FOUNDATION FOR
Health Care Quality

Improving health outcomes through collaboration, data, and finding common ground.

Integrating Food Security into Reimbursable Value-Based Care Models: An Action Toolkit

May 2026

Table of Contents

Abbreviations **3**

Glossary **4**

Background **6**

The Health Impact of Nutrition Insecurity on Chronic Disease 7

Populations Most At-Risk: A Data-Driven Approach to Equity 8

Using the Toolkit **8**

The National Landscape: 1115 Waiver Comparative Analysis **9**

Infrastructure & Data Integration: North Carolina & Tennessee 10

Workforce Integration & HRSN Team Models: Oregon & New York 10

Food is Medicine Integration: Massachusetts & New Jersey 11

Strategic Recommendations for Leadership & Policy Makers **12**

CIE Functionality, Inclusivity, and Interoperability 13

Gravity Project Implementation: Standardizing SDOH Communications 13

Legal Guidelines for MOUs and Data Sharing Agreements 14

Partnership Models: Navigating MCO, ACH, and Hybrid Structures 15

Phased Care Implementation Approach **16**

Phase 1: Foundational Workflow (Patient Care) 16

Phase 2: Integrated Care Teams (Post-Visit Coordination) 17

Phase 3: Optimized Interventions (Beyond Clinical Care) 19

Additional Resources **20**

Educational Resources for Healthcare Professionals 20

Impact of Nutrition Insecurity on Chronic Disease 21

Populations Most At-Risk for Food Insecurity 22

The Role of the Registered Dietitian in Value-Based Care 24

Standardizing SDOH Documentation: Z-Codes & G-Codes 26
Food Insecurity Resources for Patients 28
Getting Help With Food: SNAP, WIC, and Local Food Resources 29
Follow-Up Care & Your Health: Medical Nutrition Therapy 31
References **32**
Appendix **37**

Abbreviations

ACH — Accountable Communities of Health

BAA — Business Associate Agreement

CBO — Community-Based Organization

CHI — Community Health Integration

HCPCS — Healthcare Common Procedure Coding System

ICD-10-CM — International Classification of Diseases, 10th Revision, Clinical Modification

MCO — Managed Care Organization

MNT — Medical Nutrition Therapy

MOU — Memorandum of Understanding

MTM — Medically Tailored Meals

PRAPARE — Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

RD — Registered Dietitian

SNAP — Supplemental Nutrition Assistance Program

VBC — Value-Based Care

VBP — Value-Based Purchasing

WIC — Special Supplemental Nutrition Program for Women, Infants, and Children

WSHA — Washington State Hospital Association

Z code — ICD-10-CM code used to document social, economic, and environmental factors affecting health

Glossary

Closed-Loop Referral

A referral process that tracks whether a patient was successfully connected to a community service and whether the identified need was addressed. Closed-loop systems require communication back to the referring organization regarding referral status or service outcome.

Community-Based Organization (CBO)

A nonprofit, tribal, governmental, faith-based, or local organization that provides community services such as food assistance, housing support, transportation, or social care navigation.

Community Health Worker (CHW)

A frontline public health worker who supports patient education, resource navigation, follow-up, and connection to health and social services within the community.

Community Information Exchange (CIE)

A coordinated system that allows healthcare organizations, community partners, and social service providers to share information, referrals, and outcomes related to social needs.

Food Insecurity

Limited or uncertain access to sufficient food due to financial or other resource constraints.

Food is Medicine

A spectrum of nutrition interventions integrated into the healthcare system to prevent, manage, or treat specific medical conditions, including medically tailored meals, produce prescriptions, pantry stocking, and nutrition counseling.

Gravity Project

A national consensus-based initiative focused on developing standardized coding and data-sharing frameworks for social determinants of health information across healthcare and community systems.

Health-Related Social Needs (HRSN)

Individual-level social and economic needs, such as food insecurity, housing instability, transportation barriers, and utility insecurity, that affect health outcomes and healthcare utilization.

Medically Tailored Meals (MTM)

Meals specifically designed to meet the medical and nutritional needs of individuals with complex or chronic health conditions and typically incorporated into a clinical care plan.

Nutrition Insecurity

Limited or inconsistent access to foods and beverages that support health, prevent disease, and meet dietary needs. Nutrition insecurity builds on the concept of food insecurity by emphasizing diet quality and health outcomes.

Produce Prescription

A healthcare-supported intervention that provides financial support or vouchers for fruits and vegetables as part of a disease prevention or treatment plan.

Social Determinants of Health (SDOH)

The social, economic, and environmental factors that influence health outcomes, healthcare access, and quality of life.

Value-Based Care (VBC)

A healthcare delivery model focused on improving patient outcomes, care quality, and cost-effectiveness rather than reimbursing solely based on volume of services provided.

Value-Based Purchasing (VBP)

A reimbursement strategy that ties payment to quality measures, patient outcomes, and healthcare value rather than service quantity alone.

Z Codes

ICD-10-CM codes used to document nonmedical social, economic, and environmental factors that influence health status and healthcare delivery.

Z59.41 Food Insecurity

An ICD-10-CM diagnosis code used to document food insecurity when lack of food access affects healthcare delivery, treatment adherence, or disease management.

Background

The National Academy of Medicine estimates that medical care accounts for only 10 to 20 percent of the modifiable contributors to health outcomes, while the remaining 80 to 90 percent are driven by health-related behaviors, socioeconomic factors, and environmental conditions, including access to food.[1] Food insecurity, defined as the disruption of eating patterns due to limited or uncertain access to adequate food,[2] has long affected population health and healthcare affordability in the United States and is increasingly addressed in clinical settings through routine screening and referral.Screening has become more common, but current practices remain fragmented and lack consistent support from defined intervention pathways, referral infrastructure, and follow-up processes. As a result, healthcare teams and insurers struggle to determine whether improved access to food resources translates into meaningful improvements in health outcomes..[3]

Recent federal policy changes further complicate a lack of a coordinated, measurable intervention framework. Reductions to federal safety net programs, including the Supplemental Nutrition Assistance Program (SNAP) and Medicaid, are expected to increase demand for food assistance while placing additional strain on community-based organizations that already operate with limited capacity.[4] At the same time, Centers for Medicare & Medicaid Services (CMS) reimbursement policies are shifting away from broader social determinants of health screening toward more narrowly defined, clinically actionable assessments such as nutrition and physical activity, reducing flexibility for addressing social needs through traditional screening models.[5]

Despite these constraints, opportunities remain. Section 1115 Medicaid demonstration waivers allow states to test innovative approaches that integrate nutrition and other health-related social needs into care delivery, although these programs are time-limited and require evidence of value to sustain and expand.[6] In Washington State, ongoing investment in value-based care (VBC) and value-based purchasing (VBP) models can align food insecurity interventions with measurable outcomes, incentives aligned with population health, and reimbursement pathways.[7] This policy landscape supports a more targeted approach in which food insecurity is addressed through clinically integrated, nutrition-focused interventions that can be documented, tracked, and linked to outcomes.

This toolkit responds to these converging pressures by focusing specifically on food insecurity as a clinically actionable domain. It provides healthcare organizations, clinicians, registered dietitians (RDs), pharmacists, social workers, and community health workers (CHWs) with a structured approach to move beyond referral-only models. The toolkit provides ideas on how to align clinical workflows, reimbursement pathways, community partnerships, and emerging Community Information Exchange (CIE) infrastructure to support a closed-loop system in which food insecurity is identified, addressed, and tracked as part of routine care. In doing so, it positions food security work as a scalable component of value-based care and a practical pathway for advancing broader health-related social needs integration within Washington State.

The Health Impact of Nutrition Insecurity on Chronic Disease

One of the primary clinical consequences of food insecurity is its impact on nutrition security. While food insecurity reflects limited or uncertain access to adequate food, nutrition security builds on this concept by emphasizing consistent access to the nutrient-dense foods required to promote health and prevent or manage disease.[8] When access to nutrient-dense foods is limited either geographically or financially, individuals tend to rely on lower-cost, energy-dense dietary patterns that are typically more processed and shelf-stable, resulting in reduced diet quality and increased risk of diet-related chronic disease, including diabetes, hypertension, and cardiovascular disease.[2,9] For patients with existing chronic conditions, these constraints create a fundamental barrier to implementing medical nutrition therapy and adhering to treatment plans.[10]

In addition to dietary patterns, food and nutrition insecurity are associated with chronic stress responses that contribute to metabolic dysregulation and inflammation, further worsening disease outcomes.[9] These combined effects are reflected in poorer disease control and increased risk of complications, including higher hemoglobin A1c levels in diabetes, poorer blood pressure control in hypertension, and increased risk of cardiovascular events.[9,11] At the system level, food insecurity is associated with increased healthcare utilization and higher healthcare expenditures, including greater reliance on emergency department and inpatient care services.[12] As healthcare systems and payers continue to shift toward VBC and VBP models, this relationship highlights the opportunity of addressing nutrition insecurity as a modifiable driver of both clinical outcomes and cost.

Populations Most At-Risk: A Data-Driven Approach to Equity

Food insecurity remains a significant and unevenly distributed public health challenge. In 2024, approximately 13.7 percent of U.S. households experienced food insecurity, representing the highest prevalence in nearly a decade.[13] Disparities are particularly pronounced among Black and Hispanic households, which experience food insecurity at rates approximately 1.5 to 2 times higher than the national average.[2]

In Washington State, an estimated 11 percent of residents experience food insecurity, with higher rates observed in rural communities and communities of color.[14] These disparities reflect differences in income, employment, housing stability, transportation access, and local food environments, all of which influence the ability to obtain consistent, nutritious food.[2,9]

In addition to racial disparities, certain populations are more vulnerable to the clinical consequences of nutrition insecurity, including children, individuals with chronic disease, individuals with disabilities, and low-income populations. These groups are more likely to experience barriers to accessing adequate nutrition and are more susceptible to the negative health effects of nutrition insecurity, including impaired disease management and increased risk of complications. [2,10]

Identifying at-risk populations is only the first step to addressing these health and nutrition disparities. A data-driven approach to health equity requires consistent documentation, coordinated referral systems, and the ability to track whether interventions are successful. The Foundation for Healthcare Quality recommendations emphasize the importance of integrating social need data into clinical workflows, linking this data to standardized coding systems, and using social needs data to inform both patient care and system-level decision making.[3] This toolkit builds on that framework by focusing on food insecurity as a measurable and actionable domain, supporting healthcare organizations in translating population health goals into operational and reimbursable care processes.

Using the Toolkit

This toolkit is designed to support Washington State healthcare organizations in moving from identifying to addressing food insecurity within clinical care. This toolkit focuses on:

- Integrating food insecurity into routine care through coordinated workflows, partnerships, and data systems.
- Strengthening connections between healthcare systems and community-based organizations to support referral and follow-up processes.
- Using standardized documentation and coding practices to align food insecurity interventions with reimbursement pathways and VBC models.
- Roles of the interdisciplinary care team, including clinicians, RDs, social workers, community health workers, and pharmacists, to support coordinated care delivery.

The toolkit is organized to support implementation across multiple levels and includes:

- a comparative analysis of Section 1115 Medicaid waivers that illustrates how states are funding nutrition-related services and infrastructure.
- Recommendations for Washington State leadership and policy makers on implementation and alignment to Health Care Authority (HCA) value-based purchasing initiatives and Community Information Exchange (CIE) development.
- A phased implementation approach that allows organizations to adopt workflows based on current capacity.

Additional sections include role-based action guides to support integration into clinical workflows and patient-facing resources to support navigation of food assistance programs and nutrition-related care. Together, these components can support a coordinated approach to addressing food insecurity as part of routine clinical care.

The National Landscape: 1115 Waiver Comparative Analysis

Strategic Blueprint: Lessons for Washington State Implementation

Section 1115 Medicaid demonstration waivers allow states to test Medicaid delivery models that differ from standard federal requirements to meet Medicaid program objectives. Because these demonstrations require monitoring and evaluation, states must be able to document implementation, track outcomes, and demonstrate value over time.[15,16] For Washington State, the most useful national examples are states that show how waiver authority can be translated into

infrastructure, improved statewide workforce utilization, and reimbursable food security interventions.

Infrastructure & Data Integration: North Carolina & Tennessee

North Carolina and Tennessee provide two useful models for building social needs infrastructure. North Carolina's NCCARE360 is a statewide coordinated care network designed to electronically connect people with identified needs to community resources and provide feedback on the outcome of those referrals. This makes North Carolina one of the clearest examples of a CIE-style infrastructure model, where referral exchange, resource navigation, secure information sharing, and outcome tracking are organized through a shared system. Notably, this system connects community-based organizations, social services agencies, health systems, healthcare providers, and more. [17]

Tennessee offers a complementary data and workflow model through TennCare's Health Starts initiative. Health Starts links provider partnerships, technology supports, and workforce development to improve how social needs are identified, documented, referred, and tracked.[18] TennCare III provides the broader 1115 waiver context for this work, while Health Starts demonstrates how Medicaid managed care can support social determinants of health (SDOH) screening, Z-code documentation, closed-loop referrals, and community resource navigation.[19,20,21] These designs can inform Washington State by showing that CIE development should extend beyond serving as a basic resource directory. A more robust approach supports standardized screening, coded documentation, referral tracking, loop closure, and reporting that can be used by healthcare organizations, providers, managed care entities, community-based organizations, and any other point of client contact where health or social needs are addressed.

Workforce Integration & HRSN Team Models: Oregon & New York

Oregon, like Washington, uses a familiar regional Medicaid delivery structure while assigning Health-Related Social Needs (HRSN) work to existing clinical and community roles. Oregon's HRSN nutrition benefits require Oregon Health Plan (OHP) Medicaid members seeking MTM to receive a referral to a RD from a health care provider. The dietitian develops a nutrition care plan, and if MTM are indicated, the member's Coordinated Care Organizations (CCO), a Medicaid accountable care organization, or their health care provider who accepts "open-card" Medicaid reimbursement directly from the state, connects the member with an MTM provider.[22] Members

then meet with the dietitian regularly to assess whether the meals continue to meet care plan goals.[22,23] This model is useful for Washington because it demonstrates how existing Medicaid delivery structures can incorporate RDs, providers, CCOs, and community food providers into a coordinated nutrition intervention workflow rather than creating a separate food assistance program.

New York provides a complementary model through the New York Health Equity Reform (NYHER) waiver and regional Social Care Networks. These networks create formal structures for HRSN screening, navigation, referral, service delivery, contracting with community-base4d organizations (CBOs) and healthcare providers, and payment through regional lead entities.[24] The Center for Health Care Strategies describes New York's model as including Social Care Navigators, CHW-related financing pathways, information technology (IT) platform use, reporting requirements, and enhanced HRSN services in areas such as care management, nutrition, housing, and transportation.[25] The New York State Academy of Nutrition and Dietetics also identifies opportunities for RDs to participate in NYHER food and nutrition services.[26] For Washington, Oregon and New York show that food security work should be assigned to a structured team, not left to isolated referrals from individual clinicians.

Food is Medicine Integration: Massachusetts & New Jersey

Massachusetts and New Jersey provide two distinct Food is Medicine models. Massachusetts demonstrates a more comprehensive HRSN nutrition benefit structure under its MassHealth 1115 demonstration. Approved waiver materials and CMS payment methodology support reimbursable nutrition-related services, including MTM meals, food boxes, and food prescriptions or vouchers.[27,28] Three home delivered meals, or more for high risk children or pregnant women, can be delivered for up to 6 months with a one-time 6-month renewal.[27] Alternatively, vouchers for fruits and vegetables are also available. For meal recipients, cooking supplies such as pots, pans, utensils, and refrigerators are made available to meet client needs.[27] This model is useful for Washington because it outlines how Food is Medicine services can be implemented as reimbursable Medicaid benefits rather than stand-alone food access programs. Washington already has fruit and vegetable incentive infrastructure and has received approval under Medicaid Transformation Project (MTP) 2.0 for HRSN nutrition supports, including medically tailored meals, pantry stocking, fruit and vegetable prescriptions, nutrition counseling, and short-term grocery

provision.[29] However, Massachusetts provides a more mature example of how those services can be defined, paid for, and operationalized through a statewide HRSN nutrition benefit structure.

New Jersey provides a narrower, condition-specific Food is Medicine model through its NJ FamilyCare Medically Indicated Meals Pilot. The pilot is authorized within the state's 1115 demonstration and is designed for pregnant enrollees with preexisting or gestational diabetes who also have an identified nutrition-related need. Medically indicated meals must be approved by a Registered Dietitian Nutritionist and meet the needs of a pregnant and diabetic individual, and the pilot also allows additional meal support for household members to support adherence to the intervention.[30,31] Compared with Massachusetts, New Jersey is less comprehensive because it focuses on a defined population and does not appear to include the same breadth of nutrition counseling or ongoing RD assessment requirements. However, it offers Washington a practical structure by which specific high-risk populations could be served. Together, Massachusetts and New Jersey show that Food is Medicine programs can be implemented either as broad HRSN nutrition benefits or as targeted pilots designed to generate evidence for expansion.

Strategic Recommendations for Leadership & Policy Makers

System-Level Alignment: State, WSHA, and Health Systems

For food security interventions to move from isolated activity to sustainable clinical practice, Washington leaders [e.g., Health Care Authority (HCA), Managed Care Organizations (MCOs), and Accountable Communities of Health (ACHS)] must address fragmented data infrastructure, unclear responsibility for follow-up, and inconsistent reimbursement. Meaningful intervention requires shared infrastructure to document needs, track referrals, support community partners, and measure outcomes.[3,7,29,32]

- **Coordinate implementation**: Align operations across the HCA, MCOs, ACHs, community care hubs, health systems, pharmacy networks, and CBO partners.
- **Define system roles:**
    - HCA & MCOs: align reimbursement and Medicaid transformation priorities.
    - Delivery sites, systems, community pharmacies, and the Associations that support these groups: support clinical workflows and documentation standards.

    - ACHs, community care hubs, and CBOs: support regional service delivery and follow-up.[32,33]

- **Measure beyond screening:** Treat food insecurity as a measurable clinical and operational issue, with documentation, referral completion, intervention delivery, and follow-up incorporated. .[3,7]

CIE Functionality, Inclusivity, and Interoperability

Washington's Community Information Exchange (CIE) can function as active care coordination infrastructure, moving beyond passive resource directories. A statewide CIE could support determining whether patients were connected to services and whether their identified need(s) were addressed. [32,33]

- **Carve out core functions:** Bidirectional referral, referral status updates, closed-loop confirmation, service outcome documentation, and reporting as core functions of the CIE.
- **Design for inclusivity:** Adequate support is needed for small, rural, tribal, and culturally specific CBOs that might otherwise be excluded by high technical burden, uncompensated reporting requirements, or duplicative documentation. If possible, individual clients can update their status independently, with a client interface to remove barriers to services and improve equity.
- **Support participation:** Low-burden onboarding, technical assistance, flexible participation options, and payment mechanisms that compensate CBOs for both service delivery and administration are key facilitators for engagement. [3,32]
- **Interoperability as a fundamental element:** Interoperability across CIE systems, EHRs, MCO care management platforms, community care hub systems, and standardized coding workflows will facilitate evaluation of food security data at the patient, organization, payor, and population level.[34,35]

Gravity Project Implementation: Standardizing SDOH Communications

Standardized documentation is the foundation for measurement, cross-sector communication, and reimbursement for HRSN interventions, like food insecurity. The Gravity Project provides consensus-based data standards for using and sharing information about HRSN that can be

adopted across clinical, payor and community systems to support alignment in screening, referral, and follow-up documentation. [34,35]

- **Standardize terminology:** Use consistent screening, referral, diagnosis, and intervention documentation so food insecurity data remains comparable across organizations. SDOH-related ICD-10-CM Z codes range from Z55-Z65 and are used to document nonmedical factors such as housing, food insecurity, and transportation that influence health.[36]
- **Document clinical relevance:** Capture food insecurity screening results, referral actions, intervention type, and follow-up status in workflows. Document food insecurity in the medical record, with supporting notes from appropriate team members.[36]
- **Define return on investment:** To foster shared understanding, alignment around the definitions of screening, referral, service receipt, loop closure, and need resolution are critical. Insights from aggregated, standardized food insecurity data can inform quality improvement, payor reporting and reimbursement, care management, and evaluation of interventions to address HRSN and improve health.[7,34,36]

Legal Guidelines for MOUs and Data Sharing Agreements

Formal agreements between healthcare organizations, MCOs, ACHs, community care hubs, and CBOs close the loop in food security work. Template agreements can reduce the legal and administrative burden on individual organizations.[3,32,33]

- **Define responsibility:** Identify who is responsible for screening, referral, accepting referrals, the information that may be shared, and how unresolved needs are escalated between partners in formal agreements (MOUs, data sharing agreements, business associate agreements, service agreements).
- **Clarify consent and privacy:** Define consent workflows, privacy expectations, data security requirements, and permitted data-sharing use cases in agreements.
- **Protect CBO capacity:** Prevent uncompensated documentation for CBOs and reimbursable referrals for healthcare organizations in agreements.
- **Provide templates.** Develop standardized agreement templates that can be adapted by MCOs, ACHs, health systems, community care hubs, and CBO partners.

Partnership Models: Navigating MCO, ACH, and Hybrid Structures

Washington needs flexible partnership and HRSN-team models that can be adapted based on regional and organizational capacity. A single statewide model may not fit every community or partner, but consistent statewide standards are still needed to support coordinated, accountable, and sustainable food insecurity interventions across healthcare and community settings. Washington's leadership strategy should focus on partnership structures that support identifying, addressing, documenting, reimbursing, and evaluating food insecurity as part of routine care.[32,33]

- **Set statewide standards:** HCA and state-level partners should define core standards for screening, documentation, referral tracking, loop closure, data sharing, reporting, and reimbursement, while allowing regional entities to determine how those standards are implemented locally.[32,33]
- **Support regional implementation:** ACHs and community care hubs can help translate statewide standards into regional workflows by coordinating referral networks, supporting CBO onboarding, providing technical assistance, and managing cross-sector partnerships.[32,33]
- **Align MCO reimbursement and care management:** MCOs can support food security interventions by aligning reimbursement, care management expectations, referral follow-up, and reporting requirements with HRSN and VBP goals.[32]
- **Develop internal HRSN workflows:** Health systems, clinics, and pharmacies should establish internal HRSN teams or designated workflows for integrating food insecurity screening, documentation, referral coordination, follow-up, billing alignment, and quality improvement into clinical care.
- **Treat CBOs as implementation partners:** CBOs should be included in planning, reimbursement design, referral workflows, and reporting expectations rather than treated only as downstream referral destinations.[32,33]
- **Build integrated accountability:** The strongest partnership models bring payment, workflow, and accountability into alignment. Screening without referral capacity leaves gaps, and referrals without follow-up do not complete the loop. Food assistance that is not documented cannot be evaluated, and reimbursement that does not include CBO participation is unlikely to reach patients effectively.[3,7,32]

Phased Care Implementation Approach

Adaptable Workflow Models for Addressing Food Insecurity

A phased approach allows healthcare organizations to integrate food insecurity interventions incrementally based on clinical capacity, staffing, technology, and community partnership infrastructure. This approach aligns with Foundation for Health Care Quality screening workflow recommendations by recognizing that social need screening can occur at multiple points in care, including check-in, rooming, the clinical visit, discharge planning, and follow-up.[37] The goal is to help organizations begin with feasible screening and documentation workflows, then build toward coordinated referral follow-up, interdisciplinary care teams, and reimbursable Food is Medicine interventions.

Phase 1: Foundational Workflow (Patient Care)

The objective of Phase 1 is to establish a baseline workflow for identifying food insecurity, documenting it consistently, and connecting the result to the care team. Organizations should begin by defining when screening occurs, who administers the screening tool, where results are documented, and how a positive screen becomes visible for follow-up.

- **SDOH risk identification:** Administer a validated food insecurity or HRSN screening tool during intake, rooming, annual wellness visits, chronic disease visits, discharge planning, or other defined points of care. Organizations may use a comprehensive tool such as PRAPARE or a shorter validated tool such as the 2-question Hunger Vital Sign, depending on workflow capacity and patient population.[38,39]
- **Patient-centered communication:** Screening should be introduced in a way that normalizes food insecurity as a common health-related need and reduces stigma. Staff should use supportive, patient-centered language and explain why the information is being collected and how it may be stored and shared with the patient's care team and referral partners to support care coordination. The purpose of the data collection should be clearly communicated as connecting patients with appropriate resources and support.[37]

- **SDOH coding and documentation:** When food insecurity affects care, organizations should document the finding in the medical record using ICD-10-CM Z59.41, Food insecurity, with supporting documentation from appropriate care team members. CMS guidance notes that SDOH-related Z codes are used to document nonmedical factors that influence health and may be supported by documentation from clinicians, social workers, CHWs, case managers, nurses, or other care team members when included in the official medical record.[36]
- **Billing alignment:** Organizations should not rely on HCPCS code G0136 as a broad SDOH screening code. For 2026, G0136 describes administration of a standardized, evidence-based assessment of physical activity and nutrition, lasting 5 to 15 minutes and billed no more often than every 6 months. The code is payable when both physical activity and nutrition risk assessment are performed, or when one domain is reasonable and necessary based on the clinical scenario. Some insurances require a 30-day follow up for this billing code. Practitioners should refer patients to relevant resources and incorporate assessment results into medical decision-making, diagnosis, treatment plan, and planned follow-up.[40]

Phase 2: Integrated Care Teams (Post-Visit Coordination)

Once food insecurity is identified and documented, the focus shifts from screening to coordinated response. Phase 2 requires organizations to define who receives the referral, who follows up with the patient, how community referrals are made, and how the care team determines whether the patient received services. This phase should include internal HRSN teams or designated workflows so responsibility does not fall to individual clinicians alone.

- **Clinical care flows:** Health systems and clinics should create internal workflows that route positive food insecurity screens to the appropriate team member based on the patient's clinical and social needs. CMS guidance notes that SDOH-related Z codes may be documented by clinicians, social workers, CHWs, case managers, nurses, or other care team members when included in the official medical record.[36] EHR alerts may support follow-up in settings with integrated records, but the essential requirement is a defined triage process that assigns responsibility for next steps (see Appendix Figure 1).
    - **Refer to an RD when nutrition-related disease or clinical nutrition risk is present:** Patients with diabetes, hypertension, cardiovascular disease, pregnancy-related

nutrition risk, malnutrition risk, renal disease, gastrointestinal disorders, or other nutrition-related conditions should be referred to an RD for medical nutrition therapy, nutrition assessment, and care planning.

    - **Refer to a social worker or care coordinator when broader social needs are present:** Patients with needs beyond food access, such as housing instability, transportation barriers, insurance issues, safety concerns, income instability, caregiving barriers, or complex benefits navigation, should be referred to a social worker or care coordinator.
    - **Refer to a CHW or community navigator when the primary need is food access:** Patients whose main need is connection to food resources should be referred to a CHW or community navigator for food assistance enrollment, CBO referral, follow-up, and loop closure.
    - **Utilize pharmacists and primary care teams as identification and referral partners:** Pharmacists and primary care teams can support screening and referral, particularly when food insecurity affects medication adherence, diabetes management, hypertension control, or other chronic disease care.
- **Pharmacy integration:**
    - Include community pharmacies in food insecurity screening and referral partners, especially for patients managing chronic conditions or with pregnancy-related medication needs. Prioritize interoperability with other platforms and clear documentation pathways that allow needs identified in the pharmacy to be communicated to the broader care team.
    - Advocate for community pharmacy inclusion in statewide CIE planning
-
- **Community Health Integration billing:** Healthcare organizations with both a billing practitioner and interdisciplinary care team members, such as a CHW, may evaluate use of Medicare Community Health Integration codes when food insecurity or another SDOH need is identified as interfering with diagnosis or treatment. CHI services require an initiating visit personally performed by the billing practitioner, documentation of the unmet SDOH need and its relationship to the treatment plan, patient consent, and

services furnished by auxiliary personnel under general supervision. HCPCS code G0019 covers the first 60 minutes per calendar month of CHI services, and G0022 may be used for each additional 30 minutes.[40]

- **Follow-up and closing the loop:** Organizations should use the CIE, community care hub data-sharing partnerships, or other closed-loop referral systems to send referrals to community partners and track whether the patient accessed services. Follow-up should distinguish between a referral sent, a referral accepted, a service received, and a need resolved. Washington's HRSN screening and referral infrastructure emphasizes screening, referral coordination, follow-up, outcome tracking, and support for community partners, making this a key operational step for food insecurity workflows.[32,33]

Phase 3: Optimized Interventions (Beyond Clinical Care)

The final phase involves moving from general food resource referrals to clinically tailored nutrition interventions that can be linked to health outcomes. Organizations at this phase should have defined referral workflows, interdisciplinary care team roles, community partnerships, documentation standards, and reimbursement pathways.

- **Food is Medicine programs:** Implement advanced supports such as medically tailored meals, produce prescriptions, pantry stocking, short-term grocery provision, and nutrition counseling when funding and state support are available. Washington's MTP 2.0 nutrition supports include nutrition counseling and education, medically tailored meals, pantry stocking, fruit and vegetable prescriptions, and short-term grocery provision.[29] Long-term sustainability planning should include reimbursement alignment, community partnership development, outcome tracking, and evaluation of healthcare utilization and clinical outcomes to support ongoing investment in Food is Medicine interventions.
- **RD-led nutrition care management:** For patients with chronic disease, pregnancy-related risk, malnutrition risk, or complex nutrition needs, RDs should be integrated into the food insecurity workflow through MNT, nutrition assessment, intervention planning, and follow-up. Oregon provides a useful example of using existing Medicaid delivery structures to incorporate RDs into medically tailored meal workflows, including referral from a healthcare provider, RD development of a nutrition care plan, connection to a meal provider through the CCO or open-card provider, and ongoing reassessment.[22,23]

- **Formal CBO partnerships:** Organizations should move from informal referral lists to formal partnerships with CBOs, food banks, medically tailored meal providers, produce prescription partners, and culturally specific food access organizations. These partnerships should include clear service expectations, referral pathways, data-sharing processes, feedback loops, and payment or administrative support where appropriate.[3,32]

Additional Resources

The following resources are intended to support implementation of the food insecurity toolkit in clinical, community, and patient-facing settings. Organizations may adapt these materials based on patient population, staffing, technology, payer requirements, Community Information Exchange participation, and local food security partnerships. The below educational resources are meant to inform clinician and staff-facing material on food insecurity support.

Educational Resources for Healthcare Professionals

- Impact of Nutrition Insecurity on Chronic Disease
- Populations Most At-Risk for Food Insecurity
- The Role of the Registered Dietitian in Value-Based Care
- Standardizing SDOH Documentation: Z-Codes & G-Codes

Impact of Nutrition Insecurity on Chronic Disease

Why it matters: Food insecurity, or the limited or uncertain access to adequate food, can contribute to nutrition insecurity resulting in limited access to health-sustaining, nutrient-dense foods.[1] This challenge affects whether patients can follow nutrition recommendations, take medications safely, manage chronic disease, recover from illness, and avoid emergency healthcare visits.[1,2]

Patients may have difficulty managing:

- Diabetes
- Hypertension
- Cardiovascular disease
- Kidney disease
- Malnutrition risk
- Medication timing and adherence[1,2,4]

Food insecurity may affect:

- Medical nutrition therapy adherence
- Medication adherence and safety[4]
- Blood sugar control
- Blood pressure management
- Chronic disease self-management
- Hospital recovery[1,2]

What staff should do

When food insecurity is identified:

1. Document the need in the medical record.[3]
2. Use ICD-10-CM **Z59.41 Food insecurity** when food access affects care.[3]
3. Refer to the appropriate community resource or clinician based on the patient's needs.[2,4]
4. Track whether the referral was completed.[2]
5. Follow up to determine whether the patient received support and document how food access affects symptoms, treatment adherence, or disease management.[2,3,4]

References

1. Berkowitz SA, Basu S, Meigs JB, Seligman HK. Food insecurity and health care expenditures in the United States, 2011-2013. *Health Serv Res.* 2018;53(3):1600-1620. doi:10.1111/1475-6773.12730
2. McCarthy D, Lewis C, Horstman C, Bryan A, Shah T. *ROI Calculator for Partnerships to Address the Social Determinants of Health: Guide to Evidence for Health-Related Social Needs Interventions: 2022 Update*. Commonwealth Fund; 2022. Accessed May 5, 2026. https://www.commonwealthfund.org/sites/default/files/2022- 09/ROI_calculator_evidence_review_2022_update_Sept_2022.pdf
3. Centers for Medicare & Medicaid Services*0020*. Published 2023. Accessed April 30, 2026. https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf
4. Lakada I, Stutsky M, Huynh C, Periyasamy S, Idusuyi A. Implementation and outcomes of a pharmacist-led social determinants of health screening and intervention program in an integrated health system specialty pharmacy model. *J Am Pharm Assoc (2003)*. 2026;66(2):103008. doi:10.1016/j.japh.2025.103008

Populations Most At-Risk for Food Insecurity

Why it matters

Patients at higher risk for food insecurity may also have more difficulty managing chronic disease, be more likely to miss appointments, not be able to take their medications as prescribed, and experience more preventable emergency room visits and hospitalizations. Food insecurity is not evenly distributed across the population. Risk is shaped by income, housing, transportation, disability, racism, local food environments, and availability of food.[1,2] Screening should be offered consistently and respectfully as a routine part of care, rather than based on assumptions about risk based on appearance, diagnosis, insurance type, or perceived income.[1,] Explaining why the information is being collected, how it will be used, how it will be protected, and whether it may be shared with referral partners helps build trust and transparency. Identifying risk is only the first step; teams should also track whether patients are connected to support and whether those supports reduce barriers to care.

Patients at higher risk may include:

- Low-income individuals and families
- Children and households with children
- Older adults
- People with disabilities
- People with chronic diseases
- Pregnant or postpartum people
- Rural communities
- Communities of color
- Tribal communities
- Patients with housing or transportation instability
- Patients with language, technology, or benefits navigation barriers

Equity considerations

Staff should explain why the information is being collected, how it may be used, and whether it may be shared with referral partners. Identifying risk is only the first step. Healthcare organizations should also track whether patients are connected to support and whether those supports reduce barriers to care.[3,4]

Equity-focused workflows should:

1. Use patient-centered, non-stigmatizing language.
2. Offer culturally appropriate food and nutrition resources when available.
3. Avoid screening only patients who “look” at risk.

4. Include rural, tribal, and culturally specific CBOs in referral pathways.
5. Track whether interventions are reaching populations most affected by food insecurity.
6. Use data to identify gaps in access, referral completion, and outcomes.

Selected References

1. Office of Disease Prevention and Health Promotion. *Food Insecurity*. Healthy People 2030. US Dept of Health and Human Services. Accessed March 20, 2026. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity
2. Northwest Harvest. *Key Facts and Statistics*. Published 2025. Accessed March 20, 2026. https://www.northwestharvest.org/resources/key-facts-statistics/#WA
3. Foundation for Health Care Quality. *Social Need Screening*. Bree Collaborative; June 27, 2023. Accessed May 1, 2026. https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Screening-Recommendations-0627.pdf
4. Foundation for Health Care Quality. *Advancing Equity Recommendations*. Bree Collaborative; June 27, 2023. Accessed May 1, 2026. https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Advancing-Equity-Recommendations-23-0627.pdf

The Role of the Registered Dietitian in Value-Based Care

Why it matters

Registered Dietitians (RDs) play an important role in value-based care by connecting clinical nutrition care, chronic disease management, and health-related social needs interventions. As healthcare systems increasingly address food insecurity and nutrition-related disease, RDs can support both direct patient care and broader care coordination efforts.[1,2]

Food and nutrition insecurity may affect:

- Diabetes management
- Hypertension control
- Cardiovascular disease risk
- Kidney disease management
- Malnutrition risk
- Medication adherence
- Hospital recovery and readmission[3,4,5]

RDs are trained to:

- Assess nutrition-related disease risk
- Provide medical nutrition therapy
- Develop nutrition care plans
- Support Food is Medicine interventions
- Coordinate with healthcare and community partners
- Monitor nutrition-related outcomes[6]

Oregon's Medicaid HRSN nutrition benefit model demonstrates how RDs can be integrated into coordinated workflows involving providers, Medicaid entities, and medically tailored meal services.[7,8]

RDs in value-based care models may support:

- Food insecurity screening workflows
- Interdisciplinary HRSN teams
- Medically tailored meal eligibility assessment
- Produce prescription programs
- Nutrition counseling and education
- Chronic disease self-management
- Community referral coordination
- Population health and quality improvement initiatives[2,6]

Strategic and community-based roles:

- Community nutrition planning
- Food security partnership development
- CBO collaboration
- Public health nutrition initiatives
- Nutrition policy implementation
- Outcomes evaluation and reporting
- Value-based purchasing initiatives[2,9]

Key message

Food insecurity interventions are most effective when nutrition care is integrated into interdisciplinary workflows rather than separated from clinical care. RDs can support both patient-level interventions and system-level implementation strategies.

References

1. Magnan S. Social determinants of health 101 for health care: five plus five. *NAM Perspectives*. Published online October 9, 2017. doi:10.31478/201710c
2. Foundation for Health Care Quality. *Social Need Interventions*. Bree Collaborative; June 27, 2023. Accessed April 5, 2026. https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Interventions-Recommendations-0627.pdf
3. Gundersen C, Ziliak JP. Food insecurity and health outcomes. *Health Aff (Millwood).* 2015;34(11):1830-1839. doi:10.1377/hlthaff.2015.0645
4. Berkowitz SA, Basu S, Meigs JB, Seligman HK. Food insecurity and health care expenditures in the United States, 2011-2013. Health Serv Res. 2018;53(3):1600-1620. doi:10.1111/1475-6773.12730
5. American Diabetes Association Professional Practice Committee for Diabetes. Facilitating positive health behaviors and well-being to improve health outcomes: Standards of care in diabetes-2026. *Diabetes Care*. 2026;49(Supplement_1):S89-S131. doi:10.2337/dc26-S005
6. Washington State Health Care Authority. *Nutrition Supports*. Medicaid Transformation Project. Accessed April 30, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/nutrition-supports
7. National Academy for State Health Policy. *Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health*. Published February 5, 2021. Accessed April 15, 2026. https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/
8. Oregon Health Authority. *OHP 1115 Waiver Documents and Reports*. Accessed April 15, 2026. https://www.oregon.gov/oha/hsd/medicaid-policy/pages/ohp-waiver-documents.aspx
9. Washington State Health Care Authority. *Value-based purchasing (VBP).* HCA.wa.gov. Published 2025. Accessed April 15, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing

Standardizing SDOH Documentation: Z-Codes & G-Codes

Why it matters

ICD-10-CM Z codes and Medicare HCPCS G-codes provide standardized approaches for documenting social determinants of health (SDOH) and supporting standardized clinical documentation and care coordination workflows.[1,2,3]

SDOH-related Z codes help healthcare organizations:

- Document social needs affecting care
- Support interdisciplinary communication
- Improve care coordination
- Identify population health trends
- Track intervention outcomes
- Support planning and implementation of social needs interventions[1]

CMS guidance notes that SDOH-related Z codes may be documented by clinicians, social workers, CHWs, case managers, nurses, or other care team members when included in the official medical record.[1]

Common SDOH Z codes:

- Z59.41 — Food insecurity
- Z59.82 — Transportation insecurity
- Z59.86 — Financial insecurity
- Z59.0 — Homelessness
- Z59.81 — Housing instability[1]

HCPCS G-Codes and Community Health Integration (CHI) Services

Medicare HCPCS G-codes may support reimbursement for selected assessment and care coordination activities related to food insecurity and other health-related social needs.[2,3]

Common HCPCS G-Codes:

- **G0136 — Nutrition and/or physical activity risk assessment**
  - Standardized, evidence-based assessment (5–15 minutes)
  - Must support medical decision-making
  - Results incorporated into the diagnosis or treatment plan
  - May be separately payable during an Annual Wellness Visit or eligible E/M visit[2]
- **G0019 — Community Health Integration (CHI) services**

    - **First 60 minutes** per calendar month
    - For patients with unmet SDOH needs interfering with diagnosis or treatment[3]
- **G0022 — Additional CHI service time**
    - **Each additional 30 minutes**
    - Furnished under general supervision[3]

CHI services require:

- An initiating visit performed by the billing practitioner
- Documentation of the unmet SDOH need
- Documentation connecting the SDOH need to the treatment plan
- Patient consent
- Services furnished under general supervision[3]

Key message

Documentation alone does not resolve social needs, but standardized coding may improve communication, coordination, reimbursement, population health tracking, and evaluation of intervention effectiveness.[1,3]

References

1. Centers for Medicare & Medicaid Services. *Improving the Collection of Social Determinants of Health (SDOH) Data With ICD-10-CM Z Codes*. Published 2023. Accessed April 30, 2026. https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf
2. Novitas Solutions. *Revision to Social Determinants of Health Risk Assessment (HCPCS Code G0136).* Accessed May 1, 2026. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00313277
3. Noridian Healthcare Solutions. *Community Health Integration (CHI) Services*. Last updated December 23, 2025. Accessed May 1, 2026. https://med.noridianmedicare.com/web/jeb/specialties/care-coordination/community-health-integration-chi-services

Food Insecurity Resources for Patients

- Getting Help With Food: SNAP, WIC, and Local Food Resources
- Follow-Up Care & Your Health: Medical Nutrition Therapy

Getting Help with Food: SNAP, WIC, and Local Food Resources

(Patient Resource Handout)

Food insecurity can make it harder to manage health conditions, recover from illness, take medications safely, and follow nutrition recommendations. Your healthcare team may ask questions about food access so they can help connect you with support services and community resources.[1]

SNAP (Basic Food Assistance)

The Supplemental Nutrition Assistance Program (SNAP) helps eligible individuals and families buy food using a monthly benefit card, including:

- Fruits and vegetables
- Meat, poultry, and fish
- Dairy products
- Breads and cereals
- Non-alcoholic beverages
- Seeds and plants that produce food for the household to eat[2]

WIC (Food for Women, Infants, & Children)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program provides food benefits, nutrition support, breastfeeding support, and health referrals for:

- Pregnant individuals
- Postpartum individuals
- Infants
- Young children under age 5[3]

Other community food resources

Ask your healthcare team or community organizations for help connecting to:

- Food banks and pantries
- Community meal programs
- School meal programs
- Produce prescription programs
- Medically tailored meal programs
- Local transportation or food delivery support

What to expect after your healthcare visit

If you or your family have trouble accessing food, your care team may:

- Ask follow-up questions about your food access needs
- Provide information about food programs
- Refer you to a community resource or navigator
- Connect you with a registered dietitian or other healthcare professional
- Follow up to make sure you were able to receive services

Key message

Food insecurity is common and can affect health in many ways. Asking for help is an important step toward supporting your health and well-being.

References

1. Office of Disease Prevention and Health Promotion. *Food Insecurity.* Healthy People 2030. US Dept of Health and Human Services. Accessed March 20, 2026. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity
2. Washington State Department of Social and Health Services. *Basic Food Program.* Accessed May 2, 2026. https://www.dshs.wa.gov/esa/community-services-offices/basic-food
3. Washington State Department of Health. *Women, Infants and Children Nutrition Program (WIC).* Accessed May 2, 2026. https://doh.wa.gov/you-and-your-family/wic

Follow-Up Care & Your Health: Medical Nutrition Therapy

Food access can affect your ability to manage health conditions, recover from illness, take medications safely, and follow nutrition recommendations. Your healthcare team may recommend follow-up nutrition care to help support your health goals.[1]

What is Medical Nutrition Therapy?

Medical Nutrition Therapy, also called **MNT**, is personalized nutrition counseling provided by a Registered Dietitian or **RD**. MNT includes nutrition assessment and individualized recommendations to help manage or improve specific health conditions.[2]

What happens during a nutrition visit?

An RD may help with:

- Diabetes
- Heart Disease
- High blood pressure
- Kidney disease
- Food allergies
- Eating disorders
- Malnutrition or unintended weight loss
- Food insecurity[2]

An RD may offer to:

- Review your medical history
- Discuss eating patterns and food access
- Help create realistic nutrition goals
- Provide meal planning ideas
- Help connect you with food resources or community programs
- Support long-term disease management[2]

Following up with your RD is important to:

- Monitor symptoms and nutrition status
- Adjust nutrition goals
- Address barriers to healthy eating
- Connect you with additional services[2]

Key message

Nutrition care should be personalized, realistic, and connected to your overall health goals. Your healthcare team is there to support you, not judge you.

References

1. Gundersen C, Ziliak JP. Food insecurity and health outcomes. *Health Aff (Millwood).* 2015;34(11):1830-1839. doi:10.1377/hlthaff.2015.0645
2. Academy of Nutrition and Dietetics. *What Is Medical Nutrition Therapy?* Published March 18, 2021. Reviewed March 3, 2026. Accessed May 2, 2026. https://www.eatright.org/health/wellness/healthful-habits/what-is-medical-nutrition-therapy

References

1. Magnan S. Social determinants of health 101 for health care: five plus five. *NAM Perspectives*. Published online October 9, 2017. doi:10.31478/201710c
2. Office of Disease Prevention and Health Promotion. *Food Insecurity*. Healthy People 2030. US Dept of Health and Human Services. Accessed March 20, 2026. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity
3. Foundation for Health Care Quality. *Social Need Interventions*. Bree Collaborative; June 27, 2023. Accessed April 5, 2026. https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Interventions-Recommendations-0627.pdf
4. Kaiser Family Foundation. *The Implications of Federal SNAP Spending Cuts on Individuals with Medicaid and Other Health Coverage*. KFF. Published 2024. Accessed April 10, 2026. https://www.kff.org/medicaid/the-implications-of-federal-snap-spending-cuts-on-individuals-with-medicaid-and-other-health-coverage/
5. Centers for Medicare & Medicaid Services (CMS), HHS. Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; etc. Final Rule. *Fed Regist*. 2025;90(225):53448-54088. (to be codified at 42 CFR §410, 411, 416, 419, 482, 485, 488, 489). Accessed April 15, 2026. https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
6. Centers for Medicare & Medicaid Services. *About Section 1115 Demonstrations*. Medicaid.gov. Published 2026. Accessed April 15, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations
7. Washington State Health Care Authority. *Value-based purchasing (VBP).* HCA.wa.gov. Published 2025. Accessed April 15, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing

8. U.S. Department of Agriculture. *USDA Actions on Nutrition Security*. U.S. Dept of Agriculture; 2022. Accessed April 15, 2026. https://www.usda.gov/sites/default/files/documents/usda-actions-nutrition-security.pdf

9. Odoms-Young A, Brown AGM, Agurs-Collins T, Glanz K. Food insecurity, neighborhood food environment, and health disparities: state of the science, research gaps and opportunities. *Am J Clin Nutr*. 2024;119(3):850-861. doi:10.1016/j.ajcnut.2023.12.019

10. American Diabetes Association Professional Practice Committee for Diabetes. Facilitating positive health behaviors and well-being to improve health outcomes: Standards of care in diabetes-2026. *Diabetes Care*. 2026;49(Supplement_1):S89-S131. doi:10.2337/dc26-S005

11. Gundersen C, Ziliak JP. Food insecurity and health outcomes. *Health Aff (Millwood)*. 2015;34(11):1830-1839. doi:10.1377/hlthaff.2015.0645

12. Berkowitz SA, Basu S, Meigs JB, Seligman HK. Food insecurity and health care expenditures in the United States, 2011-2013. *Health Serv Res*. 2018;53(3):1600-1620. doi:10.1111/1475-6773.12730

13. Rabbitt MP, Reed-Jones M, Hales LJ, Suttles S, Burke MP. *Household Food Security in the United States in 2024*. US Dept of Agriculture, Economic Research Service; 2025. https://ers.usda.gov/sites/default/files/_laserfiche/publications/113623/ERR-358.pdf?v=42589

14. Northwest Harvest. *Key Facts and Statistics.* Published 2025. Accessed March 20, 2026. https://www.northwestharvest.org/resources/key-facts-statistics/#WA

15. Centers for Medicare & Medicaid Services. *About Section 1115 Demonstrations.* Medicaid.gov. Accessed April 15, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

16. Centers for Medicare & Medicaid Services. *1115 Demonstration Monitoring & Evaluation*. Medicaid.gov. Accessed April 15, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation

17. North Carolina Department of Health and Human Services. *NCCARE360*. Accessed April 15, 2026. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nc-resource-platform

18. TennCare. *Health Starts*. Tennessee Department of Finance and Administration. Accessed April 15, 2026. https://www.tn.gov/tenncare/providers/programs-and-facilities/health-starts.html

19. Centers for Medicare & Medicaid Services. *TennCare III Medicaid Section 1115 Demonstration*. Published January 8, 2025. Accessed April 15, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-rebasing-appvl-01082025.pdf

20. NORC at the University of Chicago. *Addressing Health-Related Social Needs Through Medicaid Managed Care*. Accessed April 30, 2026. https://www.norc.org/content/dam/norc-org/pdfs/SDOH%20Brief.pdf

21. Milbank Memorial Fund. *Tennessee Medicaid's Health Starts Provider Partnerships.* Published August 3, 2022. Accessed April 15, 2026. https://www.milbank.org/publications/tennessee-medicaids-health-starts-provider-partnerships/

22. National Academy for State Health Policy. *Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health.* Published February 5, 2021. Accessed April 15, 2026. https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/

23. Oregon Health Authority. *OHP 1115 Waiver Documents and Reports.* Accessed April 15, 2026. https://www.oregon.gov/oha/hsd/medicaid-policy/pages/ohp-waiver-documents.aspx

24. New York State Department of Health. *Information for Health-Related Social Needs Service Providers*. Accessed April 30, 2026. https://healthweb-back.health.ny.gov/health_care/medicaid/redesign/sdh/scn/hrsn_svs_prov.htm

25. Center for Health Care Strategies. *Funding Community Health Worker Services in New York: Options Under Medicare and Medicaid.* Published August 2025. Accessed April 30, 2026. https://www.chcs.org/media/Funding-Community-Health-Worker-Services-in-New-York-Options-Under-Medicare-and-Medicaid.pdf

26. New York State Academy of Nutrition and Dietetics. *New York Health Equity Reform (NYHER).* Accessed April 30, 2026. https://eatrightny.org/new-york-health-equity-reform-nyher/

27. Massachusetts Executive Office of Health and Human Services. *MassHealth Section 1115 Demonstration Technical Corrections: Special Terms and Conditions.* Approved December 13, 2024. Accessed April 30, 2026. https://www.mass.gov/doc/masshealth-1115-demonstration-technical-corrections-stcs-12-13-24-0/download

28. Centers for Medicare & Medicaid Services. *MassHealth Medicaid and CHIP Section 1115 Demonstration.* Published October 9, 2024. Accessed April 30, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-hrsn-payment-methodology-approval.pdf

29. Washington State Health Care Authority. *Nutrition Supports.* Medicaid Transformation Project. Accessed April 30, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/nutrition-supports

30. Centers for Medicare & Medicaid Services. *New Jersey FamilyCare Comprehensive Demonstration.* Medicaid.gov. Accessed April 30, 2026. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82571

31. New Jersey Department of Human Services, Division of Medical Assistance and Health Services. *Medically Indicated Meals Pilot Program Details and Request for Proposals for Managed Care Participation*. Published August 4, 2025. Accessed April 30, 2026. https://www.nj.gov/humanservices/dmahs/home/NJFamilyCare_MIMPilot_08-04-2025.pdf

32. Washington State Health Care Authority. *HRSN Screening and Referrals.* Medicaid Transformation Project. Accessed April 30, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/hrsn-screening-and-referrals

33. Washington State Health Care Authority. *Community Information Exchange (CIE).* Medicaid Transformation Project. Accessed May 1, 2026. https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/community-information-exchange-cie

34. Health Level Seven International. *SDOH Clinical Care Scope.* HL7 FHIR Implementation Guide: SDOH Clinical Care for Multiple Domains. Accessed April 30, 2026. https://www.hl7.org/fhir/us/sdoh-clinicalcare/stu1/sdoh_clinical_care_scope.html

35. Health Level Seven International. *The Gravity Project Completes Food Insecurity and Housing Data Identification*. The Standard. Published December 17, 2020. Accessed April 30, 2026. https://blog.hl7.org/topic/gravity

36. Centers for Medicare & Medicaid Services. *Improving the Collection of Social Determinants of Health (SDOH) Data With ICD-10-CM Z Codes.* Published 2023. Accessed April 30, 2026. https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

37. Foundation for Health Care Quality. *Social Need Screening*. Bree Collaborative; June 27, 2023. Accessed May 1, 2026. https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Screening-Recommendations-0627.pdf

38. National Association of Community Health Centers. *PRAPARE Implementation and Action Toolkit*. Accessed May 1, 2026. https://prapare.org/prapare-toolkit/

39. Children's HealthWatch. *The Hunger Vital Sign™*. Accessed May 1, 2026. https://childrenshealthwatch.org/hunger-vital-sign/

40. Novitas Solutions. *Revision to Social Determinants of Health Risk Assessment (HCPCS Code G0136)*. Accessed May 1, 2026. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00313277

41. Noridian Healthcare Solutions. *Community Health Integration (CHI) Services.* Last updated December 23, 2025. Accessed May 1, 2026. https://med.noridianmedicare.com/web/jeb/specialties/care-coordination/community-health-integration-chi-services

Appendix

Figure 1. Integrated Care Teams