

THE FOOD IS MEDICINE ADVOCACY TOOLKIT

Using Advocacy to Expand Opportunities for Food and Nutrition Services in Public and Private Healthcare Systems



CENTER for HEALTH LAW
and POLICY INNOVATION
HARVARD LAW SCHOOL

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About the Authors

God's Love We Deliver is New York City's leading nonprofit provider of life-sustaining meals and nutritional counseling for people living with severe and chronic illnesses, such as HIV/AIDS, cancer, cardiovascular disease, Alzheimer's disease, renal failure and over 200 others. All services are provided free of charge, and in their over 30-year history, God's Love has never had a waiting list. Last year, God's Love provided over 1.4 million meals to 5,600 individuals. On the national level, God's Love leads The Food Is Medicine Coalition, a volunteer association of nonprofit food and nutrition services (FNS) providers across the country seeking to preserve and expand coverage of FNS for people with severe illness. God's Love executes an annual Advocacy Capacity Building Project for the field, and continues their deep commitment to serving people living with HIV/AIDS by sitting on the AIDS United Public Policy Committee and co-chairing the Federal AIDS Policy Partnership (FAPP) Structural Interventions Workgroup.

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI's Food is Medicine initiative promotes access to healthy food as an essential component of holistic healthcare that should be considered a reimbursable "core medical service" and identifies and promotes key legal and policy levers that help to increase access to healthy foods. Some of CHLPI's work to date includes releasing two national reports: *Food is Medicine: Opportunities in Public and Private Health Care for Supporting Nutritional Counseling and Medically Tailored, Home-Delivered Meals* and *Food is Prevention: The Case for Integrating Food and Nutrition Interventions into Healthcare*. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

This toolkit is written by Karen Pearl and Alissa Wassung of God's Love, and Sarah Downer, Katie Garfield, Robert Greenwald, Emily Broad Leib, and Samir Zaffer of CHLPI¹ to serve as a companion piece to the two earlier reports described above. This toolkit compliments the earlier reports by providing hands-on, practical guidance for implementing some of the core concepts described in both *Food is Medicine* and *Food is Prevention*.

The Center for Health Law and Policy Innovation provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

¹ We would also like to thank Malinda Ellwood for her contributions to the toolkit through the fall of 2014.

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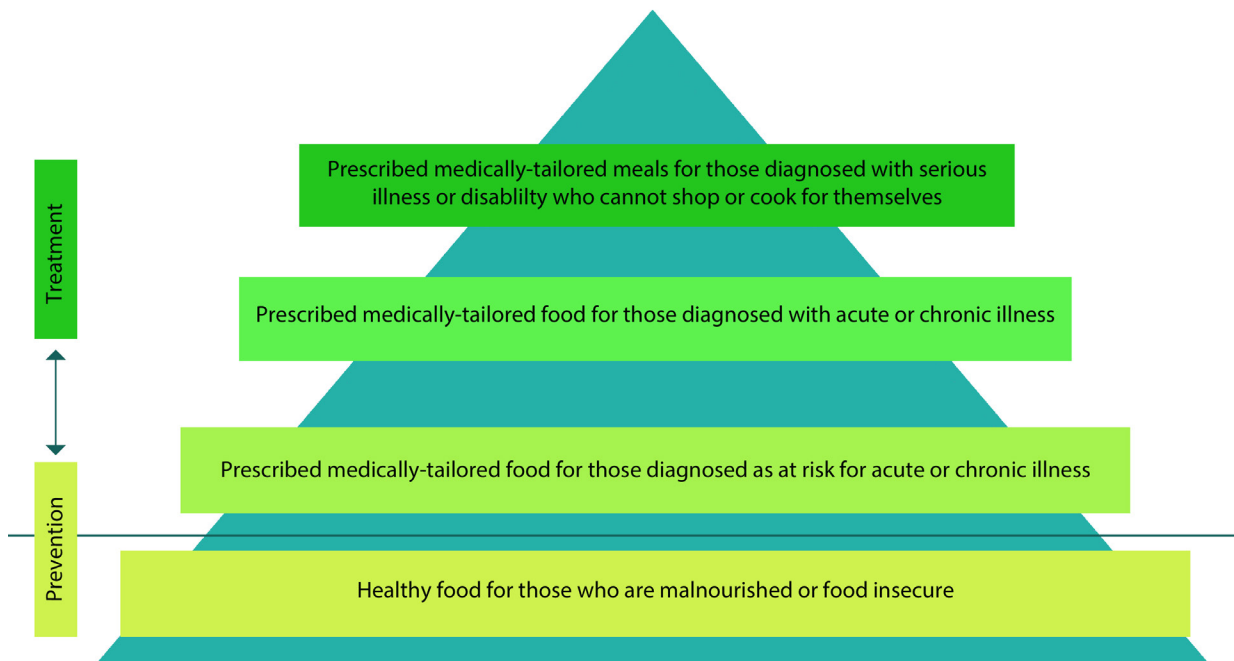
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INTRODUCTION

Across the country, the evolving healthcare landscape is creating new opportunities for integration of food and nutrition services (FNS) into our healthcare systems. Specifically, recent changes have created new opportunities for FNS providers to obtain reimbursement from both public and private insurers and integrate their innovative services into a variety of healthcare delivery models. A growing body of research demonstrates that FNS are cost-effective health interventions that improve health outcomes among beneficiaries and patients with significant health needs. As a result, insurers and medical providers (such as physicians and hospitals), are recognizing the enormous potential of providing insurance coverage of FNS. However, increased interest in FNS from public and private insurers, hospitals, and other healthcare entities is often slow to translate into partnerships and contracts for services without sustained effort on the part of FNS providers. FNS providers therefore have important roles to play in creating partnerships with providers, educating healthcare entities about the efficacy of their services, and advocating for policies that allow and/or require healthcare dollars to be spent on FNS.

This toolkit is designed to support the efforts of FNS providers by providing practical guidance on how to identify and take advantage of opportunities for acquiring new funding streams from health insurance systems and their associated delivery models and programs. The more medically tailored your program is, the more appealing it is to insurers and medical providers who are looking to improve patient care. Thus, at present, many of the opportunities showcased in this toolkit are more readily available to the more customized food and nutrition services, like home-delivered meals individually tailored for a client's unique medical circumstances, or nutritious congregate meals for populations in group care settings. In this toolkit, these providers are called Medically Tailored Food and Nutrition Providers (MTFNPs). When providing less specifically tailored services, like grocery bags and food pantries that offer healthy alternatives, FNS providers will need to be more diligent in seeking out and advocating for new insurance-based funding opportunities. Whether your service is currently reimbursable or not, this toolkit will help you lay the groundwork to accomplish that goal. With the concerted advocacy efforts of FNS providers nationwide, all services may one day be eligible for reimbursement in our public and private healthcare systems.

Food is Medicine: A Spectrum of Services



Part I. What is Advocacy?

'Advocacy' may traditionally be thought of as an action or process by an individual or group that aims to influence political, economic, and social decisions. Often, we assume the targets of our advocacy will always be government officials. This is not always the case in the current healthcare landscape. Throughout this toolkit, we will be using a slightly broader definition of 'advocacy' that expands the potential targets of collective action. In addition to advocacy for policy change, which may be necessary, we will also be using the concept to encompass persuading providers and health insurers to award your agency contracts to provide FNS to their vulnerable beneficiaries. These providers and insurers are often extensions of state and/or federal health insurance programs and are legitimate targets for advocacy.

A. Why Advocate?

More and more, FNS providers are seeing their funding streams shrink or dry up entirely. As a result, FNS providers have two options: accept the inevitable decline in services, or mobilize and advocate for policies that support your clients' well-being and fund your services.

Faced with this choice, FNS programs across the nation have been exploring the potential funding opportunities afforded by recent healthcare reform initiatives such as the Affordable Care Act (ACA). As part of these efforts, many programs have initiated strong advocacy strategies aimed at promoting FNS reimbursement as a crucial component of healthcare reform. Others, though, remain unsure of where to begin when trying to build an advocacy agenda. No matter where you are in launching your own advocacy efforts, this toolkit will give you new ideas on how best to promote your program and change policy to allow public and private insurers to provide sustainable funding for FNS.

This toolkit will help you navigate the complex world of healthcare reform. It will help you understand the potential opportunities for your program, and discuss internal and external strategies to consider in developing your advocacy plan. It will not address specific skills that are more generic to advocacy campaigns. You can read about and learn those specific skills—such as conducting a Congressional visit, writing a letter to the editor, and others—through many of the advocacy guides available on the web. We have listed a number of these guides in the "[Resources](#)" section of this toolkit.

B. Getting Started

All good advocacy starts with knowing where you want to end up. Only by knowing what you want to achieve can you set your strategy in motion and assess your progress. The world of healthcare reform is complex, and there are opportunities for FNS providers in many different healthcare programs, including Medicaid, Medicare, private insurance, and innovative programs that are being piloted in many states.

With research and planning, you will be able to determine the best opportunities to pursue, the steps you need to take, and how you will determine whether or not you are making progress. Let's get started.

Part II: Policy Research: Understanding the Existing Healthcare Landscape in Your State

A. The Importance of Policy Research

Whether you are just starting to explore partnerships with healthcare providers and insurers, or are well on your way, policy research is vital to the success of your advocacy efforts. Policy research sets the stage for any advocacy plan. By gaining a better understanding of the current policy landscape in your state—and how your program fits

into that landscape—you will be better equipped to map out your advocacy strategies.

Policy research will help you understand where the opportunities lie for your organization. Is there an existing policy that allows for reimbursement for FNS? Is that policy working? Do you need to advocate for a new law or policy? Additionally, by engaging in ongoing policy research, you will be able to stay on top of shifts in the policy landscape so that you can adjust your advocacy strategies as new opportunities arise.

B. Policy Research Techniques for Nonprofits

Finding straightforward information about health insurance coverage of meals and other nutrition services can be difficult. To begin your research, try using the following three techniques to locate information about Medicaid, Medicare, and other health insurance programs operating in your state: **1. use internet resources; 2. sign up for policy-tracking systems; and 3. consult with others.** These strategies are described in more detail below.

1. Use Internet Resources

Begin your research by searching relevant state and federal websites. This should give you some idea of the eligibility requirements and services associated with the available insurance programs. Each program should have a member services handbook (or other equivalent) describing all of the available benefits and how the program operates. Contact the administering agency directly to learn more about covered services and how to become a provider. Note, though, that member services or eligibility workers are not likely to be knowledgeable about information pertinent to FNS providers. Instead, try to identify an agency administrator or policy-focused staff member before reaching out.

2. Sign Up for Policy-Tracking Systems

As nonprofit providers, time is often your most valuable asset. As few of us have the resources to hire someone to do policy research full-time, it is important to adopt strategies that maximize the time you have available. In order to save time, while remaining up-to-date on relevant policy reforms, you can sign up for policy-tracking systems that bring information to you, such as: (1) listservs, (2) Google Alerts, and (3) newsletters and periodicals.

By signing up for healthcare-related listservs, your organization can benefit from the collective knowledge of a larger group that is interested in topics that may be relevant to your efforts to establish reimbursement for your services. Some listservs that could be particularly relevant to FNS providers include:

- The listserv for your state Medicaid program.
- Listservs related to any Medicaid innovation projects (e.g., dual eligible projects or Balancing Incentives Programs) in your state.
- Listservs related to your state’s Medicaid waiver programs (e.g., [“Home and Community Based Services Waivers”](#)).
- The listserv for your local HIV/AIDS Planning Council.

You can also bring information regarding healthcare reforms to you by setting up [Google Alerts](#). By setting up Google Alerts related to FNS and healthcare, you will be able to stay abreast of any new developments in these areas that are reported on the internet. When setting up your initial Alerts, you may wish to use broad search terms such as “(insert state) Medicaid reform,” “food is medicine,” or “healthcare innovation.” However, as time goes on, you can refine your research strategy to better reflect your ongoing understanding of the healthcare landscape in your state.

Finally, you can save valuable time by signing up to receive relevant newsletters and periodicals. Certain

funders and foundations that are concerned with healthcare reform more broadly, or with the well-being of specific disease populations, are ideal sources of information. [The Kaiser Family Foundation](#), for example, is a superb resource. By signing up to receive their daily newsletters, you can capitalize on the Foundation's significant experience, expertise, and resources related to healthcare reform. Additionally, if you already have referral relationships with insurance companies, your program should sign up to receive their newsletters. They are often the first to know about what is changing in your local healthcare environment. Be creative and open-minded about where you might find relevant information. As you learn more about your state's healthcare landscape, you will be able to refine your sources.

3. Consult with Others

Finally, do not be afraid to consult with other organizations that may have greater knowledge or research resources than you do. Given that nonprofit FNS providers tend not to have deep pockets when it comes to hiring outside help, you likely will want to begin by reaching out to organizations willing to provide free or low-cost assistance. For example:

- Healthcare-focused think tanks, advocacy organizations, and academic programs at local universities, often nonprofit themselves, may help community-based organizations navigate healthcare reform as part of their program mission or array of projects.
- Some enterprising law or public health student may wish to help your organization think through policy options as a thesis project or practicum.
- Your local nonprofit or volunteer lawyers association may have a pro bono healthcare expert who can offer assistance.
- Research consulting firms can help up to a point before you will need to pay for their services.
- Your local or state-based association of nonprofits, as well as local healthcare and anti-hunger coalitions, can also be great resources.
- Many nonprofits have had great success recruiting doctors, health plan executives, or former health department officials to their Boards. The expertise and contacts of these individuals can help develop and shape your advocacy plan, open doors, and operationalize your strategy.
- Finally, educational webinars, many of which are free, are a great source of information and education about the structure of healthcare in your state. When you first start listening, it may sound like alphabet soup, but over time, the new vocabulary and the infrastructure will become clear to you.

C. Policy Research Questions by Insurance System

Using the research techniques described above, you can begin to assess the opportunities afforded by the public and private health insurance systems in your service area. While many healthcare systems operate with some degree of state and federal partnership, the way that Medicaid, Medicare, and private insurance systems function varies state by state. As a first step, FNS providers must therefore become familiar with existing coverage of nutritional counseling, home-delivered meals, and other food and nutrition services within their state systems. By doing so, you will be able to identify both current opportunities to secure funding for the food and nutrition services you provide (in insurance lingo "third-party reimbursement") and areas where advocacy might improve these opportunities.

To help you initiate your research efforts, the following section provides an overview of some of the opportunities for FNS reimbursement available in public and private systems as well as the kinds of research questions that you can ask when trying to determine if they are a good fit for your program.

1. Medicaid in Your State

Medicaid: An Overview

Medicaid is a federal and state-funded program administered by the Centers for Medicare and Medicaid Services (CMS) that provides health insurance to certain categories of low-income individuals. The federal government requires all states that participate in the Medicaid program to provide coverage for children, pregnant women, parents, elderly, and disabled individuals who meet established income criteria (a/k/a the “traditional” Medicaid population).¹ Under the ACA, states now also have the option to expand their Medicaid programs to cover all adults up to 133% (138% with the 5% income disregard) of Federal Poverty Level (FPL) (a/k/a the “expansion population”).²

For beneficiaries in the traditional Medicaid population, federal law and regulations establish two categories of Medicaid benefits: mandatory and optional.³ All state Medicaid programs must cover mandatory benefits, such as inpatient hospital care, for most Medicaid beneficiaries. In addition to these mandatory benefits, states may choose to cover any number of federally-approved optional services. In contrast, beneficiaries in the expansion population receive benefits based upon a state-designed “Alternative Benefit Plan” (ABP),⁴ which must cover ten categories of services, known as Essential Health Benefits.⁵

Aside from basic federal guidelines, states have considerable flexibility in setting their eligibility criteria and the type, amount, duration, and scope of their covered services. As a result, Medicaid coverage varies between states and between populations within a state. FNS providers will therefore need to look at their state’s Medicaid program to see what it covers and for whom.

Medicaid Coverage of Nutritional Counseling

Under federal Medicaid rules, nutritional counseling is not specifically listed as either a mandated or optional benefit for the traditional Medicaid population.⁶ However, because of the broad flexibility given to states in defining benefits, states can choose to cover nutritional counseling under one of their existing categories of coverage. For example, states can cover nutrition counseling as part of the mandated category of physician services,⁷ or as part of an optional benefit category like preventive services.⁸

Similarly, states that chose to expand Medicaid may provide coverage of nutritional counseling for their expansion population as part of an ABP. Some groups within the expansion population are also guaranteed access to this service because all ABPs must provide coverage of services given an “A” or “B” rating by the United States Preventive Services Task Force.⁹ Specifically, all “adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors,” who are in the expansion population are eligible for “intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.”¹⁰

Example of State Medicaid Coverage of Nutritional Counseling

Some states cover nutritional counseling services in their Medicaid program, but choose to limit who can provide them. For example, in Massachusetts, MassHealth (Massachusetts’s Medicaid program) generally covers Medical Nutrition Therapy (MNT), defined as “nutritional diagnostic therapy and counseling services for . . . management of a medical condition,” if the service is provided by a MassHealth-registered physician, a registered dietitian or a licensed nutritionist.¹¹ A registered dietitian or licensed nutritionist cannot receive reimbursement under MassHealth unless she is under the supervision of a physician or another approved MassHealth provider. Because neither registered dietitians nor licensed nutritionists can become MassHealth providers on their own,¹² for a FNS provider in Massachusetts to receive Medicaid reimbursement for nutritional counseling services, it must partner with a physician or other approved MassHealth provider.

Action Step Questions

To determine whether the Medicaid nutritional counseling funding opportunities described above are relevant to your program, answer the following research questions about your state. Your answers will help you to develop your advocacy plan. (See “Part III: Developing an Advocacy Plan”).

- Has my state expanded Medicaid? If not, are there officials who support Medicaid expansion that could help to ensure food and nutrition services are included in proposals to expand Medicaid (e.g., in the ABP)?
- Does my state’s existing Medicaid program (traditional Medicaid and/or Medicaid expansion) cover nutritional counseling and, if so, which beneficiaries are eligible for such services?
- Are there any specific requirements as to who can provide services such as nutritional counseling (e.g., as in Massachusetts, must a registered dietician partner with a licensed Medicaid provider)?
- Who should I contact to learn more about becoming a Medicaid provider?

Medicaid Coverage of Home-Delivered Meals and Other FNS

For most beneficiaries, Medicaid does not provide coverage of home-delivered meals or any other FNS as a healthcare benefit. However, in some states, certain populations are able to receive coverage of FNS through the operation of Medicaid waivers. A state may use a Medicaid waiver to cover non-traditional services, provide targeted services to specific populations, and/or perform other activities or cover other services that the federal Medicaid program would otherwise not allow for a limited period of time (usually 3-5 years).¹³ To figure out whether your state covers home-delivered meals or other FNS, you will need to determine whether your state has any of the following waivers:

- **1915(c) Waivers (Home-Delivered Meals Only):** The main option through which states cover home-delivered meals is the Section 1915(c) Home and Community Based Services (HCBS) waiver. Almost all states currently have approved 1915(c) waivers (though not all of these waivers cover home-delivered meals).¹⁴ Section 1915(c) HCBS waivers support in-home and community-based services in order to help states avoid institutionalizing individuals who would otherwise need to be placed in a nursing home.¹⁵ The main target populations for HCBS waiver services are seniors, people with physical and intellectual disabilities, and people with mental illnesses. While federal law delineates certain specified benefits that states may cover as part of HCBS, it also permits states to request additional services that may be approved by the CMS.¹⁶ Home-delivered meals have been allowed under this category.
- **1115 Waivers (Home-Delivered Meals and Other FNS):** In addition to waivers that are specific to HCBS, states also have the option to apply for Section 1115 Demonstration Waivers.¹⁷ Section 1115 Demonstration Waivers are designed to give states broad options to expand eligibility, offer different kinds of benefits, and experiment with various care delivery models in order to improve Medicaid programs.¹⁸ Some states, like New York, use 1115 waivers to provide HCBS.¹⁹
- **Delivering Waiver Services:** In many states, waiver services may be contracted through Managed Care Organizations (MCOs). These are organizations that receive a capitated (or set) payment amount to provide particular types of services to a population of individuals who are eligible for Medicaid. In these states, it may be the MCOs themselves who create contracts with FNS providers.

Examples of Medicaid Waiver Coverage of Home-Delivered Meals

In 2011, Maryland’s Living at Home 1915(c) waiver allowed physically-disabled individuals ages 18-64 to receive a range of services, including nutrition services and home-delivered meals.²⁰ Similarly, the state’s Older Adults waiver included nutritional services and home-delivered meals among the services that Medicaid provides for individuals 65 and older.²¹ Moveable Feast, a FNS program that provides clients with medically-

tailored, home-delivered meals (i.e., a Medically Tailored Food and Nutrition Provider (MTFNP)) in Maryland, responded to a state Request For Proposal (RFP) to provide home-delivered meal services to individuals covered by these waivers.²² Moveable Feast was selected by the state as a provider, and currently provides services for eligible individuals at a reimbursement rate that is determined by the state.²³ Moveable Feast does not assess qualifications for HCBS among their clients, but instead receives referrals for home-delivered meals from case managers who coordinate waiver services for individuals already enrolled in HCBS. Once Moveable Feast receives a referral, they provide home-delivered meals, and then bill the state directly for these services.²⁴

By contrast, God's Love We Deliver (God's Love), an MTFNP in New York City, receives Medicaid reimbursement through contracts with Managed Long-Term Care (MLTC) plans.²⁵ MLTC plans are MCOs that are paid a capitated rate by New York Medicaid to provide comprehensive health services to a long-term care population under an 1115 Demonstration Waiver.²⁶ God's Love negotiates directly with the MLTC plan and the plan then pays God's Love for the nutritional counseling and/or home-delivered meals provided to the client. While nutritional counseling is required for all clients, some MLTC plans provide their own nutritional counseling services separate from God's Love. In such cases, God's Love only provides and receives reimbursement for the cost of the home-delivered meals.

Locating Your State's Waivers

CMS, the federal agency that oversees the Medicaid and Medicare programs, maintains a list of waivers in each state. This list can be accessed at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html. The search function allows you to narrow your search by state and type of waiver. Note that understanding waiver documents can be difficult. The purpose and administration of the waiver will be far more complex than just coverage of a specific service like meals. Keep in mind that you are only looking to find out whether your state covers home-delivered meals and how you can become a provider.

Action Step Questions

To determine whether the Medicaid waiver funding opportunities described above are relevant to your program, answer the following research questions about your state. Your answers will help you to develop your advocacy plan. (See "Part III: Developing an Advocacy Plan").

- *Does my state have any 1915(c) (HCBS) or 1115 waivers that cover home-delivered meals? If yes, which Medicaid beneficiaries are eligible to receive home-delivered meals?*
- *Are there any specific requirements as to who can provide these meals?*
- *Which agencies or organizations are responsible for deciding which providers will provide these meals?*
- *Who should I contact to learn more about becoming a Medicaid provider or subcontractor with a Medicaid-approved plan?*

2. Medicare

Medicare: An Overview

Medicare is the federal health insurance program that covers most people over the age of 65 as well as disabled individuals regardless of age (disabled individuals must have been disabled for more than twenty-four months or have end-stage renal disease). Medicare offers four types of coverage: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug coverage (Part D).²⁷ People enrolled in Part A and/or B receive coverage directly from Medicare, while people enrolled in Part C (Medicare Advantage) receive all Part A and B services through a private company, such as a managed

care organization (MCO).²⁸ Unlike Medicaid, which is a state and federal partnership, Medicare is a federal program, and benefits and eligibility are more consistent across states for Part A and B services. Medicare permits reimbursement for nutritional counseling under Medicare Part B for certain populations (described below) and reimbursement for home-delivered meals through Medicare Advantage and/or Special Needs Plans under Medicare Part C.

Medicare Coverage of Nutritional Counseling

Medicare covers MNT under its Part B services for beneficiaries with kidney disease, diabetes, or who have recently had a kidney transplant. In each case, the patient must first receive a referral from a healthcare provider.²⁹ Medicare defines MNT as “nutritional assessment, one-on-one counseling, and therapy services, either in person or through an interactive telecommunications system” provided by a registered dietitian or Medicare-approved nutrition professional.³⁰ Registered dietitians may enroll directly as Medicare providers by obtaining a National Provider Identifier and completing the Medicare enrollment process.³¹ The registered dietitian can then bill Medicare directly for nutritional counseling services.

Medicare Coverage of Home-Delivered Meals

In general, Medicare Parts A and B do not cover home-delivered meals.³² However, under Medicare Part C (Medicare Advantage), individuals may choose to receive Medicare benefits through private companies, called Medicare Advantage (MA) plans. MA plans may provide coverage of home-delivered meals as a supplemental benefit if “the service is: 1) Needed due to an illness; 2) Consistent with established medical treatment of the illness; and 3) Offered for a short duration.”³³ Physicians and non-physician practitioners can order covered meals immediately following a surgery or inpatient hospital stay, and can also prescribe meals for patients with chronic illnesses like diabetes in order to “transition the enrollee to lifestyle modifications.”³⁴

Some Medicare Advantage plans, called Special Needs Plans (SNPs) are specifically designed to target individuals with chronic illnesses. Some SNPs may be able to provide home-delivered meals without the restrictions imposed on regular MA plans.³⁵ However, SNPs are not available in every area, and so FNS organizations will need to investigate their local options.

Example of Medicare Coverage of Home-Delivered Meals

Every state will have different MA plans and SNPs, and these plans may also vary by county or zip code. For example, in Los Angeles, the Central Health Medi-Plan SNP allows coverage of “up to 10 frozen, precooked, nutritious meals delivered to your home after surgery or an inpatient stay at a medical facility,” while other plans offered in Los Angeles County and other counties do not cover home-delivered meals.³⁶

Locating Local MA Plans and SNPs

One way to identify the MA plans and SNPs available in your state (or service area) is to visit the federal Medicare website: <https://www.medicare.gov/find-a-plan/questions/home.aspx>. This website has a search function that allows prospective enrollees to research Medicare Advantage plans and SNPs in their particular zip code area. You can use this site to compile a list of available plans.

Action Step Questions

To determine whether the Medicare funding opportunities described above are relevant to your program, answer the following research questions about your state. Your answers will help you to develop your advocacy plan. (See “Part III: Developing an Advocacy Plan”).

- What MA plans and SNPs are available in my state (or service area)? Do any of the available MA plans, including SNPs, cover home-delivered meals?
- If yes, which Medicare beneficiaries are eligible to receive home-delivered meals?
- Are there any specific requirements as to who can provide these meals?
- Who should I contact at each plan to learn more about becoming a provider?

3. Program of All-Inclusive Care for the Elderly (PACE)

PACE: An Overview

The Program of All-Inclusive Care for the Elderly (PACE) is a joint Medicare-Medicaid program (based on a capitation model) that states can implement to help keep elderly people in their homes and communities instead of in institutionalized care.³⁷ PACE Elder Service Plans (ESPs) provide all benefits authorized by Medicare and Medicaid and also include a range of additional medical and social services, including nutritional counseling and meals.³⁸ PACE programs are operated by nonprofit agencies.³⁹ Beneficiaries who enroll in a PACE ESP agree to receive health services only from their PACE ESP organization.⁴⁰ Thirty-two states currently have PACE programs,⁴¹ but services may not be available in every town. To qualify for PACE services, an individual must be age 55 or older, require a nursing facility level of care, live within a PACE organization’s service area, and be able to live safely in the community with the support of PACE.⁴² In addition to dual eligibles (i.e., individuals who qualify for both Medicaid and Medicare), PACE also serves individuals who meet these criteria who have only Medicare or Medicaid.⁴³

Locating Local PACE Plans

To locate PACE plans in your state (or service area) begin by visiting: <http://www.npaonline.org/pace-you/find-pace-program-your-neighborhood>. This site will provide you with additional information about the PACE program as well as the option to perform a geographic search for PACE plans. To learn more about the available PACE plans, you should compile a list of plans in your area and then contact the coordinating agencies for each plan to determine how coverage of home-delivered meals works and/or how to become a provider.

Action Step Questions

To determine whether the PACE funding opportunities described above are relevant to your program, answer the following research questions about your state. Your answers will help you to develop your advocacy plan. (See “Part III: Developing an Advocacy Plan”).

- Are there any PACE plans in my state (or service area)? Who are the coordinating agencies?
- Which beneficiaries are eligible to receive home-delivered meals under these plans?
- Are there any specific requirements as to who can provide these meals?
- Who should I contact to learn more about becoming a provider?

4. Healthcare Initiatives Under Medicare and Medicaid that Incentivize Innovative Partnerships

Programs That Incentivize Innovative Partnerships: An Overview

Aside from regular Medicare and Medicaid, there are several alternative healthcare programs that incentivize Medicare and/or Medicaid providers and/or payers (i.e., insurers) to take proactive measures to improve health outcomes and reduce healthcare costs. Some of these programs currently allow coverage of nutritional counseling and home-delivered meals as is permitted through Medicaid and Medicare. As research demonstrates, the provision of FNS leads to lower healthcare costs and reduced rates of hospitalization, among other health benefits.⁴⁴ FNS providers are therefore well-positioned to partner with providers in these healthcare entities.

Dual Eligible Demonstration Projects

In addition to PACE, a number of demonstration projects are currently working to find innovative ways to improve care for individuals who are dually eligible for both Medicaid and Medicare. Because FNS providers often serve individuals with complex healthcare needs, there may be significant overlap between the dual-eligible enrollees being targeted in these projects and clients in need of FNS. Thus, some dual eligible demonstration projects currently include coverage of FNS.

Example of Dual Eligible Demonstration Project: Integrated Care Organization or ICO

For instance, in the fall of 2013, Massachusetts began implementing “One Care,” a dual-eligible demonstration project in which Integrated Care Organizations (ICOs) receive a streamlined capitated per-member per-month rate comprised of blended MassHealth (Massachusetts Medicaid) and Medicare funding.⁴⁵ The ICOs provide coordinated medical and behavioral health services, long-term care, and prescription drugs to dual-eligible individuals aged 21 to 64.⁴⁶ ICOs have discretion to provide additional benefits and community-based support as needed or requested by the client.⁴⁷ They can also subcontract with other providers to offer these services. The overarching goal of Massachusetts’s ICO demonstration project is to provide coordinated services that result in better patient health outcomes and lower health costs.⁴⁸ In line with these goals, Community Servings, a Massachusetts-based FNS provider, has contracted to provide medically-tailored meals for individuals enrolled in the One Care program through Commonwealth Care Alliance.⁴⁹

To find out if your state is participating in a dual eligible demonstration project, you can click on the following link: <http://dualsdemoadvocacy.org/state-profiles>. Select your state to see the status and, if applicable, location and contact information of dual eligible demonstration projects in your state.

Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are a new method of organizing care delivery and payment.⁵⁰ An ACO is a partnership of providers who agree to provide all Medicare services, and whose reimbursement is partially contingent on meeting quality metrics and reducing care costs.⁵¹ (Note that while we focus on ACOs in Medicare here, ACOs can exist in both the Medicaid and Medicare programs and in the private market, all of which are good targets for advocacy.)

Over time, some Medicare ACOs that meet certain milestones for quality and cost-savings will move towards a capitated per-member per-month rate, which will allow them to have more flexibility in providing services that Medicare might not ordinarily cover.⁵² This flexibility will create an opportunity for FNS providers to contract with ACOs to provide non-traditional benefits that improve health outcomes and lower costs, like home-delivered meals and other FNS interventions.

To begin locating Medicare ACOs in your state you can visit the following websites: <http://innovation.cms.gov/initiatives/Pioneer-aco-model/> and <https://www.cms.gov/Medicare/Medicare-Fee-for-Service->

[Payment/sharedsavingsprogram/ACOs-in-Your-State.html](https://www.cms.gov/medicare/innovation/center-for-medicare-and-medicare-innovation/ACO-in-Your-State.html).

Center for Medicare and Medicaid Innovation (CMMI)

The Center for Medicare & Medicaid Innovation (CMMI) is a recently-created government office that (a) encourages the sharing of best practices in Medicare and Medicaid, (b) pilots new models of healthcare service delivery, and (c) engages a range of stakeholders in implementing new data-driven changes to models of care.⁵³

CMMI demonstration projects can include services that Medicare and Medicaid would not traditionally pay for, such as food-based interventions. For example, two states that have CMMI-funded awards to innovate within their Medicaid programs are using parts of these grants to provide incentives for purchasing healthy food. Minnesota's program provides pre-diabetic participants with healthy food cookbooks, cooking tools, and debit cards that can be used for the purchase of food.⁵⁴ Texas's program, which is available to patients with both a physical chronic health diagnosis and a behavioral diagnosis, gives each participant a flexible spending account that the participant may use to buy nutritional or medicinal foods that are part of an individually-tailored Wellness Action Plan.⁵⁵ Additionally, CMMI has recently announced a new innovation model program that will allow Medicare Advantage plans in seven states greater flexibility in providing supplemental benefits—such as FNS—to targeted groups of beneficiaries.⁵⁶ Future CMMI projects could build upon these initial efforts by including coverage of medically-tailored home-delivered meals and other FNS interventions. Additionally, if these CMMI projects are successful, they can be used as examples to support broader coverage of FNS services in the Medicare and Medicaid systems.

Healthcare providers, hospitals, and their partners may apply for innovation grants through the CMMI's competitive process. If accepted, these organizations can receive considerable funding and technical assistance to design and implement new models of health-care delivery.⁵⁷ FNS providers can partner with potential applicants to provide their services as part of an innovative care model.

To review the various CMMI-funded Innovation Models, visit <http://innovation.cms.gov/initiatives/index.html#views=models>. This website notes whether projects are complete, ongoing, or still accepting applications for funding. It also provides a map that shows active and already-complete CMMI projects in each state.

Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP is part of the Section 1115 Demonstration Waiver program. It provides states with funding that can help hospitals and other providers to change how they provide care to Medicaid beneficiaries. The waivers, though once specifically focused on safety net hospitals, now support a variety of delivery system reforms across public and private hospitals, and, in some cases, non-hospital providers.⁵⁸

Notably, in order to receive DSRIP funds, eligible providers must meet predetermined performance metrics. Typically, in the early years of the project, these metrics are process-focused, requiring the providers to meet certain milestones in developing their infrastructure or redesigning their delivery systems.⁵⁹ However, over time, these metrics become more outcomes-focused, requiring providers to demonstrate improvements in clinical outcomes.⁶⁰ Thus, DSRIP providers may have incentives to identify effective strategies for improving patient health, such as partnering with FNS providers. FNS providers should therefore check their state Medicaid websites to determine whether any DSRIPs have been—or may be—implemented in their states.

For more information, see the overview of DSRIP initiatives developed by *The Kaiser Family Foundation* at <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.

Example of Delivery System Reform Incentive Payment (DSRIP) Program

In 2014, New York State received approval from CMS to reinvest \$8 billion in Medicaid savings in a DSRIP project with the ultimate goal of driving down avoidable hospitalizations by 25% statewide.⁶¹ The project has a five-year timeline, but it was important for community-based organizations (CBOs) to join provider systems at the outset of the project. God's Love created a team of program staff dedicated to this project. The team divided up the NYC-based Performing Provider System (PPS) meetings, testified at hearings on DSRIP, wrote public comment about the efficacy of FNS, and attended many web conferences. Thus, God's Love was able to become partners in all of the NYC-based PPS. The contractual arrangements for the actual mechanism of reimbursement are at the discretion of each provider system and are yet to be finalized, but God's Love is positioned to take advantage of the innovation available within the program by ensuring that each PPS values the role of FNS in reducing avoidable hospitalizations.

5. Healthcare Innovation through Private Insurance

Private Insurance: An Overview

Like public health insurance programs, private insurers currently have strong incentives to provide services that improve outcomes while cutting costs. Under the Affordable Care Act, private insurers can no longer refuse to cover an individual based on a pre-existing health condition, discriminate against medically-needy clients when administering coverage, or set annual or lifetime coverage limits. Additionally, the ACA improved the ability of low-income individuals to afford coverage by providing premium tax credits and copayment subsidies for plans purchased on the new state and federal marketplaces. As a result of these reforms, many high-need patients are now covered by private insurance, and insurers are motivated to find ways to reduce the ensuing costs.

Because food and nutrition services such as home-delivered meals have been shown to both reduce healthcare costs for high-need patients and improve outcomes, FNS providers are well-positioned to contract with private insurers for reimbursement of their services.

Private Insurance Coverage of Food and Nutrition Services

As with Medicaid expansion plans, all qualified health plans (QHPs) sold on the state and federal marketplaces (as well as most other plans sold outside of the marketplaces) must now provide coverage of the ten categories of Essential Health Benefits and all preventive services that receive an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF).⁶² Because the USPSTF gives a "B" rating to counseling interventions to promote healthful diet and physical activity for "adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors,"⁶³ most private plans must cover nutritional counseling for adults meeting these criteria.

Beyond covering USPSTF-recommended nutritional counseling services, there are no federal requirements for covering nutrition services such as home-delivered meals. As noted above, though, insurers have strong incentives to offer coverage of low-cost, high-impact services. Therefore, some plans may independently choose to cover home-delivered meals and/or other FNS, or may be open to the idea of doing so. Therefore it is important to familiarize yourself with the benefits offered by the plans operating in your service area. To begin to identify these plans, visit the marketplace website relevant to your state (e.g., www.healthcare.gov).

D. Exploring Opportunities and Identifying Barriers

Your initial research regarding the Medicaid, Medicare, and private insurance systems in your state, will allow you to complete the first step towards establishing an advocacy plan: identifying potential reimbursement opportunities. Once you have identified the potential opportunities in your state, you should determine which opportunities might

be a good fit for your organization.

To do so, take a moment to think about your program. Where on the continuum of FNS does your program lie? How dedicated is your program to disease prevention, management, and/or treatment? What level of intensity of illness and symptoms do your clients experience? How much do you tailor your program according to good nutrition standards and the individual circumstances of the clients you serve? By comparing your organization's goals, limitations, and client base to the requirements of the available opportunities, you will be able to identify which opportunities to pursue.

FNS CONTINUUM OF CARE

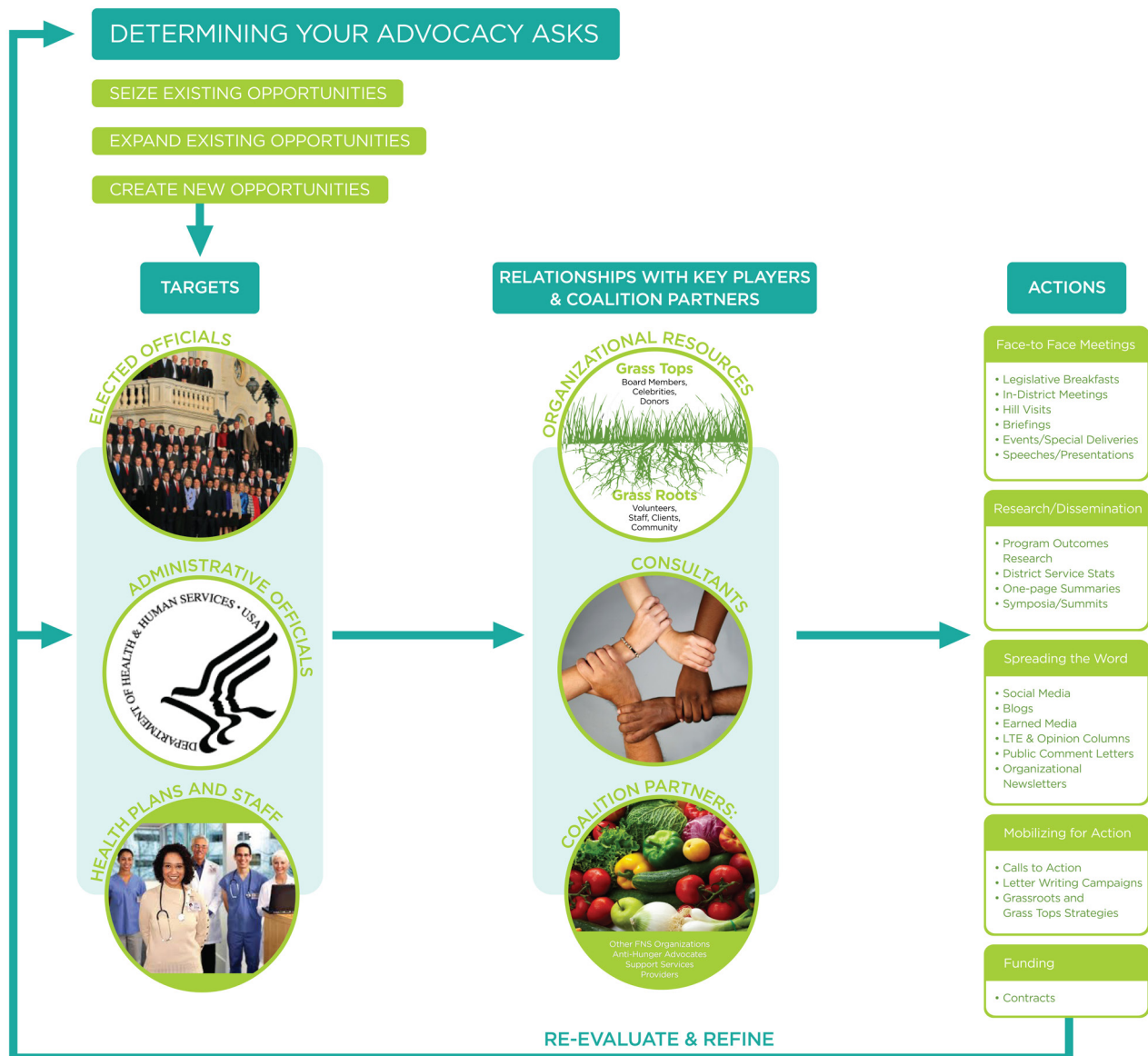


Through your policy research, you will also be able to identify some of the specific barriers that currently prevent you from establishing reimbursement relationships with public and private insurers and healthcare providers. For example, you may identify barriers at the state level (e.g., lack of Medicaid expansion), insurer level (e.g., lack of coverage for FNS), or provider level (e.g., lack of policies/practices for contracting with FNS providers). The opportunities and barriers that you identify in your research will form the foundation for your advocacy plan.

Part III: Developing an Advocacy Plan

Once you have identified the opportunities and barriers to establishing reimbursement relationships with the health insurers in your state, you will be able to form your advocacy plan. This plan will identify the goals you are seeking to achieve, the barriers that you are looking to overcome, and the strategies that you will use to do so. In developing your plan, you should make sure to address the following key elements: **(A.) determining your advocacy asks;** **(B.) determining your advocacy targets;** **(C.) developing relationships with key players;** **(D.) determining your coalition partners;** **(E.) messaging;** **(F.) data collection;** and **(G.) clarifying the steps that will take you to your goals.**

• YOUR ADVOCACY PLAN •



The figure above is a great way to visualize the formation of your advocacy plan. At the top, you have the first step in formulating an advocacy plan, determining your advocacy asks (**Section A.**). Along the left side are your advocacy

targets (**Section B**). Your relationships and coalition partners are in the center (**Sections C. and D.**). The tools you will use, such as Messaging (**Section E.**) and Data Collection (**Section F.**), and the actions you will take towards your goals are along the right side (**Section G.**). Your advocacy plan will be a unique combination of the moving parts in this figure, designed to address your specific advocacy environment and goals.

A. Determining Your Advocacy Asks

The advocacy “ask” is the specific change that you would like to effect. It might be a change to current laws, regulations, contracting relationships, funding practices, or a combination of such changes. **Each advocacy ask falls into one of three categories:**

- **Seizing an existing opportunity:** When seizing an existing opportunity, your advocacy ask will typically be a request for a provider or insurer to choose to contract with your organization for the provision of FNS. For example, through advocacy efforts, Moveable Feast seized the opportunity that existed in the 1915(c) HCBS waiver in Maryland to provide home-delivered meals and to be reimbursed through Medicaid for those services.
- **Expanding an existing opportunity:** In contrast, when expanding upon an existing opportunity, your ask will seek to build upon a current relationship or policy so that your organization can serve a broader population. For example, in Chicago, Illinois, through a merger, Heartland Health Alliance expanded opportunities in the operations of a Federally Qualified Health Center to provide medically-tailored grocery bag and home-delivered meal services to their high-risk, high-need population.
- **Creating a new opportunity:** Finally, if broader changes are required to meet your funding goals, your ask may be a request for a provider or insurer to create a new opportunity for reimbursement of FNS. For example, in New York, God’s Love We Deliver is seeking to create a new opportunity through its advocacy work to expand Medicaid managed care plans to include coverage—and therefore reimbursement—for home-delivered individually tailored meals for those most at risk for hospitalization. Similarly, Project Open Hand in San Francisco and Project Angel Food in Los Angeles have been working to create an opportunity for FNS reimbursement in the California Medicaid system. To do so, they engaged a consultant to help introduce their programs to key officials at the Department of Health Care Services (DHCS), who are responsible for California’s 1115 Waiver submission. As a result of advocacy on the topic, DHCS has indicated that FNS will be potentially reimbursable under California’s renewed 1115 Waiver.

Where you land in framing your ask will require policy research as well as an assessment of the internal and external capacity of your organization. Some organizational change will undoubtedly be required before you begin providing services to Medicaid, Medicare, private insurers, and/or innovation projects. Understanding your own capacity to make the required changes will be important as you identify your advocacy asks and as you develop the rest of your advocacy plan. This type of assessment is discussed in Part IV.

B. Determining Your Advocacy Targets

To be successful in becoming part of and/or making changes in healthcare reform, you must identify the specific “targets” that can help you reach your goals. These are the people and institutions with influence and/or power to make the desired change. Often, you will focus on multiple targets. For example, you might work with many different legislators to enact a change to a law. Or, you might work with many different people within your state Medicaid agency to have them add Medicaid coverage of FNS through a waiver or State Plan Amendment.

Identifying the right targets is not easy. In fact, many FNS providers have found that they need to start “somewhere” and follow the leads identified at one meeting to schedule the next, until they arrive at the right person who can truly effect the desired change and/or help develop the road map to getting there.

Advocacy targets for healthcare reform might include elected officials, agency officials, private insurers, and hospitals. Depending upon your ask—whether you are looking to seize, expand, or create an opportunity—your targets will differ. While there is no hard and fast rule, here’s a guide for getting started in choosing your best targets:

- **Change in legislation:** Meet with elected officials.
- **Change in Medicaid or Medicare coverage and/or regulations:** Meet with agency officials (Departments of Health, Human Services, Mental Hygiene, Social and Human Services, etc.).
- **Change in provider policies/practices:** Meet with hospital and health plan administrators.

C. Developing Relationships with Key Players

It is important to remember that good advocacy, like so many other parts of your program, relies on your ability to build productive relationships. The targets of your advocacy efforts must be providers, insurers, and policymakers you get to know, and who get to know you and your program. When you plan a project, you need to include the time it takes to build these relationships into your plan—preferably before you need anything specific from the other party. The more ambitious the project, the better relationships you will need as a foundation. Not only does your advocacy network help when building knowledge and formulating your advocacy plan, but mobilizing the relationships you have created will be key to accomplishing policy change.

Whether you are forming relationships with elected or administrative officials, health plan staff, coalition partners, or any other target, the guidelines are the same. The process to initiating the relationship is two-fold: you need to isolate what the other party wants, needs, or cares about, and you need to be vocal about what value you bring to the relationship that helps meet the other party’s needs. This will help you make the case for the relationship that you propose. Additionally, as the relationship progresses, you need to be clear about what *you* want from the relationship long-term. By doing so, you will keep the relationship on track and continuously contributing to your advocacy goals. For guidance on how to effectively communicate your organization’s value and goals, see the section on “[Messaging](#)”.

D. Determining Your Coalition Partners

Often, the most successful advocacy efforts are accomplished in coalition with other programs that share similar goals. Participating in a coalition can help your organization build knowledge and shape its advocacy plan. Additionally, mobilizing your coalition can be key to accomplishing your desired policy change. Coalitions can be local, statewide, or national efforts. In order to build an effective coalition, begin by reaching out to FNS providers in your community or state who share your policy objectives. To expand your coalition, also think about whether to include other nonprofits that are working towards similar ends and might amplify your message, such as food banks or other social service providers. Finally, don’t forget key stakeholders such as clients, medical professionals, board members, staff, and volunteers. The stronger the voice for change, the greater your chance of success.

One word of caution: there are many coalitions working on healthcare reform, and you must choose where to spend your efforts wisely. Your time is not unlimited; seek to join coalitions or develop coalitions where your issue and voice are not diluted. You may have to do a cost-benefit analysis to determine whether a coalition will help you advance your goals, especially if there is a real cost associated with joining an already existing collaboration. Joining a coalition is a great way to raise the profile of an issue and make a big push for a legal or regulatory change, but it might not always be the best way to achieve more discrete goals. If, for example, you identify an opportunity to obtain referrals from health plans for providing FNS services to their beneficiaries, you will likely need to spend the majority of your advocacy energy working only with colleagues and health plan staff to secure that opportunity (e.g., giving presentations, negotiating contracts, etc.), rather than in coalition.

E. Messaging



To achieve your advocacy goals, you will need to carefully craft and deliver your organization's message to key targets. Your message should include your ask, followed by no more than 3-4 key message points. For each point, you should have supporting research, documentation, service data, and/or client stories. The presentation of your message should be focused and concise to ensure that your targets understand what you want and why it should be done.

When developing your message, consider including an explanation of how your program can help insurers and medical providers meet the Triple Aim of healthcare reform, which encompasses the national goals of: (1) better health outcomes; (2) lower healthcare costs; and (3) improved patient satisfaction.

Many insurers and medical providers are motivated to achieve these three goals in order to meet performance benchmarks and receive financial incentives. Therefore, highlighting the role of your services in achieving the Triple Aim can be an effective messaging strategy.

Once you have your message points well-developed, practice them until you know them cold. Then, be disciplined about using them in your meeting. Stick to the 3-4 points and the supporting data. Do not go off-message, even to share something else that is wonderful about your program.

Here is an example of a message that has been used successfully at God's Love We Deliver with hospital systems that are working to reduce hospitalization and re-hospitalization among high-need, at-risk populations.

Food Is Medicine Messaging

FNS Meets the Triple AIM
Better health outcomes: Malnourished PLWH have unsuppressed viral loads, lower CD4. Malnourished patients are almost 2x as likely to be rehospitalized in 15 days.
Lower costs: Overall healthcare costs for malnourished patients are 3x higher.
Improved patient satisfaction: Clients report that FNS help them live more independently, eat more nutritiously, and manage medical treatment and medications more effectively.

Low Cost, High Impact Intervention
\$20 per day vs \$4000 per night in a hospital
You can feed a person for 1/2 the year by saving one night in the hospital.

1 in 3 People Who Are Hospitalized Suffer from Malnutrition
Higher rates of re-hospitalization
Lower rates of discharge to home/higher to institutions Longer hospital stays

We Are Unique
We are the only home delivered meal program that medically tailors meals to each client's specific medical circumstances (diagnosis, medications, side effects, allergies, etc.)
Special diets (all low salt, no fillers, no preservatives)
Flexible delivery schedule

KEY MESSAGE:
Food is Medicine: The hospital must incorporate FNS into post-hospital discharge care if it is going to meet its lower readmission, lower cost and improved quality goals

Of course, if you find that your presentations are not getting you closer to your goals, it is time to review your message and adjust it for higher impact. Refining your message is a continuous process that often involves the incorporation of new information that you learn at each meeting along the path to reaching your advocacy goals.

F. Data Collection: The Role That Program Data and Research Play in Establishing Partnerships

Everyone “gets” that FNS are good for people’s health. Your challenge is to encourage insurers and medical providers to move beyond that general intuitive understanding and adopt specific beliefs in the efficacy of FNS in improving health outcomes and lowering costs. Moreover, you must convince them that they should pay *you* to provide those services. To do so, you need to prove to your targets, and in some cases your allies, that your intervention works and saves money in both the short term and long run. You also need to demonstrate that you are an expert in delivering your services.

In order to make this case, you must gather both general resources that link nutritious food and improved health as well as specific examples from your own program. Solid data in both of these areas will help to counter opposition and address concerns. Once gathered, you must then present this data in a compelling manner to your targets in order to achieve your desired outcome.

This section will walk you through the finding, framing, and dissemination of research data to make the case that food is medicine for people living with severe and/or chronic illness.

1. How to Find General Data

There are some wonderful free resources for existing data on FNS as a healthcare intervention.

Finding Resources on the Success of FNS

There are many resources available that establish the link between diet and health. If you want to show that the integration of FNS into healthcare systems addresses the Triple Aim, you will be looking for studies that are concerned with the impact of “food insecurity” and “malnutrition” on health outcomes and healthcare costs, studies on nutrition and diet, and studies on the impact of nutrition on specific illnesses (e.g., diet-related diagnosis codes). These studies can focus on specific demographic populations (e.g., the elderly, those with cardiovascular disease, etc.), or address the issue more broadly. It is up to you to figure out which studies are relevant to your particular ask and to mobilize the data on your argument’s behalf.

When gathering your general data, it can be particularly helpful to identify studies that the FNS provider community has participated in to show that programs just like yours have achieved great results. The pilot study from FNS provider MANNA in Philadelphia, PA is one of the most relevant studies to-date, showing that participation in a medically-tailored FNS program vastly reduces healthcare costs and improves health outcomes for individuals living with severe chronic illness. The 2013 study compared expenditures for overall healthcare, hospital stays, and emergency room visits of a group of MANNA clients with those of a similar group of individuals who received healthcare from the same Managed Care Organization (MCO), but who did not receive FNS. The results were dramatic: MANNA clients had significantly lower healthcare expenditures than the comparison group. On average, the MCO paid out \$12,000 less per month per client for MANNA clients.⁶⁷ MANNA clients also had shorter hospital stays than the control group and were more likely to be released from the hospital to their homes as opposed to sub-acute care facilities.⁶⁸ The CHAIN Study Factsheets 1, 2 and 3, from the CHAIN study at the Mailman School of Public Health, show similar outcomes for people living with HIV/AIDS.⁶⁹ The next few years should also see results from several FNS studies that are currently in process around the country.

Many of these studies are available free online. For additional resources, nutrition interns or student volunteers with access to university libraries are usually willing to engage in a research project on your organization's behalf. The national provider coalition, the Food is Medicine Coalition, also has a Research Subcommittee that is engaged in cataloging studies that show the efficacy of FNS. If you are a member of the Food is Medicine Coalition, you will be sent periodic updates on research. [The Academy of Nutrition and Dietetics](#), public opinion polls, and nonprofit or collaborative surveys, can also be excellent resources for gathering data to make the case for FNS.

Finding Resources on the Need for FNS

There are also many resources available that you can use to demonstrate the ongoing need for FNS in your service area. For example, if there are food insecurity surveys that are done in your area, these can be used to underscore the need for your services. For example, local (especially city) and state governments often keep food security or malnutrition statistics on their population. Additionally, most HIV Planning Councils engage in a needs assessment for their populations, and every nonprofit hospital is required to do a [Community Health Needs Assessment](#) every three years, to keep their nonprofit status. Food insecurity in the community is almost always measured or mentioned in these assessments.

Many excellent resources are also available online that you can use to gather broader national data on issues such as food insecurity and hunger. The [NHANES](#) survey is an annual food security study that measures a variety of food-related issues nationwide. [FRAC](#) and [Feeding America](#) also have excellent resources on hunger.

By gathering data across a variety of these sources you will be able to be responsive to what your audience requests. Some local officials will want to see national data, and some will want to see local demonstrations of efficacy. Others will want both. The data you use will in large part be dictated by your target's focus at the time.

2. Collecting Data to Demonstrate the Effectiveness of *Your* Program Services

Demonstrating the general efficacy of and need for FNS may not, however, be sufficient to convince insurers and medical providers to pay for your services. To secure reimbursement for your program, it is helpful to also gather data demonstrating that the FNS that *you* deliver has a real and cost-effective impact on patient health. To gather this data, first consider whether your organization needs to engage in further research. If you already have enough appropriate information to back up your advocacy, further research may be unnecessary. Existing data resources such as client surveys, growth statistics, yearly metrics, and others can be great for showing program efficacy.

If you determine that the data that you currently have regarding your program are insufficient, you may want to consider adding some additional outcomes questions to your evaluation model. Additionally, if public officials want to see more definite results in your state-based population, there may be a reason to engage in a more rigorous study. But, again, if your arguments are working, you may want to wait until a specific request for additional data comes from either a target or a funding agency to engage in your own study.

If you decide to go the route of a formalized study of outcomes, it is best to begin by reaching out to your colleagues at other FNS providers that have already navigated these waters. By tapping into this expertise and help, your organization will be better equipped to handle issues such as finding funding and research partners and crafting a well-designed research plan.

3. Presenting Data to Make Your Argument Accessible to the Reader

Many of the basics of good messaging have been laid out in the Section above, so this section will focus only on how messaging relates to data and research. Ideally, your research will clearly show that the needs or problems you want to address are real and serious, and that the methods you recommend for addressing them have, in fact, been proven

successful. Sometimes this type of argument is best presented as a cost-benefit analysis, with the punchline being, “How could you *not* invest in FNS for chronically and/or critically ill persons?”

Remember that you must tailor research and data presentations for your audience. Make the data serve your persuasive narrative. Your goal is to make your research as compelling as possible to the audience in front of you.

G. Taking Action To Reach Your Goals

Once you have identified your asks, targets, and allies; developed your message; and marshaled the data necessary to support it, it is time to determine what actions your organization can take to spread its message and achieve its goals. Every advocacy plan has multiple action steps, and is often the result of an iterative process where actions are taken, then evaluated, suggestions are offered and a revision to the plan is made. Advocacy plans often have a number of components, with some activities happening simultaneously and others sequentially. Write out your plan, list each action that you plan to take, what you hope to accomplish with each action, the time frame for its implementation, and how you will evaluate whether the action was successful. You can then review your progress and adjust your plan mid-course, if necessary.

As you work to develop your plan, consider whether some of the following actions might help you to achieve your advocacy goals:

- **Face-to-face Meetings:** These meetings could be with elected officials in their district offices or in the Capitol. They could also be with agency officials who can influence health policy, and who may be able to advise you on the best path for your work (e.g., regulation, legislation, waiver, etc.). You might host a legislative or policy breakfast, and ask an elected or government official to speak at the event. Of course, one of the most persuasive tactics is inviting people to visit your program and/or deliver a meal with you. Finally, depending upon your goals, you might meet with hospital and health plan administrators as well. You might attend meetings at the hospital or health center, or host medical providers and administrators on a visit at your program; in both circumstances, be prepared to speak about the role of FNS in meeting the hospital/health plan goals.
- **Spreading the Word:** The power of social media cannot be ignored in today’s world. Social media and your own website blogs and/or blogs on other sites have great potential to educate your stakeholders about your program, advocacy goals and plans, and your impact in helping clients manage their chronic and severe illnesses. If you are mounting an advocacy action day, using social media to ensure you have knowledgeable and passionate advocates ready to help is an invaluable resource. Another way to make your point and garner important support is by strategically using your organization’s newsletter (both online and in print), presentations, and speeches to spread your message to your target audiences. Many states hold sessions where public testimony can be given; grab those chances and make your point. Do it over and over again, and you will find that you have allies in positions of power who can help you along the path to meeting your goals. Finally, if you cannot publicly testify about how your issue is key to the success of healthcare reform, use every opportunity to submit public comments in writing and to sign on to letters put out by national, state, or local advocacy organizations that advance your positions.
- **Mobilizing for Action:** Used effectively, “Calls to Action” can help an advocacy campaign make progress. There are many calls to action that you can use. You can ask people to join a letter writing, email, or social media campaign. These campaigns can be directed specifically to elected officials on discrete advocacy asks or to other targets that will raise general public awareness of your issue. You can also use campaigns to garner earned media through efforts that seek to get Letters to the Editor published in your local press and stories about your program’s impact printed in newspapers, magazines, and online or run on radio or TV. Finally, you can schedule Advocacy Days for all of your stakeholders when appropriate. This is most effective when you are working on legislation and budget appropriations issues and a group of you “flood” the Capitol or local district offices with your requests and message points ready to go.

The exact actions that you decide to include in your advocacy plan will depend upon your advocacy asks, targets, relationships, and partners. For example, if your ask is that your state adopt a Medicaid waiver that will expand coverage of FNS, your actions will need to focus on influencing Medicaid agency officials, and, potentially, state legislators (depending on whether your state requires legislative action for such a change). If your organization has a strong relationship with state Medicaid agency officials, then your advocacy plan should include meetings to discuss the change. In contrast, if your organization participates in a large and active coalition, your plan should include activities that engage your coalition, such as letter-writing and social media campaigns.

As you determine which actions are right for your organization, be sure to consider how you might include and utilize all of your key stakeholders: grass tops (such as board members, celebrities, and major donors), grassroots (such as staff, volunteers, and other supporters) and clients (often your best advocates, as they make the impact of your services real and deliver the message in the most effective and heartfelt manner).

More specifics about how to engage in these various advocacy plan tactics are available on the websites listed in the [“Resources”](#) section of this toolkit.

Lobbying vs. Advocacy

As you make your way into the world of legislation and regulation reform by asking the state to expand or establish coverage for your services, your activities may cross the line from advocating for your clients’ needs to lobbying for the passage or expansion of specific rules, legislation, and/or budgets. Different states have different rules that define the boundary between advocacy and lobbying. It is imperative that you know your city’s and state’s rules. In general, lobbying is defined as an attempt to influence specific legislation or funding, including both legislation and funding that have already been introduced in a legislative body and specific legislative or funding proposals that you may oppose or support. Knowing whether you are crossing into lobbying is important for a number of reasons.

The first is that you need to consider how you talk about the concept of “lobbying” to your internal and external constituencies. Lobbying in the nonprofit world can have negative connotations. If your activities qualify as lobbying, this will be something that you will need to bring to the leadership of your organization, including the Board of Directors, to ensure that you have their support.

The second is that in most states, if you are lobbying, you will need to register and report on your activities to the state and/or city. There are generally two types of lobbyists: retained and employed. Retained lobbyists are outside consultants who you pay to represent you and your interests. Employed lobbyists are staff members who lobby as part of or all of their jobs. You can have one or both in your organization and both types of lobbyists usually have to report their activities. Consultants who are hired as lobbyists must register as lobbyists. With employed lobbyists, the ‘amount’ of lobbying is usually calculated on an hourly basis, and, if the employed lobbyist reaches a certain threshold of spending from their salary (the level of which varies by city and state but, for example, could be just \$5,000/year), the employed lobbyist will need to register as a lobbyist, track lobby activities and the time spent on them, and report on them as required by the city and/or state.

When determining your reporting responsibilities, it is particularly important that you understand the rules that apply in your state. Each state and locality is different, so you must research what the law says about your specific situation. Federal requirements are much less likely to be an issue for your organization. Currently, the threshold and requirements for registering with the federal government as a lobbyist are so high that no one provider would be likely to reach them in a year (though it is nonetheless important to check). Additionally, your main lobbying targets will most likely be state, rather than federal, in nature.

There are two types of lobbying: direct lobbying and grassroots lobbying. In some states, when you report lobbying you may have to specify which type. Direct lobbying is usually targeted specifically at legislators or legislation. This includes administrative officials, such as officials from the Department of Health or Aging. It does not include targets at healthcare plans that you are trying to persuade to contract with you (they are not public officials, although they receive and subcontract with public funds). Grassroots lobbying is directed at the general public, expresses a viewpoint on a matter, then asks the public to take action and tells them how to engage. Again, states have their own definitions of exactly which actions qualify in each case. Some states are stricter than others.

It is also important to know whether your activities qualify as lobbying so that you can apply the proper internal controls. You must keep track of what money is being used to support lobbying activities. Most often, at the state level, because of the low thresholds to qualify as a lobbyist, it is acceptable to use your general unrestricted operating funds to pay your employees for this type of service. There may also be a limit to the amount of money you may expend as a local or state lobbyist. Please remember that every state is different and you must pay attention to your own local laws when navigating these waters.

Finally, it is important to understand whether anyone in your organization has engaged in lobbying so that you can properly allocate the resources and time necessary to track and report your activities. Lobbying reporting can be time consuming, even if you have nothing to report in a given reporting period (often each quarter). If you are required to report, plan to take some time to think through your internal controls, develop a bookkeeping system, and then train the person whose responsibility it is to keep track of lobby activities and the money expended by each person representing your organization. Lobbying audits can be nerve-racking and may come with high fines if procedures are not followed correctly, so it is best to have everything carefully tracked from the beginning.

Many volunteer or nonprofit lawyers' alliances have regular training sessions on lobbying laws for nonprofits. Take full advantage of these opportunities, as lobbying laws change over time and these trainings will be focused on your local and state layout.

Part IV: Internal Strategy: Revamping Your Organization to Prepare for New Opportunities

You've done your research. You've developed your advocacy plan and messages. You've identified the opportunities in your service area for the integration of FNS into healthcare insurance and delivery systems and are ready to take action. However, there is one more step to take before you initiate your advocacy plan.

You must engage in an internal assessment of your organization's capacity to manage contracting, data collection, third party billing, and all the related requirements that contracts with insurers and providers often bring. Without ensuring your internal capacity, your organization may succeed in convincing insurers and medical providers to expand their coverage and use of FNS, but fail to ultimately secure the contracts that flow from that expansion.

A. Anticipating Programmatic Changes: Service Trends in the New Healthcare Landscape

Remember, FNS providers are living in a new healthcare landscape that is different in many ways from the atmosphere of the nonprofit world. As you perform your internal assessment, it is therefore important to analyze your internal capacity to handle the unique challenges of this new environment. Some current trends to consider include:

Internal Assessment



1. Heightened Consumer Engagement: Consumers/clients/patients/members (all systems have different names for the people they serve) are better informed. They know what benefits they are eligible for, and they are vocal—and sometimes even demanding—when they are not pleased with a service.

2. You Are Only as Good as Your Product: Every day, your product—the FNS you provide—will be evaluated by the client, and if they are not pleased, they will ask to be taken off your program.

3. Many Different and New Customers to Please: Your “user” will be redefined because you will be working with multiple customers simultaneously, such as clients, health plans, hospitals, and state regulators. It may be best to think of these new “users” and the strategies that you have for interacting with them in the same way that you consider and

relate to foundations, corporations, and individual donors that support your program. Your messaging may be different but the demands of the relationships are similar.

4. Greater Volatility: The client can switch plans or providers and healthcare plans can change subcontractors; you have to keep track of all the changes.

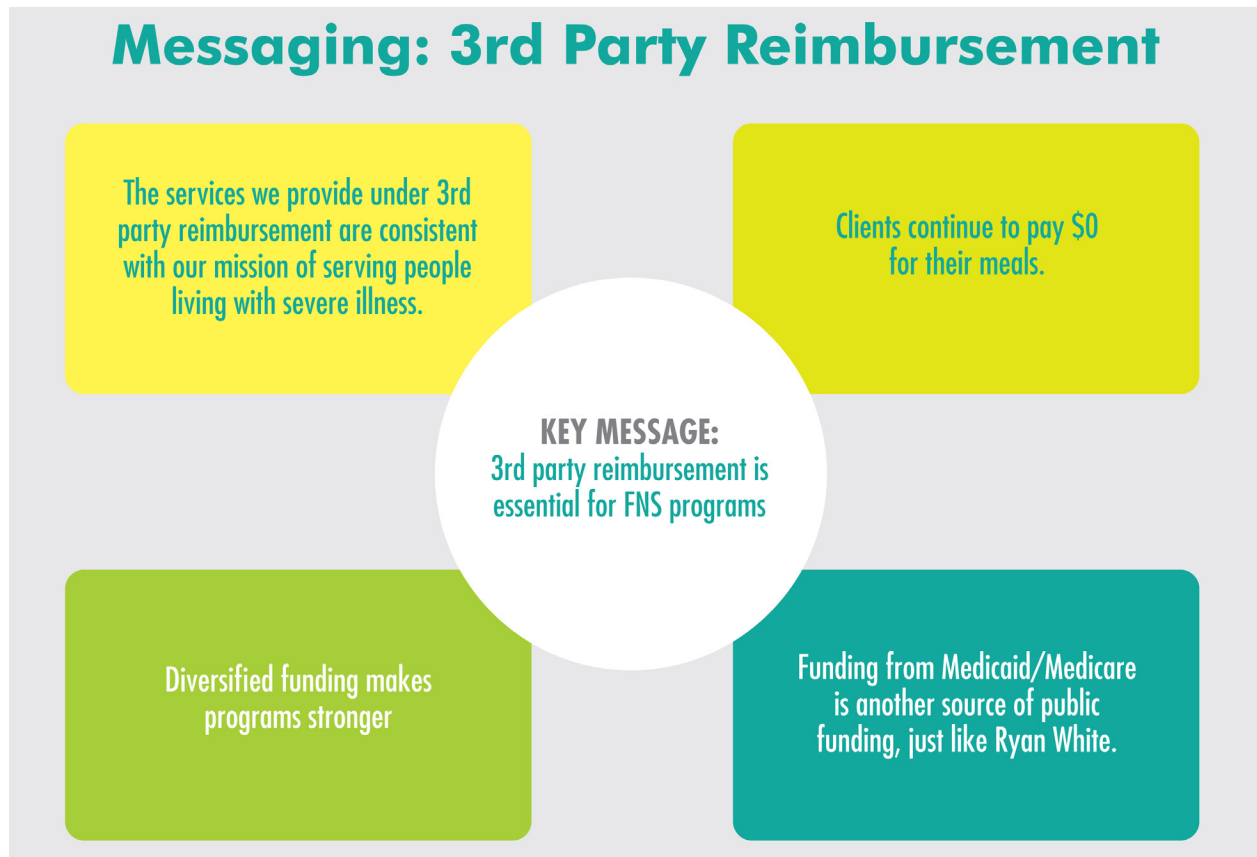
B. Anticipating Administrative Changes: Understanding How Third Party Billing May Affect Your Program and Mission

While you are working to secure opportunities within the new healthcare environment, you must also prepare to address issues around third party billing that may arise from many of your internal constituents as well as from your program design. Below are some of the key issues that require considerable thought and preparation.

1. Mission Issues

- FNS providers must think about mission issues in terms of who they want to serve and what they want to provide, and whether they will be able to accomplish those goals while accepting third party billing.
- Some Boards, staff, volunteers, and donors will question whether accepting third party billing and/or working with health plans and hospitals is a departure from the organization’s mission; have these discussions early so that all stakeholders are aligned and your messages to your various internal groups are ready.
- Stay true to your mission and expertise by describing to your Board and internal constituencies, and also external targets, the value that you bring to clients as a provider within the new healthcare system.

Here is an example of a message box that has been used at God's Love when discussing mission alignment and third party reimbursement.



2. Contracting

- Decide whether you have in-house resources to negotiate contracts with health plans, insurers, and/or hospitals.
- Engage outside counsel if you need someone to do this.
- Figure out the unit cost of each service you provide; you cannot enter into negotiations, let alone finalize a contract, without having confidence that you are covering your costs for everything that is required of you in your contract.

3. Program Delivery Model

- Consider the potential changes that you may be asked to make, from keeping health plans informed daily of missed deliveries or clients who were not home, to delivering on days that you may not normally be in a neighborhood, to adding more meals than you are accustomed to providing (such as breakfast).
- Decide whether you are able to expand your service area as some plans may cover communities where you are not yet delivering.
- Decide how flexible and expansive you can be, and whether you can add flexibility over time. Some plans will understand if you are not able to scale up to everything they would like at the beginning, as long as they know when their members will get the more expanded services.

4. Billing Issues

- Depending upon your state, you may be able to obtain a billing number and therefore bill Medicaid and/or insurers directly for FNS, or you may become a subcontractor to a health plan's contract.
- Be able to translate what you are offering to medical terminology and procedure codes (e.g., CPT codes, if your state has them for MNT and/or FNS, and ICD-10 codes).
- Set aside the resources to purchase the software necessary to bill for your services.

5. Administrative and Financial Burden

- Ensure that you have the proper staff in place. Billing is complex and time-consuming. You must have staff who can dedicate enough time to getting it right so that you are able to get paid for the services you provide. You must also have in place the program/operations staff needed for service expansion, if your contracts require you to grow services and add clients.
- Be certain you have adequate technology and systems to meet the data collection, retrieval, and reporting requirements under your healthcare contracts.

C. Strategic Planning for the Future

Advocacy work is never done. The healthcare landscape will continue to evolve, and your work to ensure that FNS are part of healthcare reform efforts will not cease. Make advocacy for the inclusion of FNS in public policy and funding a key part of your strategic plan to ensure support from your Board of Directors, staff, and volunteers into the future.

D. Celebrate Your Success!

Successful advocacy takes time. As you achieve success with your advocacy plan, make sure to celebrate and share your victories. Share the good news with your Board, staff, and volunteers. Tell the stories in your online and print newsletter, on your website, and in social media. Celebrating your victories will not only keep your team motivated, but also help spread the word that **food is medicine** and that the integration of FNS into healthcare delivery systems is critical to meeting the goals of healthcare reform.

Conclusion

With the enactment of the ACA, the healthcare landscape in our nation has evolved rapidly to emphasize cost-effective, high-quality care. A growing body of research demonstrates that food and nutrition-based interventions can be a core component of such care. As a result, insurers and healthcare providers are showing increased interest in partnering with FNS organizations and providing reimbursement for their services. We hope that the contents of this toolkit have helped you to develop and refine your advocacy plan so that your organization can successfully seize, expand upon, or create opportunities to engage in these relationships and ensure that patients receive the healthy, nutritious foods that they need.

Appendices

Appendix A: Resources

Many websites currently provide fantastic resources regarding key advocacy strategies such as: scheduling appointments to meet with legislators and officials; conducting advocacy visits; developing policy letters, talking points, and meeting agendas; and creating op-eds and sign-on letters. Several helpful websites include:

- **Bolder Advocacy:** <http://bolderadvocacy.org/>
- **Community Toolbox:** <http://ctb.ku.edu/en>
- **FRAC Action Council, Advocacy Tools:** <http://frac.org/leg-act-center/advocacy-tools/>

Appendix B: Glossary of Terms

The table below is a glossary of terms that will help you to comprehend better your state’s healthcare landscape in the context of opportunities discussed in this paper. **Bolded words within the definitions are separately defined in the glossary.**

Term	Definition
1115 Demonstration Waiver	Allows for 5-year state projects that promote the objectives of the Medicaid and Children’s Health Insurance Program (CHIP) through (1) expanding eligibility, (2) providing services beyond Medicaid’s scope of coverage, and (3) implementing delivery systems that improve care and reduce costs. Must be cost neutral, which means that implementing the waiver services will not cost more than the target population already costs the state for Medicaid-based care.
Accountable Care Organization (ACO)	A healthcare delivery system that brings physicians, hospitals, and insurers into one network so that they can provide higher quality care to patients. Initially incorporated into the Medicare program under the Patient Protection and Affordable Care Act and now open to Medicaid and private payers and providers as well, this model places providers at financial risk in order to encourage greater collaboration, specifically through provider sharing of patient medical records. A portion of the savings gained from improved patient treatment is returned to providers as an incentive payment. ACOs are promising healthcare partners that may have the flexibility to choose to cover home-delivered meals as one method of reducing costs.
Alternative Payment Model	An alternative to a fee-for-service model. Encouraging better health outcomes, lowered costs, and coordinated care among physicians, this model gives financial incentives to providers to improve the quality of care as opposed to increasing the quantity of care (which the fee-for-service model arguably encourages). Examples of alternative payment models include risk-based and budget-based payment, such as capitation , bundled payments , and shared savings arrangements.
Area Agencies on Aging (AAA)	Private, nonprofit entities dedicated to implementing and overseeing programs to serve a state region’s older population. The agencies provide services to older adults that allow them to remain in their homes or communities. Federally funded through the Older Americans Act (OAA)—specifically through the OAA Nutrition Program—AAAs can provide home-delivered meals.
Balancing Incentive Program	Authorizes enhanced federal matching funds to states that make reforms to their long-term care programs in order to increase nursing home diversions and patient access to non-institutional long-term services and supports (LTSS) . The goal is to keep more people in their homes and communities. States must spend less than 50% of total Medicaid LTSS on community LTSS to be eligible for this program.

Term	Definition
Bundled Payment	A single payment to providers or healthcare facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Payments are based on the expected costs for “clinically defined episodes that may involve several practitioner types, settings of care, and services or procedures over time.” A prospective payment in which providers share one payment for a personalized set of primary and specialty services delivered within a specific time period. Theoretically, bundled payments should encourage collaboration among providers to coordinate services and control costs in order to produce improved patient outcomes.
Capitated Payment	A payment method that allocates providers and/or insurers a fixed amount of money per patient per unit of time. This model places financial risk on the provider and/or insurer to perform well and deters suboptimal care by measuring the rates of resource utilization.
Centers for Medicare and Medicaid	A federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare program and collaborates with state governments to help implement Medicaid .
Children’s Health Insurance Program (CHIP)	Provides health insurance coverage to children in families that cannot afford private coverage but whose higher income disqualifies them for Medicaid. Allocates federal matching funds to states for coverage implementation.
Community First Choice 1915(k)	Allows states access to a 6% increase in federal matching funds for expenditures related to providing home and community-based attendant services to Medicaid enrollees with disabilities under the State Plan.
Delivery System Reform Incentive Payment (DSRIP) Program	Federal funding support to states that aims to reduce hospital use by reforming care delivery systems. Reforms must advance the “Triple Aim” of improving population health, enhancing patient experience and outcomes, and reducing cost of care. DSRIP plans focus on building community-level collaboration to achieve population health improvement. Fund distribution is linked to achievement of project milestones. Funds must be matched by states.
Dual Eligibles	Term used to refer to the approximately 9 million, low-income adults over age 65 and low-income disabled people who are jointly enrolled in Medicaid and Medicare. This demographic is most representative of the population likely to qualify for home-delivered meal services permitted by Medicaid waivers. Under the Community First Choice 1915(k) plan, states can provide home and community-based services specifically for dual eligible participants.
Essential Health Benefits (EHB)	<p>Under the ACA, these are the mandatory categories of services that Medicaid Alternative Benefit Plans and non-Grandfathered Health Plans offered through the Health Insurance Marketplace must cover. They are broadly defined and include the following ten categories:</p> <p>Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care.</p> <p>In general, each state has the opportunity to define the ten categories by referencing a “benchmark” plan.</p>

Term	Definition
Federal Medical Assistance Percentage (FMAP)	The percentage of cost share that the Federal government assumes for Medicaid programs (as distinct from what state governments pay). This funding often comes in the form of enhanced matching funds. For the years 2014 through 2016, the ACA established 100% FMAP coverage for low-income adults with earnings up to 138% of the federal poverty level .
Federal Poverty Level (FPL)	The poverty level guideline determined by household size and income. The 2015 FPL can be found here: http://aspe.hhs.gov/poverty/15poverty.cfm . The FPL is one metric used to determine patient eligibility for waiver services.
Fee-for-Service Model	A payment method in which providers are paid per health service provided (such as a set price for a primary care visit).
Grandfathered Health Plan	A health plan or individual insurance policy purchased on or before March 23, 2010 that is exempted from changes required by the Affordable Care Act. All plans and policies are subject to scrutiny: those making changes that reduce benefits or increase costs to enrollees can lose their “grandfathered” statuses.
Home and Community Based Services (HCBS)	Opportunities for Medicaid beneficiaries to receive community-targeted health services (such as nutritional counseling and home-delivered meals). These services target the most vulnerable populations (in particular, the elderly and disabled) with the aim of keeping individuals in their homes and communities as opposed to in nursing facilities. To qualify for services, individuals must have mental illnesses, chronic diseases, disabilities from aging, and/or physical disabilities that would otherwise require nursing facility level of care.
Integrated Care Organization (ICO)	A healthcare system that coordinates healthcare services for dual-eligible individuals who require the highest level of care. They are paid a combined Medicare and Medicaid amount to provide services for this population, including physical health, behavioral health, long-term care, and pharmacy services. Because this population consists of the low-income elderly and disabled, which comprises the most vulnerable population with the highest healthcare needs, ICOs are plausible partners for home-delivered meal providers.
Long-term Services and Supports (LTSS)	The set of services designed to support long-term care for children, disabled patients, and older adults over age 65. These services can include both home and community based services (HCBS) and institutional services (such as nursing home support).
Managed Care Organization (MCO)	Similar to Health Maintenance Organizations (HMOs), these insurers provide most Medicaid benefits to enrolled patients in exchange for a monthly per-patient payment from the state.
Marketplace	A website that consumers and small businesses can use to purchase private health plans (known as Qualified Health Plans). States were given the option of developing and administering their own marketplace or having their residents access insurance through federally-run marketplaces (FFMs). States are also permitted to use a hybrid state and federal marketplace model. Marketplaces help consumers determine their eligibility for tax credits and subsidies for private plans, as well as eligibility for Medicaid.

Term	Definition
Medicaid	A federal and state-funded health coverage program that provides health insurance to certain categories of low-income individuals. The federal government requires all states who participate in the Medicaid program to provide coverage for all children, pregnant women, parents, elderly, and disabled individuals who meet certain income criteria. To be eligible, individuals must be citizens or immigrants who have had a green card for more than five years. Aside from these basic federal guidelines, states have flexibility in setting eligibility criteria, and every state Medicaid program is different.
Medicaid Health Homes	The ACA created this optional benefit for states to establish Health Homes to coordinate care for people with Medicaid who have certain chronic conditions. Medicaid Health Home providers are expected to coordinate primary, acute, and behavioral healthcare services and Long-term Services and Supports to treat individuals with chronic conditions. Qualifying patients must have two or more chronic diseases, one chronic condition and be at risk for a second, or one serious and persistent mental health condition.
Medicaid Waiver	States can apply for waivers in order to test new or existing ways to improve healthcare delivery in Medicaid and CHIP. The four types available are 1115 Research & Demonstration Projects, 1915(b) Managed Care Waivers, 1915(c) Home and Community-Based Services (HCBS) Waivers, and Concurrent 1915(b) and 1915(c) Waivers.
Medical Home (also known as “Patient Centered Medical Home”)	Refers to a philosophy of care delivery that emphasizes whole-person care coordinated by a central healthcare location, provider, or facility. Healthcare received through a medical home is meant to be comprehensive (incorporating acute care, chronic care, and preventive/wellness-based care) and delivered by a team of providers, from physicians to nurses to pharmacists, to social workers and other community supports. It must be tailored to the patient’s unique needs and providers must be committed to improving patient outcomes.
Medical Nutrition Therapy (MNT)	Medical nutrition therapy (MNT) is an evidence-based approach to nutrition care provided typically by a licensed Registered Dietitian Nutritionist (RDN). The provision of MNT may include one or more of the following: nutrition assessment/re-assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. Many MTFNPs provide this service independent of reimbursement from public or private insurance. However, within Medicare, there are specific requirements regarding how MNT can be provided. To be eligible, Medicare patients must meet at least one of the following criteria: have diabetes, have kidney disease, have had a kidney transplant in the last 36 months, or have a referral for the service from a healthcare provider. Normally, an enrolled Medicare provider performs this service.
Medically Tailored Food and Nutrition Provider (MTFNP)	Food and nutrition providers that cook and distribute meals for individuals living with severe and chronic illness that are tailored to their unique dietary needs.
Medicare	A federal health insurance program that covers most people over the age of 65 as well as disabled individuals regardless of age (disabled individuals must have been disabled for more than twenty-four months or have end-stage renal disease). Medicare offers four types of coverage: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C) and prescription drug coverage (Part D). People enrolled in Part A and/or B receive coverage directly from Medicare, while people enrolled in Part C receive all Part A and B services through a private MCO. Unlike Medicaid, which is a state and federal partnership, Medicare is entirely a federal program, and benefits and eligibility are more consistent across states for Part A and B services.

Term	Definition
Medicare Advantage Plan	A private managed care plan that contracts with Medicare to cover Part A and Part B benefits for enrollees (as opposed to regular Part A and B, which operate on a fee for service basis).
Medicare Special Needs Plan (SNP)	A Medicare Advantage Plan targeting patients with specific diseases and tailoring treatments to best meet their needs. In general, patients can only join SNPs if they have Medicare Parts A and B, live in the plan's service area, and meet at least one of the three categorical requirements, which include Chronic Condition SNP (C-SNP), Institutional SNP (I-SNP), and Dual Eligible SNP (D-SNP). D-SNPs are targeted for dual eligibles and can cover home-delivered meals, depending on the provider.
Modified Adjusted Gross Income (MAGI)	The IRS metric used to determine individual eligibility for deductions or tax credits. For new health plan enrollees in 2014, MAGI is used to determine insurance coverage tax subsidies for those whose income is no more than 400% of the federal poverty level .
Money Follows the Person (MFP)	A demonstration grant provided to applicant states so that they can bolster their LTSS programs, specifically by helping patients with chronic conditions and disabilities transition back into their communities from long-term care or nursing facilities. A major goal is to "increase the use of home and community-based services and reduce institutionally-based services."
Nursing Facility Level of Care (NFLC)	Patients are determined to require this level of care when they need at least one of the three main nursing facility services: skill nursing or medical care and related services; rehabilitation from injury, disability, or illness; and long-term care needed due to mental or physical condition. The NFLC criteria is often written into 1915(c) Home and Community-Based Services (HCBS) Waivers that explicitly cover home-delivered meals.
Patient Protection and Affordable Care Act (ACA)	Signed into law in 2010 as a comprehensive healthcare reform package, the ACA requires citizens and legal residents to have health insurance and makes provisions for cost-sharing subsidies and tax credits to make premiums affordable. Individual and business consumers can purchase coverage through their state-based health Marketplaces . Certain employers are required to provide health insurance for their workers or face penalty fees. The ACA requires health plans to allow dependent coverage for children up to age 26, and prohibits insurers from denying enrollees due to pre-existing conditions or placing lifetime limits of dollar value on coverage. Additionally, the act gave states the ability to expand Medicaid programs to cover all adults up to 133% of the federal poverty level (138% with the 5% income disregard).
Pay-for-Performance Model	This model of healthcare payment links financial incentives to physician performance indicators. Provider reimbursement reflects his/her performance, which is evaluated based upon patient health outcomes and the care processes implemented. Theoretically, these programs should encourage physicians to optimize the level of patient care because they provide bonuses to healthcare providers who meet performance metrics; certain programs can penalize providers who fail to achieve their goals or cost savings.
Pioneer ACO Model	Seeking to align private payers with provider incentives and to achieve cost savings for Medicare, this pilot program was designed for healthcare organizations already experienced in coordinating care for patients. The twenty-three ACOs accepted into the program will undertake innovative steps to switch from a shared savings payment model to a population-based payment model . Beneficiaries must be enrolled in Medicare parts A and B; they cannot be participating in Medicare Advantage plans.

Term	Definition
Population-based Payment Model	Also known as “global payment” or “total cost of care payment,” this payment model aligns provider incentives with patient interests in order to yield both improved patient health and higher provider reimbursement. Under this model, providers assume some level of financial risk and receive a set amount of payment in order to care for a group of patients. If providers meet the quality of care targets (demonstrate measurable patient health improvements), then they may keep part of the cost savings.
Premium Assistance Demonstrations (also known as “Private Option”)	A model of state Medicaid expansion in which states use federal funds to provide private insurance coverage to newly eligible Medicaid beneficiaries.
Program of All-Inclusive Care for Elderly (PACE)	A chronic care program that serves individuals who are 55+, certified by the state to need nursing home care, and live in the PACE provider area. This program delivers both medical and social services and often covers home-delivered meals, depending on the specific program.
Qualified Health Plans (QHP)	An insurance plan offered through the Health Insurance Marketplaces. QHPs must provide Essential Health Benefits and obey cost-sharing restrictions.
Shared Savings Programs	A Medicare initiative that improves the coordination and cooperation among providers serving fee-for-service beneficiaries. The program increases provider accountability for patient outcomes because providers share in the savings from reduced patient costs. Eligible providers and hospitals can participate when they join entities such as Accountable Care Organizations .
State Innovation Models (SIM)	A federal initiative that provides funds to states to implement innovative, state-based models for healthcare delivery. Innovative models must “design or test improvements to public and private health payment and delivery systems,” focusing on patients enrolled in Medicare, Medicaid, and CHIP.
State Plan Amendment (SPA)	A State Plan is a contract between a state and the federal government that specifies how the state will modify and administer its Medicaid program. Plans specify the characteristics of the specific populations to cover, the services provided, and methods of implementation and reimbursement for services. A State Plan Amendment describes a permanent change to the established State Plan for Medicaid.

ENDNOTES

- ¹ See 42 C.F.R. §§ 435, et seq.
- ² See 42 C.F.R. § 435.119; KAISER FAM. FOUND., THE EFFECTS OF THE MEDICAID EXPANSION ON STATE BUDGETS: AN EARLY LOOK IN SELECT STATES (Mar. 2015), available at <http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/> (last visited Oct. 12, 2015).
- ³ See 42 C.F.R. §§ 440.1, et seq.; *Benefits*, MEDICAID, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html> (last visited Oct. 12, 2015).
- ⁴ See 42 C.F.R. § 440.305(b).
- ⁵ See 42 C.F.R. § 440.347(a).
- ⁶ See 42 C.F.R. §§ 440.1, et seq; *Benefits*, MEDICAID, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html> (last visited Oct. 12, 2015).
- ⁷ Physician services are defined broadly under federal law as “services furnished by a physician-- (1) Within the scope of practice of medicine or osteopathy as defined by State law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.” 42 C.F.R. § 440.50.
- ⁸ Preventive services are defined as: “services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to--(1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency.” 42 C.F.R. § 440.130(c); see also KATHLEEN SEBELIUS, REPORT TO CONGRESS ON PREVENTIVE SERVICES AND OBESITY-RELATED SERVICES AVAILABLE TO MEDICAID ENROLLEES (2014), <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/rtc-preventive-obesity-related-services2014.pdf>.
- ⁹ See 78 Fed. Reg. 42224, citing 45 C.F.R. § 147.130.
- ¹⁰ *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVICES TASK FORCE, <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> (last visited Oct. 12, 2015).
- ¹¹ Bulletin from Tom Dehner, Medicaid Director, Massachusetts Office of Medicaid, to Physicians Participating in MassHealth (Jul. 2007).
- ¹² *Id.*; *Information About Massachusetts Insurers*, MASS. DIETETIC ASS’N, <http://www.eatrightma.org/content5664> (last visited Oct. 12, 2015).
- ¹³ See *Waivers*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (last visited Oct. 12, 2015); FAMILIES USA, STATE PLAN AMENDMENTS AND WAIVERS: HOW STATES CAN CHANGE THEIR MEDICAID PROGRAMS (June 2012), available at <http://familiesusa.org/product/state-plan-amendments-and-waivers-how-states-can-change-their-medicaid-programs>.
- ¹⁴ A few states, such as Arizona, Rhode Island, and Vermont, do not currently have 1915(c) waivers. See *Demonstrations & Waivers*, MEDICAID, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html (last visited Oct. 12, 2015).
- ¹⁵ See 42 C.F.R. §§ 441.300, et seq.; *1915(c) Home and Community-Based Waivers*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html> (last visited Oct. 12, 2015).
- ¹⁶ 42 C.F.R. § 440.180(b)(9).
- ¹⁷ See 42 C.F.R. §§ 431.400, et seq.
- ¹⁸ *Section 1115 Demonstrations*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Oct. 12, 2015).
- ¹⁹ See, e.g., *Demonstration Approval*, MEDICAID, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-ca.pdf>.
- ²⁰ *MD 0353 R02 00 Approval Letter*, MEDICAID, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.
- ²¹ *MD 0265 R04 00 Approval Letter*, MEDICAID, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.
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