American Heart Association.

Health Care Food™

Accelerating the Integration of **Food Is Medicine in Health Care**

ADVANCES IN THE FOOD IS MEDICINE FIELD

Annual Update 2026





Presented by Health Care by Food™,
a food is medicine initiative of the American Heart Association

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ABBREVIATIONS

AI - Artificial Intelligence

BMI – Body Mass Index

BP - Blood Pressure

CBO - Community-Based Organization

CHW – Community Health Worker

CI – Confidence Interval

CMMI - Center for Medicare & Medicaid Innovation

CMS - Centers for Medicare & Medicaid Services

DASH – Dietary Approaches to Stop Hypertension

DBP - Diastolic Blood Pressure

DSME – Diabetes Self-Management Education

EPIS – Exploration, Preparation, Implementation, Sustainment

FIM - Food is Medicine

FIMCON – Food is Medicine Conference

FY – Fiscal Year

GusNIP - Gus Schumacher Nutrition Incentive Program

HbA1c - Hemoglobin A1c

HCXF - Health Care by Food (American Heart Association initiative)

HF – Heart Failure

HHS - U.S. Department of Health and Human Services

HTN - Hypertension

IHS – Indian Health Service

ILOS - In Lieu of Services

LDL Cholesterol – Low-Density Lipoprotein Cholesterol

MA - Medicare Advantage

MAHA ELEVATE – Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence

MTGs - Medically Tailored Groceries

MTMs - Medically Tailored Meals

NIH - National Institutes of Health

ONR – Office of Nutrition Research

P4 – Produce Prescription Pilot Program

PRx - Produce Prescription

RCT - Randomized Controlled Trial

RD – Registered Dietitian

RHTP – Rural Health Transformation Program

SNAP - Supplemental Nutrition Assistance Program

SBP – Systolic Blood Pressure

SSBCI - Special Supplemental Benefits for the Chronically Ill

T2D – Type 2 Diabetes

KEY TAKEAWAYS

The Food Is Medicine Field is Entering a More Mature Phase.

The evidence base grew substantially this year, with articles **increasing 68%**, from 34 in 2025 to 57 in 2026, alongside strong growth in randomized and quasi-experimental studies. The field is increasingly moving beyond feasibility to examine effectiveness, implementation, and scale.

The Findings are Encouraging, but Nuanced.

Medically tailored meals and groceries produced some of the strongest signals for improved clinical outcomes and reduced healthcare utilization and costs. Produce prescription programs consistently improved produce access, intake, and participant experience, while clinical findings remained mixed. Across interventions, outcomes varied by participant risk, program design, and engagement levels.

Matching Intervention Type and Design to Patient Needs, Preferences, and Circumstances is Essential.

Programs should account for participants' clinical needs, functional capacity, food access barriers, cultural and food preferences, cooking and storage capabilities, and delivery needs, recognizing that these factors may change over time. Food provision alone may not be sufficient: stronger outcome signals often emerged when programs paired food with counseling, education, coaching, or care navigation, although the added effects of these services require further study.

Policy Momentum Continues Despite Fiscal Pressures.

Federal investment in FIM and nutrition research **increased by $24 million since FY 2024**, with continued bipartisan interest. States also continued to innovate through Medicaid: **16 states now have approved or pending Section 1115 waivers that include FIM, and six others offer FIM through managed-care flexibility.**

Early Implementation at Scale is Yielding Encouraging Results.

State Medicaid evaluations from Massachusetts, North Carolina and California found that FIM programs were associated with **21.4% to 31% lower hospitalization or inpatient service use, 13% to 22% lower emergency department use, and reductions in healthcare costs,** respectively. Continued evaluation will help identify how program design, eligibility, duration, and delivery models affect outcomes.

The Next Phase Requires a Focus on Scaling and Sustainability.

Priorities include designing programs for measurable impact, strengthening infrastructure and real-world economic evidence, and establishing safeguards that support quality and program integrity. Together, these steps can help translate growing momentum into sustainable, scalable healthcare solutions.

INTRODUCTION

Momentum around food is medicine (FIM) has accelerated since our 2025 Advances in the Field Report. As demand grows for effective solutions to treat and manage diet-related chronic conditions, FIM remains at the center of innovation, investment, and policy discussions.

This report highlights key developments from July 2025 through June 2026, including new research, policy changes, and strategic developments across the FIM field. This update is for healthcare leaders, public health practitioners, advocates, researchers, FIM providers, funders, policymakers, and other stakeholders working to advance FIM. Annual updates to this analysis will track the field's progress and emerging opportunities.

FOOD IS MEDICINE: DEFINED.

The American Heart Association's Health Care by Food (HCXF)™ initiative defines FIM as the provision of healthy food — including medically tailored meals (MTMs), medically tailored groceries (MTGs), and produce prescriptions (PRx) — to treat or manage specific clinical conditions in a manner that is integrated with, and paid for by, the healthcare sector.[1,2]

Healthcare integration distinguishes FIM from other food and nutrition assistance programs, food access and emergency food efforts, and population-level healthy food initiatives.



STATE OF THE SCIENCE

This compendium highlights key findings from FIM research published or released ahead of print between July 1, 2025, and June 30, 2026. Results are synthesized by intervention type (MTMs, MTGs, PRx), with publication summaries shown in Figures 1 and 2 and detailed study information provided in Supplemental Materials.

The primary outcomes of interest for this report were healthcare utilization, costs, and clinical outcomes, alongside engagement measures and patient-centered learnings, and this state of the science section is organized according to these outcome domains.

Results from randomized controlled trials (RCTs) and large retrospective evaluations are presented first because they provide stronger evidence. Results from non-randomized studies follow, as they provide lower-strength evidence and are generally better interpreted as hypothesis-generating.

Last year, the state of the science showed:

- FIM interventions were feasible, well accepted, and showed promise for supporting the management of certain clinical conditions, including hypertension (HTN), type 2 diabetes (T2D), and heart failure (HF), as well as improving psychosocial well-being.
- For some outcomes, including blood pressure (BP) and hospital utilization, longer engagement was associated with incremental improvements.
- Most studies, however, were pilots assessing feasibility and acceptability, limiting conclusions about clinical effectiveness and longer-term outcomes for varied populations.

This Year, the Evidence Base Grew Meaningfully

- FIM research studies using rigorous study designs increased in number, with RCTs and real-world evaluations yielding evidence that FIM could improve key clinical outcomes, like BP and hemoglobin A1c (HbA1c), and have the potential to reduce hospital utilization and healthcare costs.
- Findings for MTMs and MTGs have been particularly promising, with some studies demonstrating statistically significant improvements in clinical outcomes and others reporting reductions in healthcare utilization and costs.
- Findings from evaluations in states such as Massachusetts and North Carolina suggest that longer-duration interventions, including six-month services authorized through Section 1115 demonstrations, may provide participants with greater opportunity to achieve measurable improvements in utilization, clinical outcomes, and costs.

- Results varied across populations, settings, intervention designs, and study methods. Important questions remain regarding optimal program design, intervention dose and duration, target populations, scalability, and long-term clinical and economic effects.
- The field is increasingly moving beyond initial questions of feasibility toward a deeper understanding of effectiveness and implementation. Interventions are also becoming more comprehensive, with food support increasingly delivered alongside complementary services such as education and counseling, and more responsive to participants' needs and circumstances.

The FIM Research Landscape Is Expanding and Becoming More Rigorous

- The number of FIM publications increased by **68% in one year**, rising from 34 to 57.
- The strongest growth occurred among studies using more rigorous designs:
  - **RCTs:** increased fourfold, from 2 to 8.
  - **Quasi-experimental studies:** increased 2.5-fold, from 4 to 10.
- PRx studies accounted for most of the overall growth. However, the PRx evidence base includes only one RCT and one pilot RCT, indicating that the literature remains weighted toward real-world, implementation-focused evaluations rather than randomized studies.
- MTMs and MTGs are driving much of the highest-rigor research:
  - **MTGs:** five RCTs and one pilot RCT.
  - **MTMs:** two RCTs and three pilot RCTs.
- At the same time, the number of qualitative and mixed-methods studies is increasing, providing important insights into how FIM interventions can be implemented successfully and scaled across settings.

Understanding Study Strength

- **Fully powered RCTs** provide the strongest evidence of intervention effectiveness.
- **Pilot RCTs and pilot prospective cohort studies** assess feasibility and refine intervention or study procedures before a well powered larger scale trial—in both cases they are usually precursors to fully powered RCTs.
- **Prospective cohort and quasi-experimental studies** evaluate outcomes over time and provide stronger evidence than pre-post studies without comparison groups. However, they offer less certainty about causality than RCTs. Quasi-experimental studies measure impact relative to a non-randomized control or comparator.
- **Retrospective cohort studies** analyze existing data, while qualitative and mixed-methods studies explore experiences, implementation, and context.

Figure 1. The cumulative number of FIM publications grew steadily between July 2024 and June 2026

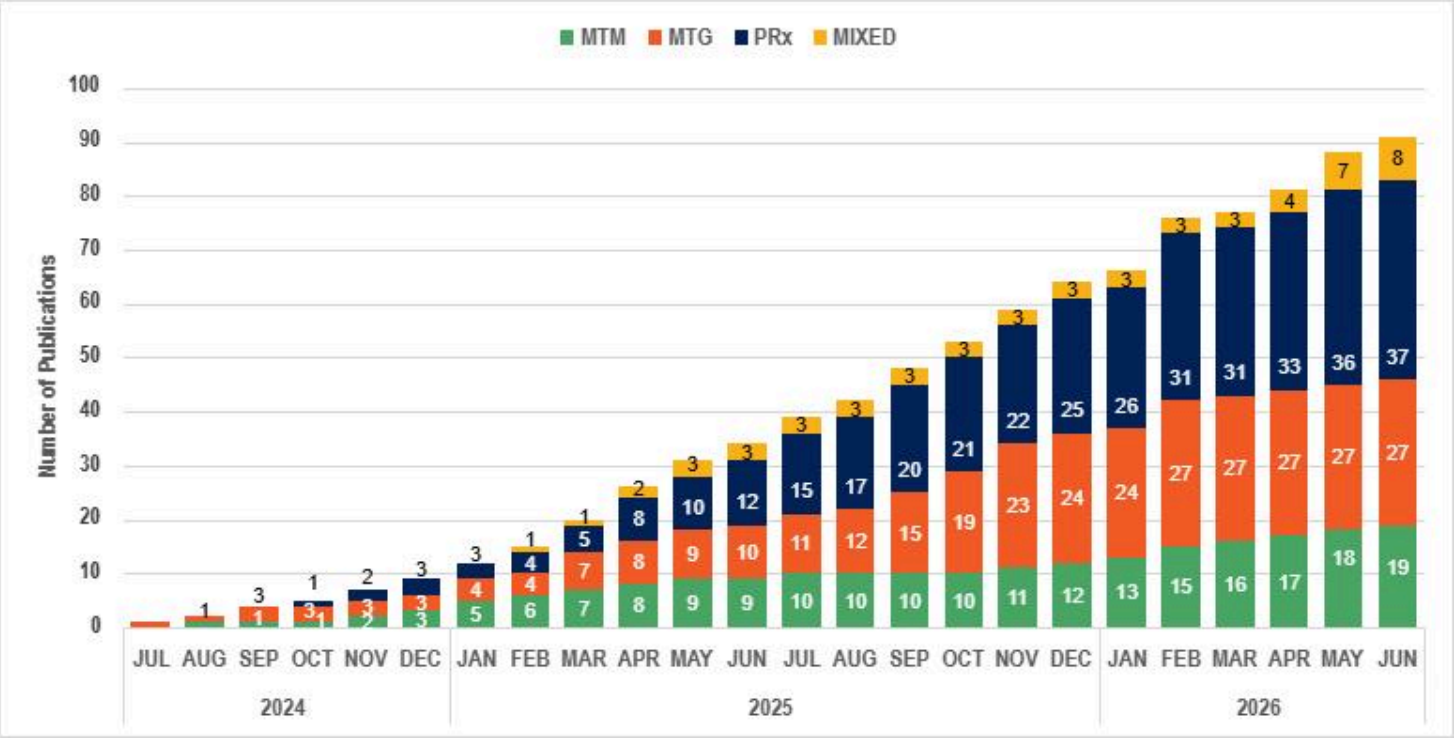
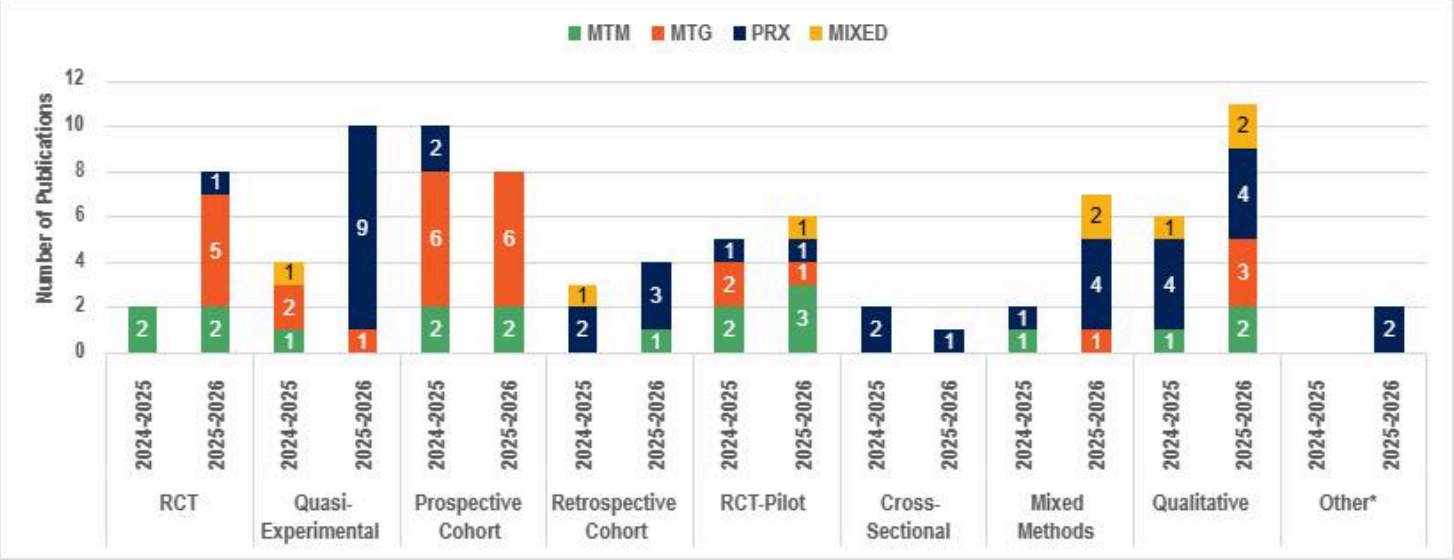


Figure 2: The FIM evidence base grew in both breadth and rigor, with increasing publications across intervention types and study designs year over year.



*Note: *Other includes a microsimulation study and value-based care pilot*

In 2026, HCXF launched the inaugural Most Impactful FIM Research Award, awarded to the research team behind the publication, "Pilot study of a heart healthy food box intervention for Native Americans with uncontrolled hypertension: methods and results from the Chickasaw Healthy Eating Environments Research Study ."

Medically Tailored Meals

Key MTM takeaways:

- MTMs are associated with substantial reductions in hospitalizations, emergency department visits, and healthcare costs in different populations.
- Behavioral support (community health workers [CHWs] or registered dietitians [RDs] using tools like motivational interviewing and nutrition counseling) may enhance meal provision and support clinical impact and acceptability.
- Participant experiences highlight the importance of meal quality, variety, and alignment with individual goals and preferences (e.g., taste, cultural relevancy, religious preferences) to support long-term engagement and maximize program effectiveness.

Overview

Ten publications evaluated MTM interventions (two funded by HCXF[3,4]):

- Two RCTs
- Three pilot RCTs
- Two qualitative studies
- One prospective cohort study
- One pilot prospective cohort study
- One retrospective cohort study

Studies evaluating MTM interventions included patients with cancer, heart failure, hypertension, obesity, type 2 diabetes, as well as those with food insecurity, and Medicaid beneficiaries with multiple chronic conditions.[3-12]

Healthcare Utilization and Cost Outcomes

In one of the first studies to examine the real-world implementation of MTMs across an entire state Medicaid population, Massachusetts Medicaid data demonstrated that large-scale MTM interventions can reduce healthcare utilization and generate substantial healthcare cost savings among medically complex populations.[12]

- **MTM participation was associated with 31% fewer hospitalizations, 20% fewer emergency department visits, and approximately $3,400 lower healthcare costs per participant, with savings offsetting nearly all program costs.**
- Benefits were greatest among participants with high comorbidity and chronic conditions such as cardiovascular disease, T2D, and chronic kidney disease. For example, for those with chronic kidney disease the cost reduction was ~$12,300 per person.

Clinical Outcomes

Meaningful improvements were seen in interventions that targeted clinical markers (BP, cachexia, glycemic control and weight). These findings suggest that MTMs can improve cardiometabolic outcomes across diverse clinical populations, particularly when tailored to specific disease states and paired with complementary supports such as nutrition counseling or CHW engagement.

- RCT • A remote intervention incorporating a short course (14 days) of DASH (Dietary Approaches to Stop Hypertension)-aligned meals followed by RD counseling improved diet quality and reduced both systolic (SBP) (mean 5 mm Hg reduction, p=0.048) and diastolic BP (DBP) (mean 4 mm Hg reduction, p=0.03) among veterans with HTN and obesity at 6 month follow-up.[10]
- A pilot RCT using an adaptive intervention combining 3 months CHW support and MTMs produced substantial BP improvement (67% achieving >10 mm Hg reduction in SBP) among adults with food insecurity with uncontrolled HTN.[7]
- A small pilot RCT of 9-11 weeks of carbohydrate-restricted, high fat MTMs delivered during head and neck cancer radiotherapy demonstrated high adherence (92%) and appeared to mitigate treatment-related weight loss with a trend toward greater fat-mass loss and preservation of lean (muscle) mass.[8]

Although limited by the lack of a control group, prospective cohort studies found consistent improvements in reported clinical outcomes.

- Six weeks of calorie-restricted meal intervention followed by six weeks of self-managed diet significantly improved insulin sensitivity, glycemic control, and weight among adults with T2D and obesity.[11]
- A pilot culturally tailored MTM intervention among Navajo adults with HF significantly improved Kansas City Cardiomyopathy Questionnaire perceived physical limitation (increased 23 points, p=0.001) and social limitation (increased 9 points, p=0.045) scores. Among participants with obesity, weight decreased 2.3 kg (about 5 lbs., p=0.03). Additionally, the intervention significantly (p<0.05) improved food security, quality of life, and cultural connectedness among all participants.[3]

Implementation and Participant Experience

Collectively, these findings underscore the complexity of FIM implementation and the need for flexible program models. Successful MTM implementation appears to depend not only on the clinical appropriateness of the meals provided but also on program design, participant-centered support, and meal acceptability. Meal quality, variety, cultural relevance, and alignment with participants' goals and preferences may shape long-term engagement and overall program effectiveness.

- RCT • For example, one RCT found that feeding only the enrolled participant was as effective as feeding the entire household, and that commercial shipping was as effective as dedicated delivery drivers. Both approaches were highly acceptable to participants, suggesting flexibility in program design.[4]

Qualitative work identified a consistent tension: **MTMs reduced the financial, physical, and logistical burdens of accessing and preparing medically supportive food, while participants noted challenges related to food preferences, portion size, variety, and cultural fit.**

- In a qualitative subsample of participants enrolled in the Massachusetts Medicaid MTM program, completers reported that MTMs reduced the time, financial and physical burden associated with meal preparation, whereas non-completers were more focused on diet quality and weight loss goals. Although participants in both groups initially described meals as bland and portions as small, completers appeared to adapt over time, while non-completers more frequently cited taste preferences as a reason for discontinuing the program.[9]
- Similarly, in a qualitative study of patients with lung cancer, participants valued the convenience of home-delivered meals and reduced meal-preparation burden but commonly reported concerns regarding meal taste, variety, and customization,[5] and participants receiving MTMs during long-duration infusion treatment frequently reported modifying meals by adding seasonings or condiments to improve palatability.[6]



Medically Tailored Groceries

Key MTG takeaways:

- Multiple trials provide consistent evidence that MTG interventions improve BP and other cardiometabolic risk factors, particularly when paired with behavioral or clinical support.
- Many of the effective MTG interventions included supporting services, such as nutrition education provided by CHWs and RDs, motivational interviewing, or care coordination.
- Participant choice, cultural relevance, convenience, and program flexibility are important determinants of engagement, highlighting the importance of considering patient preferences and lived experience in the design phase.

Overview

Seventeen publications evaluated MTG interventions, including:

- Five RCTs
- One pilot RCTs
- Five prospective cohort studies
- One pilot prospective cohort study
- Three qualitative studies
- One mixed-methods study
- One quasi-experimental study

These studies examined MTG interventions across diverse populations, including adults with T2D, HTN, cardiovascular disease, cancer survivorship, pregnancy-related conditions, food insecurity, and post-hospital discharge populations.[13-29]

Interventions varied, including home-delivered grocery boxes, healthy food vouchers, and grocery subsidies paired with nutrition counseling or CHW support.

Clinical Outcomes

Several MTG interventions produced clinically meaningful improvements in glycemic control and weight, with particularly consistent findings from models that paired food provision with T2D education, CHW support, or RD-delivered counseling. However, not all interventions produced measurable clinical improvements.

RCT

- Two randomized voucher studies did not significantly improve HbA1c, although both studies observed increased vegetable and fruit intake.[14,20] Notably, the inclusion criteria for both studies included adults with T2D or prediabetes, whereas studies limited to participants with diagnosed T2D demonstrated more favorable HbA1c responses.
- Participants receiving MTG delivery plus CHW support experienced a 0.85 percentage-point reduction in HbA1c at 3 months (p=0.039) and 1.65 percentage-point reduction at 6 months (p=0.012), whereas the MTG-only group experienced no significant change.[25]

Although limited by the lack of a control group, prospective cohort studies found consistent improvements in HbA1c.

- A clinic-community partnership providing culturally tailored food vouchers to Latino adults with T2D was associated with clinically meaningful HbA1c reductions (mean change of 0.34 percentage points, p=0.008, with 38% of participants achieving >0.5 percentage-point reduction) over a median 251-day period.[13]
- A home-delivered MTG program paired with T2D self-management education (DSME) was associated with reduced HbA1c by 0.56 percentage-points (p=0.01) over 12 weeks among food pantry clients with T2D.[21]

- The Delaware Food Farmacy program, which combined weekly DASH-aligned grocery deliveries with CHW support, was associated with a 0.52 percentage-point reduction (p=0.027) in HbA1c over 6 months.[22]

Several studies also demonstrated improvements in BP and other cardiovascular risk factors.

RCT
- Black adults with untreated elevated BP in the GoFresh RCT who received home-delivered DASH-patterned groceries and RD counseling experienced greater reductions in SBP (3.4 mm Hg greater decrease), DBP (2.4 mm Hg greater decrease), and LDL cholesterol (8 mg/dL greater decrease), compared with participants receiving grocery stipends for self-directed shopping.[19] This is noteworthy in part because the group receiving grocery stipends received $500 a month that was not restricted to healthy food.

RCT
- Meanwhile, the Healthy Food First trial found that flexible food subsidies produced greater BP (-2.5 mm Hg; 95% CI, 0.9-4.1 mm Hg) improvements than home-delivered food boxes.[17]

RCT
- Among adults recovering from acute coronary events, the provision of MTGs emphasizing fiber-rich foods or healthy fats was associated with sustained reductions in sodium intake.[23]

Although limited by the lack of a control group, a pilot prospective cohort study found promising improvements in blood glucose and SBP.

- Among pregnant individuals with food insecurity and gestational diabetes (or related conditions), an online grocery prescription program was associated with very modest reductions in blood glucose (-3 mg/dL) and SBP (-3 mm Hg). The program also achieved a 96% redemption rate and was associated with increased vegetable and fruit purchases.[15]

Implementation and Participant Experience

Sustained engagement depends on reducing practical barriers, personalizing support, and building sufficient organizational capacity.

- One feasibility study illustrated the potential of integrating MTGs into discharge planning and highlighted the potential role of nutrition support during care transitions. The HealthyLink program provided participants with a one-time, three-day supply of home-delivered heart-healthy groceries following hospital discharge. The proportion of participants reporting fair to poor physical health decreased (69% to 42%, p=0.01), and those reporting fair to poor mental health decreased (47% to 25%, p=0.01) following the intervention. Satisfaction with food delivery, food quality, and usefulness of the foods delivered ranged from 86% to 98%.[16]

- Two studies demonstrated particularly strong participation and redemption rates. An online MTG program among pregnant adults found 96% redemption[15] and a clinic-community food voucher program among Latino adults with T2D observed a median of 17 redemptions (of a possible 24) during a six-month program.[13]

- However, engagement can be more difficult to sustain for an in-person hospital-based MTG program. As an example, in a program for patients undergoing bariatric surgery experiencing food insecurity, 91% of participants attended at least one visit, but the median attendance was 5.5 of 26 clinic visits in a 6-month period. Reported barriers include transportation, health limitations, food storage constraints, and limited program operating hours.[18]

Qualitative studies highlighted the importance of incorporating participants' needs, preferences, and lived experiences into program design before implementation, while also planning for program sustainability and scale. Across studies, **participant choice, convenience, cultural relevance, and flexibility emerged as recurring factors supporting engagement and sustained participation.** Further research is needed to understand how programs can incorporate these features while remaining sustainable and scalable.



- Interviews among participants in a maternal health program reported favorable themes such as improved food security, healthier eating behaviors, and emotional well-being, while also emphasizing the value of CHWs, home delivery, and empathetic engagement.[24]
- Participants receiving healthy food vouchers reported greater agency over food choices, improved emotional well-being, and reduced financial stress, although many felt benefit amounts were insufficient and noted difficulty maintaining healthier purchasing habits after the intervention ended.[27]
- CHW support, personalized coaching, and nutrition education were consistently associated with stronger engagement and, in some cases, more favorable clinical outcomes.[22,25]
- At the systems level, a mixed-methods evaluation of charitable food-healthcare partnerships found high overall satisfaction among participating organizations but identified workforce limitations, funding constraints, and limited outcome measurement capacity as ongoing barriers to scaling MTG programs.[26]

Produce Prescriptions

Key PRx takeaways:

- PRx programs are one of the most developed and widely studied FIM models, with the number of studies roughly doubling from the 2025 report, though evidence from RCTs remains limited.
- The most consistent PRx findings are high benefit activation and redemption among enrolled participants, improved vegetable and fruit intake, reduced food security, and gains in food-related skills and knowledge. However, initial reach and sustained benefit use varied across programs.
- Clinical outcomes are promising but mixed, with stronger improvements in higher baseline risk participants (i.e., higher HbA1c or more elevated BP).
- Implementation research approaches are also maturing, with studies applying the Consolidated Framework for Implementation Research to identify barriers and facilitators to program sustainability, and human-centered design methods to co-develop a culturally tailored intervention.
- Economic evidence is developing and encouraging but remains limited to simulation modeling and program evaluation.
- Emerging evidence suggests that enrollment and engagement may vary by demographic and socioeconomic characteristics, highlighting the importance of examining differences in program reach and sustained engagement across populations.

Overview

A total of 25 new PRx publications (two funded by HCXF[30,31]) were identified, more than double the 12 PRx publications captured in the 2025 report. **PRx programs remain among the most studied and implemented FIM interventions, but their evidence base includes the fewest RCTs.**

- One RCT
- One RCT pilot
- One microsimulation study
- Nine quasi-experimental studies
- Four qualitative studies
- Four mixed-methods studies
- One value-based care pilot
- Four cross-sectional, or retrospective cohort studies

These studies evaluated PRx programs among adults, children, and families with cardiometabolic conditions or risk factors, including T2D or prediabetes, HTN, and obesity. Some studies included participants who also experienced food insecurity, were enrolled in Medicaid, or were uninsured.[30-54]

Across these studies, PRx programs used produce vouchers or restricted-use debit cards redeemable at farmers markets and grocery retailers, as well as direct home delivery of produce boxes and food pharmacy distribution. Many programs paired these benefits with nutrition education, culinary medicine, DSME, health coaching, or physical activity support.

Healthcare Utilization and Cost Outcomes

Economic evidence remains limited to simulation modeling and program evaluations.

- A microsimulation study that modeled integration of PRx studies into healthcare across all 50 states projected that for adults with T2D and food insecurity, depending on the state, 94 to 9,240 cardiovascular events could be averted over 10 years, generating 92 to 9,990 quality-adjusted life years. It would be cost-effective in all 50 states, and cost-saving from a healthcare perspective in 43 states.[35] These modeled estimates assumed that all eligible adults enrolled, remained enrolled without dropout, and experienced stable intervention effects over time.
- A descriptive report of a four–year value-based care pilot suggests that an approach combining AI-based risk identification with targeted care coordination and supportive services, including PRx, can generate both clinical and economic benefits. Among participants enrolled in the PRx program for six months, the report estimated net savings of $118 per patient per month. The broader model (not specifically limited to the PRx services) saved $806,208 among 884 patients in its first year and approximately $4 million across more than 3,000 patients over four years.[44] While the methodology for estimating cost savings was validated by actuarial consultants, the study did not describe a concurrent comparison group or provide details about the benchmark used to estimate savings.

Why is There Limited Economic Evidence?

Several factors help explain why it will take a while to develop more conclusive economic evidence.

- Early FIM studies often focused on feasibility, acceptability, and clinical outcomes rather than prospectively incorporating economic evaluations.
- Rigorous effectiveness research is a necessary foundation for cost-effectiveness research. Without it, the ability to draw valid causal conclusions about an intervention's economic effects is limited.
- Assessment of economic effects over longer time periods also require longer follow-up periods, additional funding, access to claims and cost data, and collaboration among payers, providers, researchers, and program implementers.

As the evidence base continues to mature, future studies that incorporate economic outcomes may help clarify the value and sustainability of FIM interventions.

Clinical Outcomes

Evidence for clinical outcomes is promising but mixed. Several observational, pre-post, or real-world studies reported improvements in HbA1c, BP, weight, BMI, waist circumference, or other clinical markers. **Stronger associations were seen among participants with persistently elevated HbA1c, uncontrolled BP, or other indicators of poorer baseline health status, suggesting that clinical risk may help identify patients most likely to benefit from PRx interventions.**[36,37,44,48,50,53] However, effect sizes on clinical endpoints remain small and inconsistent in this year's larger and more rigorous RCTs,[47,50] indicating that **program design, dose, and duration and engagement play important roles in shaping clinical outcomes.**

RCT

- In a large pragmatic RCT, clinical outcomes were null, as well as in several pilot or mixed-methods studies.[31,47,51] Participant engagement is an important factor in program success. In the RCT study, only 30% of participants used more than 80% of their vouchers, more than 35% used less than 60%, and over 20% never activated the benefit.[47]
- A multisite analysis also found statistically significant mean reductions in SBP and DBP (SBP: -1.77 mmHg; DBP: -2.03 mmHg), with the largest reductions among participants with stage 2 HTN at baseline (SBP: 10.7 mmHg; DBP: 5.7 mmHg).[48]
- Among adult cancer survivors with obesity, an analysis comparing PRx participation and engagement with RD-delivered motivational interviewing versus no engagement with an RD demonstrated sustained weight loss from baseline for those who engaged with RD in the first 6 months of the trial (-3.6 kg at 6 months and -2.15 kg at 12 months). Those who engaged with an RD after six months had greater sustained weight loss at 12 months (-3.0 kg vs. -1.7 kg).[28]
- Hypothesis-generating findings were reported in two uncontrolled, single-group pre-post studies, in which participants experienced within-participant reductions in HbA1c after participating in PRx programs. In a multisite analysis of four PRx programs, mean HbA1c declined by 0.5 percentage points overall and by 1.9 percentage points among participants with a baseline HbA1c greater than 9%.[48] In a 15-week PRx program, mean HbA1c declined by 0.31 percentage points overall and by 0.84 percentage points among participants with a baseline HbA1c greater than 7%.[53]
- Across the broader evidence base, findings for weight, BMI, waist circumference, and lipid outcomes were inconsistent, with studies generally reporting clinically insignificant effects[29,36,44,50,53] or null findings.[29,31,47,52,54]
- Psychosocial outcomes, including loneliness, depression, stress, fatigue, perceived health, and self-efficacy, improved in some studies, particularly when programs included coaching, education, or community components.[34,38,49-51]

Implementation and Participant Experience

PRx programs are feasible and acceptable across delivery models, but benefit availability alone does not ensure engagement.

- Voucher-based produce prescription programs achieved high benefit activation, although redemption levels varied across studies. Among enrolled participants, 79% to 92% activated their benefits. Participants subsequently redeemed an average or median of 57% to 88.3% of the voucher funds available to them. Studies also reported high produce use, strong participant satisfaction, and a willingness among participants to recommend produce prescription and related nutrition education programs.[31,32,37,42,47,52,53]
- Reaching and enrolling eligible participants remains a challenge. Enrollment was 20% in a pediatric primary care program and 22.6% among eligible adults contacted by a large integrated health system.[32,52]

PRx Benefit Use at a Glance



79% to 92%
of enrolled participants activated their benefits.



57% to 88.3%
of available voucher funds were redeemed.

Among studies reporting specific redemption data, redemption rates were:

- $45.60 of an $80 monthly benefit, or 57%[32]
- Median of $53.48 of an $80 monthly benefit, or 67%[52]
- $34.18 of approximately $46.26 per month, or 74.2%[37]
- $44.15 of a $50 monthly benefit, or 88.3%[31]

Enrollment, activation, and spending varied by demographic and socioeconomic characteristics, suggesting a need for tailored implementation support.

- Enrollment was lower among older adults, men, Medicaid-enrolled patients, residents of under-resourced areas, and non-Hispanic White and Hispanic or Latino participants compared with non-Hispanic Black participants. Among card activators, each 10-year increase in age was associated with 15% higher adjusted odds of spending more than $53 per month, while spending more than $70 per month was associated with being married or non-Hispanic Black.[52]

- Likewise, a national descriptive analysis of GusNIP produce prescription programs found that most enrollees were women (77%), while only 5.5% were ages 18 to 24 years. However, the GusNIP study described participant characteristics and did not evaluate factors associated with enrollment. Qualitative and mixed-methods studies also found that participants valued PRx programs for benefits beyond food access.[41]
- Studies using human-centered design and implementation frameworks suggest that PRx programs may be more acceptable, feasible, and sustainable when they are integrated into healthcare workflows, co-designed with communities, tailored to cultural food preferences, supported by nutrition education or coaching, and connected to broader social services.[28,30,34,40,43,45,49]
- Barriers varied by PRx delivery model. Market- and pickup-based programs often faced transportation and access challenges, whereas home-delivery programs reduced travel barriers but could still encounter issues related to delivery scheduling and produce customization. Limited staffing, communication gaps between clinical and program teams, persistent affordability challenges, and uncertainty about how to maintain gains after the program ends were broader challenges across models.[34,40,51]
- PRx was recognized as providing financial relief, reliable produce access, improved food knowledge, social connection, and support for self-care.[30,34,49,51] In one study of an AI-based app, participants identified personalization as an important feature.[43]



Mixed FIM Intervention Comparison

Key mixed FIM intervention takeaways:

- MTGs may be more acceptable than MTMs for some participants because they can be tailored to individual preferences and may provide greater agency over food selection and meal preparation. However, preferences are likely to vary across populations and settings based on participants' needs, circumstances, and physical capabilities. Cost may also influence program design and feasibility, as MTGs are typically less expensive to provide than MTMs.
- Findings suggest that participant preference, clinical condition, mobility status or functional capacity, food access barriers, delivery burden, cost, and program fit may be important when deciding among MTM, MTG, or other FIM models.

Overview

Evidence comparing FIM intervention types remains limited. Five publications were identified, all of which were funded by HCXF:[55-59]

- One pilot RCT
- Two qualitative studies
- Two mixed-methods studies

- A pilot RCT found that 90-day MTM and MTG interventions following hospitalization for HF did not reduce HF readmissions or emergency department visits compared with usual care. However, a hierarchical composite of death, HF events, and clinically meaningful improvement in health status favored the interventions (win ratio, 1.21; 95% CI, 1.14–1.29). Compared with MTM participants, MTG participants reported higher adherence (5.5 vs. 4.7 days per week; p=0.001), acceptability (4.16 vs. 3.62; p=0.005), and Net Promoter Scores (8.62 vs. 7.27; p=0.02), suggesting greater acceptability of MTGs in this population.[55]
- A feasibility study tested a screening tool designed to help match rural and urban participants with either MTMs or MTGs. The approach appeared feasible, as 73% of eligible participants who were referred enrolled in the program, and 95% of those enrolled completed the program, and most participants felt that the option recommended by the tool was appropriate for them.[56] Exploratory findings suggested improvements in BP in several groups, although the study was not designed to assess effectiveness.[56] Barriers to participation in this study were embarrassment about discussing food insecurity, lack of understanding of available food benefits, and concerns about taking resources from others.[59]
- A human-centered qualitative design study involving adults participating in cardiac rehabilitation identified barriers to participation, including food access, scheduling constraints, and cultural food preferences. The findings highlighted the importance of personalized navigation, clinician endorsement, and participant-centered communication in supporting engagement and retention.[57]



- An EPIS-informed qualitative study involving HCXF-funded researchers, community-based organizations (CBOs), and a food vendor identified priorities for future FIM research and implementation. These included larger and more coordinated studies; clearer guidance on intervention dose, duration, and measurement, earlier involvement of CBOs and vendors, stronger data infrastructure, cultural tailoring, and trust-based engagement. Stakeholders also emphasized measuring household, social, cultural, and community benefits in addition to clinical outcomes.[58]

Future Directions for Research

This year, the evidence base expanded in both size and rigor, yielding an increased understanding of dimensions of program effectiveness.

Effects on healthcare utilization, costs, and clinical outcomes varied considerably by intervention type, participants' baseline health and clinical risk, program design (including the availability of supportive services), and benefit use.

Clinical and healthcare utilization findings were generally more consistent for MTMs and MTGs. In contrast, PRx programs showed more consistent findings for vegetable and fruit intake, acceptability, and feasibility, while evidence for downstream clinical outcomes remained mixed. This pattern may partly reflect differences in intervention intensity and mechanism: MTMs directly replace prepared meals, and MTGs often support broader dietary change, whereas PRx generally provides a smaller, produce-specific benefit that requires participants to obtain other foods.

Matching intervention type to patient needs is essential.



MTMs

are likely to be particularly relevant for patients with complex medical needs, limited functional capacity, or high healthcare utilization risk, including populations with cancer, HF, or other serious health conditions.[3,5,8,12]



MTGs

cost less than MTMs and showed some of the strongest clinical evidence, particularly for BP and glycemic outcomes when paired with DASH-patterned groceries, RD counseling, DSME, CHW support, or flexible grocery subsidies.[13,17,19,21,25]



PRx

programs remain one of the most widely studied models, but few RCTs have been conducted and clinical and hospital utilization outcomes remain mixed.[46-48,53,54]

Low engagement rates are still a challenge in terms of achieving the greatest potential rates of program effectiveness. Studies comparing multiple FIM models further suggest that participant preferences, clinical condition, functional capacity, food access barriers, delivery burden, and cost may help determine which intervention is the best fit for a given patient.[55,56]

Improvements in dietary intake, while important, did not consistently translate into measurable clinical improvements.

This distinction is especially relevant for PRx programs, which often focus on increasing vegetable and fruit access and consumption. Increases in vegetable and fruit intake may be too small to meaningfully affect BP or glycemic control. In addition, measuring vegetable and fruit intake alone does not capture changes in overall diet quality, and any benefits may be offset by cooking style or continued consumption of foods high in saturated fat, added sugars, sodium, or other less healthful components. Some MTM and MTG interventions providing DASH-aligned meals or groceries improved clinical outcomes,[10,19] suggesting that approaches targeting the broader diet may be more likely to produce measurable clinical benefits than PRx interventions. Future studies should assess comprehensive diet quality to clarify whether mixed or null findings reflect insufficient dietary change, the intervention design, or other factors.



Food provision alone may be insufficient for achieving durable clinical or economic impact.

Studies with stronger outcome signals often included behavioral or clinical support such as RD counseling, DSME, motivational interviewing, CHW support, coaching, culinary education or care navigation.[7,10,19,25,28,38,53] However, studies typically did not compare food provision with and without these services, limiting the ability to determine their incremental effects.

Similarly, benefit availability alone does not guarantee uptake, behavior change, or clinical improvement.[4,31,47,50,51] Achieving high rates of participant engagement remains critical to program effectiveness. **This highlights the need to move beyond broad implementation efforts toward more precise approaches that align intervention components with patient needs and preferences while maintaining strong participant engagement.**

Findings should be interpreted cautiously.

Of 57 studies, 14 (25%) were randomized (eight full-scale and six pilot RCTs) and 10 (18%) were quasi-experimental; the remainder (57%) used observational, qualitative, mixed methods, or other designs. Many studies lacked well-matched comparison groups, and observed changes may have been influenced by benefit use, baseline clinical risk, supportive services, regression to the mean, selection bias or missing data rather than representing true intervention effects.[60] Follow-ups beyond 12 months also remain uncommon, limiting conclusions about whether dietary, clinical, utilization, and economic effects can be sustained. Future work should prioritize adequately powered randomized or rigorous quasi-experimental designs with appropriate comparison groups, strategies to minimize missing data, and longer follow-up.

Collectively, these studies help shift the field from asking whether FIM can be effective in improving health outcomes toward a needed focus on how FIM should be designed, targeted, implemented, and sustained to achieve health impacts cost-effectively.

Late-Breaking Evidence:

Two RCTs published after the literature review search period represent important advances in the FIM evidence base, though were not included in the report's study counts or formal synthesis:

MUTTON-HF

In MUTTON-HF, a culturally and medically tailored meal program incorporating traditional Navajo foods **reduced the incidence of all-cause hospitalizations or emergency department visit within 90 days post randomization from 57.0% to 40.6% and the incidence of HF-specific hospitalizations at 60 days from post randomization from 13.0% to 3.8%** among adults with HF. This represents a 28% reduction in the composite outcome of hospitalizations or ED visits, a 52% reduction in hospitalization rates, and a 71% reduction in HF hospitalizations specifically. The intervention also improved HF-related quality of life (the Kansas City Cardiomyopathy Questionnaire score) and food security.[61]



Photo Credit: Lead Study Author

KPSC MTG

The Kaiser Permanente Southern California (KPSC) MTG trial, a culturally-tailored MTG intervention, reduced HbA1c by 0.66 percentage points from the baseline, compared with 0.25 percentage points reduction in the usual-care group, **for a treatment difference of −0.40 percentage points at six months (95% CI, −0.73 to −0.08) among adults with T2D**. The intervention also improved food and nutrition security. HbA1c reduction was not significantly different by baseline HbA1c or between higher-dose ($135-$210 per month) and lower-dose ($100-$170 per month) MTG arms.[62]



Together, these trials reinforce the importance of matching FIM intervention type, intensity, cultural context, and supportive services to participants' clinical needs and capabilities.

Future Research Directions

Although the evidence base on FIM interventions is rapidly growing, and initial progress has been made in identifying which models may best fit populations, many important research questions need to be examined. Future research should:

- Build on this progress by determining which intervention types and components are most effective for which patients, considering clinical risk, functional capacity, food access barriers, and participant preferences.
- Characterize the dose-response relationship between intervention intensity and health outcomes. Examine how benefit amount, frequency and duration of food provision, and availability of supportive services influence outcomes. Identify both the minimum intensity needed to achieve clinically meaningful effects and the extent to which greater intensity yields incremental benefits. Assess the cost-effectiveness of interventions with differing durations, designs, and levels of intensity.
- Examine different forms of tapering of benefits or preparing participants to succeed post intervention. These could include step-down models, graduation planning, ongoing coaching, connection to SNAP or other food resources, self-management tools, and community-based support.
- Incorporate rigorous economic evaluations to assess both cost-effectiveness and potential cost savings, including short-term and long-term healthcare spending.

FIM POLICY UPDATES

This section summarizes federal and state FIM policy developments.

At the Federal Level

The Trump administration continues to spotlight the role of diet in chronic disease and healthcare, and FIM remains a promising area with bipartisan support and alignment with many of the administration's priorities.



Key federal takeaways:

- Congress continues to increase funding for FIM, a rare occurrence in the current fiscal and political environment, thanks to the field's collective advocacy in maintaining congressional bipartisan support and unified set of funding priorities.
- FY 2026 investments represent a $24 million increase in dedicated federal funding for FIM and nutrition research programs since FY 2024.
- Congressional members continue to introduce and support numerous bills on FIM in a bipartisan manner.
- CMS continues to express interest and support for FIM innovation.

Continued Efforts to Support Investment in Research and Pilots

The signed fiscal year (FY) 2026 Labor, Health and Human Services, Education, and Related Agencies bill provides **approximately $31.2 million in total funding for FIM and nutrition research** across federal agencies, including the Department of Health and Human Services (HHS) and the National Institutes of Health (NIH).[63]

These FY 2026 investments represent a $24 million increase in dedicated federal funding for FIM and nutrition research programs since FY 2024.

Key Provisions Related to FIM That Received Bipartisan Support Include:

- $2 million for the HHS FIM initiative, consistent with prior years' funding
- $5 million increase for the NIH Office of Nutrition Research (ONR)
- $15 million in new funding for a maternal PRx grant program through the Health Resources and Services Administration
- $7 million for the Indian Health Service (IHS) Produce Prescription Pilot Program (P4), a $4 million increase above FY25, funded through a separate bill[64]
- Language encouraging NIH to support additional research on FIM, including the approved concept for FIM Centers of Excellence
- Language directing the Department of Veterans Affairs (VA) to provide funds consistent with the VA's estimate to support local PRx programs, funded through a separate bill[65]

The NIH published its first FIM highlighted topic, signaling FIM as a priority area for future research and encouraging investigators to submit research proposals evaluating the effectiveness, implementation, and health impacts of FIM interventions for diet-related chronic disease.[66] NIH uses highlighted topics to indicate areas of new or emerging interest that may not have specific dedicated funding. The NIH ONR is leading this highlighted topic, with support from 12 other NIH Institutes, Centers, and Offices, including the National Heart, Lung, and Blood Institute.



Held immediately after FIMCON, the 2026 Food Is Medicine Advocacy Day convened 230+ attendees from 40 states, Washington, DC, and Puerto Rico for over 200 congressional meetings.

Photo Credit: A.E. Landes Photography

Complementary PRx efforts are also underway through other federal agencies and in Congress. The IHS currently operates a PRx Program, while the bipartisan Produce Prescriptions for Veterans Act (H.R. 7267, S. 3706),[67,68] introduced in February 2026, would classify PRx as a medical service through the Veterans Health Administration (VHA). It would enable the agency to provide debit cards or vouchers to purchase vegetables and fruits for veterans with diet-related chronic conditions. The bill, sponsored by Reps. Chellie Pingree (D-ME), Vern Buchanan (R-FL) and Sen. Dick Durbin (D-IL), would address VHA's current lack of authority to provide food-based benefits for veterans with diet-related chronic conditions. Another key funding mechanism for PRx programs is through GusNIP, which provides $5 million per year in competitive grants.[69]

The Heart Association Showcases HCXF at Congressional Black Caucus Foundation's 54th Annual Legislative Conference

At the Congressional Black Caucus Foundation's 2025 Annual Legislative Conference, the Heart Association showcased the potential of FIM through panel discussions, fireside chats, a half-day HCXF Summit, and a Culinary Stage. U.S. Reps. Shontel Brown (OH-11) and Danny Davis (IL-&) joined HCXF leaders, stakeholders, and volunteers to highlight the role of food, culture, access, and lived experience in health.



Photo Credits: Zoeica Images

HCXF at the Food is Medicine Conference (FIMCON) 2026

FIMCON, a new national Food is Medicine Conference, convened more than 750 food and nutrition leaders, healthcare professionals and providers, FIM practitioners, researchers, policymakers and program participants in Washington, DC on June 1-2, 2026, to advance FIM research, policy, and practice.[70] Several HCXF staff and affiliates participated as speakers, and senior federal officials spoke including Centers for Medicare and Medicaid Services (CMS) Administrator Dr. Mehmet Oz. A bipartisan congressional panel discussed opportunities to advance FIM, while state-level leadership highlighted FIM in various states including Delaware Lieutenant Governor Kyle Evans Gay; Elizabeth Kromm, Assistant Secretary, Population Health and Strategic Initiatives for the Maryland Department of Health; and Melanie Bush, Deputy Secretary, State Medicaid Director, North Carolina Department of HHS. HCXF co-planned the conference alongside the Center for Health Law and Policy Innovation of Harvard Law School, the Food is Medicine Coalition, the Food is Medicine Institute at Tufts University, and the National Produce Prescription Collaborative.



Photo Credits: A.E. Landes Photography

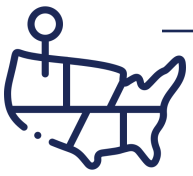
FIM Innovation in Medicare

Traditional Medicare does not cover FIM services, but Medicare Advantage (MA) plans may offer food-related supplemental benefits, including Special Supplemental Benefits for the Chronically Ill (SSBCI). These benefits support members with complex chronic conditions, such as cardiovascular disease, who are at high risk for hospitalization. In 2026, nine out of ten plans offering SSBCI included a food and produce benefit, though 90% of these benefits are provided as flexible grocery allowances versus a targeted FIM intervention.[71]

The bipartisan Medically Tailored Home-Delivered Meals Program Pilot Act (H.R. 5439; S. 2834) has advanced in Congress, including unanimous approval by the House Ways and Means Committee in the previous Congressional session, though the legislation has not yet been brought to a full congressional vote.[72,73] The bill would establish a six-year Medicare Part A demonstration program allowing hospitals to provide medically tailored home-delivered meals and medical nutrition therapy to eligible beneficiaries with diet-related conditions following hospital discharge. Other bipartisan legislation, such as the Accountable Produce is Medicine Act (H.R. 8355; S. 5267) introduced by Reps. Lloyd Smucker (R-PA) and Sharice Davids (D-KS), and Sens. Jim Banks (R-IN) and Alex Padilla (D-CA), would direct the Center for Medicare and Medicaid Innovation (CMMI) to conduct a PRx model, along with other activities.[74,75]

CMMI announced in March 2026 the MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) Model, which will test lifestyle and functional medicine approaches to address chronic disease among traditional Medicare beneficiaries.[76] Through provision of approximately $100 million for up to 30, three-year cooperative agreements, the model will evaluate interventions, generate evidence on cost and quality outcomes, and inform future Medicare coverage decisions. Cooperative agreements will be awarded in two rounds: the first in late 2026 and the second in 2027. Although all interventions must include either nutrition or physical activity, the funding does not cover the cost of food.

At the State Level



Key state takeaways:

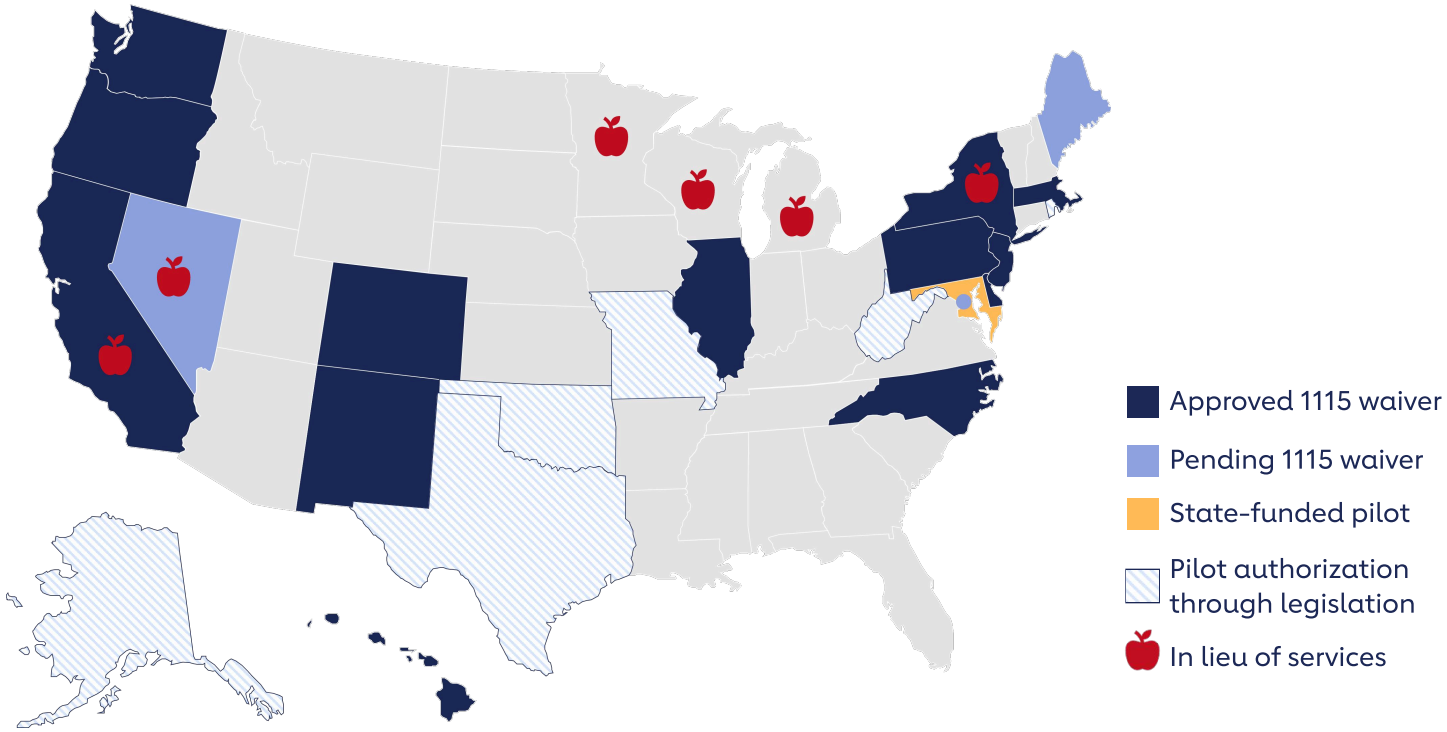
- Despite significant pressures on state budgets and Medicaid programs this year, states continued to find ways to advance FIM innovation through pilots.
- State Medicaid FIM pilots continued to generate promising evidence of improved health outcomes and reduced healthcare utilization in a cost-effective way, strengthening the case for sustained investment and broader integration into Medicaid programs.

FIM Innovation in Medicaid

Medicaid remains one of the most active areas of FIM innovation, with states launching some of the nation's largest FIM pilots and demonstration programs. Jointly funded by the federal government and states, Medicaid is administered by states within federal requirements, giving states flexibility in how they design and operate their programs. Although federal law does not explicitly authorize the direct provision of food in Medicaid except in limited cases, CMS has allowed states to use existing flexibilities to provide time-limited, medically appropriate nutrition services through Medicaid. As a result, states have integrated FIM interventions through Section 1115 demonstration waivers, managed care innovations, and other benefit design strategies.

The implementation of the One Big Beautiful Bill Act includes significant changes to how budget neutrality is calculated for 1115 waivers. As outlined in CMS' June 11, 2026, State Medicaid Directors Letter, beginning January 1, 2027, states will be required to submit more rigorous analyses on the fiscal impacts of demonstration services.[78] These analyses will be reviewed by the CMS Chief Actuary to determine whether waivers remain budget neutral relative to projected spending without the waiver. These changes heighten the need for strong evidence on the health, utilization and cost impacts of FIM interventions.

Figure 3. Landscape of State Innovation



Only states with services that align with the Heart Association's FIM definition have been highlighted.

"Pilot authorization through legislation" refers to states that have enacted legislation enabling pursuit of a FIM pilot, generally through an approved Medicaid mechanism. Enactment alone does not indicate that a pilot is operational; rather, it reflects state authorization and intent to advance future implementation.

1115 waivers.

1115 waivers have become a key pathway for testing and evaluating the impact of FIM on healthcare utilization, costs, and clinical outcomes.

16 states have approved or pending 1115 waivers that include FIM services, enabling states to test, evaluate and refine new approaches to address diet-related disease within clinical care.[77]

ILOS Waivers:

States are also leveraging managed care flexibilities to implement FIM interventions. **Six states are offering FIM through "in lieu of services and settings" (ILOS) authority**, allowing Medicaid managed care organizations to provide medically appropriate, cost-effective nutrition supports as alternatives to traditional covered services. One additional state, Texas, is also working to launch an ILOS FIM program. Although some states use ILOS authority to provide meals that help prevent or delay institutional placement or serve as a substitute for home care, this count includes only ILOS programs that provide FIM to address specific clinical conditions.

State Funded Pilot Programs:

Maryland has taken a different approach to piloting FIM. The state recently launched two large FIM pilot programs across all payers, providing MTMs for recently hospitalized patients with T2D and PRx for high-risk pregnancy, HTN and other nutrition-sensitive conditions.[79,80]

State Medicaid Legislation:

FIM remains a prominent policy issue in state legislatures. Over the past year, several states enacted legislation that demonstrates bipartisan support and creates new pathways for implementation. Notably, West Virginia and Missouri authorized new FIM pilots through 1115 waivers, reflecting the continued growth of Medicaid-based innovation. Rhode Island established a FIM task force to develop recommendations for a statewide pilot program and authorized the state to apply for a future 1115 waiver to implement the pilot.[81-84] These states join Alaska, Oklahoma, and Texas that passed similar bills in recent years authorizing new FIM pilot programs.

North Carolina approved $9 million in appropriations to restart portions of its 1115 waiver program. With the inclusion of federal matching funds, the state now has $25 million in one-time, non-recurring funding to begin operations after the waiver program was paused in July 2025.[85]

States are also moving beyond pilot authorization to focus on implementation and program alignment. This includes requirements to:

- Strengthen coordination across state agencies (e.g., Medicaid agencies, public health departments, and social service programs) to support FIM delivery
- Establish program standards
- Align FIM initiatives with existing nutrition and social support programs

Of note, Kentucky adopted a resolution directing state agencies to advance FIM initiatives including pilot programs involving MTMs and PRx.[86] While resolutions are non-binding and express the opinion or intent of the legislature rather than creating an enforceable law, this resolution demonstrates state leadership support for future pilot development.

What We Are Learning From FIM Pilots in Medicaid

A growing body of real-world evidence from state Medicaid FIM pilot programs continues to demonstrate reductions in healthcare utilization and costs.



In Massachusetts, the state's summative evaluation of its 1115 waiver "Flexible Services" program addressing health-related social needs found that **FIM participants had 23% lower hospitalization rates and 13% fewer emergency department visit rates.**[87] A separate peer-reviewed evaluation focused specifically on the MTM program within the state's Medicaid waiver found even greater impacts, **including 31% fewer hospitalizations, 20% fewer emergency department visits, and approximately $3,400 lower healthcare costs per participant.**[12]



Although released before the period covered by this report, similar results are emerging from California's evaluation of its ILOS "Cal-AIM Community Supports" program addressing health-related social needs. The state's 2024 Year 3 ILOS monitoring report found that MTMs and medically supportive foods were associated with **21.4% fewer inpatient services, 6.7% fewer outpatient facility services, and 22% fewer emergency department services.**[88]



North Carolina released a draft summative evaluation report of its 1115 waiver "Healthy Opportunities Pilots" program addressing health-related social needs. The evaluation found that the program **reduced healthcare costs an average of $164 per beneficiary per month, compared to expected costs without the program.** This included the cost of services and administrative overhead. Savings were driven by a significant shift in patient care from emergency department visits and inpatient hospital admissions to outpatient provider care. Of note, the evaluation included services beyond FIM such as housing, transportation, and interpersonal safety.[89]

As of September 2026, the report is under review by CMS and is subject to change.

Table 1: Early results from FIM Medicaid pilots show promising impacts on healthcare utilization and costs.

Outcome Area	Range of Findings
Hospitalizations / Inpatient Services	21.4% to 31% lower[1]
Emergency Department Use	13% to 22% lower[2]
Outpatient Facility Services	6.7% lower[3]
Healthcare Costs	$164 lower per month to $3,400 lower per participant[4]

[1]CA: 21.4%; MA: 23%, 31%.[2] MA: 13%, 20%; CA: 22%.[3] CA: 6.7%.[4] NC: $164/month; MA: $3,400/participant.

These findings highlight the potential of FIM interventions to improve health outcomes and reduce healthcare utilization. While these evaluations were conducted in real-world Medicaid settings rather than RCTs, several employed rigorous evaluation methods including matched comparison groups to better assess the impact of the intervention. Together, **they provide valuable real-world evidence that early implementation at scale is yielding encouraging results and informing the integration of FIM into Medicaid delivery systems.** Further research is needed to determine how best to match services to clinical populations, establish appropriate intervention dose and duration, balance standardization with flexibility, and develop the infrastructure necessary for effective delivery.

Continued evaluation will be critical to understanding how program design, eligibility criteria, service duration, and delivery models affect outcomes and inform future coverage and implementation decisions.

States advancing FIM through the Rural Health Transformation Program

States are also leveraging the federal Rural Health Transformation Program (RHTP) to advance FIM initiatives. Although RHTP funding cannot be used for the direct provision of food, CMS encouraged states to incorporate nutrition-focused strategies into their applications. Several states have proposed using RHTP resources to support FIM via allowable uses such as program infrastructure through investments in referral systems, workforce development, technology, cross-sector partnerships, distribution networks, and community-based implementation capacity. While many states are using RHTP to address broader food and nutrition security priorities, several have specifically incorporated FIM approaches. For example:

DELAWARE

proposes establishing FIM infrastructure in Kent and Sussex counties to support access to FIM services and strengthen community partnerships to support long-term implementation.[90]

NORTH CAROLINA

proposes engaging regional networks called NC ROOTS Hubs that coordinate services with community partners to connect patients with MTMs, healthy food boxes, and nutrition education while investing in local food infrastructure and referral systems.[91]

VIRGINIA

proposes supporting food pharmacy programs through its "Live Well, Together" initiative by funding infrastructure, technology, distribution networks, and partnerships between healthcare providers and CBOs to deliver FIM services.[92]



STRATEGIC PRIORITIES FOR THE FIELD

The 2025 Advances in the Field Report outlined foundational opportunities and challenges shaping the FIM field, including expanding research and funding, strengthening Medicaid pathways, standardizing definitions and evaluation approaches, improving data transparency, and engaging the full range of stakeholders needed to support scalable FIM interventions. Those priorities remain central.

This year's evidence suggests the field is entering a more mature phase, shifting from questions of feasibility toward questions of optimization, targeting, implementation, financing, and sustainability.

Design for Measurable Health Impact and Decision-Maker Needs

The next phase of FIM should focus on achieving clearly defined outcomes while using resources efficiently to maximize impact. **Clinical impact should not be assumed as an automatic result of providing food.** FIM programs should be intentionally designed to achieve specific goals through targeted eligibility criteria, strategies that achieve high levels of participant engagement, appropriate intervention intensity and duration, supportive services as appropriate, and outcome measures aligned with the intended mechanism of action.

Ongoing efforts to establish consistent reporting standards for participant risk factors, intervention dose and duration, benefit utilization, supportive services, clinical outcomes, healthcare utilization, costs, and implementation requirements will help inform program design, coverage, and payment decisions.

Match FIM Models to Patient Need

As FIM programs scale, the field needs models that better reflect the realities of patients' lives. Food and health needs and preferences can change over time — including within a relatively short intervention period or disease course — as clinical status, treatment side effects, functional capacity, caregiving responsibilities, transportation, housing, food storage, cooking ability, and personal preferences shift. **Programs should be designed and tested to assess what level and type of support is appropriate at a given point in time and adjust as needs change, including supporting step-down models.**

Building FIM intervention models that are capable of adaptation to shifts in patients' needs and preferences will require stronger evidence, clearer eligibility and reassessment criteria, coordinated referral pathways, and better alignment across healthcare, community, and food-sector partners.

The goal is not only to identify what works for whom, but to create FIM systems that respond to changing needs while maintaining participant choice, continuity, clinical impact, and economic value.

Build the Infrastructure for Sustainable Scale



Photo Credit: Turk Studios

As FIM moves from pilots to broader implementation, building strong infrastructure is becoming as important as intervention design. Programs require standardized measures, clear eligibility and referral pathways, robust data systems, and sustainable implementation models. **Although Medicaid initiatives, supportive policies, and statewide coalitions are helping build this foundation, variation in program design and evaluation continues to limit opportunities for cross-program learning.** Payers and self-insured employers are an increasingly important part of this picture, as both look for clearer evidence on how to structure, cover, and evaluate FIM benefits for the populations they serve.

Technology, procurement, and program accountability will also play an increasing role as programs scale. Success will depend on efficient referral and data systems, reliable access to high-quality and culturally relevant foods, and practical safeguards that support program integrity without adding unnecessary administrative burden.

Strengthen the Financial and Actuarial Case

As payer interest in FIM grows, so does the need to demonstrate economic value alongside clinical outcomes. **Because evidence needs vary across payers and delivery systems, studies should clearly define the decisions they are intended to inform, the economic questions they address, and the timeframe for expected impacts.**

Building the financial case for FIM will require more consistent reporting of costs, intervention intensity and duration, utilization impacts, outcomes, and implementation costs. Greater use of payer-relevant economic analyses, including a shift from modeled or simulated projections toward analyses of real-world cost and utilization data, can help inform decisions about benefit design, coverage, contracting, and scale.

Ensure Program Integrity

Finally, program integrity for FIM must be a high priority for the field.

Program integrity encompasses the policies, standards, and oversight mechanisms that ensure FIM interventions are delivered effectively, achieve intended outcomes, and use resources appropriately. Key elements include evidence-based program design, clear eligibility criteria, clinically appropriate services, provider standards and accreditation where appropriate, consistent implementation and monitoring, meaningful outcome measurement, and safeguards against fraud, waste, and abuse.

As FIM interventions scale, strong program integrity will be essential to maintaining quality and sustaining long-term support among patients, providers, payers, and policymakers.

What's Next



The FIM field is moving beyond early momentum. The evidence base continues to expand and become more rigorous; policy activity remains strong at both the federal and state levels; Medicaid remains a key platform for innovation; and stakeholders across healthcare, research, policy, and community sectors are increasingly focused on how to implement FIM in ways that are clinically impactful, financially sustainable, and operationally feasible.

The next phase of the field will require actionable evidence to inform real-world decisions about benefit design, coverage, payment, and scale. Research should help identify which interventions work best, for whom, under what circumstances, and what core components are needed to most reliably and efficiently achieve meaningful outcomes over time.

At the same time, stronger infrastructure will be needed to translate evidence into practice. As FIM becomes more integrated into healthcare delivery and financing, the field must balance standardization and accountability with the flexibility and personalization that help make interventions relevant, accessible, and effective for participants.

Keep up with the next phase at healthcarexfood.org

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