capitation for the Medicaid Program is the aggregate amount of capitation for the 12-month period. It can be calculated from the individual monthly capitation rates by rate category and rate cell, multiplied by enrollment over the full Program Duration.

> **Tip:** Most states publicly share the cost of their managed care program in capitation or expenditure reports. Sometimes these are monthly reports and in other cases they are annual reports

Calculated Field: 5b) CMS Threshold for Additional Documentation calculates the 1.5% threshold described above. If 3c) Total Program Costs for this ILOS *plus costs for all other ILOS* (excluding Institutes for Mental Disease) exceed this threshold amount, the Medicaid agency will be required to submit additional documentation on cost effectiveness and may also require additional funding for the Medicaid agency to administer the program.

Calculated Field: 5c) CMS Limit is the total dollar amount that could be allocated to all ILOS while complying with the CMS Limit of 5% of Total Capitation. ILOS programs will not be approved by CMS if expected costs *for all ILOS* exceed this 5% amount.

Calculated Field: 5f) Net Program Costs as a Percent of Capitation. This projects how much the total capitation may be impacted by the inclusion of this ILOS. It is calculated as 4m) Net Program Costs After Savings divided by 5c) Total Capitation for the Managed Care Program.

> **Tip:** The California ILOS program costs as a percentage of the managed care capitation in calendar year 2023 was 0.15% and increased to 0.8% in the 2025 rate certification. California's ILOS includes 12 services spanning housing, nursing facility diversion, and nutrition[25].

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23 https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf, page 6

24 https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf, page 5

25 Community Supports or In Lieu of Services Annual Report: Department of Health Care Services 1915(B) Waiver Report to the Centers for Medicare and MEdicaid Services for Calendar Year 2024. 2024 https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf

CONCLUSION AND FUTURE OPPORTUNITIES

FIM grocery programs offer a promising pathway to improve health outcomes for Medicaid enrollees with diet-sensitive conditions, but their long-term success depends on realistic, actuarially sound cost estimates. The framework and calculator presented in this paper help policymakers and advocates move beyond assumptions by grounding projections in the mechanics of Medicaid rate-setting, participation patterns, and evidence-based savings. Looking ahead, the accuracy and credibility of fiscal analyses will increase as we continue strengthening the evidence base for FIM grocery interventions; improving data sharing between Medicaid agencies, MCOs, and FIM providers; and developing clearer state pricing guidance. High-quality cost prediction is essential not only for securing CMS approval but also for building sustainable, impactful FIM programs that advance health equity and responsibly integrate nutrition supports into Medicaid.

APPENDIX A: DEFINITIONS

DEFINING FIM GROCERY PROGRAMS

This paper uses the umbrella term FIM grocery programs to refer to Produce Prescriptions, Medically Tailored Groceries and Healthy Groceries. The Coding4Food project's definitions of these services are below:

- **Produce Prescription:** Provides all forms of produce, such as fruits, vegetables, and legumes. Can be fresh, canned, frozen, or dried if WIC/FDA-compliant. Excludes juices and nut butters. One unit equals 1 cup-equivalent per day per week and could be provided as a set of produce or in a cash value.
- **Medically Tailored Groceries:** Shelf-stable and perishable foods meeting 1/3 of weekly dietary needs, customized to medical and nutritional requirements by a dietitian as part of a therapeutic diet plan.
- **Healthy Groceries:** Shelf-stable and perishable foods meeting 1/3 of weekly dietary needs per U.S. dietary guidelines, with limits on sugar, saturated fat, and sodium. May be modified for disease-specific needs.

KEY DEFINITIONS

Capitation (or Capitated Premium): Capitation is a way states pay managed care organizations (MCOs), which are health insurance plans that manage Medicaid benefits. Instead of paying for each doctor visit, test, or procedure, the state Medicaid agency gives MCOs a set amount of money each month for each person they cover - also known as the capitation rate, expressed as a cost per member per month (PMPM). The MCO then uses that money to pay for members' care. In general, if care costs less than expected, the MCO can keep the savings; if it costs more, the MCO must cover the difference.

Medical Loss Ratio (MLR): MLR is a measure of how much of a health insurance plan's capitation premium goes to patient care or quality programs, versus administrative costs or profit. MLR is calculated as a health plan's spending on healthcare service provision and healthcare quality improvement programs, divided by total capitated premium. For example, if an MCO has an MLR of 90%, it means 90 cents of every dollar the plan receives through a capitation premium is spent on medical care and quality improvement, and 10 cents go to things like overhead or profit. States can set MLR requirements and, if they do, the minimum MLR must be 85% (42 CFR 438.8). MCOs have an incentive to count services, including those that address HRSN like FIM, towards the numerator side of the MLR, in order to meet these requirements. While other clinical services would also support achievement of these long-term services, FIM's potential for short and/or long-term cost savings would be beneficial.

Rate Cell: A capitation rate cell is a grouping of Medicaid MCO enrollees organized by eligibility category, age, gender, geographic region, and/or health status for which a state establishes a capitated premium. Rate cells allow states to account for differences in expected healthcare costs across populations and ensure payments to managed care organizations reflect the risk and service needs of each group. For example, the rate cell for older adults may have higher costs and premiums than younger enrollees due to higher expected level of healthcare service use.

Rate Setting: Rate setting is typically an annual process in which the state Medicaid agency uses various data sources to predict the average cost of enrollees for the next contract year. That average cost becomes the capitated premium or the fixed amount that the MCO gets paid for that person. Typically, states may pay different capitation rates for different rate cells or population groupings.

APPENDIX B: PREDICTING COST SAVINGS

The evidence base for cost-savings as a result of FIM grocery programs is limited. This appendix provides three potential avenues for creating an educated and realistic estimate of savings.

LEVERAGE AVAILABLE EVIDENCE

These literature reviews compile the available evidence. We also suggest you look at the studies cited within these review papers, because there may be studies more relevant to your intervention and target population.

- Food is Medicine: Peer-Reviewed Research in the United States (March 2023 Center for Health Law and Policy Innovation)
- Medically Tailored Food Packages (April 2025 HealthBegins)
- Medically Tailored Meals (November 2024 HealthBegins)
- A Systematic Review of "Food Is Medicine" Randomized Controlled Trials for Noncommunicable Disease in the United States: A Scientific Statement From the American Heart Association (June 2025 American Heart Association)
- Food is Medicine Research Action Plan (April 2024, Aspen Institute)

ASSUME A SMALL REDUCTION IN POTENTIALLY PREVENTABLE COSTS

Collect data on potentially avoidable costs for the serviced population and then predict a small amount of savings from that data.

Potentially Avoidable Costs for Diet-Sensitive Conditions like Diabetes	Potentially Avoidable Costs for Perinatal Populations
◦ Emergency Room Visits ◦ Hospitalizations ◦ Home Health Services ◦ Short-term nursing or rehabilitative care ◦ Emergency Medical Transportation ◦ Pharmacy ◦ Outpatient Services ◦ Outpatient Services	◦ Emergency Room Visits ◦ Emergency Medical Transportation ◦ NICU stays ◦ Pharmacy

The MACStats data set provides some overall data on utilization of emergency rooms and other services that may provide some initial starting data.

REVIEW STATE FIM EVALUATIONS

	Program type	Population	Savings Offset Range
Massachusetts	Nutritional Flexible Services include medically tailored meals, home-delivered meals, food boxes or groceries, produce prescriptions, food vouchers, kitchen supplies, connection to community food pantries and federal nutrition program assistance	ACO enrollee with a health need criteria (behavioral health need, complex physical need, assistance with activities of daily living, high ER use, or high-risk pregnancy) and food insecurity	23% reduction in hospitalization 13% reduction in ED visits Net savings of $210 per person
California	Medically Tailored Meals and Medically Supportive Food (groceries, produce prescriptions, healthy food vouchers and food pharmacies)	Individuals with chronic conditions (diet-sensitive conditions, including high-risk perinatal and behavioral health) Individuals being discharged from hospital or skilled nursing facility at high risk of readmission Individuals with extensive care coordination needs	18.7% reduction in inpatient services costs, 6.0% reduction in outpatient services costs, 20.0% reductions in PMPM emergency room costs A net increase in costs of 2.2%
North Carolina	Food and nutrition case management, evidence-based group nutrition class, diabetes prevention program, fruit and vegetable prescription, Healthy Food box (delivered or pick up, Healthy Meal (delivered or pick up), Medically Tailored Meal)	Individuals with a qualifying physical or behavioral health condition and a qualifying social risk factor	Reduction in total cost of care: ~5% ($85 PMPM) (includes all HOP Interventions)

REVIEW OTHER STATE COST PROJECTIONS

	Program type	Population	Duration	Program Costs	Takeup assumption	Savings Offset Range
Oklahoma SB806 Fiscal Analysis and the MFSN Quarterly Convening (Enacted)	FreshRx	Individuals with diabetes (5,901 enrollees)	Unknown	$508 dollars annually	5%	$72 PMPM (most likely scenario per actuary) or a 4.6% reduction in Medical costs
Virginia (Not Enacted)	Healthy Food boxes plus nutritional counseling	All pregnant and postpartum enrollees (31,467 enrollees)	Nine months	$270 PMPM (cost of nutritional counseling of $63.58 not incorporated)	95%	$0
Colorado (Legislatively mandated report-ot Enacted)	Prescription Food Boxes	Food-insecure individuals with a qualifying diet sensitive diagnosis	Six Months	$60 PMPM	100%	None
Rhode Island (Introduced-Not Enacted)	Fruit and vegetable prescriptions or vouchers, clinical nutrition education and other interventions	3 or more chronic diet-sensitive conditions (minimum of 284 people)	Six month	$880 PMPM	Unknown	None
Texas (Enacted)	Nutrition Counseling and Instruction	Pregnant Medicaid Enrollees	Unknown	Unknown	Unknown	State assumes that the costs could be absorbed using existing budget.

LEARN MORE

Website: medicaidfoodsecuritynetwork.org

Contact: MFSN@strength.org

JOIN THE MOVEMENT

Together, we are building a strong network that helps anti-hunger and healthcare advocates work with Medicaid programs and Medicaid-serving systems to meet the food needs of children and families, close SNAP and WIC enrollment gaps, and improve health and food security.

Subscribe to our digests, which summarize news in the Medicaid food security and FIM space and provide deep-dive case studies.