

The Food is Medicine Regulatory Landscape

Changes and Implications from 2025 and 2026

The policy environment has shifted, but the evidence has not.

Policy changes have affected state approaches to scaling Food is Medicine (FIM) programs at the federal level, particularly through Medicaid. These policy shifts do not reflect a weakening evidence base, a reduced underlying need, or loss of momentum. On the contrary, the evidence linking FIM to improved health outcomes and value continues to strengthen.

FIM interventions fit well within the broader direction of healthcare transformation efforts, including models that emphasize whole person care, preventive services, and better management of diet sensitive conditions. Today, momentum is largely driven by state agencies, risk-bearing health plans, and a new Medicare demonstration.

1. What Has Changed at the Federal Level

Federal actions from the Centers for Medicare & Medicaid Services (CMS) between March 2025 and April 2025 reshaped how states can use Medicaid to fund FIM programs. None of them invalidate existing waivers; all of them narrow the path for new ones.

When	Action	What It Means
March 2025	HRSN guidance rescinded	CMS withdrew key Biden-era guidance that provided a detailed framework for states to provide a clear path to cover health-related social needs (HRSN) like housing and nutrition supports through Section 1115 demonstrations, Medicaid managed care “in lieu of services and settings” (ILOS), home and community-based services (HCBS) authorities, and Children's Health Insurance Program (CHIP) Health Service Initiatives. CMS will now review new HRSN and social determinants of health (SDOH) proposals case by case, creating uncertainty regarding federal support and approach to expansion.
April 2025	DSHP and DSIP phased out	CMS began phasing out Designated State Health Programs (DSHP) and Designated State Investment Programs (DSIP), which some states have used to help fund their share of 1115 demonstration costs, including HRSN efforts. This change creates additional budgetary pressures for states when funding HRSN initiatives.
Ongoing	Existing waivers remain valid	Approved 1115 demonstrations with HRSN components continue to operate. CMS may revisit them at extension or amendment, but none were automatically invalidated.

2. States as the Primary Engine for Current Scaling

Efforts to scale FIM are shifting away from clear, expansion-oriented federal leadership and toward more state-driven, state-specific decision making through more flexible and decentralized pathways. These pathways are also more outcomes-driven and aligned with value-based care goals.

Medicaid Pathways

Outside of 1115 demonstrations, states may turn to other pathways. ILOS under managed care contracts has become a common scaling vehicle in the absence of clarifying guidance from CMS.

State legislatures and Medicaid agencies are exploring state-only funding and braided financing to sustain programs where federal approval is less certain.

States are embedding nutrition interventions into value-based purchasing and quality strategies, and supporting partnerships between health plans, providers, and community organizations.

Payer and Health Plan Innovations

Risk-bearing plans in state Medicaid and commercial markets are driving momentum by integrating FIM into population health, care management, and alternative payment models.

Rather than relying on a single federal pathway, states are tailoring approaches based on local policy context, managed care structures, and demonstrated return on investment. Return on investment data is shaping alternative payment models that reward nutrition outcomes.

States remain the primary engines for FIM integration in Medicaid, using 1115, ILOS, and legislation to adopt and sustain services even as CMS policy stalls. Taken together, these shifts mean greater fragmentation and variability between states, but also more room for locally tailored approaches that align with value-based care.

3. A New Opportunity at the Federal Level: MAHA ELEVATE

In March 2026, CMS released the Notice of Funding Opportunity for MAHA ELEVATE, a CMS Innovation Center demonstration testing evidence-based lifestyle interventions for Medicare beneficiaries. It is one of the first national Medicare models to explicitly include FIM services but does not allow for the purchase of food itself or testing FIM interventions as a routinely covered Medicare and/or Medicaid benefit. This signals a growing focus on upstream, preventive approaches via Medicare and shifts the FIM landscape by creating a Medicare-focused bridge between Medicaid- and waiver-based FIM efforts and potential future Medicare policy.

About MAHA ELEVATE

\$100M total agreement funding	3 years demonstration period	Up to 30 participating organizations	Fall 2026 first cohort launch
--	--	--	---

Kaiser Permanente supports flexible, evidence based Food Is Medicine policies that allow — but do not mandate — health systems and health plans to provide medically appropriate food and nutrition interventions tailored to patient needs, supported by robust data collection and public investment to build evidence, scale effective models, promote healthy food access without unduly restricting choice, and ensure individuals can receive appropriate interventions regardless of their source.