

Medicaid Food Security Network Quarterly Meeting

September 17, 2026



Welcome!

Share the following with us in the chat:



Name / Pronouns



Organization & Title / Role



What questions or thoughts are you bringing to the meeting today? Give a rose and a thorn!

Housekeeping



Zoom Recording: This meeting will be recorded and available on the Network website.



Use the chat feature: Feel free to submit questions through the chat. We also will have time for Q&A near the end of the meeting.



Make sure you are muted: Please stay muted while others are presenting. Feel free to use the chat and/or hand raising features.



**Medicaid Food
Security Network**

MFSN Meeting Objectives



Increase awareness of new resources in the field available to support partnering with Medicaid to address food and nutrition security



Articulate innovative strategies and inspirational case studies related to program and policy opportunities to address food security, focusing on Medicaid managed care regulations and flexibilities to support food security and Food is Medicine



Foster collaboration and engagement among attendees through breakout discussions, Q&A, and sharing of insights, aiming to generate actionable ideas and commitments for ongoing engagement with MFSN initiatives

Refresher: The Network's **Mission & Vision**



Support anti-hunger advocates to **engage, influence, and partner** with state Medicaid programs and Medicaid-serving systems **in adopting and implementing effective strategies** to support the full spectrum of food needs of children and families enrolled in Medicaid with an emphasis on **increasing Food is Medicine access, including closing the enrollment gap in SNAP and WIC.**



MFSN provides state and national anti-hunger and healthcare advocates, and other stakeholders with **infrastructure for collaboration, technical assistance, and tools for policy and advocacy.** MFSN participants will be able to successfully **identify, advocate for, and implement** effective, **state-specific policies and programs** for every state Medicaid program.

Meeting Flow

1. Welcome & Introductions (10 min)
2. Meet New MFSN Director (5 min)
3. Feeding America Reports (15 min)
4. 1115 Budget Neutrality Guidance (10 min)
5. Model MCO contract language (10 min)
6. Breakout Room Discussions (30 min)
7. Closing Remarks (10 min)



Meet the New MFSN Director



Meaghan Butler
Director of
Medicaid & Food
Security

Coming in 2027: Next MFSN Summit!



Medicaid Food Security Network National Summit

Advancing Food and Nutrition Security
Through Medicaid: Innovations & Insights

Save the Date | March 17-18, 2027 | Dallas, Texas



Medicaid Food
Security Network

Call for Session Ideas & Speakers



Medicaid Food Security Network National Summit

Advancing Food and Nutrition Security
Through Medicaid: Innovations & Insights

March 17-18, 2027 | Dallas, Texas



SHARE OUR STRENGTH



**We're
beginning to
shape the
agenda for our
second Summit
and want to
hear from you!**



Medicaid Food
Security Network

MFSN Policy Dashboard + Legislative Tracker

Users can filter by state and policy strategy and navigate to individual policy summaries

Follow link bit.ly/MFSNdash or QR code →



Also check out our new Medicaid food security/SNAP/WIC and FIM legislation tracker:

medicaidfoodsecuritynetwork.org/tracking-state-medicaid-legislation/

Public Charge Rule: Resources



Public Charge Regulation Toolkit
<https://bit.ly/3TskZjM>



Public Charge Rule Q&A
<https://bit.ly/4cNbKBn>



Medicaid Food
Security Network

Today's Speakers



Adam Dewey



Perri Kramer

Adam Dewey is a Research Director on the Health, Research and Evaluation department at Feeding America. He oversees the annual Map the Meal Gap study, which Feeding America has produced since 2011, providing and analyzing local estimates of food insecurity and food costs across the country. Adam also works on issues related to charitable food assistance and access to help food banks assess and improve the convenience, experience, and perceptions of charitable food assistance at the local level. Adam holds a master's degree in public policy from the University of Michigan Ford School of Public Policy and a bachelor's degree in philosophy, politics, and economics from Pomona College.

Perri Kramer serves as Sr. Manager, Health Initiatives at Feeding America. She spearheads initiatives to forge healthcare partnerships and implement food-as-medicine programs to ensure communities receive nutritious, culturally-aligned food resources. Her diverse food systems expertise spans national grocery chains, school nutrition programs, regenerative agriculture startups, restaurant operations, and organic farming—experiences that fuel her passion for building resilient regional food networks that nourish people and the environment. Perri holds a B.A. with cum laude honors from The Colorado College and Masters of Environmental Management at Duke University, further deepening her commitment to sustainable food system transformation.

Today's Speakers



Katie Garfield



Kathryn Jantz

Katie Garfield, J.D., is a Clinical Instructor and the Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School. She currently directs its initiatives that focus on better equipping the U.S. health care system to identify and respond to health-related social needs, including the Center's Food is Medicine project. In her work on these initiatives, she conducts legal and policy research regarding current pathways to integrate innovative services into health care delivery and financing. She also provides education and technical support to a range of community-based organizations, state agencies, health care providers, and coalitions who are working to develop or implement strategies to achieve these goals. Katie is also a licensed member of the Massachusetts Bar.

Kathryn Jantz is Founder and Principal of Hearthwise Consulting, where she advises policymakers, payers, and providers on designing and implementing programs that support whole-person health. With more than 15 years of experience driving large-scale delivery system reform, she brings deep subject-matter expertise in Medicaid policy, Food is Medicine, maternal health, and social care integration. Previously, she served as Consulting Practice Director at HealthBegins, where she led multi-state Medicaid transformation and health equity initiatives and helped design tools to measure return on investment in social health. She also served as Director of the Accountable Health Communities Model at Rocky Mountain Health Plans.



Feeding America: Adam Dewey & Perri Kramer

Summer 2026
Update

Feeding America National Organization



THE NETWORK STRATEGIC FRAMEWORK

In concert with the Feeding America network – comprised of the Feeding America national organization, partner food banks, affiliate food banks, redistribution organizations, Partner State Associations, regional cooperatives and agency partners – the framework focuses the network's collective action on **five priorities over the next five years.**



Improve Neighbor Access & Experience

Ensure fair access to preferred foods, convenient services and dignified experiences for all neighbors facing hunger.



Enhance Food Sourcing & Sharing

Expand partnerships and improve food sourcing and sharing across the network to better meet neighbors' needs and preferences



Expand Policy Advocacy

Advocate for policy change in collaboration with neighbors and other partners to increase neighbor access to resources and address the root causes of food insecurity.



Increase Holistic Supports

Build partnerships and increase network capacity to expand holistic supports available to neighbors to help address the root causes of food insecurity.



Transform Technology, Measurement & Data

Evolve networkwide measurement, data sharing and technology to learn, advance collective priorities and illustrate the network's full impact.

Map the Meal Gap

What: Annual study on local food insecurity and food prices

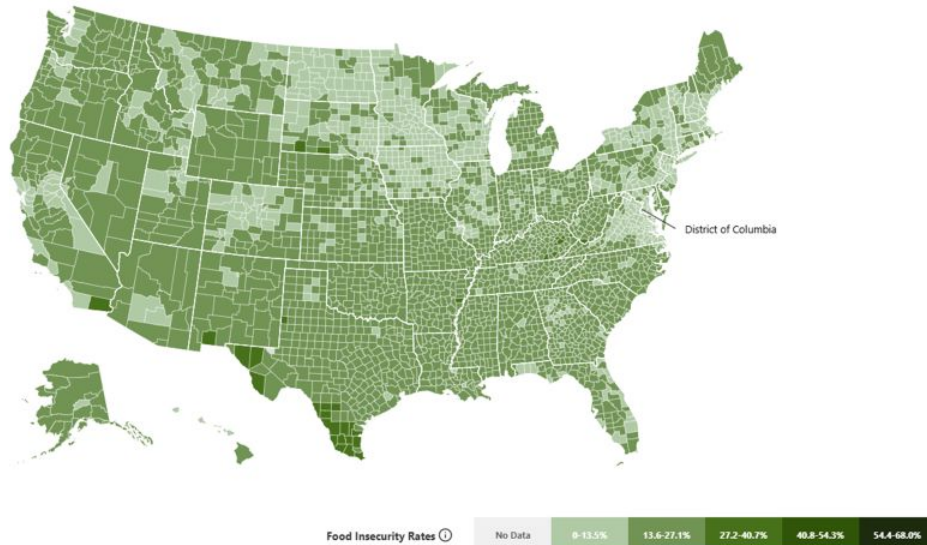
Why: To inform program and policy decisions

Who: Individuals, children, seniors, older adults, racial/ethnic groups

Where: Counties, service areas, districts, states

How: Modeled or estimated using historical data from federal surveys like the CPS-FSS

When: Spring or early summer



* Food insecurity is defined by the USDA as a household-level economic and social condition of limited or uncertain access to adequate food.

What Map the Meal Gap Measures

Overview of the estimates we produce by population and place

Measure and Population	Place					
	Nation ³	State	Metro	District	Service Area	County
Food insecurity						
Overall (all ages)	✓	✓		✓	✓	✓
Black (all ethnicities), Hispanic (all races), and White (non-Hispanic)	✓	✓		✓	✓	✓
Asian American, Native Hawaiian, and Pacific Islander, and Native American ¹	✓					
Child (<18 years)	✓	✓		✓	✓	✓
Older adults (50-59) and seniors (60+) ¹	✓	✓	✓			
Federal nutrition program eligibility²	✓	✓		✓	✓	✓
Meal cost²	✓	✓			✓	✓
Food budget shortfall²	✓	✓			✓	✓

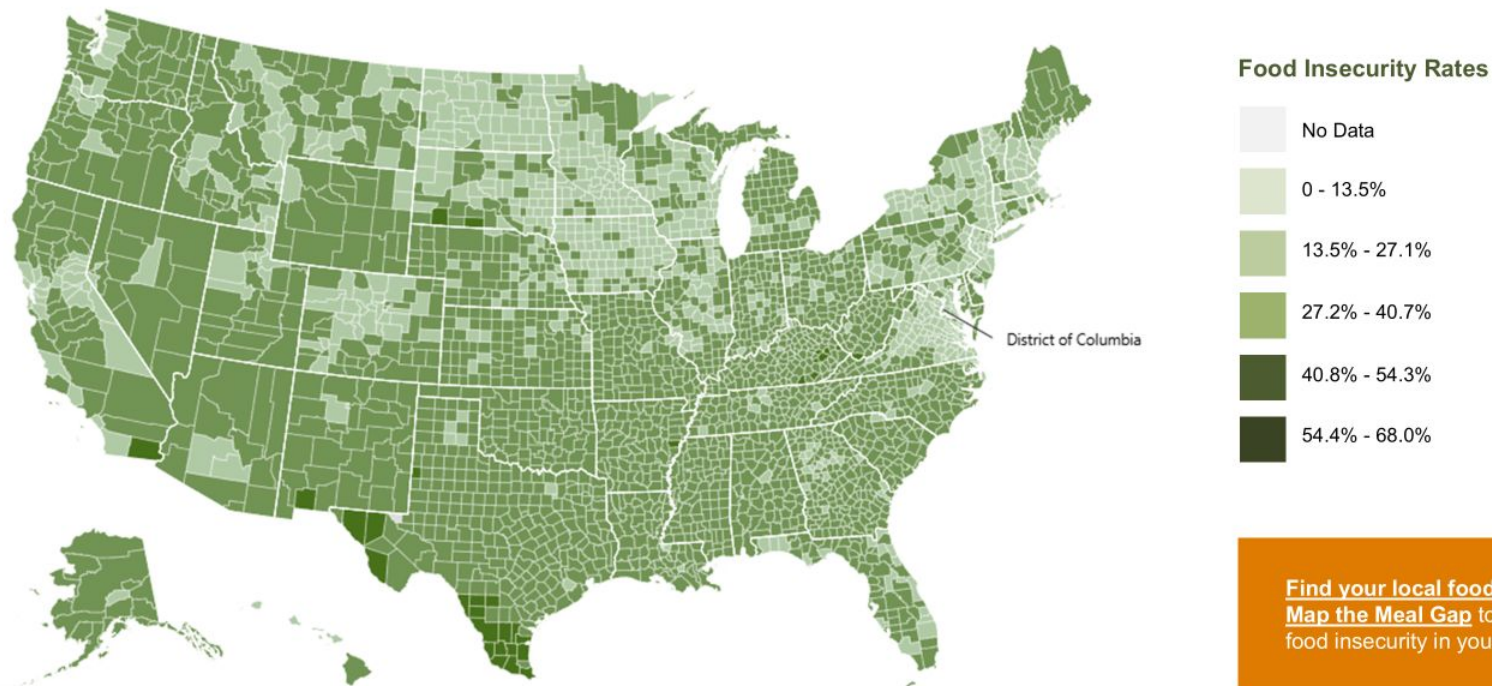
¹ Food insecurity estimates for these groups are produced by analyzing data from the Current Population Survey; they are not modeled like other food insecurity estimates.

² Estimates of income eligibility are available for all individuals and children in food-insecure households. Shortfall estimates are available only for the overall population. Meal cost estimates reflect reported spending among people who are food secure.

³ Local food insecurity estimates align with official national statistics from the USDA Economic Research Service, but Feeding America typically defers to the USDA ERS when discussing national food insecurity prevalence.

Every County is Home to People Experiencing Food Insecurity

Estimated percentage of people in food-insecure households by county as of 2024

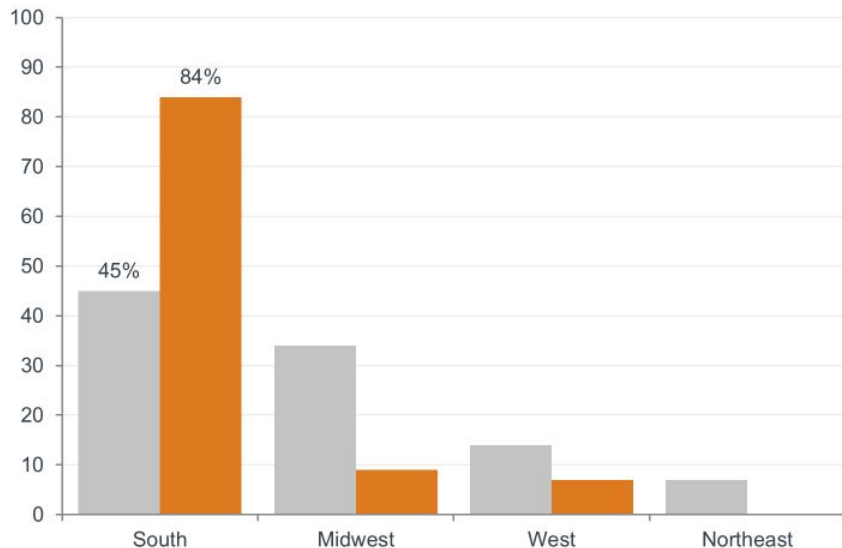


High Food Insecurity Is Concentrated in the Rural South

Percent of counties overall versus counties with the highest estimated rates of food insecurity (21.5% or more)

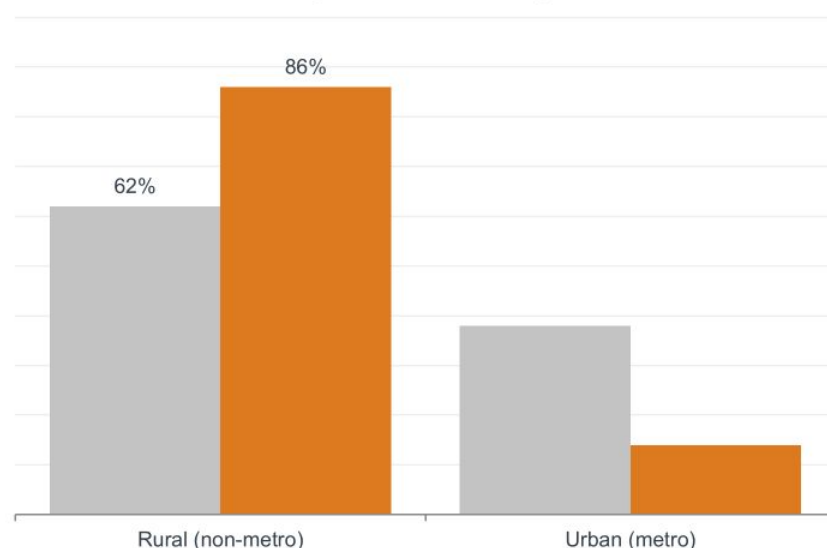
By Region

■ All counties ■ Counties with high rates of food insecurity



By Rurality

■ All counties ■ Counties with high rates of food insecurity



Source: Feeding America. (2026). *Map the Meal Gap 2026: A Report on Local Food Insecurity and Food Costs in the United States in 2024*

Note: High-food-insecurity counties are those in the top 10% nationally ($\geq 21.5\%$ estimated rate, $n=316$). Rural/urban defined by USDA ERS 2023 Rural-Urban Continuum Codes.

National Food Budget Shortfall Surpasses \$33 Billion in 2024

Additional dollars (in billions) needed among all people in food-insecure homes in the U.S.



\$23.16

Weekly shortfall per person among food-insecure households

\$33.6 billion

Annual shortfall among all people in food-insecure households



Source: Calculated by Feeding America using national data from the Current Population Survey (CPS) and USDA ERS, localized using data from NielsenIQ

Note: The national food budget shortfall is derived by multiplying the number of individuals in food-insecure households (USDA ERS), the average weekly dollars needed per food insecure person (CPS), the number of weeks in a year, and the average duration of household food insecurity (USDA ERS). For example, in 2024, 47.9M x \$23.16 x 52 x 7/12 = \$33.6B

Food as Medicine 3.0 Overview

Beyond nutritious food access, food banks are partnering closely with health care sites to deliver whole person care for food-insecure patients. FAM3 continued years of support from Elevance Health Foundation with program evaluation led by the Center for Nutrition and Health Impact.



Programs
implemented across

13 states

Elevance[®]
Health

Foundation

CENTER FOR
Nutrition &
Health Impact

FEEDING[®]
AMERICA

FAM3 Reach & Neighbor Engagement



1.4M

Patients screened for food insecurity

161,972

Households received food

35,620

Participants referred to Supplemental Nutrition Assistance Program (SNAP)



5,624

Baseline and follow-up surveys completed

343

Participants in the claims data analysis

1,240

Participants' clinical health records analyzed

Who FAM3 Reached

FAM3 programs reached **patients navigating both food insecurity and significant health challenges**, including high rates of diet-related conditions like hypertension, cardiovascular disease and diabetes.



“For the first time, I had some good decent meals, the vitamins that I needed. ... I'm walking, eating better. My stomach feels better and my sugar is better.

PARTICIPANT FROM VIRGINIA

PARTICIPANTS WERE

An average of

47 years old



Nearly

3/4

were women



More than

1/2

with children in the household

38%

Black or African American

27%

Hispanic or Latino

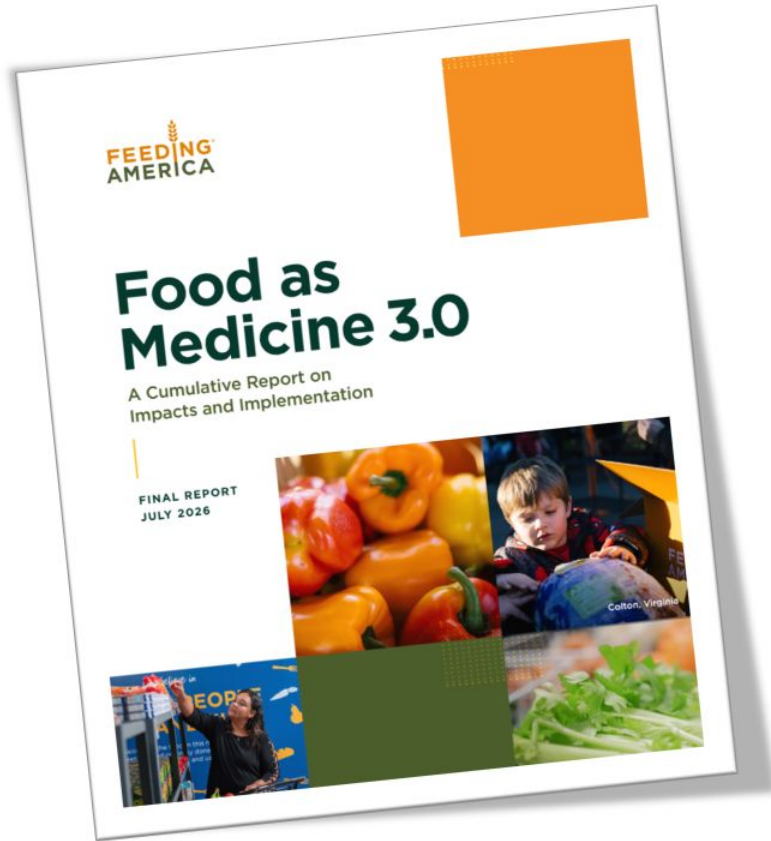
26%

White or European American



1 in 6

preferred to
engage in Spanish



What's in the Report - and How to Use It

Program Design Recommendations

Based off three years of evaluation, findings show how program design influences outcomes.

Site Case Studies

Individual analyses of all 21 food banks showing program design, participant reach and outcomes and testimonials.

Methodology

Survey examples and definitions to help CBOs design and implement food as medicine programs.

Plus! An Initiative Highlights Report

A companion piece that makes the story accessible for partners, funders, and policymakers.

Looking Ahead

Translating learnings into action across the network and food as medicine field

Research & Learning

Build the evidence base and position FANO as the bridge between research, policy, and implementation.

Credibility & Positioning

Turns evidence and insights into messaging and thought leadership, influencing the food & health sector.

Partnerships & Opportunities

Engages healthcare and other strategic stakeholders to advance food as medicine work to improve the health and well-being of neighbors.



A Catalyst for Change

Thank You

Reach out to us directly:

Adam Dewey adewey@feedingamerica.org

Director Research Translation Engagement &
Dissemination

Perri Kramer pkramer@feedingamerica.org

Sr. Manager, Health Impact



1115 Budget Neutrality Guidance:

Katie Garfield



CENTER *for* HEALTH LAW
and POLICY INNOVATION
HARVARD LAW SCHOOL

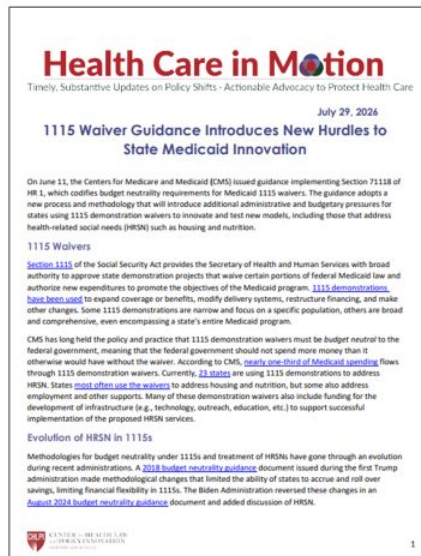
MEDICAID 1115 DEMONSTRATIONS

UPDATE ON BUDGET NEUTRALITY GUIDANCE

Sept. 17, 2026
Katie Garfield, JD
Center for Health Law and Policy Innovation

CMS BUDGET NEUTRALITY GUIDANCE

- Historically, CMS has required for Section 1115 demonstrations to be “**budget neutral**” to the federal gov’t
- H.R.1 put this requirement into statute AND introduced a **new requirement** that demonstrations be certified as budget neutral by the CMS Chief Actuary before approval
 - Goes into effect on **January 1, 2027**
- CMS released new **guidance** on how states/CMS must calculate budget neutrality on June 11, 2026
- CMS will also be releasing **proposed regulations** in the future



Guidance: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf>

CMS Slide Deck: <https://www.medicaid.gov/medicaid/downloads/smd26003-ppt.pdf>

CHLPI Health Care in Motion: https://chlpi.org/wp-content/uploads/2026/07/HCIM-1115-guidance_7.29.26_FINAL.pdf

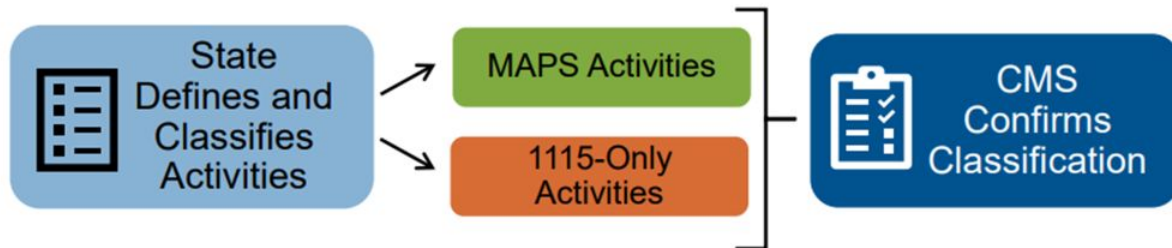
CMS BUDGET NEUTRALITY GUIDANCE

Key Difference from Preceding Guidance for Nutrition Supports

- **Categorization of Services**

- **Medically Authorizable Populations and Services (MAPS):** The activity (service + population) could have been approved under another Medicaid authority.

- ★ • **1115-only:** Activity could only be carried out under an 1115 waiver (because the service or population could NOT have been approved under other authorities)
 - Budget neutrality will focus on **1115-only** activities (costs of these activities will need to be offset by savings, costs of MAPS activities will not)



CMS BUDGET NEUTRALITY GUIDANCE

- **Calculating Budget Neutrality**

- States must analyze **costs** (including direct costs, indirect costs, administrative costs) and **savings** for each 1115-only activity
- States then **combine** these costs/savings across all 1115-only activities to determine the **NET** financial impact of ALL the 1115-only activities
- Net financial impact must be **equal to or less than zero**



CMS BUDGET NEUTRALITY GUIDANCE

What we know about categorization of Health-Related Social Need (HRSN) Services

- HRSN infrastructure **will be categorized as** 1115-only
- HRSN services will be categorized as 1115-only **unless** the service and population could be covered by another authority (e.g., HCBS)
 - CMS has indicated it expects these to be 1115-only



For example, the change will impact “Supplemental Health-Related Social Needs Aggregate Ceiling (SHAC)” expenditures, which were authorized as hypothetical expenditures in demonstration approvals since September 2022 and will now require cost and savings analysis as an 1115-only activity.

TAKEAWAYS

- Beginning January 1, 2027, 1115 demo applications, renewals, and amendments will need to be prospectively approved by the CMS Actuary as “budget neutral”
 - Any costs categorized as “1115-only” will need to be offset by savings
 - Including HRSN infrastructure and (likely) many HRSN services
 - In this environment, research on cost-savings will be crucial
 - This process may create additional delays in CMS approvals
-



Embedding Strategies to Address Food Insecurity in Medicaid Managed Care Contracts: Kathryn Jantz

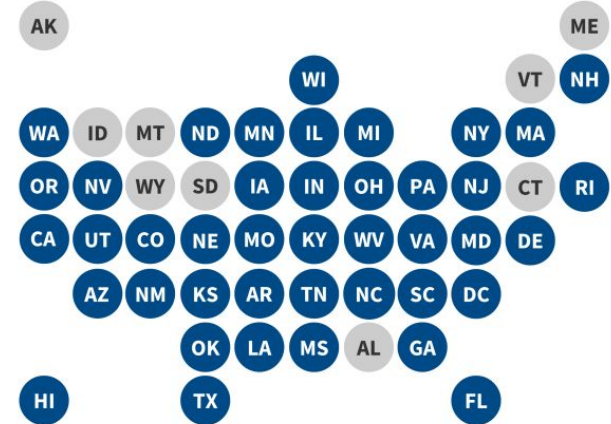
Why leverage MCO contracts?

1. Most states have MCOs.
2. Leverages existing infrastructure.
3. May not impact the state budget.
4. Implemented by Medicaid agency.

Most States Contract with Comprehensive Medicaid Managed Care Plans

- Contracts with comprehensive managed care plans (42 states, including DC)
- Other managed care (primary care case management) or no managed care (9 states)

Source: Annual KFF survey of state Medicaid officials, Nov. 2023.



Four main principles

Financial

Reimbursement
or incentive
structures
increase fidelity to
contract
requirements.

Accountability

Reporting
requirements also
improves fidelity
to contract
requirements.

Accessibility

Populations with
specific needs
require
accommodations,
or services won't
reach everyone
they're meant for.

Member Engagement

Giving enrollees
real input into
design and
implementation
improves
interventions.



Considerations for MCO contracts



Screening & Referral

Health Risk
Assessments

Social Needs
Screening



Assistance & Navigation

Care Coordination

Community Health
Workers



Quality & Population Health

CBO Partnerships

SNAP & WIC
Coordination

Quality
Improvement



Investments & Benefits

Community Reinvestment

Medical Loss Ratio

Value-Added Services

Value-Based Payment
and Hospital Financing



**Medicaid Food
Security Network**

Example Section

4.1 Community Reinvestment

Community reinvestment requirements redirect a portion of MCO profits into community-level investments. Ideal contract language includes:

- Clear requirements around the percent of funding that must be reinvested.
- Community engagement and a transparent approval process guiding a community reinvestment plan.
- Funding of local CBOs, typically defined criteria such as a physical presence or headquarters in the state or community where MCO members live, and/or having a certain percentage of food procured from same-state farms and food producers.
- Inclusion of food as a priority domain.

Using the Managed Care Contract Brief

Who should use the brief? Medicaid agency staff and advocates.

When should we use the brief? While MCO contracts can, and are, changed regularly, the most significant changes tend to occur during reprocurements.

How should we use the brief? Find the section of the MCO contract pertaining to the topic. Use the bulleted lists to identify potential ways to strengthen the contract. For examples, visit the Medicaid Food Security Network dashboard.

Don't hesitate to email us!! We love hearing that you are using our resources and are happy to help.

How to Join a Breakout Room

- Once the host opens the breakout rooms, a pop-up window should appear, inviting you to join a room.
- Select the *Join* button in the pop-up window to move into the room of your choice or your assigned room.
- If the *Join* button does not appear, look for the *Breakout Rooms* button under the *More* menu.
- For an open discussion, remain where you are and do not join a room.



Breakout Rooms by Topic

Breakout Room 1:

Map the Meal Gap

Facilitator: Adam
Dewey

Notetaker:
Madeline Moritsch

Breakout Room 2:

Food as Medicine 3.0

Facilitator:
Perri Kramer

Notetaker:
Katrina Scott

Breakout Room 3:

1115 Budget
Neutrality
Guidance

Facilitator:
Kathryn Jantz

Notetaker:
Elena Rees

Breakout Room 4:

Model MCO
Contract
Language

Facilitator:
Meaghan Butler

Notetaker:
Sarah Mills





Share Out

What were highlights
from your breakout
room discussion?



Closing Remarks

Network Events and Next Steps

Contact

**For any questions related to the MFSN,
please contact:**

Meaghan Butler

Director, Medicaid & Food Security

Share Our Strength

mbutler@strength.org

MFSN@strength.org

<https://medicaidfoodsecuritynetwork.org/>

