



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



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



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

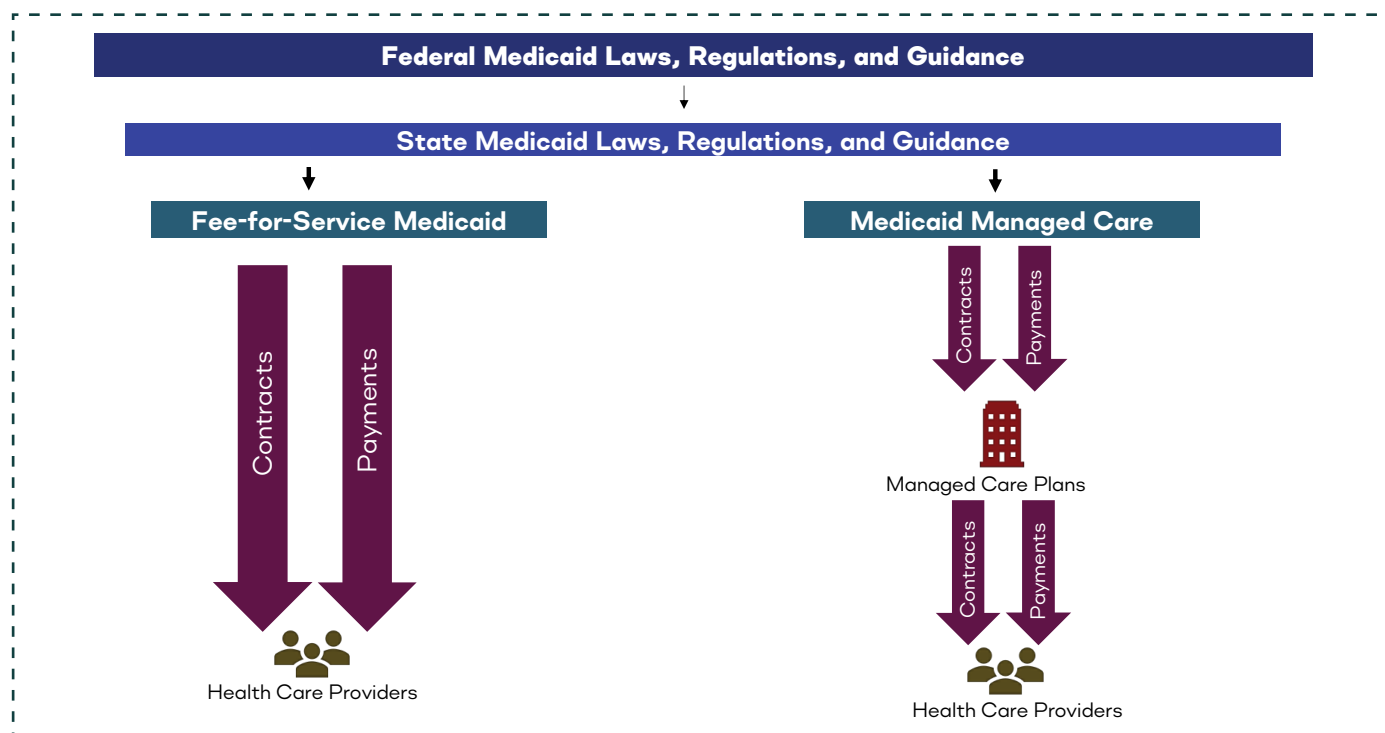
Requests for information, or RFIs, can be used in advance of a request for proposals to gather information in order to identify potential issues or concerns and inform the government's approach to procurement.⁶³ Governmental organizations may also hold public hearings, conduct their own market research, 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 law⁷² 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 may 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 Program¹⁴³ and various state-led local food purchasing incentive programs¹⁴⁴ 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 services¹⁶⁹ 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

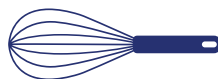
demonstrate and evaluate the impact of produce prescriptions on improving dietary health, reducing food insecurity, and decreasing the use and cost of healthcare.²⁵⁰ The statute authorizing the program requires the prioritization of projects based on a set of criteria, including whether the program provides “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 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 | Alaska Stat. § 36.15.050

Name of Statute | Use of local agricultural and fisheries products required in purchases with state money

Type of Preference | Mandatory

Details of Preference | 7%

Type of Preference | Discretionary

Details of Preference | Up to 15%

What is Covered

Agricultural and fisheries products

Who is Covered

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 withheld for non-compliance.



ARIZONA

Statute | None



ARKANSAS

Statute | Ark. Code Ann. § 15-4-3804

Name of Statute | Procurement Goal - Distributor requirements

Type of Preference | Benchmark

Details of Preference | 20% of agency's purchases of food products should be spent on local farm or food products

What is Covered

Farm or food products

Who is Covered

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

Name of Statute | Procurement goal - Preference

Type of Preference | Mandatory

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

What is Covered

Local farm or food products

Who is Covered

Agencies that receive at least \$25,000 from the state and offer a food service program



CALIFORNIA

Statute | Cal. Gov't Code § 4331

Name of Statute | Preference to supplies manufactured or produced in state

Type of Preference | Tie-breaker

Details of Preference | Price, fitness, and quality being equal

What is Covered
Goods

Who is Covered

State, state institutions, state offices, counties, and cities

Additional Information

Not applicable to educational agencies

Statute | Cal. Food & Agric. Code § 58595

Name of Statute | Solicitation of bids; acceptance

Type of Preference | Benchmark

Details of Preference | 60% by December 31, 2025

What is Covered

Agricultural food products

Who is Covered

State-owned or state-run institution



COLORADO

Statute | Colo. Rev. Stat. § 24-103-907

Name of Statute | Preference for state agricultural products

Type of Preference | Mandatory

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

Agricultural products

Who is Covered

Governmental bodies



CONNECTICUT

Statute | Conn. Gen. Stat. § 4a-51

Name of Statute | Duties of Administrative Services Commissioner re purchases

Type of Preference | Mandatory

Details of Preference | When comparable in cost

What is Covered

Dairy products, poultry, eggs, beef, pork, lamb, farm-raised fish, fruits or vegetables

Who is Covered

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

Name of Statute | Preference of products produced in Georgia; vendor preference

Type of Preference | Reasonableness

Details of Preference | When reasonable and practicable, so long as quality is not sacrificed

What is Covered

Agricultural products, excluding beverages for immediate consumption

Who is Covered

The state and any of its departments, agencies, or commissions

Statute | Ga. Code Ann. § 36-84-1

Name of Statute | Preferences for products manufactured in Georgia; reasonableness

Type of Preference | Reasonableness

Details of Preference | When reasonable and practicable, so long as quality is not sacrificed

What is Covered

Agricultural products, excluding beverages for immediate consumption

Who is Covered

Local governments, meaning county, municipality, or consolidated government



HAWAII

Statute | Haw. Rev. Stat. § 103D-1002

Name of Statute | Hawaii products

Type of Preference | Mandatory

Details of Preference | 15%

What is Covered

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

Governmental agencies



IDAHO

Statute | Idaho Code § 67-9210

Name of Statute | Award of Contract

Type of Preference | Tie-breaker

Details of Preference | When bids and quality are the same

What is Covered

Goods

Who is Covered

State agencies



ILLINOIS

Statute | 130 Ill. Comp. Stat. 500/45-50

Name of Statute | Illinois agricultural products

Type of Preference | Discretionary

Details of Preference | Preference may be given to otherwise qualified bidder using in-state agricultural products

What is Covered

Agricultural Products

Who is Covered

State agencies

Statute | 30 Ill. Comp. Stat. 595/10

Name of Statute | Procurement goals for local farm or food products

Type of Preference | Benchmark

Details of Preference | 20% by 2020

What is Covered

Farm or food products

Who is Covered

State agencies and State-owned facilities

Type of Preference | Benchmark

Details of Preference | 10% by 2020

What is Covered

Farm or food products

Who is Covered

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

Name of Statute | Price preference for Indiana agricultural products

Type of Preference | Discretionary

Details of Preference | Up to 10%

What is Covered

Agricultural products

Who is Covered

Governmental bodies and instrumentalities of the state performing governmental functions



IOWA

Statute | Iowa Code § 73.1

Name of Statute | Preference - conditions

Type of Preference | Tie-breaker

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

Products

Who is Covered

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

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

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

Agricultural products

Who is Covered

State agencies



LOUISIANA

Statute | La. Stat. Ann. § 38:2251

Name of Statute | Preference for products produced or manufactured in Louisiana; exceptions

Type of Preference | Discretionary

Details of Preference | Up to 10%

What is Covered

Meat, seafood, produce, eggs

Who is Covered

Each procurement officer, purchasing agent, or similar official

Type of Preference | Discretionary

Details of Preference | Up to 7%

What is Covered

Meat and meat products processed in-state
Domesticated or wild catfish processed in-state but grown outside

Produce processed in-state but grown outside
Food or food products

Who is Covered

Each procurement officer, purchasing agent, or similar official



MAINE

Statute | Me. Stat. tit. 7 § 214-A

Name of Statute | Maine foods procurement program

Type of Preference | Benchmark

Details of Preference | 20% by 2025

What is Covered

Food or food products

Who is Covered

State institutions

Statute | Me. Stat. tit. 7 § 219

Name of Statute | Food self-sufficiency

Type of Preference | Discretionary

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

Food

Who is Covered

State institutions



MARYLAND

Statute | Md. Code Ann.,
State Fin. & Proc. § 14-407

Name of Statute |
Percentage price
preference for locally
grown foods

Type of Preference | Mandatory

Details of Preference | Required to
establish a percentage price preference

What is Covered

Food

Who is Covered

State schools and facilities

Type of Preference | Discretionary

Details of Preference | Up to 5%

What is Covered

Food

Who is Covered

State schools and facilities

Statute | Md. Code, State
Fin. & Proc. § 14-703

Name of Statute |
Procurement procedures

Type of Preference | Benchmark

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

Food

Who is Covered

Office for the Certified Local
Farm and Fish Program,
Maryland Department of
Agriculture



MASSACHUSETTS

Statute | Mass. Gen. Laws ch. 7, § 23B

Name of Statute | Preference for
Massachusetts farm products

Type of Preference | Mandatory

Details of Preference | 10%

**What is
Covered**

Agricultural
products

Who is Covered

A state agency, authority or
trustees or officers of a state
college or university



MICHIGAN

Statute | None



MINNESOTA

Statute | Minn. Stat. § 16C.12

Name of Statute | Agricultural
Food Products Grown in State

Type of Preference | Reasonableness

Details of Preference | Encourage and make
a reasonable attempt to identify and purchase
food products grown in the state

What is Covered

Agricultural
products

Who is Covered

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 | N.C. Gen. Stat. § 143-59

Name of Statute | Preference given to North Carolina products and citizens, and articles manufactured by State agencies; reciprocal preferences

Type of Preference | Tie-breaker

Details of Preference | So long as there is no sacrifice or loss in price or quality

What is Covered

Food or other products

Who is Covered

Secretary of Administration and any state agency



NORTH DAKOTA

Statute | None



OHIO

Statute | Ohio Admin. Code 123:5-1-06

Name of Statute | Ohio preferences

Type of Preference | Mandatory

Details of Preference | 2%

What is Covered

Products raised, grown, produced, mined or manufactured in Ohio or a border state

Who is Covered

State agencies



OKLAHOMA

Statute | Okla. Stat. Tit. 74 § 85.17A

Name of Statute | Bidding preferences - Reciprocity - Awarding contracts.

Type of Preference | Tie-breaker

Details of Preference | When price, fitness, availability, and quality are otherwise equal

What is Covered

Goods

Who is Covered

State agencies



OREGON

Statute | Or. Rev. Stat. § 279A.128

Name of Statute | Preference for goods fabricated or processed within state or services performed within state.

Type of Preference | Discretionary

Details of Preference | Up to 10% and above 10% with written findings of good cause for setting a higher preference

What is Covered

Goods that are fabricated or processed in state

Who is Covered

A contracting agency that uses public funds



PENNSYLVANIA

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

Name of Statute | Preference to goods produced or grown in this state, including agricultural products

Type of Preference | Tie-breaker

Details of Preference | When all other factors are equal

What is Covered

Goods and agricultural products

Who is Covered

All departments and agencies

Statute | Tenn. Code Ann. § 12-3-1108

Name of Statute | Tennessee meat producers; purchasing preference; departments, agencies and institutions

Type of Preference | Tie-breaker

Details of Preference | So long as the terms, conditions and quality are equal to those obtainable from producers located elsewhere

What is Covered

Meat, meat food products, meat by-products

Who is Covered

All departments, agencies and institutions of state government using state funds



TEXAS

Statute | Tex. Gov't. Code Ann. § 2155.444

Name of Statute | Preference to Texas and United States Products and Texas Services

Type of Preference | Tie-breaker

Details of Preference | If the cost to the state and quality are equal

What is Covered

Agricultural products

Who is Covered

Comptroller and all state agencies



UTAH

Statute | Utah Code Ann. § 63G-6a-1002

Name of Statute | Reciprocal preference for providers of state products

Type of Preference | Reciprocal

Details of Preference | Applies preference of any state that gives a preference to items produced, manufactured, or grown in that state

What is Covered

Items produced, manufactured or grown

Who is Covered

State, its agencies, departments, instrumentalities, and institutions



VERMONT

Statute | Vt. Stat. Ann. tit. 29, § 909

Name of Statute | State purchase of food and agricultural products

Type of Preference | Tie-breaker

Details of Preference | Other considerations being equal and considering the results of any econometric analysis conducted

What is Covered

Food and agricultural products

Who is Covered

Secretary of Administration, Commissioner of Buildings and General Services, and any state-funded institutions



VIRGINIA

Statute | Va. Code Ann. § 2.2-4328

Name of Statute | Preference for local products and firms; applicability

Type of Preference | Tie-breaker

Details of Preference | Preference to goods produced in Virginia

What is Covered
Goods

Who is Covered
Governing body of a county, city or town

Statute | Va. Code Ann. § 2.2-4324

Name of Statute | Preference for Virginia goods, U.S. goods, and Virginia residents

Type of Preference | Tie-breaker

Details of Preference | So long as the terms, conditions and quality are equal to those obtainable from producers located elsewhere

What is Covered
Goods

Who is Covered
Public bodies



WASHINGTON

Statute | Wash. Rev. Code § 39.26.260

Name of Statute | Preferences—In-state procurement

Type of Preference | Reciprocal preference

Details of Preference | Applies preference of other states with in-state preference

What is Covered
Goods

Who is Covered
State agencies



WEST VIRGINIA

Statute | W. Va. Code § 19-37-2

Name of Statute | State-funded institutions to purchase food from in-state sources; exception

Type of Preference | Benchmark

Details of Preference | Minimum of 5%

What is Covered

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

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

Name of Statute | Preference for Wyoming materials and Wyoming agricultural products required in public purchases; exception; cost differential; definition.

Type of Preference |
Discretionary

Details of Preference |
Up to 5%

What is Covered

Agricultural products

Who is Covered

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	<p>Embed Local Food Priorities in 1115 Demonstration Waivers</p> <p>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.</p>	<p>HAWAII</p> <p><i>"Hawaii 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."</i></p> <ul style="list-style-type: none"> • Meal delivery services; • Grocery store and grocery delivery services; • Farms and farmers markets; • Community gardens and seedling stores; • Food "hubs" and distributors that contract with local farms; • Health-care providers, such as FQHCs, RHCs, and hospitals; • Educational institutions, such as community colleges; • QI health plans; and • Other community-based organizations and food pharmacies, which may also be located within one of these organizations."²⁷¹
Medicaid Section 1115 Demonstration Guidance	<p>Use Implementation Guidance to Elevate Local Food & Community-Based Organizations</p> <p>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.</p>	<p>MASSACHUSETTS</p> <p><i>"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)."</i></p> <p>...</p> <p><i>[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</i></p> <p><i>"[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</i></p> <p>NEW YORK</p> <p><i>"[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</i></p> <p><i>"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</i></p>

Policy Lever	Opportunity	Example(s) of Language Used by States
Medicaid Managed Care Plan Selection	<p>Require Alignment with Local Values in Medicaid Contracting</p> <p>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.</p>	<p>OHIO</p> <p><i>"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 . . . [partnering with community-based organizations and contribute to solutions addressing [social determinants of health] -related needs, such as . . . lack of access to nutritious food. . . ."276</i></p> <p><i>"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</i></p>
In Lieu of Services and Settings (ILOS) Guidance	<p>Incorporate "Local" into In Lieu of Services & Settings Definitions (ILOS) and Targets</p> <p>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.</p> <p>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.</p>	<p>MICHIGAN</p> <p><i>"[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</i></p> <p><i>"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</i></p> <p>CALIFORNIA</p> <p><i>"[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</i></p>

Policy Lever	Opportunity	Example(s) of Language Used by States
Medicaid Reimbursement Rates for Nutrition Services	<p>Align Reimbursement Rates with True Costs of Local Food and Consider Using Fee Schedules to Promote State Food Sourcing Values</p> <p>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.</p>	<p>MASSACHUSETTS</p> <p><i>"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.</i></p> <ul style="list-style-type: none"> • <i>[Health Related Social Needs] Supplemental Services Fee Schedule: Expected Unit Cost: \$14.86</i> • <i>[Health Related Social Needs] Supplemental Services Fee Schedule: Maximum: \$18.58 (see Note 1)</i> <p><i>Note 1:</i> <i>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."</i>²⁸¹</p>
Legislative Directives	<p>Legislate Support for Local Sourcing & Community-Based Organizations</p> <p>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.</p>	<p>OKLAHOMA</p> <p><i>"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."</i>²⁸²</p>

Policy Lever	Opportunity	Example(s) of Language Used by States
Medicaid Section 1115 Infrastructure Funding	<p>Invest in Local Food Infrastructure Through Demonstration Funding</p> <p>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.</p>	<p>CALIFORNIA</p> <p><i>"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.</i></p> <p><i>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."</i>²⁸³</p> <p>OREGON</p> <p><i>"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."</i>²⁸⁴</p> <p><i>"The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.</i></p> <ol style="list-style-type: none"> <i>Technology</i> <i>Development of business or operational practices</i> <i>Workforce development</i> <i>Outreach, education and stakeholder convening"</i>²⁸⁵

ENDNOTES

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