# MAXIMIZING THE IMPACT OF NUTRITION INTERVENTIONS WITH LOCAL FOOD PROCUREMENT

## Envisioning a Food is Medicine marketplace that integrates America's local producers to build thriving local economies and food systems

CHLPI
CENTER *for* HEALTH LAW *and* POLICY INNOVATION
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**About the Authors**

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more effective and equitable healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy. CHLPI is comprised of the Harvard Law School Health Law and Policy Clinic and the Harvard Law School Food Law and Policy Clinic. For more information, visit chlpi.org/FLPC.

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This report contains terms and phrases that are commonly abbreviated to improve readability and streamline text. To help readers navigate these abbreviations, we provide this key to the abbreviations used throughout this report.

| ABBREVIATION | DEFINITION |
|---|---|
| ACO(s) | Accountable Care Organization(s) |
| CMS | Centers for Medicare & Medicaid Services |
| FIM | Food is Medicine |
| GusNIP | Gus Schumacher Nutrition Incentive Program |
| HCBS | Home and Community-Based Services |
| HHS | United States Department of Health and Human Services |
| HRSN | Health Related Social Needs |
| ILOS | In Lieu of Services and Settings |
| LFPP | Local Food Promotion Program |
| MCO(s) | Managed Care Organization(s) |
| USDA | United States Department of Agriculture |

## INTRODUCTION

The leading causes of death in the United States are closely tied to poor diet.[1] Approximately one out of seven U.S. households is food insecure,[2] and only 7.4% of Americans eat the recommended daily intake of fruits and vegetables.[3] Consequently, 47.7% of adults in the United States have been diagnosed with hypertension,[4] the prevalence of obesity among adults is 40.3%,[5] 15.8% have diabetes,[6] and 11.3% have high cholesterol.[7] The costs of these and other diet-related health conditions to the U.S. economy exceeds $1.1 trillion in medical expenses and lost worker productivity each year, a figure which does not account for other costly impacts such as reduced military readiness or lower academic performance due to poor health.[8]

Prescribed nutrition interventions, often referred to as Food is Medicine (FIM), have emerged as a promising strategy to address this health crisis. Food is Medicine interventions connect patients to or provide patients with foods tailored to their medical needs through the healthcare system.[9] Produce prescriptions, medically tailored groceries, and medically tailored meals are three common examples of Food is Medicine interventions.[10] Though these interventions can help address health-related social needs like food security, their primary purpose is to ensure that the medical and nutritional needs of patients are met.[11] Thus, Food is Medicine interventions can build on nutrition security programs, like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other healthy food policies to provide access to nutritious food as part of a patient's treatment plan, but may not supplant these programs.[12]

Several policy options have emerged over the last decade to allow the integration of nutrition interventions into U.S. health insurance systems.[13] Among these, Medicaid flexibilities have gained particular momentum. Medicaid serves as a safety net health insurance program for adults and children with low incomes, qualifying pregnant people, older adults, and individuals with disabilities.[14]

A growing body of research shows that these nutrition interventions are a cost-effective approach to improving healthcare outcomes.[15]

- Researchers estimate that providing produce prescriptions to eligible food insecure patients with diabetes could prevent around 292,000 cardiovascular events and save $36.9 billion in U.S. healthcare costs each year.[16]
- Modeling shows that offering medically tailored meals to adult patients covered by Medicare, Medicaid, or private insurance who have diet-related conditions and physical activity limitations that affect their ability to shop for and cook their own meals could prevent an estimated 2.6 million hospitalizations and save $23.7 billion in U.S. healthcare costs annually.[17]
- A 2024 evaluation of North Carolina's Healthy Opportunities Pilot, which began providing

food interventions through Medicaid in March 2022, found that service spending (spending for medical care and Healthy Opportunity Pilot services, like nutrition interventions) was on average $85 less per participant per month and longer program participation was associated with greater annual reductions in cost.[18]

- In Massachusetts, a 2025 evaluation of its Medicaid Flexible Services Program, which provides nutrition interventions in partnership with community-based organizations, found that the program was associated with a 23% reduction in hospitalizations and a 13% reduction in emergency department visits.[19] The flexible services studied in this evaluation included a range of nutrition interventions such as medically tailored meals, home-delivered meals, food boxes, and produce prescriptions.[20]

While there is increasing recognition of the beneficial health outcomes and healthcare cost savings as a result of Food is Medicine, policymakers and researchers are just beginning to consider the other potential impacts of Food of Medicine on broader systems, such as local food systems and regional and state economies.

Opportunities exist to multiply the benefits of Food is Medicine interventions by sourcing food that offers the most value to program participants and the communities in which they live. As Food is Medicine has emerged as a strategy for addressing the diet-related healthcare crisis facing our country, there is increasing interest in how states and other localities can tailor their Food is Medicine initiatives to boost local economies by supporting local farmers and producers, local food retailers, and community-based organizations. By keeping food dollars circulating in the local economy, communities benefit from a multiplier effect as those funds continue to fuel local businesses and employment.[21]

**Researchers estimate that locally-produced food purchases have a multiplier effect of between $1.32 and $1.90, meaning that there is an additional $.32 to $.90 worth of local economic activity for each dollar spent on local food.[22]**

Local food systems may also foster other benefits ranging from improved health outcomes, positive environmental impacts, strengthened communities, and increased food system resilience.[23] Recognizing the intersection between the healthcare and food systems, the U.S. Department of Health and Human Services (HHS) includes "food quality and production effects" among the four domains it identified to assess the quality and impact of Food is Medicine programs.[24] The "food quality and production effects" domain defines success to include: increased use of regional food, stronger local food economies, increased support for regional producers and food businesses, and expanded local food systems.[25]

## ABOUT THIS REPORT

This report uses local food procurement to examine how state governments can incorporate local and regional policy priorities into their development and implementation of Food is Medicine interventions, while maximizing program impacts.

The report begins with an overview of the nuts and bolts of procurement, including the legal framework that drives differences between private and government purchasing procedures. Many Food is Medicine programs have been implemented by private entities using nongovernmental funds, which has afforded significant flexibility regarding food purchasing procedures and priorities. As funding for Food is Medicine programs incorporates more governmental funding streams, state and federal procurement rules are implicated, potentially imposing requirements or restrictions on how those funds are used. This report focuses on Medicaid because many states are utilizing Medicaid flexibilities to scale Food is Medicine programs, though the content and recommendations could apply to other public insurance programs.

This report concludes with strategies that prioritize local food purchasing in Food is Medicine policy and provides examples of states that are testing approaches for integrating local values into Food is Medicine programs to maximize healthcare investments.

Because procurement is a highly specialized area of the law, and one with state-level legal intricacies, this report is not intended to be a how-to guide, and state agencies should consult with counsel to obtain tailored legal advice on the potential to use their state's procurement process and requirements to support local purchasing, or other state and local values.

### DEFINING LOCAL

**While "local" suggests a geographic area where the buyer and seller are in close proximity to one another, there is no widely accepted or standardized definition for local goods and services.[26] Whether food is considered local depends on who is using the term "local" and in what context.[27] Some federal programs define local foods as those that have not been transported more than 400 miles from their place of origin or those that are distributed in the state where they are produced.[28] Most states consider products grown within the state to be local, but some also include regionally produced products.[29] Institutions may also set their own definitions of local, which may vary considerably and be based on geographic boundaries, the distance a food travels, the type of food, or the time that it takes to transport the food.[30]**

Procurement policies are a set of guidelines used within organizations—and in some cases laid out in state or federal laws—to establish and standardize the procedure for acquiring goods and services.[31] Procurement policies may encompass various considerations, including how different vendors can compete for business and what standards an organization will consider when sourcing goods and services.[32] Notably, procurement policies can extend beyond mere cost considerations to align with broader community interests, such as supporting small businesses, including those owned by socially or economically disadvantaged individuals, women, or service-disabled veterans,[33] promoting community health and nutrition, strengthening local and community-based economies, ensuring environmental sustainability, fostering valued workforces, or prioritizing equity, accountability, and transparency.[34]

**PROCUREMENT**

**Generally, procurement is the process of obtaining and purchasing goods and services. Procurement sometimes differs from direct purchasing in that it often involves a series of steps, including the solicitation of bids, as well as price and contract negotiation, in addition to the purchase itself.**

The integration of considerations beyond cost into Food is Medicine food procurement presents a significant opportunity to amplify the effectiveness and impact of Food is Medicine initiatives, but understanding procurement policies is vital, as rules differ depending upon the source of an institution's funds. While private institutions generally have flexibility in their food purchasing choices, institutions operating with federal, state, and local funds must adhere to specific procurement requirements.[35]

## Government Purchasing

There is increasing recognition of the dual function and power of public institutions as related to procurement: governments purchase significant amounts of goods and services while also designing the policies that govern these purchases.[36] Government procurement policies both ensure that government entities acquire goods and services that offer the most value to the public and clearly outline evaluation criteria for the purchasing process. These policies further aim to create transparency and foster competition.[37]

### *Purchases that Use Federal Awards*

The procurement of goods and services may be subject to certain restrictions and requirements depending on whether the purchaser is using federal, state, or private funds. Purchases made with "federal awards," such as grants and cooperative agreements, must follow specific policies and procedures and are subject to specific limitations.[38] For example, prior to October 2024, federal

awards were subject to a general restriction on geographic preferencing in the procurement process.[39] Under this restriction, goods or services purchased using monies from "federal awards" could not preference in-state goods over out-of-state goods without federal statutory authority permitting or encouraging such a preference (e.g., school foods).[40] In October 2024, a regulatory change removed this general prohibition against geographic preferences.[41] While this change signaled that the federal government is becoming more supportive of state preferences for local goods and services, other restrictions on procurements with federal award monies remain.

### *Acquisition Thresholds*

Procurement procedures using public funds can also vary depending on the size of the expenditure.[42] Across local, state, and federal levels, procurement practices often distinguish between formal and informal bidding processes. For purchases below a certain threshold, institutions may use an **informal bidding** process and have more flexibility to make purchases based on considerations other than cost.[43] In contrast, a **formal bidding** process typically entails public solicitation of bids, established criteria for bid evaluation, consideration of all bids, and a mandate to award the contract to the lowest bidder.[44] Requests for proposals or invitations for bids may embed values within the criteria that will be used to evaluate bids.

The federal government has set a "simplified acquisition threshold" that allows informal bidding for small purchases made with federal funding.[45] The federal simplified acquisition threshold is set at $250,000 as of January 2025.[46] For aggregate expenditures at or below that federal threshold, federal agencies and other institutions that have been awarded federal funds (such as through grants or cooperative agreements) can utilize informal bidding processes.[47] An informal bidding process relaxes many of the requirements, which means that institutions can solicit a smaller number of bids and do not necessarily have to award the contract to the lowest bidder.[48]

The federal government also sets a "micro-purchase threshold." As of January 2025, the micro-purchase threshold is $10,000.[49] For aggregate expenditures below the micro-purchase threshold, federal agencies and other institutions that are spending federal funds can purchase directly from a supplier without soliciting any other bids.[50] For aggregate expenditures below the simplified acquisition threshold but above the micro-purchase threshold (in other words, those between $10,000 - $250,000 that are using the informal bidding process), agencies and institutions must still obtain price quotes from "an adequate number of qualified sources."[51]

Embracing the distinction between formal and informal bidding processes allows institutions increased flexibility to select vendors for smaller purchases. State and local governments can set small-purchase thresholds lower than those set by the federal government, and the lower, more restrictive threshold will always apply.[52] States with small-purchase thresholds that are lower than the federal threshold can consider raising that threshold to allow state institutions greater flexibility in sourcing products and make it easier for local and regional vendors to submit bids.[53]

### *Procurement Processes*

For purchases above the micro-purchase threshold, jurisdictions generally must use a competitive

procurement process that includes invitations to bid or requests for proposals. **Invitations to bid** are used when the only thing that will differentiate bidders is the price (in other words, when it is possible to outline clearly and completely all project specifications).[54] Such specifications can be used to detail requirements such as product variety (catfish, which is only available in commercial quantities from Mississippi), origin labeling (Made in Montana), or geographic preference.[55] For example, one Virginia school district's invitation to bid specified a geographic price preference for beef raised and processed within a 100 mile radius and provided that $0.50 per pound would be deducted from the quoted price for bids meeting the preference.[56] These specifications are then used to determine which vendors have submitted responsive bids, with the jurisdiction then selecting the lowest price bid from among the responsive bids.[57]

Jurisdictions often use **requests for proposals** when they wish to consider factors other than price.[58] Large contracts, especially those involving services or programs, are typically procured using requests for proposals.[59] A request for proposals, or RFP, will describe what goods, products, or services the governmental entity is seeking, outline anticipated contractual terms and conditions, detail information that should be included in any responses to the request for proposals, and explain how proposals will be evaluated.[60] Requests for proposals often solicit two components: a technical proposal explaining how the work will be completed and a cost proposal setting out the prices for the work described in the technical proposal.[61] Typically, proposals are evaluated and scored in order to select one or more vendors with whom the governmental entity will then negotiate the final contract price.[62]

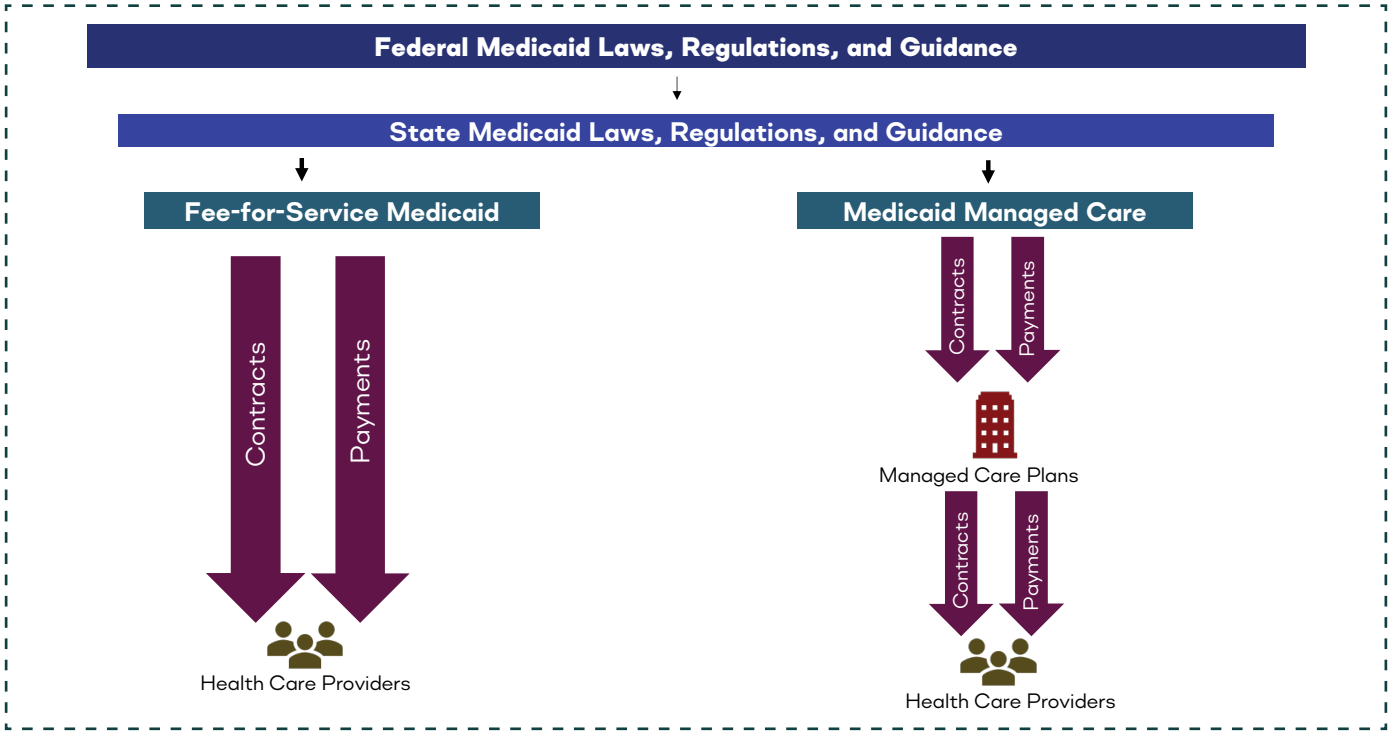
**Requests for information**, or RFIs, can be used in advance of a request for proposals to gather information in order to identify potential issues or concerns and inform the government's approach to procurement.[63] Governmental organizations may also hold public hearings, conduct their own market research, share draft requests for proposals or use other techniques to solicit information from interested stakeholders.[64] Public participation in the procurement process helps ensure that government contracts reflect public needs, interests, and values that are important to the community that will be served.[65]

Once a vendor is selected and the procurement process is completed, the governmental entity will enter into a contract with the selected vendor.[66] Some contracts will require review and approval from legislative bodies or other governmental agencies.[67] For example, the Centers for Medicare & Medicaid Services (CMS) must review and approve all state contracts with Managed Care Organizations (MCOs).[68] After the contract is finalized, the governmental organization that entered into the contract will monitor and oversee implementation to ensure that the vendor is fulfilling the contract terms and conditions.[69] This oversight also allows assessment of the quality of services and ensures that any issues that arise are timely identified and corrected.[70] In the context of Medicaid Managed Care, states are required to develop and implement written strategies to assess and improve the quality of healthcare services.[71] The next section takes a closer look at procurement within Medicaid.

## Procurement Within Medicaid

Medicaid is a joint federal- and state-funded program. Federal law[72] provides the overarching structure for Medicaid by establishing basic requirements regarding eligibility standards,[73] enrollment processes,[74] and benefit categories.[75] Within that structure, each state has the autonomy to develop and implement its own program.[76]

States may use several approaches to pay for and deliver Medicaid services to beneficiaries. Generally, states choose to administer their Medicaid through two main pathways: fee-for-service or managed care.[77] In the fee-for-service model, states pay healthcare providers directly for providing services.[78] In the managed care model, states pay a MCO (i.e., a health plan).[79] The MCO then contracts with its network of healthcare providers and can establish its own payment structure with the provider network (e.g., payment based on services performed or value-based payment, which incentivizes providers to focus on quality of care and health outcomes).[80] About 75% of Medicaid beneficiaries in the U.S. were covered under managed care as of 2022.[81] The two administration pathways are depicted in the graphic below.[82]




In most circumstances, Medicaid payments are not considered federal awards. However, state law may consider Medicaid payments a federal award if reimbursed on a "cost-reimbursement basis."[83] For example, local educational agencies can be compensated for medical services provided to a Medicaid beneficiary in a school setting even when the school is not equipped to bill for those services like a typical healthcare provider.[84] The local educational agency can be reimbursed based on the actual cost of those services and, in such cases, the cost-reimbursement is considered a federal award.[85] But in general, state purchasing of goods and services – such as food – with Medicaid funds is generally not constrained by federal award restrictions and requirements.

Moreover, states have significant flexibility in determining with which healthcare providers and health plans to contract in their Medicaid program.[86] Medicaid Managed Care contracts can be valued at billions of dollars and last three to five years,[87] making bidding processes highly competitive.[88] States consider a range of factors in these selection processes, such as health services offered, member engagement initiatives, accountability metrics, value-based payment (when healthcare providers are paid based on the quality of care delivered),[89] and integration of care.[90] These factors often stem from a state's programmatic goals and ideas for innovation, and are stated in the state's request for proposals.[91] States can use this process to award contracts to plans and providers that further these priorities. The flexibility of this framework provides mechanisms for states to tailor Medicaid Food is Medicine programs to implement values such as local food purchasing.

## Local Values in Food Procurement

Governments have a variety of tools at their disposal for aligning purchasing practices with public priorities and values, including laws requiring or preferencing certain goods, services, or suppliers. Regarding food procurement, one of the most well-established methods for achieving ancillary benefits, such as positive local economic impacts, is the use of local food purchasing preferences. Local food procurement requirements, as well as other food procurement values, can be implemented through legislation,[92] regulations,[93] executive orders,[94] or informally through individual procurement processes.[95] Such policies can be complemented by supportive strategies, such as the use of forward contracts (an agreement to purchase a specific product at a future date) and technical assistance, as described below. Additionally, government funding can be used to support local and regional food systems and the participation of small or mid-sized producers in institutional procurement.

### *Local Values in Laws and Regulations*

Values-based procurement policies are a tool for aligning the procurement of goods or services – in this case, food – with values beyond cost to improve outcomes for public health, food businesses, food workers, consumers, the environment, and animals.[96] In a traditional food procurement model, vendors that offer the lowest cost food products tend to win contracts, although these costs often fail to consider the full scope of externalities associated with its production and consumption, overlooking the **true cost of food** or the benefits of local purchasing.[97]

**THE TRUE COST OF FOOD**

**Americans spend about $1.1 trillion annually on food, however, this price tag is not the "true cost" of food as it does not include healthcare costs or environmental impacts. Medical costs and lost productivity related to diet-related health conditions account for the majority of these hidden costs, almost doubling the cost of our food system. When these healthcare, environmental, and other external costs, such as underpayment of food system workers and agricultural subsidies, are considered, the true cost of food is nearly three times as much as the sticker price ($3.2 trillion a year).[98]**

There is no one-size-fits-all solution and values can be defined uniquely by a government entity or an organization, which may choose to target a single value, or any combination of values based on its needs and priorities. There are several noteworthy examples of cities and states successfully aligning procurement practices with core values beyond cost, showcasing the adaptability of values-driven procurement policies to different legal frameworks.[99] Some cities, such as Boston, have enacted comprehensive policies tying in a broad range of values, including support for local small- and mid-sized agricultural producers and food processing businesses, sustainable food production systems, valued agricultural and food systems workers, healthy and humane animal care, and the promotion of health through increased consumption of vegetables, fruits and whole grains.[100] Boston's ordinance aims to provide transparency and accountability through a baseline assessment and regular reporting requirements.[101] This ordinance is anticipated to redirect millions of dollars of city funds from industrial food businesses to small and mid-sized local producers.[102]

At the state level, many states have passed laws that preference the purchasing of local (in-state) products. In California, state law requires state agencies, institutions, and offices, along with counties and cities receiving state money, to prefer supplies manufactured or produced in the state, followed by those partially manufactured or produced in the state.[103] Some states with preferences for local products strengthen their preference by including a **price preference**, which requires or allows a government entity to purchase more costly local food options. For example, Hawai'i law promotes the use of Hawaiian "agricultural goods, value-added products and commodities" by requiring governmental agencies to give a 15% price preference to bids for any agricultural, aquacultural, horticultural, silvicultural, floricultural, or livestock product that was raised, grown or harvested in the state.[104] As a result, even when local Hawaiian agricultural goods cost up to 15% more than those from another state, the price adjustment would favor the purchase of the local goods. Such policies are commonly referred to as **mandatory price preferences**.

**Discretionary price preference** policies, on the other hand, give purchasers leeway to preference purchases based on certain values even when they cost more, but do not require them to do so.[105] For example, Indiana allows for, but does not require, up to a 10% price preference for agricultural products grown, produced, or processed in the state.[106]

Of note, states can also have a mix of policy mechanisms regarding local food product preferences. Alaska state law, for instance, requires state entities and school districts receiving state money to purchase agricultural or fisheries products harvested from within the state as long as the in-state product costs less than 7% more than the cost of comparable out-of-state products.[107] In addition to this mandatory price preference, Alaska also has a discretionary price preference, allowing state entities to give up to a 15% price preference on in-state product procurement. That is, collectively, Alaska has a preference of not less than 7% (mandatory) nor more than 15% (discretionary).

A **tie-breaker preference** requires that the purchaser award the contract to the vendor that aligns with defined values criteria when two or more producers are offering the same food products on otherwise equal terms.[108] Oklahoma, for instance, requires that state agencies give preference to in-state goods if the price, fitness, availability, and quality of the goods are otherwise equal.[109]

Some state or local governments have **benchmark laws** that set quotas or other goals for the purchase of certain products.[110] For example, Illinois law set a goal that by 2020, "20% of all food and food products purchased by State agencies and State-owned facilities . . . and public universities" would be local food products.[111] In New York state, the governor signed an executive order setting a goal of procuring at least 30% of all food purchased by state agencies from New York producers by the end of 2027.[112] Passing a benchmarking law, even in the absence of penalties for not meeting the benchmark, still serves as an indication of a government's endorsement of certain values within the procurement process.[113]

A **reciprocal preference** allows states to give a preference to in-state vendors or products that is equal to the preference given by another state to its own resident vendors or products.[114] For example, Utah applies a reciprocal preference to *goods* that are produced in Utah against a vendor offering goods that are produced in a state that preferences goods produced in that state.[115] Minnesota, on the other hand, gives a preference to resident *vendors* over nonresident vendors from a state that gives a preference to vendors from that state.[116] Reciprocity for in-state products or vendors serves to strengthen local economies by ensuring that resident bids are on a level playing field with bids from states that preference their own products or vendors.

Despite most states adopting some form of generalized local food procurement laws, a handful of states (nine plus the District of Columbia) have yet to adopt any procurement preference laws that apply across state agencies (however, some of these states do have policies in place to support local farm-to-school programs).[117] A 50-state summary (plus the District of Columbia) of local food purchasing preference laws that broadly apply across state agencies is provided in **Appendix A**.

While not specific to food procurement, some states include a preference for small or locally-based businesses and organizations. For example, the California Government Code requires state agencies to set a minimum goal of 25% participation by small businesses, including microbusinesses, in the procurement of goods, information technology, and services.[118] The law further directs state agencies to provide a 5% price preference to small businesses and microbusinesses when awarding contracts for goods and services.[119] This preference means that a small business can secure a contract even when its bid is slightly higher than that of the lowest responsive bidder. Laws in Idaho, South Dakota, and New Hampshire preference bidders with an economic presence in their state when their bids are otherwise comparable to the proposals of out of state bidders.[120]

Advocates should be aware of their state procurement preference laws as some of these many be relevant to Food is Medicine programs in the state, or maybe helpful as they show a general background state goal to support local or in-state producers. However, whether these state preferences apply to the purchase of Food is Medicine interventions with state funds, including food purchases, will depend on how the law is crafted, and the specific agencies covered by the law. This is because some state procurement preferences apply to only certain agencies and not others. For example, Massachusetts's procurement preference law only requires that a procurement officer make "best efforts" to purchase in-state farm products for state colleges and

universities but includes a mandatory 10% price preference for purchases made on behalf of other state agencies and authorities.[121]

There may also be state or federal court decisions interpreting the scope and applicability of specific state laws and their corresponding regulations. Advocates in states that have local preferences in place should work with state officials to see if preferences apply to Food is Medicine interventions and if not, to think about how to better align the two. Regardless, such laws set forth state policy priorities that should be considered during the procurement process so that government purchasing does not inadvertently undermine established public goals and priorities.[122]

### *Strategies to Facilitate Local Food Purchasing*

In some regions, imposing a requirement for local foods may not be feasible because of the length of the growing season, availability of local foods, or limited numbers of producers. Additionally, small and mid-sized producers face a variety of barriers to entry into new markets that would enable them to sustain and scale their production. To achieve a scale by which they can participate in institutional food procurement, or provide agricultural products for Food is Medicine programs, small local farmers may be challenged by a lack of resources for capital and infrastructure investments, limited access to processing and packaging services, or limited distribution systems.[123] These challenges can impede the ability of producers to meet the potential institutional demand for locally-produced agricultural products. Some strategies that governments and community-based organizations can use to support local producers are discussed below.

Government funded entities can leverage **forward contracting** to set the price and quantity of food to be purchased at a future date, thus providing producers assurance of future sales that aids business planning and allows producers to adapt what they will grow to meet the needs of the institutional buyer, as agreed upon in the contract terms.[124] In North Carolina, the Department of Agriculture and Consumer Services collaborates with an advisory board of school districts to formulate a list of products needed for the following year and facilitates arranging forward contracts for these products.[125] In Massachusetts' Health Related Social Needs Medicaid demonstration, MassHealth has allowed lump sum advance payments.[126] By allowing Food is Medicine providers to receive upfront payments instead of waiting until after nutrition interventions have been delivered, state Medicaid agencies can give these providers the flexibility to contract with and pay producers in advance for certain crops or to make immediate payment upon delivery. This approach helps sustain farming operations with narrow profit margins.

**Food Hubs,** which aggregate, distribute, and market agricultural products primarily sourced from local and regional producers, can help address the lack of distribution systems or challenges with achieving the needed scale and cost efficiencies for getting local foods into markets.[127] While wholesale customers, such as governmental institutions and community-based service providers, may face challenges purchasing sufficient volumes from small and mid-sized producers, they can overcome many of these challenges by utilizing food hubs to meet their demand for local or otherwise differentiated products.[128] Food hubs help strengthen agricultural economies by

lowering the barriers to market entry and providing the infrastructure that facilitates more local and regionalized food systems.[129] Community-based Food is Medicine providers are increasingly turning to food hubs to assist with the sourcing of high-quality food products from the producers in and around the communities they serve.[130]

**HOW TWO FOOD HUBS ARE BUILDING PRODUCER CAPACITY FOR NEW MARKETS**

### 4P FOODS

This mid-Atlantic region based food hub aims to "rebuild a regenerative and equitable food system" by working with local farmers who "ethically steward land, food, animals, and communities."[131] 4P Foods works with farmers from over 200 small to mid-sized family farms and provides sufficient compensation to support equitable sourcing and fair labor practices.[132] 4P Foods aggregates food products from these producers in its warehouses for distribution to Food is Medicine initiatives, as well as other sale outlets.[133] Since 2021, 4P Foods has been partnering with Children's National Hospital to improve diet quality for families in Washington, D.C. who are food insecure and whose members have or are at risk of developing diet-related health conditions.[134] Through a collaboration with the Department of Veterans Affairs, 4P Foods' services are expanding to include the distribution of produce prescription boxes to Maryland veterans living in rural areas.[135]

### THE ACRE COLLECTIVE: ADVANCING AGRICULTURE, COMMUNITY, RESILIENCE & EQUITY

Led by nonprofit regional food distributor The Common Market, The Georgia ACRE Collective aims to increase stable end markets and build supplier capacity for healthy, local, sustainable and equitably produced foods in Georgia.[136] To enhance Georgia's local and regional food system, ACRE is working to expand access to land, markets, and capital for Georgia's small- to mid-sized farms.[137] ACRE's strategies include: 1) forward purchasing commitments, which enable farmers to plan production based on guaranteed demand while providing buyers with pricing certainty; and 2) direct investments in farmers, through zero-interest working capital loans, infrastructure grants, and tailored technical assistance.[138]

Public and private organizations, universities, agricultural extension offices, state and federal agencies, and other organizations can provide **technical assistance** and other support to connect small and mid-sized food producers with institutional purchasers. For example, Kentucky-based Food is Medicine provider Need More Acres Farm provides mentorship and training to local refugee and minority farmers seeking to increase their access to markets and institutional buyers.[139] Need More Acres Farm further supports limited resource farmers by purchasing the entirety of their produce for produce prescription boxes, and supplements any gaps in supply by sourcing from medium-sized farmers.[140] The organization also uses their cold storage delivery vehicle to collect produce from farmers who are unable to deliver their products.[141]

In recent years, several federal and state programs have **provided dedicated funding** to support

local food procurement, particularly in schools, food banks, and other community nutrition programs. These initiatives aim to open new markets for local producers, improve access to fresh and culturally relevant foods, and strengthen regional food system resilience.

Though some landmark programs—such as the Local Food Purchase Assistance Cooperative Agreement Program and the Local Food for Schools Cooperative Agreement Program—saw their funding cut in early 2025, other efforts remain active.[142] Notably, the Resilient Food Systems Infrastructure Program[143] and various state-led local food purchasing incentive programs[144] continue to provide critical support for institutional sourcing of local food.

| PROGRAM | PROGRAM TYPE | LOCAL FOOD IMPACT |
|---|---|---|
| Local Food Purchase Assistance[145] | Federal Non-competitive Cooperative Agreements | Funds procurement of foods grown in-state or within 400 miles. Builds supply chain resilience and expands economic opportunities for local producers. |
| Local Food Promotion Program[146] | Competitive Federal Grant | Funds development, coordination, and expansion of local and regional businesses that aggregate, market, and distribute local food, like food hubs. |
| Resilient Food System Infrastructure Program[147] | Federal Non-competitive Cooperative Agreements | Supports mid-chain infrastructure—aggregation, processing, marketing, storage—for local food, including use in institutional procurement. |
| Local Food for Schools[148] | Federal Non-competitive Cooperative Agreements | Enables schools and childcare programs to purchase domestically grown local foods—especially from small businesses and socially disadvantaged producers—to meet community dietary needs. |
| State-level local food purchasing incentives[149] | State and Local Programs (varied structures) | Offers incentives or reimbursements to buy local food, supporting both farmer incomes and student nutrition. |

These investments have demonstrated strong economic returns. For example, the initial $691 million in funding distributed through the Local Food Purchase Assistance Program in 2022 generated an estimated at $1.53 billion in total economic impact—more than doubling its investment through local multiplier effects.[150]

**To estimate the economic multiplier effect of local food purchasing, programs can use this Local Food Impact Calculator developed by the United States Department of Agriculture (USDA) and Colorado State University.[151]**

Though the federal government sets the baseline requirements of the Medicaid program, states are given significant ownership over its implementation, resulting in variation in how Medicaid is administered across states. This flexibility allows for states to be innovative in finding new ways to provide better care for Medicaid beneficiaries. As highlighted above, states can further their programmatic goals and values by capitalizing on the competitive nature of selecting healthcare providers and plans with whom to contract. States can also leverage the creative avenues that have been built into the Medicaid system to pay for the direct provision of food for beneficiaries with diet-related conditions. This Section dives deeper into how states are connecting Medicaid coverage for nutrition interventions with food purchasing and procurement policies that maximize the broader societal benefits of Food is Medicine programs.

## Food is Medicine in Medicaid Basics

As the need and support for Food is Medicine interventions has grown, states have explored a range of options to pay for and deliver nutrition services in their Medicaid programs, each of which presents its own benefits and challenges for implementation. This section briefly explores three example pathways to coverage in Medicaid: 1115 demonstration waivers, 1915 Home and Community-Based Services (HCBS) authorities, and In Lieu of Services and Settings (ILOS). All three options allow states flexibility to integrate local values into their Food is Medicine initiative's procurement framework.

**For a comprehensive overview of these and other Medicaid coverage pathways, including a discussion of allowed nutrition services, scope of potential beneficiary populations, legal and regulatory requirements, the application process for each pathway, and examples of state implementation, see Food is Medicine: A State Medicaid Policy Toolkit.**

### *Section 1115 Demonstrations*

Medicaid Section 1115 demonstrations arise from Section 1115 of the Social Security Act,[152] which empowers the Secretary of Health and Human Services "to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program"[153] and can be used with both fee-for-service and managed care models of Medicaid administration. Within an 1115 demonstration, states can tailor the population reach based upon the state's needs and priorities, choosing to target groups according to age, defined risk factors, geographic locale, and/or individual characteristics.[154]

Over the past several years, Section 1115 demonstrations have gained particular momentum as a pathway for states to provide Medicaid coverage for nutrition interventions.[155] As of June 2025, sixteen states (including the District of Columbia), had approved 1115 demonstrations or pending proposals that provide Medicaid coverage for the direct provision of food.[156] Of the three pathways discussed in this report, 1115 demonstrations provide states with the most flexibility. States can use 1115 demonstrations to provide Food is Medicine services to any beneficiary based on an individual assessment of their unmet nutritional needs.[157]

Unique to 1115 demonstration authority, states can seek approval for infrastructure funding with a federal match for use within four categories of investment: (1) technology, (2) business development, (3) workforce development, and (4) outreach, education, and stakeholder convenings.[158] Infrastructure funding provides additional support for states, MCOs, healthcare providers, and community-based providers to deliver services and address common implementation challenges, such as integrating service providers into the Medicaid system.[159]

### *Section 1915 HCBS Authorities*

A second pathway for covering Food is Medicine with Medicaid is through Home and Community-Based Services (HCBS) authorities. One of the most common types of HCBS authorities are HCBS waivers that arise out of Section 1915(c) of the Social Security Act, which allow states to provide care for people in their homes or communities, instead of in an institutional setting.[160] 1915 waivers are codified at 42 U.S.C. Section 1396n(c)(1),[161] and can be used with both fee-for-service and managed care models of Medicaid administration.

Notably, 1915(c) waivers are more restrictive than 1115 demonstrations. HCBS benefits are reserved for beneficiaries who "would require institutionalization in the absence of HCBS."[162] Additionally, unlike 1115 demonstrations, infrastructure funding is not available to support the implementation of 1915(c) waivers.[163]

### *Medicaid Managed Care: In Lieu of Services and Settings (ILOS)*

A third pathway for covering Food is Medicine with Medicaid is through In Lieu of Services and Settings (ILOS). ILOS can only be administered via the managed care route of Medicaid administration.[164] MCOs may provide ILOS coverage for their beneficiaries when "[t]he State determines that the ILOS is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan."[165] However, once a service is approved as an ILOS, the service is offered at the *option* of each MCO.[166]

The main constraint of the ILOS pathway is that there are several requirements that must be met. To use ILOS, states must satisfy four requirements:[167]

1. The ILOS must be a cost-effective and medically appropriate alternative to a state plan offering;
2. Use of ILOS by beneficiaries cannot be required;
3. The ILOS must be included in the managed care plan contract and offered to beneficiaries at the option of the managed care plan; and
4. The ILOS cost should be factored into the capitation rates unless a federal provision explicitly requires otherwise.

**_Value-added services_ are those services that a MCO chooses to offer even though the services are not covered by the State plan.[168] States can include provisions in their Medicaid Managed Care contracts encouraging MCOs to offer value-added services[169] and could further express a preference for local providers in their managed care contracting.**

## Integrating Local Values into Food is Medicine

As states are using or planning to use the above pathways to cover food and nutrition services through state Medicaid programs, some are considering how they can use the flexibilities described above to align their Medicaid spending with their state's food systems goals. In providing coverage for food and nutrition services, states have the opportunity to prioritize local food systems, leverage the expertise of organizations embedded in and familiar with the unique nutrition needs of their communities, and reinvest wealth in their local economies. This section discusses state efforts to include community, economic, and food systems values in 1115 demonstration applications, 1115 implementation guidance, the Medicaid Managed Care procurement process, ILOS guidance, and legislation to design and maximize the impacts of Food is Medicine programs. Finally, the section highlights how grants and infrastructure funding can support programs, including procurement of local food. A table of the state examples described below, the payment pathway used, and the state policy language is compiled in **Appendix B**.

### *Medicaid Section 1115 Demonstration Applications*

States can embed local food and other food system priorities in Medicaid policies, like their 1115 demonstration waivers. Among the thirteen states that have 1115 demonstrations in place for the provision of food and the three states that have requests pending as of June 2025,[170] Hawai'i is the first and only state that explicitly integrated local and community-based food sourcing values into its demonstration application.[171]

In January 2024, Hawai'i requested a five-year extension to its existing 1115 demonstration and sought new approval to provide nutrition supports, such as medically tailored meals and fruit and vegetable prescriptions.[172] CMS approved Hawai'i's 1115 demonstration request in January 2025.[173] Throughout its demonstration drafting process, Hawai'i gathered stakeholder feedback, including feedback from community-based organizations that were already providing nutrition services, prioritizing culturally appropriate foods, and collaborating with local farmers.[174] In addition to sourcing local foods, many of Hawai'i's nutrition service organizations are guided by "Pilinahā", which is a Native Hawaiian framework for health that emphasizes the connections to land, community, the past, and a better version of oneself in order to optimize health.[175] The demonstration's inclusion of local organizations has the potential to strengthen ongoing local programs as well as their proposed Food is Medicine initiative.[176] To build on and support the work of these programs, Hawai'i's request "encourage[d] the inclusion of local growers, community gardens, and other community-based organizations to support the purchase of locally grown food and strengthen Hawai'i's intrinsic food system."[177]

In addition to incorporating community input and values, Hawai'i's waiver amendment is conceptually aligned with its general procurement preference for foods produced in the state.[178] The state requires that, when selecting agricultural product contracts based on lowest prices, government agencies must discount bids for products raised, grown or harvested in Hawai'i by 15%.[179] This makes it more likely that government contracts select local food products. CMS's approval of Hawai'i's request to extend its 1115 demonstration did not specifically mention food systems values, as this priority does not come from CMS but rather from the state.[180] However, CMS's approval specifically confirmed that Hawai'i's determination of whether a service provider is qualified to provide Food is Medicine services could include consideration of its ability to provide culturally appropriate services, which could be demonstrated by the provider's "willingness and ability to draw on community-based values, traditions, and customs."[181]

## SPOTLIGHT: TRADITIONAL AND INDIGENOUS FOODS

American Indian and Alaska Native peoples have lower life expectancies (5.5 years less than the general U.S. population) and are disproportionately burdened by diet-related conditions.[182] For example, a study of 2009-2011 population data found that American Indian and Alaska Natives peoples are more than three times as likely to die from diabetes than other Americans.[183] These disparities may be attributed to "disproportionate poverty, discrimination in the delivery of health services, and cultural differences." [184]

Providing culturally appropriate foods in Food is Medicine programs can expand program benefits for the populations they serve. Integrating traditional and Indigenous foods into food and nutrition services for Native communities has been found to improve diet quality, quality of life, chronic disease risk, and participation in cultural practices.[185]

Recently, Food is Medicine programs at the federal and state levels have focused on integrating traditional and Indigenous foods in their services. The Indian Health Services Produce Prescription Pilot Program, launched in 2023, awarded about $2.5 million to five tribal organizations to decrease food insecurity and improve health outcomes through increased intake of fruits, vegetables and traditional foods, and the promotion of tribal food sovereignty.[186] Some awardees have included a focus on enhancing agricultural capacity and supporting agricultural production of traditional foods as part of their programs.[187]

While Native communities have expressed the desire for culturally appropriate foods in Food is Medicine programs, barriers remain in the procurement of such foods.[188] Community stakeholders report challenges including the lack of commodification of traditional foods, which causes difficulty in purchasing such foods even if the potential supply is plentiful.[189] Similarly, Native farmers report a lack of access to Indigenous seeds, plants, and production capacity.[190]

Federal programs, such as the USDA's Indigenous Food Sovereignty Initiative, seek to address these barriers.[191] For example, the Indigenous Animals Harvesting and Meat Processing Grant Program aims to support traditional harvesting methods of Indigenous animals,[192] and the Tribal Forest Protection Act directs funds to support forest restoration and access on Tribal lands, which can improve agricultural capacity of traditional crops, food access, and food security for Native communities.[193]

States have also started including pathways to fund traditional practices and Indigenous foods in medicine. On October 16, 2024, CMS approved state 1115 demonstrations in Arizona, California, New Mexico, and Oregon, to allow state Medicaid agencies in those states to cover traditional/Indigenous healthcare practices.[194] Because traditional practices vary widely, these waivers do not specify which practices are covered, instead leaving the door open to meet traditional healthcare needs, including through the use of traditional foods.

Colorado offers another state example. While Colorado's 1115 demonstration amendment,[195] approved in 2025,[196] did not mention local agricultural products, local economies, or community-based organizations,[197] its Department of Health committed to considering these values in subsequent implementation based on public comment.[198] Feedback gathered during the public comment period on Colorado's proposed 1115 demonstration amendment expressed concerns about outsourcing Food is Medicine services and sending state Medicaid funds out of state.[199] Several public comments suggested integrating local and community values by prioritizing community-based organizations to act as nutrition service providers, prioritizing local food procurement from small businesses, farms and food hubs, and using infrastructure funds to invest in value chain coordination and local procurement.[200] For example, commentors recommended that the state request infrastructure funding to: 1) invest in technical and operational support to connect Colorado producers to Food is Medicine providers, 2) form a partnership between the state Department of Agriculture and the state Department of Public Health and Environment to integrate existing state best practices, and 3) explore how existing partnerships and infrastructure, such as those developed through planning for the Local Food Purchasing Program and Community Food Access Program, could support Food is Medicine programs.[201] Such recommendations are in line with Colorado state procurement laws that require government entities to preference agricultural products produced in-state so long as the in-state product's quality is comparable to the out-of-state product, there is sufficient in-state supply, and the price does not unreasonably exceed the lowest out-of-state bid.[202]

As states seek CMS approval to provide Food is Medicine services such as produce prescriptions and medically tailored meals, they could consider incorporating state values, such as preferences for local food procurement or providers, in their 1115 demonstration applications.

### *Medicaid Section 1115 Demonstration Guidance*

States can also use implementation guidance to preference community-based organizations as Massachusetts and New York have done, or build on these examples to create preferences for the use of locally-produced food in Food is Medicine programs. Massachusetts's 1115 demonstration includes provisions for nutrition services, such as medically tailored meals and produce prescriptions, designed to meet a member's nutritional and dietary needs.[203] In its 2022 implementation guidance for its 1115 demonstration, Massachusetts encouraged Accountable Care Organizations (ACOs) to partner with community-based organizations to provide these services so as to "leverage existing community-based expertise and capacity."[204] ACOs are groups of healthcare providers who voluntarily coordinate care for their Medicaid patients in order to reduce medical errors and unnecessary services.[205] While Massachusetts ACOs have the autonomy to select service providers, they were required to consider the providers' capacity and cultural competency to provide care in accordance with members' needs.[206] For example, this guidance instructed ACOs to consider how service providers will provide culturally appropriate food options and meals.[207] Though Massachusetts's implementation guidance did not specifically mention local food systems, implementation guidance in the future or in other states could be even more specific in prioritizing the use of local foods or strengthening local economies.

In an effort to shape New York's implementation of its 1115 demonstration waiver, a wide array of stakeholder groups including healthcare providers and payers, government, community-based nutrition providers, retailers, Food is Medicine program participants, and agricultural producers, formed the "New York State Food as Medicine Project" to develop a set of recommendations to serve as a blueprint for the sustainable and equitable integration of Food is Medicine services into New York Medicaid.[208] The project advised the New York State Department of Health to adopt incentives for values-driven procurement practices that support and prioritize local economies, environmental sustainability, valued workforce, and small- and medium-sized family farms.[209] Further, it recommended that the Department of Health provide infrastructure funding for "local sourcing and values-based procurement."[210]

CMS approved the amendment of New York's 1115 demonstration waiver in January 2024 to allow for nutritional support services.[211] Though the above recommendations are not fully reflected in New York's guidance for the Social Care Networks leading the coordination of health-related social need services under the demonstration, New York has defined allowable providers as non-profit community-based organizations, and only in the absence of these providers may the services be provided by for-profit organizations.[212] This definition serves the state's goal that culturally competent services be provided by organizations that are representative of the communities of beneficiaries who need to be served.[213]

Regardless of whether states include local or community values in their 1115 demonstration applications, they have the opportunity to integrate their values into 1115 demonstration policy and guidance documents, as the above states have done. In doing so, they can build on existing community knowledge, food systems, and infrastructure to best serve local communities.

### *Medicaid Managed Care Plan Selection*

Most states have incorporated managed care into their Medicaid programs. For these states, the Medicaid Managed Care procurement process offers an opportunity to select health plans that align with statewide goals around nutrition, health equity, and local food systems.[214] By embedding food and nutrition priorities into contract requirements, states can help address food insecurity while also supporting local economies.

For example, Ohio's Medicaid Request for Applications required MCOs to support the state's efforts to reduce health disparities by "partnering with community-based organizations" and addressing social determinants of health, including "lack of access to nutritious food."[215] Additionally, Ohio mandates that MCOs reinvest a portion of their annual profits into the community.[216] This reinvestment—starting at 3% and increasing over time to a maximum of 5%—could be directed towards expanding access to locally grown produce and supporting regional food infrastructure.
Some health plans have proactively initiated strategies to guide their engagement with suppliers. For instance, Elevance Health's Supplier Code of Conduct outlines a commitment to sourcing from diverse vendors, including small, minority-, women-, and veteran-owned businesses, among others.[217] The Code also affirms Elevance's commitment to fair labor standards and human rights

across its supply chain.[218] These types of supplier standards allow health plans to distinguish themselves competitively as they bid for Medicaid Managed Care contracts.

By aligning procurement policies, reinvestment requirements, and supplier standards, states and MCOs have a powerful opportunity to advance Food is Medicine initiatives, strengthen regional food systems, and build values-based healthcare delivery networks.

### *In Lieu of Services and Settings (ILOS) Guidance*

States have flexibility in designing their ILOS guidance and can employ this guidance to accomplish specific state food systems values and goals within Food is Medicine programs. One way to do so is to provide guidance that encourages and prioritizes community engagement by requiring that Food is Medicine providers be locally-based or participating in the local food system. States such as Michigan and California have incorporated local values into their ILOS policy guidance, seizing an opportunity to advance their state's priorities.

Michigan is using ILOS to pay for nutrition services as part of its commitment to deliver "equitable, coordinated, and person centered care" to Michigan residents.[219] In approving nutrition-based ILOS, Michigan aspires to support local organizations that participate in the Michigan food economy and keep the provision of Food is Medicine services within the community.[220] In September 2024, the Michigan Department of Health and Human Services published new ILOS policy guidance for its four Food is Medicine interventions: medically tailored home delivered meals, healthy home delivered meals, healthy food packs, and produce prescriptions.[221] The policy guidance stipulates that providers of these Food is Medicine interventions must demonstrate experience and expertise in offering these specialized services and expresses a strong preference that providers be locally-based and actively engaged in the local food economy.[222] In contract year 2025, at least 30% of ILOS providers must be locally-based and this percentage will increase each year at yet-to-be-determined intervals.[223] Michigan defines "locally-based" to include community-based organizations that participate in the Michigan food economy and have a physical presence in Michigan (one or more offices in Michigan, preferably in the service region).[224]

Michigan's phased in approach acknowledges that it may not be possible, especially at the outset, to have an across-the-board requirement for local providers due to the limited availability of service providers in some locations. By building in a preference and a ramping-up period, Michigan's policies aim to create some balance and diversity in its Food is Medicine providers. Michigan is the first state to include explicit language around support for the local food economy and requirements regarding the use of locally-based providers through ILOS, providing an example for other states that wish to incorporate state values around local food procurement into their ILOS programming.

In a similar vein, California ILOS guidance published in July 2023 encouraged managed care plans to work with nontraditional partners, including local Food is Medicine providers, that have "an existing footprint in the communities they serve."[225] Though this language does not explicitly

mention local food systems, organizations with an existing community footprint may be more likely to have relationships with local producers and return economic investments to the communities where they are based.

**INVESTING IN COMMUNITY: LOCAL PROCUREMENT MODELS IN CALIFORNIA'S FOOD IS MEDICINE INITIATIVES**

An example of a non-profit community-based organization with an existing community footprint in the California Food is Medicine landscape is the Sonoma County-based Ceres Community Project. Since its inception in 2007 – long before California's nutrition supports waiver was introduced – Ceres Community Project, a medically tailored meal provider, has been sourcing local, organic foods and has emphasized building strong relationships with local vendors.[226] Through local food purchasing, Ceres Community Project is also investing in the local economies where its clients and their families live and work.

Alameda County Recipe4Health, a produce prescription program, is another example of a California-based Food is Medicine program embedded in its local community that has adopted a local purchasing model built upon partnerships with Black, Indigenous, and People of Color-owned or led farms and the use of regenerative and/or organic produce since 2019.[227]

Local food sourcing allows these programs to help support local economies. For instance, every dollar spent on agriculture in California generates an additional $1.56 for the state economy while every job created within the agricultural industry results in an additional 1.29 jobs in the state.[228]

For additional information on how two California Food is Medicine providers' food procurement operations embody their organizational and community values, see these case studies detailing the efforts of Ceres Community Project and Recipe4Health.[229]

As seen in Michigan and California, states have flexibility in designing their ILOS guidance and can employ this guidance to accomplish specific state values and goals within Food is Medicine procurement.

### *Medicaid Reimbursement Rates for Nutrition Services*

In setting reimbursement rates for nutrition services, states should consider the actual costs to local providers, the production methods and quality of the products, and other relevant factors that enable Food is Medicine programs to source foods that align with state values. To comply with federal law, states must ensure provider compensation is "consistent with efficiency, economy, and quality" and payments must be sufficient to ensure that Medicaid beneficiaries have similar access to care and services as other members of their community.[230]

For example, Massachusetts's 1115 demonstration, known as MassHealth Health Related Social Needs Services (HRSN), provides a detailed breakdown of reimbursement rates for covered

nutrition interventions, which can be reimbursed up to 125% of expected costs.[231] The state buffered expected costs "to allow for variation in costs over time and across geographies."[232] For medically tailored home delivered meals, the program anticipates a per meal cost of $14.86, but reimburses up to $18.58 per meal.[233] Massachusetts offers, on average, a higher reimbursement rate in accordance with the significantly higher costs of living as compared to other states.[234] When rate setting for Food is Medicine programs, states could potentially go one step further to signal values within their fee schedules by specifying food purchasing preferences and reimbursement rates that incentivize quality food purchasing aligned with state values. For example, states could set higher rates for locally-produced foods or food produced using organic or regenerative production practices while still allowing for other variations in costs as Massachusetts has done. Such an approach would recognize that higher investments in food purchases also come with measurably higher returns to the state in the form of reduced long-term healthcare, environmental, and other external costs.[235]

### *Legislative Directives*

Legislatures looking to advance local economies and state values can do so by designating how state funding must be used within procurement of Food is Medicine services. Building on the success of California's Advancing and Innovating Medi-Cal initiative (CalAIM), the California legislature has been advancing legislation to make Food is Medicine interventions a fully covered benefit for its Medicaid participants, rather than an optional service. California's Assembly Bill 1975 would have encouraged sourcing from small-to-medium-sized farms, beginning farmers, or socially disadvantaged producers, and those employing regenerative, organic, or other climate-smart practices and established a working group to advise the State Department of Health Care Services regarding implementation.[236] The bill, which passed in the legislature in September 2024 but was vetoed by the Governor, would have established a working group to advise the State Department of Health Care Services on the development of guidance to make this transition a reality, including guidance on permitted and preferred Food is Medicine providers, values-based procurement, and equitable food sourcing.[237]

In Oklahoma, legislators in the 2025 session passed a bill to direct the state's Health Care Authority to seek federal approval to provide coverage for nutrition interventions.[238] At the behest of concerned stakeholders, the bill text was amended to add language directing the Health Care Authority and any entities it contracts with for the provision of Medicaid services to "prioritize the inclusion of community-based organizations and local growers to support the purchase of locally grown food in nutrition prescriptions" whenever feasible.[239] Other states could consider similar legislation to ensure that their state Medicaid agency implements Food is Medicine programs consistent with the state's food system priorities.

As demonstrated in Oklahoma, engaged stakeholders and strong coalitions are key to identifying and advancing local values that strengthen Food is Medicine initiatives. Launched in 2023, the Oklahoma Food is Medicine Coalition is led by representatives from the Oklahoma State Department of Health, FreshRx Oklahoma, and Hunger Free Oklahoma.[240] The more than 100

groups that participate in the coalition represent the wide diversity of stakeholders invested in the development of Oklahoma's Food is Medicine programs, including all three of the state's contracted Medicaid Managed Care plans. The coalition's mission and goals identify local food sourcing as priority,[241] a value which, with their support, was reflected in the enacted Oklahoma legislation directing the Health Care Authority to seek approval to cover nutrition services.

### *Infrastructure Funding and Grants*

One of the key challenges of integrating Food is Medicine programs into Medicaid is building the infrastructure and capacity of community-based organizations to provide these services. Historically, philanthropic donations and grants funded many of the services provided by community-based organizations. However, these funding streams can be resource-intensive, limited in duration, and uncertainty regarding future funding limits the ability of programs to scale their services. To address these challenges, many Medicaid 1115 demonstrations have included funding for infrastructure and capacity building for community-based Food is Medicine providers, health insurance plans, and other stakeholders. As described below, some states are planning to use a portion of these infrastructure investments for equipment and cold storage that facilitates the distribution of fresh, local foods. Grants have and can continue to advance food systems values, with some notable examples of federal funding for Food is Medicine programs highlighted below.

CMS allows four types of infrastructure investments to support the implementation and scaling of initiatives: technology, business and operations development, workforce development, and education and outreach.[242] Plans and protocols for the expenditure of infrastructure funds must be approved by CMS and are subject to monitoring and evaluation consistent with Section 1115 demonstrations.[243] Through California's PATH CITED initiative, the state is using $1.85 billion in infrastructure funding to build the operational capacity of organizations to participate in California's Food is Medicine programs.[244] The state allocates infrastructure funds directly to community-based organizations, government agencies, Federally Qualified Health Centers, and other organizations.[245] These investments have expanded the availability and use of nutrition supports providers.[246] An illustrative list of how California's CITED funds can be used includes modifications to physical infrastructure, like cold storage.[247] Increased capacity to store fresh local foods supports both local agriculture and nutritional health programs. Oregon is also planning to allocate infrastructure funds for the purchase of commercial refrigerators to expand program capacity.[248]

Still, many community-based organizations continue to rely on public and private grant funding to implement and sustain their Food is Medicine programs, even with growing access to more sustainable funding streams, such as those discussed above. Some of these grants incorporate one or more values-based factors, including the use of locally or regionally produced foods, into their evaluation criteria for applicants.

The primary source of federal grant funding for one category of Food is Medicine programs—produce prescription programs—is the Gus Schumacher Nutrition Incentive Program (GusNIP), overseen by the USDA.[249] Within GusNIP, the Produce Prescription Program funds projects that

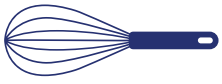
demonstrate and evaluate the impact of produce prescriptions on improving dietary health, reducing food insecurity, and decreasing the use and cost of healthcare.[250] The statute authorizing the program requires the prioritization of projects based on a set of criteria, including whether the program provides "locally or regionally produced fruits and vegetables" and has "demonstrated the ability to provide services to underserved communities."[251]

The USDA, acting through the Secretary of Agriculture, can establish additional criteria for assessing and prioritizing GusNIP grant applications.[252] In 2024, produce prescription grant applicants were encouraged to meet the program's goals and priorities by tapping into "Traditional Ecological Knowledge in collaboration and consultation with Tribal Nations and Indigenous Peoples" and to highlight how proposed projects would exemplify "high quality community food security work."[253] Projects that "emphasize food and nutrition security, nutritional quality, environmental stewardship (e.g., food loss and waste, climate), culturally sensitive food and/or food practices, and economic and social equity" qualified as "high quality community food security work."[254] Mention of this criteria was embedded in the assessment of an applicant's plan for evaluating its project, including its ability to share project results coming out of their "high quality community food security work."[255]

Other USDA grants, while not explicitly tailored to Food is Medicine, can and have been leveraged to bolster such programs by aligning the procurement of food within the program with the values the grant targets. One example is the Local Food Promotion Program (LFPP), which supports the development, coordination, and expansion of local and regional food businesses, like food hubs, that connect consumers to locally and regionally produced agricultural products.[256] The Farmer's Food as Medicine program, established by the Public Health Alliance of Southern California, is an example of a LFPP-funded Food is Medicine program.[257] Farmer's Food as Medicine is using LFPP funding to link small farms, many of which are run by socially disadvantaged producers, with healthcare institutions to supply medically supportive food through Foodshed, a farmer-owned cooperative that aggregates and distributes local foods.[258]

In summary, Medicaid 1115 demonstration infrastructure funding can be used to build providers' capacity to procure, store, and distribute local foods through investments in technology, business and operations, and workforce development. Grants and other funding supporting Food is Medicine programs often consider food systems values when developing and evaluating proposed projects. Government entities and other funders wishing to maximize impact on community health outcomes, in addition to individual patient outcomes, can integrate food sourcing requirements tailored to those goals or provide the flexibility to use funding for such purposes.

## RECOMMENDATIONS FOR STATES AND COMMUNITY PARTNERS



As interest in Food is Medicine interventions grows, states and communities have a strategic opportunity to integrate local food systems goals into these programs. Aligning nutrition services

with regional agricultural and food system priorities can support producers and stimulate local economies, while improving public health. Drawing on examples from state Medicaid policies and community-based initiatives, such as those described above, presented below are actionable recommendations for state policymakers and Food is Medicine providers to support locally grounded program design and implementation.

## What Should State Policymakers Do?

- **Map and Mobilize Existing Assets:** Inventory state-level infrastructure, like food hubs, community-based organizations with food sourcing capacity, and grant programs that can serve as platforms for expanded local procurement within Food is Medicine interventions, and help matchmake to connect Food is Medicine providers with these resources. Understanding existing assets also helps identify resource gaps which may need targeted funding and support.
- **Audit and Align Procurement Policies:** Understand any relevant state-level procurement preferences—such as local sourcing mandates or supplier diversity requirements—to see if these apply to Food is Medicine programs in your state, or use them where possible to guide policy design and vendor selection within Food is Medicine programs. Connect Food is Medicine initiatives with state sustainability efforts, economic development, and health equity for broader impact and buy-in.
- **Leverage Medicaid Flexibilities:** Regardless of which Medicaid coverage pathway or pathways your state uses to provide coverage for Food is Medicine interventions, at each stage of the process consider which policy levers can be used to support the sourcing of nutrition services consistent with community and local food system priorities. The examples below illustrate a range of strategies that have been used by states across Medicaid coverage pathways.
    - **Embed local food priorities in Medicaid policies** as Hawai'i did in its 1115 demonstration waiver application when it identified its intent to source Food is Medicine interventions that support "the purchase of locally grown food" and strengthen the state's "intrinsic food system."[259] In Oklahoma, the legislature directed the state Medicaid agency to seek federal approval for Food is Medicine coverage under Medicaid—explicitly instructing health agencies and contractors to "prioritize the inclusion of community-based organizations and local growers" in delivering nutrition interventions, when feasible.[260]
    - **Use implementation guidance to elevate local food and community-based organizations** as Michigan did in its ILOS policy guidance that prioritizes local engagement by requiring that Food is Medicine providers demonstrate community ties and mandating that at least 30% of services be locally-based and rooted in the state's food economy.[261] Though Massachusetts's and New York's implementation guidance does not mention local food systems, both states offer examples of guidance that prioritizes community-based providers. Massachusetts's Flexible

Services Program guidance encouraged partnerships that "leverage existing community-based expertise and capacity."[262] In its guidance to the lead entities coordinating health related social needs services, like Food is Medicine interventions, New York articulated its intent that services be provided primarily by community-based non-profit organizations and only in the absence of such providers may services be provided by for-profit entities.[263] Such guidance provides potential models for states to build upon in order to more specifically prioritize local producers.

- **Require alignment with local values in Medicaid contracting** as Ohio did when it mandated that Medicaid Managed Care plans partner with community-based organizations to increase access to nutritious foods and reinvest a percentage of their annual profits back into the community.[264]
- **Align reimbursement rates with true costs of local food** and consider using fee schedules to promote state values around food sourcing and quality. To support providers and account for regional cost differences, Massachusetts reimburses covered nutrition interventions at up to 125% of expected costs (accommodating for regional differences and fluctuations in costs over time), with rates designed to reflect the higher cost of living in the state relative to others.[265] When setting rates for Food is Medicine programs, states can expand on Massachusetts's approach by using fee schedules to encourage local and sustainable food sourcing. For example, higher reimbursement rates for locally produced, organic or regenerative foods can incentivize providers and demonstrate the state's support for local producers, economies, and food systems.
- **Invest in local Food is Medicine infrastructure** as California and Oregon are doing with their 1115 demonstration infrastructure funding which can be used for cold storage, making it easier to source, store, and distribute fresh, local food.[266]

Appendix B summarizes the various policy levers that states have used to integrate local food and community-based organizations into their Food is Medicine initiatives and includes examples of the policy language used by states.

- **Form Cross-Sector Collaborations to Set Food Systems Priorities:** State Medicaid agencies should partner with state departments of agriculture, local producers, community-based organizations that provide nutrition supports, healthcare providers, plans, and advocates to define shared goals and build partnerships that that incorporate local food system needs and values. Such collaborations can also be useful in identifying additional strategies to support local food sourcing, such as the need for flexible payment arrangements (e.g., advance payments), technical assistance, or dedicated funding to support local food procurement.

## What Can Food is Medicine Providers Do?

- **Infuse Local Values into Food Sourcing:** Embed organizational and community values into program procurement practices and menu development. Organizations that are working to

address nutrition insecurity can reinvest wealth into their communities by sourcing locally, strengthening local economic conditions. Prioritizing organic and regeneratively grown products can support community or state goals around sustainable agricultural and public health by reducing exposure to environmental chemicals, such as pesticides, herbicides, and insecticides.

- **Strengthen Ties with Local Producers:** Build direct purchasing relationships with farmers and regional suppliers to keep food dollars circulating locally and support regional food system resilience. Have conversations with regional producers to understand their capabilities and what they need to collaborate with Food is Medicine programs. Help producers plan ahead by discussing anticipated product needs for the following year, and consider forward contracts that specify the types and quantities of products to be purchased and agreed-upon prices.
- **Utilize Food Hubs and Aggregators:** Work with food hubs that source, aggregate, and distribute foods aligned with state or local values to meet the nutrition and operational needs of your programs. Food hubs can help reduce administrative and logistical burdens by aggregating products from smaller producers to meet demand and by providing transportation, storage, and packaging services.
- **Measure and Communicate Impact:** Track contributions to the local food economy—through job creation, farm viability, and environmental benefits—and quantify the multiplier effect of local food purchases.
- **Tell the Story of Community Impact:** Share how institutional partnerships, bulk purchasing, and stable markets improve farmer sustainability, diversify crops, and expand healthy food access.
- **Build Coalitions and Collective Power:** Join or convene local coalitions to strengthen advocacy, shape Medicaid Food is Medicine procurement goals and requirements, and expand access to nutrition interventions grounded in community values.
- **Engage in Policy Development:** Submit public comments and meet with state Medicaid agency representatives to advocate for prioritizing community-based organizations, small farms, and local and regional food suppliers in program design. Engage with state legislators to ensure that legislation related to Food is Medicine services requires Medicaid agencies to use funding in ways that advance local economies and food systems.

By leveraging Medicaid flexibilities, existing procurement policies, local values, and community-based partnerships, states can create sustainable models that connect healthcare and food systems. Strategic investments in infrastructure, technical assistance, and cross-sector capacity will be essential to sustain and scale these efforts. With coordinated leadership and intentional policy design, Food is Medicine programs can not only improve health outcomes but also strengthen regional food systems to create lasting, place-based value.

## CONCLUSION

While there is established precedent for considering values beyond cost in state procurement of goods and services, many states are just beginning to apply this lens to Food is Medicine programs as a tool to improve population health and reduce health disparities, all while investing in local producers and building more resilient food systems. The state policy examples highlighted above show how Medicaid flexibilities, procurement policies, and community engagement requirements can be leveraged to align interventions with broader goals such as economic development.

By embedding local values into Food is Medicine procurement, states can create a coordinated approach that empowers community providers, supports diversified and regionally adapted agriculture, and expands access to nutrient-dense foods—improving health outcomes while strengthening local economies. Policymakers can take actionable steps such as forming cross-sector food system partnerships, aligning procurement rules and preferences for Food is Medicine programs, and directing resources towards locally sourced, culturally relevant nutrition interventions. Food is Medicine providers can advance this work by building relationships with local producers, documenting the economic and health impacts of their efforts, and participating in policy development.

Through intentional design and investment, states have a powerful opportunity to shape Food is Medicine programs that improve clinical outcomes and strengthen local and regional food systems—delivering measurable benefits for both people and the places they live.

# APPENDIX A (STATE PROCUREMENT PREFERENCES TABLE)

## ALABAMA

**Statute** | None

## ALASKA

| Statute / Name of Statute | Type of Preference / Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|
| **Statute** \| Alaska Stat. § 36.15.050<br>**Name of Statute** \| Use of local agricultural and fisheries products required in purchases with state money | **Type of Preference** \| Mandatory<br>**Details of Preference** \| 7%<br>**Type of Preference** \| Discretionary<br>**Details of Preference** \| Up to 15% | Agricultural and fisheries products | State agencies or school districts receiving state funds |

**Additional Information**

Solicitations for purchases must include preference for in-state products. If not, must certify in writing why in-state products were not purchased. State money can be witheld for non-compliance.

## ARIZONA

**Statute** | None

## ARKANSAS

| Statute / Name of Statute | Type of Preference / Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|
| **Statute** \| Ark. Code Ann. § 15-4-3804<br>**Name of Statute** \| Procurement Goal - Distributor requirements | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 20% of agency's purchases of food products should be spent on local farm or food products | Farm or food products | Agencies that receive at least $25,000 from the state and offer a food service program |
| **Statute** \| Ark. Admin. Code 006.27.3-R1:15-4-3804<br>**Name of Statute** \| Procurement goal - Preference | **Type of Preference** \| Mandatory<br>**Details of Preference** \| Lowest bid is only accepted if it does not exceed lowest bid from provider of local food/farm products by more than 10% and the lowest bid is not a provider of local food/farm products | Local farm or food products | Agencies that receive at least $25,000 from the state and offer a food service program |

# CALIFORNIA

| | | | |
|---|---|---|---|
| **Statute \| Cal. Gov't Code § 4331**<br>**Name of Statute \| Preference to supplies manufactured or produced in state** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| Price, fitness, and quality being equal | **What is Covered**<br>Goods | **Who is Covered**<br>State, state institutions, state offices, counties, and cities |

**Additional Information**

Not applicable to educational agencies

| | | | |
|---|---|---|---|
| **Statute \| Cal. Food & Agric. Code § 58595**<br>**Name of Statute \| Solicitation of bids; acceptance** | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 60% by December 31, 2025 | **What is Covered**<br>Agricultural food products | **Who is Covered**<br>State-owned or state-run institution |

# COLORADO

| | | | |
|---|---|---|---|
| **Statute \| Colo. Rev. Stat. § 24-103-907**<br>**Name of Statute \| Preference for state agricultural products** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| Quality must be comparable to out of state products, available in adequate quantity, suitable for the use required by the purchasing entity, and the resident bidder's bid/price does not exceed the lowest bid or "reasonably" exceeds the lowest bid for products produced outside the state | **What is Covered**<br>Agricultural products | **Who is Covered**<br>Governmental bodies |

# CONNECTICUT

| | | | |
|---|---|---|---|
| **Statute \| Conn. Gen. Stat. § 4a-51**<br>**Name of Statute \| Duties of Administrative Services Commissioner re purchases** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| When comparable in cost | **What is Covered**<br>Dairy products, poultry, eggs, beef, pork, lamb, farm-raised fish, fruits or vegetables | **Who is Covered**<br>Commissioner of Administrative Services (manages state procurement) |

# DELAWARE

**Statute | 19 Del. Admin. Code § 4106-11.0**

**Name of Statute | Agricultural Products**

**Type of Preference** | Environmental Impact

**Details of Preference** | Purchases over $100,000 shall consider environmental impact.

**What is Covered**

Agricultural Products

**Who is Covered**

State agencies

**Type of Preference** | Environmental Impact

**Details of Preference** | Purchases under $100,000 require 3 quotes from local distributors, one must be within 25 miles to reduce the impact of transportation to market and use of fossil fuels.

**What is Covered**

Agricultural Products

**Who is Covered**

State agencies

**Additional Information**

Up to 10% of total points awarded or costs of goods for consideration of reduced fuel consumed to reach market/Agency recipient and products provided by agricultural businesses which are certified for Best Management Practices, Good Food Handling Practices and Good Agricultural Practices through the Delaware Department of Agriculture or surrounding State's equivalent program.

# DISTRICT OF COLUMBIA

**Statute** | None

# FLORIDA

**Statute | Fla. Stat. § 287.082**

**Name of Statute | Commodities manufactured, grown, or produced in state given preference**

**Type of Preference** | Tie-breaker

**Details of Preference** | Equal with respect to price, quality, and service

**What is Covered**

Commodities

**Who is Covered**

State agencies

**Additional Information**

Not applicable to state universities and colleges

# GEORGIA

| | | | |
|---|---|---|---|
| **Statute \| Ga. Code Ann. § 50-5-60**<br>**Name of Statute \| Preference of products produced in Georgia; vendor preference** | **Type of Preference** \| Reasonableness<br>**Details of Preference** \| When reasonable and practicable, so long as quality is not sacrificed | **What is Covered**<br>Agricultural products, excluding beverages for immediate consumption | **Who is Covered**<br>The state and any of its departments, agencies, or commissions |
| **Statute \| Ga. Code Ann. § 36-84-1**<br>**Name of Statute \| Preferences for products manufactured in Georgia; reasonableness** | **Type of Preference** \| Reasonableness<br>**Details of Preference** \| When reasonable and practicable, so long as quality is not sacrificed | **What is Covered**<br>Agricultural products, excluding beverages for immediate consumption | **Who is Covered**<br>Local governments, meaning county, municipality, or consolidated government |

# HAWAII

| | | | |
|---|---|---|---|
| **Statute \| Haw. Rev. Stat. § 103D-1002**<br>**Name of Statute \| Hawaii products** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| 15% | **What is Covered**<br>Class II products, defined as any agricultural, aquacultural, horticultural, silvicultural, floricultural, or livestock product is raised, grown, or harvested in the State | **Who is Covered**<br>Governmental agencies |

# IDAHO

| | | | |
|---|---|---|---|
| **Statute \| Idaho Code § 67-9210**<br>**Name of Statute \| Award of Contract** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| When bids and quality are the same | **What is Covered**<br>Goods | **Who is Covered**<br>State agencies |

# ILLINOIS

| | | | |
|---|---|---|---|
| **Statute \| 130 Ill. Comp. Stat. 500/45-50**<br>**Name of Statute \| Illinois agricultural products** | **Type of Preference** \| Discretionary<br>**Details of Preference** \| Preference may be given to otherwise qualified bidder using in-state agricultural products | **What is Covered**<br>Agricultural Products | **Who is Covered**<br>State agencies |
| **Statute \| 30 Ill. Comp. Stat. 595/10**<br>**Name of Statute \| Procurement goals for local farm or food products** | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 20% by 2020 | **What is Covered**<br>Farm or food products | **Who is Covered**<br>State agencies and State-owned facilities |
| | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 10% by 2020 | **What is Covered**<br>Farm or food products | **Who is Covered**<br>Public schools, child care facilities, after-school programs and hospitals who are funded by State dollars and who spend more than $25,000 per year on farm or food products |

# INDIANA

| | | | |
|---|---|---|---|
| **Statute \| Ind. Code § 5-22-15-23.5**<br>**Name of Statute \| Price preference for Indiana agricultural products** | **Type of Preference** \| Discretionary<br>**Details of Preference** \| Up to 10% | **What is Covered**<br>Agricultural products | **Who is Covered**<br>Governmental bodies and instrumentalities of the state performing governmental functions |

# IOWA

| | | | |
|---|---|---|---|
| **Statute \| Iowa Code § 73.1**<br>**Name of Statute \| Preference - conditions** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| When found in marketable quantities in the state, are of a quality reasonably suited to the purpose intended, and can be secured without additional cost | **What is Covered**<br>Products | **Who is Covered**<br>Commission, board, committee, officer, or other governing body of the state, or of any county, township, school district or city |

**Additional Information**

Not applicable to a school district purchasing food while the school district is participating in the federal school lunch or breakfast program

# KANSAS

**Statute** | None

# KENTUCKY

| | | | |
|---|---|---|---|
| **Statute \| Ky. Rev. Stat. Ann § 45A.645**<br>**Name of Statute \| Agencies to purchase Kentucky-grown products meeting quality standards and pricing requirements if available - Reports - Marketing assistance - Annual report - Vendors' duties.** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| If the products are available and if the vendor can meet the applicable quality standards and pricing requirements of the state agency | **What is Covered**<br>Agricultural products | **Who is Covered**<br>State agencies |

# LOUISIANA

| | | | |
|---|---|---|---|
| **Statute \| La. Stat. Ann. § 38:2251**<br>**Name of Statute \| Preference for products produced or manufactured in Louisiana; exceptions** | **Type of Preference** \| Discretionary<br>**Details of Preference** \| Up to 10% | **What is Covered**<br>Meat, seafood, produce, eggs | **Who is Covered**<br>Each procurement officer, purchasing agent, or similar official |
| | **Type of Preference** \| Discretionary<br>**Details of Preference** \| Up to 7% | **What is Covered**<br>Meat and meat products processed in-state<br>Domesticated or wild catfish processed in-state but grown outside<br>Produce processed in-state but grown outside<br>Food or food products | **Who is Covered**<br>Each procurement officer, purchasing agent, or similar official |

# MAINE

| | | | |
|---|---|---|---|
| **Statute \| Me. Stat. tit. 7 § 214-A**<br>**Name of Statute \| Maine foods procurement program** | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 20% by 2025 | **What is Covered**<br>Food or food products | **Who is Covered**<br>State institutions |
| **Statute \| Me. Stat. tit. 7 § 219**<br>**Name of Statute \| Food self-sufficiency** | **Type of Preference** \| Discretionary<br>**Details of Preference** \| If an emergency or supplemental food program for elderly or low-income persons, shall purchase in-state products to the extent practicable | **What is Covered**<br>Food | **Who is Covered**<br>State institutions |

# MARYLAND

| | | | |
|---|---|---|---|
| **Statute \| Md. Code Ann., State Fin. & Proc. § 14-407**<br>**Name of Statute \| Percentage price preference for locally grown foods** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| Required to establish a percentage price preference | **What is Covered**<br>Food | **Who is Covered**<br>State schools and facilities |
| | **Type of Preference** \| Discretionary<br>**Details of Preference** \| Up to 5% | **What is Covered**<br>Food | **Who is Covered**<br>State schools and facilities |
| **Statute \| Md. Code, State Fin. & Proc. § 14-703**<br>**Name of Statute \| Procurement procedures** | **Type of Preference** \| Benchmark<br>**Details of Preference** \| 20% of total dollar value of procurement contracts for food from certified local farms and certified Chesapeake invasive species providers | **What is Covered**<br>Food | **Who is Covered**<br>Office for the Certified Local Farm and Fish Program, Maryland Department of Agriculture |

# MASSACHUSETTS

| | | | |
|---|---|---|---|
| **Statute \| Mass. Gen. Laws ch. 7, § 23B**<br>**Name of Statute \| Preference for Massachusetts farm products** | **Type of Preference** \| Mandatory<br>**Details of Preference** \| 10% | **What is Covered**<br>Agricultural products | **Who is Covered**<br>A state agency, authority or trustees or officers of a state college or university |

# MICHIGAN

**Statute** \| None

# MINNESOTA

| | | | |
|---|---|---|---|
| **Statute \| Minn. Stat. § 16C.12**<br>**Name of Statute \| Agricultural Food Products Grown in State** | **Type of Preference** \| Reasonableness<br>**Details of Preference** \| Encourage and make a reasonable attempt to identify and purchase food products grown in the state | **What is Covered**<br>Agricultural products | **Who is Covered**<br>State agencies |

# MISSISSIPPI

**Statute | Miss. Code Ann. § 31-7-15**

**Name of Statute | Preferences for awarding contracts for commodities; procurement of products made from recovered materials; state agencies to purchase products manufactured or sold by Mississippi Industries for the Blind whenever economically feasible**

**Type of Preference** | Tie-breaker

**Details of Preference** | When equal with respect to price, quality and service

**What is Covered**

Commodities

**Who is Covered**

State agencies

# MISSOURI

**Statute | Mo. Rev. Stat. § 34.07**

**Name of Statute | Preference to Missouri products and firms**

**Type of Preference** | Tie-breaker

**Details of Preference** | When quality is equal or better and price is the same or less, or whenever competing bids, in their entirety, are comparable

**What is Covered**

Commodities

**Who is Covered**

Any agent of the state or the commissioner of administration

# MONTANA

**Statute | Mont. Code Ann. § 18-4-132**

**Name of Statute | Application**

**Type of Preference** | Reasonableness

**Details of Preference** | Available in adequate quantity, meets acceptable quality standards, and the price does not exceed or reasonably exceeds the price of food products produced outside the state

**What is Covered**

Food products

**Who is Covered**

The department

**Additional Information**

A bid reasonably exceeds the lowest bid or price quoted when, in the discretion of the person charged by law with the duty to purchase food products for a governmental body, the higher bid is reasonable and capable of being paid out of that governmental body's existing budget without further supplemental or additional appropriation.

# NEBRASKA

**Statute** | None

# NEVADA

**Statute | Nev. Rev. Stat. § 333.3354**

**Name of Statute | Preference for bid or proposal submitted by Nevada-based business: Amount of preferences**

**Type of Preference** | Mandatory

**Details of Preference** | 5% when the majority of goods are produced in state

**What is Covered**

Commodities

**Who is Covered**

State agencies

# NEW HAMPSHIRE

**Statute** | None

# NEW JERSEY

**Statute | N.J. Stat. Ann. § 52:32-1.6**

**Name of Statute | Review, modification of bid, product specifications relative to "Jersey Fresh," "Jersey Grown," "Made with Jersey Fresh" products or commodities; enhanced visibility; rules, regulations**

**Type of Preference** | Discretionary

**Details of Preference** | Preference for "Jersey Fresh," "Jersey Grown," other agricultural food products and commodities grown or raised in New Jersey, and "Made With Jersey Fresh" baked goods or other food products baked or made with "Jersey Fresh" products unless cost is unreasonable

**What is Covered**

Agricultural or horticultural products, commodities, or goods

**Who is Covered**

Agencies and departments of the State government, county, municipality or school district

# NEW MEXICO

**Statute** | None

# NEW YORK

**Statute | N.Y. State Fin. Law § 165**

**Name of Statute | Purchasing restrictions**

**Type of Preference** | Discretionary

**Details of Preference** | Gives agencies the authority to require all or some food products be in-state, but can also opt not to do so

**What is Covered**

Food products

**Who is Covered**

The office of general services and any other agency, department, office, board or commission

# NORTH CAROLINA

| Statute | Name of Statute | Type of Preference | Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|---|---|
| N.C. Gen. Stat. § 143-59 | Preference given to North Carolina products and citizens, and articles manufactured by State agencies; reciprocal preferences | Tie-breaker | So long as there is no sacrifice or loss in price or quality | Food or other products | Secretary of Administration and any state agency |

# NORTH DAKOTA

**Statute** | None

# OHIO

| Statute | Name of Statute | Type of Preference | Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|---|---|
| Ohio Admin. Code 123:5-1-06 | Ohio preferences | Mandatory | 2% | Products raised, grown, produced, mined or manufactured in Ohio or a border state | State agencies |

# OKLAHOMA

| Statute | Name of Statute | Type of Preference | Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|---|---|
| Okla. Stat. Tit. 74 § 85.17A | Bidding preferences - Reciprocity - Awarding contracts. | Tie-breaker | When price, fitness, availability, and quality are otherwise equal | Goods | State agencies |

# OREGON

| Statute | Name of Statute | Type of Preference | Details of Preference | What is Covered | Who is Covered |
|---|---|---|---|---|---|
| Or. Rev. Stat. § 279A.128 | Preference for goods fabricated or processed within state or services performed within state. | Discretionary | Up to 10% and above 10% with written findings of good cause for setting a higher preference | Goods that are fabricated or processed in state | A contracting agency that uses public funds |

## PENNSLYVANIA

**Statute | 4 Pa. Code § 7a.41**

**Name of Statute | Commonwealth agency purchases**

**Type of Preference** | Discretionary

**Details of Preference** | When available at competitive prices and so as to not trigger reciprocal preference laws

**What is Covered**

Agricultural products

**Who is Covered**

All agencies under the jurisdiction of the Governor

## RHODE ISLAND

**Statute | R.I. Gen. Laws § 37-2-8**

**Name of Statute | Rhode Island foodstuffs**

**Type of Preference** | Mandatory

**Details of Preference** | When available and of good quality, must purchase them at the prevailing market price

**What is Covered**

Food

**Who is Covered**

State governmental entities and public agencies

## SOUTH CAROLINA

**Statute | S.C. Code Ann. § 11-35-1524**

**Name of Statute | Resident vendor preference**

**Type of Preference** | Mandatory

**Details of Preference** | 7%

**What is Covered**

South Carolina end product, defined as a product made, manufactured, or grown in South Carolina

**Who is Covered**

State procurement officers

## SOUTH DAKOTA

**Statute** | None

# TENNESSEE

| | | | |
|---|---|---|---|
| **Statute \| Tenn. Code Ann. § 12-3-1113**<br>**Name of Statute \| Preference to goods produced or grown in this state, including agricultural products** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| When all other factors are equal | **What is Covered**<br>Goods and agricultural products | **Who is Covered**<br>All departments and agencies |
| **Statute \| Tenn. Code Ann. § 12-3-1108**<br>**Name of Statute \| Tennessee meat producers; purchasing preference; departments, agencies and institutions** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| So long as the terms, conditions and quality are equal to those obtainable from producers located elsewhere | **What is Covered**<br>Meat, meat food products, meat by-products | **Who is Covered**<br>All departments, agencies and institutions of state government using state funds |

# TEXAS

| | | | |
|---|---|---|---|
| **Statute \| Tex. Gov't. Code Ann. § 2155.444**<br>**Name of Statute \| Preference to Texas and United States Products and Texas Services** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| If the cost to the state and quality are equal | **What is Covered**<br>Agricultural products | **Who is Covered**<br>Comptroller and all state agencies |

# UTAH

| | | | |
|---|---|---|---|
| **Statute \| Utah Code Ann. § 63G-6a-1002**<br>**Name of Statute \| Reciprocal preference for providers of state products** | **Type of Preference** \| Reciprocal<br>**Details of Preference** \| Applies preference of any state that gives a preference to items produced, manufactured, or grown in that state | **What is Covered**<br>Items produced, manufactured or grown | **Who is Covered**<br>State, its agencies, departments, instrumentalities, and institutions |

# VERMONT

| | | | |
|---|---|---|---|
| **Statute \| Vt. Stat. Ann. tit. 29, § 909**<br>**Name of Statute \| State purchase of food and agricultural products** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| Other considerations being equal and considering the results of any econometric analysis conducted | **What is Covered**<br>Food and agricultural products | **Who is Covered**<br>Secretary of Administration, Commissioner of Buildings and General Services, and any state-funded institutions |

# VIRGINIA

| | | | |
|---|---|---|---|
| **Statute \| Va. Code Ann. § 2.2-4328**<br>**Name of Statute \| Preference for local products and firms; applicability** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| Preference to goods produced in Virginia | **What is Covered**<br>Goods | **Who is Covered**<br>Governing body of a county, city or town |
| **Statute \| Va. Code Ann. § 2.2-4324**<br>**Name of Statute \| Preference for Virginia goods, U.S. goods, and Virginia residents** | **Type of Preference** \| Tie-breaker<br>**Details of Preference** \| So long as the terms, conditions and quality are equal to those obtainable from producers located elsewhere | **What is Covered**<br>Goods | **Who is Covered**<br>Public bodies |

# WASHINGTON

| | | | |
|---|---|---|---|
| **Statute \| Wash. Rev. Code § 39.26.260**<br>**Name of Statute \| Preferences—In-state procurement** | **Type of Preference** \| Reciprocal preference<br>**Details of Preference** \| Applies preference of other states with in-state preference | **What is Covered**<br>Goods | **Who is Covered**<br>State agencies |

# WEST VIRGINIA

| | | | |
|---|---|---|---|
| **Statute \| W. Va. Code § 19-37-2**<br>**Name of Statute \| State-funded institutions to purchase food from in-state sources; exception** | **Type of Preference** \| Benchmark<br>**Details of Preference** \| Minimum of 5% | **What is Covered**<br>Fresh produce, meat and poultry products, milk and other dairy products, and other foods grown, produced, or processed by in-state producers | **Who is Covered**<br>Each state-funded institution, including, but not limited to, schools, colleges, correctional facilities, governmental agencies, and state parks |

# WISCONSIN

**Statute** | None

# WYOMING

| | | | |
|---|---|---|---|
| **Statute \| Wyo. Stat. Ann. § 16-6-105**<br>**Name of Statute \| Preference for Wyoming materials and Wyoming agricultural products required in public purchases; exception; cost differential; definition.** | **Type of Preference \|** Discretionary<br>**Details of Preference \|** Up tof 5% | **What is Covered**<br>Agricultural products | **Who is Covered**<br>Every board, commission or other governing body, every person acting as purchasing agent for the board, commission or other governing body of any state institution or department, and every county, municipality, school district and community college district |

This summary of local food preferences in the 50 states and Washington, D.C. builds upon resources developed by Vermont Law School,[267] the National Association of State Procurement Officials,[268] ChangeLab Solutions,[269] and the Harvard Law School Food Law and Policy Clinic of the Center for Health Law and Policy Innovation.[270] This table includes purchasing preferences that are broadly applicable to state agencies and does not include purchasing preferences that are more narrowly tailored to apply to school food procurement.

# APPENDIX B (STATE POLICY EXAMPLES TABLE)

| Policy Lever | Opportunity | Example(s) of Language Used by States |
|---|---|---|
| **Medicaid Section 1115 Demonstration Applications** | **Embed Local Food Priorities in 1115 Demonstration Waivers**<br><br>States can integrate local and community-based food sourcing values in the 1115 demonstration waiver application and ensure that waiver amendment plans are conceptually aligned with state procurement preferences. | **HAWAI'I**<br><br>*"Hawai'i will encourage the inclusion of local growers, community gardens, and other community-based organizations to support the purchase of locally grown food and strengthen Hawaii's intrinsic food system.*<br><br>• *Meal delivery services;*<br>• *Grocery store and grocery delivery services;*<br>• *Farms and farmers markets;*<br>• *Community gardens and seedling stores;*<br>• *Food "hubs" and distributors that contract with local farms;*<br>• *Health-care providers, such as FQHCs, RHCs, and hospitals;*<br>• *Educational institutions, such as community colleges;*<br>• *QI health plans; and*<br>• *Other community-based organizations and food pharmacies, which may also be located within one of these organizations."*[271] |
| **Medicaid Section 1115 Demonstration Guidance** | **Use Implementation Guidance to Elevate Local Food & Community-Based Organizations**<br><br>States can design their 1115 demonstration implementation guidance to encourage, or in some cases mandate, partnerships with community-based organizations to leverage existing community resources, expertise, capacity, and cultural competence. | **MASSACHUSETTS**<br><br>*"In administering the program, . . . [Accountable Care Organizations] must also ensure entities and persons delivering [flexible services] have the capacity and competency to do so, including appropriately tailoring services and goods to the members' needs (e.g., having the cultural competency to serve different populations referred to them).*<br><br>*. . .*<br><br>*[Accountable Care Organizations] should strategically seek partnerships with [Social Service Organizations] that leverage existing community-based expertise and capacity, and promote effectiveness, efficiency, and scalability of their [flexible services] programs."*[272]<br><br>*"[T]he delivery entity will maintain high levels of cultural competence and have adequate resourcing to address the needs of a diverse population (e.g., bilingual staff, culturally appropriate meals, continuous diversity, equity, and inclusion training)."*[273]<br><br>**NEW YORK**<br><br>*"[Community-based organizations] are primarily responsible for delivering [Health Related Social Needs] services. CBOs may also conduct [Health Related Social Needs] Screening and Navigation to services for Medicaid members, if designated to do so by the [Social Care Network] Lead Entity upon meeting specific criteria."*[274]<br><br>*"The [New York State Department of Health's Office of Health Insurance Programs] intent is that [Social Care Networks] will be composed primarily of not-for-profit entities providing Enhanced [Health Related Social Needs] Services."*[275] |

| Policy Lever | Opportunity | Example(s) of Language Used by States |
|---|---|---|
| **Medicaid Managed Care Plan Selection** | **Require Alignment with Local Values in Medicaid Contracting**<br>States can leverage their Medicaid Managed Care procurement process to select health plans that align with statewide goals around nutrition, health equity, and food systems. By embedding food and nutrition priorities into contract requirements, states can address food insecurity while also supporting local economies. | **OHIO**<br>*"The [Managed Care Organization] must participate in and support the [Ohio Department of Medicaid's] efforts to reduce health disparities, address social risk factors, and achieve health equity. The [Managed Care Organization's] health equity efforts must include . . . [p]artnering with community-based organizations and contribute to solutions addressing [social determinants of health] -related needs, such as . . . lack of access to nutritious food. . . ."*[276]<br><br>*"The [Managed Care Organization] must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The [Managed Care Organization's] community reinvestment must be used to support population health strategies within the region or regions the [Managed Care Organization] serves. The [Managed Care Organization] must contribute 3% of its annual profits to community reinvestment. The [Managed Care Organization] must increase the percentage of the [Managed Care Organization's] contributions by 1% each subsequent year, for a maximum of 5% of the [Managed Care Organization's] annual profits."*[277] |
| **In Lieu of Services and Settings (ILOS) Guidance** | **Incorporate "Local" into In Lieu of Services & Settings Definitions (ILOS) and Targets**<br>States have flexibility in designing their ILOS guidance and can employ this guidance to accomplish specific state food systems values and goals within Food is Medicine programs.<br>One way to do so is to provide guidance that encourages and prioritizes community engagement by requiring that Food is Medicine providers be locally-based or participating in the local food system. | **MICHIGAN**<br>*"[Michigan Department of Health and Human Services] has a strong preference for ILOS Providers to be locally-based. However, [Michigan Department of Health and Human Services] recognizes that locally-based ILOS Providers may need to develop infrastructure, capacity, and experience to deliver ILOS. In contract year 2025, [Michigan Department of Health and Human Services] requires at least 30% of each ILOS type be provided by locally-based ILOS Providers. . . . The minimum percentage of ILOS provided by locally-based ILOS Providers will increase further in contract year 2026 and beyond."*[278]<br><br>*"To be a locally-based ILOS Provider, an organization must be a community-based organization, have a physical presence in Michigan, defined as having one (1) or more office locations in Michigan—preferably in the Region(s) the ILOS is being provided—and participate in the Michigan food economy. Participating in the Michigan food economy includes growing, processing, preparing, retailing, distributing or managing waste from food produced within the state of Michigan."*[279]<br><br>**CALIFORNIA**<br>*"[California Advancing and Innovating Medi-Cal] has challenged [Managed Care Plans] to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. . . . These providers include . . . organizations that prepare and deliver medically-tailored food and nutrition. . . . [Managed Care Plans] should contract with organizations that have experience delivering Community Supports services and an existing footprint in the communities they serve. . . ."*[280] |

| Policy Lever | Opportunity | Example(s) of Language Used by States |
|---|---|---|
| **Medicaid Reimbursement Rates for Nutrition Services** | **Align Reimbursement Rates with True Costs of Local Food and Consider Using Fee Schedules to Promote State Food Sourcing Values**<br><br>In setting reimbursement rates for nutrition services, states can consider the actual costs to local providers, as well as variations in cost based on regional differences or cost fluctuations. States can expand the factors used to set reimbursement rates, potentially tying fee schedules to production methods and food quality, or other relevant factors, to enable programs to source foods that align with state values. | **MASSACHUSETTS**<br><br>*"Medically Tailored Home Delivered Meals: Prepared medically tailored meals that reflect appropriate nutritional needs based on defined medical diagnosis and standards reflecting evidence-based practice guidelines, deliver to the Enrollee.*<br><br>• *[Health Related Social Needs] Supplemental Services Fee Schedule: Expected Unit Cost: $14.86*<br>• *[Health Related Social Needs] Supplemental Services Fee Schedule: Maximum: $18.58 (see Note 1)*<br><br>*Note 1:*<br>*Upper payment limit of 125% of the Expected Unit Costs. The 125% factor is to allow for variation in costs over time and across geographies."*[281] |
| **Legislative Directives** | **Legislate Support for Local Sourcing & Community-Based Organizations**<br><br>States can direct how funding must be used within procurement of Food is Medicine services in ways that advance local economies and bolster state values. | **OKLAHOMA**<br><br>*"Wherever feasible, the [Oklahoma Health Care] Authority and contracted entities under the state Medicaid program shall prioritize the inclusion of community-based organizations and local growers to support the purchase of locally grown food in nutrition prescriptions."*[282] |

| Policy Lever | Opportunity | Example(s) of Language Used by States |
|---|---|---|
| **Medicaid Section 1115 Infrastructure Funding** | **Invest in Local Food Infrastructure Through Demonstration Funding**<br><br>States can allow 1115 demonstration infrastructure investments to enhance provider capacity—such as cold storage upgrades for Community-Based Organizations and Federally Qualified Health Centers—making it easier to source, store, and distribute fresh local food. | **CALIFORNIA**<br><br>*"Providing Access and Transforming Health (PATH) enables California community-based organizations (CBOs), hospitals, county agencies, Tribes and Indian Health Care Providers, among others to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management (ECM) and Community Supports and Justice Involved services under CalAIM.*<br><br>*The goal of PATH's $1.85 billion funding is to address gaps in local organizational capacity and infrastructure throughout the state over a five-year period. By providing additional resources such as staff, billing systems, and data exchange capabilities, community partners will be better equipped to contract with managed care organizations and expand the services they offer to Medi-Cal beneficiaries."*[283]<br><br>**OREGON**<br><br>*"In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 9.6.a. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $119M on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline."*[284]<br><br>*"The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.*<br><br>a. *Technology*<br>b. *Development of business or operational practices*<br>c. *Workforce development*<br>d. *Outreach, education and stakeholder convening"*[285] |

## ENDNOTES


1 The US Burden of Disease Collaborators, *State of US Health, 1990–2016: Burden of Diseases, Injuries, and Risk Factors Among US States*, 319 JAMA 1444 (2018).

2 U.S. DEP'T OF AGRIC., ECON. RES. SERV., HOUSEHOLD FOOD SECURITY IN THE UNITED STATES IN 2023, ERR-337 8 (2024), https://www.ers.usda.gov/webdocs/publications/109896/err-337.pdf?v=57.6 [https://perma.cc/NSS3-3A8L].

3 AM.'S HEALTH RANKINGS, *Fruit and Vegetable Consumption in the United States*, https://www.americashealthrankings.org/explore/measures/fvcombo (last visited Dec. 31, 2024) [https://perma.cc/X9R8-8TSS].

4 CHERYL D. FRYAR ET AL., HYPERTENSION PREVALENCE, AWARENESS, TREATMENT, AND CONTROL AMONG ADULTS AGE 18 AND OLDER: UNITED STATES, AUGUST 2021–AUGUST 2023, NAT'L CTR. FOR HEALTH STAT., NCHS DATA BRIEF NO. 511 (Oct. 2024),https://www.cdc.gov/nchs/data/databriefs/db511.pdf https://www.cdc.gov/nchs/data/databriefs/db511.pdf [https://perma.cc/TSQ8-B8ZG].

5 SAMUEL D. EMMERICH ET AL., OBESITY AND SEVERE OBESITY PREVALENCE IN ADULTS: UNITED STATES, AUGUST 2021–AUGUST 2023, NAT'L CTR. FOR HEALTH STAT., NCHS DATA BRIEF NO. 508 (Sept. 2024), https://www.cdc.gov/nchs/data/databriefs/db508.pdf [https://perma.cc/H8B6-VFFN].

6 JANE A. GWIRA ET AL., PREVALENCE OF TOTAL, DIAGNOSED, AND UNDIAGNOSED DIABETES IN ADULTS: UNITED STATES, AUGUST 2021–AUGUST 2023, NAT'L CTR. FOR HEALTH STAT., NCHS DATA BRIEF NO. 516 (Nov. 2024), https://www.cdc.gov/nchs/data/databriefs/db516.pdf [https://perma.cc/F5Y2-PCNP].

7 MARGARET D. CARROLL ET AL., TOTAL AND HIGH-DENSITY LIPOPROTEIN CHOLESTEROL IN ADULTS: UNITED STATES, AUGUST 2021–AUGUST 2023, NAT'L CTR. FOR HEALTH STAT., NCHS DATA BRIEF NO. 515 (Nov. 2024), https://www.cdc.gov/nchs/data/databriefs/db515.pdf [https://perma.cc/7BRU-YUVR].

8 THE ROCKEFELLER FOUND., TRUE COST OF FOOD: MEASURING WHAT MATTERS TO TRANSFORM THE U.S. FOOD SYSTEM (July 2021), https://www.rockefellerfoundation.org/wp-content/uploads/2021/07/True-Cost-of-Food-Full-Report-Final.pdf [https://perma.cc/DH6K-4WNZ].

9 KURT HAGER ET. AL., FOOD IS MEDICINE RESEARCH ACTION PLAN, FOOD & SOCIETY AT THE ASPEN INST. 29 (Apr. 2024), https://aspenfood.org/wp-content/uploads/2024/04/Food-is-Medicine-Action-Plan-2024-Final.pdf. [https://perma.cc/LF2J-8R3R].

10 *Id.* at 32-34.

11 ERIKA HANSON ET. AL., FOOD IS MEDICINE: A STATE MEDICAID POLICY TOOLKIT, CTR. FOR HEALTH LAW AND POLICY INNOVATION & FOOD IS MEDICINE COALITION 4 (July 2024), https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf [https://perma.cc/C29S-9AUF].

12 *See, e.g.*, Dariush Mozaffarian et al., *A Food is Medicine Approach to Achieve Nutrition Security and Improve Health,* 28 NAT. MED. 2238 (2022).

13 ERIKA HANSON ET. AL., FOOD IS MEDICINE: A STATE MEDICAID POLICY TOOLKIT, CTR. FOR HEALTH LAW AND POLICY INNOVATION (July 2024) https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf [https://perma.cc/C29S-9AUF].

14 *See* CTRS. FOR MEDICARE & MEDICAID SERVICES, *CMS' Program History*, https://www.cms.gov/about-cms/who-we-are/history (last visited Sept. 10, 2024) [https://perma.cc/2LUR-GKMX].

15 *See, e.g.*, Aleda M H Chen et al., *Food as Medicine? Exploring the Impact of Providing Healthy Foods on Adherence and Clinical and Economic Outcomes,* 5 EXPLORATORY RES. IN CLINICAL SOC. PHARMACY (2022); Yueying Gao et al., *The Effect of Food-is-Medicine Interventions on Diabetes-related Health Outcomes Among Low-income and Food-insecure Individuals: A Systematic Review and Meta-analysis*, 47(2) CAN. J. DIABETES 143 (2023); Alyson Haslam et al., *The Effect of Food Prescription Programs on Chronic Disease Management in Primarily Low-Income Populations: A Systematic Review and Meta-Analysis*, 28(3) NUTRITION HEALTH 389 (2022).

16 Lu Wang et al., *Health and Economic Impacts of Implementing Produce Prescription Programs for Diabetes in the United States: A Microsimulation Study*, 12 J. AM. HEART ASS'N 15 (2023).

17 Shuyue Deng et al., *Estimated Impact of Medically Tailored Meals on Health Care Use and Expenditures In 50 US States*, HEALTH AFFAIRS 44:4, 433-442 (2025).

18 CTRS. FOR MEDICARE & MEDICAID SERVS., *Interim Evaluation Report NC Healthy Opportunities Pilots* 11-12, 93 (Nov. 5, 2024), https://www.ncdhhs.gov/healthy-opportunities-pilots-interim-evaluation-report/open [https://perma.cc/VU3P-9FCP].

19 Kurt Hager et al., *Medicaid Nutrition Supports Associated With Reductions in Hospitalizations and ED Visits in Massachusetts*, 2020–23, HEALTH AFFAIRS 44:4, 413-421 (2025).

20 *Id.*

21 SARAH LOWE ET AL., TRENDS IN U.S. LOCAL AND REGIONAL FOOD SYSTEMS: A REPORT TO CONGRESS, U.S. DEP'T OF AGRIC., ECON. RES. SERV., ERR-068 16-18 (2015), https://ers.usda.gov/sites/default/files/_laserfiche/publications/42805/51173_ap068.pdf?v=32005 [https://perma.cc/XY24-A2MG].

22 B.B.R. Jablonski et. al., *Assessing the Economic Impacts of Food Hubs to Regional Economies: A Framework Including Opportunity Cost*, (2016); AGRIC. & RES. ECON. REV.; STEVE MARTINEZ ET AL., LOCAL FOOD SYSTEMS, CONCEPTS, IMPACTS, AND ISSUES, U.S. DEP'T OF AGRIC., ECON. RES. SERV., ERR-97 (2010), https://ers.usda.gov/sites/default/files/_laserfiche/publications/46393/7054_err97_1_.pdf?v=47124 [https://perma.cc/E4D7-WG7H]; Ken Meter, *Metrics from the Field: Learning How To Multiply*, 1 J. AGRIC., FOOD

Sys. & Cmty Dev. 9 (2010); *see also,* Emma Brinkmeyer et al., Local Food Systems: Clarifying Current Research, North Carolina State Extension (2023) https://content.ces.ncsu.edu/local-food-systems-clarifying-current-research [https://perma.cc/BQB9-WWAJ].

23 *See* Emma Brinkmeyer et al., Local Food Systems: Clarifying Current Research, North Carolina State Extension (2023) https://content.ces.ncsu.edu/local-food-systems-clarifying-current-research [https://perma.cc/BQB9-WWAJ].

24 U.S. Dep't of Health & Human Services, *Food is Medicine, Measurement Domains*, https://odphp.health.gov/foodismedicine/research-and-measurement/food-medicine-analytic-framework/measurement-domains (last visited Jan. 7, 2025) [https://perma.cc/T4RF-9N86].

25 *Id.*

26 *See* Harvard Law School's Food Law and Policy Clinic & John Hopkin's Center for a Livable Future, Good Laws Good Food: Putting Local Food Policy to Work for Our Communities 101, 101 (2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK]; Vermont Law School Ctr. for Agric. & Food Sys., Defining Local Food: An Analysis of State Approaches and Challenges 5-7 (Aug. 2021) https://www.vermontlaw.edu/wp-content/uploads/2024/07/Local-Food-Definitions.pdf [https://perma.cc/JW4V-6WX2].

27 Vermont Law School Ctr. for Agric. & Food Sys., Defining Local Food: An Analysis of State Approaches and Challenges 5-7 (Aug. 2021) https://www.vermontlaw.edu/wp-content/uploads/2024/07/Local-Food-Definitions.pdf [https://perma.cc/JW4V-6WX2].

28 Food, Conservation, and Energy Act of 2008, P.L. 110-246, §6015.

29 Cong. Res. Serv., R44390, The Role of Local and Regional Food Systems in U.S. Farm Policy 3-4 (Feb. 2016) https://crsreports.congress.gov/product/pdf/R/R44390/4#:~:text=Local%20and%20regional%20food%20systems3,urban%20gardens%2C%20or%20farms%20using [https://perma.cc/N384-AJJW].

30 Hannah Leighton, *Measuring Up: When, How, and Why to Define "Local"*, Farm to Institution New England (Oct. 2, 2017) https://www.farmtoinstitution.org/blog/measuring-when-how-and-why-define-local [https://perma.cc/4SXE-B2HL]; *see also* Ctr. for Good Food Purchasing et. al., AiA Aligned Framework 10 (Sept. 2023) https://drive.google.com/file/d/1n0qi0SaC6wJfUTapeqmXm0Gd8C6Kmnil/view (defining local as within 250 miles, or 500 miles for meat, poultry, and seafood.)

31 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 102 (Sept. 2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

32 *Id.*

33 15 U.S.C. §644(g)(1)(A).

34 Ctr. For Good Food Purch., *The Good Food Purchasing Values*, https://goodfoodpurchasing.org/good-food-values/#values (last visited Dec. 2, 2023) [https://perma.cc/T34H-7HA6].

35 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 104, 105 (Sept. 2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

36 Policy Link, Equitable Development Toolkit: Local Food Procurement 2 (Mar. 2015), https://www.policylink.org/sites/default/files/edtk_local-food-procurement.pdf [https://perma.cc/P3ND-Q4JY].

37 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 104 (Sept. 2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

38 *See* 2 C.F.R. § 200.319.

39 *See* 2 C.F.R. § 200.319 (amended Oct. 1, 2024) (removing the prior subsection (c), which previously stated, "The non-Federal entity must conduct procurements in a manner that prohibits the use of statutorily or administratively imposed state, local, or tribal geographical preferences in the evaluation of bids or proposals, except in those cases where applicable Federal statutes expressly mandate or encourage geographic preference.").

40 *Id.*; 42 U.S.C. § 1758(j).

41 *Id.*

42 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 104 (Sept. 2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

43 *See e.g.,* U.S. Dep't of Agric., Procuring Local Foods for Child Nutrition Programs 38-44 (2022), https://fns-prod.azureedge.us/sites/default/files/resource-files/June22F2SProcurementGuide508.pdf [https://perma.cc/8RDY-KZK3].

44 2 C.F.R. § 200.320(b).

45 2 C.F.R. § 200.320(a); 48 C.F.R. pt. 13.

46 48 C.F.R. § 2.101.

47 2 C.F.R. § 200.320(a); 48 C.F.R. pt. 13.

48 *Id.*

49 48 C.F.R. § 2.101.

50 2 C.F.R. § 200.320(a); 48 C.F.R. pt. 13.
51 *Id.*
52 2 C.F.R. § 200.317.
53 Colo. Food Sys. Advisory Council, A 50-State Policy Scan on the Role of State Procurement Policy in Buying Colorado Food 5 (June 24, 2021), https://cofoodsystemscouncil.org/wp-content/uploads/2021/08/InstitutionalProcurement_Brief_8-20-21.pdf [https://perma.cc/J49A-L2L9].
54 U.S. Dep't of Agric., Procuring Local Foods for Child Nutrition Programs 46 (2022), https://fns-prod.azureedge.us/sites/default/files/resource-files/June22F2SProcurementGuide508.pdf [https://perma.cc/S6E9-BHEB].
55 Id. at 46-47, 96, 100.
56 Id. at 103.
57 Id. at 46-47.
58 In the Public Interest & Local Progress Impact Lab, Harnessing the Power of Procurement: Issues, Considerations, and Best Practices to Advance Equity in the Contracting of Good and Services 4-5 (July 2023), https://inthepublicinterest.org/wp-content/uploads/2023/07/0723-ITPI-Procurement.pdf [https://perma.cc/HJ8M-5HXV].
59 *Id.*
60 *See generally* 15A Federal procedure, L.Ed. § 39:74 (2024).
61 U.S. Dep't of Agric., Procuring Local Foods for Child Nutrition Programs 47 (2022), https://fns-prod.azureedge.us/sites/default/files/resource-files/June22F2SProcurementGuide508.pdf.
62 *Id.*
63 *See generally* 15A Federal procedure, L.Ed. § 39:78 (2024).
64 *Id.*
65 In the Public Interest & Local Progress Impact Lab, Harnessing the Power of Procurement: Issues, Considerations, and Best Practices to Advance Equity in the Contracting of Good and Services 12 (July 2023), https://inthepublicinterest.org/wp-content/uploads/2023/07/0723-ITPI-Procurement.pdf [https://perma.cc/HJ8M-5HXV].
66 *Id.* at 6-7.
67 In the Public Interest & Local Progress Impact Lab, Harnessing the Power of Procurement: Issues, Considerations, and Best Practices to Advance Equity in the Contracting of Good and Services 6-7 (July 2023), https://inthepublicinterest.org/wp-content/uploads/2023/07/0723-ITPI-Procurement.pdf [https://perma.cc/HJ8M-5HXV].
68 42 C.F.R. § 438.3(a).
69 In the Public Interest & Local Progress Impact Lab, Harnessing the Power of Procurement: Issues, Considerations, and Best Practices to Advance Equity in the Contracting of Good and Services 7 (July 2023), https://inthepublicinterest.org/wp-content/uploads/2023/07/0723-ITPI-Procurement.pdf [https://perma.cc/HJ8M-5HXV].
70 *Id.*
71 42 C.F.R. § 438.340.
72 42 U.S.C. § 1396 et seq.
73 *See e.g.*, 42 C.F.R § 435 et seq.
74 *See, e.g.*, 42 C.F.R §§ 435.1200, 435.1205, 438 et seq.
75 *See* 42 U.S.C. §§ 1396d(a) (covered benefits), 1396a (mandatory services); 42 C.F.R. §§ 440.1-185 (service definitions), 440.210-225 (mandatory and optional services); *see also* Medicaid.gov, *Mandatory & Optional Medicaid Benefits*, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html (last visited Mar. 10, 2023).
76 *See, e.g.,* 42 C.F.R. §§ 430.10, 430.12(c).
77 *See* Hannah Maniates, Why Did They Do It That Way? Understanding Managed Care, Nat'l Ass'n of Medicaid Dirs. (Jan. 22, 2024), https://medicaiddirectors.org/resource/understanding-managed-care/ [https://perma.cc/9BKR-47UH].
78 *Id.*
79 *Id.*
80 *See* 42 C.F.R. § 438.2.
81 KFF, *State Health Facts, Total Medicaid MCO Enrollment,* https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 30, 2025) [https://perma.cc/3EGQ-WPNY].
82 *See* Kristin Sukys, Erika Hanson, Katie Garfield & Emily Broad Leib, Center for Health Law and Policy Innovation, Mainstreaming Produce Prescriptions in Medicaid Managed Care: A Policy Toolkit and Resource Library (June 2023), https://chlpi.org/wp-content/uploads/2023/06/Mainstreaming-Produce-Prescriptions-in-Medicaid-Managed-Care-V6.pdf [https://perma.cc/2TVA-DLRZ].
83 *See* 2 C.F.R. § 200.502(i) (indicating that "Medicaid payments ... for providing patient care services ... are not considered Federal awards ... unless a state requires the funds to be treated as Federal awards ... because reimbursement is on a cost-reimbursement basis.").
84 Ctrs. for Medicare & Medicaid Servs., *Delivering Services in School Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming* 5-7, 49-50 (2023) https://www.medicaid.gov/medicaid/financial-management/downloads/

sbs-guide-medicaid-services-administrative-claiming.pdf.

85 *Id.*

86 Kristin Sukys, Erika Hanson, Katie Garfield & Emily Broad Leib, Center for Health Law and Policy Innovation, Mainstreaming Produce Prescriptions in Medicaid Managed Care: A Policy Toolkit and Resource Library 18-19 (June 2023) https://chlpi.org/wp-content/uploads/2023/06/Mainstreaming-Produce-Prescriptions-in-Medicaid-Managed-Care-V6.pdf [https://perma.cc/2TVA-DLRZ]; *see* 45 C.F.R. § 75.327; 42 C.F.R. § 431.51(c)(2).

87 *See* Hannah Maniates, Why Did They Do It That Way? Understanding Managed Care, Nat'l Ass'n of Medicaid Dirs. (Jan. 22, 2024), https://medicaiddirectors.org/resource/understanding-managed-care/ [https://perma.cc/9BKR-47UH].

88 *See* Presentation by Moira Forbes & Sean Dunbar, *Understanding Medicaid Managed Care Procurement Practices Across States*, Medicaid and CHIP Payment and Access Commission (MACPAC) (Apr. 8, 2022), https://www.macpac.gov/wp-content/uploads/2022/04/Understanding-Medicaid-Managed-Care-Procurement.pdf [https://perma.cc/7C5L-6GA4].

89 *See Value-based Purchasing (VBP)*, HealthCare.gov, https://www.healthcare.gov/glossary/value-based-purchasing-vbp/ (last visited Nov. 4, 2024) [https://perma.cc/2QBQ-PYDS].

90 *See* Hannah Maniates, Why Did They Do It That Way? Understanding Managed Care, Nat'l Ass'n of Medicaid Dirs. (Jan. 22, 2024), https://medicaiddirectors.org/resource/understanding-managed-care/ [https://perma.cc/9BKR-47UH]; *see* Presentation by Moira Forbes & Sean Dunbar, *Understanding Medicaid Managed Care Procurement Practices Across States*, Medicaid and CHIP Payment and Access Commission (MACPAC) (Apr. 8, 2022), https://www.macpac.gov/wp-content/uploads/2022/04/Understanding-Medicaid-Managed-Care-Procurement.pdf [https://perma.cc/7C5L-6GA4].

91 *See* Presentation by Moira Forbes & Sean Dunbar, *Understanding Medicaid Managed Care Procurement Practices Across States*, Medicaid and CHIP Payment and Access Commission (MACPAC) (Apr. 8, 2022), https://www.macpac.gov/wp-content/uploads/2022/04/Understanding-Medicaid-Managed-Care-Procurement.pdf [https://perma.cc/7C5L-6GA4].

92 *See, e.g.*, Mass. Gen. Laws ch. 7, § 23B(a).

93 *See, e.g.*, Ark. Admin. Code 006.27.3-R1:15-4-3804.

94 *See, e.g.*, Exec. Order No. 14005, 86 F.R. 7475 (2021).

95 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 104 (2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

96 Catherine G. Campbell, *Values-Based Institutional Food Procurement Programs: A Narrative Review*, 12 J. of Agric. Food Sys., & Community Dev. 123 (2023).

97 Sheryl Hendriks, et al., The True Cost and True Price of Food, United Nations Food Systems Summit 2021 (June 1, 2021), https://sc-fss2021.org/wp-content/uploads/2021/06/UNFSS_true_cost_of_food.pdf [https://perma.cc/6A5L-2WU7].

98 The Rockefeller Found., True Cost of Food Measuring What Matters to Transform the U.S. Food System (July 2021), https://www.rockefellerfoundation.org/wp-content/uploads/2021/07/True-Cost-of-Food-Full-Report-Final.pdf [https://perma.cc/CS7B-8MS3].

99 *Local Coalition Building*, Good Food Purchasing Program, https://goodfoodcities.org/cities/ (last visited Dec. 3, 2023) [https://perma.cc/5SYE-WEP5].

100 City of Boston, An Ordinance Regarding Good Food Purchasing Standards in the City of Boston 2 (2019), https://drive.google.com/file/d/17rgJwVF8BZ9xal3Q5DGLZWpZ7wweLcT0/view?usp=sharing [https://perma.cc/66C4-UHMW].

101 *Id.* at 3.

102 Andrea Germanos, *Boston City Council Passes Groundbreaking Food Justice Ordinance*, Good Food Purchasing Program (Mar. 20, 2019) https://goodfoodcities.org/boston-city-council-passes-groundbreaking-food-justice-ordinance/ [https://perma.cc/9H9P-L66Q].

103 Cal. Gov. Code § 4331.

104 Haw. Rev. Stat. § 103D-1002.

105 Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 106 (2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

106 Ind. Code § 5-22-15-23.5.

107 Alaska Stat. Ann. § 36.15 (2023).

108 Colo. Food Sys. Advisory Council, A 50-State Policy Scan on the Role of State Procurement Policy in Buying Colorado Food 1 (2021) https://cofoodsystemscouncil.org/wp-content/uploads/2021/08/InstitutionalProcurement_Brief_8-20-21.pdf [https://perma.cc/J49A-L2L9].

109 74 Okl. St. Ann. § 85.17A (2022).

110 Colo. Food Sys. Advisory Council, A 50-State Policy Scan on the Role of State Procurement Policy in Buying Colorado Food 4 (2021) https://cofoodsystemscouncil.org/wp-content/uploads/2021/08/institutionalprocurement_Brief_8-20-21.pdf [https://perma.cc/J49A-L2L9].

111 30 Ill. Comp. Stat. Ann. § 595/10.

112 Governor Hochul Exec. Order No. 32, https://www.governor.ny.gov/sites/default/files/2023-08/EO_32.pdf.

[113] Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 107 (2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

[114] *State Preference Repository,* Nat'l Ass'n of State Procurement Off.'s, https://www.naspo.org/research-and-innovation/state-preference-repository/ [https://perma.cc/H85X-8JVR].

[115] Utah Code Ann. § 63G-6a-1002.

[116] Minn. Stat. § 16C.06(7).

[117] Vermont Law Sch. Ctr. for Agric. & Food Systems, Defining Local Food: An Analysis of State Approaches and Challenges (Aug. 2021), https://www.vermontlaw.edu/wp-content/uploads/2024/07/Local-Food-Definitions.pdf [https://perma.cc/JW4V-6WX2].

[118] Cal. Gov't Code § 14838(a).

[119] *Id.*

[120] Id. Code § 67-9210; SD Codified L § 5-18A-25; N.H. Admin. Code § Adm 606.01(f).

[121] Mass. Gen. Laws ch. 7, § 23B.

[122] In the Pub. Interest, Harnessing the Power of Procurement: Issues, Considerations, and Best Practices to Advance Equity in the Contracting of Good and Services, 47 (July 2023) https://inthepublicinterest.org/wp-content/uploads/2023/07/0723-ITPI-Procurement.pdf [https://perma.cc/HJ8M-5HXV].

[123] Cong. Res. Serv., R44390, The Role of Local and Regional Food Systems in U.S. Farm Policy, 8-9 (Feb. 2016) https://crsreports.congress.gov/product/pdf/R/R44390/4#:~:text=Local%20and%20regional%20food%20systems3,urban%20gardens%2C%20or%20farms%20using [https://perma.cc/N384-AJJW].

[124] Harvard Law Sch. Food Law and Pol'y Clinic & John Hopkins Ctr. For a Livable Future, Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities 108 (2017), https://chlpi.org/wp-content/uploads/2013/12/good-food-good-laws_toolkit-10.23.2017.pdf [https://perma.cc/G8PF-X8FK].

[125] U.S. Dep't of Agric., Procuring Local Foods for Child Nutrition Programs 61 (2015), https://fns-prod.azureedge.us/sites/default/files/resource-files/June22F2SProcurementGuide508.pdf.

[126] *See* presentation by MassHealth, Health Related Social Needs (HRSN) November Stakeholder Meeting (Nov. 2023), https://www.mass.gov/doc/health-related-social-needs-hrsn-november-stakeholder-meeting-november-2023-0/download; Letter from Angela D. Garner, Dep't of Health & Human Serv., to Mike Levine, Massachusetts Office of Health & Human Services (Dec. 13, 2024) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-dmnstrn-aprl-tchnl-crctns-atcmnt-u-p.pdf.

[127] James Matson, et. al., U.S. Dep't of Agric., Service Report 73, The Role of Food Hubs in Local Food Marketing 5 (2013) https://www.rd.usda.gov/files/sr73.pdf.

[128] *Id.* at 5-6.

[129] James Matson, et. al., U.S. Dep't of Agric., Service Report 73, The Role of Food Hubs in Local Food Marketing 6 (Jan. 2013) https://www.rd.usda.gov/files/sr73.pdf.

[130] *See* Nour Hammad et al., Ctr. for Health Law and Pol'y Innovation, Values at the Heart of Ceres Community Project's Food Sourcing and Procurement Operations, a California Food is Medicine Program (May 2025) https://chlpi.org/wp-content/uploads/2025/06/Ceres-Case-Study-May-2025-V3.pdf; Nour Hammad et al., Ctr. for Health Law and Pol'y Innovation, The North Star Guiding Alameda County Recipe4Health's Food Sourcing Operations as a Food as Medicine Model (May 2025) https://chlpi.org/wp-content/uploads/2025/06/Alameda-County-Case-Study-May-2025-V4.pdf.

[131] *About Us*, 4P Foods, https://4pfoods.com/about/mission/ [https://perma.cc/Q6PD-7WU9].

[132] *About Us*, 4P Foods, https://4pfoods.com/about/mission/ [https://perma.cc/Q6PD-7WU9]; *Building Regenerative Local Food Systems to Enhance Community Health and Resilience,* U.S. Dept. of Health and Human Serv., Office of Disease Prevention & Health Promotion, https://odphp.health.gov/foodismedicine/promising-practices-and-tools/real-world-examples/building-regenerative-local-food-systems-enhance-community-health-and-resilience [https://perma.cc/JMY9-PVEP].

[133] *Building Regenerative Local Food Systems to Enhance Community Health and Resilience,* U.S. Dept. of Health and Human Serv., Office of Disease Prevention & Health Promotion, https://odphp.health.gov/foodismedicine/promising-practices-and-tools/real-world-examples/building-regenerative-local-food-systems-enhance-community-health-and-resilience [https://perma.cc/JMY9-PVEP].

[134] *Id.*

[135] Press Release, The Rockefeller Foundation, *Rockefeller Foundation and U.S. Department of Veterans Affairs Expand Access to Healthy Foods for America's Veterans* (March 11, 2025) https://www.rockefellerfoundation.org/news/rockefeller-foundation-and-u-s-department-of-veterans-affairs-expand-access-to-healthy-foods-for-americas-veterans/ [https://perma.cc/DE2T-YWNL].

[136] The Georgia Acre Collective, Building Resilient Agriculture through Forward Purchasing Commitments and Direct Farmer Financial Investment 5 (Jan. 2025) https://www.thecommonmarket.org/assets/uploads/reports/Building-Resilient-Agriculture-through-Forward-Purchasing-Commitments-and-Direct-Farmer-Financial-Investment_1.pdf [https://perma.cc/W7HZ-NCA2].

[137] The Georgia Acre Collective, Building Resilient Agriculture through Forward Purchasing Commitments and Direct

Farmer Financial Investment 6 (Jan. 2025) https://www.thecommonmarket.org/assets/uploads/reports/Building-Resilient-Agriculture-through-Forward-Purchasing-Commitments-and-Direct-Farmer-Financial-Investment_1.pdf [https://perma.cc/W7HZ-NCA2].

138 The Georgia Acre Collective, Building Resilient Agriculture through Forward Purchasing Commitments and Direct Farmer Financial Investment (Jan. 2025) https://www.thecommonmarket.org/assets/uploads/reports/Building-Resilient-Agriculture-through-Forward-Purchasing-Commitments-and-Direct-Farmer-Financial-Investment_1.pdf [https://perma.cc/W7HZ-NCA2].

139 *About Us*, Need More Acres, https://needmoreacres.com/about/ [https://perma.cc/W97Q-HYWE].

140 Virtual Interview with Michelle Howell, Harvard Law Sch. Food Law and Pol'y Clinic (Oct. 8, 2024).

141 *Id.*

142 Ben Brasch et al., *USDA's $1B in Cuts Leaves Farmers and Schools Bracing for Impact*, The Washington Post (March 12, 2025) https://www.washingtonpost.com/nation/2025/03/12/usda-funding-local-farms-schools-food-banks/.

143 *Resilient Food Systems Infrastructure Program*, U.S. Dep't of Agric., https://www.ams.usda.gov/services/grants/rfsi [https://perma.cc/8D2B-HNN5].

144 Cassandra Bull & Colleen Matts, Farm to School Local Food Purchasing Incentives: An Introduction to Incentives, Mich. St. U. Ctr. for Regional Food Sys. (May 2024) https://www.canr.msu.edu/foodsystems/uploads/resources/MSU-015a-1-Incentives-101_rem.pdf [https://perma.cc/3G6D-DMT6].

145 *Local Food Purchase Assistance Cooperative Agreement Program,* U.S. Dep't of Agric., https://www.ams.usda.gov/selling-food-to-usda/lfpacap#:~:text=The%20Local%20Food%20Purchase%20Assistance,and%20National%20Policy%20Requirements%20section. [https://perma.cc/3WM6-RZ64].

146 *Local Food Promotion Program*, U.S. Dep't of Agric., https://www.ams.usda.gov/services/grants/lfpp [https://perma.cc/YE7Y-MVHP].

147 *Resilient Food Systems Infrastructure Program*, U.S. Dep't of Agric., https://www.ams.usda.gov/services/grants/rfsi [https://perma.cc/8D2B-HNN5].

148 *Local Food for Schools Cooperative Agreement Program*, U.S. Dep't of Agric., https://www.ams.usda.gov/selling-food-to-usda/lfs [https://perma.cc/YXG9-42A4].

149 Cassandra Bull & Colleen Matts, Farm to School Local Food Purchasing Incentives: An Introduction to Incentives, Mich. St. U. Ctr. for Regional Food Sys. (May 2024) https://www.canr.msu.edu/foodsystems/uploads/resources/MSU-015a-1-Incentives-101_rem.pdf [https://perma.cc/3G6D-DMT6].

150 Wallace Ctr. at Winrock Int'l, USDA Local Food Purchase Assistance Program: Initial Impacts, Opportunities and Recommendations 6 (June 2023) https://wallacecenter.org/wp-content/uploads/dlm_uploads/2024/10/Local-Food-Purchase-Assistance-Program-Initial-Impact-Report_Wallace-Center_-Full-Report-2.pdf [https://perma.cc/S2MX-M3PK].

151 Local Food Impact Calculator, https://calculator.localfoodeconomics.com/ (last visited May 1, 2025).

152 *See* 42 U.S.C. § 1315.

153 *See About Section 1115 Demonstrations*, Ctrs. For Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html (last visited Oct. 12, 2024).

154 42 U.S.C. § 1315(a)(1).

155 *See* Erika Hanson et al., *The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A U.S. Survey*, 2 Health Aff. Scholar 1 (2024).

156 *State Waivers List,* Medicaid.gov, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html (last visited Jan. 21, 2024).

157 *See* Policy Guidance from Anne Marie Costello, Acting Deputy Administrator and Director, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), Ctrs. for Medicare & Medicaid Services (Jan. 1, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf [https://perma.cc/3MAY-UTX8].

158 *See* Erika Hanson et al., *The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A U.S. Survey*, 2 Health Aff. Scholar 1, 6 (2024).

159 *Id.*

160 *See National Overview of 1915(c) HCBS Waivers*, Ctrs. for Medicare & Medicaid Servs. (Sept. 10, 2024), https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/national-overview-1915-c-waivers [https://perma.cc/P5SK-9XSQ]; *see Home & Community-Based Services 1915(c)*, Ctrs. for Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html (last visited Oct. 12, 2024).

161 *See* 42 U.S.C. § 1396n(c)(1).

162 *1915(c) Waivers*, Medicaid and CHIP Payment and Access Commission (June 24, 2019), https://www.macpac.gov/subtopic/1915-c-waivers/ [https://perma.cc/SMM6-ZZTU].

163 *See* Erika Hanson et al., Ctr. for Health Law and Pol'y Innovation, Food is Medicine: A State Medicaid Policy Toolkit 29 (2024), https://www.healthlawlab.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit-2024.pdf [https://perma.cc/6HGZ-QK3Z].

164 42 C.F.R. § 438.3(e)(2)(i).
165 *Id.*
166 42 C.F.R. §§ 438.3(e)(2)(i); 438.16.
167 42 C.F.R. § 438.16.
168 42 C.F.R. § 438.3(e)(1)(i).
169 Erika Hanson et al., Ctr. for Health Law and Pol'y Innovation, Food is Medicine: A State Medicaid Policy Toolkit 20 (2024), https://www.healthlawlab.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit-2024.pdf [https://perma.cc/6HGZ-QK3Z].
170 *State Waivers List*, Ctrs. for Medicare & Medicaid Servs., https://www.medicaid.gov/medicaid/section-1115- demo/demonstration-and-waiver-list/index.html.
171 Letter from Josh Green, M.D., Governor, State of Hawai'i to Xavier Becerra, Sec'y of Health & Human Servs. submitting the *QUEST Integration Section 1115 Demonstration Extension Application* 49 (Nov. 22, 2023) https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf [https://perma.cc/DFZ7-AM3X].
172 *Id.* at 49-52.
173 Letter from Chiquita Brooks-LaSure, Dep't of Health & Human Servs., to Judy Mohr Peterson, Med-QUEST Division Administrator, State of Hawai'i, Dep't of Human Servs. (Jan. 8, 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/hi-quest-int-dmnstn-aprvl-01082025.pdf [https://perma.cc/J3JB-BRJB].
174 Virtual Interview with Monica Esquivel, Univ. of Haw. Mānoa Associate Professor, Harvard Law Sch. Food Law and Pol'y Clinic (Nov. 5, 2024).
175 *Id.*
176 *Id.*
177 Letter from Josh Green, M.D., Governor, State of Hawai'i to Xavier Becerra, Sec'y of Health & Human Servs. submitting the *QUEST Integration Section 1115 Demonstration Extension Application* 49-55 (Nov. 22, 2023) https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf [https://perma.cc/DFZ7-AM3X].
178 Haw. Rev. Stat. §§ 103D-1001-2.
179 *Id.*
180 Letter from Chiquita Brooks-LaSure, Dep't of Health & Human Servs., to Judy Mohr Peterson, Med-QUEST Division Administrator, State of Hawai'i, Dep't of Human Servs. 169-70 (Jan. 8, 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/hi-quest-int-dmnstn-aprvl-01082025.pdf [https://perma.cc/J3JB-BRJB].
181 *Id.*
182 U.S. Dep't. of Health and Human Serv., Indian Health Serv., Disparities Fact Sheet, https://www.ihs.gov/newsroom/factsheets/disparities/ (last visited April 11, 2025) [https://perma.cc/W29W-NKTX].
183 *Id.*
184 U.S. Dep't. of Health and Human Serv., Indian Health Serv., Disparities Fact Sheet, https://www.ihs.gov/newsroom/factsheets/disparities/ (last visited April 11, 2025) [https://perma.cc/W29W-NKTX].
185 Nat'l Resource Ctr. on Native American Aging, *Identifying Our Needs: A Survey of Elders Cycle VIII (2020-2023)* 106 https://www.nrcnaa.org/needs-assessment [https://perma.cc/T2V2-ZRYX]; Hing Man Chan et al., *The First Nations Food, Nutrition and Environment Study (2008–2018)—rationale, design, methods and lessons learned*, 112 (Suppl 1) Can. J. Pub. Health, 8 (2021); Sampat Ghosh et al., *Embracing Tradition: The Vital Role of Traditional Foods in Achieving Nutrition Security*, 12(23) Foods 4220 (2023).
186 *Produce Prescription Programs*, Indian Health Serv., https://www.ihs.gov/nutrition/produce-prescription-programs/ [https://perma.cc/V2VP-KZCQ].
187 *P4 Grantee Highlights,* Indian Health Serv., https://www.ihs.gov/nutrition/produce-prescription-programs/p4-grantee-highlights/ [https://perma.cc/V2VP-KZCQ].
188 *Native American Diabetes Project*, Project Angel Food, https://www.angelfood.org/programs-and-pilots/native-american-diabetes-project- [https://perma.cc/EN5K-7T93].
189 A Malli et al., *Impacts of Colonization on Indigenous Food Systems in Canada and the United States: A Scoping Review*, 23 BMC Public Health 2105 (2023),; Carmen Byker Shanks et al., *Perceptions of food environments and Nutrition Among Residents of the Flathead Indian Reservation*, 20 BMC Public Health 1536 (2020).
190 Elisabeth Miltenburg et al., *Relationality, Responsibility and Reciprocity: Cultivating Indigenous Food Sovereignty within Urban Environments*, 14(9) Nutrients 1737(2022).
191 *USDA Indigenous Food Sovereignty Initiative*, U.S. Dep't of Agric., https://www.usda.gov/tribalrelations/usda-programs-and-services/usda-indigenous-food-sovereignty-initiative [https://perma.cc/GR7W-BFUS].
192 *Indigenous Animals Grant*, U.S. Dep't of Agric., https://www.usda.gov/iag [https://perma.cc/CC4L-TECM].
193 *Tribal Forest Protection Act/638 Project Authority*, U.S. Dep't of Agric., Forest Service, (June 4, 2024), https://www.fs.usda.gov/managing-land/national-forests-grasslands/restoration/tribal-forest-protection-act-638.
194 Press Release, Ctrs. for Medicare & Medicaid Serv., *Biden-Harris Administration Takes Groundbreaking Action to Expand Health Care Access by Covering Traditional Health Care Practices* (Oct. 16, 2024) https://www.cms.gov/newsroom/press-releases/biden-

harris-administration-takes-groundbreaking-action-expand-health-care-access-covering [https://perma.cc/6EGL-3UGW].

195 Colorado's waiver amendment specifically targets three populations: 1) those experiencing homelessness or those at risk of homelessness, 2) those transitioning from nursing care facilities, Intermediate Care Facilities for Individuals with Intellectual Disability, or Regional Centers, and 3) those transitioning out of foster care.

196 Letter from Chiquita Brooks-LaSure, Dep't of Health & Human Servs., to State of Colo. Dep't of Health Pol'y & Fin. approving *Colorado Medicaid Coverage of Services to Address Health Related Social Needs: Substance Use Demonstration Amendment Request* (Jan. 13, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/co-continuum-care-appvl-01132025.pdf [https://perma.cc/FRR9-HRRK].

197 Letter from State of Colo. Dep't of Health Pol'y & Fin. to Chiquita Brooks-LaSure, Dep't of Health & Human Servs., submitting *Colorado Medicaid Coverage of Services to Address Health Related Social Needs: Substance Use Demonstration Amendment Request* (Aug. 12, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/co-continuum-care-08122024-pa.pdf [https://perma.cc/6QBJ-Y87R**].**

198 Letter from State of Colo. Dep't of Health Pol'y & Fin. to Chiquita Brooks-LaSure, Dep't of Health & Human Servs., submitting *Colorado Medicaid Coverage of Services to Address Health Related Social Needs: Substance Use Demonstration Amendment Request* 56 (Aug. 12, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/co-continuum-care-08122024-pa.pdf [https://perma.cc/6QBJ-Y87R**].**

199 *Id.* at 55.

200 *Id.*

201 *Id.*

202 Colo. Rev. Stat. § 24-103-907.

203 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Health Related Social Needs (HRSN) Service Manual – HRSN Supplemental Nutrition Services (Dec. 10, 2024), https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/download [https://perma.cc/W62L-RBSP].

204 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Contract Year 2023-2024 (CY23 – CY24) Flexible Services Program (FSP) Guidance Document 25 (Dec. 5, 2022), https://www.mass.gov/doc/contract-year-2023-2024-flexible-services-program-guidance-document/download [https://perma.cc/M6DG-WSJ6].

205 Ctrs. for Medicare & Medicaid Serv., *Accountable Care Organizations (ACOs): General Information* https://www.cms.gov/priorities/innovation/innovation-models/aco (last visited May 30, 2025) [https://perma.cc/QQR7-WUYB].

206 *Id*.

207 *Id.* at 50-51.

208 New York State Food as Med. Project, Executive Summary and Recommendations 4 (Oct 13, 2023), https://thefoodpantries.org/wp-content/uploads/FAM/FINAL_FOOD-AS-MEDICINE-combined.pdf [https://perma.cc/LEF5-6SZF].

209 *Id.* at 2.

210 *Id.* at 1-2.

211 Letter from Daniel Tsai, Dep't of Health & Human Serv., to Amir Bassiri, Medicaid Director, New York Dep't of Health (Jan. 9, 2024) https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_cms_ltr.pdf [https://perma.cc/65EF-MZT7].

212 New York State Dep't. of Health, Social Care Network: Program, Billing, and Data Governance Operations Manual 19-20, 146-152 (Jan. 2025) https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf [https://perma.cc/N799-VLRP] (New York has nine Social Care Network lead entities that will provide regional coordination and support for organizations providing health-related social needs services in the state.)

213 New York State Dep't. of Health, Social Care Network: Program, Billing, and Data Governance Operations Manual 19-20 (Jan. 2025) https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf. [https://perma.cc/N799-VLRP].

214 Ctr. for Health Law and Pol'y Innovation, Combatting Diet-Related Disease in Oklahoma Through Food is Medicine in Medicaid managed Care 2 (June 2024), https://www.healthlawlab.org/wp-content/uploads/2024/06/OK-FIM-Medicaid-Managed-Care-Issue-Brief-June-2024.pdf [https://perma.cc/B4ZB-33DN].

215 Ohio Dep't of Medicaid, Requests for Applications: Ohio Medicaid Managed Care Organizations, RFA NUMBER ODMR-2021-0024, Attachment A, 124-126 (Sept. 2020) https://dam.assets.ohio.gov/image/upload/procure.ohio.gov/pdf/ODMR20210024930202011535 5ODMR20210024.pdf.

216 Ohio Dep't of Medicaid, Requests for Applications: Ohio Medicaid Managed Care Organizations, RFA NUMBER ODMR-2021-0024, Attachment A, 129 (Sept. 2020) https://dam.assets.ohio.gov/image/upload/procure.ohio.gov/pdf/ODMR20210024930202011535 5ODMR20210024.pdf.

217 Elevance Health, Supplier Code of Conduct 9 ( Oct. 2024) https://www.elevancehealth.com/content/dam/elevance-health/documents/Elevance_Health_Supplier_Code_of_Conduct.pdf [https://perma.cc/UCS2-5BJG].

218 Elevance Health, Supplier Code of Conduct 17 ( Oct. 2024) https://www.elevancehealth.com/content/dam/elevance-health/documents/Elevance_Health_Supplier_Code_of_Conduct.pdf [https://perma.cc/UCS2-5BJG].

219 Mich. Dep't of Health and Hum. Servs., Michigan's Comprehensive Health Care Program: In Lieu of

Services Policy Guide 3 (Sept. 2024), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/202409-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf?rev=208ec8afcdcd4f31ad289d2b13ff2c5c&hash=22E955A3B3B21C19B3391678CFCB30D0.

220 *Id*.

221 *Id.*

222 *Id.* at 6, 9, 12, 15.

223 *Id.* at 22.

224 *Id*.

225 Cal. Dep't of Health Care Servs., Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide 54 (July 2023), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf [https://perma.cc/J2GH-WVT2].

226 Virtual Interview with Cathryn Couch, Founder and CEO of Ceres Community Project, Harvard Law Sch. Food Law and Pol'y Clinic (Oct. 10, 2024).

227 Virtual Interview with Dr. Steven Chen, Chief Medical Officer Recipe4Health, Harvard Law Sch. Food Law and Pol'y Clinic (Oct. 31, 2024).

228 Mechel Paggi, California Agriculture's Role in the Economy and Water Use Characteristics, The Ctr. for Agric. Bus., Cal. State U. 2-4 (2011), https://bpb-us-e1.wpmucdn.com/wordpressua.uark.edu/dist/9/350/files/2017/11/2011CA_California_Agricultures_Role_in_the_Economy_and_Water_Use_Characteristics.pdf [https://perma.cc/ZV56-9MCS].

229 Nour Hammad et al., Ctr. for Health Law and Pol'y Innovation, Values at the Heart of Ceres Community Project's Food Sourcing and Procurement Operations, a California Food is Medicine Program (May 2025) https://chlpi.org/wp-content/uploads/2025/06/Ceres-Case-Study-May-2025-V3.pdf; Nour Hammad et al., Ctr. for Health Law and Pol'y Innovation, The North Star Guiding Alameda County Recipe4Health's Food Sourcing Operations as a Food as Medicine Model (May 2025) https://chlpi.org/wp-content/uploads/2025/06/Alameda-County-Case-Study-May-2025-V4.pdf.

230 42 U.S.C. § 1396a(a)(30(A).

231 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Health Related Social Needs (HRSN) Supplemental Services Fee Schedule 1 (Oct. 29, 2024), https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download [https://perma.cc/95LF-XM2P].

232 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Health Related Social Needs (HRSN) Supplemental Services Fee Schedule 1 (Oct. 29, 2024), https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download [https://perma.cc/95LF-XM2P].

233 *Id*.

234 *Cost of Living Data Series*, Mo. Econ. Res. and Info. Ctr., https://meric.mo.gov/data/cost-living-data-series [https://perma.cc/C2D8-CQ3A].

235 The Rockefeller Found., True Cost of Food Measuring What Matters to Transform the U.S. Food System (July 2021), https://www.rockefellerfoundation.org/wp-content/uploads/2021/07/True-Cost-of-Food-Full-Report-Final.pdf [https://perma.cc/CS7B-8MS3].

236 Medi-Cal: medically supportive food and nutrition interventions, A.B. 1975, 2023-2024 Reg. Sess. (Cal. 2024).

237 *Id.*

238 An Act relating to nutrition services, S.B. 806, 2025 Reg. Sess. (Ok. 2025).

239 *Id.*

240 Oklahoma Food is Medicine Coalition, https://app.smartsheet.com/b/publish?EQBCT=fb2eea4f7fbf4598b0b34cdacfba39cd [https://perma.cc/2S34-VV8W].

241 *Id.*

242 Erika Hanson et al., *The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A US Survey*, 2 HEALTH AFFAIRS SCHOLAR qxae013 (Feb. 2024).

243 Elizabeth Hinton & Amaya Diana, *Section 1115 Medicaid Waiver Watch: A Closer Look at Recent Approvals to Address Health-Related Social Needs (HRSN)*, KFF (Mar. 4, 2024), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiver-watch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/ (last visited Jan. 1, 2025) [https://perma.cc/XX3S-56XE].

244 HCS PATH, https://www.ca-path.com/ [https://perma.cc/CTG4-C8XB].

245 CITED, HCS PATH, https://ca-path.com/CITED [https://perma.cc/3SPZ-DH65].

246 Press Release, California Department of Health Care Services, *California Awards Nearly $147 Million to Strengthen Community Health Services* (Aug. 30, 2024) https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2024/24-29-PATH-CITED-Roiund3-08-30-24.aspx [https://perma.cc/5FQG-YWJ9].

247 CITED, HCS PATH, https://ca-path.com/CITED [https://perma.cc/3SPZ-DH65].

248 Oregon Health Authority, 2022-2027 HRSN Infrastructure Protocol, Attachment J, 4 https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-HRSN-Infrastructure-Protocol-Final.pdf [https://perma.cc/2923-SXGR].

249 *Gus Schumacher Nutrition Incentive Program - Produce Prescription*, U.S. Dep't of Agric., https://www.nifa.usda.gov/grants/programs/hunger-food-security-programs/gus-schumacher-nutrition-incentive-program (last visited March 20, 2025) [https://

perma.cc/7BRS-PKTU].

250 7 U.S.C. § 7517(c).

251 7 U.S.C. § 7517(2)(B).

252 7 U.S.C. § 7517(2)(B)(x).

253 U.S. Dep't of Agric., Request for Applications: The Gus Schumacher Nutrition Incentive Program Produce Prescription Program 8 (2023) https://www.nifa.usda.gov/sites/default/files/2023-11/FY24-GusNIP-PPR-RFA-508-P.pdf [https://web.archive.org/web/20250206180323/https://www.nifa.usda.gov/sites/default/files/2023-11/FY24-GusNIP-PPR-RFA-508-P.pdf].

254 *Id.* at 28.

255 *Id.*

256 *Local Food Promotion Program*, U.S. Dep't of Agric., https://www.ams.usda.gov/sites/default/files/media/LFPP_Factsheet.pdf (last visited Jan. 1, 2025) [https://perma.cc/X9NU-C6DC].

257 U.S. Dep't of Agric., Local Food Promotion Program Fiscal Year 2023 Description of Funded Projects 2 (2023) https://www.ams.usda.gov/sites/default/files/media/LFPPFY23DescriptionofFundedProjects.pdf [https://perma.cc/46SC-C7DE].

258 *Id.*

259 Letter from Josh Green, M.D., Governor, State of Hawai'i to Xavier Becerra, Sec'y of Health & Human Servs. submitting the *QUEST Integration Section 1115 Demonstration Extension Application* 53-55 (Nov. 22, 2023) https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf [https://perma.cc/DFZ7-AM3X].

260 An Act relating to nutrition services, S.B. 806, 2025 Reg. Sess. (Ok. 2025).

261 Mich. Dep't of Health and Hum. Servs., Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide 6, 9, 12, 15, 21-22 (Sept. 2024), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/202409-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf?rev=208ec8afcdcd4f31ad289d2b13ff2c5c&hash=22E955A3B3B21C19B3391678CFCB30D0.

262 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Contract Year 2023-2024 (CY23 – CY24) Flexible Services Program (FSP) Guidance Document 25 (Dec. 5, 2022), https://www.mass.gov/doc/contract-year-2023-2024-flexible-services-program-guidance-document/download [https://perma.cc/M6DG-WSJ6].

263 New York State Dep't. of Health, Social Care Network: Program, Billing, and Data Governance Operations Manual 19-20, 146-152 (Jan. 2025) https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf [https://perma.cc/N799-VLRP].

264 Ohio Dep't of Medicaid, Requests for Applications: Ohio Medicaid Managed Care Organizations, RFA NUMBER ODMR-2021-0024, Attachment A, 124-126, 129 (Sept. 2020) https://dam.assets.ohio.gov/image/upload/procure.ohio.gov/pdf/ODMR20210024930202011535 5ODMR20210024.pdf.

265 Commw. of Mass. Exec. Off. of Health and Hum. Servs., Health Related Social Needs (HRSN) Supplemental Services Fee Schedule 1 (Oct. 29, 2024), https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download [https://perma.cc/95LF-XM2P]; *Cost of Living Data Series*, Mo. Econ. Res. and Info. Ctr., https://meric.mo.gov/data/cost-living-data-series [https://perma.cc/C2D8-CQ3A].

266 CITED, HCS PATH, https://ca-path.com/CITED [https://perma.cc/3SPZ-DH65]; Oregon Health Authority, 2022-2027 HRSN Infrastructure Protocol, Attachment J, 4 https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-HRSN-Infrastructure-Protocol-Final.pdf [https://perma.cc/2923-SXGR].

267 Vermont Law Sch. Ctr. for Agric. & Food Systems, Defining Local Food: An Analysis of State Approaches and Challenges (Aug. 2021), https://www.vermontlaw.edu/wp-content/uploads/2024/07/Local-Food-Definitions.pdf [https://perma.cc/JW4V-6WX2].

268 *State Preference Repository*, Nat'l Ass'n of State Procurement Off.'s, https://www.naspo.org/research-and-innovation/state-preference-repository/ (last visited Jan. 17, 2025) [https://perma.cc/Q5BU-AK4L].

269 ChangeLab Solutions, State Laws Promoting Use of Locally Grown Food and Agricultural Products in Public Contracts (Dec. 2011), https://www.changelabsolutions.org/sites/default/files/LocalFoodsStateLawsTable_FINAL_Rebranded.pdf [https://perma.cc/GH6R-XGQE].

270 Harvard Law Sch. Food Law and Pol'y Clinic, Increasing Local Food Procurement by Massachusetts State Agencies 51-54 (Apr. 2015), https://chlpi.org/wp-content/uploads/2013/12/Increasing-Local-Procurement-by-Massachusetts-State-Agencies_FINAL_FULL-REPORT.pdf [https://perma.cc/3CAF-CFU8].

## APPENDIX B ENDNOTES

[271] Letter from Josh Green, M.D., Governor, State of Hawai'i to Xavier Becerra, Sec'y of Health & Human Servs. submitting the *QUEST Integration Section 1115 Demonstration Extension Application* 53-55 (Nov. 22, 2023) https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf [https://perma.cc/DFZ7-AM3X].

[272] Commw. of Mass. Exec. Off. of Health and Hum. Servs., Contract Year 2023-2024 (CY23 – CY24) Flexible Services Program (FSP) Guidance Document 25 (Dec. 5, 2022), https://www.mass.gov/doc/contract-year-2023-2024-flexible-services-program-guidance-document/download [https://perma.cc/M6DG-WSJ6].

[273] *Id*. at 51.

[274] New York State Dep't. of Health, Social Care Network: Program, Billing, and Data Governance Operations Manual 15 (Jan. 2025) https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/docs/operations_manual.pdf [https://perma.cc/N799-VLRP].

[275] *Id*.

[276] Ohio Dep't of Medicaid, Requests for Applications: Ohio Medicaid Managed Care Organizations, RFA NUMBER ODMR-2021-0024, Attachment A 124-126 (Sept. 2020) https://dam.assets.ohio.gov/image/upload/procure.ohio.gov/pdf/ODMR20210024930202011535 5ODMR20210024.pdf.

[277] *Id*. at 129.

[278] Mich. Dep't of Health and Hum. Servs., Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide 22 (Sept. 2024), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/202409-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf?rev=208ec8afcdcd4f31ad289d2b13ff2c5c&hash=22E955A3B3B21C19B3391678CFCB30D0.

[279] *Id.*

[280] Cal. Dep't of Health Care Servs., Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide 54 (July 2023), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf [https://perma.cc/J2GH-WVT2].

[281] Commw. of Mass. Exec. Off. of Health and Hum. Servs., Health Related Social Needs (HRSN) Supplemental Services Fee Schedule 1 (Oct. 29, 2024), https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download [https://perma.cc/95LF-XM2P].

[282] An Act relating to nutrition services, S.B. 806, 2025 Reg. Sess. (Ok. 2025), https://www.oklegislature.gov/cf_pdf/2025-26%20ENR/SB/SB806%20ENR.PDF

[283] HCS PATH, https://www.ca-path.com/ [https://perma.cc/CTG4-C8XB].

[284] Oregon Health Authority, 2022-2027 HRSN Infrastructure Protocol, Attachment J, 1 https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-HRSN-Infrastructure-Protocol-Final.pdf [https://perma.cc/2923-SXGR].

[285] *Id.* at 3.

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