Food-as-Medicine in U.S. Health Policy: Medicaid Innovation, Medicare Advantage Benefits, and the Emerging Coverage Framework

By Scott Silberberg

2026

LEE ALVAREZ Chief Revenue Officer – lalvarez@marwoodgroup.com
JENNIFER MEYERS Managing Director – jmeyers@marwoodgroup.com
KYLE HOLMES Director – kholmes@marwoodgroup.com

MARWOOD GROUP

Introduction

Food-as-medicine is emerging as a durable component of American health policy, reflecting a broader shift toward integrating social determinants of health into care delivery. Policymakers and payors are increasingly recognizing nutrition as a clinical tool to manage chronic, diet-sensitive conditions that drive significant healthcare spending, particularly among Medicaid and Medicare populations. Federal policy has enabled state Medicaid programs and Medicare Advantage plans to scale nutrition programs such as medically tailored meals and groceries by creating multiple pathways for coverage. This paper highlights the experience in California, which suggests that these interventions can reduce downstream costs while improving health outcomes. At the same time, Medicare Advantage plans are expanding nutrition benefits as part of care management strategies for high-risk populations. Together, these developments indicate that food-as-medicine programs are likely to continue to scale across the country as they become more permanently integrated into public insurance coverage.

Food-as-Medicine Is Becoming a Durable Health Policy Framework

Diet is a significant contributor to chronic disease. Diet-sensitive conditions such as diabetes, hypertension, and cardiovascular disease account for a significant share of healthcare spending, particularly among more vulnerable populations covered by Medicaid and Medicare. These conditions disproportionately affect individuals experiencing food insecurity. As a result, policymakers have started to adopt a “Food-as-Medicine” approach (sometimes called Food is Medicine), stressing the importance of nutrition in improving patient outcomes.

Food-driven approaches to health are viewed favorably by state and federal regulators, who believe that policy that aims to expand food-as-medicine is necessary to change the economics of chronic disease as well as improve patient outcomes. By taking a preventative approach to diet-sensitive conditions, the downstream costs of inpatient stays and emergency room visits can be reduced significantly.

Federal regulators have provided states and payors with multiple pathways to incorporate nutrition interventions (such as medically tailored groceries, meals, and foods) into healthcare delivery. State Medicaid agencies have begun using waiver authorities and managed care flexibility to pilot new nutrition benefits. At the same time, Medicare Advantage plans have incorporated food benefits into supplemental offerings designed to improve care management for high-risk populations.

While program designs vary across states and payors, the underlying policy trajectory points toward broader adoption. As policymakers increasingly focus on preventive care, population health, and social determinants of health, nutrition interventions are likely to become more deeply embedded in public insurance programs.

Federal Policy Supports Continued Expansion of Food-Based Interventions

There continues to be bipartisan support in improving nutritional access. The 2022 White House National Strategy on Hunger, Nutrition, and Health explicitly encourages the use of Medicaid waivers to pilot food-as-medicine interventions. More recently, the "Make America Healthy Again" (MAHA) strategy released in 2025 further underscores federal interest in improving health outcomes through expanding access to healthy foods.

Currently, nutritional benefits are not part of Federal Medicaid law. However, food-as-medicine interventions have been able to scale through the use of Section 1115 waivers, which can be used for non-traditional Medicaid benefits. In the context of food-as-medicine programs, states can use 1115 waivers to pilot nutrition interventions if they demonstrate that the cost of providing food services is offset by reductions in other healthcare spending. There is already an established precedent of waivers being used for nutritional services. Section 1915 home-and-community-based services (HCBS) waivers have historically allowed states to provide home-delivered meals for high-need individuals, such as disabled and long-term care populations, who would otherwise require institutional care.

More recently, Medicaid managed care regulations have allowed states to approve nutrition interventions under "in lieu of services" (ILOS) authority. This framework allows managed care organizations (MCO) to cover medically appropriate substitutes for traditional Medicaid services as long as the substitutes prove to be cost-effective. This opens the door for MCOs to cover medically-tailored meals and groceries if they are expected to reduce more expensive healthcare utilization.

State Medicaid Programs Are Rapidly Scaling Nutrition Benefits

State Medicaid programs have been the primary laboratories for food-as-medicine innovation. As of year-end 2025, nearly half of states across the country cover some form of nutrition benefit through 1115 waiver or ILOS authorities, including medically supportive foods (MSF), medically tailored groceries (MTG), medically tailored meals (MTM), and home-delivered meals. These programs may vary by state but there are general patterns that they follow. [Figure 1 – page 4]

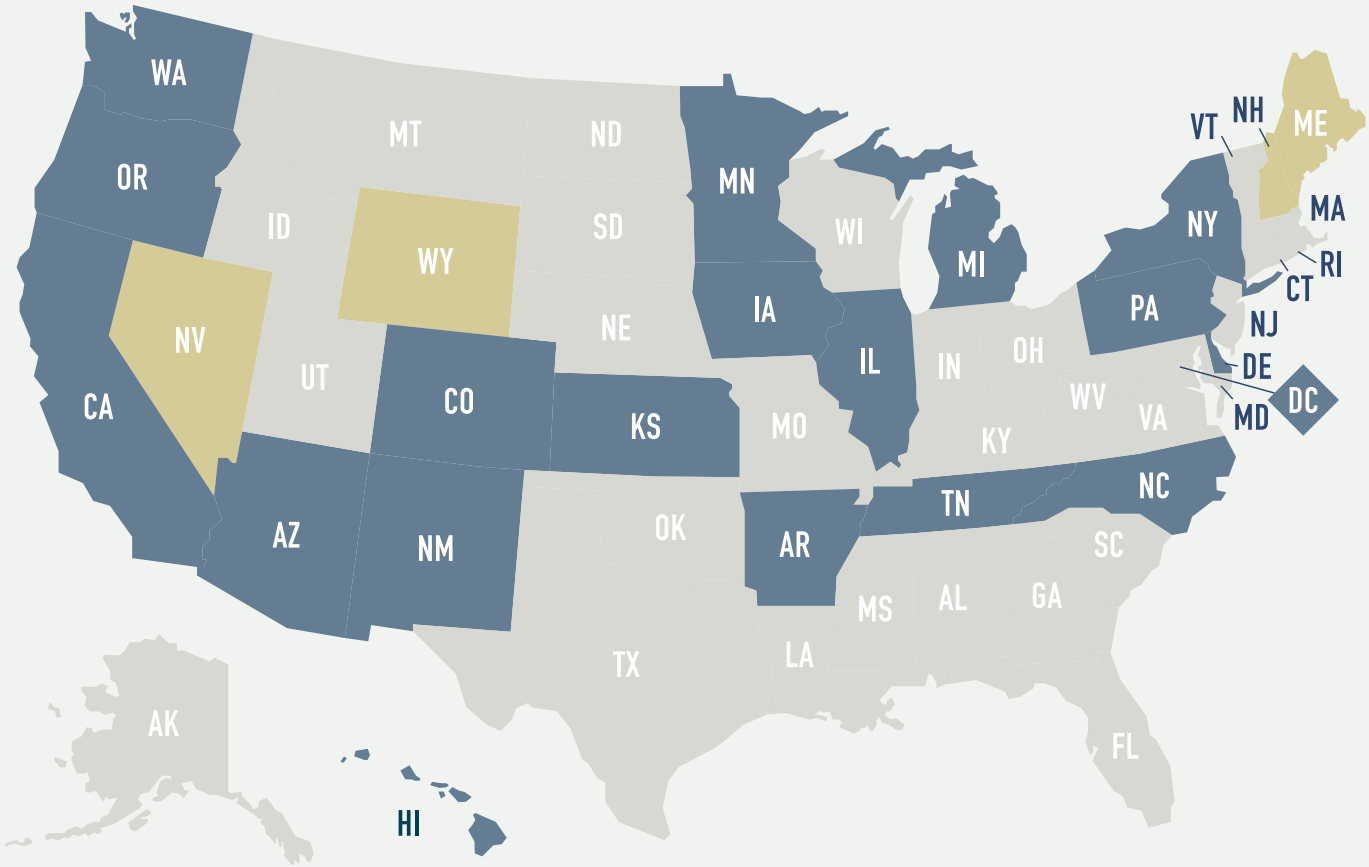
Firstly, nutrition benefits usually are designed for people with diet-sensitive and chronic conditions such as diabetes, cardiovascular disease, hypertension, obesity, cancer, and behavioral health disorders. All of these are diagnoses that can likely be ameliorated with nutritional services, and therefore this targeted intervention through food-as-medicine programs are a cost-effective strategy to address them.

Secondly, screenings for food insecurity and social risk factors are often part of food-as-medicine programs. In practice, this often means that beneficiaries must meet both clinical and social eligibility criteria to receive nutrition services.

Thirdly, most programs rely on Medicaid managed care plans to administer nutrition benefits. MCOs typically contract with community-based organizations, food delivery providers, and nonprofit organizations to deliver meals or grocery packages to eligible beneficiaries.

State interest in nutrition programs appears to be growing. 10 states have expanded coverage since 2024, and 4 states (Maine, Nevada, New Hampshire, and Wyoming) are pursuing new benefits through pending 1115 waiver applications. While adoption remains uneven across the country, the trajectory suggests that food-as-medicine initiatives will continue to expand as states evaluate early evidence from existing programs.

Figure 1 – Nutrition Services Provided Under Medicaid 1115 Waiver or ILOS Authority



State covers at least one nutritional supports (MSF, MTG, MTM, or home-delivered meals) through 1115/ILOS authority[1]

State has pending 1115 waiver that would cover nutritional supports

State does not offer nutritional supports through 1115 waiver or ILOS

1 Medically Supportive Food (MSF) is interchangeable with Produce Prescription; Medically Tailored Groceries (MTG) is interchangeable with Pantry Stocking. While only a few states cover home-delivered meals under 1115/ILOS authority, almost all states do cover this benefit for elderly or disabled beneficiaries at an institutional level of care who qualify for services under their 1915 HCBS waivers.

California Demonstrates the Cost-Effectiveness Case for Food-as-Medicine

California's Medicaid program is one of the clearest examples of food-as-medicine integration at scale, with early evidence highlighting improved health outcomes and cost effectiveness. An April 2025 report published by the state found that the medically-tailored food benefit has been cost-effective and associated with a 20% reduction in ED services, an 18.7% reduction in inpatient services, and a 6% decrease in outpatient facility services.

Under the state's CalAIM initiative, the California Department of Health Care Services (DHCS) introduced a set of "Community Supports" services in 2022 designed to address social determinants of health for high-need Medicaid beneficiaries. Among these services is the medically tailored meals (MTM) benefit, which authorizes MCOs to cover meals or groceries as ILOS to individuals with diet-sensitive health conditions. Although Community Supports services are technically optional, every MCO in California has elected to offer MTM, and plans do not expect this to change. Plans view the benefit as consistent with state policy priorities emphasizing preventive care and improved management of high-cost patients.

DHCS guidance supports increased uptake of food-as-medicine utilization. Eligibility criteria is purposefully broad, leading MCOs to increasingly approve authorization requests. Plans have also faced pressure from DHCS to expand provider networks, often contracting with non-traditional vendors such as food banks and community-based organizations, and typically paying at the higher end of state-recommended rate ranges to ensure adequate access. California provides a strong blueprint for other states to follow. While further evaluation will be necessary to assess long-term impacts, the California experience suggests that targeted nutrition interventions may produce meaningful cost savings while improving patient outcomes.

Medicare Advantage Has Become a Key Platform for Nutrition Benefits

Medicaid waivers have driven much of the innovation in the food-as-medicine space, and Medicare Advantage (MA) plans have become an important avenue to increase nutrition services in healthcare coverage. MA plans have the flexibility to offer supplemental benefits that improve health outcomes or support care management. Historically focused on services such as dental, vision, and hearing, supplemental benefit offerings expanded in 2019 when CMS broadened the definition to include services that reduce avoidable healthcare utilization, including meal delivery.

Legislative advancements such as the Bipartisan Budget Act of 2018 allowed MA plans to provide grocery allowances, meal delivery and other nutrition support. From 2018 to 2025, the share of individual MA plans offering meal benefits increased from 22% to 70%, while the share of Special Needs Plans (SNP) offering meal benefits increased from 32% to 82%.

MA plans that offer nutritional benefits mostly serve high-need populations, especially those who are dually eligible for Medicaid and Medicare and those with diabetes. MA plans view nutritional benefits as a tool to reduce hospitalizations and improve adherence to care plans, especially for members who are food insecure, homebound, or lack transportation access.

From a policy perspective, nutrition benefits align with MA incentives to manage total cost of care and improve Star Ratings through enhanced member satisfaction and care management. However, plans are increasingly evaluating these benefits through a cost-benefit lens. Risk adjustment pressures and rising medical costs are driving reassessment of supplemental benefit offerings, with lower utilization benefits at risk of reduced funding or transition to value-added services.

As MA enrollment grows, nutrition benefits are likely to persist, particularly within SNP populations, but their scope will depend on demonstrated utilization and cost savings.

Food-as-Medicine Is Likely to Become a Permanent Feature of Health Policy

By including nutrition into healthcare delivery, health policy has advanced to seriously address social determinants of health. Food-as-medicine initiatives help manage chronic disease and support preventative care, especially for at-risk populations.

Legislative support for nutritional interventions is bipartisan, and the outlook is positive for food-as-medicine operators. Federal regulators continue to allow states and insurers to incorporate nutrition services through existing Medicaid waivers and managed care authorities as well as Medicare Advantage supplemental benefits.

Policy makers and healthcare stakeholders are faced with the challenge of scaling food-as-medicine programs while maintaining stable financing. They can look to the success of already implemented programs to help guide the structuring of new programs. While program structures may continue to evolve, the integration of nutrition services into public insurance programs is likely to expand.

As more states adopt nutrition benefits and additional evidence emerges regarding cost-effectiveness, food-as-medicine interventions are likely to become more standard components of healthcare delivery.

About the author

Scott Silberberg, Vice President – Mr. Silberberg is a member of the project execution team focused on due diligence within the Advisory Group. Before joining Marwood, Mr. Silberberg worked as a research associate at Health Management Associates, providing Medicaid regulatory and market research for business development and consulting purposes. Prior to HMA, Mr. Silberberg worked as a research assistant at Hospital for Special Surgery, managing data acquisition for clinical research projects at the country's leading orthopedic hospital. Mr. Silberberg graduated with honors from King's College London with a Master of Arts in Political Economy, and holds a Bachelor of Arts in International Relations from the University of St. Andrews.

LONDON

Devonshire House,
1 Mayfair Place,
London, W1J 8AJ
T: +44 20 3178 2500

NEW YORK CITY

733 Third Avenue
11th Floor
New York, NY 10017
T: 212-532-3651

WASHINGTON DC

1025 Connecticut Avenue
NW Suite 610
Washington, DC 20036
T: 202-371-0012

www.marwoodgroup.com