



Summary: Accountable Produce is Medicine Act of 2026

The **Accountable Produce is Medicine Act of 2026** would require the **Center for Medicare and Medicaid Innovation (CMMI)** to launch and test a new federal payment and care-delivery model focused on reducing chronic disease through food-based interventions. Specifically, the bill directs CMMI to include an “**Accountable Produce is Medicine Bundled Payment Model**” within 180 days after enactment. The model would use bundled payments under **Medicare, Medicaid, and CHIP** to support selected programs that provide a structured package of health and nutrition services to eligible patients with chronic conditions.

At a high level, the legislation is built around a simple proposition: **diet-related chronic diseases drive major health care costs, and targeted food-as-medicine interventions may improve outcomes while lowering spending.** The bill’s findings state that evidence-based interventions such as medically tailored meals, medically tailored groceries, produce prescriptions, and nutrition counseling have the potential to improve health outcomes and reduce expenditures, and that CMMI should incorporate these kinds of interventions into its innovation models where appropriate.

What the bill would do

The core of the legislation is the creation of a **mandatory CMMI demonstration model** rather than a permanent nationwide benefit. The Secretary of Health and Human Services would be required to select **at least five eligible programs**, each participating for **at least two years**, and the overall model would run for **not less than five years**. These selected programs would receive bundled payments to furnish a defined set of “Accountable Produce is Medicine” services to eligible individuals.

This is important because the bill does not simply authorize food benefits in the abstract. Instead, it creates a **structured, accountable, data-driven demonstration** with defined screening requirements, service requirements, patient eligibility standards, and outcomes tracking. It is designed to test whether integrating nutritious food and related care supports into health care financing can reduce chronic disease burden and total cost of care.

Who could participate

The legislation defines both the patient population and the types of entities that could participate.

An **eligible individual** must be enrolled in **Medicare Part A or Part B, Medicaid, or CHIP**. In addition, the individual must live in a **medically underserved area, rural area, health professional shortage area, or another area the Secretary deems appropriate**. The individual must also have a qualifying condition such as **diabetes, obesity, cardiovascular disease, hypertension, malnutrition, or another chronic disease or condition selected by the Secretary**.

Finally, a physician or other health care professional must determine that the person would benefit from participation, the program must find the person prepared to participate, and the individual cannot already be receiving substantially duplicative services.

An **eligible program** is defined broadly as a **provider of services or supplier enrolled in Medicare, Medicaid, or CHIP**. That gives HHS considerable latitude in choosing participants. In practice, likely participants could include hospitals, physician groups, federally qualified health centers, rural providers, accountable care organizations, health-system-affiliated community programs, or other enrolled suppliers that can organize and manage this service package.

What services selected programs would have to provide

For each patient determined eligible, the selected program must provide a **one-year package of services**. These services are broader than just delivering produce. They include:

- a personalized health risk assessment and prevention plan
- care coordination
- telehealth services related to chronic disease monitoring, education, and follow-up
- remote patient monitoring items and services, when clinically appropriate
- lifestyle modification services, including nutrition counseling, exercise programs, and smoking cessation counseling
- healthy, nutrient-dense foods meeting standards set by the Secretary

The inclusion of these elements makes the bill more of a **population health and chronic disease management model** than a narrow produce-prescription program. It links food access to care management, telehealth, patient monitoring, and behavior-change support. For providers, that means participation would likely require operational capacity well beyond distributing food. For agriculture stakeholders, it means the food component would sit inside a larger clinical and payment framework rather than function as a standalone procurement program.

Why the agriculture language matters

One of the most notable features of the bill is its clear preference for certain food sourcing approaches. In selecting participating programs, the Secretary must give priority to programs that furnish **fresh, frozen, or minimally processed fruits and vegetables without added sugars, sodium, or saturated fats**, along with other **plant-based, nutrient-dense foods** such as nuts, seeds, intact whole grains, beans, and lentils.

The bill goes further by stating that the healthy foods provided under the model should meet standards set by the Secretary, with **preference given to produce grown within 250 miles of the selected program or through the use of regenerative agriculture**. The bill defines regenerative agriculture as a conservation management approach emphasizing natural resources through improved soil health, water management, and natural vitality.

For **farmers, ranchers, and agricultural interests**, this is one of the bill's biggest opportunities. It signals that the demonstration could create a **federally supported demand channel for regionally grown produce and foods associated with regenerative practices**. While the bill does not establish a direct farm subsidy or procurement entitlement, it creates a framework in which selected

health care programs may prefer or be incentivized to source from local and regionally aligned producers. That could benefit produce growers, food hubs, aggregators, distributors, and agricultural organizations that can help build traceable, reliable supply chains into health care settings.

For **ranchers**, the opportunity is more indirect. The bill's priority language is heavily centered on fruits, vegetables, and plant-based nutrient-dense foods. It does not appear to emphasize animal protein as a core preferred category. Ranchers and livestock interests may therefore see fewer direct benefits unless they are involved in broader regional food-system partnerships or in program logistics that support clinical nutrition initiatives. The strongest alignment is likely for produce growers and diversified agricultural operations with strong regional distribution capacity. That is an inference from the bill's explicit food-priority language.

Operational implications for providers

For health care providers, this legislation would create both opportunity and administrative responsibility. Selected programs would be required to:

- screen referred individuals for eligibility
- track which services each patient receives
- regularly evaluate engagement and adherence
- collect quarterly data including weight, blood pressure, and blood glucose, plus any other measures the Secretary requires
- evaluate results at the end of the year and submit data needed for HHS to assess cost savings
- reassess patient eligibility for reenrollment

The bill also authorizes **disenrollment** if a patient is not adequately engaging or adhering to program requirements, based on standards established by the Secretary. That underscores that this is intended to be a performance-oriented model rather than an open-ended nutrition support program.

Financially, the Secretary would determine the **form, manner, and amount of the bundled payment**, and beginning in the **third year** of the model, selected programs **may be required to assume financial risk** for performance. That provision is especially important for providers. Early participation could be relatively manageable, but over time the model may evolve toward greater accountability for outcomes and spending.

The bill also provides that services under the model must be furnished **without deductibles, copayments, coinsurance, or other cost-sharing**. That could improve patient uptake and adherence, but it also means providers will depend heavily on adequate model design and bundled payment levels from HHS.

