VIEWPOINT

HEALTH CARE POLICY AND LAW

The Future of Nutrition Interventions in Medicaid

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Poor nutrition is now the leading cause of global morbidity and mortality, surpassing deaths caused by smoking.[1] Clinical interventions that provide healthy food to prevent and manage chronic disease—sometimes termed *food is medicine* (FIM)—have emerged as promising innovations. Food insecurity, meaning uncertain access to the food needed for an active healthy life, is a common barrier to healthy eating in the US and is strongly linked to poor health.[2] FIM programs often, but not always, address food insecurity as part of a clinical management strategy. FIM programs are individual-level clinical interventions to improve dietary intake to prevent or treat specific health conditions. This focus distinguishes FIM from federal nutrition programs like the Supplemental Nutrition Assistance Program (SNAP), which promotes population-level food security for low-income households. Given the importance of nutrition in disease management, it is crucial to support FIM innovations within Medicaid, which has emerged as a major pathway for FIM in the US. We argue that there are 2 mistaken perspectives threatening these FIM programs: (1) the underrecognition of nutrition as a core, biological component of clinical care and (2) the view of clinical FIM interventions and federal food assistance programs as substitutes for each other, rather than complementary strategies to advance health.

Medicaid makes FIM nutrition benefits available to select beneficiaries primarily, but not exclusively, through Section 1115 Demonstration Waivers.[3] This regulatory pathway allows state Medicaid programs to pilot innovations likely to improve the health of beneficiaries while remaining budget neutral. Currently, the Centers for Medicare and Medicaid Services (CMS) has approved 13 Medicaid 1115 Demonstrations that pay for FIM services, with 3 more pending.[3] Program eligibility varies by state but typically includes food insecurity or other nutritional risk, plus clinical factors such as a diet-related illness, pregnancy, or high health care utilization.[3-5]

Recent evaluations of demonstrations in Massachusetts and North Carolina, which we coauthored independently, provide evidence for the effectiveness of FIM among 30 000 Medicaid beneficiaries across the 2 states.[4,5] Both interventions, despite differing approaches and contexts, showed favorable impacts on emergency department utilization, hospitalizations, and health care spending among adults. These Medicaid evaluations suggest that FIM programs can offer meaningful clinical benefits. Of course, not all FIM programs have their intended effects. Outcomes can vary by program duration, intensity, convenience for participants, and patient population. There is still limited high-quality evidence demonstrating the impact of FIM on clinical outcomes, and more randomized trials are needed to evaluate findings from observational studies.[2]

Medicaid 1115 Demonstrations provide an important mechanism to research FIM approaches because they are required to include robust, independent evaluations. By their nature, policy evaluations of 1115 Demonstrations include individuals less likely to participate in traditional academic research and offer large samples, thus generating more generalizable and representative evidence. Medicaid FIM interventions enable investigation of key research gaps, such as which populations benefit the most, the optimal dose and duration of services, and how to implement FIM effectively under budget constraints.

However, barriers are growing to further nutrition interventions in Medicaid. In March 2025, CMS rescinded guidance encouraging states to submit 1115 Demonstration Waivers addressing health-related social needs, which had been the major pathway for including nutrition programs in Medicaid.[6] Complicating the landscape are significant cuts to Medicaid that will begin in late 2026, possibly creating state-level budgetary pressure to pull back on FIM. For example, to address budgetary concerns even prior to these cuts, Massachusetts narrowed eligibility criteria to those with the most severe food insecurity and narrowed the eligible medical conditions.[7]

Nutrition as a Biological Determinant of Health

FIM is often discussed under the rubrics of social determinants of health and health-related social needs. This paradigm creates a mental model in which some treatments, such as medications, are within the core scope of health care, while others, such as nutrition services, exist in a social realm outside health care. Such thinking was exemplified in a recent CMS announcement: "this administration believes that the health-related social needs guidance distracted the Medicaid program from its core mission."[6] Fundamentally, nutrition is a biological determinant of health that plays a key role in preventing and managing disease and should be core to Medicaid's mission. The term *food is medicine* was coined by community-based organizations for just this reason, as a reminder that food and nutrition exist within both the social realm and health care space.

It is true that access to healthy food is socially determined, in the sense that policies and institutions determine who experiences these barriers to health. Food also provides multidimensional meaning through cultural identity, enjoyment, religious celebration, and community building. However, the social determination of poor nutrition should not relegate nutrition interventions to the periphery of clinical care. After all, medication access and cost-related medication underuse is similarly socially determined, but no one could argue that medications are not core clinical interventions. Ultimately, while it is important not to overmedicalize food, it is also important not to undermedicalize it.

Complements, Not Substitutes

Medicaid-funded FIM is also threatened by the view that its goals would be better accomplished through federal nutrition programs

such as SNAP. We argue that FIM treatments should be seen as complements of, not substitutes for, federal nutrition programs. Whereas SNAP supports population-level food security and general health promotion, FIM provides individual-level, tailored nutrition interventions to prevent and/or treat specific conditions. While SNAP is an entitlement benefit, FIM is only available to a high-risk subset of the Medicaid population within 1115 Demonstrations, and eligibility includes clinical factors. Critically, FIM and federal assistance programs can support patients synergistically. For example, in Massachusetts, several organizations connect Medicaid members to application assistance for SNAP to address household-level food insecurity while also enrolling them in FIM services to treat patient-level, diet-related conditions such as diabetes.

Critics of FIM programs argue that funding Medicaid FIM could take away dollars from SNAP. However, this zero-sum framework is unlikely to be true for several reasons. Federal population nutrition support programs and FIM programs have separate funding mechanisms: SNAP expenditures are authorized through the Farm Bill, and Medicaid FIM expenditures are authorized through the Social Security Act. Furthermore, they are administered through distinct agencies (the US Department of Agriculture and CMS) and overseen by separate congressional committees. Finally, Medicaid 1115 Demonstrations require budget neutrality by offsetting costs through increased efficiencies or improved health. This means that the demonstration programs do not add to the federal budget and thus do not compete for SNAP dollars.

Conclusion

FIM can improve treatment for patients with complex health needs amid stubbornly high rates of diet-related illnesses, poor nutrition, and food insecurity. Nutrition is a biological component of clinical care, and FIM and federal nutrition programs offer synergistic benefits for health. Medicaid provides an important setting to learn about the impact of FIM, as state-by-state innovation and responsiveness to local conditions offer opportunities for rapid progress and evaluation. Even in the face of impending cuts to Medicaid, smaller-scale FIM efforts could still improve patient health, test innovations, and improve the research base for nutrition services. We hope clinicians and policymakers will support FIM Medicaid nutrition programs to advance Medicaid's mission within a challenging funding environment.

ARTICLE INFORMATION

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