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Vermont Benefit Coverage Framework: A Toolkit for Food Is Medicine Reimbursement Implementation

Developed by the VT Food Is Medicine Task Force



BI-STATE PRIMARY CARE ASSOCIATION

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Executive Summary

The Vermont Food Is Medicine (FIM) Benefit Coverage Framework[i] provides a roadmap for integrating clinically appropriate nutrition interventions into Vermont's health care system through standardized eligibility criteria and sustainable reimbursement pathways. Developed by the Vermont FIM Task Force, this Framework is intended to guide policymakers, payors, health care providers, community organizations, and other partners in improving health outcomes, reducing health care costs, and strengthening Vermont's local food system.

"Food Is Medicine" refers to health care-connected interventions that use nutritious food and nutrition support to prevent, manage, and treat diet-related conditions. These interventions—including Produce Prescriptions (PRx), Medically Tailored Groceries (MTG), Medically Tailored Meals (MTM), culinary medicine, and nutrition education—are integrated into clinical care, targeted to specific health needs, and designed to improve measurable health outcomes. A growing body of research demonstrates that these interventions can improve the management of conditions such as diabetes, hypertension, cardiovascular disease, and chronic kidney disease while reducing preventable health care utilization.

Vermont has already established a strong foundation for FIM through partnerships among health centers, hospitals, farms, food hubs, community organizations, and statewide networks. Existing programs have demonstrated improvements in patient outcomes while simultaneously supporting local agriculture and rural economies. However, most programs remain dependent on time-limited grant funding, creating inconsistent access for patients and uncertainty for providers. This framework addresses that challenge by proposing standardized recommendations for patient eligibility, covered conditions, qualifying interventions, service duration, reimbursement, and referral pathways.

As Vermont explores opportunities to incorporate FIM into Medicaid's and other payor's models, this framework offers a practical, evidence-informed foundation for implementation. By establishing consistent reimbursement and clinically appropriate standards for care, Vermont can expand access to nutrition interventions, improve health outcomes, reduce avoidable health care spending, and strengthen the resilience of both its health care and food systems.

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Summary of Key Recommendations

A statewide Food Is Medicine (FIM) benefit that integrates nutritious food and nutrition support into health care to improve health outcomes, reduce avoidable health care costs, and create sustainable reimbursement pathways is recommended. This includes a tiered eligibility model that matches services to a patient's level of need, providing Medically Tailored Meals for individuals with the highest medical and functional needs, Medically Tailored Groceries for patients with moderate medical complexity, and Produce Prescriptions for individuals with diet-related conditions or elevated health risks.

The Framework is built on three key recommendations:

1. Match the intervention to the patient's level of need.
2. Provide services long enough to improve health.
3. Treat FIM as health care.

Proposed Eligibility Framework

Food Is Medicine Intervention	Who Qualifies?*	Recommended Benefit
Medically Tailored Meals (MTMs)	Identified chronic condition, and a social or high-risk health need, as well as limitations in ability to prepare meals.	10 MTMs/week for a minimum of 6 months; $15-20 per meal.
Medically Tailored Groceries (MTGs)	Identified chronic condition, and a social or high-risk health need.	$150-$250 per month in MTG benefits.
Produce Prescriptions (PRx)	Identified chronic condition, and a social or high-risk health need.	$100-$250 per month in PRx benefits.

**See the Eligibility Framework in Chapter 4 for the list of proposed eligible chronic conditions, social needs, high-risk health conditions, and additional FIM services.*

By standardizing eligibility criteria, benefit levels, and duration of services, Vermont can ensure patients receive the right level of nutrition support while creating a consistent, statewide approach that strengthens both the health care system and Vermont's local food economy.



Chapter 1: Introduction and Background

What is the purpose of this Benefit Coverage Framework?

This Benefit Coverage Framework is intended to serve as a practical resource for policymakers, payors, health care providers, community organizations, and other interested organizations working to advance Food is Medicine (FIM) in Vermont. Grounded in the recommendations of the Vermont FIM Task Force, it reflects the Task Force's assessment of the most effective path forward for building sustainable coverage and reimbursement models for FIM services. The Framework is designed to inform decision-making on how these interventions can be integrated into Vermont's health care and nutrition systems to improve health outcomes, expand access, and address diet-related chronic disease. As part of a broader strategic roadmap, it supports efforts to help Vermonters achieve better health through coordinated, evidence-based nutrition services. This Framework supports the recommendation that FIM be expanded to improve health outcomes.

For FIM programs to scale statewide, organizations need reliable reimbursement for eligible services such as Medically Tailored Meals (MTMs), Medically Tailored Groceries (MTGs), Produce Prescriptions (PRx), nutrition counseling, and care coordination. Community providers cannot expand staffing, infrastructure, or geographic reach without knowing payment mechanisms exist. Many FIM initiatives begin through grants or pilot funding. Although these resources are valuable for launching innovation, they are often time-limited and unpredictable. A sustainable reimbursement would reduce dependence on grant cycles by creating durable financing pathways tied to health care coverage.

This Benefit Coverage Framework creates the foundation for:

- Predictable payment for approved services
- Capacity for community-based providers to participate
- Long-term planning and workforce development
- Consistent referrals from health care providers

There are several possible pathways for consideration, which can work together or in isolation:

Medicaid: Vermont can leverage Medicaid payment pathways such as an 1115 demonstration waiver and/or home and community-based services authorities to cover evidence-based FIM interventions for eligible members.

Private Payors: Commercial insurers and plans regulated by state agencies may cover FIM services when linked to chronic disease management, reduced utilization, or value-based care goals.

Legislative Action: State legislation can establish standards, pilot authorities, appropriations, reporting requirements, or mandates that support broader adoption.

Currently, eligibility for FIM services varies by grant requirements, health care clinic, geography, or provider. A Vermont-specific framework can establish standardized, evidence-based eligibility criteria that reflect:

- Diet-related chronic conditions prevalent in Vermont
- Food insecurity and nutrition insecurity
- Pregnancy needs
- Rural transportation and food access barriers
- High-risk transitions such as hospital discharge
- Cost-effectiveness and clinical outcomes

Standardized criteria help ensure fair access, simplify referrals, and align reimbursement with measurable outcomes.

This Benefit Coverage Framework is the cumulative work of 41 FIM Task Force members whose expertise spans across research, health care, public health, payor, agriculture, FIM program operations, and other sectors (see Appendix 1). Furthermore, this Framework has the support of 24 organizations across health care, agriculture, academia, FIM providers, insurance payors, and others (see Appendix 2).

Purpose and structure of the Benefit Coverage Framework

Taken together, the recommendations in this Framework are intended to provide Vermont with a clear and practical foundation for moving FIM from short-term, grant-funded programs toward more sustainable coverage and reimbursement. The Framework provides a structured proposal of who should be eligible for FIM services (when a given payment pathway allows the state or individual payors to define eligibility), which interventions should be considered for coverage, and the factors that should guide decisions about intervention intensity, duration, and reimbursement. In doing so, it provides a common framework for policymakers, payors, health care providers, and community-based organizations to support consistent access while directing resources toward interventions and populations most likely to benefit.

The Framework is not intended to prescribe a single financing mechanism or operational model. Rather, it provides a foundation that can be adapted across Medicaid, commercial insurance, legislative initiatives, and other potential funding pathways. The sections that follow describe the scope of the Framework and the analysis conducted in this Framework, which outline considerations for developing sustainable FIM coverage in Vermont. There are three chapters following this introductory chapter, followed by references and appendices. Chapter 2

is the Return on Investment of Food Is Medicine Report, Chapter 3 is the Food Is Medicine in Vermont: Stories from the Field Report, and Chapter 4 is Vermont's FIM Eligibility Framework.

Scope

This Framework provides an evidence-informed approach to designing and implementing FIM benefits, integrating economic analysis, patient experience, and program design to support coverage decisions. The scope of this Framework includes information relevant to development of reimbursement mechanisms for FIM. This does not include other components needed to operationalize FIM, such as procurement systems, transportation and distribution systems, food hubs, care coordination processes and workflows, and other components not essential to development of FIM reimbursement pathways.

Return on Investment of Food Is Medicine Report

The Return on Investment of Food Is Medicine Report includes a brief overview of the national research on cost effectiveness of various FIM programs. This includes the potential cost neutrality or cost savings of FIM programs when assessing program cost with the savings of prevented complications of diet-related conditions.

Using a cost effectiveness model from Tufts University, we calculated the potential cost savings of existing FIM programs in VT.

Because the majority of the existing FIM programs in VT partner with local farms and support the local agricultural industry and economy, we have additionally calculated the potential reinvestment of FIM dollars into the local economy. This is because with every dollar spent on local products, research has demonstrated that a portion of this is reinvested back into the local economy.

Food Is Medicine in Vermont: Stories from the Field Report

The Food Is Medicine in Vermont: Stories from the Field Report captures the narratives of FIM participants, farmers providing goods to FIM programs, and health care provider perspectives. This report showcases the impact of FIM on Vermonters, through their own words. Understanding the experiences of those connected with FIM demonstrates the power of FIM beyond what quantitative data can tell us.

Vermont's FIM Eligibility Framework

Vermont's FIM Eligibility Framework synthesizes national evidence on the clinical effectiveness of different FIM interventions. This evidence is considered alongside benchmarks from existing Section 1115 FIM reimbursement models in other states to inform a proposed eligibility framework for FIM reimbursement in Vermont. The framework can then be adapted to the requirements and restrictions of individual payment pathways. This Framework breaks down eligibility by FIM type (MTMs, MTGs, and PRx), and lists the types of health conditions covered, if additional eligibility criteria are required (such as a social stressor or high-risk condition), the dose (frequency of service), duration (length of service), and optional add-ons (such as nutrition

therapy or culinary medicine). We further recommend what provider types should be eligible to refer participants to, and verify eligibility for, FIM programs. Eligibility is tiered, with the most intensive FIM type (MTMs) structured with the strictest eligibility criteria, and the least intensive (PRx) having the most flexible criteria.

Additionally, a reimbursement amount that was developed using a combination of national evidence and local FIM program context is proposed for each FIM type. We used reimbursement amounts in other states as benchmarks to determine the appropriateness of the proposed reimbursement amounts.

Evaluation metrics, payment pathways, referral workflows, and food procurement systems are beyond the scope of this report.

What is Food Is Medicine?

In this Framework, FIM serves as a bridge—linking clinical care, nutrition supports, and local food systems—to create a more coordinated and responsive approach to health. FIM refers to a set of approaches that integrate food and nutrition into health care delivery to support the prevention and management of diet-related conditions. FIM interventions are distinct from food access programs in purpose, eligibility requirements, and programmatic oversight. Rather than a single program, FIM is a tool for delivering care—bringing to life interventions such as MTMs, MTGs, PRx, culinary medicine, and nutrition supports within clinical and community settings. These approaches are designed to help individuals access and use the foods that align with their health needs, translating clinical guidance into practical, everyday action. By embedding food into care delivery, FIM connects what happens in a clinical setting with what happens at home, making it easier for individuals to follow through on lifestyle change recommendations and manage their health over time.

FIM can be a pragmatic extension of health care—one that addresses a well-recognized driver of health outcomes: access to nutritious food. Research supports that FIM is effective in supporting individuals in managing conditions such as diabetes, hypertension, and cardiovascular disease; reducing strain on the health care system; and strengthening the connection between health care and community resources.

What about food insecurity and nutrition insecurity?

Food insecurity (FI) and nutrition insecurity (NI) are related, but distinct terms. USDA Economic Research Services defines FI as "the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways," and acknowledges that the reality of each household falls on a continuum of from 'high food security' to 'very low food security.'[1] A commonly used tool to measure FI rates in Vermont health centers is the Hunger Vital Sign 2-question screening tool, which asks the questions on a Likert scale:

1. "Within the past 12 months we worried whether our food would run out before we got money to buy more."
2. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."[2]

According to USDA ERS' 2025 report, *Household Food Security in the United States*, 9.4% of households in Vermont experienced food insecurity. This is an increase of 19% from the prior 3-year state average (2019-2021).[3] This rate increases for certain populations of Vermonters. For example, among cancer survivor patients at FQHCs in the U.S., rates are significantly higher at 83.6%.[4] National data consistently show that individuals with diet-related chronic conditions—particularly diabetes—experience FI at significantly higher rates than the general population, with approximately 1 in 5 people with diabetes affected.[5] Food insecurity not only increases the risk of developing these conditions but also makes them more difficult to manage, contributing to worse clinical outcomes and higher health care utilization.[5]

Vermont-specific Behavioral Risk Factor Surveillance System (BRFSS) data demonstrates a clear relationship between FI and diet-related chronic conditions. For example, adults experiencing FI are significantly more likely to have hypertension (41% compared to 24% among food-secure adults), as well as other risk factors.[6]

Given that FI is not only a social condition but an economic condition, it is known that FI is more prevalent among low-income households.[1] Additional Vermont BRFSS analyses show that FI is associated with poorer overall health status and quality of life, reinforcing its role as a key driver of chronic disease burden in the state.[7] For many patients, FI is a clinical barrier to managing chronic disease. By addressing access to nutritious foods as part of a patient's treatment plan, FIM interventions have the potential to improve disease management while also enhancing dignity, autonomy, and long-term health.

Nutrition insecurity is related to FI but differs in what it measures. While FI assesses the quantity of food generally, NI assesses the quantity of *nutritious* foods relative to the person's health needs. Understanding of NI as a distinct concept from FI is relatively new, and a newly validated screening tool to measure NI emerged in 2025.[8] In a study of more than 20,500 U.S. adults, NI affected 18% to 44% of respondents and was especially common among young adults, low-income households, and Hispanic/Latinx populations.[8] The study found that NI only partially overlapped with FI, indicating that many people who have sufficient food may still lack consistent access to foods that support health and chronic disease prevention.[8] While health centers in Vermont are currently working to integrate this new screening tool into their workflows, we do not yet have data on the rates of NI in Vermont.

Although FIM is closely connected to food insecurity (FI) and nutrition insecurity (NI), these concepts are not synonymous. FI and NI describe challenges that can negatively influence health, whereas FIM is a health care intervention designed to address those challenges for individuals with clinically identified nutrition-related needs. Importantly, not every person experiencing food or nutrition insecurity requires a FIM intervention, and not every person who could benefit from FIM necessarily meets the criteria for food or nutrition insecurity. Rather, FIM complements existing nutrition assistance and community resources by providing targeted, clinically appropriate nutrition support as part of a patient's care plan. Understanding the

distinctions between these concepts is essential for developing appropriate eligibility criteria and ensuring that FIM benefits are directed to those most likely to experience improved health outcomes.

Why is Food Is Medicine needed?

FIM programs have emerged in response to a growing disconnect between the nation's health care spending and the underlying factors that shape health outcomes. Diet-related chronic diseases—including cardiovascular disease, diabetes, hypertension, chronic kidney disease, and some cancers—represent some of the leading causes of morbidity, mortality, and health care spending in the United States.[9] Cardiovascular disease alone remains the leading cause of death nationally and is estimated to cost the U.S. health care system more than $250 billion annually in direct and indirect costs.[10] At the same time, the cost of nutritious foods has continued to rise, placing healthy diets increasingly out of reach for many households. Research consistently shows that healthier dietary patterns cost more than calorie-dense, nutrient-poor alternatives, creating structural barriers for individuals and families attempting to manage chronic conditions through nutrition.[11]

Food Insecurity further compounds these challenges. Individuals experiencing FI are more likely to delay health care, experience complications related to chronic illness and require costly emergency or inpatient services.[12] Yet despite the significant impact that nutrition has on health outcomes, the U.S. health care system continues to spend far more on downstream medical treatment than on upstream prevention and nutrition supports. Health care expenditures in the U.S. exceed $4.5 trillion annually, while only a small fraction is invested in addressing nutrition, food access, and other non-medical factors that heavily influence long-term health outcomes.[13]

FIM programs seek to address this misalignment by integrating nutrition supports into health care delivery. Rather than treating food access and chronic disease management as separate issues, FIM approaches recognize nutritious food as a foundational component of health and a practical tool for improving outcomes, reducing preventable utilization, and supporting healthier communities.

What are the different types of Food Is Medicine programs?

Food Is Medicine encompasses several different types of programs, which are distinct and serve specific needs. These programs vary with regards to ease of implementation and intended participants. Where available, we have utilized definitions created by regional and national leaders in FIM, with additional Vermont context provided.

It is beyond the scope of this Framework to go into detail regarding specific foods or micronutrients. The decision about what is appropriate for a given diet-related condition should be in the purview of those with a certification in nutrition.

Medically Tailored Meals



Medically Tailored Meals (MTMs) are frozen or refrigerated, ready to heat, or hot prepared meals that are aligned with household food preferences, and provide "…an estimated 1⁄3 of the recommended dietary intake(s), per therapeutic, evidence-based dietary specifications for conditions"[14] for each meal. They are the most complex to implement, given the addition of food preparation and tailoring needs. For this reason, they can also be the most challenging to scale.

Meals are designed by a registered dietician (RD) or a state-credentialed individual in nutrition. They are intended for individuals who are diagnosed with severe illness or a chronic condition and who lack the skills/knowledge/ability to prepare healthy meals. If the individual screens positive for FI or NI that strengthens the argument for their eligibility. Referral sources for MTMs include but are not limited to: RDs, social workers, case managers, community health workers (CHWs), community partners, and patient self-referral. Individuals who verify participant eligibility and can thus "prescribe" MTMs include a patient's medical provider or a FIM program administrator. Anticipated outcomes of MTMs include improved health outcomes including reductions in hospitalizations, increased medical appointment adherence, and greater reported sense of wellbeing. Examples of MTM usage in Vermont include FIM programs that utilize nationally-sourced prepared frozen meals (e.g., Mom's Meals) to ship directly to patients, and a small pilot in southern Vermont by non-profit Grateful Hearts.

Medically Tailored Groceries

Medically Tailored Groceries (MTGs) can be viewed as an intervention that is more medically tailored than Produce Prescriptions, but does not include fully prepared foods as MTMs do. MTGs can be thought of as providing the ingredients to patients to enable them to prepare MTMs in their home. Importantly, MTGs should be utilized for patients who have the ability to prepare their own meals. The Task Force members deemed existing national definitions inadquate, and thus, this defintion was created by merging two existing defitions[15, 16]:

"Medically Tailored Groceries (MTG) include a selection of groceries, such as vegetables, fruits, grains, beans, lean proteins and/or dairy (locally sourced when possible) prescribed by an RD (or another person certified in nutrition) for a broad range of patients—those with diet-related acute and chronic conditions who can shop, pick up, or have food delivered, and prepare food at home."



The definition of MTGs by Coding4Food, for the purposes of billing is: "Shelf-stable products (produce and other perishables if able) designed to meet at least 1⁄3 of the comprehensive recommended intake for one person per week, based on a Registered Dietitian Nutritionist (RDN) or other nutrition professional's assessment of their nutritional needs and disease- specific, evidence-based tailoring as part of a therapeutic diet plan."[14]

Produce Prescriptions

Members of the Task Force felt the existing Produce Prescription (PRx) definitions were inadequate, and created a more Vermont-centric definition of PRx:



"A Produce Prescription (PRx) is a medical treatment or preventive service referred or prescribed by a clinical and/or community health team to patients with diet-related health risks or conditions and documented challenges in accessing nutritious foods. Produce prescriptions may include fruits, vegetables, nuts, seeds, eggs, dairy, beans, and legumes that are fresh, frozen, canned, minimally processed, without added fats, sugars, or salts; as well as tailored programming to support nutrition and culinary education. Produce prescriptions may be issued to patients in the form of coupons or vouchers to food retailers, Community Supported Agriculture (CSA) boxes, picked up in health care settings, or home delivered. They are provided at low or no cost to the patient."

In Vermont, most PRx take the form of CSA shares from local farms. Locally sourced produce is a key component of PRx in Vermont. Once partnerships with farms are created, this intervention is one of the easier forms of FIM to implement. This intervention may be more effective when paired with culinary education, such as providing recipes for potentially unfamiliar produce and cooking demonstrations.[17]

Culinary Medicine

As defined by Chef R. Leah Pryor, Culinary Medicine Manager at UVMH, Culinary Medicine is an evidence-informed, hands-on approach that integrates the science of medicine and nutrition with the art and practice of cooking, food preparation, and shared eating to support health, prevent and manage disease, and improve well-being. Culinary Medicine translates nutrition guidance into practical, affordable, and enjoyable meals that align with participant's preferences while building the skills, confidence, and agency people need to make health-supporting food choices in daily life. Culinary Medicine may include cooking education, meal planning, food selection, budgeting, label reading, disease-specific nutrition education, teaching kitchen programs, clinical or community-based classes, and workforce training for health care, public health, culinary, and community professionals.

A culinary medicine expert based in Vermont, Chef Pryor explains the program as the tool that helps to ensure effectiveness of the nutritious foods provided to patients:

> "*Culinary Medicine is the applied tool of the Food Is Medicine movement—where evidence meets practice. It equips clinicians, educators, and communities with the skills to translate nutrition science into daily life through food. It is the 'sugar that helps the medicine go down'—making health accessible, engaging, and culturally relevant. More importantly, it creates safe, inclusive spaces where individuals feel seen, respected, and empowered within health care and wellness environments.*
>
> *Food Is Medicine is the vision. Culinary Medicine is the practice.*"

Are Meals on Wheels considered FIM?

Meals on Wheels, a federal program designed for older and/or disabled adults, is run by the Area Agencies on Aging in Vermont. The degree of the medical tailoring of the meals provided through the Meals on Wheels program varies across Vermont, ranging from meals that meet the Older Americans Act requirements but are not otherwise altered for a diet-related condition, to more Medically Tailored Meals for a variety of conditions such as diabetes and hypertension. The question of whether Meals on Wheels programs can be considered "Food Is Medicine" is not straightforward, nor would it be the same answer across programs.

While the eligibility for Meals on Wheels may overlap with eligibility for FIM programs, there are key differences. Meals on Wheels eligibility includes an age requirement (individuals must be over age 60); Meals on Wheels eligibility also requires that individuals are unable to get or prepare meals on a temporary or permanent basis and have a condition that prevents them from leaving their home. A key difference between MTM's and Meals on Wheel's eligibility, is that for MTMs—and indeed, the majority of FIM programs—a clinical diet-related diagnosis (such as diabetes or hypertension) is required, whereas such diagnoses are not required for Meals on Wheels participation.

What are *not* considered FIM programs?

Food access programs that provide general nutrition assistance, rather than being clinically targeted to address a specific health condition or health-related need, are not considered FIM programs. Examples of such food access programs include food pantries, soup kitchens, and other charitable food access. This also includes federal nutrition programs such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP).

How is FIM different from federal nutrition programs?

FIM refers to health care connected nutrition interventions that use healthy food and nutrition support to prevent, manage, and treat diet-related health conditions. While federal public benefit programs such as SNAP (3Squares in VT) and WIC help households afford food, FIM programs are clinically targeted services designed to improve health outcomes. These approaches serve different purposes, rely on different funding streams, and use different eligibility criteria, but they are most effective when coordinated together.[18] As noted above, general food assistance aims to reduce hunger and supplement food budgets; FIM is intended to address specific health conditions such as diabetes, hypertension, heart disease, pregnancy-related nutrition risks, or recovery after hospitalization.[18]

FIM does not replace or duplicate public benefits. It fills a different role.[18] FIM provides *clinical nutrition interventions* that federal nutrition programs were not designed to deliver. For example:

- A patient with uncontrolled diabetes may need MTGs with carbohydrate guidance.
- A person leaving the hospital may need home-delivered MTMs aligned with renal or cardiac diets.
- A pregnant patient with gestational hypertension may need added nutrition support beyond standard WIC benefits.

Some states such as Michigan and Massachusetts have policies requiring coordination with SNAP and WIC to avoid duplication while expanding access to all eligible supports. When FIM and federal nutrition benefit programs are combined, it can create a more complete and effective nutrition safety net.

In VT, there are also state funded food security programs that provide nutritious food to those who are eligible, while also strengthening local agriculture. These include:

- **Crop Cash/Farm Share:** Programs linked with 3SquaresVT that offer matching funds, doubling or tripling value for fresh produce at farmers markets.
- **Vermont Foodbank & Partners:** Over 300 regional food shelves and meal sites distribute food throughout the state, including the mobile "VeggieVanGo" program, which brings produce to schools, clinics, and hospitals.

- **Universal School Meals:** Legislation providing free breakfast and lunch to all students.
- **Commodity Supplemental Food Program (CSFP):** Specifically supports residents aged 60+ with nutritional boxes.

One example of how federal nutrition benefits can be paired effectively with FIM involves a household where only one family member is the direct recipient of a FIM intervention. For instance, a patient with a diet-related chronic condition may be referred to a FIM program that includes visits with an RD, nutrition education, and recipes designed to support management of that condition. Although the FIM benefit is prescribed to that individual patient, the impact can extend far beyond one person. If that same household also receives federal benefits such as SNAP or WIC, the family can use those resources to purchase additional fruits, vegetables, whole grains, and other ingredients needed to prepare the recommended meals for everyone in the home. In this way, public benefits help scale the clinical nutrition intervention from one patient to the full household.

The result is a complementary model in which FIM provides health care guidance, disease-specific nutrition support, medically tailored foods for the individual, and behavior-change tools, while SNAP or WIC helps the family afford the additional foods needed to put those recommendations into practice for the entire family. This combination not only supports the patient's ability to manage a chronic condition but also creates healthier eating patterns for others in the household.

An example of a FIM workflow

There are four key components for inclusion of all FIM interventions:



Graphic source: https://odphp.health.gov/foodismedicine/understanding-food-medicine/types-interventions

An ideal FIM patient workflow should be simple for patients, integrated into clinical care, and include strong follow-up and feedback loops. It should connect screening, referral, enrollment, service delivery, and outcome monitoring into one seamless process. This aligns with national FIM best practices that emphasize screening, referral support, care team involvement, food provision, education, and ongoing evaluation.[19]

1. **Screen & Identify Need:** Patient is screened for FI, NI, and/or diet-related health conditions.
2. **Assess & Refer**: Care team determines eligibility and refers the patient to the appropriate FIM intervention. The care team assesses readiness for participation by discussing the patient's goals, interest in improving their health through nutrition, and commitment to working with an RD and other members of the care team.
3. **Enroll & Activate Benefit**: Patient is enrolled in the program and receives access to FIM foods and supports. Patients are supported during this time to apply for federal or state benefits if not already participating, such as 3Squares or WIC.
4. **Engage & Support**: Patient utilizes the benefit(s) and receives nutrition education, care coordination, and ongoing support as needed.
5. **Monitor & Reassess**: Program and clinical outcomes are tracked, patient needs are reassessed, and referrals or benefits are adjusted accordingly.

What are other states doing in this space?

Across the U.S., states are increasingly moving beyond pilots to embed FIM into Medicaid and other payor programs, with a clear trend toward both program standardization and reimbursement pathways. Federal guidance from the U.S. Department of Health and Human Services highlights that many states are using existing Medicaid authorities—particularly Section 1115 demonstration waivers, managed care "in lieu of services," and home- and community-based services—to cover FIM interventions such as MTMs, MTGs, and PRx.[20]

- North Carolina's Healthy Opportunities Pilot integrates food services (including PRx and MTMs) into Medicaid, with services billed through standardized care management infrastructure.[20]
- California's CalAIM initiative allows Medicaid managed care plans to cover medically supportive food and meal delivery as "Community Supports," effectively creating a statewide reimbursement pathway with the intent to avoid higher-cost care.[21]
- Massachusetts (MassHealth) has implemented nutrition prescription programs and medically tailored food benefits—often authorized for defined durations (e.g., up to six months with renewal options)—demonstrating how states are operationalizing both eligibility criteria and duration of services.[20]
- Other states, including Oregon, Illinois, and Washington, received federal approval to test similar Medicaid-funded models, via Section 1115 demonstrations, further signaling a shift toward normalization of integration of FIM into Medicaid offerings.[22]

Many states are also intentionally aligning FIM programs with existing nutrition supports like SNAP and WIC, recognizing that layering these benefits can increase overall "dose" and improve outcomes and that doing so does not constitute duplication.

States are moving from grant-funded pilots toward integrated, reimbursable benefits, using Medicaid as the primary vehicle, though private payors are also increasingly seeing the value of including FIM benefits. While approaches vary, common elements are emerging across states, including: clinically targeted eligibility, defined program types (e.g., meals, groceries, PRx), specified duration of services, and growing emphasis on sustainable reimbursement mechanisms tied to health care cost savings and outcomes.

What does Food Is Medicine look like in Vermont?

The Food Is Medicine Landscape in Vermont

Vermont's Food Is Medicine landscape is currently driven largely by PRx programs. There are five health care-supported Community Supported Agriculture (CSA) and farm share initiatives happening in 9 out of the 14 counties in VT.[23] These programs connect clinical care with local agriculture, allowing providers to prescribe produce to patients who are FI and have a diet-related chronic condition, or are at risk for developing a chronic condition. In 2025, 36 for-profit farms and 3 non-profit farms participated in the CSA in Health Care programs and reached 1,139 people. Of those enrolled, 79% were insured by Medicare or Medicaid.[23]

Of the five CSA PRx programs, one program is based within a Federally Qualified Health Center (FQHC), and another program partners closely with an FQHC. Little Rivers Health Care (LRHC) has been operating PRx programs in its communities for the past four years. Additionally, the Northern Tier Center for Health (NOTCH) operates a non-profit social grocery store in Richmond, VT and partners with Healthy Roots Collaborative to offer a seasonal CSA PRx program for eligible patients in Franklin and Grand Isle Counties. One additional FQHC-based FIM program closed its program in the spring of 2025 due to funding and staffing uncertainty, but the outcomes of their program and their FIM approach are worth noting because of the positive results. Lamoille Health Partners (LHP) operated a MTM and MTG program. Patients who met eligibility criteria and who were unable to prepare their own meals were provided a prepared meal which was ordered and shipped directly to the patient via Mom's Meals. Additionally, those patients who were able to prepare their own meals were prescribed MTGs. Recipes were curated by an RD, and an online order was placed by the coordinator to the local grocery store. The groceries were delivered directly to the patient via Instacart.

LRHC, LHP, and NOTCH programs leveraged Bi-State Primary Care Association's Health Center Controlled Network (HCCN) data warehouse and analytic supports to evaluate the programs' effectiveness. Bi-State tracked patient eligibility, enrollment, and participation, monitoring a dashboard of CVD risk indicators, such as blood pressure and cholesterol as well as HbA1c. There were statistically significant clinical improvements for FIM participants compared to their clinical data prior to participation. For example, average systolic blood pressure of patients

enrolled in the food program for at least 3 months was statistically lower ($p = 0.009$), and cholesterol was lower after being enrolled for at least 6 months ($p = 0.025$).

Simultaneously, while the FQHCs were planning and establishing their FIM programs, the Vermont Sustainable Jobs Fund, in collaboration with the Farm to Plate network, created the "VT Food Security Roadmap"[24] to focus on food security. This statewide, multi-sector effort provides a shared, policy-focused strategy to ensure that all Vermonters are food secure by 2035. Recognizing that food security is deeply interconnected with health, housing, and income, the Roadmap focuses on systemic solutions, such as strengthening economic stability, expanding access to federal nutrition benefits, investing in resilient local agriculture, and improving community infrastructure. The Roadmap ensures that FIM efforts are not siloed but rather part of a broader cross-sector movement. The FIM Task Force—which launched in January 2026—operationalizes the Roadmap's interconnection with health by focusing on connecting food and health care along with advocating for sustainable reimbursement for FIM programs.

In Fall 2025, two additional FQHCs committed to advancing FIM programming. Northern Counties Health Care (NCHC) is in the process of developing a Teaching Kitchen, while Battenkill Valley Health Center (BVHC) is in the planning phase, exploring strategies that may include community gardens and a partnership with community non-profit, Grateful Hearts, to provide MTMs to eligible Vermont patients. At present, Grateful Hearts is the only known provider producing MTMs in the state, operating as a pilot initiative supported through funding from the Food Access in Health Care (FAHC) Network.

Established in 2020, the FAHC Network currently brings together six statewide organizations to advance FIM efforts across Vermont: Bi-State Primary Care Association, Farm to Plate, Hunger Free Vermont, VT Academy of Nutrition and Dietetics, VT Foodbank, and the VT Program for Quality in Health Care. The Network's goal is to strengthen the full continuum of FIM activities, from increasing screening and referrals for food and nutrition insecurity to expanding access to interventions such as MTMs, and everything in between. To advance this work, the Network has launched three rounds of community initiative funding through a Request for Proposals opportunity. As a result, 21 community organizations have been supported to date. These investments, totaling over $376,000 to date, have reached 10 of Vermont's 13 rural counties.

Vermont Food Hub Collaborative

The Vermont Food Hub Collaborative is a statewide network of nonprofit food hubs that play a critical role in moving food from farms to communities across Vermont. Made up of six organizations—including ACORN, the Center for an Agricultural Economy, Food Connects, Green Mountain Farm to School, the Intervale Center, and the Vermont Farmers Food Center—the collaborative works both independently and together to aggregate, market, and distribute locally produced food.[28] By coordinating logistics like storage, transportation, and sales, these food hubs create efficient pathways that connect farmers with buyers ranging from households and grocery stores to schools and institutions. In doing so, the collaborative not only helps ensure that fresh, local food can reliably move from point A to point B, but also strengthens

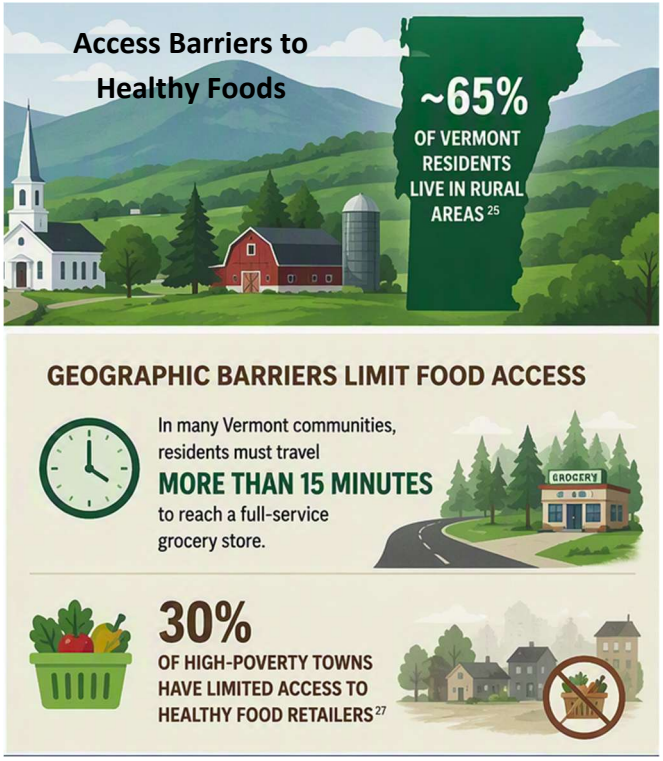
farm viability, expands market access, and supports a more resilient and accessible food system for all Vermonters.[29]

It is anticipated that the demand for local, fresh produce will increase if FIM reimbursement mechanisms are implemented, and it will be essential to coordinate with the VT Food Hub Collaborative in the future to ensure that all Vermonters have access to local produce. Demand for food directly ties into the Vermont Agriculture and Food System Strategic Plan.[30]

The *Food Is Medicine in Vermont: An Unmet Needs Analysis* report provides a critical, cross-sector view of how FIM is currently functioning across the state and where key gaps remain.[31] Drawing on input from clinicians, dietitians, community health workers, and food providers, the report reinforces that while Vermont has a strong foundation of locally driven programs, often centered around PRx, community partnerships, and food hubs, the system remains highly fragmented and largely dependent on short-term grant funding. The findings highlight consistent barriers across sectors, including limited clinical integration, lack of standardized referral pathways, transportation challenges, and insufficient infrastructure to support coordination and data tracking. At the same time, the report underscores a shared commitment to using food as a therapeutic tool and points to a clear path forward: building a more coordinated, sustainable, and reimbursable FIM system that better connects health care and community food networks. Framed within Vermont's broader food system, where organizations like the Food Hub Collaborative help move food efficiently from producers to communities, this analysis helps illustrate both the promise of FIM and the structural investments needed to scale its impact statewide.

Access Barriers

Vermont's largely rural landscape creates distinct and persistent challenges for addressing hunger and diet-related conditions across both rural and more urban communities.[25] As of 2023, an estimated 13.9% of children in Vermont live with FI—nearly half of whom fall above the income eligibility thresholds for SNAP or WIC, highlighting gaps in traditional safety net coverage.[26] In many parts of the state, schools serve as critical access points for nutrition yet face structural barriers that limit their reach. These challenges are compounded by geographic barriers to food access.[27] Together, these factors demonstrate the limitations of relying solely on traditional food access points and highlight the need for integrated, health care-connected approaches to nutrition support.



What are the policy realities in Vermont?

Vermont's current Section 1115 Medicaid waiver demonstration is set to expire at the end of 2027. From fall 2026 through the first half of 2027, the Vermont Agency of Human Services (AHS), the state's Medicaid agency, will work with stakeholders to develop an application to renew the 1115 waiver, known in the state as the Global Commitment to Health. Bi-State and our partners will work with AHS on potential opportunities to include FIM in the Vermont Medicaid program.

In addition to Medicaid, Bi-State and its partners are working with commercial payors to understand their capacity to include FIM as a benefit. In addition to defining the benefit and eligible groups, commercial payors would need to evaluate the impact of this benefit on rates, which need to be approved by the Green Mountain Care Board and supported by the Department of Financial Regulation, two regulatory bodies that oversee commercial insurers.



Chapter 2: Return on Investment of Food Is Medicine

Economic and Health Impacts of Medically Tailored Meals and Produce Prescription Programs

This chapter addresses the Return on Investment (ROI) of FIM focusing on Medically Tailored Meals (MTMs) and Produce Prescriptions (PRx). Beginning with a review of the national evidence, this chapter then examines the Vermont FIM landscape, followed by Vermont-specific analyses of PRx and MTMs and an assessment of the local economic impact associated with partnerships with Vermont farms.

National economic evidence for Medically Tailored Meals

MTMs have been shown to be clinically effective as well as cost savings. A national economic evaluation by Hager et al.[32] used nationally representative Medical Expenditure Panel Survey data to estimate the potential effects of expanding MTM coverage among U.S. adults with a diet-sensitive condition, food insecurity, and limitations in instrumental activities of daily living. The model identified approximately 6.31 million adults who met the study's eligibility criteria.

These findings provided in the Table 2.1 show that, when targeted to individuals with diet-sensitive disease and significant functional limitations, MTMs have the potential to be not only clinically beneficial but cost-saving from a health care perspective.

Table 2.1: Key MTM findings

Outcome	National modeled impact
Eligible adults	6.31 million
Hospitalizations averted, Year 1	1.59 million
Hospitalizations averted, 10 years	18.26 million
Annual program cost	$24.8 billion
Annual health care expenditures avoided	$38.7 billion
Net annual health care savings	$13.6 billion
Net 10-year savings	$185.1 billion

Source: Hager et al. (2022).

These modeled findings are supported by real-world evidence from Medicaid-funded MTM programs. The Tufts Food Is Medicine Institute's recent analysis of the first three years of MTMs in Massachusetts delivering MTM as 10 weekly meals with an average duration of 6.5 months, to nearly 2,000 patients and compared to flexible services recipients not receiving

MTM, demonstrated 31% fewer hospitalization while on the program, and health care savings offset 98% of the programmatic costs in the first year.[33] Net cost savings were seen in patients with chronic kidney disease, cardiovascular disease (including heart failure), depression, and diabetes; and among patients living in neighborhoods with higher socioeconomic stress levels.[33]

National economic evidence for Produce Prescription Programs

National Modeling of Produce Prescriptions

The economic case for PRx programs has also been evaluated using nationally representative data. Wang et al.[34] modeled the potential health and economic effects of providing PRx to U.S. adults with both diabetes and food insecurity. The model estimated that approximately 6.5 million U.S. adults would be eligible for the intervention, examining outcomes over the lifetime of the modeled population.

The findings of this study are presented in Table 2.2 and are relevant to Vermont because they demonstrate that the value of PRx extends beyond direct medical expenditures. Improvements in health can reduce future health care costs while also reducing productivity losses associated with chronic disease. The study also found that the intervention remained cost-effective when shorter time horizons were considered, although the full health and economic benefits were greater when modeled over the lifetime.

Table 2.2: Key PRx findings

Outcome	National modeled impact
Adults with diabetes and food insecurity	~6.5 million
Cardiovascular events prevented	292,000 over modeled lifetimes
Quality Adjusted Life Years[ii] gained	260,000
Program costs	$44.3 billion
Health care savings	$39.6 billion
Productivity savings	$4.8 billion
Health Care Incremental Cost-Effectiveness Ratio	$18,100/QALY
Societal perspective	Cost-saving

Source: Wang et al., (2023).

Clinical and Economic Findings from Multisite PRx Programs

National modeling provides an estimate of potential long-term impact for PRx programs, and evaluations of PRx programs provide additional information about what happens when these

[ii] A quality-adjusted life year (QALY) is a measure that combines the length of life and quality of health experienced, with one QALY representing one year of life in perfect health. QALYs gained reflect improvements in health and survival attributable to an intervention and provide a standardized way to compare health benefits with the costs of achieving them; when considered from a societal perspective, these health gains may also contribute to improved productivity, workforce participation, and reduced caregiver burden.

interventions are implemented in real-world settings. Hager et al.[35] evaluated nine PRx programs operating at 22 sites across 12 U.S. states, including 3,881 participants—2,064 adults and 1,817 children—with or at risk for poor cardiometabolic health.

Among adult participants, PRx participation was associated with improvements in several clinically important cardiometabolic measures, including a 0.29 percentage-point reduction in HbA1c, an 8.38 mmHg reduction in systolic blood pressure, a 4.94 mmHg reduction in diastolic blood pressure, and a 0.36 kg/m² reduction in BMI.[35] These changes are clinically relevant because improved glycemic control and lower blood pressure are associated with reduced risk of diabetes-related and cardiovascular complications, while modest improvements in BMI may contribute to improved cardiometabolic risk. The magnitude of the blood pressure reductions is particularly notable given the well-established relationship between blood pressure and cardiovascular events. PRx participation was also associated with a 0.85-cup-per-day increase in fruit and vegetable consumption among adults, a one-third reduction in the odds of experiencing food insecurity, and greater likelihood of reporting improved health status[35] Together, these findings suggest that PRx programs can simultaneously address food access and dietary quality while producing measurable improvements in clinical indicators of cardiometabolic health.

The cost of the produce incentives[iii] averaged approximately $63 per participant per month, with programs operating for approximately four to ten months.[35] These clinical findings indicate that relatively modest investments in produce access can be accompanied by measurable improvements in clinical risk factors among patients at risk for cardiometabolic disease. Although this study did not calculate a payor ROI, its findings provide important evidence supporting the potential clinical value of PRx as a health care intervention.

State-Specific Economic Impact of Produce Prescription Programs

A 2025 microsimulation study by Wang et al.[36] examined the potential health and economic impact of expanding PRx programs to adults ages 40–79 with both diabetes and food insecurity in all 50 states. The analysis incorporated state-specific data from the 2021–2023 Behavioral Risk Factor Surveillance System (BRFSS), supplemented with National Health and Nutrition Examination Survey (NHANES) data, and applied pooled estimates of PRx effectiveness and program costs from 20 existing programs. Health and economic outcomes were projected over both five- and ten-year periods, including cardiovascular disease (CVD) events, quality-adjusted life years (QALYs), program costs, health care savings, and net costs.

Vermont had the lowest proportion of adults estimated to be eligible for PRx in the nation, with approximately 2.0% of adults ages 40–79—or about 7,000 Vermonters—estimated to have both diabetes and food insecurity.[36] Despite this comparatively small eligible population, the state-specific modeling found that PRx was net cost-saving in Vermont in both 5 year ($4.9 million) and 10 years ($9.1 million) increments. The analysis projected that the health care savings generated by preventing cardiovascular events and other downstream health care

[iii] Produce incentives are one type of PRx, where participants are given a certain amount of funding—often via cash or gift card—on a set regular basis (i.e. monthly) to purchase produce. This differs from other PRx models which provide the produce directly to the participants.

expenditures would exceed the costs of providing the intervention. The study also found that PRx was most likely to be cost-saving among Medicare beneficiaries, followed by Medicaid and privately insured populations.

Vermont's relatively small eligible population does not preclude a favorable return on investment; rather, the modeling suggests that targeting PRx to Vermonters with both diabetes and food insecurity can generate health care savings that exceed program costs. This provides state-specific support for considering PRx as a reimbursable health care intervention, particularly when eligibility criteria prioritize individuals with significant clinical and nutritional need. Importantly, the model's findings remained favorable under a range of assumptions, including analyses using a shorter five-year time horizon and more conservative enrollment and retention assumptions.

The broader national economic case for Food Is Medicine

The economic rationale for FIM extends beyond the savings attributable to any single intervention. Poor diet and food insecurity impose substantial costs on the U.S. economy through increased health care spending and lost productivity. The Rockefeller Foundation's *True Cost of Food* analysis estimated that diet- and food-related health costs—including direct medical costs and productivity losses—are estimated to be approximately $1.1 trillion annually in the United States.[37] This broader economic burden provides important context for considering FIM reimbursement: can strategically investing in nutrition prevent costly health outcomes and reduce expenditures elsewhere in the health care system?

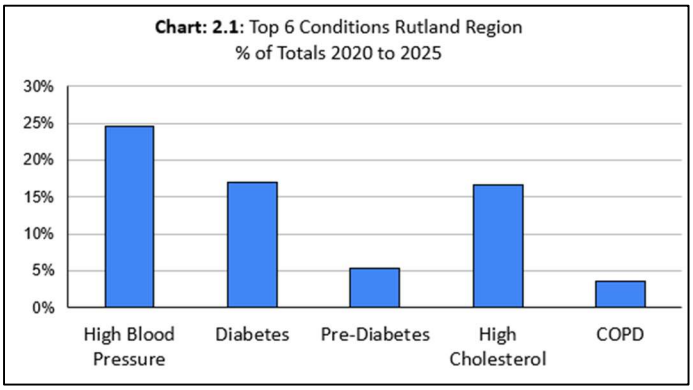
Vermont's current "CSA Healthcare Program Community of Practice" analysis

Vermont has an established infrastructure for connecting local food systems with health care through the "CSA Healthcare Community of Practice," which was founded in 2021. Community-supported agriculture (CSA) programs provide a unique mechanism for connecting Vermont farms, community organizations, and health care partners to address food access and health simultaneously. In 2025, the CSA Healthcare Community of Practice included 50 participating community organizations and health partner sites, 39 participating farms, and five food hubs and health care entities developing and implementing CSA-based produce prescription (PRx) programs.[23] This existing network provides an important foundation for expanding PRx reimbursement and demonstrates Vermont's capacity to deliver nutrition interventions through locally rooted partnerships.[23]

Health Impact

Vermont's existing PRx programs generate data on the health needs of participants and the clinical outcomes associated with participation. Screening data from the Rutland County VT

Farmers Food Center (VFFC) Farmacy Program, presented in Chart 2.1, identified high blood pressure and diabetes as the two most commonly reported chronic conditions among participants, demonstrating that PRx programs are reaching Vermonters with conditions for which improved access to nutritious food may be particularly relevant.



Several Vermont Federally Qualified Health Centers (FQHCs), including the Northern Tier Center for Health (NOTCH) and Little Rivers Health Care (LRHC), have implemented grant-funded food and PRx programs and have documented clinical and operational outcomes. Both programs have observed improvements in HbA1c, with longer participation associated with greater reductions in average HbA1c. These findings are consistent with national research demonstrating improvements in glycemic and cardiometabolic measures among PRx

Chart 2.2: A1C outcomes for FIM participants in FQHC 1

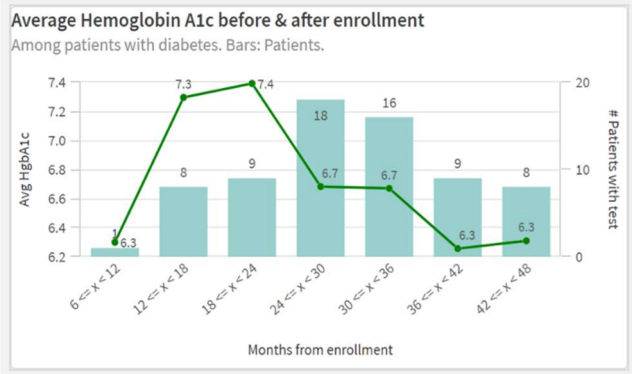
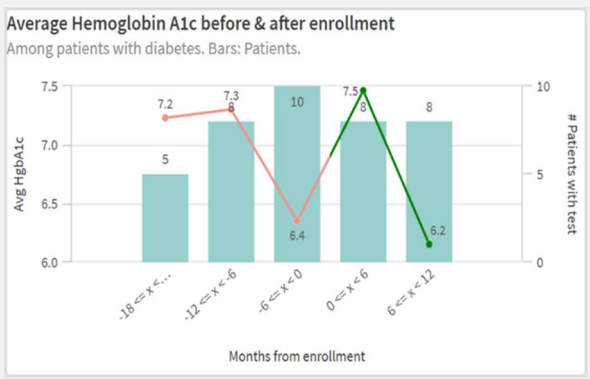


Chart 2.3: A1C outcomes for FIM participants in FQHC 2



participants[35] and provide Vermont-specific information that these interventions can be integrated into health center care models. Both showed that the longer the program was in the place, the lower the average HbA1c. (See Charts 2.2 and 2.3, developed by Bi-State using data from LRHC's and NOTCH's FIM Programs.)

Additional Vermont FQHC data demonstrate improvements in blood pressure and cholesterol among participants tracked through 12 months following enrollment in PRx programs. Continued monitoring of participants' clinical outcomes will provide additional information about the durability of these improvements and the potential health care utilization and cost implications of sustained PRx participation. (See Charts 2.4 and 2.5, developed by Bi-State using data from LRHC's and NOTCH's FIM Programs.)

Chart 2.4: Cholesterol outcomes for FIM participants in FQHC 1

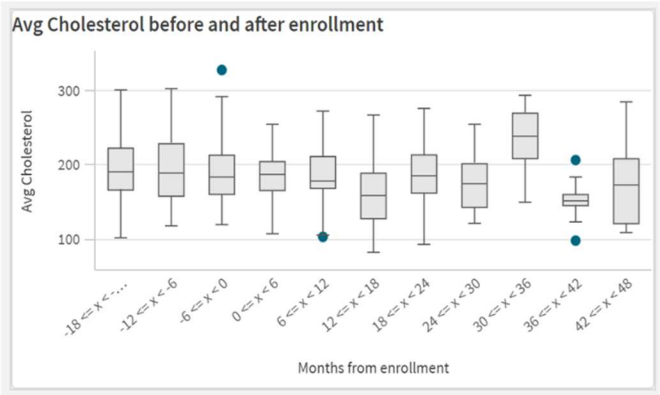
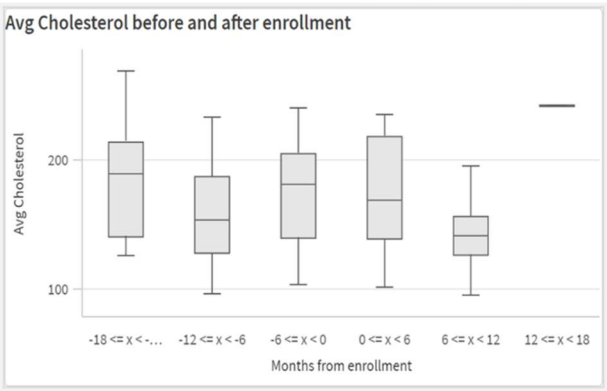


Chart 2.5: Cholesterol outcomes for FIM participants in FQHC 2



Vermont's ROI analysis

Several analyses were conducted to estimate the potential health care and broader economic value of Vermont's existing and potential FIM programs. The microsimulation model's projected outcomes are grounded in empirical data showing that PRx improve dietary quality and cardiometabolic risk factors.[34] In real-world pre/post interventions, on average, these interventions:

- Increase fruit and vegetable consumption by 0.8 servings (95% confidence interval [CI], 0.45 to 1.15) per day.
- Reduce body mass index (BMI) by 0.36 kg/m^2 (95% CI, 0.15 to 0.55),
- Reduce HbA1c levels by 0.63% (95% CI, 0.28 to 0.98).

The Vermont-specific analysis examined two types of economic benefits associated with FIM. The first, presented below, estimates health care savings associated with improved health outcomes and reduced health care utilization using microsimulation modeling and data from existing programs. The second examines the economic benefits generated when FIM programs purchase food from Vermont farms and food hubs, using existing FIM investment in local farms and drawing on economic return research and a food impact calculator. Because these two analyses represent distinct forms of value that accrue to different sectors, they are presented separately rather than combined into a single ROI figure. Health care savings primarily benefit payors and the health care system, while local economic benefits accrue to Vermont farms, food producers, businesses, and communities. These measures provide a more complete picture of the potential value of investing in FIM.

Perspective	Value Generated by FIM Programs
Health Care ROI	Reduced health care expenditures through improved health outcomes and fewer avoidable hospitalizations, emergency department visits, and complications.
Economic ROI	Increased investment in Vermont farms, food hubs, and local businesses, strengthening rural economies and supporting agricultural resilience.

For PRx programs, three scenarios were modeled to examine both the performance of Vermont's existing programs and the potential impact of expanding PRx statewide:

- **Scenario A** modeled existing Vermont PRx programs using their current participant populations and program characteristics.
- **Scenario B** modeled the same existing programs under a more targeted eligibility approach, analyzing outcomes if the participation had been limited to individuals with both diabetes and food insecurity (DM + FI), consistent with the population examined in national PRx economic research.
- **Scenario C** used the Vermont Behavioral Risk Factor Surveillance System (BRFSS) data to estimate the potential health and economic impact of scaling PRx statewide to reach Vermonters with both diabetes and food insecurity.

The three scenarios provide a progression from current-state program performance, to targeted program design, to potential statewide scale, allowing Vermont to assess how changes in eligibility and program reach could affect the overall value of PRx.

The analysis for Scenario C utilizes updated assumptions from prior research and estimates the five-year clinical and economic impacts of implementing a statewide PRx program covering an eligible cohort of 9,000 individuals with diabetes and food insecurity in Vermont.[iv] The findings suggest that the PRx intervention yields robust, compounding public health benefits. Economically, the initiative rapidly shifts from a low-cost program in year 1 to a likely cost-saving intervention by year 2 and beyond from both health care and societal perspectives.

The key ROI results are listed below and described in detail following Table 2.3. Negative numbers in the table indicate cost savings. For example, the ROI of a PRx Program that focuses on individuals who experience FI and have diabetes (Scenario B) points to a one-year net health care savings of $50,100, with an additional one-year economic benefit of $726,200 if local farms are utilized; and a 5-year net health care savings of $207,200.

[iv] This scenario is similar to an analysis conducted in a study by Wang et al. (2025), where analysis looked at 7,000 Vermonters with diabetes and food insecurity.[36] The reason the analysis population numbers differ between Scenario C and the 2025 study, is due to utilization of different BRFSS survey years, and the need to utilize multiple imputation in the 2025 study since the BRFSS used in the study did not have the food insecurity questions included.[36] Therefore, the current Scenario C is more current than that represented in the previous study.

Table 2.3: Key Scenario Analysis Takeaways

Scenario	Program Type	Eligibility Criteria	Population Size	Net 1-year health care costs /savings ($K)***	Net 5-year health care costs /savings ($K)***	1-year economic benefit by using local farms ($K)+++
A	PRx*	FI + CCs	926	$319.3	$1,397.3	$762.2
B	PRx**	FI + DM	926	$-50.1	$-207.2	$762.2
C	PRx++	FI + DM	9,000	$200+	$-2,700	Not calculated
D	MTMs	DSC + IADLs	19,461	$-53,000.0	Not calculated	Not calculated
E	MTMs	DM + IADLs	5,736	$-26,000.0	Not calculated	Not calculated

*Notes: FI=Food insecurity; DM=diabetes; CC=assorted chronic conditions; DSC=diet-sensitive conditions; IADLs=instrumental activities of daily living; *=analysis of existing PRx programs in VT; **=analysis of existing PRx programs in VT if eligibility was modified to be only individuals with FI and DM; ***= a negative number indicates savings; +=includes assumptions of startup expenses; ++=uses different cost assumptions than the existing PRx programs in VT; +++=estimate using the Local Food Impact Calculator [38].*

Current Produce Prescription (PRx) impact in Vermont

PRx programs provide FI patients with bags or boxes of produce, or financial incentives (vouchers or electronic benefits) to purchase fruits and vegetables, most often combined with nutritional counseling. There were three PRx microsimulation models conducted, with all scenarios showing a reduction in medical spending, and Scenarios B and C demonstrating net cost savings. This microsimulation modeling analysis evaluates the clinical and economic impacts of implementing Vermont's existing PRx program over a five-year period covering a cohort of 926 adults with FI and diet-related chronic conditions (diabetes, hypertension, or CVD) (Scenario A). An additional microsimulation was conducted to discern the impact if all 926 adults in the existing PRx programs had both FI *and* diabetes (Scenario B). The validated Tufts Diabetes, Obesity, and Cardiovascular disease Microsimulation Model (DOC-M) was utilized. A final microsimulation model was conducted projecting if PRx programs were expanded statewide (Scenario C). This model was populated with individuals participating in the 2024 BRFSS representing the noninstitutionalized Vermont adult population aged 25-79 with FI and diet-related chronic conditions. All projected monetary values are reported in 2026 US dollars and discounted at an annual rate of 3%.

Key Findings from Vermont-Specific Analyses

Scenario A Analysis: Vermont's Existing PRx Programs

1. Reducing the Health Care Cost Curve

Vermont's total annual program cost per enrolled patient was $627 ($393 food and $234 administrative costs). The program is projected to reduce medical spending, with cumulative health care cost savings increasing over time for the 926-person chronic-condition cohort shown in Table 2.4.

- Year 1 health care cost averted: $245.0K (95% UI: $110.2K, $403.4K).

- Five-year cumulative health care cost averted: $1.15M (95% UI: $530.3K, $1.87M). These savings accumulate steadily and offset about 45% of cumulative food and administrative costs by year 5, but they do not fully offset program costs in the mean estimates.

2. Projected Net Costs and Estimated ROI

Accounting for real annual cost per participant of the program, averted health care costs offset a meaningful share of program costs, although the mean net cost in Scenario A remains positive at each time horizon from the health care perspective.

- Year 1: Program costs total approximately $564.4K for 926 participants, including $353.4K in food costs and $211.0K in administrative costs. After accounting for health care cost savings, the mean net cost is $319.3K from the health care perspective (95% UI: $161.2K, $454.1K).

- Year 5: By year 5, cumulative program costs reach approximately $2.54M ($1.59M in food costs plus $951.1K in administrative costs). Health care savings offset about 45% of these program costs in the mean estimate, leaving a year-5 net cost of $1.40M from the health care perspective (95% UI: $674.4K, $2.02M). Thus, the program delivers growing health care-utilization benefits but is not net cost-saving over the five-year horizon.

Table 2.4 summarizes the progression of the program cost impacts from Year 1 to Year 5 for the 926-person chronic-condition cohort representing the existing PRx programs in Vermont.

Table 2.4. Projected health care cost savings, intervention costs, and net costs for current PRx program for 926 individuals with chronic conditions and food insecurity in Vermont.

Horizon	Health care Cost Saved ($K)	Food Cost ($K)	Admin Cost ($K)	Net Cost, Health care Perspective ($K)†
1 year	245.0 (110.2, 403.4)	353.4	211.0	319.3 (161.2, 454.1)
2 year	481.9 (216.6, 792.5)	688.5	411.0	617.6 (306.4, 883.0)
3 year	711.3 (329.5, 1,171.8)	1,006.3	600.7	895.7 (435.1, 1,278.5)
4 year	936.6 (431.1, 1,562.0)	1,307.8	780.7	1,151.9 (526.9, 1,658.7)
5 year	1,147.1 (530.3, 1,868.2)	1,593.2	951.1	1,397.3 (674.4, 2,015.8)

Notes: All monetary values are in 2026 US dollars. All costs were discounted by 3% annually. Estimates represent the mean differences in projected health and economic outcomes for a statewide PRx program covering the specified Vermont cohort of 926 individuals with chronic conditions and food insecurity, compared with usual care, from 1,000 Monte Carlo simulations, with 95% uncertainty intervals derived from the 2.5th and 97.5th percentile values. †Net costs in a health care perspective was calculated as intervention cost minus health care cost averted, compared to usual care. Negative value represents cost saving.

Scenario B Analysis: PRx for 926 Individuals with Diabetes and Food Insecurity

Table 2.5 presents an alternative scenario assuming the same PRx intervention is applied to 926 Vermont adults with *diabetes* and food insecurity. In this higher-risk diabetes scenario, projected health care cost savings are substantially larger than in the mixed chronic-condition cohort: $610.5K in year 1 (95% UI: $241.2K, $1.04M) and $2.73M by year 5 (95% UI: $1.09M,

$4.68M). Because intervention costs are similar while expected health care savings are higher, the diabetes scenario is cost-saving on average from the health care perspective at each time horizon. Mean net savings are $50.1K in year 1 and $207.2K by year 5. However, the uncertainty intervals include both savings and net costs (year 5 UI: -$2.15M to $1.43M), so these results should be interpreted as a more favorable scenario analysis rather than a guaranteed cost-saving estimate.

Table 2.5. Projected health care cost savings, intervention costs, and net costs for PRx program for 926 individuals with diabetes and food insecurity in Vermont.

Horizon	Health care Cost Saved ($K)	Food Cost ($K)	Admin Cost ($K)	Net Cost, Health care Perspective ($K)†
1 year	610.5 (241.2, 1,043.1)	351.0	209.5	-50.1 (-484.1, 320.2)
2 year	1,180.8 (475.6, 2,018.6)	683.8	408.2	-88.7 (-926.9, 615.8)
3 year	1,725.2 (687.9, 2,968.5)	999.0	596.4	-129.9 (-1,374.2, 906.6)
4 year	2,241.8 (857.9, 3,879.1)	1,297.9	774.9	-169.0 (-1,812.9, 1,215.8)
5 year	2,731.0 (1,088.6, 4,678.1)	1,580.3	943.5	-207.2 (-2,152.9, 1,434.0)

Notes: All monetary values are in 2026 US dollars. All costs were discounted by 3% annually. Estimates represent the mean differences in projected health and economic outcomes for a statewide PRx program covering the specified Vermont cohort of 926 individuals with diabetes and food insecurity, compared with usual care, from 1,000 Monte Carlo simulations, with 95% uncertainty intervals derived from the 2.5th and 97.5th percentile values.†Net costs in a health care perspective was calculated as intervention cost minus health care cost averted, compared to usual care. Negative value represents cost saving.

Scenario C Analysis: Scaling PRx Statewide for people with Diabetes and Food Insecurity

1. Clinical Drivers & Quality of Life Impact

Looking at analysis of scaling PRx programs to 9,000 Vermonters with diabetes and food insecurity, additional health benefits can be seen.[iv] By helping to address nutritional barriers in this high-risk population, the program is projected, by year 5, to prevent 55 heart attacks and other cardiovascular disease (CVD) cases (95% uncertainty interval [UI]: 25, 92) and gain 52 quality-adjusted life years (QALYs) (95% UI: 13, 91).

Similar to programs in Vermont, the interventions in the real-world pre/post interventions varied in the amount of produce provided (from $15 to $140 per month, or approximately 10-25 lb per distribution), provision method (food-box pickup or delivery, paper vouchers, electronic debit cards, or community-supported agriculture shares), nutrition education (none, printed recipes, cooking demonstrations, dietitian counseling, or structured diabetes self-management classes), and duration (approximately 3-12 months).[34] While intervention effects may vary by program design, the current literature did not allow a rigorous assessment of how these factors modified effect sizes[v]. We assumed that the average effects apply across programs, with uncertainty incorporated in the model.

2. Reducing Health Care Costs: The program is projected to reduce total medical utilization, resulting in health care cost savings over time.

[v] Effect sizes describe the magnitude of a difference or change associated with an intervention, helping show how large or meaningful an observed effect is rather than simply whether a statistically significant difference exists.

- Year 1 health care cost averted: reduce baseline health care expenditures by $4.6 million (95% UI: $1.9M, $7.6M), representing an approximate 3% reduction in total health care costs for this patient cohort.

- Five-Year cumulative health care cost averted: $20.5 million (95% UI: $8.6M, $34.3M), representing an approximate 3% reduction in total health care costs for this patient cohort.

3. Projected Net Costs and Estimated ROI

While the program requires upfront investments for food procurement and administrative oversight, the averted health care costs are projected to outpace these expenses by Year 2, presenting a plausible ROI:

- Year 1 (Setup phase): The program costs approximately $727 per participant per year in Year 1 (food costs of $485 plus $242 in administrative costs). On average, the program operates at a net cost of $0.2 million from both health care (95% UI: -$3.1M, $3.0M) and societal (95% UI: -$3.2M, $3.0M) perspectives.

- Years 2–5: The intervention becomes cost-saving. The program costs approximately $570 per participant per year in Years 2–5 (food costs of $485 plus $85 in administrative costs), falling to this level after higher first-year setup costs. By Year 5, the mean cumulative net saving is $2.7 million (health care perspective) and $3.1 million (societal perspective).

Table 2.6 presents the five-year clinical and economic impact of statewide scaling of a PRx program for 9,000 individuals with diabetes and food insecurity in Vermont, representing all eligible individuals.

Table 2.6. Projected health care cost savings, intervention costs, and net costs for statewide PRx program for 9,000 individuals with diabetes and food insecurity in Vermont.

Horizon	Total CVD Cases Averted	QALYs Gained	Health care Cost Saved ($M)	Food Cost ($M)[†]	Admin Cost, ($M)[†]	Net Cost, Health care Perspective ($M)[††]
1 year	13 (4, 24)	11 (4, 18)	4.6 (1.9, 7.6)	3.2 (2.3, 4.0)	1.6 (1.2, 2.0)	0.2 (-3.1, 3.0)
2 year	24 (9, 42)	21 (7, 36)	8.8 (3.7, 14.6)	6.2 (4.5, 7.9)	2.1 (1.5, 2.7)	-0.6 (-6.8, 5.0)
3 year	35 (14, 60)	32 (10, 57)	12.9 (5.3, 21.5)	9.0 (6.6, 11.5)	2.6 (1.9, 3.3)	-1.3 (-10.3, 6.7)
4 year	45 (19, 72)	42 (11, 75)	16.8 (6.6, 28.2)	11.7 (8.5, 15.0)	3.1 (2.3, 3.9)	-2.0 (-14.0, 8.4)
5 year	55 (25, 92)	52 (13, 91)	20.5 (8.6, 34.3)	14.2 (10.4, 18.2)	3.5 (2.6, 4.5)	-2.7 (-17.7, 9.8)

Notes: All monetary values are in 2026 US dollars. All costs and QALYs and were discounted by 3% annually.
[*]Estimates represent the mean differences in projected health and economic outcomes for state wide PRx program covering all diabetes patients with food insecurity compared to the usual scenario of current health care from 1,000 Monte Carlo simulations, with 95% uncertainty intervals derived from the 2.5[th] and 97.5[th] values. [†] Intervention costs include food costs and administrative costs. [††] Net costs in a health care perspective was calculated as intervention cost minus health care cost averted, compared to usual care. Negative value represents cost saving.

PRx Scenario Analysis Conclusions

Implementing a PRx program for 926 Vermont adults with food insecurity and diet-related chronic conditions is projected to improve diet-related risk factors and reduce health care spending over the five-year horizon. When the eligibility for the existing PRx programs changes from patients who have FI and a variety of chronic conditions to only patients who have both FI and diabetes, the program becomes net cost saving within the first year. Statewide scaling of a PRx program for 9,000 individuals with diabetes and food insecurity in Vermont, with a $50 per month benefit level[vi] is projected to become net cost saving in Years 2-5. This analysis supports PRx as a promising, evidence-based investment that helps mitigate chronic diseases burdens and lowers overall financial burdens on both the health care system and society at large. (See Appendix 4: Technical Appendix for further detail on the structure and process of the analysis.)

Implications of National Economic Modeling of PRx for Vermont

Vermont's experience is further supported by national economic modeling demonstrating the potential value of FIM interventions. Wang et al.[36] modeled the health and economic effects of PRx programs for adults with diabetes and FI across all 50 states and found that PRx was cost-effective across states and payor perspectives, although the magnitude of benefit varied by state characteristics, payor mix, and population served. Vermont was among the states in which PRx represented favorable value, supporting the potential for targeted nutrition interventions to serve as a preventive health care investment. These national estimates should not, however, be interpreted as predictions of specific savings that would result from a Vermont FIM benefit. Rather, they provide a basis for evaluating the potential economic value of FIM while Vermont builds state-specific evidence on clinical outcomes, health care utilization, and costs.

Sustainable reimbursement would allow Vermont to move beyond small, grant-funded programs toward a more consistent benefit that can be evaluated and refined over time. State-specific data could inform benefit design, identify populations and interventions that generate the greatest value, and assess the effects of investing in nutrition as part of health care. Vermont's existing PRx infrastructure and partnerships with local farms and food hubs also creates an opportunity for health care investments to generate benefits beyond the health care system by supporting Vermont's agricultural economy and strengthening local food infrastructure.

Vermont Medically Tailored Meals Cost-Effectiveness and Return-on-Investment Analysis Summary

This summary estimates the potential annual health care utilization and cost impacts of providing 10 Medically Tailored Meals per week for an average of eight months to Vermont adults age 18 and older with Medicare, Medicaid, or private coverage who have one or more

[vi] Benefit level referenced consists of dollars for food vouchers only; does not include the administrative costs which are factored in separately.

diet-sensitive conditions or diabetes and limitations in instrumental activities of daily living (IADLs), using data from a previously published study by the Food Is Medicine Institute.[39] State-specific estimates for Vermont were derived using BRFSS data, with BRFSS measures selected to closely correspond to the diet-sensitive conditions and limitations used to define MTM eligibility in the underlying national analysis.

Table 2.7: One-Year Estimated Impact of Medically Tailored Meals for Vermonters

Metric	Vermont Adults with Multiple Diet-Sensitive Conditions[vii] and IADL[viii] (n=19,461)	Vermont Adults with Diabetes and IADL[vi] (n=5,736)
Program costs	$70 million (95% UI: 69, 71)	$21 million (95% UI: 20, 21)
Annual averted inpatient hospitalizations	5,200 (95% UI: -18,800 to 30,800)	1,500 (95% UI: -5,500 to 9,100)
Number needed to treat (MTMs) to prevent one hospitalization per year	3.7 people (95% UI: -1.0, 0.6)	3.7 people (95% UI: -1.0, 0.6)
Annual health care expenditure savings	$123 million (95% UI: 45, 210)	$47 million (95% UI: 17, 81)
Net policy cost savings	$53 million (95% UI: -24, 138)	$26 million (95% UI: -3, 60)
Net annual health care expenditure savings per person	$2,702 (95% UI: -1,224, 7,111)	$4,579 (95% UI: -531, 10,374)

In the first year, MTMs for 19,461 adult patients with diet-sensitive conditions and IADL limitations are expected to provide $123 million in annual health care expenditure savings ($53 million in net savings, after program costs are subtracted), resulting in $2,702 in net annual health care expenditure savings per person. MTMs for 5,736 adult patients with diabetes and IADL limitations are expected to provide $47 million in annual health care expenditure savings ($26 million in net policy savings after the $21 million in program costs are subtracted), resulting in $4,579 in net annual health care expenditure savings per person.

Impact of PRx programming on Vermont farms

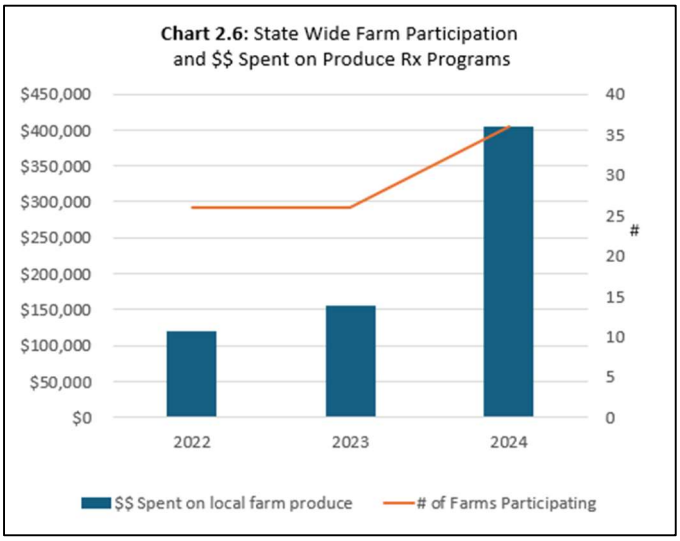
Traditional return-on-investment analyses evaluate FIM from the perspective of a health care payor by comparing program costs with reductions in medical expenditures. While this perspective is essential for informing reimbursement decisions, it does not capture the full value created by FIM programs. In Vermont, PRx programs are uniquely positioned to generate benefits across multiple sectors.

Vermont's PRx programs provide important economic benefits by purchasing food from local farms and food hubs, keeping dollars circulating within local communities rather than leaving the state through national food distributors. These investments support agricultural businesses, strengthen regional food systems, and contribute to the resilience of Vermont's rural economy while simultaneously improving patient health.

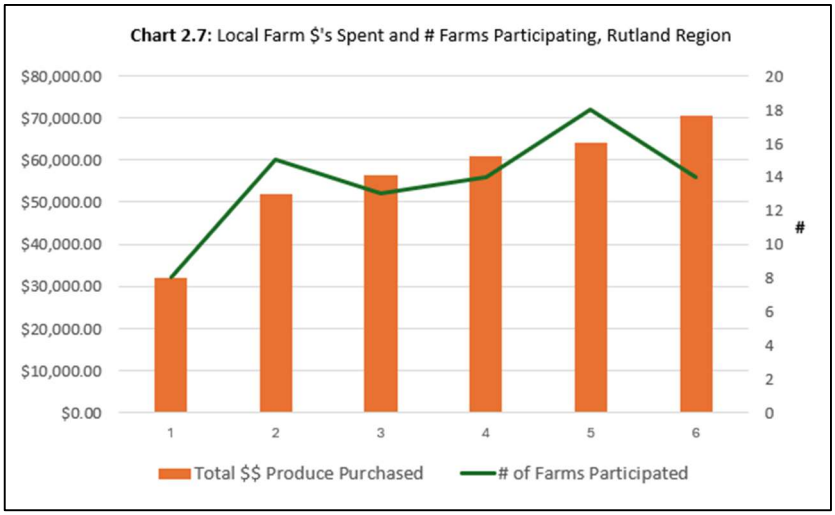
[vii] Diet-sensitive conditions include diabetes, angina, coronary heart disease, heart attack, other heart disease, emphysema, stroke, cancer, and hypertension.

[viii] Limitations in instrumental activities of daily living (IADL) such as using the telephone, paying bills, taking medications, preparing meals, doing laundry, or going grocery shopping.

Increasing reliance on and resilience of local producers is central to the Vermont Agriculture and Food System Strategic Plan 2021-2030. As noted in Chart 2.6, the number of farms participating in the CSA and Healthcare Community of Practice programs varied over the course of the program ranging from 26 to 39 different farms from 2022 to 2025. With the amount of money provided to the farms annually growing from $119,112 in 2022 to $405,430 in 2024.[40] The Rutland Region VFFC showed this similar growth over time. (See chart 2.7.) It is important to note that this work is being done with grant funding that is not consistently available for these programs.

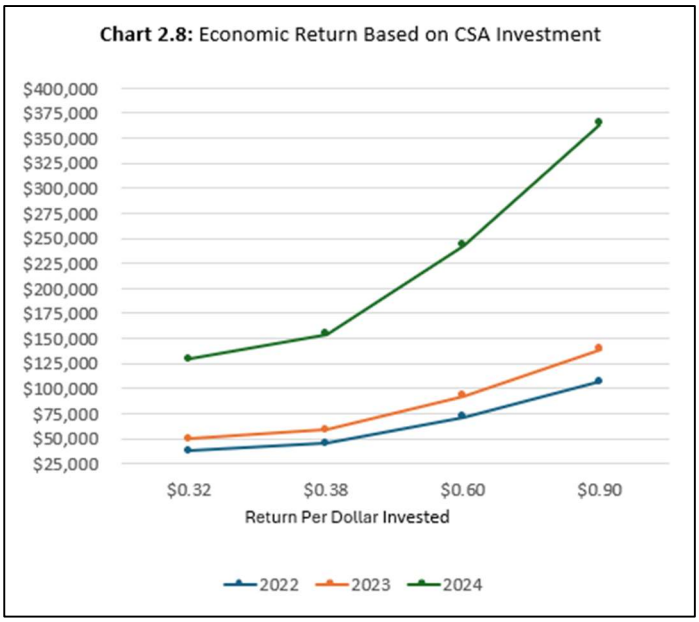


Because Vermont PRx programs operate seasonally, we examined both the observed program costs and annualized costs to facilitate comparison with year-round programs in other states. The average cost was $627.01 per participant over the duration of the program, equivalent to approximately $52.25 per participant per month of program operation. On a distribution basis (the cost per CSA share or food box), the average cost was $39.68 per participant share. When adjusted to estimate the cost of providing an equivalent intervention year-round, the average cost was $88.19 per participant per month, with weekly costs ranging from $11.41 to $25.37 (average $20.35).



These costs compare favorably with reported produce prescription program funding levels elsewhere in the United States. Published benefit values range from approximately $80 to $584 per month for pregnant participants in New Mexico and from $83.33 per month in Washington to $248.43 per month in North Carolina for individuals with food insecurity and diet-related chronic conditions.[41] Vermont's existing program costs fall below the lower end of this national range, even after annualizing costs to account for the state's shorter growing season.

Additionally, the CSA investment helps to provide stable income for Vermont's small family farms, creates jobs across the food chain as well as a stronger and more resilient local food community. Two different studies examining the larger economic effect of the investment of purchasing food from small local farms showed a multiplier effect of $1.38 to $1.60[42] to $1.32 to $1.90,[43] meaning for every dollar spent on local farms $0.32 to $0.90 is returned to the local economy. Based on the investment in 2024 ($405,430)[40] this would mean the potential for $129,737 to $364,887 being returned to the local community. Using a USDA Local Food Impact Calculator[38]—which accounts for regional variation and direct/indirect sales—we see an even higher estimated impact of $762,208 based on the 2024 PRx investment in local produce (see Appendix 5). These findings demonstrate that CSA investments are a cost-effective strategy that supports public health while creating lasting economic benefits for Vermont's agricultural communities.



Discussion

Across multiple study designs and populations, MTMs consistently demonstrate strong cost-saving potential through reductions in hospitalizations, while PRx programs show high value and favorable cost-effectiveness with significant clinical benefit.[32, 34, 35]

While these findings demonstrate that Vermont programs have historically operated very efficiently, the findings should not be interpreted as the reimbursement amount needed to sustain a statewide FIM benefit. Vermont faces higher-than-average food costs,[44] a short growing season, and the additional expenses associated with operating programs in a predominantly rural state. Furthermore, many existing programs have relied on grant funding, volunteers, donated resources, and other in-kind support that may not be available under a sustainable reimbursement model. For these reasons, the proposed reimbursement range of $100–250 per participant per month is intended to support the true costs of delivering a high-quality, clinically integrated PRx benefit that is financially sustainable over time while remaining consistent with reimbursement levels adopted in other states (see Chapter 4). These interventions align with value-based care principles by shifting spending upstream to prevent costly acute events. The magnitude of projected savings underscores the opportunity for public payors, private insurers, and health systems to incorporate FIM interventions as covered benefits.[37]

Vermont's existing PRx infrastructure demonstrates that these programs can reach individuals with substantial nutrition and cardiometabolic needs, while state-specific modeling suggests that expanding access could prevent meaningful numbers of cardiovascular events and provide favorable economic value. The modeled value is particularly strong among public payors, including Medicaid and Medicare, which serve many of the populations at greatest risk for diet-related disease and food insecurity. Together, these findings support considering FIM not simply as an additional health care expense, but as a targeted investment in prevention and chronic disease management with the potential to reduce future health care expenditures.

Expanding FIM also provides an opportunity to advance Vermont's agricultural priorities. PRx programs that purchase food from Vermont farms and food hubs direct dollars into the state's agricultural economy, creating demand for local products while connecting patients with nutritious food. This approach aligns with the Vermont Agriculture and Food System Strategic Plan 2021–2030, which envisions *"a working landscape where agriculture soils are protected, farming generates clean water, air, and healthy soils, and all residents have access to healthy culturally appropriate food"* and *"no social, cultural or infrastructure barriers to participating in the food system, from ownership to consumption."* [30]

The findings also have implications for how FIM benefits are designed and financed. The documented clinical and economic value of MTMs and PRx supports consideration of Medicaid and Medicare coverage (e.g., via the Medicaid 1115 waiver and Medicare Advantage supplemental benefits), integration of FIM into alternative payment models and accountable care arrangements, and reimbursement structures that allow programs to operate for a sufficient duration to realize downstream health benefits. Short-term grant funding can demonstrate feasibility and generate valuable program data, but sustainable reimbursement is necessary to make FIM a consistent component of care rather than an intervention available only when temporary funding is available.

For Vermont, this distinction is particularly important. The state has already developed a network of health centers, farms, food hubs, community organizations, and other partners capable of delivering FIM interventions. Establishing sustainable reimbursement would build on this existing infrastructure while allowing programs to expand, standardize eligibility and delivery, and generate the longitudinal data needed to evaluate their effects on health care utilization and costs. The opportunity is therefore not simply to fund more FIM programs, but to establish a sustainable financing mechanism that allows Vermont to capture the health, health care, and local economic value these programs can generate. As Vermont seeks sustainable strategies to prevent and manage chronic disease while controlling health care costs and strengthening its local food system, FIM offers a practical opportunity to invest in an intervention that can create value across all three priorities.

Taken together, the Vermont-specific evidence supports a tiered FIM strategy that aligns intervention intensity with the level of clinical and social need. MTMs should be prioritized for medically complex, high-risk populations with diet-sensitive conditions, including chronic kidney disease, cardiovascular disease (including heart failure), and uncontrolled diabetes, where the potential for reductions in health care utilization and expenditures is greatest.[39] PRx programs, including Vermont's existing CSA model, should be directed toward populations for whom a less

intensive intervention is appropriate but who remain at elevated risk—particularly individuals experiencing both diabetes and food insecurity. This targeted approach would allow Vermont to build on existing infrastructure while directing greater resources toward populations most likely to experience meaningful health and economic returns.



Chapter 3: Food Is Medicine in Vermont: Stories from the Field

Introduction

Across Vermont, Food Is Medicine (FIM) programs are improving health outcomes and expanding access to nutritious food through partnerships between health care providers, farms, and community organizations. These initiatives support people in Vermont managing chronic disease, recovering from illness, aging at home, and navigating food insecurity. The stories in this collection highlight the experiences of patients[ix], health care providers, farmers, and community organizations working together to improve health through nutrition access. They also demonstrate how FIM programs strengthen local farms and food systems while building healthier, more connected communities. A list of programs highlighted in this chapter can be found in Appendix 7.

Together, these stories highlight that nutritious food supports the prevention and management of diet-related chronic disease; PRx and MTM programs improve food access for individuals with complex health needs in Vermont; home-delivered meals help older adults and individuals with disabilities remain healthy and independent at home; health care providers increasingly view nutrition support as an essential component of patient care; FIM initiatives strengthen Vermont farms and local food systems; and collaboration among health care, agriculture, and community organizations creates stronger long-term health outcomes for our communities.

Food Is Medicine in Vermont: patient perspectives

FIM programs are helping patients manage chronic illness, recover from medical events, remain independent, and access nourishing food that supports their health and wellbeing. The stories in this section reflect the experiences of people in Vermont living with a wide range of health challenges, including diabetes, hypertension, mobility limitations, cancer treatment, food insecurity, and caregiving responsibilities. For many, especially those living in rural communities, barriers such as transportation, fixed incomes, disability, illness, or isolation can make accessing healthy food very difficult. FIM programs help bridge these gaps by connecting individuals with nutritious food. Some people receive weekly shares of fresh local produce through PRx programs, while others rely on medically tailored or home-delivered meals to meet their nutritional needs.

[ix] To protect patient confidentiality, patient names have been replaced with pseudonyms.

Fresh Food and Better Health: Debra's Story

FIM Intervention: Produce Prescription
Organization: Vermont Youth Conservation Corps (Health Care Share)
Location: Barre, Vermont
Health Outcome Addressed: Hypertension



Demographic: 65-year-old woman

For more than two years, Debra has received a weekly bag of produce through Vermont Youth Conservation Corps' Health Care Share. Living on a disability income while managing high blood pressure, the program has helped her access fresh vegetables she otherwise could not afford. Through the combination of nutritious produce, recipes, and nutrition education, Debra describes meaningful improvements in her health and wellbeing.

Debra's story:

"I have been receiving a Health Care Share for over 2 years now. The shares offer a wide variety of delicious vegetables, many that I have never tried before. It's a great experience to try new things, and the newsletter provides participants with healthy recipes too. Over the last two years, the Health Care Share has helped me lower my weight, lower my blood pressure, and in general has made me feel healthier. One of my favorite aspects of the program is the fact that the shares help me access produce that I otherwise couldn't afford. I am on a disability budget, and I can't afford fresh vegetables.

I hope that the Health Care Share continues and will receive more funding! Then more community members (and I) can continue to enjoy nutritious local produce at no cost and be better educated about how nutrition promotes health, the many delicious vegetables, and how to prepare fresh, healthy food."

Finding Purpose Through Food: Sherry's Story

FIM Intervention: Produce Prescription

Organization: Little Rivers Health Care-Food Farmacy
Location: Bradford, Vermont
Health Outcome Addressed: Mental Health and Wellbeing

Demographic: 66-year-old woman

For Sherry, the benefits of participating in Little Rivers Health Care's Food Farmacy extend beyond access to healthy food. Living alone, the program has provided not only nutritious ingredients but also a sense of purpose, routine and connection to healthy living. Through learning new cooking skills, preserving food, and exploring recipes, Sherry has found meaningful ways to stay engaged and support her mental wellbeing.

Sherry's story:

"I'm 66 years old and live alone, and for me the biggest benefit of being in the Food Farmacy program has been how much the healthy food has improved my mental health. Living alone means I have a lot of time on my hands. When I receive my food box, I take care of the food, figure out how to prepare it, learn how to cook it, and look for new recipes to try. Of course, I make sure I eat everything.

I've learned how to freeze food for later, make pickles, and preserve vegetables in ways I never imagined I would be doing. The food gives me something meaningful to work on during the long, cold winter months and the long daylight hours of summer.

Having healthy food and new projects to focus on has kept me busy, helped me learn new skills, and improved my mental health. For me, mental health is what helps me take better care of my physical health. The old saying 'food for thought' reminds me that mental health is just as important as physical health.

I am so thankful for this program and for the healthy food boxes. They have made a real difference in my life and have helped me in ways that go far beyond nutrition alone."

Healthy Food, Less Stress: Christine's Story

FIM Intervention: Produce Prescription

Organization: Little Rivers Health Care-Food Farmacy
Location: Wells River, Vermont
Health Outcome Addressed: Diabetes Management, Hypertension, and Mental Wellbeing

Demographic: 71-year-old woman



For Christine, participating in Little Rivers Health Care's Food Farmacy has provided access to healthy foods that support both her physical and emotional health. After the loss of her husband, Christine faced financial challenges, stress, and depression. The Food Farmacy has helped her access the fruits and vegetables she needs to better manage her diabetes and hypertension while also giving her something positive to look forward to each month.

Christine's story:

"I joined the Food Farmacy program that Little Rivers offers so that I could eat healthier and better manage my diabetes and hypertension. Before my husband passed away, we were able to buy healthy food and had what we needed. We lived on land that my father used to farm, but after my husband died, I wasn't able to afford enough healthy food to get by.

Since his passing, I have struggled with depression and PTSD. Having access to healthy food through the Food Farmacy has helped me feel less depressed and has reduced a lot of the stress in my life. I know the food helps with my diabetes, and now that I can eat more fruits and vegetables, I feel healthier overall.

One of my favorite parts of the program is receiving my food boxes. I love picking them up each month. It gives me something to look forward to and always makes me happy when I do. The Food Farmacy has helped me improve my health, reduce stress, and feel more hopeful about taking care of myself."

Meals on Wheels

The Meals on Wheels programs play a critical role in addressing food access, nutrition, and social isolation among older adults and are distinct from traditional medically tailored meal interventions. They vary by provider, population served, nutritional standards, and level of clinical oversight. Additional work is needed to determine when and how these meals may qualify as MTMs within health care payment pathways.

The following stories are from Meals on Wheels recipients.

Nourishment During Cancer Treatment: Fran's Story

FIM Intervention: Home Delivered Meals via Meals on Wheels
Organization: Northeast Kingdom Council on Aging
Location: Northeast Kingdom, Vermont
Health Outcome Addressed: Cancer treatment support and limited vision

Demographic: 77-year-old woman

Like many, Fran began receiving home-delivered meals in 2020. Lockdowns created significant barriers to food access, especially for many residents living in Vermont, which is widely known for its challenges facing those who are unable to drive. For Fran, whose limited vision and other health conditions already posed daily obstacles, home-delivered meals were not just convenient—they were essential.

In the years since the pandemic, the role of home-delivered meals has evolved. What began as a lifeline providing nourishment has increasingly also become a crucial component of health management. Meals are now designed to support the management of chronic conditions and improve overall health outcomes.

During this same period, Fran began her courageous fight with cancer. As her health needs became more complex, the meals she relied upon required additional preparation and processing to meet her medical and nutritional needs. Although Fran lost her battle with cancer in January 2026, these tailored meals played a critical role in supporting her ability to remain safely and independently in her home.

Supporting Caregiving at Home: Greg's Story

FIM Intervention: Home Delivered Meals via Meals on Wheels
Organization: Northeast Kingdom Council on Aging
Location: Northeast Kingdom, Vermont
Health Outcome Addressed: Caregiving and aging in place

Demographic: 86-year-old man

Greg first began receiving Meals on Wheels while caring for his wife during her battle with dementia. The support allowed him to spend more time focused on caregiving and less time preparing meals. Today, at 86 years old, Greg continues to rely on meal delivery to help him remain healthy, independent, and safely at home.

Greg's story:

"My late wife and I started receiving meals when she became sick with dementia and related symptoms. Providing her care at home was sometimes difficult and always time-consuming. Having meals delivered made it possible for me to spend more time on her care and less on preparing food. In fact, it may have been one of the important factors that helped me keep her at home instead of sending her for costly, less personal care elsewhere.

After her passing, I've continued to receive meal deliveries. At 86 years old, with some difficulty getting around, preparing 3 meals a day can be a burden. It is such a relief to not have to cut corners on nutritious meals since they are delivered to my door. Meals on Wheels makes a big difference for many elderly or unwell Vermonters. Without this service, more people might be forced to leave their homes and seek other care sooner. I support the work of Meals on Wheels and am thankful. It helps keep older Vermonters safer and healthier."

Food as Part of Recovery and Healing: Laura's Story

FIM Intervention: Medically Tailored Meals via Meals on Wheels
Organization: Central Vermont Council on Aging/Greater Northfield Senior Center
Location: Greater Northfield Region, Vermont
Health Outcome Addressed: Diabetes management and recovery support

Demographic: 62-year-old woman

After surgery and a series of serious health complications left Laura largely homebound, her doctor recommended home-delivered therapeutic meals through the Greater Northfield Senior Center. Over the past 16 months, the meals have supported both her recovery and her diabetes management while helping her continue living independently.

Central Vermont Council on Aging shares Laura's story:

"Laura's doctor recommended she start receiving Meals on Wheels 16 months ago when she was recovering from blood clot surgery and was immobilized at home. Laura has needed to remain on home delivered meals as she has fought infections and pneumonia that have had her in and out of the hospital for the past 16 months. She receives a therapeutic meal specially designed for diabetic support. She is served by the Northfield Senior Center. Her favorite meals are stuffed cabbage and Shepard's pie. Throughout the 16 months of service, she reports that her blood glucose has been reduced, and her diabetes is now under control. Before receiving Meals on Wheels her diabetes was not under control and she struggled with it. The meals help her to remain living independent. She has no caregivers, or anyone else to look in on her except for her Meals on Wheel's delivery driver. She would absolutely recommend therapeutic meals to anyone who is diabetic to help them control their diabetes and feel better about their health."



Managing Diabetes Through Medically Tailored Meals: Drew's Story

FIM Intervention: Medically Tailored Meals via Meals on Wheels
Organization: Central Vermont Council on Aging/Meals on Wheels of Central Vermont
Location: Central Vermont
Health Outcome Addressed: Diabetes management

Demographic: 77-year-old man

Drew is a 77-year-old man who has diabetes. He receives therapeutic meals designed to support blood sugar management. The therapeutic meals are prepared and delivered by Meals on Wheels of Central Vermont at City Hotel Café. With consistent access to Medically Tailored Meals designed to support blood sugar management, Drew reports significant improvements in both his health and quality of life.

Central Vermont Council on Aging shares Drew's story:

"Drew has been able to get his blood sugar under control and his weight down too while receiving Meals on Wheels. Drew reports that he feels much better now that he's lost weight and his blood sugar has been controlled. Previous to getting meal service his diabetes and weight were a struggle. Drew's been receiving meals since July of 2024 from Meals on Wheels of Central Vermont located in Barre, and he can't say enough good things about the quality of the meals he receives. He particularly loves all the variety of local root vegetables that are offered. His favorite meals are meatloaf, pork roast, stuffed peppers, and spaghetti. The meals help him to live independently and help him to feel more food secure. And they are a life saver for his caregiver. Drew and his caregiver highly recommend Meals on Wheels therapeutic meals to anyone who could use them to support their health."

Maintaining Independence Through Home Delivered Meals: Paula's Story

FIM Intervention: Home Delivered Meals via Meals on Wheels
Organization: Northeast Kingdom Council on Aging
Location: Northeast Kingdom, Vermont
Health Outcome Addressed: Mobility limitations and heat intolerance

Demographic: 70-year-old woman

Paula receives nutritious home-delivered meals through the Northeast Kingdom Council on Aging. Living with a spinal injury and heat intolerance that make cooking and shopping difficult, the program provides reliable access to healthy meals and reduces the daily challenges of food preparation.

Paula's story:

"I am very appreciative of these meals. Cooking meals is difficult for me due to having heat intolerance, also there are many days I am unable to get to the store to buy food. These meals give me the vegetables and meats I would not normally have.

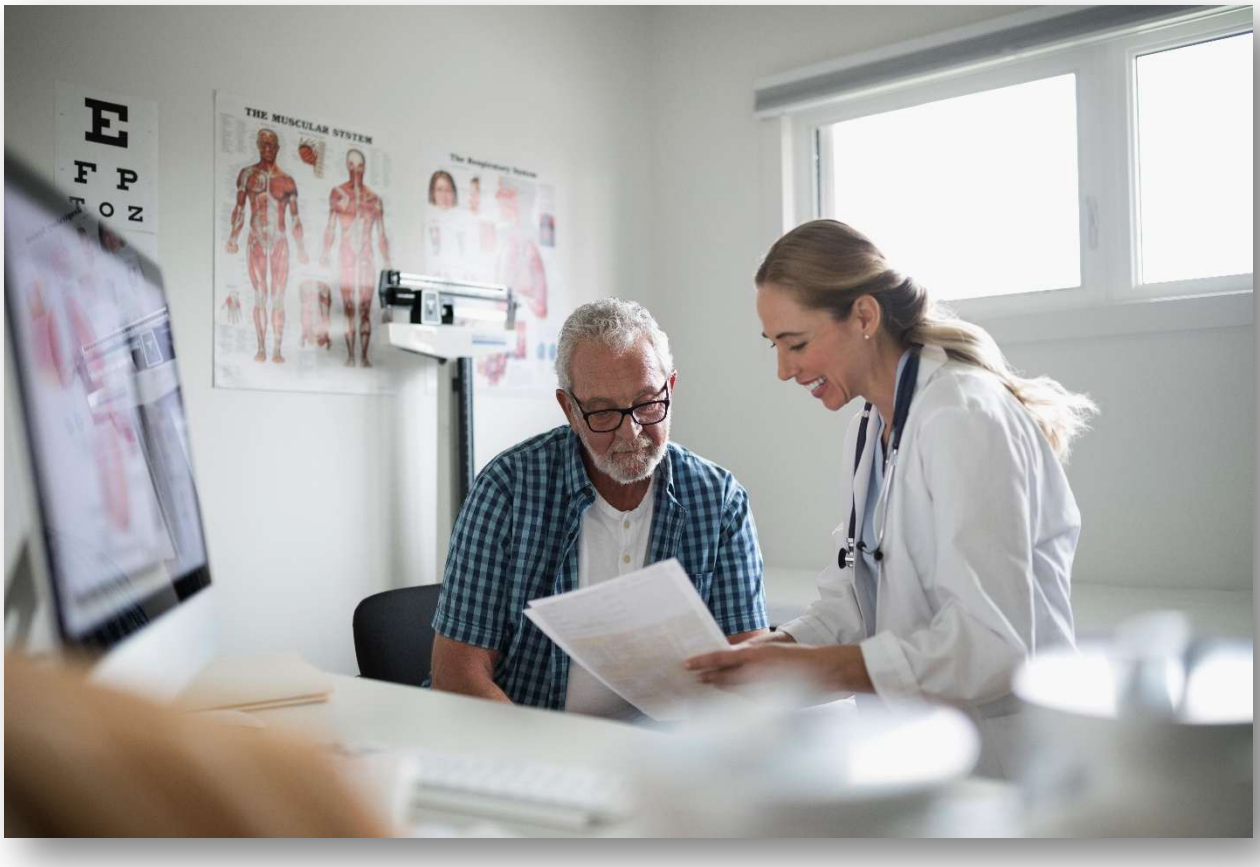
Thank you to all those involved with cooking and getting the meals to us who need them. Sometimes, these are the only nutritious meals we get to eat."

Food Is Medicine in Vermont: provider perspectives

Health care providers are increasingly recognizing that access to nutritious food is an essential component of patient care. Physicians, dietitians, nurses, care coordinators, and community health teams are seeing firsthand how food insecurity and limited access to healthy meals contribute to chronic disease, poorer health outcomes, and increased strain on individuals and families.

Food Is Medicine programs provide providers with new tools to support patient wellbeing beyond traditional clinical care. Through PRx, MTMs, and culinary education, providers are helping patients manage chronic conditions, improve diet quality, recover from illness, and remain healthier and more independent at home.

The stories in this section highlight how Vermont health care professionals are integrating nutrition into care delivery and why they view these partnerships as an increasingly important part of improving health outcomes across the state.



Reversing Diabetes Through Food Access: Central Vermont Medical Center

FIM Intervention: Produce Prescription

Health Care Partner: Central Vermont Medical Center

Location: Berlin, Vermont
Partner Organization: Vermont Youth Conservation Corps (Health Care Share)
Health Outcome Addressed: Diabetes and hypertension

Demographic: 55-year-old woman

Kelly's health care provider at Central Vermont Medical Center saw firsthand how consistent access to nutritious food transformed her health outcomes over time. Through participation in the Health Care Share program, Kelly received weekly fresh produce, nutrition education, and practical support that helped her make lasting dietary changes while managing diabetes and high blood pressure.

A provider from Central Vermont Medical Center shares this story:

"A patient with longstanding type 2 diabetes enrolled in the Health Care Share (HCS) program four years ago, which provided her with weekly deliveries of fresh, locally grown produce at no cost. This consistent access to high-quality fruits and vegetables made it easier for her to adopt healthier eating patterns, improve glycemic control, lower blood pressure, and feel more confident managing her medical conditions. With the structured support of the HCS program—nutrition education, recipe guidance, and a reliable supply of healthy foods—the patient gradually shifted her diet toward whole, nutrient dense meals that aligned with her diabetes and blood pressure management goals.

Over the course of the program, the patient achieved remarkable clinical improvements. Her A1C dropped from 7.0% to 5.2%, fully reversing her diabetes into the non-diabetic range. She also reported higher energy levels, more stable blood sugars, lower blood pressures, and improved overall well-being. By eliminating financial barriers to nutritious food and providing ongoing support, the HCS intervention played a direct and essential role in transforming Kelly's health outcomes."

Connecting Patients to Food Is Medicine: Porter Medical Center

FIM Intervention: Produce Prescription

Health Care Partner: Porter Medical Center

Location: Middlebury, Vermont
Partner Organization: Vermont Farmers Food Center (Farmacy Project)
Health Outcome Addressed: Chronic disease prevention and nutrition access

Demographic: At-risk families with health issues impacted by diet

Providers at Porter Medical Center recognize the important role nutrition plays in preventing and managing chronic disease. Through referrals to the Farmacy Project, clinicians are helping connect patients experiencing food insecurity and diet-related health challenges with locally grown produce, nutrition education, and community support.

A dietitian at Porter Primary Care shares their perspective:

"*The intersection of nutrition and health is one of the things that led me to become a dietitian. Good nutrition is essential in preventing and treating chronic conditions like diabetes, heart disease, and stroke. While individuals of all incomes, races, and ethnicities can experience diet-related diseases, those with lower incomes and in rural communities are at an even greater risk of suffering from diet-related diseases. In our community, the connection between food insecurity and health care has never been more important than it is today.*

As a dietitian at Porter Primary Care, I can use the Farmacy program to connect patients to locally produced fruits, vegetables, and sometimes protein at no cost to the patient. As a result of referring patients to the program, I have seen individuals improve their adherence to dietary recommendations, expand their food choices, and increase their fruit and vegetable consumption. Because there is no cost to participate, Farmacy has also provided patients with budget relief, enabling them to pay bills."

Food Is Medicine in Vermont: farmer stories

Strengthening Local Farms and Community Health



Vermont farmers play a vital role in FIM initiatives across the state. By growing fresh, nutrient-dense food for PRx and MTM programs, farmers are contributing directly to the health and wellbeing of their communities while also strengthening local food systems and agricultural economies.

For many farms, participation in FIM programs creates reliable markets, supports seasonal planning, and builds meaningful relationships between agriculture, health care, and community organizations. These partnerships help ensure that locally grown food reaches Vermonters who may otherwise face barriers to accessing healthy produce. The stories in this section highlight how farmers are helping shape a more connected and community-centered approach to health through local agriculture.

Growing Food for Community Health: Evening Song Farm

FIM Intervention: Produce Prescription

Farm Partner: Evening Song Farm

Location: Cuttingsville, Vermont
Partner Organization: Vermont Farmers Food Center (Farmacy Project)

Evening Song Farm has been operating in its current location in Cuttingsville, VT since 2012. The farm is owned and operated by Ryan and Kara Fitzbeauchamp alongside an amazing team. They grow certified organic produce for their community and offer a free choice, three-season CSA (45 weeks) for pickup in Rutland, Ludlow, and the barn in Cuttingsville. Their vegetables are also available at several retail outlets and restaurants. They have been part of the VFFC Farmacy Project since 2019.

Ryan Fitzbeauchamp of Evening Song Farm share's their perspective:

"Our vegetable farm has been a part of the Farmacy project since 2019, and each year we grow vegetables for the Vermont Farmers' Food Center to distribute to the Farmacy members. This program is a big win for Rutland County: it is an excellent way for our farm and other farms to be able to plan to grow a significant amount of vegetables to be distributed to folks for whom healthy food is difficult to access and also essential to their well-being. Distributing vegetables through the Farmacy project is a meaningful part of our farm's overall production and we feel great about the VFFC being able to distribute these vegetables to folks for whom it really makes a difference."



Building Farm Sustainability Through Partnership: Otter Point Farm

FIM Intervention: Produce Prescription
Farm Partner: Otter Point Farm

Location: West Haven, Vermont

Partner Organization: Vermont Farmers Food Center (Farmacy Project)

Otter Point Farm raises organic vegetables, flowers, herbs, and berries on a small farm in the heart of Vermont's banana belt in West Haven, Vermont. They focus on healthy and colorful varieties, soil health, and providing plenty of habitat for pollinators and songbirds. Their farmland is preserved by the Vermont Land Trust, and their produce is Certified Organic by Vermont Organic Farmers. They have been part of the VFFC's Farmacy Project for the past six growing seasons.

Scott and Tanya Hertzberg's perspective:

"For the past six growing seasons, we have grown organic vegetables for the Vermont Farmers Food Center's Farmacy Project. Participating in the project enables our farm to sell a greater amount of produce each year. We are a small operation with little labor outside the family. We do not have the capacity to grow and pack 250 weekly CSA boxes. Being part of the 250 share, multi-farm Farmacy Project allows us to concentrate on growing large quantities of the vegetables we grow best, such as watermelon, cantaloupe, eggplant and sweet peppers.

When we arrive at the Vermont Farmers Food Center, the many project volunteers help unload the truck, saving time and sparing me exhaustion. Together we quickly unload even a pickup full of watermelons, cantaloupe or cabbage. Farmacy is by far our favorite sales outlet. Delivering to Farmacy and talking to the staff and volunteers is the best part of the work week during the season. We are lucky that we started selling to the Farmacy Project soon after relocating to Vermont from Maryland, where we also ran a small vegetable farm. Farmacy has had a tremendous impact on our West Haven farm, increasing our financial viability and making each season more meaningful."

Farming at the Intersection of Health and Community: Yoder Farm

FIM Intervention: Produce Prescription
Farm Partner: Yoder Farm

Location: Danby, Vermont

Partner Organization: Vermont Farmers Food Center (Farmacy Project)

Yoder Farm has been operating in Danby, VT since 2012. The small family farm is owned and operated by Ryan and Rachel Yoder. They grow wild apples, berries, and greens and are known for their apple cider vinegar. They have been part of The Farmacy Project since the beginning of the project.

Ryan Yoder's perspective:

"Our farm has been growing crops for Farmacy since its inception. We provide an average of $8,000 to $10,000 worth of vegetables and berries to the program which dispenses them to patients who are prescribed the shares by local doctors. We believe that this model of health care is the cutting edge of what our society needs to do to address the crisis of chronic disease ravaging our community. This is a model which could be applied more widely to benefit our health, the environment, and our local economy. Please consider supporting this program again this year."

Expanding Access to Local Food: Last Resort Farm

FIM Intervention: Produce Prescription
Farm Partner: Last Resort Farm

Location: Monkton, Vermont

Organizations: ACORN and Vermont Farmers Food Center Farmacy Project



Last Resort Farm is a family-owned organic farm in Monkton proudly serving Vermont communities. Last Resort Farm has a stated mission and partners with local organizations Addison County Relocalization Network (ACORN) and Vermont Farmers Food Center's (VFFC) Farmacy Project to further their mission.

A farmer at Last Resort Farm shares their perspective:

"Working with ACORN and being a part of the Farmacy Program has been a pleasure and a major point of pride for us. The mission of our farm is 'to contribute to the community's well-being by using organic and sustainable farming practices to provide delicious and nutritious food.' The Food Is Medicine partnership has paired perfectly with that mission by broadening access to our nutrient-dense food for community members who were previously unreached by our farm.

There are many contributors to the sustainability of our farm, with finances being an important one. The Farmacy Program and its CSA model have provided us with the necessary positive cash flow during a typically cash-poor time of year. This program has improved the health of so many while enhancing the sustainability of local farms, what could be better?! "



Chapter 4: Vermont's FIM Eligibility Framework

National evidence: What the Evidence Shows About Outcomes, Dose, and Duration

Executive summary

Food Is Medicine is a set of targeted nutrition interventions designed to improve health by meeting people's medical and nutritional needs at the same time. The strongest evidence comes from three models: MTMs, MTGs, and PRx delivered independently or in combination with educational and behavioral strategies, like culinary medicine and medical nutrition therapy.

Across dozens of studies, including randomized trials, quasi-experimental evaluations, and large Medicaid demonstrations, FIM programs consistently improve food and nutrition security and diet quality.[45] In people with diet-sensitive chronic disease, many programs also show promise in improving clinical outcomes, reducing health care use, and spending.[33, 46-48]

The evidence is clearest on three points.

1. Matching the intervention to the need matters. Currently, MTMs show the strongest and most consistent effects among people with severe illness, functional limitations, or high health care use.[33, 49, 50] MTGs and PRx are better suited to people who can shop and cook.
2. Dose and duration matter. Programs shorter than three months rarely produce meaningful health or cost effects. Programs delivered for six months or longer show far more consistent benefits, particularly for health care utilization and costs.[33, 47, 48]
3. FIM works best when embedded in Medicaid, health systems, or care management models.

What counts as Food Is Medicine

FIM interventions provide food or food benefits with clear clinical intent. They differ from general food assistance by design, eligibility, and oversight. The three most common FIM models are MTMs, MTGs, and PRx. (See Appendix 6 for definitions.) The existing evidence of clinical efficacy of each FIM model is described below.

Medically Tailored Meals

MTMs show the most consistent evidence for reducing hospitalizations and total health care costs. This is true across multiple conditions, including diabetes, heart failure, kidney disease, HIV, and cancer treatment.[33, 49, 51, 52] The table below highlights this:

Who Benefits Most	Dose	Duration
The strongest effects are seen among people who are medically complex and under-resourced. Common conditions included: • multiple chronic conditions; • food insecurity; • limited ability to shop or cook; and • high prior use of hospitals or emergency care. • In Medicaid populations, participants often qualify based on both medical diagnosis and a functional or social risk factor.[41]	• Most effective programs provide about ten meals per week. • More meals for people with higher clinical needs, such as immediately following hospitalization.	• Programs delivered for six months show substantially stronger effects than those lasting only a few weeks.[33, 47] • <12 twelve weeks generally show limited impact on utilization, with one notable exception. In recently hospitalized heart failure patients, short (4 week) post discharge meal programs have been found to reduce rehospitalizations.[53-55] Outside this setting, short programs do not appear to produce a large enough effect on outcomes.

Outcomes

Across studies, MTMs improve food security, diet quality, and disease self management.[46, 56, 57] For example, studies have found greater reported medication adherence for people with type 2 diabetes and HIV.[58] Self-reported mental health and wellbeing often improve as well.[59]

In large Medicaid evaluations, people receiving meals had fewer hospital admissions and emergency visits. In Massachusetts, health care savings exceeded program costs in specific patient populations, producing net savings over one year. Simulation models suggest that scaling Medically Tailored Meals to eligible adults nationwide could prevent large numbers of hospitalizations annually and reduce health care spending.[39] (See Chapter 2 “Economic evidence for Medically Tailored Meals” section for more information.)

MTMs are a high intensity intervention. They are generally the most expensive of the three types reviewed in this Framework. Using them strategically, not universally, will support the greatest return. Specifically meals should be reserved for people with the highest clinical and functional need and implemented long enough.

Medically Tailored Groceries

MTG programs are more flexible for patients and generally less costly than MTMs. The evidence shows reliable improvements in food security and diet quality, with mixed but promising effects on clinical outcomes, such as blood pressure.[60-68] The table below highlights this:

Who Benefits Most	Dose	Duration
For those with: • Diet-sensitive chronic diseases who can shop and cook.	• Benefits typically range from $50 to $200 per person or household. Some Medicaid programs now allow higher amounts.[41] • What appears to matter more than dose amount is food quality and how well the groceries align with the health condition(s) being targeted.[69, 70] • MTG programs should consider which foods are replaced in the diet and be designed to improve overall diet quality rather than simply supplementing participants' existing food purchases.[19]	• Most are designed to last six months, with clinical and social need reassessment for renewal. • <3 months rarely show clinical effects.

Outcomes

Nearly all studies show improvements in food security and diet quality. Some show improvements in mental health, wellbeing, and self-reported health. Clinical outcomes such as hemoglobin A1c and blood pressure improved in some trials but not others.[60-68, 71] Results tend to be strongest among participants with worse baseline disease control.[72] Large Medicaid demonstrations show reductions in hospital use and partial or full offset of program costs, especially when participants remain enrolled for at least three months.[47]

Grocery programs are well-suited for broader deployment. They cost less than meals and can reach more people. To maximize impact, programs should be medically targeted, time limited, and paired with clinical oversight.

Produce Prescriptions

Produce prescriptions are currently the most widely implemented FIM model and are the least intensive. More information is highlighted below:

Who Benefits Most	Dose	Duration
People with: • diabetes, hypertension, obesity, or cardiometabolic risk, as well as pregnant people and families with young children.	• Most programs provide $40 to $100 per month in fruit and vegetable benefits. • Some deliver a fixed number of fruit and vegetable servings per week instead. • As with grocery programs, higher dollar amounts (e.g., >$100) do not consistently produce larger health gains.[35, 57, 73, 74]	• Longer participation is associated with greater improvements in diet quality and food security, and similar to MTMs and MTGs, a six-month duration to start is recommended.

Outcomes

The evidence consistently shows increased fruit and vegetable intake and improved food security.[67, 75, 76] Self-reported health often improves. Clinical outcomes are more mixed.[73, 74, 77] Some programs show modest reductions in hemoglobin A1c and blood pressure, particularly among participants with poor baseline control. Others show no statistically significant change. However, in analysis of three of Vermont's PRx programs, participants showed significant improvements in systolic blood pressure after 3 months ($p = .009$), and cholesterol after 6 months ($p = .025$)[x]. Simulation studies suggest that PRx could prevent large numbers of cardiovascular events over time and be highly cost-effective at scale.[34, 36]

PRx are a strong entry-level FIM strategy. They are relatively inexpensive, scalable, and durable. They are best viewed as a prevention and self-management support tool, not a replacement for more intensive interventions.

What the evidence says about duration

Across all FIM models, one lesson is clear. Short programs do not work well. Programs lasting less than three months rarely show meaningful effects on health or health care use. This is true for meals, groceries, and Produce Prescriptions. Programs lasting six months or longer show stronger and more reliable benefits. This matters for program design, budgeting, and expectations. Food Is Medicine works more like a course of treatment than a one-time benefit. States that plan for reassessment and renewal see better outcomes than those that offer brief, one-off services.

Key Takeaways

FIM does not replace clinical care, but the current evidence shows it can meaningfully improve health and wellbeing and reduce costs.

[x] Analysis conducted by Bi-State Primary Care Association with three FQHC programs in 2024.

Three principles should guide statewide policy.

- First, target intensity to the need. Use MTMs for people with the highest clinical and functional risk. Use MTGs and PRx more broadly.
- Second, fund programs long enough for them to be optimized. Six months is a reasonable minimum for meaningful impact based on current research.
- Third, treat FIM as a health care service. Build it into payor arrangements, with clinical oversight and accountability.

Proposed FIM Eligibility Framework for Vermont

Based on the national evidence of clinical and cost effectiveness, the following FIM eligibility framework is proposed. This framework is designed to serve as a foundation that can be adapted to conform with eligibility requirements and restrictions of individual payment pathways. In Table 4.1, we describe the eligibility criteria for each FIM type. Under the heading of each FIM type, the eligibility formula is provided. For ease of comprehension, a flowchart of eligibility determination is also provided in Figure 4.1.

Vermont-Specific Design Principles

Regional variation in food costs may be considered, with flexibility to increase or decrease the monthly dose (e.g., reimbursement rates for MTG and PRx) as needed. Proposed reimbursement amounts are inclusive of any expenses related to conducting a FIM program in VT including higher food prices.[xi]

FIM services should supplement and not supplant existing federal and state nutrition programs (e.g., SNAP, WIC). The state should coordinate across programs to promote access to comprehensive nutrition supports while avoiding duplication of services.

Ensuring Program Integrity

Services should be delivered in accordance with applicable federal and state program integrity and fraud and abuse requirements. Eligibility for FIM services is determined through a multi-dimensional assessment of clinical need, nutrition-related access barriers, and anticipated benefit. FIM services will be structured to ensure that provision of food or nutrition supports is clinically indicated and tied to documented health needs and not offered as an inducement for enrollment or selection of providers. Services are tiered to align intensity with clinical need. This supports responsible stewardship of Medicaid resources by focusing services on populations that are most likely to see improvement in outcomes and reduce avoidable utilization. Services are authorized for defined periods (e.g., 6 months) with ongoing reassessment to determine continued need and effectiveness. Verification of eligibility will prioritize use of existing clinical and administrative data sources, including electronic health

[xi] Proposed reimbursement amounts reflect the roughly 40% higher food prices in Vermont compared to national prices44. Oaks M. RentBlog. 2024. [cited 2026]. Available from: https://www.rent.com/blog/cost-of-living-in-vermont/..

records and claims/utilization data, to confirm qualifying conditions and risk indicators. Payors including the state should minimize administrative burden on beneficiaries by reducing duplicative documentation requirements while maintaining accurate eligibility determinations. Program oversight may include standardized referral criteria, provider accountability mechanisms, and continuous monitoring to support appropriate utilization and responsible stewardship of resources.

Vermont-Specific Proposed Clinical Objectives

Clinical objectives have been developed to assist in meeting the needs of evaluation plan development, as well as for the Section 1115 waiver application. The clinical objectives of this FIM Framework are multi-faceted and condition dependent, but include several objectives listed below. (Please see Appendix 8 for a listing of potential measures.)

Clinical Objective 1: Improve the management of diet-related chronic diseases through clinically indicated nutrition interventions.

Clinical Objective 2: Reduce food and nutrition insecurity and improve consistent access to healthy foods among eligible patients.

Clinical Objective 3: Improve clinical outcomes and reduce preventable complications associated with diet-related disease.

Clinical Objective 4: Increase adherence to recommended dietary and medical treatment plans.

Clinical Objective 5: Increase participation in complementary federal nutrition programs.

Proposed Eligibility for FIM

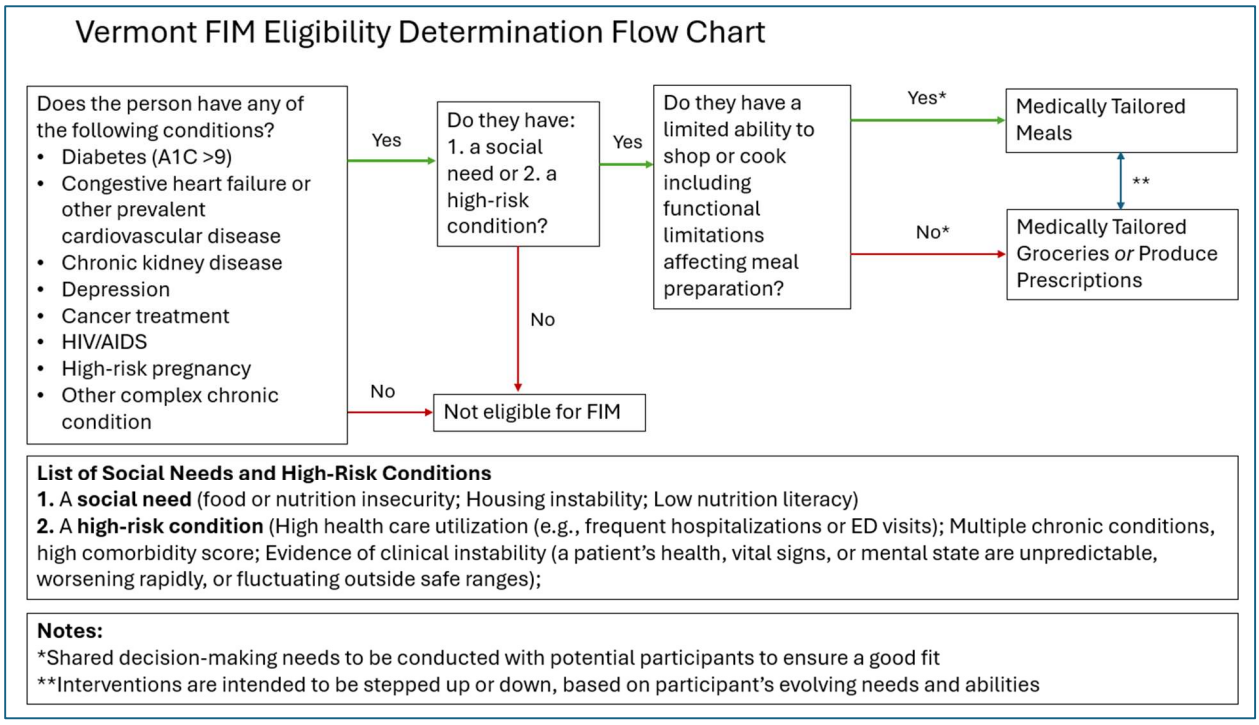
Table 4.1 summarizes the full proposed eligibility framework, and Figure 4.1 shows the eligibility pathways, with more detail, rationale, and context described following Figure 4.1. Note: The conditions listed eligibility pathways in Figure 4.1 are not comprehensive, as there is some variation in clinical condition and social needs eligibility between FIM types.

Table 4.1: Proposed FIM Eligibility Criteria and Benefits

	FIM Intervention		
	Medically Tailored Meals (CC+IADL+(SN or HRC))	**Medically Tailored Groceries** (CC+(SN or HRC))	**Produce Prescriptions** (CC+(SN or HRC))
Clinical Condition (CC)	• Type 2 Diabetes (A1C >9) • Congestive heart failure or other prevalent cardiovascular disease • Chronic kidney disease • Depression • Cancer • HIV/AIDS • High-risk pregnancy • Other complex chronic conditions (comorbidities; or individuals in need of transplant services) • Eligibility for MNT, as defined by the patient's insurance	• Type 2 Diabetes (A1C >9) • Congestive heart failure or other prevalent cardiovascular disease • Chronic kidney disease • Depression • Cancer • HIV/AIDS • High-risk pregnancy • Other complex chronic conditions	• Pre-diabetes • Individuals at risk for cardiovascular disease • Type 2 Diabetes (A1C >9) • Congestive heart failure or other prevalent cardiovascular disease • Chronic kidney disease • Depression • Cancer • HIV/AIDS • High-risk pregnancy • Other complex chronic conditions • Nutritional deficiencies such as malnutrition
Instrumental Activities of Daily Living (IADLs)	Limited ability to shop or cook, including functional limitations affecting meal preparation (ADLs or lack of cooking equipment) and/or physical inability to prepare meals.	N/A	N/A
Social Needs (SN)	• Food or nutrition insecurity • Housing instability • Low nutrition literacy	• Food or nutrition insecurity • Low nutrition literacy	• Food or nutrition insecurity • Low nutrition literacy
High Risk Condition (HRC)	• High health care utilization (e.g., frequent hospitalizations or ED visits) • Multiple chronic conditions, high comorbidity score • Evidence of clinical instability (defined as "a patient's health, vital signs, or	• High health care utilization (e.g., frequent hospitalizations or ED visits) • Multiple chronic conditions, high comorbidity score • Evidence of clinical instability (defined as "a patient's health, vital signs, or	• High health care utilization (e.g., frequent hospitalizations or ED visits) • Multiple chronic conditions, high comorbidity score • Evidence of clinical instability (defined as "a patient's health, vital signs, or

	mental state are unpredictable, worsening rapidly, or fluctuating outside safe ranges" - NIH)	mental state are unpredictable, worsening rapidly, or fluctuating outside safe ranges" - NIH)	mental state are unpredictable, worsening rapidly, or fluctuating outside safe ranges" - NIH)
Dose	10 meals per week (minimum). $15-20 per meal.	$150 - $250 per month (for 4 bags/boxes); $150 per month for vouchers.	$100 - $250 per month (for 4 shares); $100 per month for vouchers.
Duration	Minimum of 6 months, with reassessment of eligibility for reenrollment.	6 – 12 months, with reassessment of eligibility for reenrollment.	Minimum of 6 months, with reassessment of eligibility for reenrollment.
Delivery	$25 additional is provided when goods are delivered to the patient.	$25 additional is provided when goods are delivered to the patient.	$25 additional is provided when goods are delivered to the patient.
Optional add-ons, according to patient need	• Medical Nutrition Therapy (reimbursed at current MNT rates) • Culinary medicine (for those likely to regain shopping/meal preparation ability; Reimbursement dependent upon class type) • Cooking supplies (for those likely to regain shopping/meal preparation ability; up to $750 of supplies per calendar year)	• Medical Nutrition Therapy (reimbursed at current MNT rates) • Culinary medicine (reimbursement dependent upon class type) • Cooking supplies (up to $750 of supplies per calendar year)	• Medical Nutrition Therapy (reimbursed at current MNT rates) • Culinary medicine (reimbursement dependent upon class type) • Cooking supplies (up to $750 of supplies per calendar year)

Figure 4.1: FIM Eligibility Determination Flow Chart



For MTMs, we propose that eligible Vermont participants must have one of the listed diet-impacted clinical conditions, a limited ability to cook or acquire prepared meals, and either a social need or high-risk condition. A limited ability to cook or acquire prepared meals could be due to physical or cognitive limitations, lack of skill or knowledge, or other impairment. The research has shown that at least 10 meals per week are necessary to improve health and achieve cost savings. MTMs are RD-approved prepared meals which can be provided hot, refrigerated, or frozen, and are often delivered to the patient. We propose $15-20 per meal, which falls within the range of MTM price per meals found in existing Section 1115 state waivers, which range from $7 per meal in California, to $20.50 per meal in Washington.[41] The higher reimbursement amount ($20) is reserved for programs utilizing local goods as described in the Procurement of Local Goods section. For those patients who are likely to regain the ability to cook and prepare meals (such as those discharged from the hospital, or for whom the primary limitation is a lack of skill or knowledge), the optional add-ons are encouraged to facilitate behavior change. Medical nutrition therapy (MNT) combined with culinary medicine can have the greatest impact on behavior change for patients. If patients lack cooking necessities (cutting boards, utensils, pots, pans, hot plates, appliances, etc.), up to $750 worth of cooking supplies can be provided to the participant.

We propose that Vermonters who have at least one of the listed clinical conditions and have either a social need or a high-risk condition are eligible for either MTGs or PRx. This flexibility accounts for the variability in availability of the different FIM programs across Vermont. If the availability of MTGs and PRx increases to the point where patients would have access to either program across Vermont, eligibility criteria may be reassessed at that time.

MTGs can be provided either as raw ingredients (produce, protein, spices, etc.) in grocery bags or boxes or can be provided as vouchers where the patient purchases the goods themselves.

The amount of food provided in the bags or boxes should be similar to ¼ of the monthly amount as calculated by the USDA thrifty food plan reference family (family of 4).[78] The reimbursement amount in the table assumes four grocery bags/boxes per month, or at about $37.50-$62.50 per bag/box, with the higher amount reserved for programs utilizing local goods. Grocery vouchers should be capped at $150 per month. Local food procurement for providing raw produce is encouraged and outlined in more detail below. These bags/boxes can be picked up by patients, or they can be delivered. Delivery is eligible for an additional reimbursement of up to $25 per month. The optional add-ons of MNT, culinary medicine, and cooking supplies are encouraged for any patients expressing willingness and need. The use of MNT and culinary medicine is of particular importance to facilitate behavior change that will outlast the intervention time period.

PRx programs can be provided as fresh, canned, or frozen produce or as voucher programs. In Vermont, PRx programs have historically utilized CSA shares from local farms to supply the produce during the growing season, with some supplementing with root vegetables during the winter months. Herein after, "shares" shall mean CSA shares or bags/boxes of produce. The reimbursement amount in the table assumes four shares per month, or at about $25-$62.50 per share, with the higher amount reserved for programs utilizing local goods. Local food procurement for providing raw produce is encouraged and outlined in more detail below. PRx produce can either be picked up by the patient or delivered. Delivery is eligible for an additional reimbursement of up to $25 per month. Voucher-based programs are reimbursed at $100 per month per participant. The optional add-ons of MNT, culinary medicine, and cooking supplies are encouraged for any patients expressing willingness and need. The use of MNT and culinary medicine is of particular importance to facilitate behavior change that will outlast the intervention time period.

Suggested rates for Culinary Medicine are $13–$20 PPPS for brief micro-engagements, $20–$30 PPPS for demonstration-based sessions, and $60–$75 PPPS for full hands-on culinary medicine classes (describe in more detail in Appendix 9). These rates reflect bundled delivery costs, including educator time and expertise, food, disposables, materials, preparation, facilitation, coordination, and travel when applicable.

Medical Nutrition Therapy and Culinary Medicine

MNT is a personalized nutrition counseling service provided by Registered Dietitians (RDs or RDNs) that helps patients prevent or manage medical conditions and diseases. It involves nutritional assessment, a personalized nutrition plan, education and counseling, and evaluation. MNT has been found to be effective in improving health outcomes for patients with chronic diet-related conditions. It is a relatively low-cost, highly personalized intervention that can be employed in a variety of settings to a variety of individuals, making it a cost-effective, adaptable, and effective component to FIM programs.

Culinary medicine is another powerful tool for lasting behavior change for participants. It is much more than a simple "cooking class"; it is an evidence-informed, experiential intervention that translates nutrition guidance and food access into practical, repeatable behaviors. FIM programs give people access to the foods they need, while culinary medicine helps them build

kitchen confidence, practical skills, food agency, and the ability to make that food work in their daily lives. Culinary medicine services may be reimbursed on a per-participant, per session (PPPS) basis above the stated FIM reimbursement rates.

For both MNT and culinary medicine services, virtual and hybrid options should be allowed to the extent possible under State and Federal laws.

Additional Program Considerations

Referring, Prescribing, and Eligibility Verification for FIM

Vermont FIM programs utilize a variety of methods to verify patient eligibility, including some programs which have access to medical records, and some programs that rely on patient self-reported health status. We recommend that the patient's medical provider and FIM program operators be positioned to confirm eligibility.

To facilitate payor credentialing of community-based organizations, the Task Force encourages one-time additional payments be made to established VT-based FIM programs within community-based organizations or other non-medical organizations that currently lack necessary infrastructure for billing health insurance. For the purposes of this report, community-based organizations are non-health care organizations with established FIM programs operating in Vermont. Community-based organizations can apply for funding. This cost-based reimbursement shall include acquiring needed computers, software, security, and other needed improvements to allow for secure billing to Vermont's insurance payors.

One example of a community-based organization that has utilized State funds to become credentialed with Medicaid (and thus, able to bill Medicaid) is Community Servings. Community Servings is a medically tailored nutrition provider based in Massachusetts that has been in operation since 1990. The FIM Task Force has consulted with Community Servings as they are considered one of the leaders in MTM production and distribution. With considerable public and private funding, Community Servings invested in key technology and infrastructure enhancements to participate as a provide in the Massachusetts' Medicaid 1115 waiver Health-Related Social Needs (HRSN) program. For more information, see Appendix 9.

Clinical Oversight and Care Coordination

Clinical oversight should be provided by participants' referring provider, including monitoring relevant health metrics. Care coordination should be provided by either the referring provider's office or the FIM program operator. This care coordination should include assessment of social and financial needs and referrals to appropriate services (including SNAP and WIC).

Procurement of Local Goods for FIM

To support local economies, small business vitality, and farm viability, Medicaid, private insurance payors, and other payors should provide maximum reimbursement for FIM programs

(as noted in Table 4.1), who prioritize local products. For example, if a FIM program is procuring at least 75% of goods locally for PRx, or 20% of goods locally for MTGs and MTMs, they should receive the maximum reimbursement amount for the FIM type provided.

Locally is defined as:

- Goods grown/produced within the definition of "local" in Title 9, VSA § 2465a; or
- Goods that are grown and/or processed within 50 miles of the Vermont border; or
- Goods from food hubs, gleaning programs, or similar organizations located within 50 miles of the Vermont border who have a focus on regional products.

Payors should prioritize utilizing local FIM organizations first, prior to resorting to national or non-local vendors. Entities should consider factors including participant access to fresh and nutritious foods, supporting Vermont's agricultural economy, and supply chain resilience.

Voucher programs are currently not subject to this procurement of local goods reimbursement stipulation. However, we encourage future consideration of a model similar to the established CropCash model, wherein individuals using vouchers could receive extra funds to purchase local goods.

Avoiding Duplication of Services and Screening for Financial Need

Patients should receive only one type of FIM at a given time.[xii] However, FIM benefits can complement federal nutrition assistance programs, and enrollment in SNAP or WIC does not preclude eligibility for FIM.[xiii] Integrating SNAP and WIC screening and referral into FIM workflows can help connect eligible individuals to long-term nutrition supports while allowing FIM to provide an additional, clinically appropriate "dose" of nutritious foods during periods of heightened medical need. Unlike SNAP and WIC, which provide broader nutrition assistance, FIM interventions are *clinically targeted* and prescribed or recommended as part of a patient's health care plan to help prevent, manage, or treat specific diet-related conditions. This layered approach maximizes the impact of federal nutrition investments, reduces gaps in participation among individuals who are eligible but not enrolled, and helps ensure that health care and nutrition systems work together to improve health outcomes.

FIM Program Oversight

As with any program, there should be oversight and additional evaluation. The Task Force is working to develop potential metrics that can be used.

[xii] Switching between FIM types as needs changes is encouraged.

[xiii] FIM is not duplicative of SNAP or WIC, since FIM programs are designed to complement—not replace—existing federal nutrition assistance programs.18. Bank A, Jantz K, Xie J, Rees E, Scott K. Food is Medicine is complementary with SNAP & WIC: A brief on comprehensive nutrition supports for Medicaid enrollees. Medicaid Food Security Network; 2025. While SNAP and WIC play an essential role in reducing food insecurity by helping eligible households purchase nutritious foods, they are broad population-based nutrition support programs with income-based eligibility.

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Appendix 1: Methods, FIM Task Force Contributions, and Task Force Participants

Methods

Who is at the Table

Led by Bi-State Primary Care Association, the FIM Task Force is comprised of 41 individuals from a variety of organizations across Vermont. This includes, but is not limited to the VT Foodbank, VT Farm to Plate, Hunger Free VT, the VT Academy of Nutrition and Dietetics, and the VT Program for Quality in Health Care.

In addition to Task Force members from across Vermont, the Task Force received support from the American Heart Association, the Center for Health Law and Policy Innovation (CHLPI), and Tufts University Food Is Medicine Institute. The American Heart Association assisted the Task Force with policy related work, including development of FIM educational briefs and organization of an educational event at the VT Statehouse in the spring of 2026, which included testimony with four different legislative committees. A two-month technical assistance offering from CHLPI allowed for an in-depth training for Task Force members, as well as review of the draft Benefit Coverage Framework. Tufts University provided support to the Task Force through a contract with Bi-State, providing three FIM experts to provide support, expertise, and content regarding economic analysis, FIM Medicaid benefits in other states, and FIM clinical effectiveness. Utilizing the assistance from CHLPI and Tufts added rigor and data triangulation to our work.

Meeting Cadence

The Task Force met bi-weekly from January to July 2026, with four workgroups meeting regularly (typically bi-weekly) within the same timeframe. Task Force meeting content varied from presentations on topics related to FIM reimbursement, to collaborative work on specific components of the Benefit Coverage Framework. The Task Force was facilitated by Kristen Bigelow-Talbert, with substantial support from Jamie Rainville. The four workgroups consisted of:

- Policy & Reimbursement
    - Facilitated by Dr. Mary Kate Mohlmon, PhD, MS, with additional support from Rebecca Rocheleau, and data support from Dr. Ryan Martin Kane, MD, MPH, MHSc.
    - Focused on the policy environment—both state and federal—and how this may influence our work. Additionally focused on reimbursement for FIM, including what other states have done, what our current per-service and per-participant

FIM costs are in Vermont, and what a realistic and sustainable reimbursement amount could be for our proposed eligibility framework.

- Return on Investment (ROI) of Food Is Medicine
    - Facilitated by Randy Messier, MT, MSA, PCMH CCE, VT Program for Quality in Health Care, with data support from Emma Hileman, MSW, from the VT Farmers Food Center and Dr. Lu Wang, PhD, from Tufts University Food Is Medicine Institute.
    - Focused on gathering data from the VT FIM programs to complete local analysis. Synthesized national evidence of the cost effectiveness of FIM programs. Synthesized evidence for economic impact when FIM programs partner with local farms, and ran analysis to determine the current economic impact with existing FIM programs in VT.
- Stories from the Field
    - Facilitated by Hannah Baxter, Farm to Plate Network Manager, with content development and editing support from Chris Meehan, MBA, from the VT Foodbank, Neysha Stuart, MSW, from the VT Department of Health, and Christine Hadekel from the VT Youth Conservation Corps.
    - Collected and organized stories from FIM participants, farmers who partner with FIM programs, and health care providers who offer FIM programs.
- Eligibility, Dose, & Duration Framework
    - Facilitated by Dr. Kristen Bigelow-Talbert, CPHQ, MSHM, PhD, with research support from Dr. Kelseanna Hollis-Hansen, PhD, from Tufts University Food Is Medicine Institute.
    - This group focused on synthesizing the national research on clinical effectiveness of different FIM programs for a variety of diet-related conditions to determine which conditions had the evidence to support inclusion in the proposed FIM Eligibility Framework for Vermont. Based on this research, the group collaboratively created a FIM Eligibility Framework.

Cumulatively, there were 13 Task Force meetings and 34 workgroup meetings during this six-month period.

Data Collection and Synthesis

Literature searches for relevant research articles and relevant gray literature (articles and information not published in peer reviewed journals) using keywords “Food Is Medicine,” “clinical effectiveness,” and “return on investment” among others were conducted in the first quarter of 2026. There were no set inclusion or exclusion criteria, though systematic reviews and randomized control trials were given more weight in our analysis. This literature search was a collaborative effort rather than a single systematic source and included reports from experts in the FIM field. However, the time-limited nature of this work prevented a systematic review from being conducted. Thus, the resulting literature and results may not represent all the available data regarding FIM benefits, or clinical or cost effectiveness.

Data synthesis was conducted using Excel, and no meta-analysis was performed. Summaries of the synthesized research are available in the ROI and Eligibility Framework reports. The exception for the above data search and synthesis is the Stories from the Field report, which collected stories from Vermonters rather than relying on existing national research.

Funding

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Task Force Member Contributions

Name	Supportive Role	Writing	Review & Editing	ROI workgroup	Stories workgroup	Eligibility workgroup	Policy workgroup
Alyssa Greaney	Contribution of stories						
Amy Ducharme						✓	✓
Ashleen Buchanan						✓	
Chris Meehan			✓		✓		
Christine Hadekel			✓		✓		
Debbie Kennedy				✓			
Emilie A Perry	Contribution of stories				✓	✓	✓
Emily Belarmino				✓			
Emily Sylvester							✓
Emma Hileman	ROI workgroup data contributions; Contribution of stories			✓			
Grace Woroch	Contribution of stories						
Hannah Baxter	Stories workgroup lead				✓		
Heather Latino			✓				
Herbert Will	Contribution of stories				✓		✓
Ivy Enoch						✓	✓
Jamie Rainville	Task Force Conception & Support	✓	✓	✓		✓	✓
Joanne Heidkamp						✓	
Katie Garfield			✓				
Kelseanna Hollis-Hansen	Clinical effectiveness evidence lead	✓				✓	
Kim Lipinski	Contribution of stories				✓		
Dr. Kimberley Sampson						✓	

Name	Supportive Role	Writing	Review & Editing	ROI workgroup	Stories workgroup	Eligibility workgroup	Policy workgroup
Kristen Bigelow-Talbert	Task Force Lead; Eligibility workgroup lead	✓	✓	✓		✓	✓
Lu Wang	VT-Specific ROI analysis lead	✓		✓			
Maire Folan						✓	
Mary Kate Mohlman	Policy workgroup co-lead						✓
Nancy Hogue						✓	✓
Neysha Stuart			✓	✓	✓		
R Leah Pryor		✓	✓		✓	✓	
Randy Messier	ROI workgroup lead	✓	✓	✓			
Rebecca Rocheleau	Policy workgroup co-lead		✓				✓
Ryan M. Kane	State policy data lead	✓					✓
Samantha Shanks							✓
Tina Zuk	Policy support				✓		✓

**Note: Workgroup attendance is counted by attendance at ≥2 meetings.*

Task Force Participants

Name	Title	Organization	Industry
Alyssa Greaney	Programs and Outreach Coordinator	ACORN	Agriculture and Food Systems
Amy Ducharme, RN, CPHQ, CCM	Population Health Program Manager	Blue Cross Blue Sheild of VT	Private Insurance Payor
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Chris Meehan, MBA	Chief Community Impact Officer	Vermont Foodbank	Charitable Food Systems
Christine Hadekel	Food and Farm Program Director	Vermont Youth Conservation Corps	Non profit
Deborah Kennedy, PhD	Owner and consultant in FIM	Food Coach Academy	Academic Institution
Elisabeth Panighetti, MA	Relationship Manager	MVP Health Care	Private Insurance Payor
Emilie A Perry	Food Is Medicine Program Coordinator	Little Rivers Health Care	Health Center
Emily Belarmino, PhD, MS	Assistant Professor	UVM	Academic Institution & Hospital
Emily Sylvester, MS, RD, LDN, IBCLC	Founder and CEO	Mother of Fact	Nutrition
Emma Hileman, MSW	Program Director	Vermont Farmers Food Center	Agriculture Sector
Hannah Baxter	Farm to Plate Network Manager	Vermont Sustainable Jobs Fund	Agriculture Sector
Heidi Gingue	Population Health Manager	Northern Counties Health Care	Health Center
Herbert Will	Director of Nutrition	Northeast Kingdom Council on Aging	Area Agency on Aging
Ivy Enoch	Director of Policy and Advocacy	Hunger Free Vermont	Food Security
Jamie Rainville	Manager, Food Is Medicine & Health Innovations	Bi-State Primary Care Association	Public Health
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Kelseanna Hollis-Hansen, PhD	Research Assistant Professor	Tufts Food Is Medicine Institute	Academic Institution
Kim Lipinski	Director of Nutrition and Wellness	Central VT Council on Aging	Area Agency on Aging
Dr. Kimberley Sampson, MD, MSc, FACOG, DipABLM, DipABOM, MSCP	Chair of Obstetrics and Gynecology	Southern VT Medical Center	Hospital
Kristen Bigelow-Talbert, CPHQ, MSHM, PhD Candidate	Network Director, Food Access in Health Care Network	Bi-State Primary Care Association	Public Health
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Maire Folan, MS, RDN	Nutrition Education Director & EFNEP Coordinator	UVM Extension	Academic Institution & Hospital

Name	Title	Organization	Industry
Mary Kate Mohlman, PhD, MS	Director of VT Public Policy	Bi-State Primary Care Association	Public Health
Nancy Hogue, Pharm.D.	Program Manager, Lifestyle Medicine	Blue Cross Blue Sheild of VT	Private Insurance Payor
Natalie Basil	Executive Director	Greater Bennington Community Services, Inc.	Community Health & Human Services
Neysha Stuart, MSW	Public Health Program Manager	VT Department of Health	State Agency
R Leah Pryor	Manager of Culinary Medicine, Nutrition Services	UVMH	Academic Institution & Hospital
Randy Messier, MT, MSA, PCMH CCE	Senior Quality and Safety Advisor	VT Program for Quality in Health Care	Health Care Quality Improvement
Rebecca Rocheleau	Health Policy Advisor	Bi-State Primary Care Association	Public Health
Ryan M. Kane, MD, MPH, MHSc	Assistant Professor	Tufts Food Is Medicine Institute	Academic Institution
Samantha Shanks, MS, RDN, CD	State Unit on Aging Operations Team Lead	Department of Disabilities, Aging & Independent Living	State Agency
Tina Zuk	Region Sr. Lead, State Government Relations	American Heart Association	Public Health
Trishnee Bhurosy, MSc, PhD, CHES	Assistant Professor	UVM, Department of Nutrition and Food Sciences	Academic Institution & Hospital

Appendix 2: Support for the Benefit Coverage Framework

Organizations listed below have signed on to this Letter of Support for the Benefit Coverage Framework.

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525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
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BI-STATE PRIMARY CARE ASSOCIATION
1986 40th Anniversary 2026
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61 Elm Street
Montpelier, VT 05602
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To whom it may concern,

The Food Is Medicine Task Force was established in January 2026 and brought together over 30 dedicated local experts, farmers, researchers, health insurers, health care providers, and community organizations delivering Food Is Medicine (FIM) programs across Vermont. Together, they collaboratively developed a comprehensive framework to support advocacy for sustainable reimbursement mechanisms for FIM programs in Vermont.

This effort has been a collaborative, cross-sector initiative rooted in evidence, shared expertise, and a commitment to improving health outcomes while strengthening Vermont's local agricultural economy. The resulting Benefit Coverage Framework is designed to support advocacy for long-term, sustainable reimbursement pathways for Food Is Medicine programs across the state. The Framework includes three key components:

- Return on Investment of Food Is Medicine – This report summarizes national research on the effectiveness of FIM programs in treating health conditions, as well as the resulting health care cost savings. It also includes Vermont-specific analysis examining the broader economic benefits of FIM programming, including impacts on local farmers and the agricultural economy.
- Food Is Medicine in Vermont: Stories from the Field – This component highlights the importance of FIM through the experiences of Vermont patients participating in FIM programs, alongside stories from local farmers. These narratives demonstrate how reliable and sustainable investment in FIM programs can improve health outcomes while supporting Vermont's farming community and local food systems.
- Vermont's FIM Eligibility Framework – This Framework outlines proposed eligibility criteria, identifies which types of programs would qualify, defines who would be eligible to receive Food Is Medicine services, and recommends appropriate dosage, duration, and sustainable reimbursement amounts for FIM interventions.

The Task Force's work reflects a shared commitment to advancing evidence-based, and economically sustainable health care solutions in Vermont. All organizations signed onto this letter support the Food Is Medicine Benefit Coverage Framework and the continued advancement of reimbursement mechanisms for FIM that recognize the critical role nutrition plays in health and wellbeing.

We appreciate your consideration and support of this important work.

FIM Benefit Coverage Framework Support Across Industries

Organization	Industry / Sector
ACORN	FIM Provider
BCBS of VT	Payor / Insurance
Bi-State Primary Care Association	Public Health
Boston Medical Center	Health Care
Central VT Council on Aging	Area Agency on Aging
Central VT Medical Center	Health Care
Culinary Medicine Program at UVM Medical Center	Nutrition & Culinary Experts
Dartmouth Health	Health Care
Hunger Free Vermont	Public Health
Little Rivers Health Care	Health Care
Michael Latreille, MD	Individual
Northeast Kingdom Council on Aging	Area Agency on Aging
Northeast Organic Farming Association (NOFA)	Agriculture
Northern Counties Health Care	Health Care
Sravan Kakani, M.D.	Individual
Teaching Kitchen Collaborative	Nutrition & Culinary Experts
Tufts Food is Medicine Institute	Research / Academia
UVM Medical Center & UVM Health Network	Health Care
UVM Osher Center for Integrative Health	Health Care
Vermont Academy of Nutrition and Dietetics	Nutrition & Culinary Experts
Vermont Farmers Food Center	FIM Provider
Vermont Sustainable Jobs Fund	Agriculture
Vermont Youth Conservation Corps (VYCC)	FIM Provider
VT Foodbank	Charitable Food Provider

Appendix 3: Summary of National FIM Research, including MTM and PRx Programs

Program/ Study	Population Eligibility	Intervention	Key Outcomes	Costs & Savings	Overall Conclusion
Produce Prescriptions & Medically Tailored Groceries[36]	6.5 million adults with diabetes & food insecurity	Produce prescription programs (often $30–$50/month for 3–6 months)	- Prevents 292,000 cardiovascular events over a lifetime	- Cost: $44.3B - Savings: $39.6B (health care) + $4.8B (productivity) - Cost-effective at $18,100/QALY	Highly cost-effective; longer duration (>1 year) may be needed for health care use impact.
National Expansion of MTMs[32]	6.31 million US adults eligible in 2019 Mean age: 68.1 years 63.4% female 76.5% Medicare/Medicaid	MTMs for qualifying conditions (CVD, diabetes, cancer)	- 1.594 million hospitalizations averted in 1 year - 18.257 million hospitalizations averted in 10 years	- 1-year: Program cost $24.8B, savings $38.7B, net savings $13.6B - 10-year: Program cost $298.7B, savings $484.5B, net savings $185.1B	Robust cost-saving and hospitalization-reducing impact across sensitivity analyses.
True Cost of Food – Food Is Medicine Case Study[37]	National (Medicare, Medicaid, private insurance)	MTMs, Produce Prescriptions, nutrition education, dietitian counseling	- MTMs: Avert ~1.6M hospitalizations/year - Produce Rx: Prevent 292,000 Cardiovascular events, add 260,000 QALYs	- MTMs: Net health care savings $13.6B/year - Produce Rx: ICER $18,100/QALY, net savings $0.05B - FIM could reduce $1.1T annually in health care and productivity losses	Scaling FIM could make a meaningful national impact on diet-related mortality, economic burden, and chronic disease management.

Produce Prescription Multisite Evaluation[35]	3,881 participants (2,604 adults: 1,817 children) at risk for poor cardiometabolic health	Financial support for CSA/Produce for a limited time.	- Adults: HbA1c down 0.29pts; SBP down 8.38 mmHg; DBP down 4.94mm Hg; BMI down 0.36 kg/m2.	Financial incentives for produce ($63/month, 4-10 months) V.S. Avg. cost BP Meds without ins. Is $329/mth or $10 to $200/mth with insurance	Produce prescriptions improve diet, food security, perceived health, and cardiometabolic risk; supports integration into health care.
Tufts Estimated Impact of Medically Tailored Meals in 50 U.S. states[34]	Adults 40–79 years old with diabetes who experience food insecurity. Covered by Medicare, Medicaid and private insurance.	Free or discounted fruits and vegetables (averaging $47/month) Nutrition education The estimates are based on the measured effects of 20 existing PRx programs.	-6.4 million eligible patients -121,000 cardiovascular disease events prevented -122,000 quality-adjusted life years (QALYs) gained	$29.2 billion in health care cost savings $2.68 billion in net cost savings after program costs	Produce prescriptions for diabetic, food-insecure adults significantly improve health, reduce costly cardiovascular events, and generate major health care savings. The study supports statewide and national implementation of produce prescription programs.

Appendix 4: Technical Appendix--Methods for Vermont PRx Cost-effectiveness Analysis, provided by Tufts University

Research Design

This study adapted the validated DOC-M (Diabetes, Obesity, Cardiovascular Disease Microsimulation) model, a probabilistic, individual-level, health-state transition model, to assess the potential long-term health and economic impacts of implementing Produce Prescriptions (PRx) in Vermont.[79] Compared to our prior work, two updates were made to the DOC-M model: First, we incorporated an updated, US-region and insurance-type specific health care cost prediction model. Second, we used a new productivity cost prediction model based on premature morbidity and mortality. As previously described, based on individual-level data on demographics, cardiometabolic risk factors, and lifestyle behaviors, and information from intervention studies and other data on the effects and costs of the intervention and costs of the outcomes, the model projects individual health trajectories as well as economic outcomes.[79] By comparing projected outcomes between the intervention and no intervention (status quo) scenarios, the model can estimate incremental changes in number of CVD events, QALYs, health care costs, productivity losses, intervention costs, and the cost-effectiveness of policies or interventions.[34] The analysis was conducted over time horizons of 1 to 5 years to provide insights relevant to decision-makers.

Key model inputs and data sources are summarized in Supplemental Table S1, with further details below. This study follows the methodology described in the NIH project R01HL115189 – NHLBI, which solely utilized publicly available, de-identified datasets, and thus does not constitute human subjects research and did not require Institutional Review Board (IRB) oversight.

Population and Data Source

The model was populated with individual level data for adults aged 25-79 years in Vermont with self-reported diabetes and food insecurity at baseline from the Behavioral Risk Factor Surveillance System (BRFSS). Participants provided information via standardized telephone interviews, including on demographics (age, sex, race/ethnicity, education, family income), BMI, and health status (diagnosis of diabetes, coronary heart disease (CHD), stroke, high blood pressure), and smoking (current, past, or never). To correct for self-reporting bias in BMI, we adjusted the self-reported BMI in BRFSS to align with objectively measured BMI distributions from the National Health and Nutrition Examination Survey (NHANES) using established methods.[80] For variables not available in the BRFSS but required by the DOC-M

model and for current analysis—such as laboratory measurements (e.g., blood cholesterol, triglycerides, glucose), blood pressure, and food security status for eligibility assessment —we used predictive mean matching to impute values from NHANES 2013-2020 data.[81] We applied BRFSS sampling weights so that the population is representative of adults aged 25–79 with self-reported diabetes and food insecurity in Vermont, an estimated eligible population of approximately 9,000 individuals.

Intervention

Twenty published PRx interventions, each with at least 3 months duration, served as the basis for the intervention.[34] We included programs that evaluated the impact of fruit and vegetable prescriptions for at least three months on dietary intake, body mass index (BMI), and hemoglobin A1c (HbA1c). These programs varied in the amount of produce provided (from $15 to $140 per month, or approximately 10–25 lb per distribution), provision method (food-box pickup or delivery, paper vouchers, electronic debit cards, or community-supported agriculture shares), nutrition education (none, printed recipes, cooking demonstrations, dietitian counseling, or structured diabetes self-management classes), patient population (including food-insecure or low-income adults and families, and/or with diabetes, hypertension, overweight or obesity), and duration (approximately 3–12 months). Thus, the intervention effects should be interpreted as the average overall effect of all these varying approaches; insufficient evidence is available to determine potential comparative differences of these approaches.

The average age of participants across all programs was 54 years, with 69% female, 38.5% non-Hispanic Black adults, and 30.0% Hispanic adults. Among the eligible studies, most (17 of 20) enrolled adults with poor cardiometabolic health including diabetes or prediabetes, hypertension, CVD, obesity, or overweight. All programs enrolled participants who were food insecure or at high risk for food insecurity, with a weighted average of 74% being food insecure. In addition, all 10 programs that assessed the effect on HbA1c were implemented among diabetes patients, with 79% being food insecure.

Intervention Effects

The intervention effects of PRx were estimated based on average effect of these 20 PRx programs, each with at least 3 months duration, derived from de novo random-effects meta-analyses.[34] On average, PRx programs increased fruit and vegetable consumption by 0.80 servings/day (95% confidence interval [CI], 0.45 to 1.15), reduced BMI by 0.36 kg/m^2 (95% CI, 0.15 to 0.55), and reduced HbA1c by 0.63% (95% CI, 0.28 to 0.98). While such intervention effects could vary based on factors including amounts of produce provided, provision method (food box pick-up, delivery, or electronic debit card), types of nutrition education, geographic locations, patient demographics, or duration, the current literatures did not allow a rigorous assessment of the impact of these factors on the intervention effect sizes.[45] Therefore, our findings should be considered the plausible average effect of PRx programs currently described, incorporating uncertainty to account for potential heterogeneity in the estimates. We assumed

all eligible individuals enrolled in the study, with continuing enrollment of eligible individuals in the intervention each year without drop-out, and stable intervention effects over time. Because the intervention was estimated to achieve its full effects within 6 months, with stable effects thereafter (a conservative assumption), the findings can be interpreted as either the same or different individuals being enrolled in each year, based on clinical indications.

To model the effect of PRx on cardiovascular risks, we incorporated age-specific relative risks (RR) of fruits and vegetables on CHD and stroke risk estimated from meta-analyses of prospective cohorts or randomized clinical trials (Table S1).[82, 83] These RR estimates were adjusted for age, sex, body mass index (BMI) and other risk factors to reduce bias from confounding and therefore accounted for CVD effects of PRx independent of changes in BMI. To capture the fuller scope of PRx benefits, our model incorporates changes in BMI (Δ BMI) and changes in HbA1c (Δ HbA1c), which are driven both directly by PRx and indirectly through changes in fruit and vegetable consumption. To avoid double counting the benefits derived from reduced CVD events, the effects of Δ BMI and Δ HbA1c are modeled to impact health care expenditures completely independent of CVD. Specifically, the model captures costs associated with non-CVD adiposity-related outcomes (e.g., depression, back and joint pain, gallstones, and cancer) through the Δ BMI parameter. Similarly, we accounted for diabetes control via Δ HbA1c, an established determinant of health care costs among patients with diabetes (Figure S1).

Intervention Costs

Intervention costs included the food costs for fruits and vegetables plus all administrative and program delivery costs for program implementation. Food costs ($ per person per month) were calculated based on the weighted mean food box value or voucher amounts from the 20 studies included in the intervention effect size meta-analyses, adjusted for the proportion of fruits and vegetables in the food box (when other items were included) and the actual redemption rates of the vouchers. Values of the reported incentive offered to participants in each study were converted to a standardized United States dollar (USD)-equivalent amount, adjusted for inflation to 2026 dollars. The interventions offered a weighted mean of $50 per month of fruits and vegetables to the target population; and after considering unused vouchers, patients redeemed a weighted mean of $38 per month. To account for Vermont's food prices, we applied the Vermont-specific Grocery Price Index which reflect average grocery costs relative to the national average.[84]

We estimated the administrative costs of the PRx program from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) [85] each of which provides nutrition assistance for eligible individuals. Both programs provide nutrition education in addition to financial benefits, with WIC required to provide specific types and numbers of nutrition education, and nutrition education being optional in SNAP with state flexibility. The administrative costs of SNAP contribute to 5-8% of total program costs according to pre-pandemic program cost data, including state administrative expenses, eligibility certification, nutrition education, employment and training programs, benefit and retailer redemption and monitoring, payment

accuracy, EBT Systems, program evaluation and modernization, program access, and health and nutrition pilot projects. For WIC, after excluding administrative costs related to breastfeeding promotion and education (about 1.8% of total program costs), administrative costs of WIC contribute to about 21.3% of total program costs, including participant eligibility, nutrition education, health care coordination, and referral, drug abuse education, clinic operations, food delivery and warehousing, vendor monitoring, financial management, program integrity, and systems development and operations.

A state produce prescription program may share similar administrative components with both WIC and SNAP, e.g., on eligibility certification, quality control, employment and training, use of the EBT system or food delivery, benefit and retailer redemption and monitoring, and program evaluation. Such a program may have greater similarities with WIC than SNAP, as WIC includes partnerships with health care organizations and has higher intensity and consistency of nutrition education. Still, the administrative burden and costs could be lower in a PRx program than in WIC, as the former provides only produce rather than multiple categories of foods, does not require income certification, and does not need to establish separate clinical institutions (WIC clinics). We assumed that the administrative costs of a national produce prescription program would be 15% of total program costs, about 2-3-fold higher than the administrative costs of SNAP and one-third lower than the administrative costs of WIC. We also assumed the costs to be higher in the first year of implementation due to program launching, equal to 50% of food costs (33% of total program costs).

Health Care Costs

This study applied an updated health care cost prediction algorithm derived from the 2017–2022 Medical Expenditure Panel Survey (MEPS) data to estimate annual health care expenditures for each individual in the simulation model.[86] The algorithm accounted for individual demographics (age, sex, race/ethnicity), cardiometabolic conditions (BMI, diabetes, hypertension, CHD, stroke), geographic region (Northeast), and insurance type to capture regional and payor-specific variations.

In addition to health care costs associated with prevalent health conditions, the model further included event-specific and procedure-specific costs from weighted-average total payments of full discharges across relevant diagnosis-related groups from the 2023 Medicare Inpatient Prospective Payment data. The model additionally accounted for diabetes control as measured by HbA1c, an established determinant of health care costs among diabetes patients independent of other comorbidities such as CVD and hypertension[87]; and applied only the HbA1c-related costs of diabetes excluding CVD-dependent costs to avoid double-counting benefits from fewer CVD outcomes.

Societal Costs

To estimate costs from a societal perspective, the model accounted for costs of productivity losses due to morbidity and premature mortality associated with cardiometabolic

conditions including diabetes, CHD, stroke, and hypertension.[88] Morbidity costs capture the value of lost earnings from decreased productivity due to illness, including inabilities to work due to poor health or disability and workdays missed due to illness (i.e., absenteeism) among currently employed individuals.[89] Mortality costs represent the value of lost earnings and household productivity from premature mortality, were calculated using the human capital approach, incorporating lost earnings from premature death in the formal labor market and household productivity.[89] We did not estimate productivity costs for adults aged 80 years or older because workforce and household productivity participation in this age group is low. We also did not incorporate estimated economic benefits from purchases of fruits and vegetables in Vermont. A separate analysis from the Rockefeller Foundation estimated that implementation of Food Is Medicine interventions for 86,000 eligible individuals in Vermont would create upwards of 660 new jobs, provide $8.8 million in potential revenue for Vermont farmers, and generate $85 million in state GDP from local spending.[90]

Health-related quality of life

To estimate changes in quality adjusted life years (QALYs) associated with the intervention, the model incorporated a prediction algorithm derived from 2022 MEPS data to predict individual-level health-related quality of life (HRQoL),[86] measured by EQ-5D, based on annually updated individual characteristics including demographic, BMI and chronic disease conditions including diabetes, high blood pressure, and CVD history. The model also incorporated event-specific short-term (one year) decrements in HRQoL for individuals experiencing an acute CHD (-0.055) or stroke (-0.3) in a given year.

Cost-Effectiveness Modeling

Analyses followed the recommendations of the Second Panel on Cost-effectiveness in Health and Medicine.[91] We conducted analyses from both a health care perspective, incorporating intervention costs and health care cost-savings, and a societal perspective, considering productivity savings due to reduced disease burden. All costs were inflated to 2026 US dollars, and costs and QALYs discounted annually by 3%. Incremental cost-effectiveness ratios (ICERs) were calculated as the net change in costs divided by the net change in QALYs. To account for uncertainty in key model inputs, we conducted probabilistic sensitivity analyses using 1000 Monte Carlo simulations with uncertainty distributions for all input parameters, including disease incidence and mortality prediction, estimated intervention effects, diet-disease associations (relative risks), intervention costs, health care costs productivity cost prediction, and health-related quality of life prediction. BRFSS sampling weights were incorporated to provide estimates representative of the noninstitutionalized individuals with diabetes and food insecurity in each simulation. The 95% uncertainty intervals (UI) for model outcomes were estimated by jointly combining the sampling uncertainty of BRFSS and the uncertainties of multiple input parameters using the Rubin's rule.[92] All analyses were conducted in R, version 4.1.0/4.2.0.

Limitations

As with all modeling and cost-effectiveness analyses, our findings have limitations. Most interventions in our meta-analyses were real-world studies but used a pre-/post or quasi-experimental design, and additional trials with a randomized design are needed. Intervention effects were based on the pooled effects of 20 PRx programs, which had heterogeneous design features; and our findings should be considered the most plausible average effect. Further studies are needed to help identify implementation factors and patient characteristics that might alter efficacy and costs. We did not consider the potential health benefits of PRx for family members due to food sharing, possibly underestimating the full health and economic benefits. We did not consider economic benefits for farmers. We assumed that the benefits of PRx are constant and maintained only during active participation, although some sustained effects may persist beyond program completion. As a result, our estimates may be conservative and underestimate the true long-term health and economic benefits of PRx.

The uncertainty intervals in costs were wide, reflecting a small state sample and uncertainties in the estimates of intervention effects and health care costs. Health care costs in MEPS exclude individuals in nursing homes and assisted living facilities, who represent a particularly high-expenditure group; MEPS also tends to underestimate health care expenditures due to underrepresentation of high-expense cases and underreporting of health care use.[93-97] Our results may therefore underestimate health care savings associated with prevention of institutionalization among enrolled patients as well as with high-utilization patients. Despite these limitations, our results provide a plausible expected health benefits and cost effects of PRx, and the underlying uncertainty, based on the best available data and reasonable assumptions. We assumed full enrollment and no dropout, which may overestimate the program's population-level impact. Real-world PRx programs report variable retention rates; any dropout scenario would reduce projected benefits as well as costs relatively proportionally.

Key assumptions

- Eligibility defined as adults aged 25–79 with both diabetes and food insecurity at baseline
- Population estimates derived from BRFSS 2024 using sampling weights to represent the non-institutionalized Vermont population
- All eligible individuals assumed to enroll in the program
- Participants remain enrolled each year throughout the analysis period; we assumed either the same or different individuals being enrolled in each year.

- Intervention effects assumed stable over time (neither accelerating nor diminishing returns)
- Benefits assumed to apply only during active program participation; no sustained benefit are seen after the program ends. This is likely a conservative assumption, as many individuals enrolled in FIM programs are able to shift their long-term dietary habits after their program ends.
- Effect sizes derived from a de novo random-effects meta-analysis of 20 PRx programs, each of at least 3 months' duration, treated as a single pooled average across heterogeneous program designs (delivery method, produce type, education intensity, geography, demographics); program-specific factors could not be rigorously separated in the current literature
- The same average effect applied to all enrolled participants regardless of individual characteristics
- Food costs based on the weighted mean redemption value across the 20 meta-analysis studies: participants redeemed a weighted mean of $38/month ($456/year), after accounting for unused vouchers (offered value: $50/month). Costs were further adjusted to Vermont-specific food costs using the state Grocery Price Index relative to the national average
- Administrative costs assumed to equal 15% of total program costs in Years 2 onward, benchmarked to WIC and SNAP administrative cost ratios. First-year administrative costs assumed higher at 50% of food costs ($228/patient), reflecting program launch expenses; this equals 33% of total Year 1 program costs
- No other program delivery costs (e.g., clinical integration, referral systems) are modeled beyond the above
- Annual individual health care expenditures estimated using a prediction algorithm developed from MEPS 2017–2022 data, adjusted for demographics, comorbidities, geographic region, and insurance type. MEPS excludes individuals in nursing homes and assisted living facilities, and may underrepresent high-expenditure cases
- The model did not account for effects of BMI or HbA1c reductions on other outcomes beyond CVD, which would underestimate health benefits and cost-savings
- The model did not account for the sharing of food with families in the 20 studies used to generate effects, which could underestimate state-wide health benefits and cost-savings due to unobserved benefits in the family members
- The model did not account for benefits for farmers
- All monetary values expressed in 2026 US dollars

Key assumptions for Scenario A, B, and C Analyses

- Eligibility defined as:
    - Table 2.4. Adults with chronic conditions and food insecurity at baseline. Baseline characteristics (demographics, lifestyle, health data) of patients with and food insecurity estimates derived from BRFSS 2024 data.
    - Table 2.5. Adults with diabetes and food insecurity at baseline. Baseline characteristics of patients with chronic conditions and food insecurity estimates derived from BRFSS 2024 data.
    - Table 2.6. Adults aged 25–79 with both diabetes and food insecurity at baseline. All eligible individuals were assumed to enroll in the program, representing 9,000 non-institutionalized Vermont population.
- Participants remain enrolled each year throughout the analysis period.
- Intervention effects assumed stable over time (neither accelerating nor diminishing returns)
- Benefits assumed to apply only during active program participation; no sustained benefit are seen after the program ends. This is likely a conservative assumption, as many individuals enrolled in FIM programs are able to shift their long-term dietary habits after their program ends.
- Effect sizes derived from a de novo random-effects meta-analysis of 20 PRx programs, each of at least 3 months' duration, treated as a single pooled average across heterogeneous program designs (delivery method, produce type, education intensity, geography, demographics)[34]; program-specific factors could not be rigorously separated in the current literature.
- The same average effect applied to all enrolled participants regardless of individual characteristics
- Food costs based on the weighted mean redemption value:
    - Table 2.4. $393 per person per year
    - Table 2.5. $393 per person per year
    - Table 2.6. Across the 20 meta-analysis studies: participants redeemed a weighted mean of $38/month ($456/year), after accounting for unused vouchers (offered value: $50/month). Costs were further adjusted to Vermont-specific food costs using the state Grocery Price Index relative to the national average.
- Administrative costs assumed to:
    - Table 2.4. Year 1-5, $234/patient
    - Table 2.5. Year 1-5, $234/patient
    - Table 2.6. Equal 15% of total program costs in Years 2 onward, benchmarked to WIC and SNAP administrative cost ratios. First-year administrative costs assumed higher at 50% of food costs ($228/patient), reflecting program launch expenses; this equals 33% of total Year 1 program costs
- No other program delivery costs (e.g., clinical integration, referral systems) are modeled beyond the above
- Annual individual health care expenditures estimated using a prediction algorithm developed from MEPS 2017–2022 data, adjusted for demographics, comorbidities,

geographic region, and insurance type. MEPS excludes individuals in nursing homes and assisted living facilities, and may underrepresent high-expenditure cases

- The model did not account for effects of BMI or HbA1c reductions on other outcomes beyond CVD, which would underestimate health benefits and cost-savings
- The model did not account for the sharing of food with families in the 20 studies used to generate effects, which could underestimate state-wide health benefits and cost-savings due to unobserved benefits in the family members
- The model did not account for benefits to farmers who are providing goods to PRx programs
- All monetary values expressed in 2026 US dollars

Table S1. Key Model Input Parameters and Data Sources for Projecting Impact of Produce Prescription (PRx) in Vermont using DOC-M model.

Model inputs	Methods/Data sources
Baseline characteristics	Individual-level data on demographics, risk factors, and prevalent health conditions of eligible population for Vermont are obtained from BRFSS 2024.
Intervention effects	Value (95% CI)
Fruit & vegetable intake, servings/day	0.80 (0.45 to 1.15)
BMI, kg/m^2	0.36 (0.16 to 0.55)
HbA1c, %	0.63 (0.28 to 0.98)
Intervention costs	Value (SE)
Food costs, $/patient/year	456 (91)
Administrative costs, $/patient/year	
First-year	228 (45.6)
Following-year	80.4 (16.1)
Diet-disease etiologic effects	Meta-analysis of randomized trials and prospective cohort studies, Miller et al 2022.
Disease risks	
Initial ASCVD	ACC/AHA 10-year ASCVD risk model
Subsequent CVD	Framingham Heart Study 2-year risk model for subsequent CVD
Cause-specific mortality	Cardiovascular and diabetes mortality rates for Vermont by age, sex, and race/ethnicity between 2015-2019 were obtained from CDC Wonder.
Health-related quality of life	An established HRQoL prediction model [98], and event-specific short-term (one year) decrements in HRQoL for acute CHD (-0.055) or stroke (-0.3).
Health care cost	Embedded within DOC-M model, updated with newer data.
Individual health care costs prediction model	Individual level prediction algorithm based on demographics and health status was developed based on MEPS data 2017-2022. All costs were inflated to 2026 dollar.
Event/procedure costs	Updated using Medicare Inpatient Prospective Payment data, 2022.[99] All costs were inflated to 2026 dollar.
Productivity costs	Including costs of lost productivity from morbidity and premature mortality associated with cardiometabolic conditions.[88] Estimation methods are detailed.

Abbreviations: ASCVD, atherosclerotic CVD; ACC/AHA, American College of Cardiology/ American Heart Association; CDC, Centers for Disease Control and Prevention; CVD, cardiovascular disease; DOC-M model: The Diabetes, Obesity, Cardiovascular Disease Microsimulation model; PRx: Produce prescription; BRFSS: Behavioral Risk Factor Surveillance System; NHANES: National Health and Nutrition Examination Survey; MEPS, Medical Expenditure Panel Survey; SE: standard error.

* Where uncertainty around input parameters (e.g., cost of CABG/PCI) is not available, we assume 20% of the mean estimate as a standard error to generate parameters for probabilistic distributions.

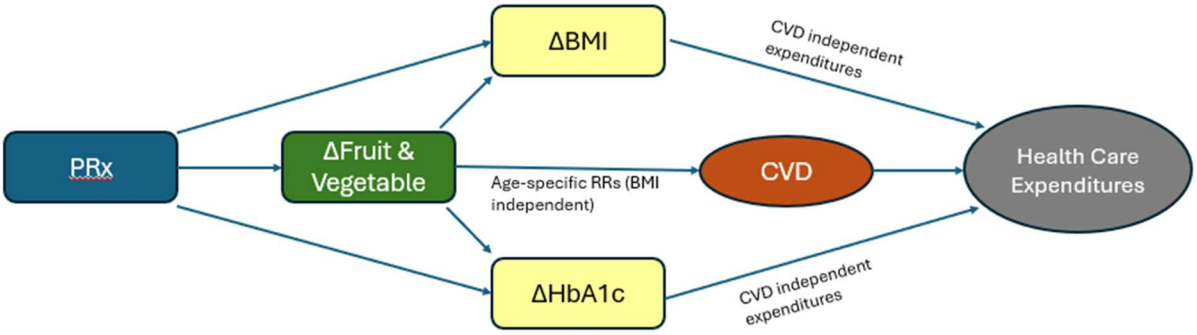


Figure S1. Produce Prescription Intervention Effects

To capture the fuller scope of PRx benefits, our model incorporates changes in BMI (Δ BMI) and HbA1c (Δ HbA1c), which are driven both directly by PRx and indirectly through changes in fruit and vegetable consumption. To avoid double counting the benefits derived from reduced CVD events, the effects of Δ BMI and Δ HbA1c are modeled to impact health care expenditures completely independent of CVD. Specifically, the model captures costs associated with non-CVD adiposity-related outcomes (e.g., depression, back and joint pain, gallstones, and cancer) through the Δ BMI parameter. Similarly, we accounted for diabetes control via Δ HbA1c, an established determinant of health care costs among patients with diabetes.

Appendix 5: Local Food Purchasing Impact Calculator

Impact Valuation for Vermont PRx Local Food Purchasing Impact
08/05/2026

$762,208.40

The number above represents the total economic activity that could be associated with your local food project (Vermont PRx Local Food Purchasing Impact); it includes the project value of **$405,430.00** plus additional economic activity stimulated by your project through local input purchases and paying local labor. This is an estimate of the upper limit, or maximum, impact that your project can have on the selected region.

Frequently Asked Questions:

Q: Does the impact valuation assume that all sales from my project are new dollars entering the local economy?

A: Yes, the impact valuation assumes that all project values represent new dollars in the local economy. However, the reality is that some of the sales captured by your project likely are not new dollars in the region; they represent sales which occurred previously at another location (e.g., conventional grocery store). The sales lost at the other location(s) would need to be subtracted from the gains associated with your project to accurately reflect this situation.

Q: Should I consider the cost of my local food project on my local economy? If so, what costs should be considered?

A: Yes, you should consider the lost productivity to your community from any land converted from one productive use to local food production, as well as any individuals that changed jobs to farm, manage the food hub, etc. When these resources were used in different ways, their productivity changed. Economists would call this change in productivity the opportunity cost of land or labor. The analysis assumes that the land farmed existed and was not previously used for another purpose, and the labor hired also existed but was previously unemployed. The reality is that the land was probably used for another purpose, and the labor may have been employed in another occupation. Therefore, there are production losses in the economy associated with the reallocation of these resources to local food production, and such losses should be subtracted from the gains associated with your project (i.e., the impact valuation) to provide a more accurate estimate of the local impact.

Q: What if some of the labor employed in my local food project lives outside of my county or region?

A: The analysis assumes that all wages generated by the project will be spent, on average, like all other wages in your community. If an employee associated with the project lives outside of the community, her spending pattern will likely be different from those of your community. In this situation, if the employee is likely to spend more of her income near her residence (e.g., she lives in a more urbanized area), then this would lower the impact valuation of your project. However, if the employee is likely to spend more of her income in the community (e.g., she lives in a more remote area), this could increase the impact valuation of your project.

https://calculator.localfoodeconomics.com

Appendix 6: Key Definitions and Acronyms

Chronic conditions/disease: "Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both."[100]

Culinary Medicine: An evidence-informed, hands-on approach that integrates the science of medicine and nutrition with the art and practice of cooking, food preparation, and shared eating to support health, prevent and manage disease, and improve well-being. Culinary Medicine translates nutrition guidance into practical, affordable, and enjoyable meals that align with participant's preferences while building the skills, confidence, and agency people need to make health-supporting food choices in daily life. Culinary Medicine may include cooking education, meal planning, food selection, budgeting, label reading, disease-specific nutrition education, teaching kitchen programs, clinical or community-based classes, and workforce training for health care, public health, culinary, and community professionals.

CSA (Community Supported Agriculture): "Consists of a community of individuals who pledge support to a farm operation so that the farmland becomes, either legally or in spirit, the community's farm; with the growers and consumers providing mutual support and sharing the risks and benefits of food production. Within Food Is Medicine programs, a CSA is typically adapted to improve access to fresh, locally grown fruits and vegetables for patients with diet-related health conditions."[101] In FIM programs, rather than purchasing a share themselves, eligible patients may receive a subsidized or fully funded CSA share through a health care organization, insurer, grant program, or PRx initiative. This approach aligns with FIM interventions that provide healthy foods as part of health care to prevent, manage, or treat chronic disease.[102]

Diet-related conditions: Nutrition-related conditions are diseases or clinical symptoms where diet and nutritional intake are primary risk factors, directly involved in treatment, or adversely affected by the patient's status.[103]

Food Insecurity (FI): Food insecurity is a household-level economic and social condition characterized by limited or uncertain access to an adequate amount of food due to insufficient financial or other resources (such as transportation).

Food Is Medicine (FIM): FIM is defined as "the provision of healthy food such as Produce Prescriptions, Medically Tailored Groceries, and Medically Tailored Meals to treat, manage or prevent diet-related health conditions in a way that is integrated with and paid for by the health care sector. Patients are referred to these services by a health care professional, health care organization or health insurance plan."[102]

Medicaid Section 1115 waivers: "Section 1115 Medicaid demonstration waivers offer states an avenue to test new approaches in Medicaid that differ from what is required by federal statute, if [in the HHS Secretary's view] the approach is likely to 'promote the objectives of the Medicaid program.' They can provide states additional flexibility in how they operate their

programs, beyond the considerable flexibility that is available under current law… Waivers have been used to expand coverage or benefits, change policies for existing Medicaid populations (e.g., testing premiums or other eligibility requirements), modify delivery systems, restructure financing or authorize new payments (e.g., supplemental payments or incentive-based payments), as well as make other program changes."[104]

Medical nutrition therapy (MNT): is a personalized nutrition counseling service provided by Registered Dietitians (RDs or RDNs) that helps patients prevent or manage medical conditions and diseases. It involves nutritional assessment, a personalized nutrition plan, education and counseling, and evaluation.

Medically Tailored Groceries (MTGs): "Medically Tailored Groceries (MTG) include a selection of groceries, such as vegetables, fruits, grains, beans, lean proteins and/or dairy (locally sourced when possible) prescribed by an RD (or another person certified in nutrition) for a broad range of patients—those with diet-related acute and chronic conditions who can shop, pick up, or have food delivered, and prepare food at home."[15, 16]

Medically Tailored Meals (MTMs): Medically Tailored Meals (MTMs) are frozen or refrigerated, ready to heat, or hot prepared meals that are aligned with household food preferences, and provide "…an estimated 1⁄3 of the recommended dietary intake(s), per therapeutic, evidence-based dietary specifications for conditions"[14] for each meal. They are the most complex to implement, given the addition of food preparation and medical tailoring needs.

Nutrition Insecurity (NI): Nutrition insecurity is limited or uncertain access to sufficient and appropriate foods needed to meet an individual's nutritional needs and support management of their health conditions, including chronic diseases.

Produce Prescriptions Programs (PRx): A Produce Prescription (PRx) is a medical treatment or preventive service referred or prescribed by a clinical and/or community health team to patients with diet-related health risks or conditions and/or documented challenges in accessing nutritious foods. PRx may include fruits, vegetables, nuts, seeds, eggs, dairy, beans, and legumes that are fresh, frozen, canned, minimally processed, without added fats, sugars, or salts; as well as tailored programming to support nutrition and culinary education. PRx may be issued to patients in the form of coupons or vouchers to food retailers, Community Supported Agriculture (CSA) boxes, picked up in health care settings, or home delivered. They are provided at low or no cost to the patient.

ROI (return on investment): "During the planning process that precedes implementation of improvement actions, projected ROI can be used to estimate how the planned intervention will affect revenue and operating costs and to adjust the intervention to better optimize both quality and financial performance. In addition, ROI can be used to show how long it will take for an intervention to break even—that is, for the returns of the practice improvement to offset the upfront and ongoing implementation costs. This analysis can be done using data from the literature."[105]

Appendix 7: Food is Medicine Programs Featured in Chapter 3

Food Is Medicine Programs Featured in This Collection

Across Vermont, FIM programs are connecting health care providers, farmers, and community organizations to improve access to nutritious food as part of health care. Through PRx, MTMs, home-delivered food, and farm partnerships, these programs help people in Vermont manage chronic disease, improve well-being, and access healthy local food.

Below are the programs and organizations featured in Chapter 3, representing a growing statewide effort to integrate nutrition into health care, strengthen local agriculture, and improve health outcomes through local food partnerships.

Addison County Relocalization Network (ACORN) Farmacy Program

The Addison County Relocalization Network (ACORN) is a community-based organization working to strengthen local food systems and support the long-term vitality of agriculture in Vermont's Southern Champlain Valley.

ACORN partners with farms, community organizations, and Food as Medicine initiatives to improve access to locally grown food while supporting regional economic resilience and community wellbeing. Through partnerships with local farms and programs such as the Farmacy Project, ACORN helps connect nutrient-dense, locally produced food with community members experiencing barriers to food access.

The organization's work focuses on reinvesting in local food economies, strengthening relationships between farms and communities, and promoting the role of local agriculture in supporting both environmental sustainability and public health.

Central Vermont Council on Aging (CVCOA)

The Central Vermont Council on Aging (CVCOA) supports nutrition and wellness programs that help older adults and individuals with disabilities maintain their health, independence, and quality of life throughout Central Vermont.

As part of its Nutrition and Wellness Opportunities programs, CVCOA provides funding, coordination, and technical assistance for home-delivered meals, congregate dining, and grab-

and-go nutrition programs across the region. Partner meal programs prepare and distribute nutritious meals that are reviewed by a registered dietitian to ensure they support the dietary needs of older adults and individuals with complex health needs.

Each year, CVCOA-supported meal programs serve more than 200,000 meals to nearly 2,000 older adults across Central Vermont. Many participants receive therapeutic or Medically Tailored Meals designed to help manage chronic conditions such as diabetes while supporting recovery, independence, and overall health. In addition to nutrition support, home-delivered meal programs provide important social connection and regular wellness contact for participants who may otherwise experience isolation or difficulty accessing healthy food.

The Greater Northfield Senior Center is a partner meal program with the Central Vermont Council on Aging. Greater Northfield Senior Center (GNSC) offers a variety of programs and events and works hard to ensure that all area seniors have access to at least one regular nutritious meal per day. Nourishing food is the cornerstone of the work at GNSC. An on-site chef cooks a homemade meal 5 days a week to be served in the dining room and to be sent out to homebound neighbors through their Meals on Wheels Program.

Meals on Wheels of Central Vermont at City Hotel Café is a partner meal program with the Central Vermont Council on Aging and has been proudly serving the community since 1993. They prepare and deliver approximately 40,000 nutritious meals per year to older adults and neighbors with disabilities. In addition to these meals, they provide safety checks and essential social connections to those they serve.

Little Rivers Health Care: Food Farmacy

Little Rivers Health Care's Food Farmacy is a Food Is Medicine program that helps patients prevent and manage chronic health conditions through improved access to nutritious food. All patients are screened for food insecurity at check-in using validated tools, including the Hunger Vital Sign and Tufts Nutrition Security Screening. LRHC takes a multi-faceted approach to supporting patients: those with cardiovascular risk factors are enrolled in the Produce Prescription program, receiving fresh produce from Willing Hands every third week; patients who screen positive for food insecurity can receive a shelf-stable food box supportive of their specific health condition; and every clinic maintains food shelves stocked with health-supportive shelf-stable foods, with no barriers to access. Through a comprehensive, patient-centered approach, participants receive nutritious foods and support that empower them to make sustainable dietary changes, improve health outcomes, and better manage chronic conditions. The Food Farmacy reflects Little Rivers Health Care's vision that all patients have fair access to both nutrition education and healthy foods that support lifelong wellness.

Northeast Kingdom Council on Aging (NEKCOA):

The Northeast Kingdom Council on Aging (NEKCOA) provides nutritious home-delivered meals to older adults and individuals with complex health needs throughout the Northeast Kingdom. Through its Home Delivered Meals program, also known as Meals on Wheels, NEKCOA helps ensure that individuals who are unable to shop for or prepare meals independently can continue living safely and healthfully at home. Meals are delivered directly to participants who are medically homebound or living with physical, cognitive, or mobility-related limitations that make meal preparation difficult. Meals are designed to meet nutritional guidelines and support the health and wellbeing of older adults and individuals managing chronic health conditions.

For many participants, the program provides more than nutrition alone. Meal delivery also offers routine wellness checks, social connection, and support that helps reduce isolation and promotes independence. The Home Delivered Meals program plays an important role in helping older Vermonters age safely in place while reducing barriers to nutritious food access in rural communities.

Vermont Farmers Food Center (VFFC) Farmacy Project

The Vermont Farmers Food Center's Farmacy Project is a community-based Food as Medicine program serving Rutland County. The program connects individuals and families experiencing food insecurity and diet-related health challenges with fresh, locally grown food, nutrition education, and community support.

Health care providers refer eligible patients to the Farmacy Project through a produce prescription model. Participants receive 10–12 pounds of fresh produce each week during the growing season at no cost. Produce is distributed through multiple pickup locations across Rutland County and is grown by local small and emerging farmers.

In addition to fresh food access, the Farmacy Project offers nutrition education, cooking classes, and community programming that support healthier eating habits and stronger connections to local agriculture. The Farmacy Project reflects a collaborative partnership among health care providers, community organizations, volunteers, and local farms working together to improve community health while strengthening the regional food system.

Vermont Youth Conservation Corps (VYCC) Health Care Share

The Vermont Youth Conservation Corps Health Care Share is a produce prescription program that connects Vermonters experiencing food insecurity with weekly shares of locally grown vegetables. The program supports individuals living with diet-

related chronic health conditions by integrating fresh food access into health care support systems. Through partnerships with health care providers and medical centers across Vermont, participants receive weekly vegetable shares prescribed as part of their health and wellness support. Shares are grown at VYCC using organic farming practices and distributed through partnering health care sites statewide.

In addition to fresh produce, participants receive nutrition education, recipes, and meal preparation guidance that support healthy eating habits and long-term dietary change. The program is designed to increase access to nutritious food while helping participants manage chronic health conditions such as diabetes and hypertension. VYCC currently grows and distributes produce for approximately 400 families through the Health Care Share program. Shares are distributed for 8–19 weeks during the summer season and for 10 weeks during the winter season.

Acknowledgements

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We extend our gratitude to the patients and participants who shared their stories and experiences; to the health care providers, dietitians, farmers, food producers, and community organizations working to integrate nutrition into health care; and to the staff, volunteers, and coordinators who make these programs possible every day.

Appendix 8: Vermont-Specific Proposed Clinical Objectives

Clinical Objective 1: Improve the management of diet-related chronic diseases through clinically indicated nutrition interventions.

Potential outcome measures:

- Change in HbA1c
- Change in systolic/diastolic blood pressure
- Change in LDL cholesterol
- Change in BMI or waist circumference (where appropriate)
- Improvement in CKD markers (e.g., eGFR, albuminuria) when applicable
- Reduction in gestational complications (pregnancy)

Clinical Objective 2: Reduce food and nutrition insecurity and improve consistent access to healthy foods among eligible patients.

Potential Measures:

- Food security status (Hunger Vital Sign, USDA 2-item or 6-item screener)
- Nutrition security status (Nutrition Security Screener)
- Fruit and vegetable intake
- Self-reported ability to obtain medically recommended foods

Clinical Objective 3: Improve clinical outcomes and reduce preventable complications associated with diet-related disease.

Potential Measures:

- Rate of emergency department visits, hospitalizations, and hospital readmissions
- Disease-specific complications
- Pregnancy complications (gestational diabetes, hypertensive disorders, preterm birth, low birth weight)

Clinical Objective 4: Increase adherence to recommended dietary and medical treatment plans.

Potential Measures:

- Medication adherence
- Attendance at nutrition visits and/or culinary medicine interventions
- Completion of teaching kitchen/cooking classes
- Dietary quality scores
- Chronic Condition Self-management confidence

Clinical Objective 5: Increase participation in complementary federal nutrition programs.

Ensure all eligible participants are participating in nutrition programs, such as SNAP and WIC.

Potential Measures:

- % screened for SNAP/WIC
- % referred
- % successfully enrolled

Appendix 9: Additional Details about FIM Programming

Medical Nutrition Therapy

MNT is currently a reimbursable service for patients with certain eligibility criteria, which is dependent upon the payor. When FIM participants are eligible for such a service, it is strongly encouraged to increase comprehension and facilitate behavior change.

Culinary Medicine

Culinary medicine services may include micro-engagements, demonstration-based education, virtual or hybrid education, and full experiential classes, which are defined below:

- **Micro-engagement:**
  A short 15–30-minute experiential touchpoint. This could include a tasting, quick skill-building moment, produce prescription add-on, pantry activation, recipe introduction, or practical "how do I use this food?" engagement.

- **Demo engagement:**
  A more structured culinary medicine demonstration, usually 30–60 minutes. This could include recipe demonstration, condition-informed nutrition education, food skills, flavor-building strategies, and tasting.

  Full culinary medicine class:
  A larger experiential class, usually 60–90 minutes, that may include hands-on preparation, deeper nutrition education, facilitated discussion, tasting, take-home recipes, behavior change support, and more coordination.

Class size may vary by setting, with micro-engagements and demonstrations generally serving 20–30 participants, and full hands-on classes generally serving 16–20 participants. Virtual and hybrid offerings may reach larger groups and provide an accessible, flexible resource for participants who face significant time, transportation, caregiving, mobility, or scheduling burdens.

Example of Medicaid Credentialing: Community Servings

One example of a community-based organization that has utilized State funds to become credentialed with Medicaid (and thus, able to bill Medicaid) is Community Servings. Community Servings is a medically tailored nutrition provider based in Massachusetts that has been in operation since 1990. The FIM Task Force has consulted with Community Servings as they are considered one of the leaders in MTM production and distribution. With considerable public and private funding, Community Servings invested in key technology and infrastructure enhancements to participate as a provide in the Massachusetts' Medicaid 1115 waiver Health-Related Social Needs (HRSN) program.

Phase one of the infrastructure enhancements to allow for billing payors for FIM services included a HIPAA gap assessment, Salesforce optimization and integration, integration software with our shipping partner, IT staffing, and administrative support. Funding from MassHealth and foundation partners supported this work. During the second phase, Community Servings again received additional funding from MassHealth to support Application Programming Interface (API) development, additional Salesforce enhancements, claims billing software and support, staff time, and administration. This work required augmented funding, from private sources, to fund the full scope of enhancements necessary to participate in the HRSN program. Substantial prior investments made by the agency, including in the areas of HIPAA compliance work, Client Relationship Management (CRM) enhancements, IT infrastructure and training, and claims billing capabilities, supported Community Servings ability to participate as an HRSN provider.

An example grant agreement of the type utilized by Community Servings is available here: https://hria.org/wp-content/uploads/2025/02/HRSN-Integration-Fund_Model-Grant-Agreement.pdf

When we prescribe food,
we prescribe health.

