Congress of the United States
Washington, DC 20515

November 14, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy,

We write to build on previous correspondence from the Make America Healthy Again (MAHA) Caucus to the Centers for Medicare and Medicaid Services (CMS) regarding the need to modernize Medicare Advantage (MA) supplemental benefit policy to more fully incorporate Food is Medicine (FIM) interventions. We encourage the Department of Health and Human Services (HHS) to explore demonstration opportunities for integrating FIM approaches into federal health programs. One promising model, Accountable Food is Medicine (AFIM), offers a framework for delivering clinically integrated, outcomes-based nutrition services that align with the Department's goals for value-based care and preventive health[1].

In the MAHA Caucus' prior letter, we called for regulatory clarity to ensure that healthy food and nutrition benefits can be recognized as "primarily health-related" under MA. Once those enabling reforms are in place, the next step is to demonstrate scalable implementation models that operationalize value-based nutrition care at the community level.

AFIM represents one such model. Rooted in accountability to patients, providers, payers, and producers, AFIM integrates clinical oversight, culturally relevant nutrition education, and access to locally grown, nutrient-dense foods. The model incorporates education and clinical accountability, with bundled payments being tied to patient outcomes rather than simply being a benefit add-on. Numerous studies exist which demonstrate that AFIM produce prescription models could generate billions of dollars in reduced health care expenses[2] and millions of averted hospitalizations[3] as well as an increase in overall health status of participants[4]. The FreshRx Oklahoma program, an AFIM produce prescription model, has demonstrated annual health care savings of approximately $12,000 per patient[5] alongside significant improvements in their A1c levels, blood pressure, and weight[6].

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[1] https://diabetesjournals.org/care/article/48/10/1783/163117/Health-and-Economic-Impact-and-Cost-effectiveness
[2] Ibid.
[3] https://tuftsfoodismedicine.org/wp-content/uploads/2023/10/Tufts_True_Cost_of_FIM_Case_Study_Oct_2023.pdf

[4] https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.122.009520
[5] https://www.oklegislature.gov/cf_pdf/2025-26%20SUPPORT%20DOCUMENTS/BILLSUM/House/SB806%20ENGR%20BILLSUM.PDF
[6] https://www.freshrxok.org/providers

AFIM's design aligns closely with HHS' priorities for preventive and value-based care. Its structure mirrors emerging payment reforms that link reimbursement to measurable outcomes. For example, AFIM incorporates bundled payments covering food, education, and clinical oversight; reimbursement tied to quantifiable outcomes such as A1c and blood pressure reduction; and incentive payments for achieving or exceeding improvement targets. This approach directly supports the Department's goals to emphasize chronic disease prevention and reduce avoidable health care utilization.

While some have expressed concern that AFIM initiatives could resemble food subsidy programs, we emphasize that these demonstrations operate squarely within the health care system, not as direct food assistance. Federal funds would not be used to purchase groceries for the general public. Rather, under accountable models like AFIM, providers prescribe and deliver specific food-based interventions as a medical service, reimbursed and evaluated just like any other component of patient care. In this structure, the provider – not the patient – procures the food as part of a bundled clinical intervention, ensuring that taxpayer dollars support evidence-based health services, not food distribution.

We respectfully request that HHS:

- Evaluate AFIM as an evidence-based model suitable for federal demonstration through the Center for Medicare and Medicaid Innovation (CMMI).
- Explore integration of food-based care interventions within existing value-based initiatives, such as MA, state Medicaid waivers, and Accountable Care Organizations (ACOs).
- Support interagency collaboration – including with the Department of Agriculture (USDA) and the Centers for Disease Control and Prevention (CDC) – to align data, evaluation, and community infrastructure for nutrition-based health interventions.

Programs like AFIM demonstrate that food can be a clinically prescribed, accountable component of care, especially for chronic and diet-related diseases such as Type 2 diabetes, obesity, and hypertension. Expanding these models nationally would not only reduce health care expenditures but also strengthen rural and local food economies that supply regenerative, nutrient-dense foods.

We appreciate your leadership in advancing value-based care and preventive health. We look forward to working with you to pilot and scale accountable, evidence-based FIM initiatives that improve patient outcomes, deliver long-term savings to federal health programs, and Make America Healthy Again.

Sincerely,

Lloyd Smucker
Member of Congress

Vern Buchanan
Member of Congress

John Joyce, M.D.
Member of Congress