Rural Accountable Food Is Medicine Initiative

Proposal to the HRSA Federal Office of Rural Health Policy (FORHP)
October 2026

Purpose and Request

The Accountable Food Is Medicine Alliance (AFIMA) requests FORHP's review and comment on a staged rural health initiative that would integrate clinically directed Food Is Medicine services into rural health delivery systems. The revised model reflects AFIMA working-group recommendations developed on September 17, 2026 and is intended to give FORHP a more specific operating design on which to react. The initiative would begin with planning/readiness grants and progress to multi-year implementation awards. Each participating patient would receive a defined 12-month intervention, with structured screening, twice-monthly food-and-education encounters, telehealth and community health worker support, a six-month reassessment, and the ability to step down intensity when outcomes are maintained. The model is provider-led, household-aware, and designed to generate common clinical and financial evidence across rural sites.

A central design feature remains that federal award funds must be permitted to pay for the prescribed food itself - including locally and regionally produced food and food from regenerative producers - as well as reasonable aggregation, storage, packing, delivery, education, telehealth, measurement, and care-coordination costs.

Why the Proposal Fits FORHP

FORHP's statutory and programmatic responsibilities include improving access to rural health care, strengthening rural delivery systems and provider networks, supporting health promotion and disease prevention, improving chronic-disease management, and testing evidence-based or evidence-informed approaches. Section 330A of the Public Health Service Act authorizes rural outreach and network activities that expand access, coordinate and improve health services, strengthen rural delivery systems, and require evaluation and sustainability. FORHP also has broader authority under 42 U.S.C. § 912 to support activities necessary to improve rural health care. [1-3]

The initiative therefore treats food as a clinical service-delivery input for defined chronic diseases - not as a stand-alone food-assistance or agricultural-development program. Rural providers remain accountable for screening, enrollment, clinical protocols, education, outcome measurement, contracting, reporting, and sustainability.

Recommended Staged Program Structure

AFIMA recommends that FORHP preserve a two-stage structure but make the transition between stages explicit: planning/readiness grantees would compete for implementation awards, with approximately one-half of the planning cohort advancing if performance, readiness, and available funding support that level of selection. Advancement should not be automatic.

Stage	Illustrative Award	Term	Primary Purpose
1. Planning & Readiness	$100,000-$150,000	12 months	Build the provider/food network, household-benefit rules, screening protocol, local/regenerative sourcing plan, data infrastructure, contracting model and implementation budget.
2. Implementation	$750,000/year	3 years	Run 12-month patient interventions in annual or rolling cohorts; measure common outcomes; test delivery, sourcing, telehealth/CHW workflows, performance incentives and sustainability.

The planning award range remains intentionally lower than the portfolio-wide FORHP average because planning and network-development awards are typically smaller than implementation, hospital, statewide, and national awards. The $750,000 annual level is reserved for implementation, where direct food procurement and delivery account for a substantial share of program cost. [4-5]

Stage 1: Planning and Readiness Grants

AFIMA recommends 20-30 one-year planning awards, with roughly half potentially progressing to implementation. Required planning work should include:

- Designate an eligible rural clinical lead and formalize contracts or agreements with food producers, aggregators, distributors, telehealth vendors, community-based organizations, and other service partners.
- Define household-based benefit rules so the clinically eligible patient remains the anchor for enrollment while the food package is calibrated to household size and avoids duplicative full benefits for multiple household members.
- Finalize screening and enrollment criteria, baseline measurement, consent, referral, adherence expectations, and six-month reassessment procedures.
- Develop the 12-month service bundle, including 24 planned food-and-education encounters, telehealth options, community health worker workflows, and flexible access through home delivery, clinic pickup, or a combined model.
- Prepare a Local and Regenerative Sourcing Plan, including producer mapping, seasonal availability, procurement targets, pricing, food-safety standards and contingency suppliers.
- Specify data architecture for EHR integration, telehealth documentation, CHW measurement, participant tracking, common outcome reporting, and actuarial analysis.
- Develop a three-year implementation budget, compliance plan, performance-incentive option, and post-grant sustainability/payment strategy.

Stage 2: Provider-Led Rural AFIM Implementation

AFIMA recommends 10-12 geographically diverse implementation awards at $750,000 per site per year for three years. A 10-site model would require $22.5 million over three years and a 12-site model $27 million over three years, before central evaluation or technical-assistance costs. FORHP could scale the number of sites if necessary to available appropriations, while preserving the proposed $750,000 annual award level and three-year implementation term.

Eligible lead entity and contracting model

The grant should be awarded to an enrolled, government-contracted or otherwise qualified rural health care provider that can be held directly accountable for clinical services, funds management, patient protections, data integrity and reporting. Preferred leads include Critical Access Hospitals, rural hospitals, Rural Health Clinics, health centers/FQHCs serving eligible rural areas, Tribal health organizations, and other rural provider entities permitted by the governing authority. The lead provider would contract with local/regional farmers, regenerative producers, food hubs, distributors, telehealth partners, CHWs and other service organizations. A food vendor should not operate the demonstration independently of the rural clinical delivery system.

Pragmatic geographic scope

Each site should serve a realistic rural catchment area rather than an overly broad region. Where appropriate, the model should be centered on a Critical Access Hospital or comparable rural provider and the communities it normally serves, with referral partners extending reach without weakening accountability.

Household-Based Clinical Benefit

The clinically eligible patient should remain the unit of clinical accountability, but the prescribed food benefit should be designed for household use. Food purchasing and meal preparation occur at the household level, and a benefit sized only for one individual may undermine adherence. AFIMA therefore recommends:

- Calibrate the food package to household size and clinical modality rather than automatically duplicating a full benefit for every household member.
- When more than one household member is clinically eligible, permit an adjusted household benefit that recognizes multiple eligible participants without unnecessary duplication or excess storage burden.
- Allow home delivery, clinic pickup, community pickup, or blended access based on geography, mobility, broadband, seasonality and local infrastructure.
- Use culturally appropriate and clinically appropriate foods, with flexibility for produce prescriptions, medically tailored groceries, medically tailored meals, or clinician-approved nutrient-dense food packages.

Screening, Enrollment and 12-Month Intervention

Enrollment should be structured and clinically targeted. AFIMA recommends that the initial demonstration prioritize adults with diagnosed type 2 diabetes and/or hypertension, with obesity and prediabetes included as additional or secondary eligibility categories if FORHP wishes to broaden the cohort. Exact clinical thresholds should be finalized with FORHP and participating clinical experts rather than fixed before agency review.

At enrollment, sites should document the qualifying condition, baseline A1c where applicable, blood pressure, weight/BMI, current medications, household size, food-access needs, delivery preference, and readiness to participate. Food insecurity may inform prioritization, but the demonstration should remain a clinical chronic-disease intervention rather than require food insecurity as the sole basis for eligibility.

Core service bundle

- 12 months of participation per enrolled patient.
- A target of 24 encounters - approximately twice monthly - that combine food distribution or fulfillment with nutrition education, coaching, monitoring, or follow-up.
- Education may be delivered in person or virtually. Telehealth should be an explicit allowable modality and may be fully virtual where clinically appropriate and feasible.
- Community health workers or trained local health coaches may support outreach, education, adherence, measurement and follow-up.
- A formal six-month reassessment of clinical response, adherence and continued need.
- A step-down option after the six-month reassessment when outcomes are maintained, such as reduced food intensity or encounter frequency, while preserving the ability to step intensity back up if control worsens.

Food Purchases, Local Sourcing and Regenerative Agriculture

The future NOFO and Notice of Award should expressly authorize food as a direct program cost when furnished under an approved clinical protocol. Allowable costs should include the food itself, reasonable preparation or minimal processing, aggregation, cold storage, packing, food-safety handling, distribution and last-mile delivery. [8-9]

Eligible foods should include fruits and vegetables; legumes; whole grains; nuts and seeds; dairy; eggs; seafood; poultry; meat; and other clinically appropriate nutrient-dense foods. Purchases from local/regional farms, ranches, fisheries, food hubs, producer cooperatives and regenerative producers should be expressly eligible.

Each implementation site should maintain a Local and Regenerative Sourcing Plan and report the dollar value and percentage of food purchases that are local/regional and regenerative. FORHP could award preference points for credible local/regional procurement targets - for example, 40 percent or more of food-procurement dollars where feasible - while allowing adjustment for seasonality, price, clinical need, food safety and remote geography. [6-7]

The core grant should generally not finance unrelated farm capital improvements, land acquisition, or broad agricultural infrastructure. Those activities are better aligned with USDA programs unless a limited cost is demonstrably necessary and allowable for patient service delivery.

Illustrative Annual Implementation Budget - $750,000

The working group recommended separating the cost of the food itself from aggregation and delivery while keeping approximately one-half of the award dedicated to the food benefit and the logistics needed to get it to patients. At the $750,000 annual award level, this dedicates $375,000 each year to prescribed food and the infrastructure required to aggregate, store, pack and deliver it. The following budget is illustrative, not prescriptive:

Category	Illustrative Amount	Share
Prescribed food purchases, including local/regional and regenerative food	$262,500	35%
Aggregation, cold storage, packing, food safety and last-mile delivery	$112,500	15%
Clinical coordination, nutrition education and telehealth support	$127,500	17%
Community health workers, outreach, measurement and follow-up	$82,500	11%
Data/EHR integration, evaluation and actuarial analysis	$82,500	11%
Local/regenerative sourcing coordination and vendor onboarding	$45,000	6%
Program administration, compliance and other allowable costs	$37,500	5%
Total	**$750,000**	**100%**

Clinical Outcomes, Utilization and Savings

The demonstration should be prescriptive about a small set of near-term measures that rural sites can collect reliably. Primary performance measures should focus on clinical change during the 12-month intervention rather than depend on short-period utilization changes.

Domain	Recommended Measures	Role in Evaluation
Primary clinical	A1c; blood pressure; weight/BMI	Core performance measures with baseline, 6-month and 12-month reporting.
Participation	Enrollment, encounter completion, adherence, retention, step-down status	Tests feasibility and identifies which delivery models work in rural settings.
Food/diet	Food security or food-access measure; diet-quality/fruit-vegetable measure	Secondary patient-reported outcomes.
Utilization	ED visits; hospitalizations/readmissions; medication changes where data permit	Secondary/exploratory; not the primary short-cohort performance test.
Financial	Cost per participant; food and logistics cost; modeled medical savings	Standardized actuarial reporting; claims-based analysis where available.
Local/regenerative	Percent and dollars of food spend; participating producers	Tests rural economic and supply-chain feasibility without displacing the health objective.

Longer-term effects such as avoided ED use, medication reduction and total-cost-of-care savings should be estimated using a standardized actuarial method and, where possible, validated with claims or encounter data. FORHP should consider a central evaluation/data-linkage function because many rural grantees will not independently have access to complete claims.

Data Infrastructure and Actuarial Support

Each site should use a common data specification covering the EHR, telehealth platform, CHW tools, food-fulfillment records, household-benefit records and outcome reporting. AFIMA recommends that FORHP require baseline, six-month and 12-month data and provide a standard reporting template.
An actuarial framework should be established before implementation begins so that all sites estimate potential savings using comparable assumptions. The model should distinguish observed clinical outcomes from modeled downstream savings and should clearly identify when claims data are unavailable.

Outcome-Aligned Incentives and Optional Year-3 Risk

AFIMA recommends that FORHP explore a limited outcome-aligned incentive structure without jeopardizing the core grant needed to operate the demonstration. For example, a small performance reserve or supplemental award could be tied to complete data reporting, retention, and improvement on agreed clinical measures.

After two years of operating experience, FORHP could consider an optional year-3 performance-contingent or shared-risk component for willing grantees, but only if HRSA confirms that the structure is permissible under the applicable grant authority and federal financial-assistance rules. The initial demonstration should not require clawback of essential base funding based on patient outcomes that may be affected by factors outside the provider's control.

Legal and Compliance Safeguards

Because the model provides food and related services to patients, FORHP should address beneficiary-inducement, anti-kickback, grant-cost, privacy, telehealth, procurement, and research/evaluation issues before the NOFO is released. AFIMA recommends that HRSA coordinate with appropriate HHS legal and oversight offices and provide grantees with clear award terms, approved benefit parameters, documentation standards, and reliance protections to the extent legally permissible.

AFIMA specifically requests FORHP guidance on whether safe-harbor, waiver, advisory, research, demonstration, or other compliance mechanisms are needed. The proposal should not assume that HRSA alone can create a new statutory safe harbor; rather, the goal is a program design that gives rural providers and their compliance officers a clear, defensible framework.

Local/regional sourcing preferences must also preserve full and open competition and comply with applicable federal procurement rules. FORHP's grants-management and legal teams should specify the permissible preference language and regenerative-sourcing documentation expected of awardees. [8]

Sustainability and Path Beyond the Grant

The initiative is intended to build and test a reimbursable rural clinical model, not create a permanent grant-funded food benefit. Each implementation site should identify a post-grant financing pathway through Medicaid and managed care, Medicare Advantage where permitted, value-based provider arrangements, commercial plans, self-insured employers, health-system community benefit, or other payment mechanisms. The final evaluation should identify which components must be financed as an ongoing benefit and which can be absorbed into normal clinical operations.

Questions for FORHP Review and Comment

1. Does FORHP agree with the staged planning-to-implementation structure and the concept of advancing roughly half of planning grantees to implementation based on readiness and available funds?
2. Which provider entities should be eligible to serve as the accountable lead, and what rural geographic or network requirements should apply?
3. Does FORHP support a household-based benefit anchored to a clinically eligible patient, including benefit calibration to household size and anti-duplication rules?

4. Would FORHP support a 12-month patient intervention with 24 food-and-education encounters, telehealth delivery, CHW participation, and a six-month step-down reassessment?
5. Can the NOFO expressly make prescribed food - including local/regional and regenerative food - and necessary aggregation and delivery allowable direct program costs?
6. Which clinical eligibility thresholds should be used for diabetes, hypertension, obesity and prediabetes, and should food insecurity be a prioritization factor rather than a mandatory criterion?
7. Can FORHP support a common EHR/telehealth/CHW data specification, central evaluation, claims-data strategy, and standardized actuarial method?
8. Would FORHP consider outcome-aligned supplemental incentives and an optional year-3 risk component, and what grant-law constraints would govern such a structure?
9. What compliance guidance or coordination with HHS OIG/CMS counsel is needed to address beneficiary inducement, anti-kickback, privacy, research/evaluation, and related concerns?
10. What award ceiling, number of sites, implementation term and timeline are feasible within FORHP's expected funding and operating plan?

AFIMA's Recommended Next Step

AFIMA proposes using this revised paper as the working document for the discussion with FORHP program, policy, grants-management, evaluation and legal/compliance staff. Following agency feedback, AFIMA can convert the concept into a more detailed model specification covering exact clinical thresholds, household-benefit formulas, encounter requirements, data definitions, actuarial assumptions, procurement standards, performance incentives, compliance terms, and implementation milestones.

Selected References

1. 42 U.S.C. § 912, Office of Rural Health Policy. https://www.law.cornell.edu/uscode/text/42/912
2. 42 U.S.C. § 254c, Rural Health Care Services Outreach, Network Development, and Quality Improvement. https://www.law.cornell.edu/uscode/text/42/254c
3. HRSA, Federal Office of Rural Health Policy Mission. https://www.hrsa.gov/rural-health/about-us/mission
4. HRSA, FY2025 Rural Health Care Services Outreach Program Awards. https://www.hrsa.gov/rural-health/grants/rural-community/outreach-program-awards
5. HRSA, FY2026 Rural Health Network Development Planning Program Awards. https://www.hrsa.gov/rural-health/grants/rural-community/network-planning-awards-2026
6. USDA AMS, Local and Regional Food Systems FAQ / local-regional sourcing framework. https://www.ams.usda.gov/selling-food-to-usda/lfs/faqs
7. USDA NRCS, Regenerative Pilot Program. https://www.nrcs.usda.gov/programs-initiatives/regenerative-pilot-program
8. 2 C.F.R. § 200.319, Competition. https://www.law.cornell.edu/cfr/text/2/200.319
9. 2 C.F.R. § 200.403, Factors Affecting Allowability of Costs. https://www.law.cornell.edu/cfr/text/2/200.403
10. HRSA, Understand the Grants Process. https://www.hrsa.gov/grants/apply-for-a-grant/understand-the-grants-process
11. AFIMA Working Group Meeting Notes, September 17, 2026 (internal program-design source).