AMPL
INSTITUTE

A View of the Field

The Landscape of Medically Tailored Nutrition in 2026

ABOUT THE AMPL INSTITUTE

Access to Medically Tailored Nutrition Through Policy and Leadership

The AMPL Institute is where excellence in providing medically tailored nutrition meets pioneering research, policy work, and provider education. Our mission is to transform the healthcare system so that medically tailored nutrition becomes a universally accessible standard of comprehensive, person-centered care.

AMPL's central policy objective is to make medically tailored nutrition an established benefit in Medicaid and Medicare. Any person living with severe, complex, or chronic illnesses should have access to medically tailored nutrition, regardless of their health condition, geography, or ability to pay.

The AMPL Institute is based at Community Servings, the largest nonprofit provider of medically tailored nutrition in New England.

ABOUT THIS REPORT

A View of the Field is the AMPL Institute's annual report on issues relevant to the provision of medically tailored nutrition in the United States. Each year, it surveys compelling challenges and opportunities in the integration of medically tailored nutrition into the U.S. healthcare system.

The AMPL Institute thanks Takeda for contributing to the development of this report.

The commentary in this report is derived from the research and analysis of the AMPL Institute. The findings and conclusions in this report are those of the authors and do not necessarily reflect positions or policies of any other organization, including the partners or funders of the AMPL Institute and Community Servings.

Where applicable, sources are cited in the notes section. The names of Community Servings clients have been changed to protect their privacy.

ACKNOWLEDGMENTS

A View of the Field was written by the following Community Servings staff members:
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Courtney S. Harrison, a student at the Friedman School of Nutrition Science and Policy at Tufts University, contributed to "The Case for Culinary Medicine." Evaluation and analysis of the Culinary Medicine Program at the AMPL Institute were conducted and reported by Stephanie Coker, MPA, doctoral student at Claremont Graduate University.

Thank you to the following individuals who interviewed with the authors and generously shared their time and expertise:

Carolyn Boyd, Senior Manager of Nutrition Services, Community Servings
Nicole Caudill, Director of Community Meals, Second Harvest Food Bank of Northwest North Carolina
Jessica Dacey, Duals Program Manager, Mass General Brigham Health Plan
Colleen Dagley, Research Dietitian, Community Servings
Alizah Diaz, Bilingual Client Services Coordinator, Community Servings
Erin DiBacco, Senior Director of Strategy and Business Development, Community Servings
Hannah Freking, Food as Medicine Director, La Soupe
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Katharine Newell, Research Dietitian, Community Servings
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Leah Hebert Welles, Chief Executive Officer, Open Arms of Minnesota
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Special thanks to the clients of Community Servings who shared their stories.
We are honored to serve you.

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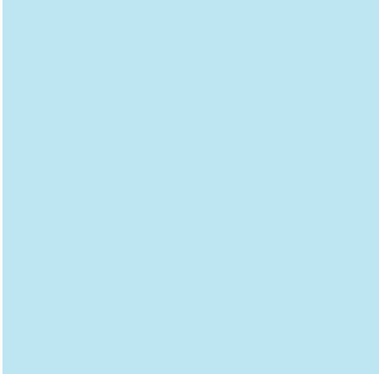


ABBREVIATIONS

ACA – The Patient Protection and Affordable Care Act
ACL – Administration for Community Living
ACO – Accountable Care Organization
ACR – Accreditation Criteria and Requirements
CBO – Community-based organization
CCFS – Community-centered Food Sourcing
CME – Continuing medical education
CMS – Centers for Medicare and Medicaid Services
DGAs – Dietary Guidelines for Americans
ED – Emergency department
FIM – Food is Medicine
FIMC – Food is Medicine Coalition
HCBS – Home- and Community-Based Services
HCPCS – Healthcare Common Procedure Coding System
HHS – U.S. Department of Health and Human Services
HOP – Healthy Opportunities Pilots
HRSN – Health-Related Social Needs
ILOS – In Lieu of Services
MAHA – Make America Healthy Again
MCO – Medicaid Managed Care Organization
MTG – Medically tailored groceries
MTM – Medically tailored meals
MTN – Medically tailored nutrition
NIH – National Institutes of Health
RCT – Randomized controlled trial
RDN – Registered dietitian nutritionist
RWHAP – Ryan White HIV/AIDS Program
SDOH – Social determinants of health
SNAP – Supplemental Nutrition Assistance Program
SSBCI – Special Supplemental Benefits for the Chronically Ill
USDA – U.S. Department of Agriculture
VA – U.S. Department of Veterans Affairs

PREFACE

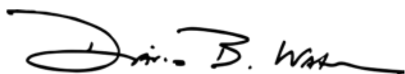
Despite shifting federal priorities over the last year, the Food is Medicine movement continues to gain ground.

New research has demonstrated that Food is Medicine interventions funded through Medicaid reduce acute healthcare use and healthcare costs. Lawmakers across the country have introduced and passed state legislation to create access to medically tailored meals. Food is Medicine not only remains a bipartisan policy issue; it's an area of enduring common ground and growing popularity.

Now is the time to stay engaged. As you read this report, I hope you're as encouraged as I am. Yes, there are challenges, but there are also extraordinary opportunities. Let's remember why we're doing this: Each meal delivery is nourishment, community, sustenance, and powerful medicine for the individuals we serve.

Every year, as the field rapidly evolves, AMPL publishes *A View of the Field* to offer a practitioner's perspective and center our mission in the national movement. Medically tailored nutrition *should* be accessible to anybody with severe, complex, or chronic illnesses, regardless of where they live or whether they can pay. We haven't achieved that goal yet. If we keep working together, I know we will.

Let's keep up the momentum.



David B. Waters,
CEO, Community Servings
Founder, the AMPL Institute

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EXECUTIVE SUMMARY

Poor nutrition is a leading cause of illness, preventable healthcare spending, and lost productivity.[1] It is directly related to heart disease, diabetes, and kidney disease—several of the leading causes of death in the U.S.[2] Food insecurity—a limited or uncertain level of access to adequate food—is associated with a higher risk of poor dietary quality and preventable chronic disease.[3] Poor nutrition is estimated to be responsible for $50 billion in healthcare costs each year.[4]

In recent years, Food is Medicine interventions have emerged as cost-effective solutions for the treatment of diet-related disease.[5] A nationwide coalition of nonprofit community-based organizations, many of which have roots in the HIV/AIDS epidemic, collaborates with the healthcare sector to provide evidence-based Food is Medicine services, such as medically tailored meals and groceries.[6]

AMPL'S VIEW OF THE FIELD IN 2026

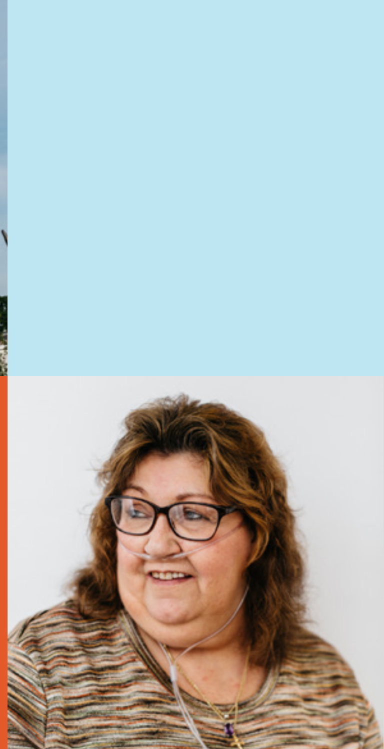
Positive Momentum for Food is Medicine on the One Hand, Challenges to Access on the Other
Food is Medicine continues to draw bipartisan interest and aligns with current federal priorities, such as reducing chronic disease rates through healthy diet. However, recent changes to Medicaid and SNAP may reduce access to healthcare and food assistance and create new budgetary constraints for state governments and challenges for policy advocates.

A Turbulent Time for Communities and Nonprofits
Pervasive economic and policy uncertainty has created funding concerns throughout the field. Some nonprofit community-based organizations are experiencing limited capacity as demand for services increases.

Food Procurement Policy in Food is Medicine
There is growing interest in the synergy between food procurement policy and Food is Medicine, with stakeholders in the field actively considering the economic, environmental, and social impacts of FIM programs.

Lessons Learned from Community Servings' Medically Tailored Groceries Evaluation
Given the varying definitions of medically tailored groceries in the field, this report summarizes Community Servings' evaluation of its successful 2025 pilot intervention.

A Growing Need for Research Amid Policy Uncertainty
Research is particularly important in today's environment of tightening state budgets. Recently published research shows that medically tailored meals and other nutrition services offered through Medicaid Section 1115 demonstrations reduce acute healthcare utilization and lower healthcare costs.



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INTRODUCTION

In September 2025, shortly before the federal government shutdown, we asked Community Servings' frontline staff how clients were doing. Were there any notable changes in this year's client experience?

The answer was that clients were facing the usual challenges.

As they navigate complex health issues and high costs of living, Community Servings clients generally face difficulty accessing and preparing healthy food independently. Last fall, one client told Senior Manager of Nutrition Services Carolyn Boyd, “It's really hard for me to manage my blood sugar because I can't afford healthy foods.” Clients also feel trepidation about program eligibility. They worry about the recertification process. The risk of losing benefits is a stressor. “Clients often live alone and they are super sick,” explains Bilingual Client Services Coordinator Alizah Diaz. “Many times they are older. They have a fixed income. And it's not easy for them to navigate the technical side,” meaning completing paperwork and complying with reporting requirements.

We heard many of the same themes throughout 2025 when we spoke with clients directly. What also became clear was that for clients, challenges do not come one at a time. For many individuals and households, complex health needs coincide with crises that fall outside of traditional healthcare—crises related to housing, finances, toxic stress, or access to food.

Today, the issue of access is key. Federal policy has changed in ways that may make it harder for certain clients to obtain the healthcare and food assistance they need. This has particularly concerning ramifications for people who are living with low incomes and with severe, chronic, and complex health needs. These are the populations that stand to benefit the most from MTN. They are also the populations that could face new obstacles to being as healthy as possible.

A HARD YEAR

It was a hard year for Cassandra, a Community Servings client in 2025. Cassandra lives near Kendall Square, Cambridge, in an income-restricted apartment. A massage therapist, she travels throughout Boston to see clients. She is the primary caregiver for her father, who lives alone in West Roxbury.

In April, Cassandra was diagnosed with ductal carcinoma. It was her second time being diagnosed with breast cancer in 10 years and, in Cassandra's words, "there was a lot of it, and the doctors knew I needed surgery right away." She got a double mastectomy just a few weeks later.

Mere days after Cassandra's diagnosis, her father had a stroke. Suddenly, Cassandra found herself managing crises on multiple fronts: She was preparing for surgery and life afterward. At the same time, she was making painful decisions about her father's long-term healthcare, finances, and housing.

Amid all of this, there was some encouragement. With funding from Massachusetts' Medicaid Section 1115 demonstration, Cassandra's health plan referred her to Community Servings for MTM. It was an enormous help after surgery, when Cassandra's mobility was limited and she was unable to take on paying work or shop for groceries. Through MTM, she had access to fully prepared, medically appropriate meals that took her dietary restrictions into account and tasted good too. She was able to rest and recover. However, she continued to experience significant stress. In the fall, Cassandra helped her father move into a nursing home. During the holiday season, she received a termination notice from the Department of Transitional Assistance about her SNAP benefits.

Cassandra's story reminds us of the many factors upon which health and well-being stand. It shows the psychological distress of one person's experience of food insecurity and illness, while caring for a family member at the same time. It previews stressors for beneficiaries of Medicaid and SNAP.

RESPONSES TO THE GOVERNMENT SHUTDOWN

On October 1, 2025, an impasse in the U.S. Congress prompted a federal government shut-down, a consequence of which was benefit disruption in SNAP,[7] the federal food assistance program that many Community Servings clients are enrolled in. Uncertainty ensued in states when the federal government suspended funding for SNAP benefits effective November 1.[8]

At Community Servings, the SNAP crisis prompted what Boyd describes as “an extremely intense time” for her department. Many callers were seeking emergency food assistance or help heating their homes. “*I don’t know what to do*,” clients said during intake calls, citing utilities costs, housing costs, and other pressures. Community members walked trolley dollies up to our front door, inquiring whether the facility was a food bank. Newly enrolling clients remarked about MTM or MTG, “This comes at a good time because my SNAP benefits won’t work this month.” Boyd says that the burden of the SNAP crisis lingered into 2026 for clients, as the winter season brought the holidays and larger heating and electric bills, placing extra strain on households’ resources.

Particularly visible during the shutdown was the degree of trust that nonprofit CBOs hold in the communities they serve and among partner organizations. Here are two examples of how the dependability of CBOs was put into action during the shutdown.

> To support emergency food access during and after the shutdown, Community Servings partnered with La Colaborativa, a nonprofit in Chelsea, Massachusetts, to hold a weekly congregate meal program for the month of November. An unplanned initiative, the partnership with La Colaborativa was made possible by philanthropy, as local donors responded to urgent appeals for support.

> In response to increases in clients' unmet social needs, Client Services staff at Open Arms of Minnesota, a FIMC member organization and MTM provider, began supporting clients in new ways—and continued doing so after the shutdown ended. "They are coming to us with more questions, so our staff are spending more time with them, solving for issues peripheral to food access," says CEO Leah Hebert Welles. Those issues included food resources (beyond MTM), the cost of utilities, the cost of housing, and domestic violence. "Clients are coming to us because other places are shut down," Welles explains. "They don't have other people to ask. They don't have other organizations to ask. They can't reach their social worker. The folks they talk to in the neighborhood are not available. Similarly, referrers are calling us with more questions because they don't have as many places to send people."

CBOS AND HEALTHCARE UNDER PRESSURE

Another challenge Community Servings has faced in the last year was a historically long waiting list for its MTM program. Due to funding shortages and growing demand, the waiting list reached over 300 eligible applicants by mid-2025. Applicants were waiting between six and 12 months before the organization could schedule their first meal delivery. According to Diaz, applicants were completely overwhelmed.

Over **220,000** people in Massachusetts qualify for MTM, according to an estimate published in *Health Affairs*' 2025 Food, Nutrition, and Health special issue. Learn more in "Research Landscape," where we summarize the study "Estimated Impact of Medically Tailored Meals on Health Care Use and Expenditures in 50 U.S. States."

By February 2026, through an increase in philanthropic funding and internal efforts to serve more clients, the waiting list had decreased to just 25 people, with wait times reduced to three months or less. However, the need itself remains. On applications, Boyd has noticed that referring providers are more frequently documenting food insecurity and the need for community supports.

Throughout the field, CBOs and other frontline service providers have been experiencing challenges driven by rising costs and policy changes.

For example, **Open Arms of Minnesota** instituted a waiting list in January 2025, pausing enrollment of new clients. The reason was an unexpected decrease of nearly $1 million in Ryan White HIV/AIDS Program funding in late 2024. The enrollment pause lasted until September 2025.

Second Harvest Food Bank of Northwest North Carolina is a FIMC member organization that offers a range of programs designed to support community health and food security, including MTM and prepared meals for seniors and children. The organization lost a planned $2 million Local Food Purchase Assistance grant and experienced a reduction in funding from the federal Emergency Food Assistance Program in 2025. “We’re feeling the tightening of the belt all the way around the food bank this year,” says Heather Martin, Senior Director of Strategic Partners at Second Harvest.

Meals on Wheels People, a FIMC member organization that provides MTM to seniors in Oregon and Washington, had to trim its 2025 budget because of the expiration of pandemic-era American Rescue Plan funds. CEO Suzanne Washington has been navigating other government funding uncertainties and a simultaneous increase in client demand. “The need is growing, but the funding is actually less,” Washington says, pointing to an aging population that is growing at the same time SNAP is being cut. “Without healthy food, you can’t have a healthy America. We should be putting money behind this effort and making sure healthy meals reach the people who need them.”

"I WAS ALWAYS WORRIED ABOUT AFFORDING JUST ABOUT ANYTHING"

To help readers more concretely understand how access to public assistance figures into the experience of clients receiving MTM, we present two stories of Community Servings clients who raised the issue of access when they spoke with us in summer 2025.

Laura was receiving cancer treatment in summer 2025. On bad days, the pain and nausea were so persistent, she could not leave home. A resident of Central Massachusetts, Laura found a lifeline in MTM—a necessary complement to her Social Security and SNAP benefits, which do not cover all her needs. "I haven't always been able to make ends meet. Now I can, thanks to you guys," Laura said. She considers eating a diet high in vegetables to be an important measure for feeling her best. "Fresh produce makes a huge difference with my labs. I notice I have a lot more energy when I'm eating more vegetables."

Laura's immune system is, in her words, "pretty kaput." She does not go to restaurants. She does not drive. A close friend checks in on Laura and helps her around the house. She appreciates that during the winter season, when icy roads and bitter cold can be isolating, Community Servings sends her a box of shelf-stable pantry items. "Just knowing the meals are coming helps with the anxiety," Laura said.

Food banks are scarce in town, Laura said. "It seems like services cut off and don't reach out here where I live. It seems like my town gets forgotten on both sides."

Over a period of five years, Jim's osteoarthritis had gotten worse, preventing him from grocery shopping or doing the things he enjoyed most, such as hiking. "It was very stressful," Jim recalled. He was waiting to be approved for Social Security benefits. He was managing diabetes and congestive heart failure. "I was always worried about affording just about anything," Jim said. Jim credits the fact that he could access healthy foods at all to Community Servings and SNAP. "Food became one less worry."

Shortly after he stopped receiving MTM, Jim made the difficult decision to move away from Southeastern Massachusetts. He was no longer able to afford his apartment. In July 2025, when he spoke with us, Jim's health was fairly stable, but his life had changed significantly. He had sold his belongings and was living with a friend in Lubbock, Texas. As he wondered whether MTM was available in his part of the country, he began to reflect on recent cuts to federal funding. He observed, "It's a shame programs like yours might have to serve fewer people in the future."

The healthcare industry is under pressure as well.

According to a recent analysis by McKinsey and Company, the healthcare sector faces significant financial headwinds in the coming years.[9] The pain points for health plans include the increasing price of healthcare services, utilization of high-cost prescription medications, inflation, and labor costs. Due in part to the expiration of COVID-era enhanced premium tax credits, which broadened access to subsidized coverage, health plans participating in ACA exchanges increased their premium rates by 18 percent in 2026.[10] Rising costs are also affecting healthcare providers.[11] Most Massachusetts health systems experienced operating losses in 2024, according to the state's Center for Health Information and Analysis.[12] Reportedly, some safety-net hospitals are anticipating that the changes to Medicaid financing in the 2025 federal reconciliation bill may bring about new risks and shrink access to primary care in the coming years.[13] These changes come during a time of affordability concerns, as 30 percent of adults in 2025 skipped recommended healthcare services due to cost.[14]

The extent to which the healthcare sector's challenges are impacting their partnerships with CBOs is unclear. "Healthcare in Minnesota is probably more interested in health outcomes today than ever before," Welles observes, quickly adding that "they are also more interested in nontraditional ways of paying for nutrition services."

At **La Soupe**, a food-rescue CBO and MTM provider in Ohio, Food as Medicine Director Hannah Freking says that exploratory talks with MCOs have been more challenging than in past years. “Potential partners tell me, ‘We know your services would have a return on investment. This sounds wonderful and we’d love to work with you. There’s just no funding.’ I’m still in great conversations with one of our MCOs about developing a pilot, but it would require us to find funding elsewhere.”

LOOMING UNKNOWNS

Even absent direct cuts to funding, this year’s pervasive uncertainty is an obstacle in and of itself for CBOs.

Reflecting on the national landscape, FIMC Manager of Policy and Projects Cate Hensley says, “There’s just a looming unknown. What will federal funding look like in the future? How will state Medicaid authorities respond to the changes in the federal reconciliation bill? What does this mean for our clients and communities? These are the major guiding questions our agencies are responding to.”

In 2026, we see the field’s nonprofit MTM providers endeavoring against complex headwinds, protecting their core mission, growing the evidence base through research, and continuing to advance the field through new and existing opportunities in philanthropy and policy.

As Suzanne Washington of Meals on Wheels People reflects on the present moment, in many ways she speaks for the field as a whole: “It’s hard to say how it’s going to play out. You just do what you can do. Try to make a difference the best you can, given the times.”

POLICY LANDSCAPE

FEDERAL POLICY OPPORTUNITIES

As in recent years, the field continues to see signs of positive and bipartisan support for MTN in federal policy.

Medicare Part A

To support MTM as a permanent benefit in Medicare nationally, the AMPL Institute advocates for the Medically Tailored Home-Delivered Meals Pilot Program Act (the MTM Bill, H.R. 5439). It remains the best current opportunity to create access to MTM through the Medicare program.

The MTM Bill would establish a six-year pilot in Medicare Part A, which does not currently cover meals.[15] (Part C, or Medicare Advantage, covers meals for certain individuals in narrow circumstances if their health plan offers meals as a supplemental benefit.) If passed and implemented, the MTM Bill has the potential to chart a broader course toward MTM coverage in Medicare.

Reintroduced in Congress in September 2025, the bipartisan bill was authored and sponsored by Representative James P. McGovern (D-MA) alongside Representatives Nicole Malliotakis (R-NY), Chellie Pingree (D-ME), Dwight Evans (D-PA), and Brian Fitzpatrick (R-PA). A companion bill was introduced in the Senate by Senators Cory Booker (D-NJ), Roger Marshall (R-KS), Bill Cassidy (R-LA), and Tina Smith (D-MN).

Medicare Part B

In July 2025, CMS solicited public comments on a proposed rule concerning Medicare Part B payment and coverage policies.[16] CMS asked whether separate coding and payment guidance for MTM as an “incident-to” service, performed under general supervision of a billing practitioner, should be created. FIMC, Food Is Medicine Massachusetts, Food for Health, Meals on Wheels America, and the Medicaid Food Security Network were among those who submitted comments strongly endorsing the proposal. FIMC’s response is available on its website.[17]

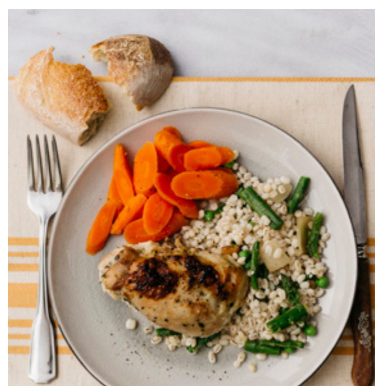
Published in November 2025, the final rule from CMS expressed appreciation for the public comments and willingness to consider them in future rulemaking but declined to create coding and payment guidance for MTM at this time.[18]

Medicare Part C

Through Medicare Part C, or Medicare Advantage, private health plans can offer food, produce, and meal benefits as General Supplemental Benefits or Special Supplemental Benefits for the Chronically Ill (SSBCI). Since SSBCI became available in 2020, the share of enrollees in Special Needs Plans offering food and produce, nonmedical transportation, and general supports for living supplemental benefits has grown significantly, according to KFF’s analysis.[19]

In fall 2025, members of the Congressional Make America Healthy Again Caucus, Representatives Vern Buchanan (R-FL), John Joyce (R-PA), and Lloyd Smucker (R-PA), publicly advocated to CMS for policy changes in Medicare Advantage to improve access to FIM services, including MTM and MTG, as supplemental benefits.[20] Specifically, they recommended that CMS allow Medicare Advantage health plans to offer healthy food as primarily health-related supplemental benefits, whereas current policy classifies such benefits as non-primarily health-related. They also recommended consistent guidelines for the dosage and duration of FIM services.

FIMC has issued several policy recommendations about FIM access in Medicare, some of which address opportunities to make administrative processes more efficient. FIMC’s comments are available at **fimcoalition.org/policy/public-positions**.



CMS Innovation Center

The CMS Innovation Center develops and tests new healthcare payment and delivery models to improve care and lower costs.[21] Over the last year, several new models have been announced with the potential to intersect with the healthcare sector's delivery of nutrition supports in the future:

The **MAHA ELEVATE** model (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence)[22] will evaluate the impact of whole-person functional or lifestyle care on Medicare members. It is the first CMS Innovation Center model to focus on functional or lifestyle medicine. While funding cannot be used to pay for food, MAHA ELEVATE has the potential to support the provision of nutrition services to Medicare members. It will launch on September 1, 2026, and consider proposals that are not currently covered by Medicare Parts A or B and that have a base of evidence supporting their efficacy.

Another new model, **ACCESS** (Advancing Chronic Care with Effective, Scalable Solutions) will have its first performance period beginning July 2026.[23] Through it, CMS will test a new outcome-aligned payment option in Original Medicare (i.e., Parts A and B) that enables providers to offer flexible and technology-supported care, such as lifestyle and behavioral supports.

LEAD (Long-term Enhanced ACO Design) builds upon the Center's earlier Medicare ACO work and aims to broaden the mix of participating providers to include smaller, independent, and rural-based practices. A goal of LEAD is to lower the financial and administrative obstacles that established and newly created ACOs are facing.[24] It aims to enhance evidence-based prevention and care coordination for patients with high needs. Notably, CMS will include an optional medical nutrition therapy benefit enhancement, expanding the qualifying conditions beyond diabetes or renal disease for beneficiaries in LEAD ACOs assuming full risk. This voluntary model will run from January 2027 through December 2036.

Americans are eager for the healthcare system to embrace nutrition interventions to help them prevent and treat chronic disease. The question is how will health policy foster forms of access that are impactful, standardized, and targeted to the people who will receive the most benefit?

– David B. Waters, CEO, Community Servings

Veterans Affairs

Veterans often face complex, overlapping health challenges that require individualized care approaches. An estimated 11 percent of U.S. veterans are food insecure, and the risk is higher among veterans with disabilities and those living in nonmetropolitan areas.[25] Compared to the average U.S. population, veterans experience obesity and associated chronic conditions, such as diabetes, chronic obstructive pulmonary disease, and heart disease, at significantly higher levels.[26]

In fall 2025, The Rockefeller Foundation awarded a two-year grant to FIMC, in partnership with the U.S. Department of Veterans Affairs, to support MTN access among veterans.[27] FIMC and the VA are working together to serve veterans experiencing food insecurity and qualifying medical and mental health diagnoses.[28]

Introduced in the U.S. Congress by Representative Vern Buchanan (R-FL), the Veterans Nutrition and Wellness Act of 2025 would establish an MTM and MTG program for eligible veterans through the VA. The bipartisan bill was co-sponsored by Representatives Gwen Moore (D-WI) and Susie Lee (D-NV).[29]

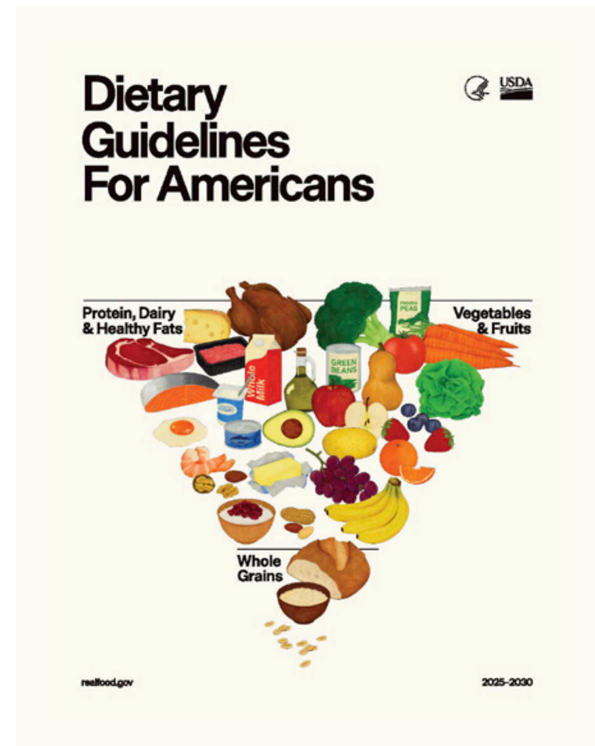
Massachusetts Opportunity

In fall 2025, a Massachusetts state budget appropriation funded Community Servings' Veterans Medically Tailored Nutrition Pilot Program. Community Servings is enrolling 50 Massachusetts veterans experiencing food insecurity, diet-sensitive chronic diseases, and mental health conditions. The program's impact is being measured through pre- and post-program surveys and focus groups, which will assess changes in food security, health status, and client satisfaction. The program has the potential to inform future coverage models for the provision of MTN for veterans with complex health needs.

The Make America Healthy Again Strategy

In the last year, the U.S. Department of Health and Human Services (HHS) placed special priority on the connection between nutrition and chronic disease. Through the Make America Healthy Again Commission, the Trump Administration pledged to promote healthier diets for Americans and reduce rates of chronic disease.[30] Long-standing bipartisan FIM priorities appear in the MAHA strategy, such as requiring nutrition education in medical schools and using healthy foods to improve health. The FY26 appropriations passed by Congress included dedicated funding for the federal FIM initiative within HHS and increased funding for nutrition research through the National Institutes of Health.[31]

Alongside others in the field, the AMPL Institute encourages HHS to make access to MTN services a core element of its strategy to prevent and treat diet-related illnesses among all Americans, particularly those experiencing severe, chronic, and complex illnesses and living with food insecurity.



2025-2030 Dietary Guidelines for Americans

In January 2026, the USDA released updated Dietary Guidelines for Americans (DGAs), the broad dietary recommendations for the general U.S. population that inform many federal nutrition policies.[32] Like previous versions of the DGAs, the new DGAs encourage the consumption of fruits, vegetables, and whole grains; recommend limiting intake of added sugars; and recommend a 10 percent limit on daily calories from saturated fat.

It is important to stress that MTN practice is premised on the provision of individually customized diets and nutrition education. These customizations are based on each MTN recipient's diagnosed health condition, dietary restrictions, and food allergies. An individual managing early-stage kidney disease, for example, requires a carefully managed protein intake. This is why the new DGAs encourage people who are managing any chronic disease to talk to their healthcare provider about how to adapt the guidelines for their specific needs—a view that we endorse.

At Community Servings, registered dietitian nutritionists provide telephonic nutrition counseling and nutrition education materials so that MTN clients are supported in their program adherence and in adopting healthier dietary behaviors. The team interprets and applies nutrition standards and guidelines, including the new DGAs, in a manner that considers the level of food access and the medical and dietary needs of each individual.

FEDERAL POLICY HEADWINDS

Recent research supports the interrelated nature of health, financial resources, food and nutrition security, and dietary quality.[33] This understanding of the connection between health and access to nutrition services explains the heightened concern in the field this year as federal healthcare and nutrition programs —key programs in addressing diet-related disease and food insecurity—have faced threatened and actual funding reductions.

Changes to Medicaid and SNAP

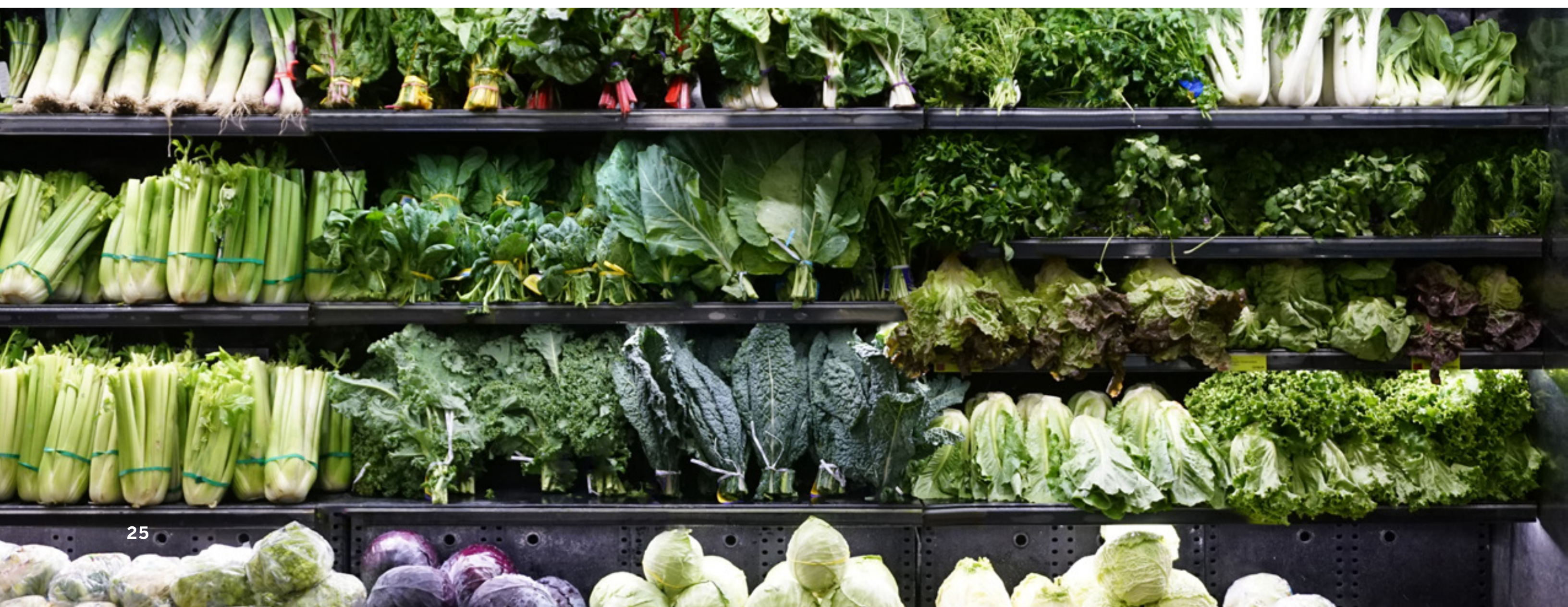
The 2025 federal reconciliation bill reduces funding to Medicaid and SNAP over 10 years and creates expanded and new eligibility requirements for beneficiaries in both programs.[34] In Massachusetts, the estimated impact of the bill includes reductions in healthcare coverage and federal healthcare spending, according to the Blue Cross Blue Shield of Massachusetts Foundation.[35]

The AMPL Institute is concerned about the impact of the bill on individuals who qualify for MTN. The majority of Community Servings' clients depend on MassHealth (Massachusetts' Medicaid program) and SNAP in some manner. Changes to these programs may limit clients' access to essential services. Individuals who are exempt from the new eligibility requirements due to a health issue or another reason will need to notify the state to continue qualifying for benefits. It is worth underscoring that new Medicaid work requirements and six-month eligibility redeterminations, for example, will not affect all MassHealth members but only the Medicaid Expansion population.[36]

The changes to Medicaid, particularly, present state governments with a significant budgetary challenge. States must balance their budgets with less federal funding and under the weight of new and complex administrative requirements. Opportunities for innovation may collide with the reality of diminishing resources. Here, the challenge extends to MTN providers, as well. The bill does not place limitations on the 1115 demonstrations or other Medicaid authorities that have authorized the provision and evaluation of FIM services in recent years—opportunities that have fostered advances for the field and the broader integration of MTN into healthcare. More generally, however, the changes to Medicaid create a scenario that may force states to make difficult choices to reduce costs.[37] This could leave FIMC member organizations without sustainable reimbursement for services to new populations—even though the need remains—forcing greater reliance on philanthropy at a time of greater need.

Last year's budget reconciliation bill did not have a section entitled Food is Medicine. It did not directly impose any changes on Food is Medicine. However, it did introduce significant changes to the landscape in which Food is Medicine operates, changes that could have real repercussions for states, for health plans, for patients on the ground. People who lose Medicaid coverage experience a lot of pressures, including strain on household budgets that could limit their access to nutrition."

– Katie Garfield, Director of Whole Person Care, Center for Health Law and Policy Innovation of Harvard Law School



We're seeing state Medicaid authorities shift to think about what it means to have a tighter budget. How does that impact FIM services, especially given the fact that Medicaid has been the primary vehicle through which FIM services are covered by our public health infrastructure? What does this mean for our clients and the communities that we serve?"

– Cate Hensley, Manager of Policy and Projects, FIMC

SNAP-Ed

Notably, the federal reconciliation bill did away with federal funding for SNAP-Ed, the grant program that supported state and local organizations in providing nutrition education and obesity prevention.[38] **Open Hand Atlanta**, a FIMC member organization and MTM provider in Atlanta, Georgia, was among the CBOs whose nutrition education efforts were put at risk. The termination of SNAP-Ed funding represented a loss to Open Hand of approximately $800,000 annually.[39]

"These classes do more than teach you how to prepare meals in a healthy manner, though that's the core," says Open Hand CEO Matthew Pieper. Participants learn how to create and manage a food budget, interpret nutrition facts labels, and shop for healthy groceries. As funding allows, Open Hand complements cooking classes in rural health centers by providing participants with boxes of fruits and vegetables. Participants with uncontrolled diabetes who received groceries were able to reach a controlled state within three months, Pieper says. "We even have testimonies and data that show that within six months, some participants no longer need their diabetes medications."

The primary reason for offering nutrition education is that it's the right thing to do. But there is also a fiscal outcome. Our cooking classes are a very low-cost investment compared to a one-day hospital stay or an emergency room visit. We can save our healthcare system significant dollars."

– Matthew Pieper, CEO, Open Hand Atlanta

With the funding change, Open Hand joined forces with other CBOs in Georgia to advocate for state support and raise awareness among policymakers about the potential impact on the local economy and community. As a result, Pieper reports that Open Hand received a budget allocation from the Georgia Department of Human Services to cover most (but not all) of its nutrition education funding gap.[40] Efforts continue to line up new philanthropic funding sources to ensure Open Hand's provision of cooking classes in the future.

Measuring the impact of changes to SNAP on national food insecurity will be challenging moving forward due to the USDA's recent cancellation of the annual Household Food Security Report.[41] [42] About 14 percent of American households were food insecure in 2024, according to the USDA's most recent report.[43]

Food is Medicine Opportunities

The federal reconciliation bill does contain noteworthy opportunities for MTN.

> It creates more opportunities for home- and community-based services (HCBS) in Medicaid, which states can use to authorize MTN services with CMS approval. Effective July 1, 2028, states may establish HCBS 1915 (c) waivers for people who do *not* need an institutional level of care, broadening the populations who may qualify for home care.[44]

> The Rural Health Transformation Program was created to improve healthcare access, quality, and outcomes in rural communities.[45] While the program cannot fund the direct provision of meals, it has the potential to be used as a funding pathway for infrastructure and training pertaining to FIM. For example, a recently passed state bill in West Virginia ties the Rural Health Transformation Program to its planned support of MTM and other FIM services through MCOs.[46]
>
> All 50 states applied for grants in 2025. Of the states with publicly available applications, around 40 proposed initiatives related to nutrition, whether in connection with chronic disease prevention or provider education, says Garfield. State grant proposals took a variety of positions relative to requiring nutrition for their CME criteria. According to one analysis, proposals from over 20 states committed to requiring nutrition-related CME, demonstrating that nutrition in medical education remains popular and bipartisan.[47]
>
> In late December 2025, CMS announced the awarding of funds to all states.
> Funding will be available from 2026 through 2030.[48]

While highly significant, the federal reconciliation bill is only one example of federal policy changes that may impact access to nutrition supports.

Older Americans Act Programs

The Older Americans Act of 1965 established authority for state grants supporting social services for the aging population and individuals with disabilities, including Meals on Wheels programs. However, reorganization and staffing reductions within HHS in 2025 cast doubt on the federal government's plans for Older Americans Act programs.[49] A corresponding concern grew among CBOs that rely on Older Americans Act funds to serve seniors.

From a federal policy standpoint, I would love to see a continued commitment to Older Americans Act funding. We use senior nutrition dollars to support MTM for people over 60. This is so important for our organization to keep serving some of the most vulnerable people in our communities."

– Leah Hebert Welles, CEO, Open Arms of Minnesota

In February 2026, Congress passed an appropriations bill that funded senior nutrition programs through the Administration for Community Living (ACL), the federal agency within HHS that manages Older Americans Act programs, and declined to adopt proposals from the administration to reorganize the ACL.[50] To the disappointment of many in the field, Congress funded Older Americans Act nutrition programs at 2025 levels.[51]

Ryan White HIV/AIDS Program

The changes to Medicaid in the federal reconciliation bill could have negative consequences for people living with HIV, reducing their access to preventive care and support services. An estimated four in 10 people with HIV are covered by Medicaid,[52] which as a program will undergo significant member eligibility and financing changes that may reduce total Medicaid enrollment in the coming years.

Separately from Medicaid, the Ryan White HIV/AIDS Program (RWHAP) funds HIV care and treatment services, including nutrition supports, for people with low incomes and diagnosed HIV.[53] Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act in 1990, the same year Community Servings was founded. RWHAP funding has been and continues to be foundational for many FIMC member organizations. Today, RWHAP is one of the only federal programs addressing nutrition and other structural interventions for individuals who are critically ill. However, RWHAP's funding is discretionary, meaning it is contingent on annual appropriations from Congress.

In spring and summer 2025, there were indications that the federal government's HIV response was shifting, potentially including cuts to RWHAP.[54] If authorized, these cuts would have been a blow to the field. However, the FY 2026 Congressional budget funded RWHAP at the 2025 level.[55] While earlier proposals were worse, level funding still represents a setback for HIV advocates.

STATE POLICY OPPORTUNITIES

In the past year, the state policy landscape has featured new and innovative opportunities for MTN. Select examples are highlighted below. These state-based initiatives are, according to Garfield, exciting indicators of the staying power of FIM. “States are still very enthusiastic and moving forward on their own,” Garfield observes, adding that state legislators in Florida and Indiana have recently introduced bills to fund FIM as well.

State Initiatives, 2025-2026

Oklahoma
Effective July 1, 2025, Oklahoma’s Food is Medicine Act (SB 806) directed the state’s Health Care Authority to seek federal approval for the provision of nutrition services through Medicaid.[56] Nutrition services, according to the law, will be designed to improve health outcomes for Medicaid members with nutrition-related chronic diseases and reduce the need for medical care. Notably, the law states that, wherever feasible, CBOs and local growers shall be prioritized.

Texas
Effective September 1, 2025, a new state law in Texas (HB 26) authorized MCOs to provide nutrition services as Medicaid In Lieu of Services (ILOS).[57] Notably, the law includes a pilot program, also through the ILOS authority, allowing MCOs to offer MTM to pregnant individuals with a chronic disease. Data on utilization and outcomes of the pilot will be reported.

West Virginia
Effective May 21, 2026, a new state law in West Virginia (HB 4982) advances a number of healthy lifestyle initiatives. Specific to FIM, the bill permits and encourages MCOs to offer MTM and other designated FIM services in accordance with the Rural Health Transformation Program. MCOs are encouraged to partner with CBOs and prioritize the use of food from West Virginia growers and farmers.[58]

Food is Medicine State Officer Program

As discussed earlier, recent changes to Medicaid and SNAP are likely to put pressure on state government capacities, making it harder for nonrequired initiatives to maintain momentum. For that reason, in January 2026, the field celebrated the announcement of the Food is Medicine State Officer Program.

A joint philanthropic initiative funded by The Rockefeller Foundation and Builders Vision, RF Catalytic Capital, the FIM State Officer Program will fund capacity-building in up to 10 states to help advance policies that improve access to healthy food for people with diet-related health conditions.[59] The Center for Health Care Strategies will facilitate a competitive state selection process. Awarded states will receive funding to hire and train FIM state officers within their Medicaid agency, public health department, or other state agency. Officers will serve as leaders and subject matter experts for FIM programming across their state and will receive individualized technical assistance based on their state's unique landscape.

In March 2026, Wisconsin publicly released a letter of intent proposing a state officer who will support the expansion of FIM benefits in Wisconsin's Medicaid program, among other goals.[60] Notably, Wisconsin launched an ILOS MTM benefit in 2025, with four health plans currently participating, and is exploring a potential 1115 demonstration waiver.

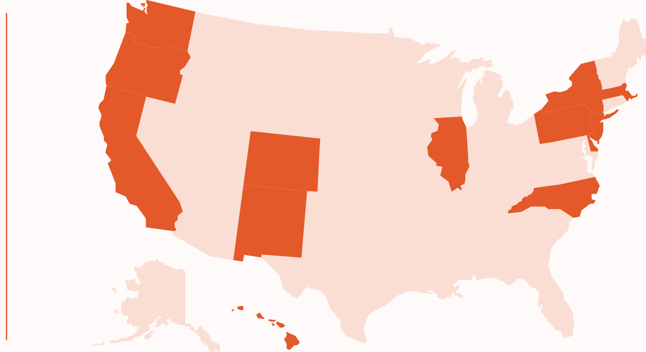
The funding period is June 2026 through June 2029. Awarded states will be announced in May 2026.

Medicaid Policy Opportunities Overview

In recent years, states have been experimenting with Medicaid authorities to address drivers of poor health and preventable healthcare spending.[61] Subject to CMS approval, states can take advantage of various Medicaid funding pathways (see table below) to pilot nontraditional services to achieve Medicaid's core objectives.

Medicaid Section 1115 demonstrations and ILOS have done a great deal to advance access to MTN. However, they have created a patchwork of access across the country. As of this writing:

Thirteen states have approved 1115 demonstrations that fund the provision of nutrition supports such as meals: California, Colorado, Delaware, Hawaii, Illinois, Massachusetts, North Carolina, New Jersey, New Mexico, New York, Oregon, Pennsylvania, and Washington.[62]



Three 1115 demonstration applications are pending with CMS from the District of Columbia, Maine, and Nevada.[63]

According to the American Heart Association, seven states are offering FIM services as managed care ILOS: California, Iowa, Michigan, Minnesota, Nevada, New York, and Wisconsin.[64]

Current information about 1115 and other waiver applications is available from KFF and CMS.

CMS Rescinds Biden-Era Guidance

In spring 2025, CMS rescinded previously issued guidance about potential Medicaid coverage pathways for nutrition and housing services (e.g., 1115 waivers, managed care ILOS, and other Medicaid pathways).[65] It is worth emphasizing that, despite the rescinding, these Medicaid flexibilities remain open. CMS did not change any currently approved waivers. Waiver applications that propose to cover nutrition and housing supports will be considered on a case-by-case basis. However, one of the outcomes of the rescinding was uncertainty throughout the field about how and according to what priorities CMS would consider such waiver applications under the current administration.

"While we're living in this moment of enthusiasm nationally for nutrition, we are still waiting for guidance from CMS about their position on nutrition and housing supports in the Medicaid program," says Garfield. "That continues to create this feeling of uncertainty that can be difficult for CBOs."

Absent direct guidance from CMS, the field will monitor the progress of pending applications from the District of Columbia, Maine, and Nevada, which propose funding meals and other nutrition services and are currently awaiting CMS approval.[66]

Medicaid Policy Opportunity Pathways[67]

	Description	Commentary
Section 1915 Home- and Community-Based Services	Allows access to home-delivered meals for people who meet (or almost meet) an institutional level of care through HCBS pathways, most commonly through section 1915(c) and 1915 (i) waivers.	Advocates in states with more constrained budgets may find this waiver type more feasible or a helpful pathway for a pilot program.
Managed Care In Lieu of Services (ILOS)	Allows medically appropriate and cost-effective substitutions for covered services. Only available to eligible individuals in states with Medicaid managed care and through participating managed care organizations (MCOs).	Policy advocates in states with Medicaid MCOs and more constrained budgets may find this waiver type to be more feasible.
Section 1115 Demonstration Waivers	Allows states to temporarily modify Medicaid programs to test new services that traditionally are not covered, provided services are budget-neutral to the federal government and supportive of the goals of Medicaid.	1115 demonstrations offer a highly flexible pathway for innovation but require a more intensive application and evaluation process than other pathways.

In states with Medicaid managed care, participating MCOs can use other flexibilities to create access to nutrition services:

Value-added services

A voluntary pathway for MCO coverage, though the MCO receives no additional funding from the state.

Quality improvement activities

MCOs improve performance metrics related to quality of care. MCOs may focus their quality improvement activities on health-related social needs.

4

SUGGESTIONS FOR ADVOCACY AND RESILIENCE AS STATE BUDGETS TIGHTEN

Between changes to Medicaid and SNAP, states are likely to experience increasing budgetary pressure in the coming years. With this comes a higher likelihood of hard decisions about how to bring down costs. How can advocates strengthen their advocacy and make their programs as resilient as possible?

We spoke with Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School, about practical ways CBOs can continue making inroads and plan for the future, even as state budgets come under strain.

ENGAGE AND EDUCATE STATE LEADERS EARLY

Elected officials need to hear from the experts, and CBO providers are the MTN experts in their communities. Advocates are encouraged to let policymakers know how clients benefit (or could benefit) from nutrition services. Help state leaders understand the value of MTN *before* any tough conversations about budget take place.

As soon as your program starts, start talking about it and the good it's doing. Get quotes from recipients. Talk about it upfront. Position your work as a way to get medical costs down."

– Jan Jones, Director of Public Policy, Second Harvest Food Bank of Northwest North Carolina

Some policymakers may not understand the interrelated nature of health outcomes and access to MTN, or nutrition supports more broadly. Explain to stakeholders the proven impact of MTM, for example, on healthcare utilization and costs. Cite the peer-reviewed research that associates MTM with averted hospitalizations and cost-savings. (See the appendix titled "The Impact of Medically Tailored Meals" for more information.) If possible, show the economic value of nutrition services within your state.

CENTER CLIENT AND PATIENT TESTIMONIALS

Collect and share the stories of individuals served. Testimonials validate your value proposition and help stakeholders put names and faces to constituents and empathize with the real-life experiences of the populations served.

CONSIDER ALL AVAILABLE FUNDING PATHWAYS

During the planning process, learn about the full array of funding pathways in your region, including philanthropy, healthcare, and government grants. In the event of lapses in funding, prepare to pivot as needed so that organizations avoid direct service interruptions and preserve existing infrastructure.

“I would encourage CBOs to tap into as many different funding streams as possible,” Garfield says. “Funding sources such as 1115 waivers have been really important and fruitful over the last couple years, and it’s my strong hope that will continue. But CBOs should make sure they are aware of other funding streams and tap into as many as possible. Diversity of funding is what’s going to make CBOs resilient over the long term in times of uncertainty.”

CASE STUDY: LA SOUPE IN OHIO

Garfield advises advocates to consider existing state priorities that are naturally aligned with FIM. Maternal health is one example that many CBOs in the field have leveraged successfully.

In June 2025, the University of Cincinnati partnered with La Soupe, a food rescue CBO and MTM provider in Ohio, on a pilot study investigating how MTM and nutrition education might impact maternal cardiovascular disease risk and birth outcomes among black individuals in Hamilton County, Ohio.[68] A cohort of about 30 participants received six months of MTM and nutrition education. Meals were designed according to La Soupe's African Heritage diet.

Healthy diet during pregnancy promotes healthy fetal development and may reduce the risk of pregnancy complications, according to the University of Cincinnati.[69]

"I worked with the university to apply for community-based funding," says Hannah Freking, Food as Medicine Director at La Soupe. "As a certified diabetes educator, I used to teach gestational diabetes classes. I have a special place in my heart for the challenges women face in becoming moms, learning about their condition, and finding and cooking healthy foods. When you add another culture into the mix, it becomes even more challenging."

DEVELOP A PLAN FOR POTENTIAL PROGRAM REFINEMENTS

If budgetary decisions in your state require hard conversations, Garfield advises MTN providers to develop a clear vision for potential MTN program refinements. "As we look at a future of state budgetary pressures, I think it can be helpful for FIM providers in this moment to be thinking about whether there are ways to refine their target populations and interventions to be as impactful as possible," Garfield explains. "Being prepared could lead to refining a program as opposed to eliminating it altogether when budgetary pressures threaten innovative programming. Making sure that FIM advocates on the ground are prepared to respond meaningfully in these cases is really important."

5

WEAVING ECONOMIC, ENVIRONMENTAL, AND SOCIAL VALUES INTO FOOD IS MEDICINE POLICY

What if FIM not only benefited individuals' health but also supported local economies, created opportunities for local farmers and fishers, and fostered a more sustainable food system?

In July 2025, the Center for Health Law and Policy Innovation of Harvard Law School published *Maximizing the Impact of Nutrition Interventions with Local Food Procurement*, a comprehensive report on the legal frameworks and state and federal policies that support the broader societal benefits of FIM programs.[70] Procurement policy can extend beyond the cost of goods and services, including economic, environmental, and food system values as well. The report highlights noteworthy examples of state-level Medicaid flexibilities, procurement policies, and recommendations for states and CBOs to align FIM with broader goals.

LOCAL FOCUS IN MEDICAID NUTRITION SUPPORTS POLICY

In recent years, state Medicaid programs have begun to highlight procurement preferences for local food vendors and CBOs. Four examples relevant to FIM follow below:

- The Oklahoma Food is Medicine Act, which passed in 2025, requires the state's Health Care Authority and Medicaid contracted entities to prioritize the inclusion of CBOs and local growers wherever feasible.[71]
- With the goal of strengthening Hawaii's food system, the state's Medicaid Section 1115 demonstration encourages MTM and grocery service providers to include local growers.[72]
- Through Massachusetts' Medicaid Section 1115 demonstration, the Health-Related Social Needs Program directs ACOs to contract with local CBOs for the provision of HRSN services, acknowledging "the importance of local, community-based expertise and capacity."[73] ACOs may contract with out-of-state providers only if there is an insufficient number of qualified in-state providers to meet demand.[74]
- The goals of Michigan's In Lieu of Services policy include supporting local participants in the Michigan food economy and providing services "in the community."[75] Meals on Wheels of Western Michigan and Jewish Family Services of Washtenaw County, both of which are FIMC member organizations and recent graduates of the FIMC Accelerator, are providing MTM with funding from Michigan's Medicaid program.

The preference for local entities speaks not just to local economic impact but also to the expertise and leadership of CBOs in the FIM movement. For FIMC Executive Director Alissa Wassung, nonprofit CBOs—the originators of the FIM movement—have the unique distinction of decades of community trust and a long-standing commitment to access, quality, and excellence. This distinction is particularly important in a moment when FIM enjoys national attention. "It is more important than ever that we support and strengthen nonprofit providers of Food is Medicine," Wassung observes. "We need to uplift community voices who can guide the movement with the wisdom of their communities."

Matthew Pieper, CEO of FIMC member organization Open Hand Atlanta, is hopeful that the new Food is Medicine State Officer Program will support synergies between food procurement and MTN in states like Georgia. As discussed in "Policy Landscape," the FIM State Officer Program is funded by The Rockefeller Foundation and Builders Vision, RF Catalytic Capital. It will support up to 10 states to advance or expand capacity and coordinate FIM efforts within state agencies. Should Georgia be awarded funding, Pieper plans to advocate for policy changes that support local farmers and make healthy foods more affordable for CBOs like Open Hand. "Much of the food that is grown in Georgia is shipped out to be processed and then shipped back in for distribution and sales," Pieper reports. "Well, that's inefficient and adds to the cost. That's something the state ought to be able to address. It would help nutrition agencies like us."

CENTERING THE BROADER IMPACT OF FOOD IS MEDICINE

> Published by The Rockefeller Foundation in March 2026, "From Farm to FIM: The Economic Impact of Local Food is Medicine" examines how states can design FIM programs to improve health outcomes while strengthening local economies and building more resilient regional food systems.

Funded by The Rockefeller Foundation, AMPL's FIM+ Case Study project is evaluating the outcomes of Community-centered Food Sourcing (CCFS), Community Servings' strategy for sourcing ingredients with the greatest possible benefit to clients, the environment, and the health and economic well-being of communities. The CCFS strategy supplies the organization's culinary operations with foods of superior quality, flavor, and freshness. It also engages farms, fishers, and growers with environmentally and socially positive business practices and a shared commitment to creating access to MTN.

With publication expected in 2027, the Case Study will be a resource for the field, educating CBOs, health plans, healthcare providers, policy leaders, and local growers and producers on best practices derived from Community Servings' CCFS approach. The project team includes the Center for Health Law and Policy Innovation of Harvard Law School, the Center for Nutrition & Health Impact, the World Food Policy Center at Duke University, and Johnson & Wales University.

6

MASSACHUSETTS' MEDICAID SECTION 1115 DEMONSTRATION: THE IMPACT OF POLICY CHANGE AT COMMUNITY SERVINGS

Through a Medicaid Section 1115 demonstration, the Massachusetts Medicaid program (MassHealth) offers eligible individuals access to MTN services. Community Servings is the largest nonprofit provider of MTM and MTG in the demonstration, which authorized the provision of housing and nutrition services through the Flexible Services Program from 2020 through 2024.

Effective January 1, 2025, the program underwent a wide-ranging policy update to support greater access to health-related social needs services among medically appropriate individuals in a more sustainable construct.[76] The Health-Related Social Needs Program (HRSN), as it is currently called, transitioned from a grant-based model to a supplemental benefit framework. The change came with new requirements and major repercussions for nutrition services providers, including, for example:

- HRSN providers must be credentialed and enroll with ACOs as health plan network providers.
- HRSN providers must submit medical claims for billing.
- Individuals receiving HRSN nutrition services must be rescreened every six months, and individuals deemed still eligible may remain on services.

Additionally, member eligibility criteria changed in 2025, becoming more restrictive:

- Updated health-needs-based criteria now qualify members for either medically tailored or nutritionally appropriate service types based on their diagnosed condition.
- Eligible individuals must screen positive for very low food security.
- Eligible individuals can be referred for services, but household members cannot.

This section details the first year of HRSN at Community Servings, showing how client reach and service delivery were affected. The implementation of new policy was successful overall, with the organization's 2025 services reinforcing the objectives of the program.

SERVICE LEVELS

Approaching the end of 2024, Community Servings anticipated a decrease in service levels given the policy changes effective January 1, 2025. Individuals previously qualifying under Flexible Services had to requalify under the new HRSN eligibility criteria. It was expected that ACO referrals would decline during the transition to new HRSN processes. It was also expected that new HRSN eligibility criteria would be more restrictive. By the end of 2025, however, Community Servings' total meals served had increased compared with prior years (see Fig. 1) due in large part to referrals for MTG (food boxes), a new service; MTG meal equivalents are included in the 2025 meal totals. Community Servings' unique ACO clients grew even more significantly in 2025 (see Fig. 2).

Meals and Grocery Support Delivered by Year

Medically tailored groceries (MTG) service was added in 2025.

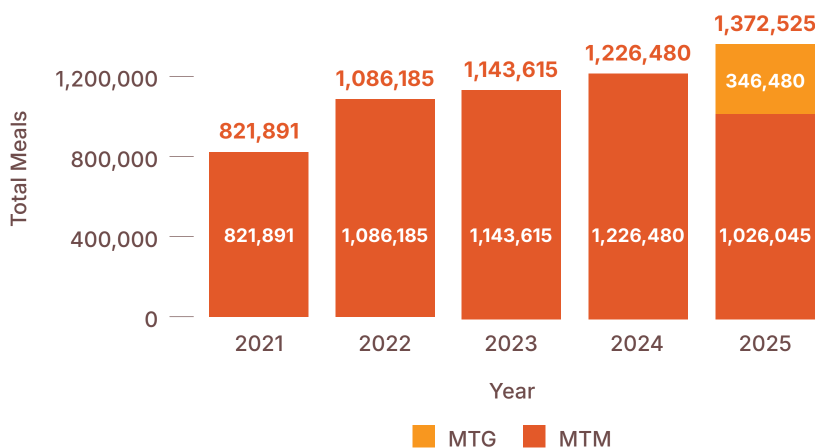


Figure 1. Total Meals by Year | Credit: Yonghan Chi

Unique ACO Clients Served (2024 vs. 2025)

Counts all clients active at any point during the year, including clients who started in a prior year.

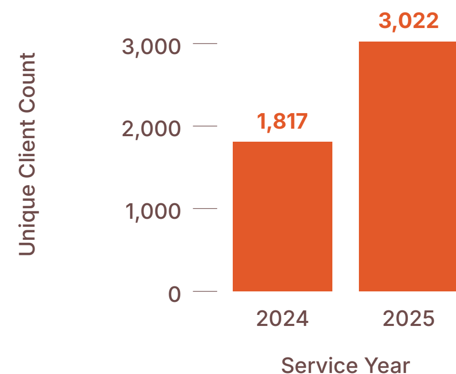


Figure 2. Unique ACO Clients Served (2024 vs. 2025) | Credit: Yonghan Chi.

According to research by UMass Chan Medical School, two of the five most common diagnoses among nutrition Flexible Services Program participants, from 2020 through 2023, were behavioral health conditions.[77] The prevalence of behavioral health conditions among ACO patients is apparent in Community Servings' data from 2024 and 2025 (see Fig. 3).

Under new policy, Community Servings is increasing its enrollment of ACO clients with primary diagnoses of lung disease, type 2 diabetes, cardiac disease, and hypertension.

Top 10 Primary Diagnoses (2024 vs. 2025)

Counts unique clients active during each year, including clients who started in a prior year.

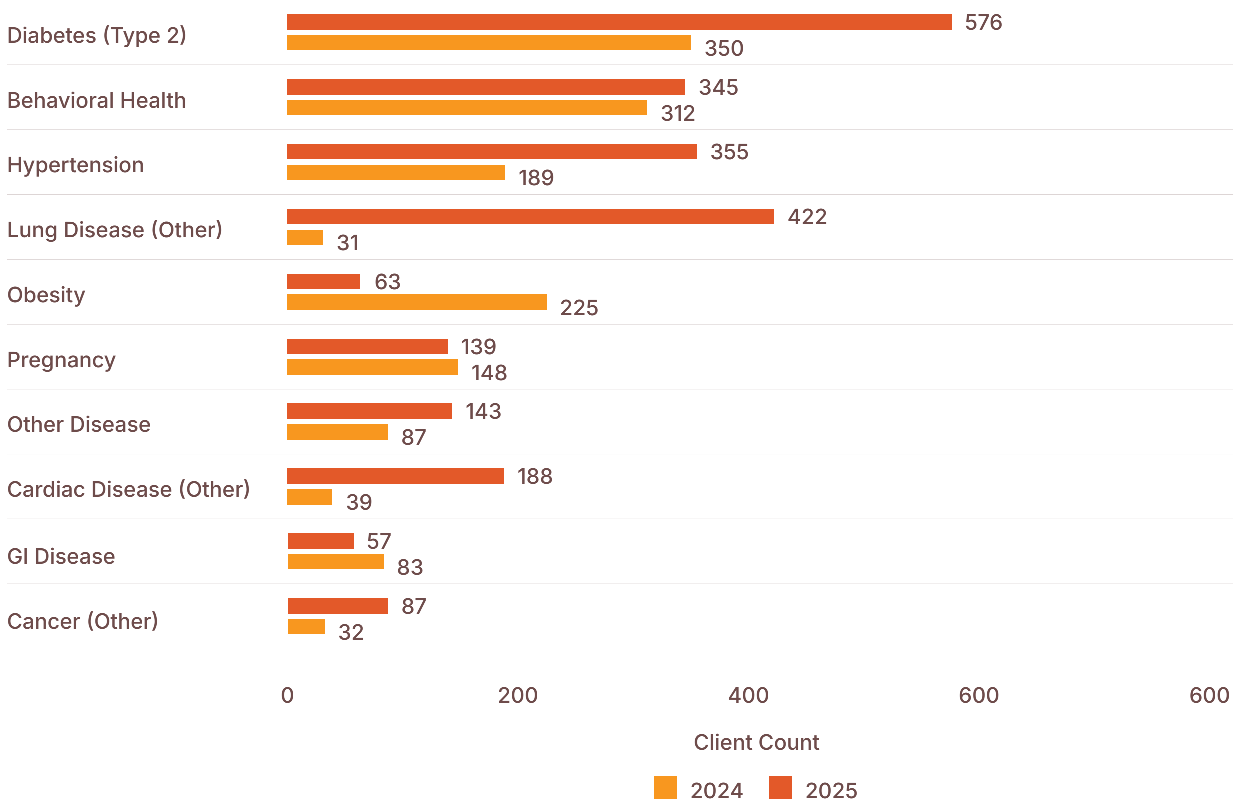


Figure 3. Top 10 Primary Diagnoses (2024 vs. 2025) | Credit: Yonghan Chi.

NEW SERVICE TYPE: MEDICALLY TAILORED GROCERIES

Community Servings planned to launch a new medically tailored groceries intervention (MTG) through the HRSN program. Prior to 2025, the organization saw opportunity for a new intervention designed for individuals who need a medically tailored diet and have the ability and resources to independently prepare meals. Community Servings tested a preliminary MTG intervention as a “step-down” from MTM in 2023 and 2024.

As with MTM, the MTG client journey begins with an initial individual nutrition assessment with a Community Servings RDN who prescribes a medical diet and (depending on the individual's ACO) is available to provide nutrition counseling. Clients receive a booklet of recipes and educational materials, including links to cooking demonstration videos.

Community Servings' Program and Culinary teams designed the MTG intervention's medical diets: Wellness-Cardiac-Diabetic, Vegetarian-Cardiac-Diabetic, and Renal. Shipped every two weeks, MTG shipments (food boxes) are the equivalent of 20 meals and include the vegetables, grains, dairy, and proteins necessary to prepare medically tailored recipes. Growing Places, a nonprofit based in Central Massachusetts, sources produce for MTG shipments from Central Massachusetts farms. MTG shipments are packaged and fulfilled by Morrissey Markets. MTG shipments are delivered by FedEx.

ACO partners started referring their patients for Community Servings' new offering starting January 1, 2025. As early as the first quarter of 2025, ACO referrals for MTG were high (Fig. 4). MTM referral volume declined in the first quarter but rose gradually before returning to prior levels in Q3 2025.

ACO Referrals vs. Extensions by Quarter (2024 - 2025)

Medically tailored groceries (MTG) service was added in 2025. Vertical line marks Jan. 1, 2025.

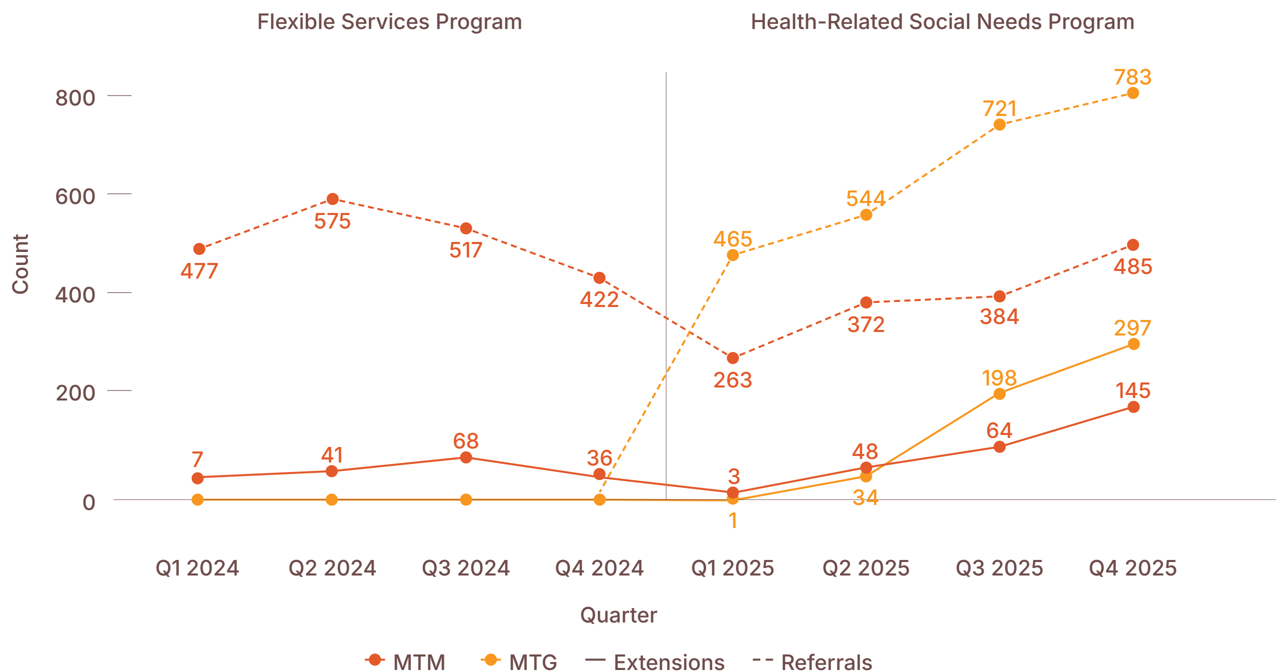


Figure 4. ACO Referrals and Extensions by Quarter (2024-2025) | Credit: Yonghan Chi

Based on anecdotal feedback from clients, MTG was well received. It provided clients with autonomy and flexibility in preparing meals. Parents and caregivers expressed their interest in sharing meals with their dependents and household members. MTG extended the food resources of the household, allowing recipients to shift their finances toward other essential needs, such as healthcare and utilities. Clients appreciated that MTG shipments were well-rounded, including not only produce but also grains, dairy, and plant and animal proteins.

In the first quarter of 2025, it was noted among Community Servings staff members that some individuals being referred for MTG were better suited for MTM. For example, some individuals in active cancer treatment were too weak to prepare food independently. Some lacked access to a stove or microwave. Some required a diet with a higher degree of modification (e.g., a soft; high-protein, high-calorie; or low-lactose diet) than is available through MTG. Community Servings adjusted its intake processes to more carefully validate the needs of ACO referrals for MTG. Community Servings also provided training and outreach to educate ACO referrers about the characteristics of appropriate recipients of MTM and MTG, including factors such as mobility, access to kitchen resources (e.g., appliances, cooking supplies), and other activities of daily living limitations.

POLICY CONSIDERATION: INCONSISTENT ACCESS TO MTM ACROSS ACOS

In 2025, Community Servings noted cases where HRSN policy could be improved to make access to MTM more consistent for eligible individuals.

At AMPL, we believe that all MassHealth enrollees who are medically eligible for MTM through HRSN should have access to the service. However, offering MTM is not a requirement that all ACO providers must meet. ACO providers are required to offer at least one HRSN nutrition service, the options being home-delivered meals, food boxes, or food prescriptions or vouchers. Consequently, even when individuals qualify for MTM by medical need, social risk factor, activities of daily living limitation, or another limitation, they can access MTM through HRSN only when their ACO chooses to offer it.

In 2025, a Community Servings client living with lung disease and mobility limitations was receiving MTM with a referral from their ACO. After several months receiving MTM, the client switched to another ACO during their plan selection period. What the client did not initially realize was that their new ACO did not offer MTM, and their health condition did not qualify them for Community Servings' philanthropic program. Inadvertently, changing health plans cost this individual access to MTM.

Ideally, the HRSN program would allow for an individual to have access to whichever medically tailored intervention they need, regardless of what ACO they belong to, in order to see the best outcomes improvements and highest cost savings."

– Erin DiBacco, Senior Director of Strategy and Business Development, Community Servings

According to anecdotal data from Community Servings' Nutrition Services team, households with multiple MassHealth members can experience confusion due to the inconsistency of HRSN nutrition service offerings across ACOs. In some cases, household members are enrolled in different MassHealth ACOs at the individual level. Parents or guardians may be enrolled in different ACOs than their dependents, for example, and as a result, household members may have access to different nutrition services, leading to complexity and confusion.

Community Servings has advocated for HRSN to provide more consistent access to MTM for eligible individuals. However, we recognize that the program budget likely limits each ACO's capacity to offer a wider array of nutrition services.

Our clients are not a number to us. They're people. I talk to them every day and get to know them. When a client loses access to MTM because their health plan isn't able to offer it, I'm thinking to myself, 'What are they going to do now?'"

– Carolyn Boyd, Senior Manager of Nutrition Services, Community Servings

IMPACT ON OPERATIONAL CAPACITY

Internally, 2025 entailed significant increases in the volume of ACO client referrals and extensions (Fig. 5). Implementing new policy in tandem with the rollout of MTG posed a challenge for resources and systems at Community Servings, particularly regarding client eligibility assessment, client enrollment, and contract billing operations. The challenge led to an increasingly urgent need for investment in program staffing and systems. New HRSN policy required extensions for ACO patients who, after six months, still qualified for services under HRSN criteria.

As discussed in 2025's *A View of the Field*, it is imperative that CBOs invest in operational capabilities, both to offer contract partners a high level of operational excellence and to support their own sustainability and scalability. As they grow, add new services, or serve new populations, resources and infrastructure may feel strain. The challenge for CBOs is that these significant operational investments are typically self-funded, requiring them to use their own limited or unrestricted resources.

ACO Referrals and Extensions (2024 vs. 2025)

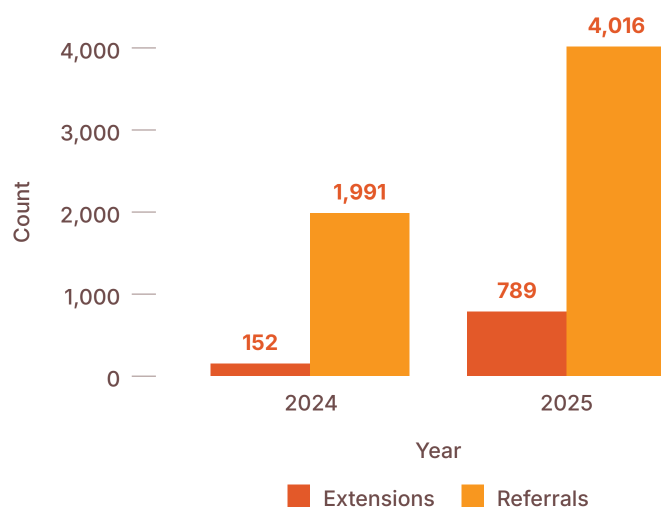


Figure 5. ACO Referrals and Extensions (2024 vs. 2025)
Credit: Yonghan Chi.

EVIDENCE OF AVERTED HOSPITALIZATIONS AND REDUCTIONS IN HEALTHCARE COSTS

Published in *Health Affairs* in April 2025, a study by UMass Chan Medical School conducted as part of the independent evaluation of the Massachusetts 1115 demonstration provided "proof of concept" that Medicaid-funded nutrition supports have the potential to reduce acute and emergency healthcare use and healthcare costs, particularly among adults with longer enrollment periods.[78]

Between January 2020 and March 2023, nutrition services (defined as MTM, referral to food assistance programs and food pantries, food prescriptions and vouchers, kitchen supplies, and food boxes) were associated with a 23 percent reduction in hospitalizations and a 13 percent reduction in emergency department (ED) visits. Significant healthcare cost reductions of $2,500 per person and net savings of $210 per person—$1.8 million for the entire subgroup—were noted among adults enrolled longer than 90 days, a finding that suggests that longer FIM enrollment may be more likely to reduce healthcare costs. Reductions in hospitalizations and ED visits were found among adults only, not children.

In October 2025, MassHealth released a road map detailing the goals of its planned 1115 demonstration for 2028 through 2032.[79] Those plans include the continuation of nutrition and housing supports. "That is reason to be hopeful," says Katie Garfield, Director of Whole Person Care, Center for Health Law and Policy Innovation of Harvard Law School. "It means that Massachusetts remains committed to these programs, especially in light of the evaluations we've had so far. I think advocates should be heartened by that." Further reason for hope appeared in early 2026, as CMS approved the final evaluation of MassHealth's Section 1115 demonstration, 2017 through 2022. Conducted by UMass Chan Medical School, the evaluation found that the overall demonstration saved Massachusetts more than half a billion dollars, maintained near-universal health coverage, improved health outcomes, and lowered rates of hospitalization.[80]

According to MassHealth's anticipated timeline, the 1115 extension request will be posted for public comment in summer and fall 2026. It will be finalized and submitted to CMS by the end of 2026.

7

A FORMAL EVALUATION OF MEDICALLY TAILORED GROCERIES IN CENTRAL MASSACHUSETTS

In 2025, the AMPL Institute partnered with UMass Chan Medical School to evaluate Community Servings' medically tailored groceries (MTG) pilot program. Funded through the Health Foundation of Central Massachusetts' Synergy Initiative Grant Program, this pilot evaluation was an opportunity to increase access to FIM in the Central Massachusetts region, identify MTG program improvements, and better understand the client experience of MTG.

Clients were recruited through a separate referral pathway from the MassHealth HRSN program.

POPULATION

Fifty-six people participated in the pilot evaluation. They were recruited from a pool of candidates from internal Community Servings lists and regional health and social services partner referrals. To qualify, participants needed to meet eligibility criteria: 1) experiencing food insecurity, 2) diagnosis of a diet-related illness, and 3) having the resources and ability to prepare meals at home.

- Twenty-five percent of program participants reported experiencing depression.
- Thirty-seven clients identified as women, and 19 clients identified as men.
- One-third of participants were 65 or older and eligible for Medicare.

Top 5 Primary Diagnoses	
Diabetes (Type 1 and 2)	28
Cancer	7
Chronic Kidney Disease	5
Hypertension	4
Lung Disease	4

Clients by Age	
18-35	4
36-49	11
50-64	24
65+	17

Clients by Race	
White	30
None provided	11
Hispanic, Latino/Latina	10
Other	3
Black or African American	2

Top 5 Cities and Towns	
Worcester	19
Leominster	7
Shrewsbury	4
Southbridge	3
Clinton	2

INTERVENTION

A Community Servings RDN conducted nutrition assessments of each participant, prescribed a medical diet, and offered one-on-one nutrition counseling.

At the beginning of the program, participants received one welcome box, which included recipes, nutrition education materials, and shelf-stable pantry items. The program home-delivered 12 MTG shipments—one every two weeks over six months (24 shipments total). Shipments were designed by Community Servings' Program and Culinary teams, packaged and fulfilled by Morrissey Markets, and delivered by FedEx. Growing Places, a nonprofit based in Central Massachusetts, sourced produce from local farms.

Every MTG shipment contained the equivalent of 20 meals and included the vegetables, grains, dairy, and proteins necessary to prepare medically tailored recipes:

Fresh produce, such as onions, squash, zucchini, carrots, broccoli, kale, and bell peppers

Grains, such as brown rice, couscous, whole-wheat pasta, tortillas, and pitas

Dairy, such as eggs, milk, Greek yogurt, and cheeses

Proteins, such as boneless, skinless chicken; ground beef or turkey; tofu; and brown lentils

Canned and frozen items, such as diced tomatoes, spinach, black beans, and garbanzo beans

PRESCRIBED MEDICAL DIETS

Fifty-one out of the 56 total participants completed the six-month MTG intervention.

Diet	Count
Diabetic	46
Renal	5
Vegetarian	5

Peer support was available to participants, with five individuals on average participating in each group session. Sessions were confidential and comprised of expert- and peer-led discussions of nutrition education and cooking techniques specific to the management of diabetes, heart disease, and other medical conditions. Feedback for peer support sessions was highly positive.

To transition participants from MTG after six months, Community Servings:

- Provided a Food, Nutrition, and Other Resources Guide, which included statewide and regional organizations
- Screened participants for MassHealth HRSN nutrition services eligibility, assisting eligible individuals with enrollment

EVALUATION AND FINDINGS

Surveys administered before and after the program were intended to capture change in participant outcomes. Additionally, qualitative interviews were conducted and analyzed by Dr. Kurt Hager of UMass Chan Medical School.

INTERVIEWS

Conducted during the summer of 2025, six qualitative interviews reinforced several anticipated quality improvements to the program. Participant feedback focused on these themes:

Ease and reliability of enrollment and customer service.

Acute stress acting as a motivator for individuals opting into MTG. Stressors included challenges with financial, physical, and mental health.

Positive reception of food quality, recipes, and group sessions. However, participants expressed a desire for greater choice in MTG shipment contents.

Appreciation of home delivery

Issues with damaged deliveries

A preference for smaller boxes and a better alert process for scheduled delivery times

Ease of meal preparation

Meals were suitable for adventurous eaters who enjoy cooking

Self-reported improvements in physical and mental health and energy for daily living

Notably, several participants mentioned experiencing improvements in mental health while receiving MTG.

SELECT PARTICIPANT QUOTES

"I feel better. I actually, physically and mentally, feel better from sticking with those foods. It's helped my blood sugar, and I don't feel as tired all the time. I'm starting to think more clearly too. You don't realize how much food affects you until you start changing it."

"The best part of the program is just feeling like someone cares. You know? And that is so important when you know somebody's out there who cares. Yeah, that was so important. And, of course, the fact that the food was very good and it helped me. I'm very grateful for it."

"If you eat right, you do feel better . . . So, I'm trying to eat better, not just for the physical but the mental too. I want to be here longer."

SURVEY

Fifty of the 51 participants who completed the six-month intervention also responded to the endpoints survey. As of late 2025, survey responses showed encouraging signs of improved self-reported health status and food security. Further analysis is forthcoming in 2026.

NEW IN 2026: MTG RANDOMIZED CONTROLLED TRIAL (RCT)

The AMPL Institute is continuing its work with the Health Foundation of Central Massachusetts' Synergy Initiative through a three-year RCT investigating the impact of MTG on depression. This will be the first MTG study to focus on depression and the first MTG trial in the U.S. with the primary outcome of depressive symptoms. Secondary outcomes will include anxiety symptoms, food insecurity, dietary quality, and changes in acute healthcare utilization, such as ED visits and hospitalizations.

STUDY POPULATION

The study will focus on patients living in Central Massachusetts with diagnosed depression and food insecurity. One hundred and fifty participants will receive a six-month MTG intervention; participants with diet-related illness will receive MTG tailored to meet their specific needs. The control group, comprised of 150 participants, will receive a $30 monthly stipend for six months. Study participants will be recruited and screened in partnership with UMass Memorial and Community Care Cooperative.

POTENTIAL RELEVANCE FOR POLICY

This study represents a new opportunity to investigate the impact of MTG on depression. Evidence could inform important policy considerations for Medicaid and Medicare.

Diagnosed depression is not currently a qualifying criterion for MTG or MTM in MassHealth's HRSN program,[81] which is funded through Massachusetts' Medicaid Section 1115 demonstration. However, of the 20,000 MassHealth members evaluated in UMass Chan Medical School's impact study of nutrition services through the Flexible Services Program, roughly one in three had an underlying depression diagnosis.[82] This study found that receiving nutrition services was associated with significant reductions in hospitalizations, ED visits, and healthcare costs. RCT evidence could support future MTG or MTM coverage for populations that currently are not eligible through HRSN.

RCT evidence could support MTM and MTG becoming standard Medicaid services in the future, especially under Medicaid "medical necessity" regulations. The FIMC Medically Tailored Meals Sustainability Blueprint, co-authored by the Center for Health Law and Policy Innovation of Harvard Law School, presents a legal framework for expanded MTM coverage in Medicaid that draws on the evidence of MTM's impact on health outcomes. Under this framework, more RCT evidence could build a case for MTG as a standard Medicaid service.

Medicare Part C SSBCI benefits currently allow health plans the option of covering FIM services.[83] RCT evidence could strengthen the case for making MTG available to seniors enrolled in Medicare Part C plans.

RCT evidence could contribute to FIMC's new accreditation standard for MTG, which is currently in development among FIMC member agencies and expected to be released in 2026.

8

VIEWS FROM THE HEALTHCARE SECTOR

The AMPL Institute sat down with healthcare partners of Community Servings to hear their perspective on FIM and why addressing nutrition access and other non-medical drivers of health is so important. Questions and responses have been compressed for clarity and brevity.

PAULINA LANGE, BOSTON MEDICAL CENTER HEALTH SYSTEM

Role Overview

I am the Senior Manager of Social Services at Boston Medical Center Health System, supporting HRSN Services for the WellSense Accountable Care Organizations.

Why Is It Important to Address Non-Medical Drivers of Health?

Access to healthy food is critical to help manage illnesses and accomplish some of the overarching goals of supporting social determinants of health, member health outcomes, and ultimately cost of care for the health system. Access to healthy food should be an important factor for health systems to consider in their decision making.

Massachusetts has been a leader in the space of providing social services through healthcare. I hope we keep investing in what we've built up. We have extensive networks and knowledge and experience delivering these services. We have learned so much. We have the opportunity to keep building on it, refining it, making it sustainable. We have ironed out a lot of the processes and learned to pivot really fast and make things work.

How Did You Chart a Course Through the Recent Policy Changes of the MassHealth HRSN Program?

We really tried to prioritize continuity of service and the relationship with our social services partners through the transition. We definitely wanted to ensure that members continued to have good experiences with services. We really tried to keep these services going for members that were receiving them under Flexible Services. I know there was a lot of work in terms of just screening members for eligibility at the end of 2024 and working with our social services organizations helped us with those efforts to make sure we continued services where people remained eligible.

What Would Be Helpful in Terms of Future FIM Research?

Analysis of specific interventions is helpful because, from an ACO perspective, we have to select different interventions through HRSN, whether it's meals, boxes, or vouchers. I don't know if we have data on efficacy and impact of each one, as well as specific populations of members, based on diagnostic criteria. I want to see anything that can point to impact on specific populations and indicate length of intervention, impact on cost and utilization.

What Is Top-of-Mind as You Look to the Future?

How do we make the provision of nutrition services more sustainable long-term? What we're seeing is that there's a lot of food insecurity and a lot of members qualify for these services. What is that going to look like in 2026 or 2027 in terms of growing caseloads of members that qualify for nutrition supports? I think maybe the opportunity is to ask, how do we structure the policy around nutrition service delivery and what duration of intervention makes the most sense, to balance broad access and impact within resource constraints? We're being forced to look at where we need to change services for next year given how many people continue to qualify—and we need room for new members to be referred in.

MICHELLE POWDERLY, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, MEDICARE ADVANTAGE

Role Overview

I'm the Director of Medicare Case and Utilization Management.

Why Is It Important to Address Non-Medical Drivers of Health?

A senior over 65 may be on a fixed income. With the rising cost of food, it's really important that we ensure that they're getting good food, and unfortunately good food is more expensive than processed food. So, this is why we prioritize meals as a benefit for our members that have been in the hospital, to make sure that once they've been discharged, they have good food to make sure they can get healthy.

If you eat well, you're going to feel better. You need the nutritional value of the food to help you sustain your health. A lot of our members have chronic diseases like diabetes and heart failure. Eating appropriately is really going to be important for them to stay healthy. When people stay healthy, they stay out of the hospital, controlling medical costs and benefiting everyone. It's a win-win.

Your Organization Has Been Offering MTM to Members for Over Five Years. Talk About Why.

We made a business decision that we wanted to partner with Community Servings, and we have the opportunity with Medicare Advantage supplemental benefits. The concept of Food is Medicine directly connects nutrition to better health outcomes and lower medical costs. We believe our medical meals program reduces hospitalizations and readmissions, improves disease management, and enhances overall member experience. The meals program aligns with our goals of providing members with preventive care strategies and control over long-term spending. Being a partner in the community and working to improve overall population health is a key differentiator for us.

What Is Top-of-Mind as You Look to the Future?

I worry that we're coming to a place where more seniors are going to need more support and care. We need to keep these foundations strong—programs from Community Servings to Meals on Wheels are critical. These programs keep seniors healthy. It is important that SDOH continues to be part of routine care and not just a temporary initiative. Sometimes it's a fad. But we're here to stay. We acknowledge the high-quality service Community Servings provides our members to keep them healthy.

If you give people quality, fresh, nutritious food that is not overly processed, you're going to have better outcomes. But there are food vendors that label themselves as medical meals when they're really very highly processed food. That does concern me. That's not healthy. If MTM becomes a health benefit, there should be parameters to protect its consistency. Patient well-being is paramount, and that includes providing them with nutritious food that aids in their recovery.

9

THE CASE FOR CULINARY MEDICINE

In 2025, a national survey by the Food is Medicine Institute at Tufts University found that interest in FIM services is high in the general public, particularly among people experiencing food and nutrition insecurity.[84]

But do healthcare providers have the knowledge and training necessary to respond to their patients' nutrition needs? To what extent are healthcare providers prepared to refer their patients for nutrition services? Only 17 percent of survey respondents saw a registered dietitian in the last year. Twenty-four percent reported that their provider had asked whether they had enough food to eat. Fewer than half of respondents reported that providers gave them clear nutrition advice. Seventy-six percent said that doctors need more training in food, nutrition, and health.

Funded by The Rockefeller Foundation, a public perception survey covering similar topics was conducted in February and March 2025 and published in May of that year.[85] The findings align with Tufts University's research, underscoring that while general awareness of FIM is low, perceived value of the FIM concept is high.

As discussed in 2025's *A View of the Field* report, there is a significant opportunity to fold nutrition education into undergraduate and graduate medical training. Medical students tend to receive little nutrition education.[86] Most graduate medical education requirements feature no or limited nutrition competencies.

The need is widely recognized, and stakeholders have made encouraging progress. Following policy momentum on this issue in 2022 and 2023, the *Journal of the American Medical Association* published an expert panel's consensus-based recommendation of 36 nutrition competencies for inclusion in physician licensing and board certification examinations.[87] HHS urged medical schools to adopt comprehensive nutrition education in 2025.[88] In March 2026, over 50 medical schools across 31 states made public commitments to update their approach to nutrition education and training through a new HHS initiative.[89]

CULINARY MEDICINE AT THE AMPL INSTITUTE

The AMPL Institute addresses the need for nutrition education through its Culinary Medicine Program, an eight-week experiential learning course for medical and dental students. Leveraging Community Servings' decades of experience as an MTN provider, the program equips students with skills, knowledge, and confidence. The objectives are to equip healthcare professionals to support the connection between nutrition and health and, ultimately, to make MTN a standard of comprehensive, person-centered care.

PROGRAM OVERVIEW

A pilot of the Culinary Medicine Program launched in spring 2025 as a joint partnership between Community Servings and the Tufts University School of Medicine, School of Dental Medicine, and the Friedman School of Nutrition Science and Policy. The course met at the Boston headquarters of Community Servings and the Tufts University School of Medicine. In class, students:

- Received instruction and hands-on practice in preparing medically tailored meals
- Strengthened counseling skills through motivational interviewing role-play
- Adapted recipes to reflect diverse cultural traditions and ingredient accessibility

For their final project, each student designed and presented a recipe aligned with a medically tailored meal plan.

EVALUATION

To understand the holistic impact of the Culinary Medicine Program, including perceived knowledge, relevance, and confidence, students completed pre- and post-program surveys, with a smaller sample participating in semi-structured interviews. Integrated analysis was conducted on the quantitative and qualitative evaluations.

FINDINGS

Measurable increase in confidence. Ratings showed a statistically significant improvement in comfort discussing diet, nutrition, and food preparation.

Understanding through hands-on learning. Most students (18 of 25) highlighted increased knowledge of food preparation techniques as one of the most beneficial skills learned.

Growing awareness. Students demonstrated increased understanding of how to prepare medically tailored meals, even though perceptions of links between personal health habits and patient outcomes did not significantly change.

Expanded perspective. Students gained new insights into food access and the realities of cooking with dietary restrictions.

Personal connection to practice. Students reported applying course lessons to their own health behaviors.

Broader understanding of context. Students recognized how social, structural, and access-related factors shape food choices and behaviors.

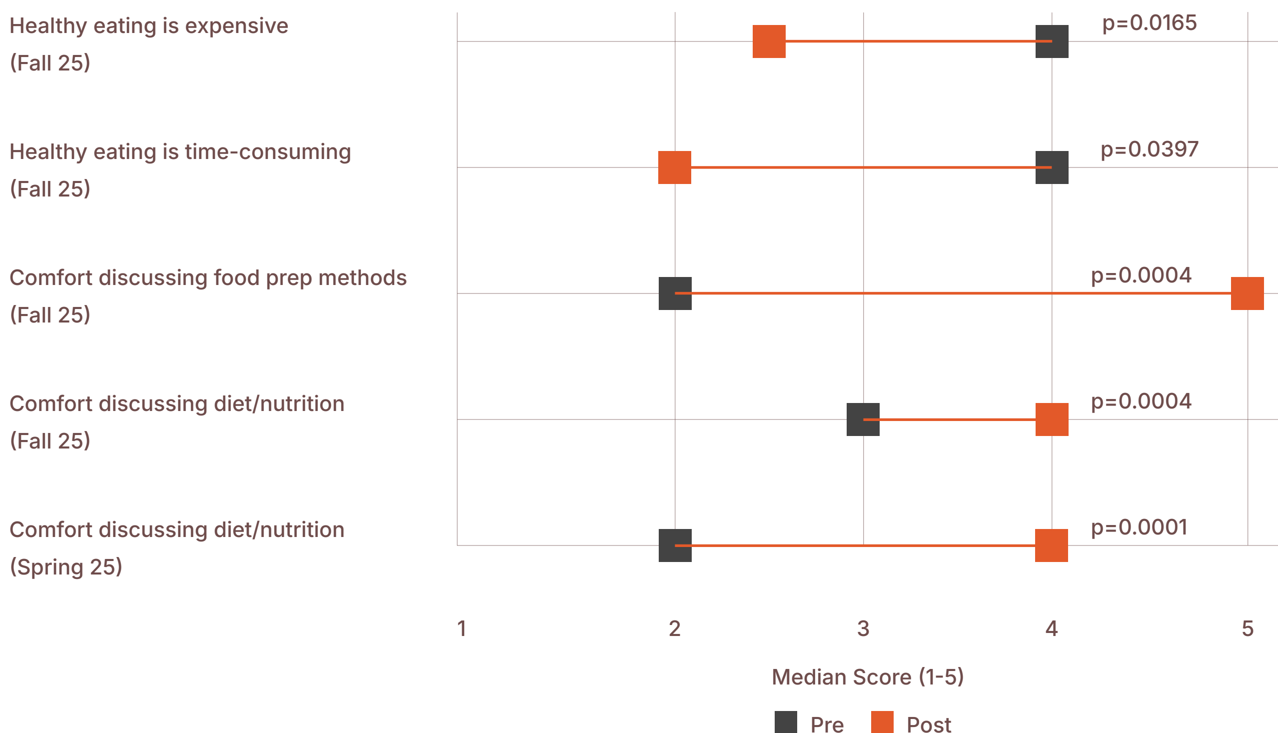
Broader understanding of context. Students recognized how social, structural, and access-related factors shape food choices and behaviors.

Greater cultural responsiveness. Exposure to diverse food traditions reinforced the importance of adapting nutrition guidance in culturally meaningful ways.

Enhanced counseling skills. Practice strengthened students' motivational interviewing and communication skills.

Interdisciplinary exposure. Students valued interprofessional learning, noting the opportunity to collaborate with peers from medicine, dentistry, nutrition, and physical therapy.

Pre-Post Connected Dot Plot of Median Survey Responses



Analysis by Stephanie Coker, MPA

STUDENT QUOTES

"It was very helpful to learn why people choose what they choose to eat. It could have different reasons, like financially or if they're in an area where there are no healthier food options. It all plays a part. So, you're able to take into account the whole spectrum of things that goes into a decision."

"Being from a nutrition background, I had already learned about diets for different diseases, but I really appreciated the focus on motivational interviewing and cultural competency, as these topics are essential for effective counseling. The exercises we did in class help give a practical perspective on how to counsel people with varied health conditions from different cultures."

"Definitely opened my eyes on how people in need lack the resources to get the food needed and how, for instance, physical mobility can impact their ability to prepare their food."

NEXT STEPS

The evaluation yielded various recommendations for improvement, such as requiring a foundational background in nutrition or providing more insight into how food security screening and FIM provision are integrated into healthcare practice.

In the 2026-2027 academic year, the Culinary Medicine Program will be scaling in partnership with Tufts University. The updated course model will feature live virtual classes and in-person cooking labs at Community Servings.

10

RESEARCH LANDSCAPE

This year, the evidence base for MTM has grown in noteworthy ways. Published research has generated new findings, including but not limited to:

- New estimates of the state-level impact of MTM on healthcare use and expenditures
- The impact of MTM provision on health outcomes and healthcare costs through Medicaid Section 1115 demonstrations in Massachusetts and North Carolina

The growing budgetary pressure upon states is an important factor here. With the rollout of the 2025 federal reconciliation bill, tightening budgets may prompt states to look for ways to lower costs and refine initiatives. Katie Garfield, Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School, makes this point in her assessment of the field today. "Research is more important than ever," Garfield says. States need the guidance of research as they identify the populations for which FIM is associated with the greatest impact and the approaches to FIM that are most effective.

While there are already associations between MTM and reductions in healthcare utilization and costs, further and stronger research will reinforce the case.

RESEARCH IN THE FIELD

"Medicaid Spending and Health-Related Social Needs in the North Carolina Healthy Opportunities Pilots Program," Seth A. Berkowitz, Jessica Archibald, Zhitong Yu, et al.[90]

Published in *The Journal of the American Medical Association* in February 2025, this study investigates nutrition and housing services provided in 2022 and 2023 through North Carolina's Healthy Opportunities Pilots program (HOP), authorized by a Medicaid Section 1115 demonstration. The findings suggest that participation in HOP was associated with increased spending at enrollment followed by a lower spending trend, including per person monthly cost savings of $85 and a reduction in ED visits compared to persons with health-related social needs who lived outside of the HOP service area.

Health Affairs Special Issue on Food, Nutrition, and Health

In March 2025, a themed issue of *Health Affairs* explored research and policy topics related to food, nutrition, and health. The issue featured articles authored by many of the field's leading experts. What follows are summaries of select articles in that issue:

"Estimated Impact of Medically Tailored Meals on Health Care Use and Expenditures in 50 U.S. States," Shuye Deng, Kurt Hager, et al.[91]

A meta-analysis of studies published from 2013 to 2023, this new study estimated the state-by-state impact on healthcare use and expenditures, which is particularly relevant to policy-makers and decision-makers in healthcare.

In total and across nearly all states, the study estimated that in just one year, MTM coverage would be associated with reductions in hospitalizations of **2.61 million** and reductions in healthcare spending of **$23.7 billion** among Medicare, Medicaid, and privately insured individuals with diet-sensitive conditions and instrumental activities of daily living limitations.

The largest annual net cost savings were in

Connecticut
($6,299 per person)

Pennsylvania
($4,450 per person)

Massachusetts
($4,331 per person)

"Medicaid Nutrition Supports Reduce Hospitalizations and Emergency Department Visits in Massachusetts," Kurt Hager, Meagan Sabatino, et al.[92]

This study evaluated the impact of nutrition services covered through MassHealth's Flexible Services Program and provided to over 20,000 members between January 2020 and March 2023. Nutrition services included MTM, connection to food assistance programs and food pantries, food prescriptions and vouchers, kitchen supplies, and food boxes. The study focused on acute healthcare utilization and costs, finding that participation in nutrition services was associated with:

23% reduction in hospitalization

13% reduction in ED visits

$712 per person reduction in healthcare costs (compared to members who were eligible but did not receive services)

A subgroup of nearly 10,000 members enrolled in 2022 and 2023, after the height of the COVID-19 pandemic, yielded significant associations:

47% percent reduction in hospitalizations

21% reduction in ED visits

$1,721 per person reduction in healthcare costs (compared to members who were eligible but did not receive services)

Another subgroup analysis looked at the impact on adults and children. Children showed no change in healthcare utilization or costs. Adults showed similar results to the full study sample.

Analysis of different lengths of MTM enrollment found a significant reduction in healthcare costs of $2,502 per adult enrolled longer than 90 days, resulting in net cost savings of $210 per person and approximately **$1.8 million for the group**.

"A Systematic Review of Food is Medicine Randomized Controlled Trials," Hilary K. Seligman, Sonia Y. Angell, Seth A. Berkowitz, et al.[93]

In June 2025, the American Heart Association published a review of FIM randomized controlled trials, evaluating current scientific knowledge of FIM and highlighting the need for higher-quality studies to better understand the relationship between participation in FIM services and health outcomes. This evaluation of the literature is an important analysis of the research gaps and the opportunities for future FIM research.

RESEARCH AT AMPL

RECENT RESEARCH

Evaluation Consortium

In partnership with the Food is Medicine Institute at Tufts University and UMass Chan Medical School, the AMPL Institute is co-leading the Evaluation Consortium, an ongoing investigation into the impact of MTM within Massachusetts' Medicaid Section 1115 demonstration.

"Why Patients Stay In or Leave a Medically Tailored Meals Program," Sara C. Folta, Jessica Burch, Matthew Alcusky, et al.[94]

Published in *Frontiers* in February 2026, this qualitative study explores a knowledge gap in the field: What motivations, perceptions, and experiences drive patients to enroll in, stay in, or withdraw early from an MTM program? The novel findings of this comprehensive evaluation have the potential to inform policymakers, healthcare professionals, and MTM providers as programs are designed and refined throughout the U.S.

The study interviewed 28 clients of Community Servings' MTM program. Half of the participants completed the program (completers), and half requested to discontinue the program early (noncompleters). The study analyzed and compared responses from the two groups across patient factors, such as health status, health goals, and motivation, and the characteristics of the intervention itself, such as perceptions about enrollment and meal quality.

FINDINGS

- **Motivations.** Interest in alleviating symptoms and regaining physical function was a common motivation for enrolling among completers and noncompleters alike. Both groups had positive perceptions of their experience enrolling in MTM and meal delivery. Both groups, including those who discontinued, perceived that MTM helped them achieve sustainable improvements in diet.

  Noncompleters were more likely to be motivated by the goals of losing weight and improving their nutrition. In contrast, completers were more motivated to alleviate financial strain and the time and physical challenges of preparing meals. This suggests an opportunity for healthcare and MTM providers to better set patient expectations in line with the clinical goals of MTM, potentially supporting longer-term program adherence and completion.

- **Adjusting dietary habits.** It may take time for patients to adjust to a healthier diet due to differences between MTM and their typical eating habits. Over time, completers adapted to the program, often coming to enjoy and appreciate MTM. However, many noncompleters were unable to adapt and withdrew because MTM did not match their usual diet in terms of flavor or portion size. Patient education about the possible differences between MTM and their usual diet could be beneficial. Similarly, patients could receive education about cues of satiety to adapt to smaller portion sizes.

- **Duration.** Many participants withdrew early because their health improved to the extent that they felt better and were able to cook independently. This suggests a need for further research regarding optimal service duration per individual and how to standardize patient assessment. A potential consideration could be transitioning patients to MTG or produce prescriptions if they are able to shop and cook independently.

OTHER RESEARCH IN PROGRESS

Evaluation Consortium: Impact of MTM on Obesity, Other Health Outcomes, and Healthcare Utilization Under Medicaid Flexible Services

Summary: Claims and clinical data analysis to assess the impact of MTM delivered through the MassHealth Flexible Services Program on health outcomes and healthcare utilization.

Status: Pursuing continuation through additional NIH grants.

Timeline: Additional publication anticipated in 2026.

Funder: NIH

Partners: Mozaffarian, Zhang, Folta (Tufts Food is Medicine Institute); Hager, Alcusky (UMass Chan Medical School)

Food is Medicine: A Randomized Controlled Trial of Medically Tailored Meals for Individuals with Type 2 Diabetes and Food Insecurity (FAME D)

Summary: Examining the impacts of increased food access on improving health outcomes for individuals with type 2 diabetes and food insecurity. Participants are randomized to receive Community Servings meals with 12 lifestyle coaching sessions over six months OR $40 food subsidy once a month for six months with usual care.

Status: Findings to be presented at American Diabetes Association's 2026 Scientific Sessions

Timeline: Anticipate publication in 2026

Funder: NIH

Partners: Berkowitz (University of North Carolina School of Medicine); Delahanty (Massachusetts General Hospital)

Food as Medicine for Families (FAME F)

Summary: Recruited 100 individuals with a chronic cardiometabolic condition to test the target of the intervention (individuals vs. household) and the delivery mechanism (shipped vs. delivered by a Community Servings driver). All individuals received the MTM intervention for 12 weeks.

Status: Completed. Findings presented at American Heart Association Scientific Sessions 2025.

Timeline: Anticipate publication in 2026

Funder: The American Heart Association

Partner: Berkowitz (UNC School of Medicine)

Food as Medicine for HIV: A Randomized Controlled Trial of MTM and Lifestyle Intervention (FAME H)

Summary: Examining the impact of increased food access and lifestyle intervention on health outcomes and quality of life for individuals with HIV, type 2 diabetes, prediabetes, high risk of developing diabetes, and food insecurity.

Status: Recruitment completed.

Timeline: Anticipate publication in the spring of 2027.

Funder: NIH

Partners: Berkowitz (University of North Carolina School of Medicine); Delahanty and Lo (Massachusetts General Hospital)

FIM+ Case Study

Summary: Developing a report and supporting evaluation and educational tools documenting community-centered food procurement practices at Community Servings.

Status: Development of case study in progress.

Timeline: Anticipate case study and supporting materials publication in 2027.

Funder: The Rockefeller Foundation

Partners: Long, Short (Center for Nutrition & Health Impact); Broad Leib, Latino (Center for Health Law and Policy Innovation of Harvard Law School); Wilson (Duke World Food Policy Center); Evans (Johnson & Wales University)

THE FOOD IS MEDICINE COALITION: SCALING A SUSTAINABLE FIELD

The Food is Medicine Coalition is the national association of nonprofit providers of MTM and MTG. Many of its member organizations, such as Community Servings in Boston, God's Love We Deliver in New York, and MANNA in Philadelphia, were founded during the HIV/AIDS public health crisis of the late 1980s and have devoted decades to addressing unmet health needs in their communities.

Speaking about health in the U.S. today, FIMC Executive Director Alissa Wassung offers a perspective grounded in the ongoing problem of access and the unique qualifications of nonprofit CBOs to serve the most vulnerable. "People who are sick *should* be able to eat. But they can't," Wassung says. "The problem is visceral. In this tumultuous time, reminding everyone that we are solving this central problem is the key to moving our cause forward."

Many families are one crisis or one illness away from default. That's the reality of our current healthcare system. Day after day, community after community, it is nonprofits that are largely answering the call for folks who are in this situation."

– Alissa Wassung, CEO, Food is Medicine Coalition

FIMC's cause is advocating nationally to make MTM and MTG accessible to the people who need them—available for free and at the highest standards of quality. FIMC does this by creating FIM service standards that support client trust, incubating and equipping nonprofit MTM providers in new and unserved geographies, advancing research on efficacy, sharing best practices among FIMC member organizations, and advocating for policy opportunities that foster broader access to FIM.

FIMC ACCELERATOR

The FIMC Accelerator is an intensive training program that teaches established nonprofits how to provide the MTM intervention in their communities. The program is co-led with Community Servings, God's Love We Deliver, the Nonprofit Finance Fund, and the Center for Health Law and Policy Innovation of Harvard Law School.

Since launching in 2020, the program has graduated 22 nonprofit organizations that offer MTM in over 20 states. There are 37 total FIMC member agencies operating in the U.S. today, with many regions still not yet served by a CBO. "The Accelerator is a strong answer to scaling," says Wassung. "Our ethos centers teaching, bringing other organizations along, blending our mission with their place-based wisdom, and recognizing the importance of communities serving communities." The latter element—"communities serving communities" — reflects FIMC's commitment to a local, community-based approach and the core belief that a region's existing nonprofits are best qualified to understand and serve their region.

As a food bank, it's one of our strategic directives to start looking at doing more than just feeding people, but really nourishing health. We didn't know a ton about MTM or FIMC, but we took a leap of faith and decided to apply for the Accelerator. We're really grateful we did. It prepared us to successfully run several MTM pilots after we graduated."

– Heather Martin, Senior Director of Strategic Partnerships, Second Harvest Food Bank of Northwest North Carolina

Currently in its sixth year, the Accelerator has been restructured, condensing its curriculum, formerly 11 months in length, into six months. “We’ve taken the time to refine and concentrate the curriculum to provide a more rapid-cycle experience,” Wassung says.

The sixth cohort features nonprofits from across the country: Delaware Food Bank in Newark, Delaware; Freestore Foodbank in Cincinnati, Ohio; Kanbe’s Markets in Kansas City, Missouri; Lanakila Pacific in Honolulu, Hawaii; Meals on Wheels Sarasota, Inc. in Sarasota, Florida; and Preble Street in Portland, Maine.

Learn more about the FIMC Accelerator, including current or upcoming application opportunities, at **fimcoalition.org/programs/fimc-accelerator/.**

FIMC ACCELERATOR GRADUATE GRANT PROGRAM

A longtime funder of the FIMC Accelerator, CVS Health significantly expanded its support in 2026 to launch the Accelerator Graduate Grant Program, which provides $25,000 grants to eight Accelerator graduate agencies to strengthen operations through capacity-building, technology upgrades, and capital improvements. These grants will enable agencies to expand MTM programs in regions where there is limited or no access to community-based MTM programs, strengthening the national field.

Awardee	Location	Project Overview
Families Anchored in Total Harmony (FAITH)	Gary, Indiana	• Expanding MTM service area • Increasing local food integration
Jewish Family Services of Washtenaw County	Ann Arbor, Michigan	• Supporting processes for healthcare partnerships • Creating claims infrastructure • Capacity-building for shipping program • Positioning CBOs as preferred MTM providers
Meals on Wheels Greenville	Greenville, South Carolina	• Launching pilot program with PRISMA Pediatric Oncology
Meals on Wheels People	Portland, Oregon	• Expanding current MTM packaging facility
Meals on Wheels of Western Michigan	Grandville, Michigan	• Purchasing kitchen equipment needed to scale MTM production and serve new MTM clients
Second Harvest Food Bank of Central Florida	Orlando, Florida	• Investing in information security and technology
Second Harvest Food Bank of Northwest North Carolina	Winston-Salem, North Carolina	• Expanding cold storage capacity
The Joy Bus	Phoenix, Arizona	• Serving new MTM clients • Continuing local sourcing in MTM production

"Food is medicine, and medically tailored meals are a proven intervention that helps improve health outcomes and reduce barriers to care," says Faith Weiner, Executive Director of Enterprise Engagement and Community Impact. "Our investment in Community Servings and the Food is Medicine Coalition strengthens the organizations on the front lines of this work and helps scale programs that reach people who need them most."

FIMC ACCREDITATION STANDARDS FOR MTM AND MTG

In 2024, FIMC published the MTM Accreditation Criteria and Requirements (ACR), the first-ever fieldwide standard of MTM as defined by FIMC's member organizations.[95] Fourteen FIMC member organizations have met FIMC's guidelines and become accredited as of March 2026.

The ACR addresses a foundational issue for the field. If MTM is to be provided through healthcare—an industry in which services must meet standards of quality, consistency, and measurability—the field must have a standard definition of MTM to govern its practice and provision. More concretely, healthcare organizations and clients need to know what is (and what is not) an evidence-based and high-quality MTM intervention.

To become accredited, nonprofit MTM providers undergo a rigorous auditing process. No matter their operational scale or geography, the MTM intervention of an accredited provider meets the needs of clients living with severe, complex, and chronic health conditions.

"Our standards and field-wide definitions are a core way we're addressing trust," says FIMC Manager of Policy and Projects Cate Hensley. "We want our clients to know that the evidence backs up the intervention that they receive from their FIMC member agency. We also want healthcare to know they can trust a FIMC-accredited agency. Our standard is now recognized in five state-based Medicaid guidance policies."

Forthcoming from FIMC in 2026 are new accreditation criteria and requirements for MTG. The formal process to develop an MTG accreditation program began in 2025. Like the creation of the MTM standard, FIMC's standards development process will draw upon current scientific evidence and best practices of the field's nonprofit providers, producing a comprehensive MTG definition that will support improved health outcomes.

MTM SUSTAINABILITY BLUEPRINT

The Medicaid program contains some of the most frequently used pathways for the provision of MTM in healthcare throughout the U.S. However, the use of these pathways depends on the legal and regulatory flexibility of pilots and demonstrations (e.g., Section 1115 waivers). In contrast to services provided through flexible waivers, standard Medicaid benefits have strict structural requirements related to benefit category and medical necessity, provider qualification, pricing and reimbursement, and monitoring and enforcement.

In other words, if MTM is to be provided as a standard Medicaid benefit, it must be structured like one. The goal of the MTM Sustainability Blueprint, a new FIMC initiative, is to help various stakeholders plan for and achieve this outcome.[96] The Blueprint details how to marry MTM program design and Medicaid benefit requirements. Ultimately, it is a guide toward a durable, long-term framework for MTM within Medicaid regulations.

Katie Garfield, a co-author of the Blueprint and the Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School, says that any MTM provider or any state with the eventual goal of incorporating MTM into Medicaid coverage beyond a waiver or demonstration program should consider the Blueprint in their planning. Otherwise, MTM providers may have to make significant adjustments to existing programs as their state makes the transition toward coverage. "Being aware of what we already know should be informing programming, research, and waivers in this moment so that we're continuing to build and grow," Garfield says. "Researchers should be thinking about the gaps in the evidence in a similar manner. They need to be aware that their research can ultimately impact who is getting MTM in a very real way as we move toward coverage, and so addressing key open questions is critical."

The existing evidence makes a persuasive case. "What I think is remarkable about the Blueprint is how much we can say about how MTM actually does fit into these benefit structures," says Wassung.

UPDATE ON THE CODING4FOOD SUBMISSION TO CMS

In January 2025, the Gravity Project and the Coding4Food Initiative submitted nine applications to CMS for Level II HCPCS codes describing MTM, MTG, and other FIM interventions.[97] Service codes are how the healthcare sector records standard services and procedures, diagnoses, and other key information for administrative use. Level II HCPCS codes (short for the Healthcare Common Procedure Coding System) are used for nontraditional services. The HCPCS data set is managed by CMS.

The submissions reflect national consensus on FIM interventions and a formal request to the federal government to create aligned, standardized service codes. The lack of standard FIM codes is an ongoing barrier to the measurement and evaluation of FIM in healthcare—particularly through Medicaid demonstrations—not to mention an administrative barrier for billing and payment. The creation of such codes would represent an important milestone in the integration of FIM into healthcare, enabling a more accurate evaluation of MTM and MTG across geographically varied pilots and demonstrations.

In August 2025, CMS informed the Gravity Project and Coding4Food that their applications were being closed and that CMS was not pursuing them at this time.[98] As a next step, the Gravity Project is convening workgroups to update its applications for MTM, produce prescriptions, and individual and group cooking education, and will re-submit them to CMS by June 2026. The Gravity Project and Coding4Food plan to resubmit additional applications in future CMS review cycles.[99]

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CLOSING

Looking to January 2027, two of the major Medicaid changes in the 2025 federal reconciliation bill will take effect: work requirements and six-month eligibility redeterminations for Medicaid Expansion members. Some individuals will be exempt from the new work requirements. However, those individuals must understand their qualifying exemptions and report them to the state. Medicaid agencies and community partners are embarking on robust outreach efforts to communicate the new requirements and educate enrollees about how to avoid interruptions in the coverage they qualify for. In Massachusetts, MassHealth intends to communicate with Medicaid Expansion members and other affected populations starting in summer 2026.[100]

The budgetary pressures resulting from Medicaid financing changes are expected to prompt states to “do more with less,” in the words of Katie Garfield, Director of Whole Person Care, Center for Health Law and Policy Innovation of Harvard Law School. Navigating this environment will demand flexibility, adaptability, and resilience from CBOs whose historic funding sources may continue to experience uncertainty. The need for strong research is also important to ensure that evidence is available to guide policymakers as they make informed, evidence-based refinements to MTN policy.

How can CBOs offering MTN persevere? Our survey of the field suggests the following:

- Educate and engage policymakers early and often, leveraging the research showing impact on health outcomes, healthcare utilization and costs, and economic value
- Plan ways to make MTN programs as targeted and impactful as possible
- Pursue all available funding sources, including those pertaining to policy priorities that reasonably lend themselves to MTN, such as maternal health
- Continue to invest in resources and systems to support operational scaling
- Continue to invest in research validating the local health and economic impact of MTN

“Many of the challenges we face boil down to finding the money to keep up the work. Today I think we have to be careful we don’t just wring our hands. We have to keep looking for efficient ways to operate, new sources of philanthropic dollars, and opportunities to self-fund. Sometimes crises prompt us to make changes for the better.”

– David Waters, CEO, Community Servings

“I’m actually encouraged by my recent dialogue with policymakers in Georgia. Even in these politically charged times, when food costs are at an all-time high, I’m still very encouraged by the momentum in the Food is Medicine movement.”

– Matthew Pieper, CEO, Open Hand Atlanta

Asked what advice she would offer to CBOs in this landscape, Open Arms of Minnesota’s CEO Leah Hebert Welles starts with one word: “abundance.” “The community builds you up in times like these,” Welles says. “Our volunteers and donors have been with us over the years. When things are really hard, they show up for you. If you tell them what’s happening, they’re really willing to go to bat for you with their foundations, with corporations, and with the resources that they have. The abundance that we need to keep going already exists in our communities.”

The premise of community abundance bore fruit for Community Servings in November 2025. In response to emergency appeals related to the government shutdown and SNAP benefit interruptions, our supporters rallied, with several making large donations to fund direct services to clients. Their gifts and responsive grants allowed Community Servings to undertake actions to address the SNAP crisis and provide a full six-month MTM intervention to about 150 clients whose MTN services were going to end in January—prematurely, some after only a few weeks of service—due to a health plan discontinuing its MTM service offering. At the time, these clients were pregnant or postpartum, undergoing cancer treatment, or experiencing end-stage renal disease, uncontrolled diabetes, or HIV. Without philanthropy, these clients would have lost access to MTM on January 1, 2026. Philanthropy has only gone so far, however. Community Servings was unable to extend coverage for the entire affected population. Two hundred other clients, enrolled with the same health plan but with less acute medical needs, lost access to MTM on the first day of the year.

"We can't do everything." That is how Carolyn Boyd, Senior Manager of Nutrition Services at Community Servings, summarizes the most difficult part of her job: telling people who are ill that she cannot help them. Maybe the individual does not qualify for Community Servings. Or maybe their needs fall outside our purview. They are asking for help paying for electricity or utilities. They need emergency food assistance. They feel unsafe leaving their house. They just enrolled in a new health plan and, without realizing it, they chose one that does not offer the nutrition services they have come to count on.

Many of the people we serve are searching for help, and too few resources are available. Describing how clients are doing in 2026, Boyd says, "They're confused. They're overwhelmed by the state of the world. They don't know what's going to happen with their benefits. They don't know what's happening with their health insurance. We try to be a constant for them, but *we can't do everything*."

For too many Americans, a single illness can prompt a crisis and require impossible choices, between seeking healthcare or heating a home, between forgoing a meal or preparing one for a dependent. The problem of access is formidable. It is also gradually remediable through public policy and through the continual integration of healthcare and social services.

Society changes slowly. In 2026, the Food is Medicine movement is leading the way.

EXIT

BROCKTON

ABOUT FOOD IS MEDICINE

Food is Medicine is the provision of food resources to prevent, manage, or treat illness.[101] Food is Medicine interventions are designed to address a patient's specific medical nutrition needs and are integrated into healthcare through referrals from healthcare providers.

Medically Tailored Nutrition

Medically tailored meals (MTM) and medically tailored groceries (MTG) are designed by a registered dietitian nutritionist (RDN) using evidence-based guidelines and based on an individual's medical diagnosis. Both MTM and MTG are provided in combination with nutrition counseling and education. These services benefit people with severe, chronic, or complex health needs.

Medically tailored nutrition can be part of an individual's treatment plan, just like any other medication prescribed by a doctor. MTM, in particular, can benefit people with limitations in instrumental activities of daily living (e.g., difficulty going shopping or preparing foods independently).

ABOUT COMMUNITY SERVINGS

Medically Tailored Meals Program (MTM)

Our MTM program offers 16 medical diets designed to improve dietary quality and health outcomes through the provision of fully prepared medically tailored meals. Diets can be customized with soft, mild, vegetarian, pescetarian, low-fiber, low-lactose, high-calorie and high-protein, and fish-free foods.

The Culinary team produces all entrees, soups, stews, and protein salads on-site in its Boston headquarters using seasonal, high-quality, and locally sourced ingredients. Chefs design the Community Servings menu to reflect a variety of culinary traditions. Meals are:

- Scratch-made from fresh, whole ingredients
- Fully prepared and delivered weekly to clients' homes
- Modified for the restrictions and needs of each individual

Medical diets are prescribed by an RDN based on a healthcare provider referral and nutrition needs assessment. RDNs identify medical diagnosis, co-occurring conditions, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related outcomes.

CORE DIETS

Community Servings' diets include entrees, soups or stews, protein salads, fresh fruit, snacks, milk, and house-made baked goods.

Wellness, Diabetic, and Cardiac Diets
Emphasize whole grains and lower-glycemic carbohydrates; limited sodium, carbs, and saturated fat

Pregnancy Health Diet
To address maternal health outcomes, features protein-rich breakfasts; high-protein, high-calorie snacks; no fish; limited sugar, sodium, and saturated fats

Renal Health Diet
Emphasizes adequate protein plus limited fluids, sodium, potassium, and phosphorus

Pediatric Health Diet
Features kid-friendly breakfasts, entrees, snacks, and house-made desserts

MEDICALLY TAILORED GROCERIES PROGRAM (MTG)

Designed for individuals who can prepare meals independently and need a medically tailored diet, MTG provides home-deliveries of the main ingredients necessary to prepare medically tailored recipes at home.

MTG medical diets (Wellness, Vegetarian, and Renal) are prescribed by an RDN based on a healthcare provider referral and nutrition needs assessment. RDNs identify medical diagnosis, co-occurring conditions, symptoms, allergies, medication management, side effects, and home cooking resources to ensure the best possible nutrition-related outcomes.

Groceries are shipped via FedEx every two weeks and include animal and plant proteins, grains, dairy, and locally grown produce. Grocery deliveries are designed by an RDN. A welcome box for newly enrolled individuals includes a recipe booklet, education materials, and links to cooking demonstration videos.

COMMUNITY SERVINGS' HEALTHCARE PARTNERS

The AMPL Institute firmly believes that the healthcare system is the appropriate space for the provision of Food is Medicine interventions. Food is Medicine shares many of healthcare's core goals: improving health outcomes, reducing cost of care, and reducing rates of chronic, diet-related illness.

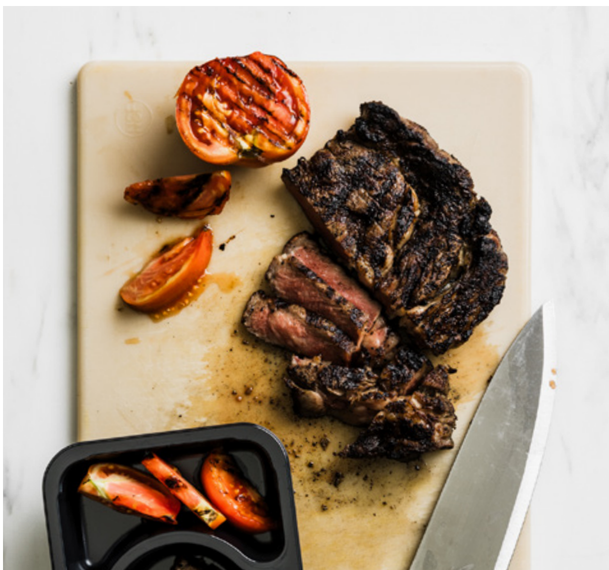
Community Servings partners with the healthcare sector in Massachusetts and Rhode Island, contracting with health plans and healthcare providers to reimburse for services. Within each contract, healthcare professionals submit client referrals to Community Servings.

As of January 2026, Community Servings contracts with:

12 Medicaid (MassHealth) Accountable Care Organizations (ACOs)
3 dual-eligible Medicare-Medicaid contracts
2 Medicare Advantage plans
2 hospital-based partners
1 home hospital program
1 community health center
1 commercial health plan

COMMUNITY-CENTERED FOOD SOURCING

Through its community-centered food sourcing strategy, Community Servings sources ingredients of superior quality and engages farms, fishers, and growers whose business practices are environmentally and socially positive. Of its total FY2025 food purchases, around 20 percent were local and regional (i.e., foods grown, harvested, and fished in New England and New York).



Access to Medically Tailored Nutrition Through Policy and Leadership

The AMPL Institute is where excellence in providing medically tailored nutrition meets pioneering research, policy work, and provider education. Our mission is to transform the healthcare system so that medically tailored nutrition becomes a universally accessible standard of comprehensive, person-centered care.

The AMPL Institute is based at Community Servings, the largest nonprofit provider of medically tailored nutrition in New England.

Research

In partnership with the Food is Medicine Institute at Tufts University, UMass Chan Medical School, the University of North Carolina School of Medicine, and others, AMPL continues Community Servings' long-standing commitment to expanding the evidence base for medically tailored nutrition. Our studies have shown that medically tailored meals improve health outcomes and reduce healthcare costs for people experiencing chronic illnesses and food insecurity.

Policy

AMPL advocates for state and federal policy changes that will increase access to medically tailored nutrition for the people who need it. Any person living with severe, complex, or chronic illnesses should have access to medically tailored nutrition, regardless of their health condition, geography, or ability to pay. Our central policy objective is to make medically tailored nutrition an established benefit in Medicaid and Medicare.

Education

Building upon Community Servings' decades of experience providing medically tailored meals, AMPL's Culinary Medicine experiential learning opportunities teach medical students, medical professionals, and community members about the power of nutrition to prevent and treat chronic illnesses.

Learn more about AMPL at **servings.org/ampl-home.**

THE IMPACT OF MEDICALLY TAILORED MEALS

To date, Community Servings has published four peer-reviewed journal articles in partnership with Dr. Seth A. Berkowitz of the University of North Carolina School of Medicine. These studies found that for individuals with complex chronic illnesses and food insecurity, MTM:

- Improves dietary quality
- Improves mental health
- Reduces healthcare utilization
- Reduces costs

PEOPLE WHO RECEIVED MTM DEMONSTRATED:

16%
Monthly net reduction in healthcare costs[102]

70%
Reduction in ED visits[103]

49%
Reduction in inpatient admissions[104]

72%
Reduction in skilled nursing facility admissions[105]

PEOPLE WITH DIABETES WHO RECEIVED MTM DEMONSTRATED:

31.4-POINT
Increase in Healthy Eating Index score[106]

17% Fewer reports of hypoglycemia and

20% Fewer reports of food insecurity compared with study participants who did not receive meals[107]

41% Fewer reports of mental health conditions interfering with daily life compared with study participants who did not receive meals[108]

Led by Shuyue Deng of Tufts University, a 2025 cost-modeling study estimated state-specific one-year and five-year changes in annual hospitalizations, healthcare spending, and the cost-effectiveness of MTM for patients with diet-related diseases and activities of daily living limitations.[109]

MTM was estimated to avert over
2.61M hospitalizations
nationally per year.

MTM was estimated to
save $23.7B
across all payers nationally per year.

Massachusetts was among the three states with the largest annual net cost savings, estimated
at $4,331 per person.

FURTHER READING

The Food is Medicine Field

2024 Food is Medicine Research Action Plan
Kurt Hager, Corby Kummer, Alexandra Lewin-Zwerdling, Zhongyu Li
Food & Society at the Aspen Institute
aspenfood.org/food-is-medicine/

Advances in the Food is Medicine Field, Annual Report 2025
American Heart Association, Health Care by Food
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Food is Medicine Coalition
fimcoalition.org

Food is Medicine Community Action Plan
Food & Society at the Aspen Institute
fimcommunity.org/

Food Is Medicine Federal Resource Hub
Office of Disease Prevention and Health Promotion, U.S. Department of Health & Human Services
odphp.health.gov/foodismedicine

Food is Medicine Massachusetts
foodismedicinema.org/

The Rockefeller Foundation Food is Medicine Initiative
rockefellerfoundation.org/initiative/food-is-medicine/

Food is Medicine Institute at Tufts University
tuftsfoodismedicine.org

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chlpi.org

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Center for Health Law and Policy Innovation & the Food is Medicine Coalition (2024)
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