

# Scaling Food is Medicine Strategies

How payers are partnering  
on medically tailored meals

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# Introduction

Over the past five years, medically tailored meals (MTMs) have gained traction as potentially cost-effective interventions to improve outcomes for consumers and reduce healthcare spending. With new guidance from the Centers for Medicare & Medicaid Services, Medicaid waivers and public support from the U.S. Department of Health and Human Services, MTMs are entering the mainstream as part of a national Food is Medicine (FIM) strategy. New York State has been a leader in integrating MTMs into state Medicaid programs, offering a model for healthcare insurance providers. In collaboration with God's Love We Deliver (GLWD), one of New York's oldest nonprofits focused on MTMs, this piece will explore:

- Current payer sentiments on nutrition and MTM partnerships
- Comparisons of MTM market solution archetypes and considerations for scalability and impact
- Payer perspectives on the future direction and opportunities for FIM solutions

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Medically tailored meals (MTMs) provide customized nutrition support for individuals with specific health conditions. Over the past three years, MTMs have gained prominence as a supplemental benefit within payers' Food is Medicine (FIM) strategies.

We review current payer scope and sentiments on nutrition-based programs, compare MTM provider segments for their reach and effectiveness, and highlight expanding ways for payers and MTM partners to work together. These payer viewpoints, vendor comparisons and future trends offer practical ideas for how MTMs can be best used to address broader health needs and lower healthcare costs.

### What makes a medically tailored meal?

MTMs are ordered by Registered Dietitian Nutritionists (RDNs) to meet nutritional needs for individuals with specific health conditions (e.g., diabetes, heart disease). Unlike other food programs, MTMs offer clinical personalization. Other programs provide more general access to food through services such as meal delivery (e.g., Meals on Wheels), congregate meals at senior centers, food pantries and produce prescriptions.



Image Source: Photo by Lydia Lee for God's Love We Deliver

#### Notes

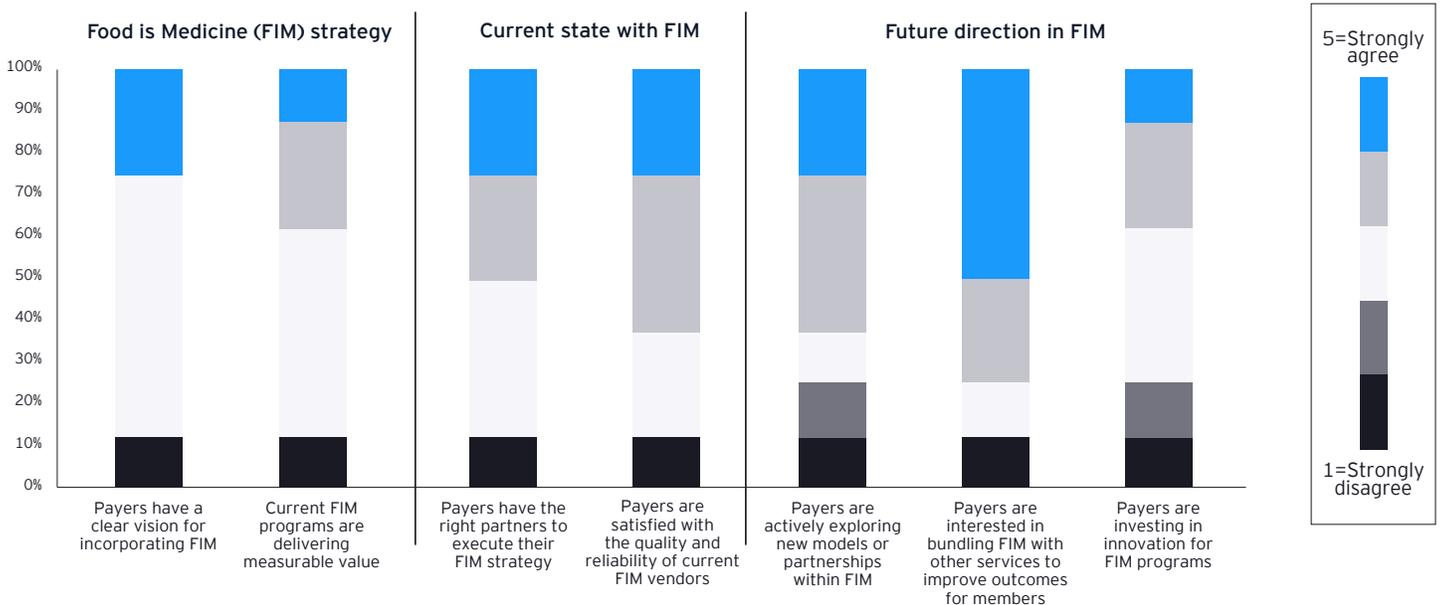
Among frameworks that organize social drivers and nonclinical factors that influence health, the two most prominent are social determinants of health (SDOH) and health-related social needs (HRSN). In this paper, we use the HRSN framework, which addresses individuals' health-related social needs as part of a holistic approach to improving outcomes.

We use the term "consumers" to refer collectively to recipients of MTM or FIM interventions, recognizing that these recipients may be clients, patients or members, depending on the organization that serves them.

## Interview takeaways

Please rate your agreement with the following statement

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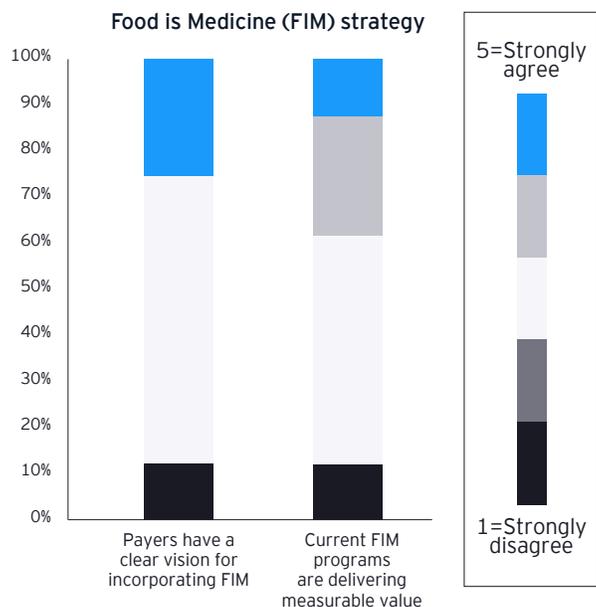
Source: EY-Parthenon interviews and analysis

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# MTM as a key FIM supplemental service

Overall, payers agree that a viable FIM strategy remains a priority. It continues to be essential for Medicaid populations and serves as a valuable supplemental benefit for Medicare Advantage consumers. However, 60% of payer leaders we interviewed expressed neutrality regarding whether payers possess a clear vision for integrating FIM; this suggests an opportunity to better articulate program objectives, demonstrate quantifiable benefits and devise creative solutions for greater impact.

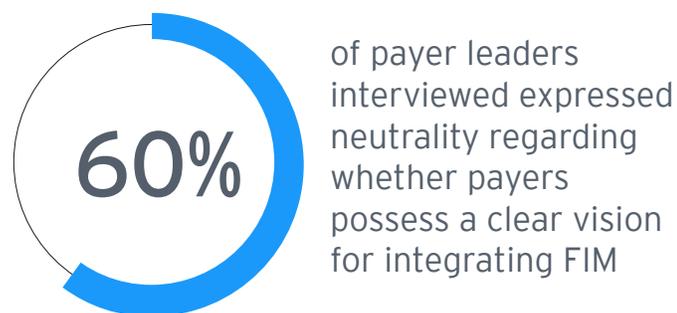




Source: EY-Parthenon interviews and analysis

## What drives payers to provide MTM programs?

Payers who provide MTMs for specific populations (e.g., chronic conditions, post-hospitalization, high social needs) cited multiple drivers, including reducing the total cost of care, improving health outcomes, increasing engagement and driving beneficiary acquisition or retention. However, payers recognize that MTMs are just one part of a suite of supportive services, making it difficult to discern their impact on outcomes and to attribute cost reduction to one service alone. This sentiment aligns with the increased focus (such as through Medicaid Section 1115 demonstration waivers) on addressing individuals' HRSN through a holistic approach – making sure that all the social factors that impact health outcomes, including nutrition, are addressed in tandem with achieving the most desirable outcomes.



## Promising prospects, but gaps in evidence

Healthcare outcomes, care plan adherence and cost savings are key outcomes tracked in MTM research. Studies show that MTM recipients report improved quality of life, fewer days when mental health interferes with daily activities and healthier eating habits – including increased fruit and vegetable intake and reduced saturated fat consumption.

Among patients with diabetes, MTMs have been associated with better glycemic control and lower body mass index. For individuals living with human immunodeficiency virus (HIV), medication adherence improved significantly after receiving MTMs. In Massachusetts, food insecurity was linked to \$2.4 billion in additional medical costs in 2016 alone.

MTM programs have shown promise in reducing emergency department visits, hospitalizations and use of emergency transport. A recent cost-modeling study from Tufts estimated that national implementation of MTMs could save \$13.6 billion in healthcare spending and avoid 1.6 million hospitalizations annually (based on data from organizations including GLWD, Food Is Medicine Coalition (FIMC)<sup>1</sup> and Community Servings<sup>2</sup>).

At the same time, gaps in research and evaluation call for higher-quality, longer-term studies to better understand the impact on clinical outcomes, such as hospitalizations and mortality, and more detailed analysis of cost reduction.

Anthem Blue Cross Blue Shield of New York is one payer that has been seeking more robust data on the effectiveness of MTM programs. In collaboration with GLWD, they initiated a pilot intervention in 2022 to provide MTM services to a select group of consumers identified by high healthcare utilization patterns. These consumers received MTM for six months, followed by a 12-month follow-up period. The pilot found a 37% reduction in inpatient hospital admissions and a 30% reduction in total costs for participants.

More collaborative projects like this will help payers assess how to best develop and scale these programs, depending on their own unique populations.

<sup>1</sup> Food is Medicine Coalition, "Medically Tailored Meals: The Proof," Food is Medicine Coalition, <https://fimcoalition.org/research/published-research/>

<sup>2</sup> Community Servings and Food is Medicine Coalition, "The Impact of Medically Tailored Meals" Community Servings and the Food is Medicine Coalition, <https://fimcoalition.org/research/published-research/#mtm-outcome>

## MTM reimbursement has become more structured but remains fragmented

Over the past three years, the reimbursement landscape for FIM interventions, particularly MTMs, has expanded from philanthropic and grant-funded pilots toward structured, though still fragmented, payment mechanisms across Medicare Advantage and Medicaid. Despite policy enthusiasm, payers feel that MTM reimbursement remains a patchwork, as Medicare Advantage covers MTM selectively (condition-specific) and inconsistently (unstandardized); Medicaid coverage varies state by state and often requires local pilots or waivers; and commercial payers are largely in exploratory or employer-sponsored stages.

### Medicare

After 2022, Medicare Advantage plans rapidly became the main insurance product in the Medicare space with nutrition-based benefits. Using Special Supplemental Benefits for the Chronically Ill, plans began reimbursing for home-delivered meals, medically tailored groceries and nutrition counseling for those who qualified based on medical condition. This expansion marked the first mainstream integration of food benefits into a large federal program. However, reimbursement is variable, with each insurer determining the scope, duration and provider network standards of FIM benefits.

### Medicaid

Between 2022 and 2025, state Medicaid agencies began testing direct reimbursement for food and nutrition services, through Medicaid Section 1115 demonstration waivers and “in lieu of services authorities in managed care. This is in addition to general value-based payment (VBP) arrangements, which can make it easier for payers to cover interventions that address social drivers of health, such as nutrition, housing and transportation. Select states have piloted covered meal services for high-risk patients, using care coordination or social services codes. Reimbursement rate-setting remains a major challenge in this space, as payments often do not cover the full cost of production, delivery and nutrition counseling, leading to sustainability concerns.

Over the past three years, payers and FIM organizations have made concerted efforts to propose procedure codes

that capture FIM interventions that occur within the health system (e.g., MTMs, groceries). Establishing codes would facilitate systemic evidence collection to identify populations most likely to benefit from FIM programs and provide a pathway to formalized funding mechanisms for food interventions. Efforts to formalize these codes through the Centers for Medicare & Medicaid Services (CMS) are ongoing.

In addition, Medicaid Managed Long-Term Care and Medicaid Advantage Plus insurance plans include home-delivered meals as one of the home-and-community-based services offered to consumers. MTMs, being a higher-quality intervention, are a covered benefit under this category of service; however, we have observed a lack of consistency in the meal providers offering this service, with many not meeting the standard needed to qualify as MTM providers.

### Increasing economic evidence to support payer uptake

Economic modeling has reinforced the fiscal case for MTM reimbursement. Studies in JAMA Network Open (2022) and Health Affairs (2025) projected that scaling MTMs nationally could save \$13 billion-\$26 billion annually, with net cost savings in nearly every state. These analyses provided payers with a rationale to include food interventions, particularly where reducing readmissions or acute utilization aligns with financial incentives. This highlights the impact of MTMs on individuals with more advanced diseases (e.g., diet-sensitive conditions and activity limitation); however, the benefits likely extend to those with milder forms of disease. MTMs could also improve outcomes for individuals with moderate nutrition-related risks, broadening both health and economic impact. Current policy proposals such as the Medically Tailored Home-Delivered Meals Demonstration Act (S.2834/H.R.5439) seek to formalize Medicare reimbursement via demonstration of Capability Maturity Model Integration authority. If enacted or piloted administratively, these policies would mark the first coordinated federal reimbursement framework for MTMs. Simultaneously, states would continue to expand Medicaid coverage through Section 1115 waivers, setting the stage for standardized reimbursement models – potentially with guidance from the CMS on rate-setting and evaluation metrics.



## What do MTM market solutions look like?

### Overview of MTM solution archetypes

Archetype	Definition	Example Vendors
<b>Community-based organizations (CBOs)</b>	<p>Nonprofit, mission-driven groups often partially funded by grants, Medicaid waivers or philanthropy, offering MTMs to health plans, individuals and vulnerable populations</p> <p>Certain community-based organizations have formed coalitions with established accreditation standards and mechanisms for self-regulation, such as the Food is Medicine Coalition</p>	Community Servings (MA), God's Love We Deliver (NY), Project Angel Food (CA), MANNA (PA), Moveable Feast (MD), FIMC member agencies
<b>Specialized meal companies</b>	For-profit companies offering scalable MTM programs for health plans, employers and individuals	ModifyHealth, Wholesome Grub, CookUnity

### MTM solution segments and key differentiating functions

Organization segment	Differentiating functions			
	Meal format	Dietitian counseling	Community embeddedness	Accreditation-quality oversight
<b>Nonprofit providers</b>	Primarily fresh, chilled or flash-frozen to maintain high quality (e.g., low sodium, low filler, preservative-free), locally prepared, delivered by volunteers and last mile delivery partners	Registered dietitian assessment, counseling or education embedded as part of program	Highly embedded; often linked to clinics, food banks and social service organizations	Often accredited by FIMC; follow evidence-based nutrition protocols and clinical integration standards
<b>Specialized meal companies</b>	Predominantly frozen or shelf-stable often with added preservatives to maintain freshness; centralized production and commercial shipping for national reach	May offer access to dietitians, often as an add-on or limited service	Limited; operate nationally or regionally	May follow self-developed quality standards with some dietitian partnering



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# Payer preferences for MTM solutions

Payers view MTM programs as a high-value component of their benefits portfolio, particularly for Medicare Advantage and Medicaid populations with complex health needs. Within Medicare Advantage, MTMs consistently rank among the top five most important supplemental benefits. Within Medicaid, MTMs are regarded as a primary high-impact intervention for dual-eligible and special-needs consumers that helps reduce avoidable utilization and support health maintenance.

To deliver tailored, timely, flavorful meals for consumers, payers shared their views on MTM capabilities that have become table stakes and where solutions start to differentiate.

**Current-state table stakes (minimum requirements) vs. differentiating features of MTM market solutions**

	Capability	Table stakes example	Differentiating examples
<b>Table stakes</b>	Registered dietitian on staff	Dietitian-approved meals, access to dietitian available upon request	Dietitians involved from intake through ongoing care, offering continuous oversight and education
	Quality food	Meals are safe to eat (e.g., frozen, shelf-stable), nutritionally adequate and palatable enough for participants to consume	Expanded choice for participants (freshly cooked, warm or frozen options); superior taste supporting adherence
	Logistical infrastructure	Reliable delivery of meals according to a set schedule in an agreed-upon service area	Reliable delivery; adapts to client needs and changing circumstances (e.g., delivery driver places food into participant's freezer rather than leaving at door)
	Personalization of meals	Ability to tailor for medical, dietary and cultural needs (e.g., can have diabetic meal plan accommodating shellfish allergy in a modified texture)	Customization, including individual meal selection (beyond "vegetarian plan")
	Data reporting	Meets baseline regulatory reporting requirements (e.g., Medicare Advantage)	Data and analytics on delivery timeliness, adherence, satisfaction
	Regulatory compliance readiness	Meets required standards	Advanced familiarity with state and federal requirements, proactive adaptation to policy changes
	Geographic coverage and scale	Broad coverage making sure there is access for eligible consumers, typically via standardized products (e.g., frozen meals); targeted coverage permits customization and engagement, but limited reach requires a multi-vendor approach	Not specified
<b>Differentiator</b>	Community partnership networks	Not a table stakes requirement	Embedded bidirectional community partnerships with local health and social services, facilitating holistic care
	Broader support impact	Not a table stakes requirement	Addresses additional HRSN through MTM touch points, reduces isolation, supports wellness checks and resource connections
	Innovative engagement	Not a table stakes requirement	Delivery staff or nutrition educators act as trusted health liaisons, conducting brief observations, educating and providing insight to care management teams

## What currently distinguishes MTM providers?

When asked what distinguishes high-performing MTM providers, payers highlighted the following:

### **Elevated quality: nutrition profile, flavor, presentation and choice**

#### **Nutrition profile, palatability and presentation**

While all MTMs are reviewed by a registered dietitian nutritionist for nutrition requirements, there is a wide range of quality and formats across providers. High-performing MTM partners go beyond simply meeting baseline nutritional requirements, consistently delivering meals that are both nutritious and enjoyable to eat while catering to consumers' cultural and ethnic preferences. These organizations prioritize recipes and ingredients that support health goals while also focusing on flavor, freshness and visual appeal; they distinguish themselves from standard providers who may only satisfy minimum nutrition requirements.

This distinction is critical because meals that technically meet condition-specific nutrition targets may not be well-balanced and good for overall health. If meals are not holistically nutritious, payers may fail to see the desired health outcomes, and there may be negative responses – both from consumers and the press. Culturally relevant meals make sure that clients receive meals that are familiar to them, increasing the likelihood that they will continue to follow the meal plan designed to meet their chronic health needs. Additionally, strict adherence to food safety protocols warrants that the service being provided is quality-controlled and does not create any health risks for individuals receiving the meals.

Meal taste and appeal are key factors influencing beneficiary acceptance and satisfaction. If meals fall short in flavor or visual appeal, consumers are less likely to eat them, which can undermine the effectiveness of the program and lead to waste. As one respondent noted, “Taste is huge, and there is a wide range of quality ... there are some really negative [MTM meals] that I want to forget.”

Meal format also plays a role. Whether meals are fresh, frozen or shelf-stable can significantly affect both taste and appeal. Some payers emphasize their use of fresh, high-quality ingredients and minimal preservatives, believing that ingredient integrity contributes to better health outcomes. As another respondent emphasized,

“

At the end of the day, the presentation and taste of the meal reflect the quality of the health plan.

– Survey respondent

To be truly effective, MTMs must feature high-quality ingredients, balanced nutrition, cultural relevancy and thoughtful preparation. They must also be flavorful and visually appealing to encourage consistent consumption and maximize impact.

#### **Choice**

Allowing consumers to choose their own meals, rather than receiving a predetermined package, gives individuals the opportunity to select options that best fit their personal preferences and lifestyles. One respondent noted, “If they can select, ‘I want these four meals,’ vs., ‘I get a package,’ that is a differentiator.” Offering choice not only in specific meals but also in meal format better aligns to consumer preferences. Flexibility improves the consumer experience and increases the likelihood of meal acceptance and satisfaction, which supports overall engagement and program effectiveness as well as client autonomy.

#### **Timely, reliable and thoughtful operations**

##### **Timely, reliable logistics**

Interviewees repeatedly emphasized the importance of timely and reliable meal delivery. Satisfaction is closely tied to whether vendors show up if they say they're going to; dissatisfaction often arises when vendors are late or unreliable, leading to complaints and reduced engagement. When highlighting what distinguished a high-performing vendor, one respondent described how important it is for a partner to “know all of the neighborhood and community routes.”

Understanding traffic patterns and having deep knowledge of delivery routes helps organizations deliver meals on time, even in challenging environments like New York City. Timely, reliable logistics, especially by a familiar consumer team, demonstrates respect for the beneficiary and creates a local, personalized feel that ultimately increases program success. Client familiarity with their delivery driver creates a positive experience that establishes meaningful connections and relationships, increasing client satisfaction.



### Thoughtful operations

Operational considerations play a crucial role in MTM programs, especially when serving populations with mobility or health challenges.

Delivery and storage are key examples. Some MTM vendors send frozen meals in bulk, which gives rise to several issues:

- The box is too large or heavy for the consumer to move
- The consumer does not have enough storage space in their home
- The delivery sits out too long and is wasted

Some solutions have integrated delivery drivers who place frozen meals directly in the participant's freezer, warranting food safety and accessibility.

### Consumer-centered customer service

Consumer-centered service is characterized by proactive communication and responsive support. Vendors who excel in this area not only act as reliable extensions of the payer brand but also support stronger consumer engagement, increased satisfaction and program adherence.

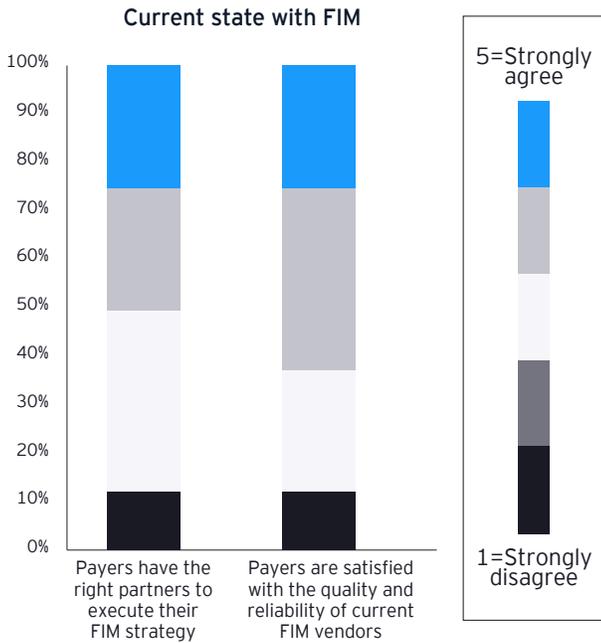
### Proactive communication

Leading MTM solutions prioritize proactive consumer engagement. This includes providing initial outreach and education on the nutritional value and purpose of the meals, as well as timely updates and follow-ups to address questions or concerns. Equally important is flagging potential issues to payer care coordination teams when a consumer may need additional support so intervention can happen early. This proactive outreach builds trust, prevents small issues from becoming larger problems and supports long-term adherence to the program.

### Responsive support

In addition to proactive communication, leading solutions offer responsive support, including clear and accessible channels to express concerns, questions or problems such as delivery issues or meal preferences. Timely and empathetic responses not only resolve individual issues but also enhance consumer engagement, reinforce satisfaction and encourage program adherence.

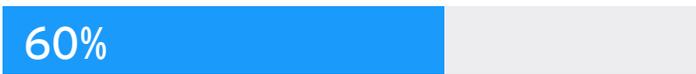
## Regional payers have higher satisfaction with FIM partners



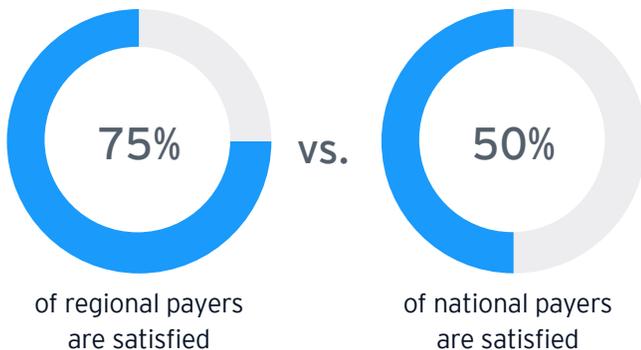
Source: EY-Parthenon interviews and analysis



payers believe they have the right partners to execute their FIM strategy



are satisfied with the quality and reliability of their FIM partners



Source: EY-Parthenon interviews and analysis

Although only half of payers feel confident that they have the right partners to execute their broader FIM strategy, satisfaction with current FIM partnerships remains relatively high. Overall, 60% of payers report being satisfied with the quality and reliability of their FIM partners. Notably, this satisfaction is more pronounced among regional payers, with 75% expressing satisfaction compared to just 50% of national payers; furthermore, only regional payers “strongly agreed” with this sentiment.

The higher satisfaction among regional payers suggests that these organizations may be leading the way in effective FIM partnerships. Their satisfaction may be attributed to stronger local MTM relationships, regional vendors’ more agile MTM operating models and deeper community engagement of regional MTM vendors.

In contrast, national payers, who often rely on broader MTM networks and standardized MTM approaches, are less satisfied with vendor quality and reliability. To bridge this gap, national payers have an opportunity to enhance their FIM services by adopting more regionally focused strategies, such as partnering with community-based organizations and local food providers. This approach may help deliver more personalized and responsive FIM solutions, ultimately benefiting both consumers and satisfying payers.

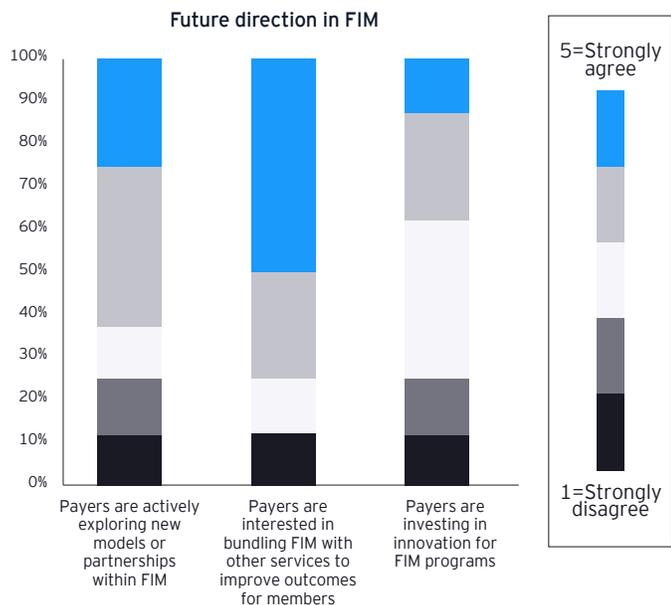




# What is the future of FIM and MTM?

More payers want to combine MTMs with other services, such as care coordination and nutrition counseling, to support whole-person care. For this to work well, they will need strong partners who know their communities and can reach people effectively.

## Interview Insights



Source: EY-Parthenon interviews and analysis

60%

are actively exploring new models or partnerships

**Insight:** This reflects a transitional moment for FIM – payers recognize its value but are still trying to figure out the most effective partners and models for sustainable delivery at scale.

75%

are interested in bundling FIM with other consumer services

**Insight:** FIM is not viewed in isolation – payers see it as part of a whole-person care strategy, alongside supportive services like transportation, care coordination or nutrition counseling.

Source: EY-Parthenon interviews and analysis

## Evolution of FIM partnerships

FIM partnerships between payers and market solutions continue to evolve toward more integrated, scalable models that position nutrition as a core component of healthcare. As payers further develop their reimbursement strategies, they are exploring sustainable ways to embed food-based care into chronic disease management and preventive health, with the goal of improving access and long-term health outcomes.

Future differentiation in MTM market solutions will center on two primary areas: enhancing consumer-centered services that help close healthcare gaps, and progressing toward value-based solutions.

## Closing healthcare gaps through partnerships

FIM programs, such as MTM, are most effective when they are part of a comprehensive healthcare approach rather than stand-alone services. If designed with this in mind, FIM programs can help address both nutritional needs and critical gaps in care (e.g., access, coordination, engagement).

## Improved outreach

Many high-need individuals, such as seniors or those living in underserved communities, may have limited engagement with the healthcare system until their conditions worsen. Traditional care models often fail to reach these individuals early. FIM programs can help by offering a practical, immediate way to engage people who might otherwise be overlooked. MTM services are often introduced at critical moments, such as after a hospital discharge or during care transitions, creating an opportunity to build trust and connect individuals with additional support during this period or afterwards.

## Support for nonclinical needs

Social factors like food insecurity, unstable housing and lack of transportation often prevent individuals from managing their health effectively. These nonclinical needs can lead to unnecessary emergency visits and



hospitalizations. FIM programs directly address one of these foundational needs – nutrition – and have an opportunity to trigger early interventions when patients disengage or face additional barriers. Community-based FIM providers also have an opportunity to identify additional HRSN of their clients, through the close relationship they build via their embedded community models.

### **Simplified navigation**

Healthcare and social support systems can be confusing and fragmented. Individuals may struggle to schedule appointments, access services or understand where to turn for help. FIM programs can simplify this experience by acting as a consistent point of contact. Meal delivery teams, care coordinators or affiliated partners can help guide individuals through the system, warranting that follow-up care happens and connecting them to related services such as preventive screenings or case management.

### **Reduced social isolation**

Many individuals living with chronic illness, particularly older adults, experience social isolation that negatively affects both physical and mental health. Isolation often leads to lower adherence to treatment plans and poorer health outcomes. FIM programs help reduce isolation by providing regular, meaningful touch points through meal delivery or check-ins.

### **Extended support for long-term behavioral change**

Most FIM initiatives focus on short-term nutrition support (like MTM), which can improve immediate health outcomes. However, lasting progress requires both transitional support systems and long-term behavioral change. Without these, many individuals will struggle to sustain healthy habits after the program ends. MTM providers have an opportunity to build and develop transitional programs such as meal prep education and medically tailored grocery access, which can include practical tools like meal planning guidance and cooking skills – all while allowing access to appropriate foods. These supports have the potential to extend the impact of MTM, promote lasting behavioral change and equip individuals with the resources needed to stay aligned with their nutritional goals. Implementing services throughout the FIM pyramid, such as MTM, medically tailored groceries, food vouchers and other nutrition-based interventions, empower FIM providers to support clients throughout their nutritional lifecycle – in turn, maintaining positive health outcomes and engagement with consumers over longer periods.

## **Community-based organizations archetypes are best positioned to close healthcare gaps through FIM**

Community-based organizations (CBOs) are uniquely positioned to bridge healthcare gaps through FIM due to their community insight, trusted relationships and access to critical support services.

### **Community insight**

CBOs have deep-rooted relationships within the communities they serve. This local understanding enables CBOs to act quickly and effectively, increasing the likelihood of successful engagement and outcomes. Their on-the-ground insight allows them to:

- Identify and respond to unique health needs within the communities
- Recognize and navigate cultural, linguistic and practical barriers to care
- Deliver interventions that are tailored and relevant to the population
- Respond and continue serving during and after crises (e.g., COVID-19)



### Trusted relationships

Because of their long-standing presence, FIM CBOs are seen as credible and approachable. Their ability to connect authentically with community members is essential to improving participation, adherence and trust in care interventions. This trust allows them to:

- Reach individuals often missed by traditional healthcare, including seniors, low-income individuals and those with limited transportation or digital access
- Engage consumers who may be reluctant to participate in institutional programs
- Support long-term behavioral change via ongoing interaction and reinforcement

### Connection to resources

CBOs often have deep relationships with other community resources and organizations, serving as hubs that coordinate access to a range of social supports. This coordination helps reduce healthcare utilization and supports more sustainable, whole-person care. Through their networks, they help individuals:

- Access housing, transportation and other nonclinical services with a direct impact on health outcomes
- Navigate complex systems, reducing the administrative burden on healthcare providers
- Avoid unnecessary emergency room visits or hospitalizations by proactively identifying and addressing unmet needs



Image Source: Photo by Rommel Demano for God's Love We Deliver

## Key supports needed for further FIM integration into care delivery

FIM partners already deliver medically supportive meals. With deeper operational integration, FIM programs can also enhance care coordination, flag emerging risks and help close care gaps. The following areas represent where payer support and infrastructure investment are required to further integrate FIM into care delivery.

### Two-way referral and communication infrastructure

**What's needed:** FIM providers need the ability to receive referrals and close the loop (e.g., sharing observations, risks and barriers back to care teams in real time).

What it looks like in practice:

- Better connection of MTM information within care management platforms
- Care teams can track meal delivery status, and FIM partners can flag issues like nonadherence, functional decline or new social risks
- These insights trigger follow-up from care coordinators or clinical teams

**Example:** A FIM partner reports that a congestive heart failure patient is skipping meals. This prompts a nurse case manager to intervene before an avoidable hospitalization occurs.

### Structured data exchange and risk-signal-sharing

**What's needed:** FIM partners need timely access to relevant consumer data – and a mechanism to contribute structured, actionable information back to the plan.

What it looks like in practice:

- Payers provide data on recent discharges, clinical risk flags or social needs screenings
- FIM partners return structured data on nutrition adherence, home environment concerns or consumer-reported challenges
- This two-way exchange strengthens population health analytics and care interventions

**Example:** A FIM partner reports that several consumers in a single area cannot store meals due to refrigeration issues. This informs the plan's community investment strategy and prompts targeted outreach by housing or social services teams.

### Inclusion in care coordination workflows

**What's needed:** FIM partners should be part of regular communication loops for high-need populations – not siloed from the care team.

What it looks like in practice:

- FIM partners participate in case review meetings for consumers with complex care needs
- Their insights supplement clinical data with real-world context from the home
- Consumer progress is tracked jointly across medical, behavioral and social domains

**Example:** A FIM team joins monthly interdisciplinary huddles focused on consumers with uncontrolled diabetes, sharing updates on food access issues or behavioral change readiness that inform the care plan.

### Value-based partnerships and opportunities

Payers are increasingly interested in partners willing to share risk or tie payment to outcomes like consumer engagement, satisfaction, reduced hospital admissions or adherence to eating plans. At the same time, payers acknowledge the complexity of these arrangements. MTMs are only one part of a broader ecosystem, and their impact on outcomes often overlaps with other programs and interventions. Despite these challenges, the movement toward outcomes-driven partnerships encourages FIM vendors to prioritize the consumer experience, measurable health improvements and cost management.

To enhance their impact, FIM organizations can forge partnerships with other ecosystem players, such as local grocery chains or food suppliers. By working closely with these partners, MTM providers could offer meals at better cost, expand the variety of healthy options and deliver additional FIM services beyond just meal delivery.

For example, a collaboration between MTM partners and a regional grocery chain could allow eligible consumers to access fresh ingredients, nutrition education or cooking demonstrations, thereby promoting sustained behavioral change and supporting long-term health. These joint efforts could also leverage existing community resources, such as Supplemental Nutrition Assistance Program (SNAP) benefits or healthy food cards, to reach a broader population and address multiple social drivers of health. Expanding FIM programs to support long-term access and self-management (e.g., post-MTM support, healthy food cards, grocery partnerships) warrants that nutrition support continues even after initial MTM eligibility ends.



Image Source: Photo by Rommel Demano for God's Love We Deliver

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# Conclusion

## What is the future of FIM and MTM?

Payers' growing interest in integrating FIM, and specifically MTM, with other consumer services highlights the need for strong, mission-aligned partnerships that can effectively address clinical gaps and social drivers of health. By working closely with community-based organizations, payers can achieve more comprehensive support, improve consumer engagement and help reduce social isolation that contributes to poor health.

### Key takeaway

To maximize the impact of FIM initiatives, payers should prioritize building collaborative partnerships with MTM providers that:

- Demonstrate the ability to impact their consumers' health and deliver cost savings
- Prioritize nutrition quality, flavor, presentation and choice to drive consumer satisfaction and adherence (e.g., embedded RDN and evidence-based guidelines)
- Possess deep community ties, including strong operations and beneficiary support that strengthen consumer relationships and the ability to address additional health-related social needs
- Collaborate through innovative payment models that prioritize outcomes, such as value-based care and in lieu of services arrangements
- Invest in data exchange with payers to improve the consumers' journey and enable further care coordination



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