HCPLAN
Health Care Payment Learning & Action Network

Applying the Evidence-Based Prevention Continuum:

Advancing Health and Value Through Nutrition-Focused Interventions



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Advancing Health and Value Through Nutrition-Focused Interventions



Despite emerging evidence that certain nutrition interventions can improve chronic condition outcomes and reduce associated hospitalizations, there is a lack of consensus among payers and funders* on whether or how to invest in, test, evaluate, and scale nutrition interventions through the health care system. This brief aims to address that gap by building on the Health Care Payment Learning and Action Network (HCPLAN) Evidence-Based Prevention Continuum. It demonstrates how payers can use evidence to inform decisions about coverage, payment, and benefit design, and how funders can use the same evidence to identify gaps and create sustainable, scalable value.

Defining "Nutrition Intervention"

A health care-connected service or program that uses nutrition support to improve health. Examples include:

- **Food is Medicine/Food for Health:** Connecting people to nutritious food as part of health care, including medically tailored meals and produce prescriptions.
- **Nutrition-oriented structured lifestyle changes:** Supporting long-term healthy habits through nutrition counseling and/or dietary behavior modification.

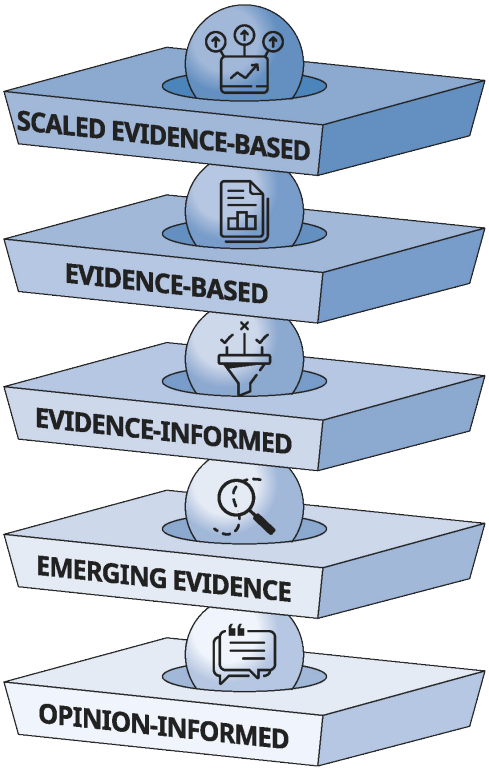
This brief focuses on nutrition interventions that can be reimbursed by and/or delivered through the health care system. Payers and funders can play several roles in the delivery of these interventions. These may include, for example, covering nutrition services as clinical benefits, funding nutrition-related research, investing in start-up companies developing new nutrition interventions, or partnering with community organizations to support delivery.

Using the Evidence-Based Prevention Continuum

Different payers and funders require different levels of evidence before they are willing to take action, and they ask different questions of that evidence. The Evidence-Based Prevention Continuum establishes a clear framework for advancing evidence generation and implementing evidence-based preventive interventions as part of permanent care delivery and payment models. The Continuum is essential because the standards, risks, and evaluation associated with preventive interventions differ significantly from those of other medical interventions.

*For the purposes of this brief, "payers" includes any entity that pays for or finances the delivery of health care services, including public payers (e.g., Medicare, Medicaid), and private health plans (e.g., commercial plans, employer-sponsored plans, Medicare Advantage, Medicaid Managed Care) and "funders" includes private equity, venture capital, philanthropic groups, and research funders (e.g., NIH, FDA, ARPA-H).

Unlike other evidence-grading tools, the Continuum is built from the payer and funder perspective. It creates a shared language for matching the strength of evidence to the typical level of payer or funder action based on the magnitude and certainty of an intervention's net benefit on health outcomes and implementation efficacy.



Existing evidence is robust, multi-centered, and widely scaled: Evidence may allow for the comparison and measurement of the effectiveness of different implementation strategies on health and implementation outcomes

Existing evidence is convincing: Evidence may be comprised of sufficient well-conducted studies of appropriate design that demonstrate consistent and precise results focused on health outcomes, and are generalizable to the intended U.S. population and setting

Existing evidence is adequate: Evidence may support the intervention's impact on health outcomes but have one or more significant limitations, such as the appropriateness of study design, quality of studies, applicability of results, overall precision, and/or heterogeneity of the outcomes

Existing evidence is nascent: Interventions in this category may require greater appropriateness of study design or quality, applicability of results, overall precision, reliability, and replicability

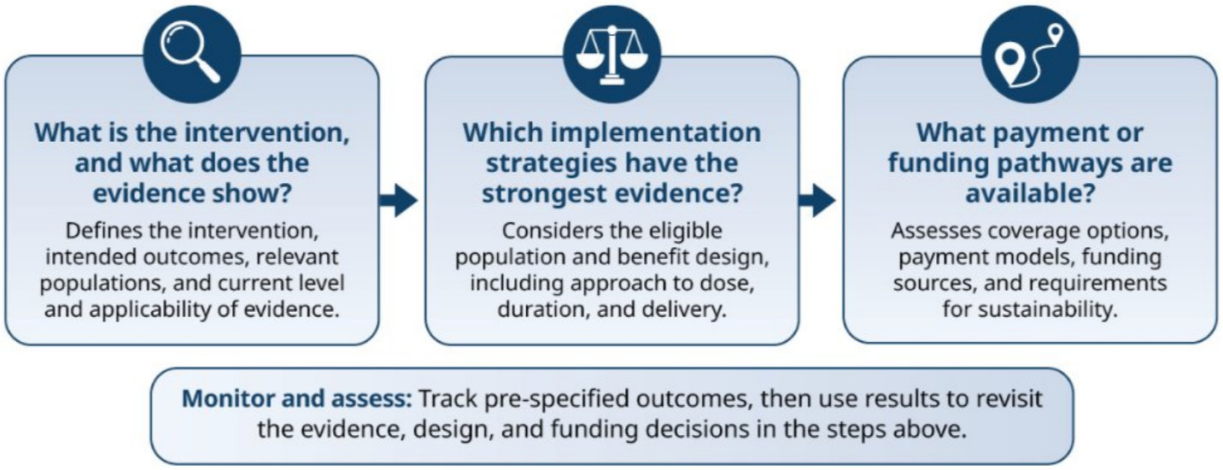
Reported claims are suggestive of a possible health benefit: Support for interventions in this category is based on factors such as satisfaction surveys, personal experience, testimonials, or clinical observation in a routine case

The Evidence-Based Prevention Continuum: five levels of evidence strength, from opinion-informed to scaled evidence-based.

- Interventions at the **Evidence-Based** and **Scaled Evidence-Based** levels are generally ready for broad integration into health care coverage.
- Interventions in **Emerging Evidence** or **Evidence-Informed** levels may be appropriate for limited pilots or targeted populations as a means of developing further evidence.
- Interventions that are **Opinion-Informed** require further evidence generation before taking the risk of scaling to broader populations.

When interpreting the Evidence-Based Prevention Continuum, payers and funders should consider the type of evidence available. For example, the Centers for Disease Control and Prevention (CDC) notes that, "evidence-based decision making occurs when the best available research evidence is combined with the experiential evidence of field based expertise and contextual evidence."[1] Evidence may demonstrate that an intervention works under specific conditions, but outcomes may differ when the intervention is implemented in another setting. Payers and funders should consider the population studied, the amount and duration of the intervention, and how it was delivered. These contextual factors may influence whether an intervention achieves similar results in practice.

This brief defines three questions to support payer and funder decision-making:



Three questions for guiding implementation and payment decisions: evidence, implementation strategy, and payment pathway, revisited through ongoing monitoring.

Together, these questions help payers and funders use the available evidence to move from understanding an intervention, to designing it well, to covering it or funding further research.

This brief illustrates how the Evidence-Based Prevention Continuum can be applied to four illustrative nutrition-focused intervention categories and is intended to support payers and funders in their assessment of nutrition interventions. *Importantly, these interventions are not intended to reflect a comprehensive list of all nutrition interventions or a set of clinical practice recommendations*.

Illustrative Nutrition-Focused Intervention Categories

Medically Tailored Meals (MTMs)

Fully prepared meals designed to meet the clinical nutrition needs of individuals with serious, complex, or chronic conditions.

Medically Appropriate and Medically Tailored Groceries (MTGs)

Unprepared foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients.

Medical Nutrition Therapy (MNT) and Nutrition Counseling

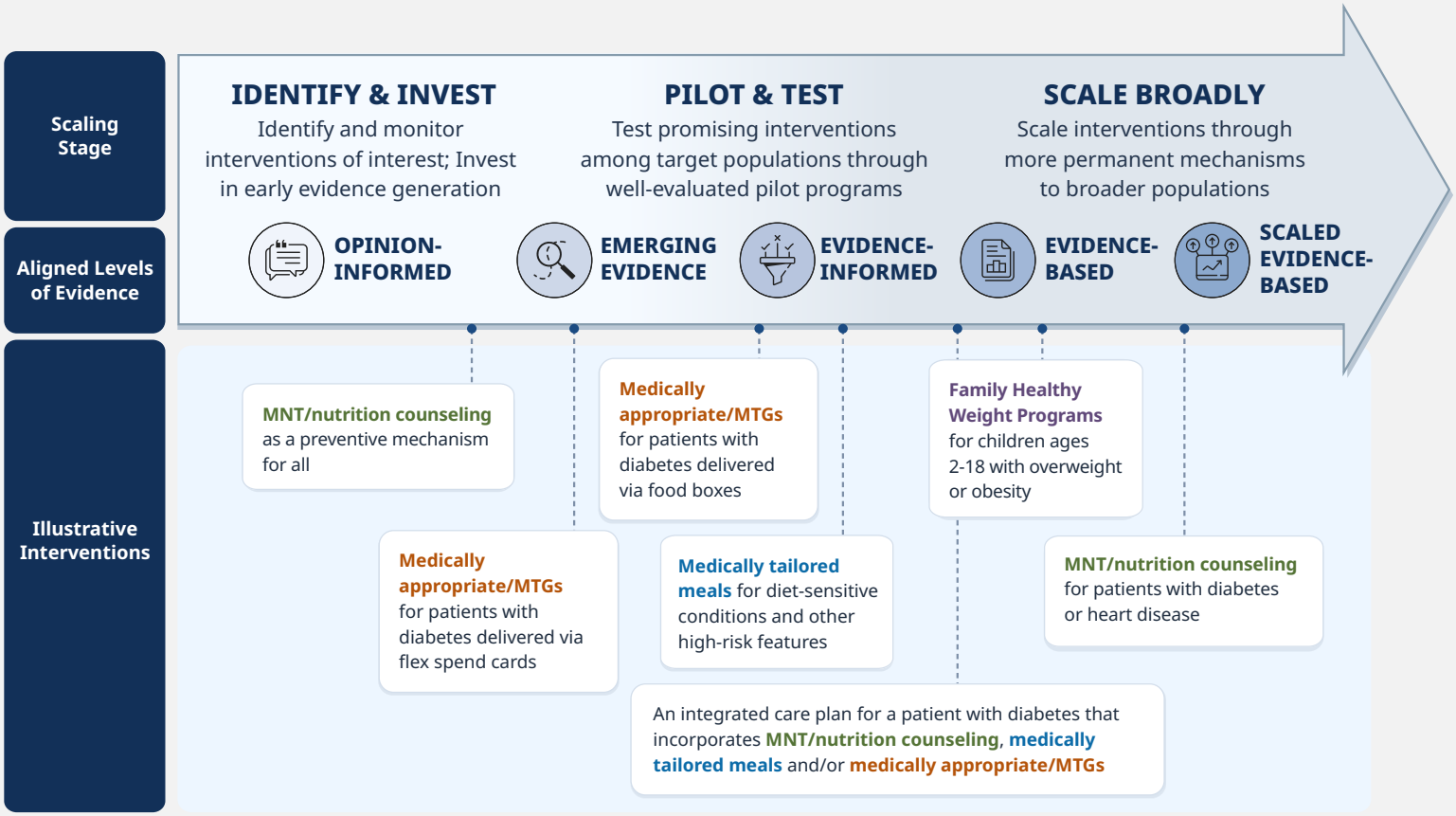
A clinical service delivered by a qualified nutrition professional that supports individuals in developing and sustaining the knowledge, skills, behaviors, and competencies needed to improve dietary patterns and health outcomes.

Lifestyle Change Interventions

Intensive health behavior and lifestyle treatment programs focused on nutrition, physical activity, and positive behavior changes.

Importantly, nutrition interventions are often offered through an integrated approach, which may be more effective than when they are delivered on their own. The following sections explore the evidence for each intervention. The **Integrating Nutrition Interventions** section and **Spotlights** show how these interventions can work together in practice.

Illustrative Nutrition Examples on the Evidence-Based Prevention Continuum



Illustrative nutrition interventions mapped to scaling stages and levels of evidence.

Placement of each intervention along the Continuum above reflects the available evidence and consensus among members of HCPLAN's Evidence-Based Prevention Workgroup. These placements are illustrative and should not be read as a linear ranking of interventions. The visual is intended to convey that implementation effectiveness, and the amount of available evidence may vary based on factors such as delivery mode (e.g., food boxes versus flexible spending cards for healthy groceries) and population (e.g., patients with heart disease versus the general population for nutrition counseling).

Using the Evidence-Based Prevention Continuum to Guide Implementation and Payment Decisions: Four Case Studies



Medically Tailored Meals

What are medically tailored meals (MTMs), and what does the evidence show?

MTMs are fully prepared meals designed to meet the clinical nutrition needs of individuals with serious, complex, or chronic conditions.[2] Meal plans are developed or reviewed by a Registered Dietitian Nutritionist (RDN) and tailored to the recipient's diagnosis, dietary requirements, functional needs, and care plan.[2]

Tailoring may occur at the individual or defined-population level, and MTM models may vary in meal frequency and duration, including short-term discharge programs and longer-term benefits. Unlike general food assistance programs, MTMs are linked to a clinical or nutrition objective and should include appropriate nutrition oversight, quality standards, and monitoring.

Using the Evidence-Based Prevention Continuum, current evidence supports MTMs as a promising, Evidence-Informed intervention for select, high-risk groups. This includes individuals with diet-sensitive conditions, meaning conditions whose management or outcomes are strongly influenced by diet, such as diabetes and heart failure. Given this evidence base, MTMs may be well-positioned for additional large-scale demonstrations to generate further clinical and implementation evidence that might move MTMs across the Continuum.

Results from randomized trials vary by population. In a 10-week trial of post-discharge MTMs among adults with heart failure, diabetes, or chronic kidney disease, MTMs did not reduce all-cause hospitalization at 90 days.[3] However, exploratory analyses found lower all-cause mortality and fewer hospitalizations among participants with heart failure.[3] Similarly, an 8-week trial of culturally tailored MTMs among patients with heart failure in the Navajo Nation reduced all-cause hospitalizations and emergency department visits, and reduced heart failure hospitalizations.[4]

These findings suggest that MTMs may be most beneficial for targeted groups, such as patients with heart failure. These two studies also demonstrate differences in the overall evidence base for MTMs which varies in the level of tailoring, study design, sample size, comparison groups, and generalizability.[3–12]

Which implementation decisions may affect evidence applicability and outcomes?

***Eligible Population*:** MTMs are most consistently associated with lower health care use when targeted at members with a defined diet-sensitive condition and elevated clinical risk. Examples include people with cardiovascular disease,[3, 4] chronic kidney disease, depression, diabetes, or high comorbidity.[7]

***Benefit Design*:** Benefit-design elements – including volume, frequency, duration, level of tailoring, cultural and contextual tailoring, delivery setting, reassessment processes, and integration with other services – may determine which evidence is most relevant and applicable. Payers and funders should consider how closely the design of the program reflected in the evidence aligns with the program they are considering.

- ***Dose*:** Meal volume, composition, and frequency should be based on the target population, clinical objective, and available evidence. Typically, this is 10 meals per week.[7, 8]
- ***Duration*:** MTMs may be provided for a short-term period, such as four weeks following hospital discharge, or as a longer-term service over six to eight months or longer when individuals have ongoing clinical or nutrition-related needs. Payers and funders might establish reassessment and renewal criteria to help determine duration of the service to increase program targeting and efficiency.[13]
- ***Delivery*:** Home-delivered MTMs have the largest evidence base to date; however, other less common delivery models include in-clinic and community-based pickup locations (e.g., food pantries, schools). Evidence and implementation considerations may differ across these delivery settings. Additionally, evidence supports pairing home-delivered MTMs with nutrition counseling, discharge planning, and care-management referral workflows to increase effectiveness.[6] Existing evidence supports models that deliver MTMs through commercial and/or nonprofit vendors that can demonstrate RDN-led clinical tailoring, cultural and dietary accommodation, food safety, and reliable delivery.[4,14]



What payment or funding pathways are available?

The examples below illustrate available payment and funding approaches. Readers should refer to applicable payer- and program-specific benefit information for additional details regarding eligibility, coverage, and duration.

Payment Pathway	Additional Information
Medicare Advantage	Medicare Advantage plans may provide MTMs through two pathways: primarily health-related supplemental benefits for a limited period, such as after hospitalization or surgery, or Special Supplemental Benefits for the Chronically Ill (SSBCI) for qualifying chronically ill enrollees, potentially on an ongoing basis, when the meals are reasonably expected to improve or maintain the enrollee's health or function.[15]
Medicaid Section 1115 demonstrations	States can test MTM coverage for defined high-risk populations (typically those with a qualifying condition plus food insecurity, capped around six months with reassessment) as part of broader demonstrations; several states have approved waivers although CMS rescinded its 2023 and 2024 health related social needs coverage guidance in March 2025 and now reviews new and renewal requests case by case.[6,7]
Medicaid managed care in lieu of services	Medicaid managed care plans may cover MTMs as an in lieu of service (ILOS) when the state permits the approach and the meals are medically appropriate and cost-effective substitutes for, or expected to reduce the need for, covered services or settings such as inpatient or skilled nursing facility care.[6,7]
Commercial payers	Commercial payers can offer MTM benefits directly as a covered benefit, giving them latitude over eligibility and duration. Kaiser Permanente, Elevance, and Geisinger are examples of private payers that provide MTM benefits.[6]
Hospitals, health systems, and clinics	For some patients, health systems, hospitals, and clinics can fund MTMs directly through operating budgets, population health and quality-improvement programs, transitional-care initiatives, community-based resources, or other prevention and care-delivery investments.[16–18]
Research Funders	Federal and philanthropic research funders support randomized trials that test whether MTMs improve outcomes for specific conditions, including diabetes, human immunodeficiency virus (HIV), and heart failure, and whether culturally tailored approaches work for particular communities.[4,12,19]
Investors	Health plan foundations and other grant makers fund community-based providers to expand meal production, delivery, and staffing so that more patients can be served and pilots can be run.[20] Investors finance scale-up infrastructure in MTM companies, such as technology, operations, and referral and delivery systems.[21,22]



Medically Appropriate and Medically Tailored Groceries

What are medically appropriate and medically tailored groceries (MTGs), and what does the evidence show?

Several interventions focus on providing medically appropriate and MTGs to members, comprised of foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the diet-sensitive health conditions of the recipients.[23] Medically appropriate groceries are preselected for a group's shared conditions without individual assessment, while MTGs add an individual nutrition assessment and personalized plan, typically involving an RDN. Programs use varying terms for this distinction.[24] Interventions focused on delivering groceries may include those which provide food directly through food boxes, preselected grocery packages, or grocery delivery, or through benefits such as cash, flex cards, or vouchers that allow members to select their own food.[23,25] Programs that provide fruits and vegetables through vouchers, debit cards, produce boxes, retail partnerships, or direct food distribution are commonly referred to as "produce prescriptions."[23]

Using the Evidence-Based Prevention Continuum, these interventions are best characterized as having Emerging Evidence. Existing evidence is largely drawn from real-world, observational studies, and implementation evaluations, while evidence of consistent improvements in clinical outcomes remains limited.[26–29] Recent randomized trials also report mixed results. A trial of home-delivered MTGs among Medicaid-insured adults with type 2 diabetes lowered HbA1c by 0.40 percentage points relative to usual care. A trial of an intensive grocery-based program with dietitian support found no difference in HbA1c relative to usual care.[30–32] The strength and applicability of the evidence vary based on the target population, food package or benefit design, delivery mechanism, benefit amount and duration, accompanying services, study design, and outcomes measured.[25]

Which implementation decisions may affect evidence applicability and outcomes?

***Eligible Population*:** Eligible populations for these benefits are typically defined by clinical criteria, such as documented chronic conditions and screened food insecurity.[33,34] Evidence to date suggests benefits are most consistently observed among patients with cardiometabolic diseases, such as diabetes and cardiovascular diseases, dual-eligible adults, and food-insecure populations meeting these defined criteria, though data is limited on whether narrower targeting itself drives stronger outcomes versus other program factors.[35–38] Payers and funders should also assess whether members have the cooking capacity, storage, transportation, equipment, caregiver support, and household stability needed to use groceries safely and consistently.

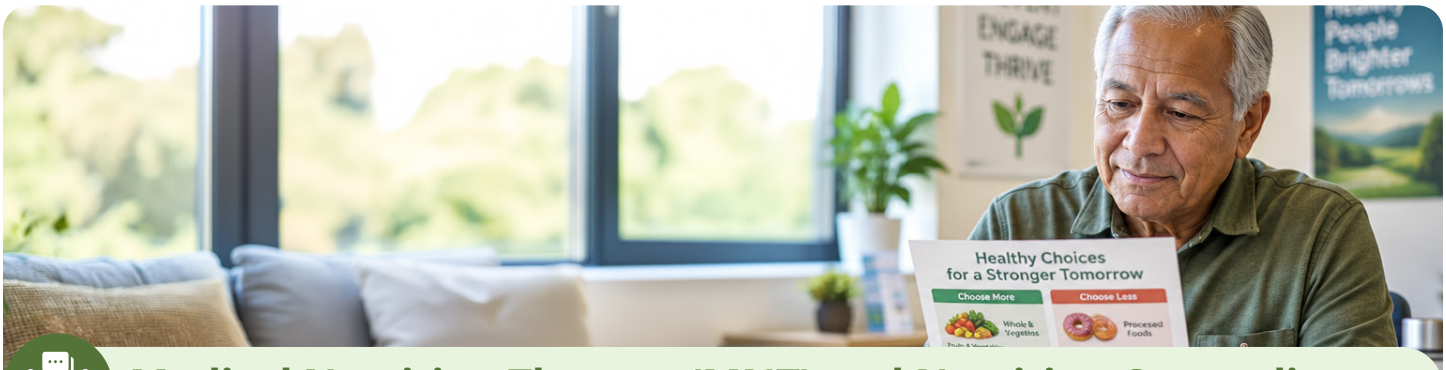
***Benefit Design*:** Because medically appropriate and MTGs can be delivered through several models, payers and funders must decide whether to offer pre-selected foods or allow members to choose.

- ***Dose*:** Medically appropriate and MTGs should consider dietary composition and intensity, and may either be delivered via spend allowance (e.g., $50 to $200 USD per month), or delivery of food boxes (e.g., weekly or biweekly) measured by weight (e.g., 10 pounds) or the amount of food provided (e.g., 6-9 types of produce or groceries for 10 meals).[38]
- ***Duration*:** The intervention may be episodic, short-term, or ongoing depending on the population and objective. Duration should reflect the expected time to impact and whether the goal is to address an immediate nutrition need, support a transition in care, or promote sustained dietary and clinical change. Generally, patient health outcomes appear to improve after 3 to 6 months.[25]
- ***Delivery*:** Several key decisions affect the level of evidence:
  - ***Individual autonomy*:** Pre-selected boxes or packages may reduce administrative burden, increase adherence, and increase impacts on healthy eating (e.g., by providing healthy foods not normally purchased),[36] while purchasing power models, such as flex spend cards, increase participant choice, improve acceptability, and may reduce waste. Examples include:
    - *Direct Provision:* Food pantry partnerships with food box home delivery and/or in clinic "food farmacy" pick up.[28]
    - *Purchasing Power:* Online and in-person grocery e-debit cards (e.g., commercial plans, Medicaid waivers), or flex spend cards (e.g., Medicare Advantage, some commercial plans).[35,39]
  - ***Delivery partner*:** The organization chosen to deliver the groceries may also affect how the evidence applies to a specific population. Payers and funders might consider the following considerations:
    - Local organizations may be more embedded in communities and have more robust cultural competency and personalized experience to improve member uptake and participation. Examples include community-based organizations or food pantries.
    - National companies may be more efficient given their larger scale, be more readily available to deploy more resources, have the ability to reach more rural areas, and have the ability to bill health care for services. Examples include commercial vendors or retailers.

What payment or funding pathways are available?

The examples below illustrate available payment and funding approaches. Readers should refer to applicable payer- and program-specific benefit information for additional details regarding eligibility, coverage, and duration.

Payment Pathway	Additional Information
Medicare Advantage	Medicare Advantage plans may offer Flex Spend Cards through SSBCI.[33]
Medicaid Section 1115 demonstrations	Medicaid nutrition supports can be implemented through state Section 1115 demonstration waivers. For example, through the Flexible Services Program in Massachusetts, accountable care organizations (ACOs) can fund nutrition interventions for qualifying members.[40]
Commercial payers	Commercial payers and integrated systems may offer grocery benefits directly or through pilots, vendor contracts, value-based arrangements, or other plan-funded approaches.[41]
Hospitals, health systems, and clinics	Hospitals and clinics can partner with community-based organizations and nonprofits funded by philanthropic or government grants to refer patients for medically appropriate MTGs.[28, 42]
Research Funders	Federal research funders support randomized trials that test whether medically appropriate and MTGs improve outcomes for specific populations, such as adults with obesity and food insecurity and patients with high-risk pregnancies.[43, 44] These trials also test the effectiveness of pairing interventions such as MTGs with other interventions such as nutrition education.[44]
Investors	Investors often finance companies that pair groceries with dietitian support and work with insurers and health systems so providers can prescribe food. Investors fund the technology, fulfillment, and partnerships these programs require.[45, 46]



Medical Nutrition Therapy (MNT) and Nutrition Counseling

What is medical nutrition therapy (MNT) and nutrition counseling, and what does the evidence show?

MNT is a personalized, nutrition-based treatment plan which may include nutrition assessment, diagnosis, intervention, and monitoring. Nutrition counseling and education are a component of MNT, delivered by an RDN or other qualified nutrition professional who supports individuals in developing and sustaining the knowledge, skills, behaviors, and competencies needed to improve dietary patterns and health outcomes.[47,48] Through personalized assessment, nutrition diagnosis, goal setting, behavior-change support, and ongoing monitoring, these services help individuals prevent disease and manage existing health conditions. They may be delivered as a stand-alone intervention or in tandem with other nutrition interventions and focus on achieving measurable behavior changes that contribute to improved health.

Using the Evidence-Based Prevention Continuum, current evidence indicates that **MNT, including nutrition counseling, is best viewed as an Evidence-Based intervention** across a broad range of clinical indications, including diabetes, hypertension, dyslipidemia, chronic kidney disease, obesity, head and neck cancer, and chronic obstructive pulmonary disease (COPD). Studies have documented clinical improvement and, for several of these conditions, cost-effectiveness when delivered by RDNs.[49,50] Available evidence suggests clinical benefit most often from structured, multi-session counseling delivered by RDNs as part of MNT, whereas brief, low-intensity nutrition counseling on its own has shown smaller or less consistent effects.[48,49,51] This section therefore focuses on MNT.



Which implementation decisions may affect evidence applicability and outcomes?

***Eligible Population*:** Payers and funders should define eligibility around diagnoses or identified health risk, establishing a person-centered care plan with achievable goals, and reassessing as needed to conclude the service if goals are achieved, working with the care team to ensure alignment of goals and outcomes.[52] MNT for cardiovascular disease and its related risk factors (hypertension, dyslipidemia, diabetes, prediabetes, and obesity) make up the majority of the current evidence base.[49,50]

Benefit Design:

- ***Dose:*** Evidence suggests effectiveness at three to six sessions, and the greatest potential improvement in outcomes is associated with five or more contacts with an RDN.[53]
- ***Duration:*** The evidence favors longitudinal, multi-session care over episodic counseling.[49,54]
- ***Delivery:*** There are several different approaches to nutrition counseling, which may impact the efficacy of the program.
  - Format: One-on-one or group; in-person vs. telehealth.[55]
  - Delivery: MNT provided by an RDN vs. nutrition education provided by community health workers.[56,25]



Payers and funders should also decide whether MNT should be linked to broader obesity, diabetes, or maternal health programs.[49] Network adequacy of RDNs and other nutrition providers varies substantially by state, so payers and funders should assess local capacity. Delivery partners should have sufficient credentialed and program-enrolled RDNs, clear billing arrangements (including independent versus incident-to billing), and the ability to document care, including assessment, diagnosis, intervention, and monitoring/evaluation. Structural gaps, such as health condition limits, caps on visits per year, networks with too few RDNs and unclear referral pathways that primary care teams do not consistently use, have led to low referral rates to RDNs even where coverage exists.[51]

What payment or funding pathways are available?

The examples below illustrate available payment and funding approaches. Readers should refer to applicable payer- and program-specific benefit information for additional details regarding eligibility, coverage, and duration.

Payment Pathway	Additional Information
Medicare Part B MNT Benefit	Original Medicare covers MNT only for diabetes, non-dialysis chronic kidney disease, and up to 36 months post-kidney transplant. Coverage requires physician referral and allows for three hours covered in year one and two hours annually thereafter.[57, 52] Medicare Advantage offers the same benefits as Medicare Part B, and some plans may choose to offer more.[58]
Medicaid state plan or managed care coverage	State approaches vary, but Medicaid can create payment pathways for and/or establish coverage for MNT via a state plan amendment (SPA) or through managed care benefit design, most commonly for chronic conditions and maternal-child populations.[51]
Commercial payers	Affordable Care Act-compliant plans and employer plans may cover RDN services for chronic conditions or risk reduction.[51] ACOs, medical homes, and specialty risk programs can include RDN services as part of chronic disease management and total-cost-of-care strategies.
Research Funders	MNT is already a covered benefit by some payers, so research funders and investors more often support new delivery models and access than basic evidence of effectiveness. Federal research funders and professional associations support trials that test how MNT works when delivered through telehealth, alone or alongside other services such as MTMs, and how dietitian-led programs perform in primary care.[59, 60]
Investors	Investors may finance the growth of virtual dietitian networks, including the technology, clinical workforce, and payer and health system partnerships needed to deliver insurance-covered care at scale, and in some cases add services such as lab testing and medication management.[61] This support helps test new delivery approaches and builds the evidence payers use to widen coverage.



Lifestyle Change Interventions

What are lifestyle change interventions, and what does the evidence show?

Lifestyle change interventions are Evidence-Based and Evidence-Informed behavior change interventions that, at minimum, aim to introduce and sustain positive behaviors in nutrition or physical activity. They follow a structured plan, often over multiple sessions, using an evidence-based curriculum delivered by a trained instructor or coach to individuals or groups. They build practical skills, such as cooking, grocery shopping, or healthy movement, to help adults and children improve wellness and prevent or manage chronic disease. Many are packaged for a specific condition, such as diabetes prevention or childhood obesity, but they share similar approaches. They are often delivered in community or non-clinical settings, and referrals can come from a health care provider, a community organization, or the person themselves. Examples include:

- Family Healthy Weight Programs (FHWPs)
- National Diabetes Prevention Program (DPP)
- Diabetes Self-Management Education and Support (DSMES)

We further explore **Family Healthy Weight Programs** to demonstrate a nutrition intervention targeted towards families and children.

Lifestyle Change Intervention Example: Family Healthy Weight Programs

What are family healthy weight programs (FHWPs), and what does the evidence show?

FHWPs are intensive health behavior and lifestyle treatment programs focused on nutrition, physical activity, and positive behavior changes.[62] While FHWPs are targeted towards children, evidence suggests that childhood obesity prevention and treatment require engagement of both children and caregivers, with interventions tailored to the family's environment, routines, and goals. Using the Evidence-Based Prevention Continuum, current evidence indicates that FHWPs are Evidence-Based for children with overweight or obesity. In addition to reducing or stabilizing a child's weight or body mass index (BMI), some studies report that FHWPs reduce parent or caregiver weight, improve metabolic markers, such as blood pressure and lipids, improve health-related quality of life, nutrition, physical activity and associated behaviors, and improve parental stress, self-efficacy, and quality of life.

Evidence is strongest for recognized programs with adequate contact time.[62–65] Several national organizations, including the U.S. Preventive Services Task Force (USPSTF) and the 2023 American Academy of Pediatrics Clinical Practice Guidelines, recommend at least 26 contact hours of intensive behavioral interventions for children and adolescents six years or older with a high BMI (>95th percentile for age and sex). The recommendation states effective interventions consist of multiple components including sessions targeting both the patient and child, offering group sessions, providing information about healthy eating, safe exercising, monitoring diet and physical activity, and goal setting. FHWPs follow these guidelines to help treat childhood obesity.[66,67] Bright Futures also recommends FHWPs.[68] Recent CDC-funded studies of FHWPs in low-income settings were associated with modest improvements in children's weight for their age and sex, with results varying by the number of contact hours a family attended.[63–65]

Which implementation decisions may affect evidence applicability and outcomes?

Eligible Population: Children ages 2 to 18 with overweight (BMI at or greater than 85th percentile for age/sex) or obesity (BMI at or greater than 95th percentile for age/sex) and their caregivers.[62]

Benefit Design: When designing plan coverage, payers should assess their covered populations' context, including rurality, staff capacity, and health care access. Flexible coverage for delivery staff, location, and virtual options is critical to ensure FHWPs are accessible, effective, and delivered to those most in need. Additionally, youth outcomes should be considered differently from adult outcomes for lifestyle interventions. Outcomes such as quality of life, physical activity measures, and dose received should be considered for youth, rather than BMI related outcomes, as these are uniquely related to age, sex, and height changes.[66]

- ***Dose:*** FHWPs are intensive, offering at minimum 26 intervention hours.[69,70]
- ***Duration:*** FHWPs should be delivered over 3-12 months.[69,70]
- ***Delivery:*** FHWPs may be delivered through health care systems, community-based organizations, public health agencies, schools and community partners, or hybrid models with clinical and community delivery. FHWPs can be delivered via telehealth, in person or often a combination of the two. Programs frequently rely on multidisciplinary teams that may include medical providers, RDNs, community health workers, health coaches, behavior specialists, and other trained staff. Intervention delivery may occur alongside traditional medical visits. Health coaches, community health workers, care coordinators, and group facilitators often perform critical functions necessary for program success.

What payment or funding pathways are available?*

The examples below illustrate available payment and funding approaches. Readers should refer to applicable payer- and program-specific benefit information for additional details regarding eligibility, coverage, and duration.

Payment Pathway	Additional Information
Medicare	Original Medicare and Medicare Advantage plans do not currently offer FHWPs as a benefit, as the primary beneficiary of a FHWP is the child.
Medicaid	Medicaid coverage of FHWPs varies from state to state. Medicaid can cover FHWPs as medically necessary preventive treatment under the Early and Periodic Screening, Diagnostic, and Treatment benefit.[69] States may also establish a defined FHWP benefit through a SPA or waivers.[69]
Commercial payers or Medicaid Managed Care	Current health care reimbursement is largely based on fee-for-service (FFS) and clinical billing and varies based on service and condition specific limitations. A bundled or hybrid FHWP payment could combine FFS billing (which includes codes for medical services, MNT, health and behavior, nutrition education, care coordination). This would ensure coverage of services: 1) by staff including RDNs, behavioral health providers, community health workers, or health coaches; 2) location of service including clinical settings, virtual delivery, community-based organizations. In cases of community-based FHWP delivery of services, the community-based organization may contract directly with the clinical entity or the payer and receive payment through invoice agreements (e.g. a value-added service), value-based care arrangement rather than traditional FFS billing to ensure coverage of all services delivered for the FHWP intervention. This mechanism would ensure tracking the service for value and impact vs FFS, with codes that are used for typical care.[70]
Research Funders	Research funders may support large trials that test whether family-based treatment can be delivered in primary care and compare models of intensive treatment, in part to address the high cost and limited insurance coverage of such programs.[71] Public health agencies fund teams to adapt and test programs so they can be sustained in real-world settings, particularly for families with lower incomes.[72]
Investors	Investors may finance virtual pediatric care companies that deliver family-centered care, drawing on pediatric guidelines and combining behavioral, nutrition, and medical services.[73, 74] This support helps programs reach families in areas with few treatment options and builds the implementation evidence payers use to expand coverage.

*As noted above, programs providing the set of services covered by FHWPs have had a Grade B recommendation by the USPSTF since 2010. This means that all payers, including Medicaid, commercial, and employer plans (and Medicare at CMS discretion) are required to cover this set of services at no cost to the beneficiary.[67]

Integrating Nutrition Interventions

Nutrition interventions should not be viewed as isolated benefits or interchangeable options. Their effectiveness depends on how well they are matched to a member's clinical needs, food access, readiness, and care plan, and how effectively they are connected to referral, enrollment, care coordination, and follow-up processes. Therefore, nutrition interventions may be viewed as complementary "building blocks" allowing payers and funders to mix and match components of different interventions to meet member needs.

An integrated model may consider the following:

Identify and refer: Establish clear eligibility criteria and referral pathways from primary care, specialty care, hospitals, care managers, and community partners.

Enroll and assess: Confirm member eligibility, address barriers to participation, and assess clinical needs, food access, preferences, cultural considerations, and ability to use the benefit.

Develop a nutrition care plan: Define the clinical or health objective, select the appropriate intervention or combination of interventions, and establish the expected duration and reassessment process.

Coordinate delivery: Connect the intervention to providers, care managers, community organizations, and vendors. Where feasible, share relevant information with referring providers and incorporate updates into clinical workflows or electronic health records.

Reassess and transition: Monitor progress and determine whether to continue, modify, step down, or conclude the intervention based on the member's needs and goals. For example, a member receiving MTMs may be able to transition to MTGs with supplementary nutrition counseling or MNT.

Measure and improve: Track referrals, enrollment, participation, intervention dose and duration, transitions between interventions, health outcomes, utilization, member experience, and data exchange with the care team. Where demand exceeds program capacity, payers and funders can enroll eligible members in randomized or staggered order to create a comparison group.



In practice, nutrition interventions are often implemented using this integrated approach. See the spotlight examples below for more information and examples of coordinated care. By applying the Evidence-Based Prevention Continuum, payers and funders can assess how evidence for an intervention varies across populations and implementation approaches, then tailor interventions to improve health outcomes for their members.

Looking Ahead: Building the Evidence Base

The interventions and discussion in this brief reflect the evidence currently available, not the limits of what nutrition interventions can achieve. Many interventions defined as Emerging Evidence or Evidence-Informed have not yet been tested at varying intensities, in different populations, or with sustained support. Some of this evidence points to potential for nutrition interventions to alter the physiology underlying specific chronic conditions.[75, 76] Payers and funders can help close these gaps by designing pilots and trials that test benefit design (including dose, duration, and delivery), use randomized or staggered enrollment where demand exceeds capacity, and measure outcomes such as clinical improvement, utilization, and total cost of care. Funding comparative and cost-effectiveness research will also help clarify which interventions work best, for whom, and in what combination. As the evidence grows, the Evidence-Based Prevention Continuum can be used to update where interventions fall and how payers and funders act on them.



Appendix

Spotlight Examples Key

Spotlight example uses medically tailored meals

Spotlight example uses medically appropriate and/or medically tailored groceries

Spotlight example uses medical nutrition therapy and/or nutrition counseling

Spotlight example uses a lifestyle change intervention

Spotlight Examples
Medically Tailored Meal Organization[7,77,78]
• *Overview*: A nonprofit organization delivers MTMs (10 meals/week plus snacks) tailored by an RDN to Medicaid members with diet-sensitive conditions and food insecurity over the course of six months with the possibility of renewal. • *How it is paid for*: Regional ACOs paid the nonprofit organization a flat weekly rate per person to cover the full program cost (e.g., food, nutritional counseling, delivery, and administrative/facility costs), under the state's Section 1115 demonstration. • *What we know*: In a propensity-weighted comparison, MTM receipt was associated with 31% fewer hospitalizations, 20% fewer ED visits, and $3,433 lower total health care costs per person, with health care savings offsetting 98% of program costs (net cost of $14.90 per person per month); savings were largest for cardiovascular disease and chronic kidney disease patients (-$10,450 and -$12,312 respectively).

Spotlight Examples

Food is Health Technology Platform[79–82]



- *Overview*: A regional commercial health plan provides members with uncontrolled type 2 diabetes (HbA1c>8%) a no-cost, personalized nutrition program that progressively transitions from MTMs to meal kits and groceries, building skills and confidence for lasting dietary change. The program combines four months of food support with six months of dietitian-led counseling, health coaching and a companion app, followed by 12 months of self-directed digital support. Powered by a third-party Food is Health technology platform and local food hubs, the model integrates clinical nutrition, food delivery, and digital engagement into a coordinated, scalable solution.
- *How it is paid for*: The health plan fully funds the program, offering it at no cost to eligible members through a monthly bundled payment. This payment enabled personalized, flexible delivery of food, clinical nutrition services, and digital support based on individual needs and progress.
- *What we know*: Program-reported data indicates that members achieved a clinically significant 1.5-point reduction in HbA1c within six months. For individuals under-65, inpatient costs decreased $153 per member per month and members experienced fewer emergency room visits. Medical costs for Medicare Advantage members who participated in the program were $227 per member per month less compared to non-participants.

Pre-Selected Grocery Boxes[83–86]



- *Overview*: One organization delivers grocery boxes, either on a weekly or biweekly basis, or picked up in community settings, by Medicaid enrollees with a qualifying diet/nutrition-related chronic illness and a qualifying social risk factor. Boxes are sized for household need, tailored for allergies, chewing/swallowing limitations, and cultural preferences, and are delivered by local community-based organizations under contract with regional coordinating entities, alongside monthly nutrition education materials. Although food boxes accounted for the largest share of services provided under the demonstration (75%), members also received fruit and vegetable prescriptions, healthy meals, housing navigation, and other support and sustaining services.
- *How it is paid for*: Services are financed through the state's Section 1115 waiver. Local Human Services Organizations (HSOs) collaborate with other community organizations to design, source, and distribute grocery boxes.
- *What we know*: Participation in the program was associated with reduced emergency department visits and lower overall health care costs, averaging about $85 less in Medicaid spending per enrollee per month.

Federally-Qualified Health Center (FQHC) Cooking Classes and Produce Boxes[90–92]



- *Overview*: An FQHC partners with a local farm/nonprofit to “prescribe” patients weekly produce boxes during harvest season. These boxes are paired with four to six weekly hands-on cooking classes for patients identified with nutrition-related health needs.
- *How it is paid for*: Philanthropically funded, a faith-based hunger relief campaign supports the farm's operations, and a private health foundation funds the cooking education component.
- *What we know*: A pilot evaluation (33 participants, 2022–2023) found significant increases in cooking self-efficacy and diet self-management, with 44% reporting increased vegetable consumption.

Spotlight Examples

Flex Spend Cards for Medically Appropriate Groceries[87–89]



- *Overview*: One national Medicare Advantage insurer offers a prepaid debit card benefit on select plans for dual Medicare/Medicaid-eligible members. Members must be eligible for SSBCI and can purchase medically appropriate groceries (e.g., produce, canned/frozen goods, grains, meat/seafood and pantry staples) in store, online, via app, or by phone, with allowances loaded monthly or quarterly depending on plan.
- *How it is paid for*: Funded directly by the health plan as a supplemental Medicare Advantage benefit, the grocery-specific dollar allowance is plan-specific.
- *What we know*: The organization reports findings from approximately 300,000 dually eligible Medicare Advantage members indicating nutritious food was the most frequently used benefit and members offered higher benefit amounts had $95 per member per month lower medical spending than members offered lower amounts. A subsequent analysis using a longer claims runout and adjudication period strengthens this association. Members offered higher benefits had $197 per-member-per-month lower year-over-year claims spending than the low-benefit group, while members offered medium benefits had $148 per-member-per-month lower spending.
- *Note*: Findings are not causal. Some members receive interventions in addition to the Spendables allowance. Analysis was not designed to quantify net financial impact, but directional findings support further exploring the long-term value and return on investment of these benefits.

Comprehensive Foodcare Platform[93–96]



- *Overview*: A national foodcare platform integrates registered dietitian-led evidence-based nutrition counseling providing personalized foodcare plans and digital meal planning and grocery purchasing with food-is-medicine benefits management inclusive of MTG and meals benefits. The model connects clinical nutrition care with affordable food access, longitudinal behavioral support, and outcomes monitoring across Medicaid, Medicare, and commercial health plan populations.
- *How it is paid for*: Health plans and employers fund foodcare through covered MNT services – integrated food-is-medicine benefits management supporting the most cost-effective approach to managing state, health plan, employer or CMS SSBCI food-is-medicine funding, and value-based arrangements. Programs can combine reimbursable MNT with MTGs or MTMs, with benefit design and duration tailored to clinical needs.
- *What we know*: In a randomized controlled trial among Medicaid members with type 2 diabetes, conducted by Kaiser Permanente and Tufts School of Nutrition, the foodcare platform-delivered groceries and nutrition support produced a statistically significant near half point reduction in HbA1c over six months versus usual care (P=0.016). Food security improved (odds ratio 2.12), and nutrition security nearly doubled to 60% (odds ratio 3.65).

Community Organization Delivery of FHWPs[98,99]



- *Overview*: A community-based organization delivers a medically monitored FHWP receiving primary care referrals for children with overweight and obesity.
- *How it is paid for*: The organization uses an invoice-billing/umbrella hub arrangement model, contracting directly with health plans (state Medicaid and private insurers) for evidence-based prevention services as listed in the billing guide.
- *What we know*: No outcome data is currently publicly available.

Spotlight Examples

Digital Health Company: Low-Carb Diabetes Remission Program[75, 76]

- *Overview:* This digital health program helps people with type 2 diabetes shift to a low-carb diet, paired with ongoing support from a doctor or nurse practitioner and a personal health coach, all delivered remotely through an app. Patients track their weight, blood sugar, and a marker of diet adherence daily, and get regular check-ins and coaching to stay on track.
- *How it is paid for:* Employers and health plans pay for the program as a covered benefit at no cost to the employee or member. The company uses a "pay for results" model. Payers only pay the full fee if patients actually hit health targets like better blood sugar control and coming off diabetes medications.
- *What we know:* The organization funded a one-year study comparing program participants to people receiving typical diabetes care. The low-carb diabetes remission program produced diabetes remission at a rate significantly greater than usual care. Participants on average brought their blood sugar down from a diabetic to a near-normal range, lost about 12% of their body weight, and cut their use of diabetes medications nearly in half. Most people on insulin were able to reduce or stop it entirely. After two years, over half of participants no longer needed diabetes medication to keep their blood sugar controlled.
- *Note:* Participants chose which group to join rather than being randomly assigned.

Biopsychosocial Obesity Treatment Benefits[97]

- *Overview*: A state Medicaid program covers a biopsychosocial obesity treatment benefit pairing family-based behavioral therapy (youth) or intensive behavioral therapy (adults) with medical nutrition therapy, delivered by licensed behavioral health and nutrition providers over a six-month course, for youth with BMI ≥95th percentile and adults with BMI ≥30 referred by a primary care provider.
- *How it is paid for*: The benefit was added through a Medicaid SPA with reimbursement structured around specific individual and group visits at defined points in the treatment pathway (initial evaluation, mid-point re-evaluation, continued treatment decision). The benefit went live for fee-for-service claims first, with managed care coverage following about 10 months later.
- *What we know*: No outcome data is currently publicly available.



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