NJ FamilyCare
Medically Indicated Meals Pilot Information
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Medically Indicated Meals Pilot
Program Details and Request for Proposals for Managed Care Participation
August 1, 2025

The purpose of this document is to provide details on a nutritional pilot for pregnant enrollees and welcome applications from NJ FamilyCare MCOs to become a MCO partner in the pilot.

CMS has approved DMAHS to operate a Medically Indicated Meals (MIM) Pilot Program under the Health Related Social Needs (HRSN) framework of NJ's current 1115 Demonstration. DMAHS has approval to operate a pilot that supports the delivery of medically indicated meals for up to 300 eligible members per demonstration year, from July 1, 2025-June 30, 2028[1].

To operate this pilot, DMAHS will select 1-2 MCO partners to offer medically indicated meals to their eligible managed care enrollees. Interested MCOs must follow the instructions in this document to apply for and receive DMAHS approval as a MCO partner collaborating with DMAHS on the MIM pilot.

MIM Pilot Goals

MIM (also known as medically tailored meals/MTM) is a "food as medicine" approach to improve maternal and infant health outcomes and reduce health disparities for NJ FamilyCare members.

DMAHS' implementation goals for the pilot:

1. Design and operate the pilot in a way that is culturally responsive and member-centered.
2. Recruit and sustain robust and equitable member engagement in the pilot.
3. Recruit and reimburse meal vendors that provide medically-indicated meals that participating members want to eat.
4. Closely align member outreach and engagement for the pilot with existing managed care obstetrical case management efforts for this high-risk population.
5. Maintain active, close DMAHS-MCO collaboration to maximize the potential positive impact of the pilot on member's pregnancy experience and pregnancy-related outcomes.
6. Prioritize a flexible implementation strategy that minimizes administrative burden where possible to create the conditions for a successful pilot.
7. Conduct a rigorous evaluation of this pilot that assesses the impact of medically-indicated meals on pregnancy-related outcomes.

[1] See page 29 (of 300) in NJ's 1115 Renewal STCs. See also NJ's HRSN Services Protocol.

MIM DMAHS Team Contacts

If you have any questions regarding the MIM pilot, please email mahs.mealspilot@dhs.nj.gov.

The MIM DMAHS team includes:

- *Primary point of contact:* Stacy Grim – Office of Policy and Innovation, 1115 Demonstration Manager
- Shin-Yi Lin, PhD – Office of Policy and Innovation, Deputy Director of Policy
- Trish Patsaros – Office of the Medical Director

MIM Benefit Description

Members eligible to be a participant in the MIM pilot

Participation in the MIM pilot is voluntary for eligible managed care enrollees.

The MCO partner must develop a process to determine member eligibility for participation in the pilot. A member is eligible to participate in the MIM pilot if they meet each of the following criteria:

1. *Managed care membership:* Is a managed care enrollee with a MCO partner that has been approved to collaborate with DMAHS on the MIM pilot.
2. *Clinical risk factor:* Is pregnant and
    1) diagnosed with diabetes prior to pregnancy, or,
    2) diagnosed with gestational diabetes during pregnancy.
3. *Social risk factor:* Individuals who meet or the USDA definition of low or very low food security and are experiencing challenges in meeting their nutritional needs. Assessment of food security status need not use USDA's Food Security Survey Module. At minimum, MCO partners must accept the Perinatal Risk Assessment as one tool to assess food security status, and accept "Yes" for any of the Psychosocial Risk Factors on the member's Perinatal Risk Assessment as one way to meet the definition for low or very low food security.
4. Has an address where they reside where they can safely receive, store and re-heat prepared meals.

Covered benefits for participants in the MIM pilot

As a participant in the MIM pilot, a member may receive meals throughout pregnancy through at least two months after the end of pregnancy.

The MCO partner must ensure that members are receiving prepared medically-indicated meals that meet each of the following criteria:

- To be "medically-indicated," meals must be approved by a Registered Dietitian Nutritionist and meet the needs of a pregnant and diabetic individual.
- These meals should be delivered to the address where the member resides.
- Each meal delivery should include detailed instructions for the individual to safely store and re-heat prepared meals. Whenever possible, meals should include information on how to recreate the meals using fresh ingredients.
- Participants can receive up to 2 meals per day. Each of these medically-indicated meals should be billed on behalf of the member using the code S5170 SC and will be reimbursed at $15/meal.

Benefits can be extended for an additional 6-month period in the postpartum period – for up to an 8-month period postpartum – if the individual continues to meet the social risk factor criteria and continues to have diabetes in the second month after the end of pregnancy. The MCO partner must develop a process of approval for this extension request that includes documentation that participants have met these extension criteria.

No nutrition-related benefits to participants in the pilot will be provided in the form of cash, as that may render the member or their household ineligible for SNAP or WIC.

To the fullest extent possible, all MIM pilot activities and services must be provided in a way that is culturally responsive. This includes meaningful access to language services and providing culturally appropriate meals when possible.

Covered benefits for participants' household in the MIM pilot

If the participant has other household members, they will have the additional option for nutrition support to be delivered to the rest of the household for the duration of their participation. This option is provided to support the participant consuming the medically indicated meal, instead of offering it to relieve food insecurity of other household members.

The MCO partner must develop a process of approval for additional household nutrition support.

The MCO partner must ensure that households are receiving support that meets each of the following criteria:

- Nutritional support should be provided in the form of a prepared meal. These meals do not need to meet the "medically-indicated" standard but should be healthy and nutritious.
- These meals should be delivered to the address where the participant resides.
- Each meal delivery should include detailed instructions for the individual to safely store and re-heat prepared meals.
- The participant's household can receive up to 10 of these additional meals per week. Each of these meals should be billed on behalf of the pregnant/postpartum member using the code S5170 UK and will be reimbursed at $8/meal.

MIM vendor requirements for reimbursement in the MIM pilot

The MCO partner must ensure that the vendor they recruit to deliver meals and receive reimbursement in the pilot meets each of the following criteria:

- Is able to provide medically-indicated meals to the participating pregnant member.
- Is able to provide additional nutrition support in the form of meals for other individuals in the household.
- Is able to deliver meals to NJ residences.
- Designs medically-indicated meals that are approved by a Registered Dietitian Nutritionist and meets the individual's nutritional needs, including personal and cultural dietary preferences whenever possible.
- Prepares and delivers meals following best practice guidelines and industry standards for food safety.

To the fullest extent possible, we encourage the MCO partner to incorporate the organization's capacity to operate in a culturally responsive way—especially with regards to offering culturally appropriate meals—during your vendor selection process.

We have a list of MIM vendors that have outreached to DMAHS staff in the Appendix of this guidance. MCO partners do not need to restrict their recruitment of a vendor to this list, it is only provided for your information.

MCO partner requirements related to the MIM pilot

Each MCO partner approved to collaborate with DMAHS on the MIM pilot must:

1. *MIM vendor identification:* Recruit a single MIM vendor to partner with for the pilot.
2. *Identification of eligible enrollees to participate*: Establish pathways to identify enrollees that must include:
    a. The MCO partner proactively identifying and engaging eligible enrollees through current workflows, and,
    b. Individuals or their clinical providers contacting the MCO partner for self-referral or direct referral to request a screening and eligibility determination.

    The MCO must describe the policy to fairly allocate spots in the event that demand for participation in the pilot exceeds capacity. Note: The following enrollees are not eligible to participate in the pilot: Cover All Kids (Phase 2, i.e., pediatric enrollees covered by state-only dollars), HCBS participants
3. *Documentation of enrollee eligibility:* Must develop criteria to assess members' clinical and social risk. Must develop a process to identify and confirm an enrollee's eligibility to participate in the pilot. Must develop the process to collect and retain documentation of each eligible enrollee meeting the clinical and social risk criteria. Documentation may include:
    a. Diagnosis codes from paid claims
    b. Perinatal Risk Assessment fields
    c. Information from the MCO partner's specific case management screening questions, intake form, or case management file for that enrollee
    d. A clinical referral

4. *Initial engagement with enrollees:* Make reasonable efforts, in collaboration with selected MIM vendor, to expeditiously notify eligible enrollees, confirm their eligibility and interest in participating, and assess them for additional household members. The MCO partner should ensure that meal delivery is initiated in a timely manner for any interested enrollees during pregnancy.
5. *Engagement with participants and alignment with existing obstetrical case management activities:* Must make reasonable efforts, in collaboration with selected MIM vendor, to continuously engage participants in the MIM pilot so that they remain in the pilot and continue to receive meal deliveries for the duration of their eligibility. This includes incorporating participants in existing obstetrical case management workflows so that any clinical, dietary and social needs are addressed in coordination with their participation in the pilot.
6. *Identification of participants eligible for 6-month extension:* Must develop a process to outreach participants in advance of the end of meal delivery at 2-months postpartum to determine whether they are eligible and interested for the extension. The MCO partner must develop a process of approval for the subset of participants eligible to receive extension of benefits for an additional 6-month period after the end of pregnancy. This process for extension must be inclusive of member-initiated and provider-recommended requests. This process must include documentation that the participant continues to meet the social risk factor criteria and continues to have diabetes in the second month after the end of pregnancy. Given that the pilot is focused on addressing nutritional needs of enrollees who are pregnant and diabetic, pilot operations will pay particular attention to comprehensive screening and identification of nutrition-related needs, and, referrals of participants to WIC and SNAP.
7. *Participants' transition at the end of pilot*: Must develop a process to engage a participant near the conclusion of their participation in the pilot to re-assess the status of the pregnancy-related health risks or needs identified in the participant's written care plan (see 5. above). As part of this re-assessment, the MCO's obstetrical case management team must determine if any new health risks or needs have arisen after the end of pregnancy, and whether identified risks or need may impact the enrollee's health up to 12 months after the end of pregnancy. Given that the pilot is focused on addressing nutritional needs of pregnant and diabetic enrollees, the re-assessment will pay particular attention to supporting access to WIC and SNAP benefits for the enrollee and their household members, and accessing any other available nutritional supports when enrollees are no longer receiving MIM benefits. For enrollees identified as having ongoing health risks or needs impacting health beyond the duration of pilot participation, their engagement with the MCO's obstetrical case management team (or Core Care Management, if appropriate) should not be concluded when their participation in the pilot concludes and may continue at least through 12 months postpartum depending on member's case.
8. *Public-facing documentation:* Must create and maintain public documentation of MIM pilot program information. This information must include, at minimum, eligibility criteria and the process for self-referral into the pilot—on a public-facing webpage of their website.

9. *Monitoring and evaluation:* Must make reasonable efforts to participate in and support any required reporting on and evaluation of the MIM pilot associated with 1115 Demonstration initiatives (see Appendix section (B) for further information on evaluation responsibilities). Given that the pilot is focused on addressing nutritional needs of pregnant and diabetic enrollees, MCO partner(s) will provide updates on participants' self-reported status on receipt of WIC and SNAP benefits as part of routine monitoring of pilot operations. While our primary focus will be on monitoring data associated with the eligible enrollees who do participate in the pilot, we would also like to collect and review data of those eligible enrollees who do not to participate to the extent that we can to proactively consider any barriers or disparities in access to the pilot.

Selection process for MCO partners

We invite each of our MCOs to submit Proposals to become a MCO partner for the MIM pilot.

Given that DMAHS only has authority to provide MIM pilot services to 300 eligible managed care enrollees per demonstration year, DMAHS intends to identify no more than 2 MCO partners for the pilot.

Interested MCOs must submit a Proposal to DMAHS and receive approval as a MCO partner collaborating with DMAHS on the MIM pilot from the MIM DMAHS team.

Timeline

MCO proposals due to DMAHS	Friday August 29, 2025
DMAHS decision	By September 30, 2025
MIM pilot launch	TBD

Submission requirements

Proposals must be submitted by **11:59pm on Friday, August 29, 2025.**

Proposals should use the associated DOCX template provided. The template provides specific guidance for each Proposal element and maximum page limits.

When complete, it should be converted into a single PDF, not to exceed 9 single-spaced pages. Proposals should be emailed to mahs.mealspilot@dhs.nj.gov with the Subject: "[MCO]: MIM Pilot Proposal, [date]". Any appendix materials that can be shared in a PDF form should be combined with the required elements of the proposal into a single PDF. If needed, an additional XLS appendix (Section 3) may be included as a second attachment to that email.

DMAHS obligations related to the MIM pilot

Review process

Prior to accepting an MCO Proposal, DMAHS will ensure that each Proposal complies with the instructions described in this Guidance and CMS requirements. DMAHS will review and evaluate all qualified responses received by the deadlines specified in this Guidance. DMAHS may designate other individuals or subject matter experts to assist in the evaluation process. Upon review, DMAHS will either grant Approval of each Proposal, or if a Proposal is not found to be approvable, DMAHS may request subsequent revisions and resubmission. Resubmission may result in a delay in timeline that may postpone the implementation date. If after resubmission a Proposal is still not found to be approvable, DMAHS may reject a MCO's Proposal.

Collaboration

Upon selection of 1-2 MCO partners, DMAHS will:

1. *Identification and engagement with enrollees:* Work with MCO partner(s) to finalize pilot design and establish pilot operations that maximize equitable enrollee recruitment and continued engagement.
2. *Ongoing process improvement:* Work with MCO partner(s) to identify interim process metrics to assess effective pilot implementation and discuss strategies for process improvement.
3. *Public-facing documentation:* Provide public access to MIM pilot program information from DMAHS' 1115 website.
4. *Formal monitoring and evaluation*: Inform and work with MCO partners to meet required reporting on and evaluation of the MIM pilot associated with the 1115 Demonstration.

Reimbursement for services

Upon selection of 1-2 MCO partners, Payments for this service will be a non-risk payment paid outside of capitation. DMAHS will make an interim payment at the beginning of the rating period based on cost estimates. Cost reconciliation will occur at the end of the rating period based on MCO financial submissions. Reimbursement procedure established in accordance with the "Non-Risk Services" (Article Eleven) introduced in the July 2025 MCO contract.

Appendix

A) Monitoring (language excerpted from 1115 Demonstration Standard Terms and Conditions[2])

The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. NQF "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

For the HRSN initiatives, in addition to reporting on the quality of care and health outcomes metrics described above, the state must track beneficiary participation, screening, rescreenings and receipt of referrals and social services over time. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The state's reporting of metrics must also capture the number of pregnant individuals with a diagnosis of either pre-existing diabetes and/or gestational diabetes served under the Medically Indicated Meals Pilot, and corresponding service utilization.

B) Evaluation

Each Pilot will be independently evaluated by the Demonstration Evaluator, Rutgers Center for State Health Policy (CSHP). Each participating MCO must cooperate with the Evaluation, and each Proposal must include a plan to do so. This may include a plan to provide data, make relevant staff accessible for interviews, or facilitate outreach to members to request that they voluntarily participate in interviews or surveys. Data may be requested in a standardized format or through a platform provided by the Evaluator.

Data regarding achievement of number of beneficiaries served, health outcomes, payments and other relevant information for each approved MCO initiative must be reported to the State annually (the Evaluator may require more frequent reporting, e.g., monthly or quarterly) to be submitted to CMS as a part of the Annual Demonstration Monitoring Reports, which will be posted to the DMAHS and CMS websites.

[2] See pages 125 and 127 (of 300; STC 12.8) in NJ's 1115 Renewal STCs.

While the pilot is underway, the selected MCOs will provide annual updates to DMAHS implementation team on identification of eligible members, outreach to eligible members, and participation in the pilot using the MCO's data sources. This will include corresponding service utilization, cost assessment and encounter data stratified by demographic subpopulations.

At the conclusion of the pilot, Rutgers will conduct a formal evaluation using quantitative claims-based metrics and qualitative informant interviews. Pending CMS approval, the evaluation will include outcome measures for the pregnant individual and the newborn including vaginal delivery rate, newborn birth weight, ED visits, spend for inpatient and outpatient care. Process measures include medical care for pregnant individuals and their newborns, postpartum glucose screening, depression screening, and cost of care. These claims-based measures are similar to HEDIS metrics around prenatal and postpartum care, cesarean delivery, and well-child visits. These data will be disaggregated by race/ethnicity and geography, as appropriate.

C) List of potential MIM vendors

For your information, this is a list of vendors that have reached out to DMAHS with interest in participating in NJ's MIM pilot. It is provided to MCO partners for your convenience in finding a vendor, if needed.

Vendor Name	**Staff Contact Name**	**Staff email**
Brooklyn Kitchen	Jackie Philbin Director of Healthcare Partnerships	Jackie.philbin@brooklynkitchen.com
Gods Love We Deliver	Dorella Walters Chief Business Development Officer	dwalters@GLWD.org
MANNA	Becca Boova-Turne Healthcare Partnership Manager	rboova-turner@mannapa.org
Roots	Ray Chaudhuri	ray@healthfulmeals.com
Mom's Meals	Cole Bradham VP, Medicaid Innovation	cole.bradham@momsmeals.com

NJ FamilyCare Medically Indicated Meals Pilot – MCO Proposal Template

Purpose: Proposal to receive approval by DMAHS as a MCO partner to operate a pilot that supports the delivery of medically indicated meals.

Name of MCO:

Primary Staff Contact for Application:

Name:

Title:

Email:

This completed proposal should be converted into a single PDF, not to exceed 9 single-spaced pages. Proposals should be emailed to **mahs.mealspilot@dhs.nj.gov** with the Subject: "[MCO]: MIM Pilot Proposal, [date]". Any appendix materials that can be shared in a PDF form should be combined with the required elements of the proposal into a single PDF. If needed, an additional XLS appendix may be included as a second attachment to that email.

This template includes comments that describe the prompts for each of the required proposal elements. The prompts include recommended page limits for each element (up to 8 pages). You have an additional page (for a document of 9 pages total) that you can use for any section of your choosing. When converting your final proposal into a PDF, please delete the comments.

Section 1: MCO goals
(0.5 page): Describe your MCO's primary goals if approved as a MCO partner for the MIM pilot.

Section 2: Proposed MIM MCO team
(0.5 page): Briefly share names of key personnel, including contact emails, titles and relevant credentials/experience. You must select one staff member to be the primary point of contact

Section 3: Population analytics of eligible enrollees
(1 page):

a) Population-wide analytics: Describe the proportion of your pregnant enrollees estimated to be eligible for the pilot. This description should include tables/graphs as well as narrative text, with analytics derived from existing data sources. Disaggregation of the eligible population by zip/geography, race/ethnicity, language spoken and/or other clinical factors is strongly recommended.
b) Targeted population: Estimate the fraction of the total program-wide 300 enrollees per demonstration year that can be recruited from among your enrollees.
    - A MCO partner can make a proposal to focus pilot implementation such that MIM pilot recruitment is limited to a sub-population of your eligible enrollees (for example, by zip/geography). If relevant, your MCO should provide a detailed description of rationale and a comparison of sub-population-level analytics with the population-wide level analytics described in Section 3a.
c) Optional: Tables/graphs associated with analytics may be included as a XLS Appendix that is not subject to the page limit.

Section 4: MIM Vendor selection and engagement
(0.5 page): Describe the criteria that will be used for MIM vendor selection. The Appendix includes a list of vendors that have outreached to DMAHS with their interest in participation in the pilot, for your information. If you have a proposed vendor already, please share rationale. Describe any other aspects of MIM Vendor engagement that isn't described elsewhere in the proposal.

Section 5: Process for enrollee identification, engagement/care planning, and transition
(2 pages): Describe key elements of your proposed workflow for pilot operations, providing details that are responsive to the expectations described above in MCO partner requirements #2-7 related to the MIM pilot. Your description must highlight:

a) elements that leverage existing processes
b) actions to promote equitable participation
c) identification and management of health-related social needs—including activities specific to supporting participants in WIC/SNAP enrollment
d) areas of collaboration with selected MIM vendor—including any specific responsibilities proposed for the MIM vendor

\Section 5: Process for enrollee identification, engagement/care planning, and transition (con't)

e) partnership with existing obstetrical case management team members and activities
f) alignment with broader health care delivery—including NJ FamilyCare obstetrical clinical providers for participants
g) Optional: If desired, you may provide detailed technical descriptions of inclusion/exclusion criteria as an Appendix that is not subject to the page limit.

Section 6: Current activities, *Anticipated strengths and Anticipated barriers*

Current activities (0.5 page), Anticipated strengths (0.5 page) and Anticipated barriers (0.5 page)

a) Describe current activities within the MCO to address the care of perinatal members with diabetes.
b) Describe your anticipated strengths that would support successful implementation of pilot operation. This can include related/recent initiatives run by your MCO, expertise recruited on MIM MCO team, and/or the ability to leverage existing workflows.
c) Describe anticipated challenges or barriers to successful implementation that would be areas of focus during pre-implementation design and ongoing monitoring. Attention to any specific equity-related challenges, as they relate to demographics described in Section 3a, is recommended.

Section 7: Monitoring

(1 page): Describe your organization's proposed internal monitoring processes—including metrics of interest—for ongoing assessment of pilot, and how they relate to your MCO goals (Section 1) and/or DMAHS goals (see Guidance).

Section 8: *Proposed pilot launch date*

(0.5 page): You must propose a date by which your MCO can begin delivering meals to pilot participants. Describe intermediate pilot milestones and proposed milestone deadlines leading up to that launch date.

Optional submission elements – not subject to the page limit

1. Tables/Graphs associated with Population Analytics in Section 3 (if in PDF format, add as an Appendix to the Proposal a single PDF; if in XLS format, include as a separate attachment emailed with the Proposal PDF)
2. Detailed technical descriptions of inclusion/exclusion criteria described in Section 5 (add as an Appendix to the Proposal in a single PDF)
3. Letters of support (add as an Appendix to the Proposal in a single PDF)

NJ HRSN Payment Methodologies and Fee Schedule: Medically Indicated Meals Pilot

Background: In accordance with the state's Section 1115 Demonstration Special Terms and Conditions (STCs), all rate and/or payment methodologies for authorized HRSN services outlined in the STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment as well as non-risk payments and capitation rates in managed care delivery systems, as required by Section 10.14. NJ must submit all documentation requested by CMS, including but not limited to the payment rate methodology, as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting FFS payment rates.

1 Health-Related Social Need (HRSN) Service Fee Schedule: Medically Indicated Meals Pilot

Service	Procedure code	Expected Unit Cost	Service unit	Service description	Methodology DMAHS used to develop rate/cap/range
Medically Indicated Meal	S5170 SC	$15	Per Meal	Prepared, medically-indicated meal	State derived cost-based payment amount by comparison to existing (non-medically indicated) meal delivery reimbursement in NJ and other Medicaid programs offering medically-indicated meal benefits. NJ compared rates to peer state benchmarks including Oregon Health Plan; North Carolina Health Opportunities Pilot; New York's Medicaid Redesign Team; Michigan's Comprehensive Health Care Program: In Lieu of Services; and MassHealth Health Related Social Needs (HRSN) Services program.
Additional nutrition support (provided in the form of meals, need not be a medically indicated meal)	S5170 UK	$8	Per Meal	Prepared meal	