JOINT COMMISSION ON HEALTH CARE

IMPLEMENTATION OF A MEDICAID IN LIEU OF SERVICE FOOD AND NUTRITION BENEFIT FOR INDIVIDUALS WITH DIET-RELATED CHRONIC CONDITIONS

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #148

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Implementation of a Medicaid In Lieu of Service Food and Nutrition Benefit for Individuals with Diet-Related Chronic Conditions

Contents

Implementation of a Medicaid In Lieu of Service Food and Nutrition Benefit for Individuals with Diet-Related Chronic Conditions

POLICY OPTIONS IN BRIEF

Option: Direct DMAS to develop a plan for a nutrition "in lieu of" service (ILOS) managed care benefit, including (i) descriptions of the services proposed to be covered and the covered services for which they will substitute and categories of individuals who will be eligible for the service, (ii) evidence of cost-effectiveness of the services proposed to be covered and the cost percentage of the services proposed to be covered, (iii) provisions for monitoring and oversight of the ILOS to meet federal requirements, and (iv) any other information required to be provided to the Centers for Medicare and Medicaid Services to support authorization of the ILOS. (Option 1, page 17)

FINDINGS IN BRIEF

Increase in diet-related chronic conditions is due, in part, to poor nutrition

Diet-related chronic conditions (DRCCs) such as obesity, cardiovascular disease, hypertension, and diabetes are increasing in prevalence and require significant health care resources. Diet quality is a modifiable risk factor for these chronic conditions. Barriers to accessing nutritious foods and lack of information contribute to increasing rates of DRCCs in Virginia.

Nutrition interventions can reduce barriers to a healthy diet and improve health outcomes

Nutrition interventions can address factors that contribute to development and progression of DRCCs. Food is Medicine (FIM) nutritional interventions such as medically tailored meals, medically tailored groceries, and produce prescriptions are implemented in clinical settings to treat or manage DRCCs.

States can implement food and nutrition interventions through their Medicaid programs

Federal rules offer several policy pathways for states to offer optional benefits, including nutrition benefits: state plan amendments (SPAs), Section 1915(c) home- and community-based services waivers, Section 1115 demonstration waivers, and managed care in-lieu-of-services and settings (ILOS) benefits. Similar to several other states, Virginia could authorize an ILOS benefit to make food and nutrition services available to Medicaid members.

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Implementation of a Medicaid In Lieu of Service Food and Nutrition Benefit for Individuals with Diet-Related Chronic Conditions

The prevalence of diet-related chronic conditions like obesity, cardiovascular disease, hypertension, and diabetes is increasing in Virginia. Interventions that provide nutritional counseling and access to healthy foods can improve health outcomes, reduce health-related complications, and lower health care costs for individuals with diet-related chronic conditions. Virginia's Medicaid program presents an opportunity to provide nutritional interventions for individuals with diet-related chronic conditions, including those who may be experiencing barriers to accessing healthy foods.

Following the 2025 General Assembly Session, the Chair of the House Committee on Health and Human Services requested the Joint Commission on Health Care (JCHC) study the impact and cost-effectiveness of substituting food and nutrition services for more intensive covered services via an "In Lieu of Service" (ILOS) benefit within the Medicaid program (APPENDIX 1). The JCHC directed staff to conduct a targeted study on this topic. The study examines implementation of a food and nutrition benefit for Medicaid members living with diet-related chronic conditions by (i) describing the prevalence and impact of diet-related chronic conditions in Virginia, (ii) identifying barriers to accessing nutritious foods, (iii) describing how nutrition interventions, including the Food is Medicine (FIM) concept, can address such barriers, and (iv) providing implementation considerations through which Virginia’s Medicaid program may offer an ILOS food and nutrition benefit.

Increase in diet-related chronic conditions is due, in part, to poor nutrition

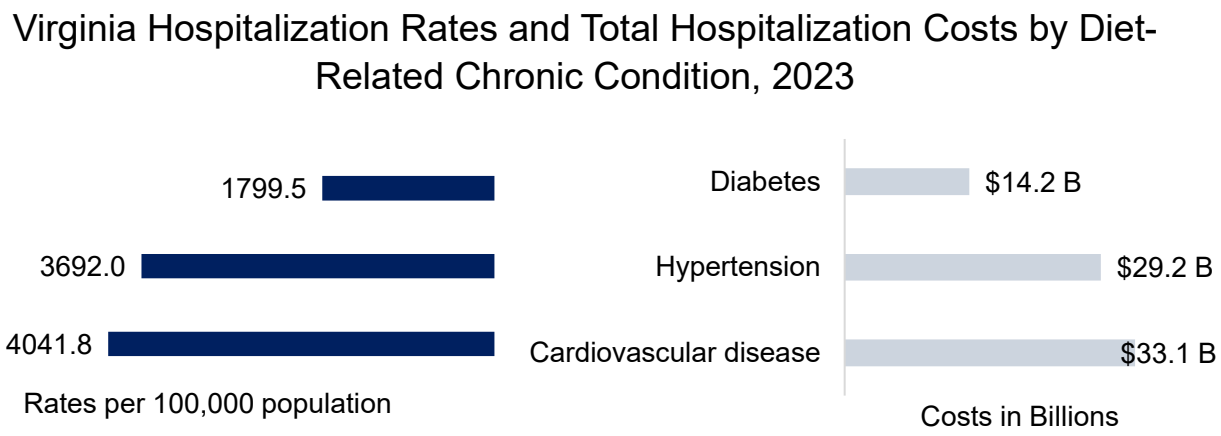
Diet-related chronic conditions (DRCCs), such as obesity, cardiovascular disease (CVD), hypertension, and diabetes, are increasing in prevalence nationally and in Virginia. Proper nutrition and a healthy diet can prevent the development of or mitigate the negative health consequences of DRCCs. However, some individuals experience barriers to accessing nutritious foods.

DRCCs are increasing in prevalence and require significant health care resources

Chronic conditions are long-term, non-communicable diseases or health conditions that last for one year or more and limit activities of daily living or require ongoing medical attention. They may be caused by a combination of genetic, physiological, environmental, and behavioral factors. Nationally, more than 75 percent of adults have at least one chronic condition, and the prevalence of chronic conditions is increasing. Treatment and management of chronic conditions require significant health care resources. As such, the costs to the health care system to treat or manage chronic conditions are high.

DRCCs are a subset of chronic conditions characterized by the significant extent to which poor nutrition plays a role in and dietary changes can help prevent, manage, or improve condition development, progression, or severity. Like all chronic conditions, DRCCs have several shared risk factors, but poor nutrition and dietary habits remain the most significant contributing and modifiable risk factors. Hospitalizations are a significant driver of the cost of treating and managing DRCCs. In Virginia, CVD, hypertension, and diabetes accounted for $76.5 billion in hospitalization costs in 2023 (FIGURE 1). DRCCs remain the leading cause of death in the United States. In Virginia, approximately 42,400 people died from DRCCs in 2023.

FIGURE 1. Diet-related chronic conditions account for highest hospitalization rates and total hospital costs among chronic conditions



SOURCE: Virginia Department of Health Chronic Disease dashboard, 2025.

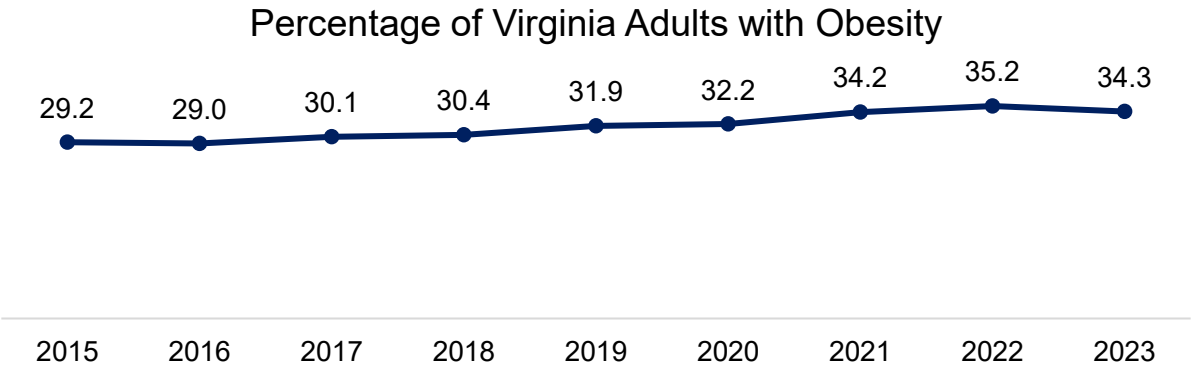
Obesity prevalence has increased among Virginia adults since 2015

Obesity is commonly defined as an accumulation of excess body fat that can develop over time because of poor dietary patterns, lack of physical activity, and genetic predisposition

for the disease. Obesity increases the risk of heart disease and is often related to the onset of type 2 diabetes and some cancers.

In 2023, 35.5 percent of U.S. adults were living with obesity. Rates of obesity are higher among lower income individuals; 39.1 percent of adults enrolled in Medicaid, a joint federal and state health insurance program for low-income individuals, were obese in 2023. The prevalence of obesity in Virginia is slightly lower than the national average but has increased over time. In 2015, 29.2 percent of Virginia adults were obese, rising to 34.3 percent by 2023, and amounting to three million Virginians being obese (FIGURE 2).

FIGURE 2. Proportion of adult population with obesity has increased since 2015

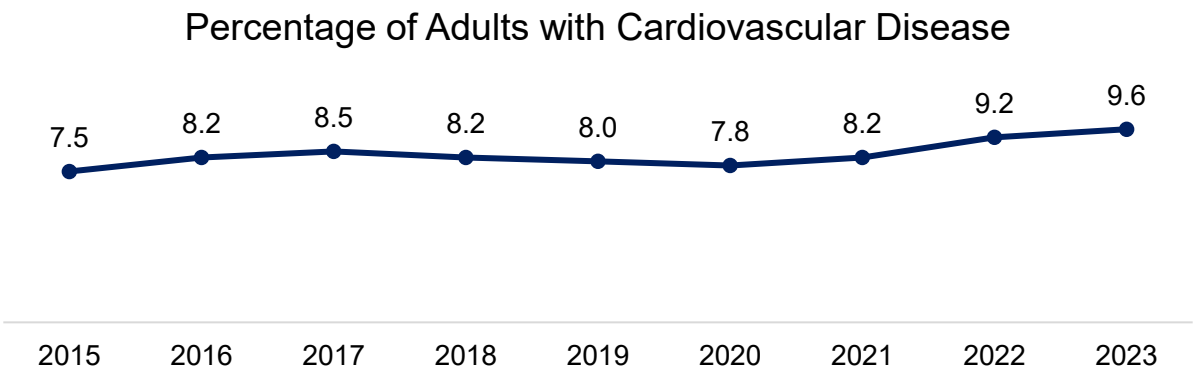


SOURCE: Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, 2025.

Cardiovascular disease remains the leading cause of death in Virginia

Cardiovascular disease (CVD) refers to a broad range of conditions, such as coronary heart disease and heart failure, which affect the heart and blood vessels. Diet significantly impacts CVD by influencing risk factors such as cholesterol levels, blood pressure, inflammation, and body weight. Diets high in fruits, veggies, whole grains, and healthy fats protect the heart, while diets heavy in saturated/trans fats, added sugars, and sodium promote CVD. CVD is associated with increased risk of cardiovascular complications and is the leading cause of death in Virginia. CVD prevalence in Virginia has increased, from 7.5 percent in 2015 to 9.6 percent in 2023 (FIGURE 3). Virginia's current rate of CVD among adults is higher than the national average of 8.5 percent, and rates of conditions that comprise CVD among lower income individuals are even higher. For example, rates of coronary heart disease, heart attack, and stroke are between 20 and 80 percent higher among adults enrolled in Medicaid compared to the general population.

FIGURE 3. CVD prevalence in Virginia adults increased between 2015 and 2023

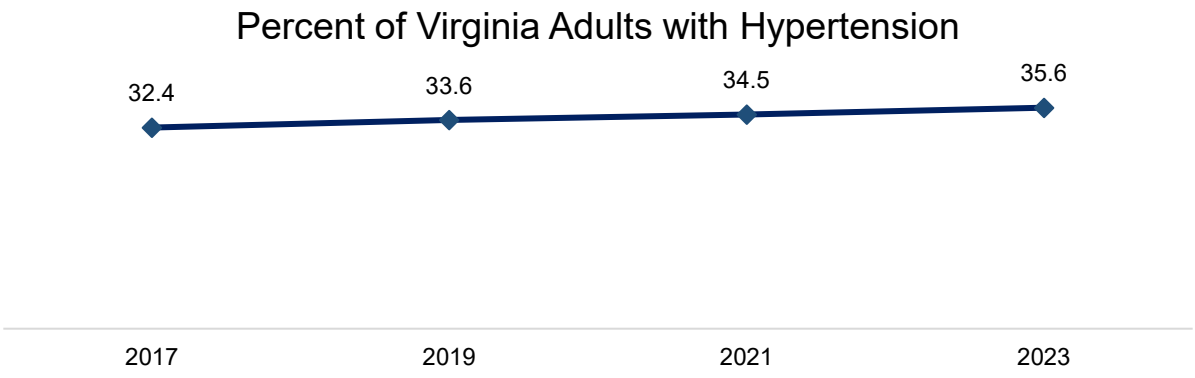


SOURCE: Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, 2025.

The percentage of Virginia adults living with hypertension has increased since 2017

Hypertension, or elevated blood pressure, occurs when the pressure in a person's blood vessels is consistently too high, defined as a systolic blood pressure of more than 130 mm Hg or diastolic blood pressure of over 80 mm Hg. Diets high in sodium, sugar, or alcohol strongly predispose individuals to hypertension, whereas diets high in potassium, magnesium, calcium, and fiber may lower blood pressure. Hypertension can lead to serious health issues, such as strokes and heart attacks. The prevalence of hypertension in Virginia adults has increased from 32.4 percent in 2017 to 35.6 percent in 2023 (FIGURE 4).

FIGURE 4. Proportion of Virginia adults diagnosed with hypertension increased between 2017 and 2023



SOURCE: JCHC staff analysis of Virginia Department of Health data, 2025.

Gestational hypertension is characterized by new-onset high blood pressure that develops after 20 weeks of pregnancy in a woman who previously had normal blood pressure. While it is temporary, having gestational hypertension increases a woman's future risk of chronic hypertension and heart disease. A healthy diet can help manage gestational hypertension, primarily by supporting healthy weight gain, reducing inflammation, and regulating blood pressure. According to March of Dimes, in 2024, 10 percent of pregnant women had hypertension during pregnancy.

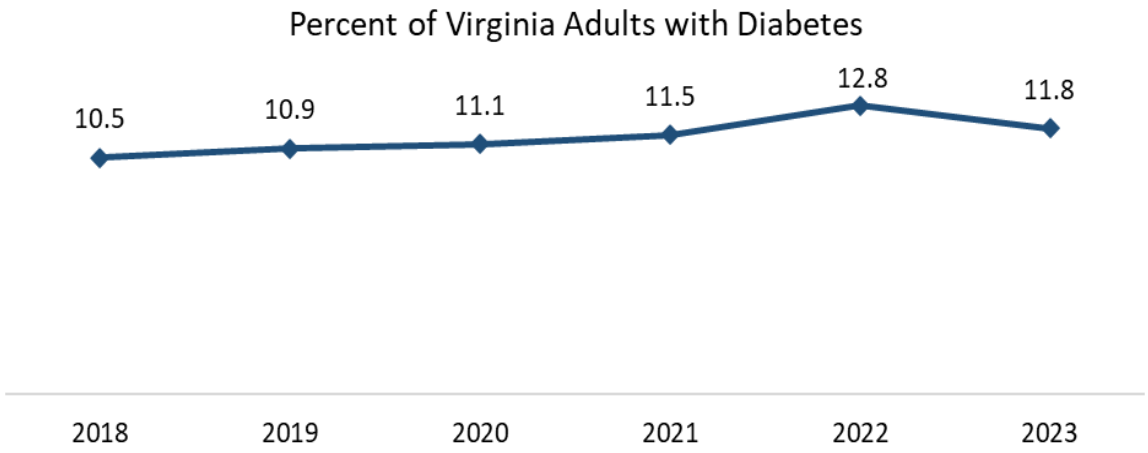
Diabetes prevalence in Virginia increased since 2018, with higher disease burden among the Medicaid population

Diabetes is a metabolic disease characterized by elevated levels of blood sugar. Diabetes can contribute to development of co-morbid conditions like cardiovascular disease and obesity. Type 1 diabetes is an autoimmune condition in which the body does not produce enough insulin to break down consumed sugar. Type 2 diabetes occurs when the body cannot use insulin effectively, resulting in high blood sugar levels.

Diet is a principal factor in treating and managing both types of diabetes but is more significant in the management of type 2 diabetes. For individuals with type 1 diabetes, diet determines how much insulin is needed to properly break down sugar consumption, whereas for individuals with type 2 diabetes, diet strongly influences body weight and insulin resistance.

Data about diabetes prevalence in the United States and Virginia often does not distinguish by type but rather represents the combined number of individuals diagnosed with both types of diabetes. The prevalence of diabetes has increased in Virginia, from 10.5 percent of adults in 2018 to 11.8 percent of adults in 2023 (FIGURE 5). Individuals with lower incomes have higher rates of diabetes. Nationally, rates of diabetes among adults enrolled in Medicaid are 40 percent higher than the rate of diabetes among all adults.

FIGURE 5. Adult diabetes prevalence increased since 2018



SOURCE: Virginia Department of Health, 2025.

Gestational diabetes is a type of diabetes that is first diagnosed during pregnancy. It occurs when the body cannot produce enough insulin to manage blood sugar levels effectively due to hormonal changes. Uncontrolled high blood sugar during pregnancy can increase the risk of complications and increase the risk of developing type 2 diabetes later in life for both the mother and the baby. Like other types of diabetes, diet plays a significant role in disease management. Many women can avoid the use of medications and manage gestational diabetes through changes in diet alone. According to the Pregnancy Risk Assessment Monitoring System survey, in 2022, 11.6 percent of mothers in Virginia were diagnosed with gestational diabetes.

Barriers to accessing nutritious foods contribute to increasing rates of diet-related chronic conditions in Virginia

Diet quality is a modifiable risk factor for several chronic conditions. A healthy diet, consisting of foods like fruits and vegetables, proteins, and healthy starches, serves as a protective factor against many chronic conditions. Such diets are associated with lower incidence and progression of obesity, type 2 diabetes, hypertension, and cardiovascular disease. For individuals already living with chronic conditions, medically supportive nutrition has been associated with improved disease control, better quality of life, reduced utilization of costly acute care services, and lower mortality. However, many individuals are unable to eat a healthy diet because they lack information about or access to healthy foods.

Individuals may lack information on the role of diet in the development of chronic conditions

Individuals may not be aware of the connection between their daily dietary choices and the development or progression of chronic diseases. Despite public health information

campaigns, there remains a significant knowledge gap where people may not fully understand how sustained consumption of highly processed foods, excess sodium, or saturated fats directly contributes to DRCCs like heart disease, type 2 diabetes, and hypertension. This lack of awareness may result from a lack of comprehensive nutrition education in early childhood, confusing or contradictory messaging in food marketing, and the difficulty of translating dietary guidelines into actionable daily habits.

Individuals may lack financial and physical access to nutritious foods

Individuals may experience food insecurity – the limited or uncertain availability of nutritionally adequate foods, or the inability to acquire such foods in socially acceptable ways - due to a lack of financial resources. Those with food insecurity typically rely on energy-dense, more processed foods as their source of energy. Although processed foods are often more affordable than fresh produce, they contain added sugars, sodium, saturated or trans fats, or other ingredients that contribute to or increase the severity of chronic conditions, putting individuals experiencing food insecurity at a greater risk of poor health outcomes due to the effects of chronic conditions. Adults who experience food insecurity are two to three times more likely to have type 2 diabetes. Within a cohort of youth, 50.8 percent of study participants with type 2 diabetes and 29.4 percent of study participants with type 1 diabetes had one or more food security concerns. The prevalence of food insecurity is also higher among low-income individuals with diabetes. Nearly one-third (32 percent) of Medicaid members with diabetes are food insecure, 25 percentage points higher than their counterparts with private insurance (7 percent). More than 1 million Virginians, or 12.1 percent of the Commonwealth's total population, experienced food insecurity in 2023.

Pregnant and postpartum women who experience food insecurity may be at an increased risk of birth and other health complications, including chronic diseases. Maternal nutrition is a strong predictor of pregnancy complications and plays a key role in birthing outcomes. An inability to access proper nutrition during the perinatal period can lead to and exacerbate poor maternal health conditions that progress into chronic conditions postpartum including gestational diabetes, anemia, preeclampsia.

Individuals with financial resources to purchase nutritious foods may still face barriers to a healthy diet. Those who live in food deserts where access to sources of nutritious food is limited or who lack personal or public transportation to reach grocery stores or other sources of food may not be able to access healthy food options even when financial resources are available. Evidence indicates that individuals living in areas with fewer fresh produce options and more fast-food options have a higher risk of obesity and diabetes than individuals living in areas with greater access to sources of healthy foods, including grocery stores and full-service restaurants.

Nutrition interventions can reduce barriers to a healthy diet and improve health outcomes

Nutrition interventions can address some of the barriers that may prevent individuals from consuming healthy foods. DRCCs may be effectively managed through use of nutrition interventions that improve a patient's diet. Extensive evidence demonstrates improved clinical outcomes, reduced health-related complications, and lower healthcare costs for individuals with DRCCs who receive health care interventions to improve diet and nutrition.

Nutrition interventions can address factors that contribute to development and progression of diet related chronic conditions

Nutrition interventions are evidence-based strategies designed to change nutrition-related behaviors, risk factors, or environmental conditions. Nutrition interventions can occur at a population level or at an individual level to improve food security and nutrition. They can also improve public health and individual health outcomes by addressing diet-related factors that contribute to the development and progression of DRCCs. Nutrition interventions have been shown to reduce blood pressure, improve cholesterol levels, and reduce the incidence of cardiovascular events and strokes. In patients with obesity, low-energy, nutritionally dense diets have led to overall reductions in abdominal adipose tissue. And in a large cohort study, adherence to high-quality dietary habits was associated with a 14 percent to 28 percent decrease in cardiovascular mortality risk among adults, compared to individuals with low adherence.

Nutrition interventions can provide information to support healthy diets

Nutrition interventions aimed at educating and informing the public can be broad, population-level initiatives or targeted, individual approaches. Population-level efforts focus on shaping the entire food environment through widely accessible tools, such as the publication of national dietary guidelines, mandatory nutrition labeling requirements for packaged foods, and large-scale public health campaigns about the benefits of balanced eating. In contrast, more targeted interventions focus on personalized education tailored to an individual's unique needs, often delivered through one-on-one nutrition counseling. Nutrition counseling is accessible via various pathways, including through food and nutrition assistance programs, health insurance plans, or community organizations.

Nutrition interventions can provide access to healthy foods

Government funded food and nutrition programs like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provide financial assistance to eligible individuals to help them purchase healthy foods. These programs target individuals with low household incomes who may lack resources to purchase nutritious foods and may include additional eligibility

criteria including age or life stage. Programs like SNAP and WIC are intended to increase food security and address basic nutritional needs. Other programs, such as food banks and food pantries, provide access to low cost or free food items to enable individuals who face financial barriers to access nutritious food. In Virginia, for example, the Federation of Virginia Food Banks and its seven regional affiliates operate the Healthy Pantry program, which works with food banks to offer more fresh fruits, vegetables, and culturally preferred foods as well as health and nutrition education. While these programs have been shown to positively impact public health, improving health outcomes and reducing the health care spending, they are not intended to address factors that contribute to the development or progression of DRCCs specifically.

Other programs and interventions provide services designed to overcome physical barriers that prevent access to healthy food, especially for those who are geographically isolated or lack reliable transportation. Interventions may specifically address transportation gaps by coordinating volunteer drivers, offering subsidized ride-shares, or partnering with community centers to run shuttle services that help individuals reach supermarkets or local food pantries. In addition, an increasing number of interventions focus on delivering groceries or prepared meals directly to an individual's residence, utilizing services such as Meals on Wheels for seniors, specialized food bank delivery routes for vulnerable populations, and innovative models for delivering healthy food boxes to underserved neighborhoods.

Food is Medicine nutritional interventions are implemented in clinical settings to treat or manage diet-related chronic conditions

Food is Medicine (FIM) interventions utilize mechanisms like nutrition interventions designed to address broader barriers to a healthy diet; however, FIM approaches treat access to nutritional food as a clinical intervention, are overseen by a health care provider, and are intended to treat specific health care conditions. Providers implementing the FIM approach to health care select interventions to treat a patient’s specific diagnosis and prescribe an amount or “dosage” and duration of the service to improve the patient’s health condition. Ongoing monitoring of the patient allows the health care provider to evaluate the impact of the intervention on the patient’s health and adjust the intervention as needed to achieve desired health outcomes.

Health care providers often collaborate with community-based organizations (CBOs), such as regional food banks and food pantries, for the delivery of food consistent with the prescribed intervention to ensure access to medically appropriate, culturally relevant foods for the patient. Patients also receive nutrition education and counseling with the FIM approach to health care. Nutrition education and counseling strategies are designed to motivate voluntary adoption of healthy food choices and nutrition-related behaviors for lasting behavioral change. The primary interventions implemented in FIM approaches to

health care are medically tailored meals, medically tailored groceries, and produce prescriptions.

Medically tailored meals provide complete meals to meet patients' dietary needs

Medically tailored meals (MTMs) are fully prepared, individualized meals designed by health care providers to meet patients' nutritional needs. Health care providers refer eligible patients, identified using appropriate clinical criteria, to a registered dietitian nutritionist who designs a meal plan for the patient and works with a selected organization or vendor to prepare and deliver meals. MTMs are typically intended for patients who need longer-term support to meet their nutritional needs and who face barriers to preparing meals that meet their nutritional needs themselves. Evidence suggests MTMs reduce episodes of hypoglycemia and decrease body mass index in patients with type 2 diabetes and can save health care systems money by reducing hospitalizations.

Medically tailored groceries provide ingredients for nutritious meals

Medically tailored groceries (MTGs) consist of boxes or bags of perishable and nonperishable grocery items customized to meet a patient's unique dietary needs and improve or mitigate a specific health condition. Health care providers identify eligible patients and refer them to registered dietitian nutritionists who select grocery items to address individual patients' specific health conditions and dietary needs. MTGs are distributed through home delivery or central hubs, such as food pantries and health care facilities. This service is appropriate for patients who are able to prepare their own meals using the MTGs provided. Evidence demonstrates that MTGs can improve quality of life, enhance healthy eating habits, and reduce health care costs through fewer emergency department visits and hospitalizations.

In Virginia, food pharmacies such as Petersburg's Walnut Hill Food Pharmacy pilot program, operated by Walnut Hill Pharmacy in collaboration with United Healthcare and FeedMore, provide MTGs, appropriate recipes, and education for patients with a diabetes diagnosis for a period of 10 months. Evidence indicates that program participants experienced an average reduction in A1c of 9.7 percent.

Bon Secour's Nourish Connect Pilot Program extends the Walnut Hill Food Pharmacy pilot program into an acute care setting. The program is offered at the health system's Southside Medical Center where food-insecure patients with chronic disease are enrolled during their inpatient stay and receive eight weeks of post-discharge MTMs or MTGs, through home delivery to overcome transportation barriers.

Produce prescriptions (PRx) provide financial assistance for medically appropriate foods

PRx programs provide patients vouchers for fresh fruits and vegetables that may be redeemed at participating food retailers. Health care providers identify eligible patients,

consistent with clinical criteria, who receive vouchers or other forms of financial assistance, usually in the form of a pre-loaded debit card, to purchase eligible food products at participating retailers such as grocery stores, farmer's markets, or food banks. PRx programs contribute to greater food security and increased intake of fruits and vegetables. They are also associated with improvements in key health indicators, including blood pressure, body mass index, and hemoglobin A1c levels.

In Virginia, Carilion Clinic, Virginia Fresh Match, Feeding Southwest Virginia, Radford University, and Local Environmental Agriculture Project (LEAP) partnered to offer the Southwest Virginia Produce Prescription (SWPRx) Program. The program provides produce vouchers and biweekly nutrition education for adult patients enrolled in Medicaid who have elevated blood pressure, prediabetes, or diabetes and who are referred by their health care provider. Vouchers may be redeemed at participating locations, including farmers markets, farm-direct stores, and grocery stores. The program, which has been in place since 2015, has demonstrated an increase in fresh produce consumption for 97 percent of participants, with longer customer participation due to improved food security.

States can implement food and nutrition interventions through their Medicaid programs

Medicaid members experience higher rates of diet related chronic conditions and food insecurity than the general public, which contributes to poorer health outcomes and higher health care costs. Medicaid program rules and structure allow states to offer services that prevent, treat, and manage diet related chronic conditions and address food insecurity for high-needs populations to improve health outcomes and reduce avoidable healthcare spending. Federal rules establish multiple pathways through which states may implement nutrition benefits and FIM interventions, allowing states to leverage their existing Medicaid program design and administrative infrastructure to make nutrition services available to Medicaid members.

Federal Medicaid rules permit coverage of nutrition services

Federal rules require states to cover a core set of mandatory services —such as inpatient and outpatient hospital care, physician services, laboratory and imaging, and home health— through their Medicaid programs. States may also cover additional services beyond the core set of mandatory services. Federal rules provide states with flexibility to determine which of these optional services to offer, to whom, and to what extent, consistent with federal requirements. Generally, services offered through a state's Medicaid plan must comply with requirements for (i) statewideness, so that services are available to eligible members across the state rather than only in select localities, (ii) comparability, so that individuals with similar medical needs have access to benefits that are similar in amount, duration, and scope, and (iii) beneficiary protections, including provisions for reasonable

promptness, clear information, and fair grievance and appeals processes so members can obtain benefits for which they are eligible.

In recent years, a growing number of states have opted to use federal flexibilities to cover services intended to address members' health-related social needs, including nutrition benefits. To be eligible for coverage through state Medicaid programs, nutrition benefits must be "allowable" services, supported by robust evidence that the interventions offered have been proven to strengthen coverage and improve downstream health outcomes, reduce health care costs, or improve health equity. "Allowable" nutrition benefits must meet federal regulatory requirements and may include home delivery of meals or pantry stocking services, nutrition prescriptions grocery provision, nutrition counseling and instruction, and case management services. Federal rules offer several policy pathways for states to offer optional benefits, including nutrition benefits: state plan amendments (SPAs), Section 1915(c) home- and community-based services waivers, Section 1115 demonstration waivers, and managed care in-lieu-of-services and settings (ILOS) benefits.

State plan amendments allow states to embed nutrition services into the core Medicaid service array

The Medicaid state plan is the foundational document defining the nature and scope of each state's Medicaid program, as required by Section 1902 of the Social Security Act and implementing regulations at 42 C.F.R. Part 430. The state plan describes the categories of individuals and types of services covered, methodologies for reimbursement of providers, and instructions on how the state will carry out required administrative activities. States can modify their state plans through state plan amendments (SPAs) that add or revise covered services, eligibility groups, provider types, or payment methods. Because the state plan represents the agreement between the state and the federal government regarding administration of the state's Medicaid program, SPAs must be reviewed and approved by the federal Centers for Medicare and Medicaid Services (CMS) prior to implementation. Services offered through the state plan, including services added through a SPA, must comply with all Medicaid program requirements unless those requirements are expressly waived under separate Medicaid waiver authority.

To amend its state plan, a state must submit an application package to CMS that includes draft SPA language, information about the anticipated federal budget impact of the proposed SPA, and evidence of any required state-level approvals. CMS must complete its review of the application package within 90 days and may approve or disapprove the application or request additional information from the state. If CMS requests additional information, the running of the 90-day review period pauses until the state responds. Once approved, a SPA is incorporated into the state's Medicaid state plan.

States may use SPAs to add certain nutrition services as a covered service under the state's Medicaid program. Because SPAs modify the underlying state plan, they are typically used to implement durable, not temporary, program changes, ensuring that added services

become stable, billable Medicaid benefits. State plan benefits are generally subject to statewideness and comparability requirements. As such, adding services through a SPA reaches the broadest pool of eligible individuals, a consideration when estimating the cost of adding a new service to the Medicaid program.

Section 1915(c) waivers allow states to target nutrition services to patients who require an institutional level of care

Federal law and regulations allow the U.S. Secretary of Health and Human Services to waive certain Medicaid program requirements, including statewideness and comparability of services, to allow states to explore new approaches to delivery of and payment for health care services. States may use waivers to cover populations or services that might not otherwise be eligible for coverage, or to provide specialized packages of benefits to defined subsets of Medicaid members. Section 1915(c) of the Social Security Act authorizes the U.S. Secretary to provide certain home- and community-based services (HCBS) to individuals who meet an institutional level of care as an alternative to care in a nursing facility or other long term care facility.

States seeking waivers pursuant to Section 1915(c) must submit an application describing the target populations and services proposed to be covered, standards for service providers and quality systems, and projected enrollment in the proposed services. States must also provide evidence of cost-neutrality, demonstrating that the cost of the services proposed to be provided will not exceed the cost of the institutional care for which the services will substitute. While federal rules require CMS to complete its review of a Section 1915(c) waiver application within 90 days of receipt, the running of the review period stops if the agency requests additional information from the state, and the review period begins again upon receipt of the requested information from the state. As a result, the review process typically takes many months to a year. Approved waivers are granted for multi-year periods and must be renewed prior to the end of the approved period.

States may use 1915(c) waivers to deliver long-term services and supports, including nutrition interventions, which may not otherwise be covered through the state Medicaid program to a narrowly defined subset of members who meet institutional levels of care. However, because Section 1915(c) waivers may only be used to provide services to those in the narrowly defined subset - individuals who meet institutional levels of care who would otherwise receive services in a nursing facility or long-term care setting but for the covered services – the population that may receive nutrition services through a Section 1915(c) waiver is limited and does not include a number of individuals for whom nutrition interventions, including FIM interventions, may be beneficial.

Section 1115 demonstration waivers allow states to cover nutrition interventions for defined populations

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain Medicaid program requirements related to statewideness and comparability of services to approve experimental, pilot, or demonstration projects that are likely to promote the Medicaid program's objectives. States may define the categories of Medicaid members who may be eligible for services through a Section 1115 demonstration waiver and the types of services to be offered. Federal rules permit states to cover services to address members' health related social needs through a Section 1115 demonstration waiver, but services must be medically appropriate for eligible members, consistent with state-defined criteria. This authority enables states to test approaches not otherwise permitted under standard Medicaid rules, including changes to benefits, eligibility, and payment models.

States wishing to implement a Section 1115 waiver program must submit a detailed application that describes the goals, target populations, covered benefits, and delivery systems to be implemented through the project. States must also provide evidence that the proposed project will meet federal budget neutrality requirements and that the cost of the proposed project will not increase state Medicaid program expenditures. Prior to submitting the application, states must provide public notice of and opportunity for submission of written public comments regarding the proposed waiver as well as at least two public hearings on the proposed waiver to allow additional opportunity for public comment. Final applications submitted to CMS must include documentation of the public notice and comment process conducted by the state, as well as information about issues raised during the process and how the state addressed the issues raised. Applications are reviewed on a case-by-case basis to determine the extent to which they are consistent with federal requirements.

Upon receipt of an application for a Section 1115 demonstration waiver, CMS must perform a completeness review, provide additional written notice and opportunity for additional public comment, and negotiate final terms and conditions of the waiver with the state. Although the minimum federal review window is 45 days after an application is determined to be complete, timelines for approval of Section 1115 waiver applications often range from six months to two years. Approved demonstrations are subject to extensive monitoring, reporting, and independent evaluation, and typically operate for five years with renewals granted for three- to five-year periods.

States may use Section 1115 demonstrations to implement services to address members' health-related social needs, including nutrition benefits. Section 1115 demonstrations provide a platform for comprehensive nutrition initiatives that bundle multiple interventions including both FIM interventions and broader nutrition interventions. However, the application and approval process for Section 1115 waivers can be lengthy,

delaying access to nutrition services, and may require extensive state resources to complete.

ILOS benefits allow managed care organizations to offer nutrition interventions as clinically appropriate substitutes for covered services

State Medicaid agencies that have entered into contracts with managed care organizations (MCOs) for the delivery of health care services for Medicaid members may allow MCOs to offer nutrition benefits in lieu of other covered services. Contracts between MCOs and state Medicaid agencies must describe the populations and services to be covered, how services will be provided and providers will be paid, and include provisions for quality and utilization management, program integrity, procedures for member grievances and appeals, and other administrative processes and procedures. MCOs must cover all services required by the state Medicaid plan ("covered services") and may offer additional services consistent with federal and state rules.

Federal rules allow state Medicaid agencies to permit MCOs to cover certain additional services "in lieu of" a covered service. "In lieu of" services (ILOS) must be a clinically appropriate and cost-effective substitute for the covered service that is likely to reduce the need for the covered service. States may authorize ILOS to address members' health-related social needs, including nutrition services, if the ILOS can be expected to reduce future need for the covered service. State Medicaid agencies and MCOs must monitor and provide oversight of ILOS utilization and spending to ensure that the ILOS achieves the intended cost and quality outcomes.

To make an ILOS available, a state must document the ILOS and the service for which the ILOS may substitute, the populations eligible for the ILOS and the process by which eligible individuals will be identified, and the rights of and protections for members receiving the ILOS in the managed care contract between the agency and each MCO. MCOs may elect to offer the authorized ILOS as a substitute for a covered service but are not required to do so. The cost of providing the ILOS may be considered as a component of the capitation rate paid to the MCO by the state agency.

CMS reviews proposed ILOS as part of the managed care contract review process. All managed care contracts and capitation rate certifications must be submitted to CMS for review. CMS has adopted a risk-based approach to reviewing ILOS included in managed care contracts based on the cost percentage of the ILOS, or the portion of the capitation rate payment attributable to the ILOS. For ILOS with a *de minimis* cost percentage – less than 1.5 percent of the total payment amount – the state agency must provide an actuary's estimation of the projected ILOS cost percentage, together with supporting documentation. If the cost percentage of an ILOS is between 1.5 and 5 percent, the state may be required to provide additional documentation including a description of the process and supporting evidence used to determine that the ILOS is a medically appropriate and cost-effective

substitute for the covered service. An ILOS may not be approved if the cost percentage exceeds 5 percent.

If an MCO elects to offer the authorized ILOS, the ILOS must be made available consistent with federal Medicaid program rules. An MCO that offers an ILOS must also continue to make the covered service for which the ILOS is offered as a substitute available to eligible members. Members receiving health care coverage through the MCO must be afforded a choice between the ILOS and the covered service.

States may use ILOS to cover a variety of clinically appropriate and cost-effective substitutes as an alternative to existing covered services. Because ILOS are reviewed as part of the managed care contract review process, they can be made available faster and with less administrative impact on the state agency than other Medicaid pathways addressing DRCCs. However, the decision to offer an authorized ILOS is at the option of each MCO, so that access to a nutrition service covered through an ILOS may be limited. Additionally, ILOS are an option for the Medicaid member, and uptake may be limited, therefore reducing the impact of the ILOS on the development and progression of DRCCs.

States have authorized ILOS to make nutrition services available to Medicaid members

In states that have authorized ILOS for nutrition services, authorized services include general nutrition interventions intended to address food and nutrition insecurity as well as FIM interventions designed to provide nutrition interventions in a clinical setting to address specific health care conditions (APPENDIX 2). Many states that have authorized a nutrition ILOS offer multiple interventions, many of which align with FIM models. Of the thirteen states for which information about ILOS program details is publicly available, six states (California, Michigan, Iowa, Wisconsin, Nevada, and Minnesota) authorize food-based ILOS, including medically tailored meals, medically tailored or nutritionally appropriate groceries or food packs, health home-delivered meals, and produce prescriptions. Additional states (New York, Kansas, and Rhode Island) offer a combination of meal benefits and nutrition education or counseling programs, while remaining states (New Hampshire, Tennessee, Texas, and Oregon) offer education-focused or less-defined food-based supports.

States often authorize a spectrum of nutrition-specific ILOS benefits, allowing MCOs to choose which to implement. In Michigan, for example, the state authorizes a defined set of four nutrition ILOS benefits including FIM interventions. These services target members with diet related chronic conditions, such as diabetes or heart disease, who also face challenges accessing or preparing food. Multiple Michigan MCOs have chosen to offer one or more of these services with most currently providing medically tailored home-delivered meals, an FIM approach, or healthy home-delivered meals, which provide more generalized nutrition support. In contrast, Minnesota operates a more decentralized approach to nutrition ILOS benefits, allowing individual MCOs to select which services to implement

rather than providing a uniform statewide menu. Two MCOs provide home-delivered meals for members after hospital discharge and a third MCO provides medically tailored home-delivered meals to adults ages 18–64 with type 1 or 2 diabetes enrolled in its Focused Wellness Program.

ILOS benefits may also be narrowly tailored to help bridge nutrition access gaps by providing nutrition services to individuals awaiting formal waiver enrollment or to other targeted populations. One state, Iowa, limits the category of individuals eligible for one nutrition FIM ILOS – medically tailored meals – to individuals who are on a waitlist for receiving services under a Medicaid Section 1915(c) home and community-based services waiver. Nevada offers a comprehensive FIM ILOS menu but targets individuals who are experiencing, or at risk of, homelessness.

States may choose to authorize an ILOS to make nutrition services available to members enrolled in managed care in addition to other strategies to offer nutrition services. California and New York have each approved an ILOS and implemented a Section 1115 demonstration program covering nutrition services. This bifurcated approach allows states to offer access to a nutrition ILOS quickly and with limited administrative burden to improve health outcomes for eligible individuals and prevent utilization of other, more costly health care services while building capacity for the delivery of nutrition services and collecting evidence of cost neutrality to support approval of a Section 1115 demonstration waiver. Section 1115 demonstration waivers, once implemented, allow states to expand access to nutrition services and offer complementary services to address members' health related social needs. Once a state launches a 1115 demonstration, an ILOS may continue to serve a complementary role, providing rapid-response clinical nutrition during acute episodes while the 1115 program provides longer term, population-level coverage.

Virginia could authorize an ILOS benefit to make nutrition services available to Medicaid members

Managed care ILOS benefits offer an opportunity to make nutrition services available to Medicaid members quickly and with limited administrative burden on the state. While availability of nutrition services offered as an ILOS is dependent on the decision of MCOs to offer the service and utilization of nutrition services is dependent on the decision of members to choose the service, an ILOS does provide a means for improving nutrition and preventing or reducing the impact of DRCCs for Medicaid members receiving health care services through MCOs. In Virginia, approximately 1.8 million Medicaid members currently receive health care coverage through the five MCOs that have entered into contracts with the Department of Medical Assistance Services (DMAS). Virginia could authorize a nutrition ILOS to build upon the existing managed care program to make nutrition interventions, including FIM interventions, available to Medicaid members.

➔ **Option 1**: The JCHC could direct DMAS to develop a plan for a nutrition "in lieu of" service (ILOS) managed care benefit, including (i) descriptions of the services proposed to be

covered and the covered services for which they will substitute and categories of individuals who will be eligible for the service, (ii) evidence of cost-effectiveness of the services proposed to be covered and the cost percentage of the services proposed to be covered, (iii) provisions for monitoring and oversight of the ILOS to meet federal requirements, and (iv) any other information required to be provided to the Centers for Medicare and Medicaid Services to support authorization of the ILOS. DMAS shall report on the plan, together with information about required next steps for implementation of the ILOS and any implementation considerations, to the General Assembly and the JCHC by October 1, 2026.

DMAS must document requirements for a food and nutrition ILOS in managed care contracts reviewed by CMS

Federal rules establish requirements for information describing an authorized ILOS, which must be included in managed care contracts. All managed care contracts, including provisions related to any ILOS authorized by a state, must be reviewed by CMS as part of the regular managed care contract review cycle. Documentation included in managed care contracts must include description of:

- *Target population for which the ILOS is determined to be a medically appropriate and cost-effective alternative.* Eligibility requirements must be based on defined clinical criteria and could be designed to target interventions to individuals with DRCCs to ensure nutrition benefits are available to populations with demonstrated need. Eligibility criteria could be even more narrowly defined to limit eligibility to individuals who are high utilizers of health care services, have recently experienced hospitalization, or who have screened positive for additional indicators of health-related social needs.
- *Proposed ILOS and the covered service for which it is determined to be a medically appropriate and cost-effective substitute.* Services must be "allowed services" and must demonstrate a reasonable expectation of avoiding or replacing more intensive services such as hospitalizations, emergency department visits, or home-health episodes. Services could be limited to evidence-based FIM strategies, which have been shown to improve health outcomes and reduce the cost of health care for individuals with DRCCs, as well as nutrition counseling to support adoption of health behaviors. An ILOS could also include broader nutrition interventions to address food and nutrition insecurity more broadly.
- *Codes to identify the ILOS in encounter data collected by the state, which will be used by the MCO to document the service provided.* Existing Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes could be utilized for services such as medically tailored meals, medically tailored groceries, or produce prescriptions. In cases in which codes are not available, DMAS would have to develop appropriate codes to track service delivery.

- *Processes by which a health care provider or appropriate managed care professional will determine and document in the Medicaid members' record that the ILOS is medically appropriate for the Medicaid member.* ILOS descriptions must include robust requirements for prior authorization and medical-necessity documentation integrated into member care plans and limit ordering and oversight to specific provider types or managed care professionals.
- *Rights and protections available to Medicaid members for whom an ILOS is available.* Rights and protections must include provisions for member choice with regard to utilization of available ILOS services, grievance and appeals procedures, and privacy safeguards.

ILOS cost percentage must not exceed CMS-established limits

DMAS must determine the projected cost percentage for the nutrition ILOS and certify that the cost percentage does not exceed federally established limits. CMS limits expenditures for ILOS to no more than five percent of total capitated payments. DMAS must determine the cost percentage – the portion of the capitated payment attributable to the nutrition ILOS – and certify that the amount does not exceed federal limits. The amount, supporting evidence, and certification must be included in the rate certification submitted to CMS for review. If the estimated cost percentage exceeds 1.5 percent, DMAS must provide additional documentation including a description of the process and supporting evidence used to determine that the ILOS is a medically appropriate service for the clinically defined target population and a cost-effective substitute for the covered benefit.

State monitoring and oversight must ensure program compliance

DMAS must establish procedures for monitoring and oversight to ensure compliance with federal requirements and collect data and information necessary to satisfy CMS reporting requirements. Any contract between DMAS and an MCO that includes authorization to offer a nutrition ILOS should include a requirement that the MCO use the Transformed Medicaid Statistical Information System (T-MSIS) - a comprehensive, national database to collect Medicaid claims and encounter reporting stratified by equity metrics (such as race, disability status, and preferred language), documentation of grievances and appeals, and tracking of utilization and substitution trends. DMAS must conduct annual audits verifying medical necessity and adherence to substitution standards and may opt to conduct additional evaluations to demonstrate ongoing impact on management of DRCCs. DMAS must also report annually to CMS regarding final actual costs of delivering ILOS services, based on MCO claims and encounter data, and the final ILOS cost percentage for the previous year. If ILOS spending exceeds 1.5 percent over a five-year period, DMAS must complete a retrospective evaluation to examine utilization savings, quality, access, and equity outcomes within 24 months. If CMS determines that the state is out of compliance with federal requirements, CMS may require the state to terminate the ILOS. States may

also opt to terminate an ILOS if the state determines that the ILOS is no longer medically appropriate or cost-effective substitute for the covered service or the state identifies noncompliance with ILOS requirements.

Appendix 1: Letter from House Committee on Health and Human Services

COMMONWEALTH OF VIRGINIA

HOUSE OF DELEGATES
RICHMOND

MARK D. SICKLES
POST OFFICE BOX 10628
FRANCONIA, VIRGINIA 22310

SEVENTEENTH DISTRICT

COMMITTEE ASSIGNMENTS:
APPROPRIATIONS
PRIVILEGES AND ELECTIONS
HEALTH AND HUMAN SERVICES
RULES

April 23, 2025

Delegate Rodney Willett
Chair, Joint Commission on Health Care
P.O. Box 29428
Henrico, VA 23242

Dear Chairman Willett,

In recent months, the Joint Commission on Health Care (JCHC) has been discussing several issues related to various social determinants of health. These include transportation, the built environment, and access to various services. Ready access to nutritious food is also one of the most important of these social determinants, especially as our constituents have dealt with increased grocery prices in the years since the COVID-19 pandemic. "Food as medicine" has become a critical part of the conversation regarding health outcomes.

This session, I sought to explore opportunities for a pilot which would target specific populations through a Medicaid In Lieu of Services (ILOS) option for nutrition options. Although no final language will become effective as a result of this General Assembly, I want to ensure that this important concept continues to be studied.

I would like to request that JCHC assess the impact and cost-effectiveness of substituting food and nutrition as a Medicaid ILOS. The assessment should potentially focus on specific populations who are experiencing food or nutrition insecurity, including pregnant and postpartum women, as well as individuals living with diabetes. Additionally, the assessment should incorporate feedback from Medicaid Managed Care Organizations and community-based food access organizations via the Virginia Food is Medicine Coalition (VFMC). To the extent possible, the assessment should consider the potential for delivery of relevant resources and information through a mobile pregnancy application. The VMFC, led by the Federation of Virginia Food Banks, brings together nutrition and food access providers across the Commonwealth and welcomes the opportunity to assist JCHC in its review.

Because Virginia faces a nutrition crisis where 700,000 Virginians lack access to affordable, nutritious food, and many will go on to suffer long term health consequences as a result, I request that JCHC prepare an analysis of amending existing waivers to provide food and nutrition coverage options, to potential target populations. I would appreciate it if JCHC could complete this assessment by November 1, 2025, in time for the General Assembly to consider in advance of the 2026 Session.

Thank you very much for your assistance.

Sincerely yours,

Mark D. Sickles, Chair, House Committee on Health and Human Services

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Appendix 2: States' nutrition-focused ILOS program details

State	Authorized ILOS Services[1]	Eligibility Criteria[2]	Service Parameters & Model Details
California[3]	Medically Tailored Meals (MTM) Medically Supportive Food (home-delivered meals, tailored groceries, vouchers, food pharmacies); Nutrition education	Diet-related chronic conditions (e.g., diabetes, CHF, hypertension, HIV, cancer); recent hospital or skilled nursing facility discharge; high care coordination needs	Duration and intensity determined by medical necessity (often time-limited); state-authorized ILOS menu; participation voluntary by MCOs and varies by county; providers include Meals on Wheels, Mom's Meals, CA Food Is Medicine Coalition
Iowa	Medically Tailored Meals Medically Tailored or Nutritionally Appropriate Food Prescriptions	Individuals on 1915(c) HCBS waiver waitlist; risk of hospitalization or institutionalization; post-acute discharge	Typically time-limited and transitional (often post-discharge); services may continue until waiver slot available; state-authorized ILOS menu; voluntary MCO participation; providers include Meals on Wheels, Mom's Meals, enrolled HCBS providers
Kansas	Medical Nutrition Therapy Home-Delivered Meals	Individuals at risk of nursing facility placement with nutrition needs; HCBS waiver	Ongoing services based on prior authorization; nutrition therapy eligibility defined at plan/state discretion; MCOs submit requests for state approval; providers include Meals on Wheels, Mom's Meals, Wolcott Foods, Area Agencies on Aging

[1] States may include additional services through their MCO contracts that are not made publicly available. Additional states may also offer nutrition related ILOS benefits that are not made publicly available.
[2] Different eligibility criteria apply to different ILOS services though not all are explicitly defined in publicly available records. The criteria provided are for summary purposes reflecting populations targeted by states.
[3] California and New York exemplify a dual-authority strategy: California's CalAIM (California Advancing and Innovating Medi-Cal) integrates medically tailored meals via 1915(b) and its Section 1115 waiver, while New York's Section 1115 waiver funds Food Is Medicine programs alongside MCO for high-risk members. Other states may adopt similar bifurcation, but these two demonstrate particularly integrated execution.

		populations (e.g., brain injury, physical disability)	
Michigan	Medically Tailored Meals Healthy Home-Delivered Meals Produce Prescription Healthy Food Packs (similar to MTG)	Diet-related chronic condition; recent hospital discharge; food insecurity and/or inability to shop or prepare meals	Meal frequency and duration based on medical necessity; produce prescriptions typically time-limited but extendable; state-authorized FIM ILOS menu; voluntary MCO participation; providers include Mom's Meals, local food providers, Michigan Primary Care Association
Minnesota	Home-Delivered Meals Medically Tailored Meals	Post-hospital discharge; disability waiver participants; adults 18–64 with type 1 or 2 diabetes (Focused Wellness Program)	Meal limits and duration depend on waiver/program standards and medical need; MCO request and state approval required; voluntary MCO participation; providers are MCO-contracted meal services
Nevada	Medically Tailored Meals Medically Tailored Groceries Healthy Food Vouchers Food Pharmacies (Produce Prescriptions) Cooking Classes	Individuals that are presently homeless or at risk of experiencing homelessness with a qualifying condition or circumstance[4]	Meal services are part of broader housing supports and services offered through Nevada MCOs targeting individuals experiencing, or at risk of, homelessness; state-authorized ILOS menu; voluntary MCO participation

[4] Qualifying conditions or circumstances include the following: serious mental/emotional/ substance use disorder, at risk of institutionalization, at risk of behavioral crisis or utilizing the emergency department, pregnant or postpartum within last 60-days, discharged from correctional or medical facility within the last 90 days, transitioning from acute care setting to home/community setting, or a victim of human trafficking or domestic violence.

New Hampshire	Diabetes Self-Management Training Medical Nutrition Therapy Partial Hospitalization for Eating Disorders	Clinical indication based on clinician and health plan judgment	Education- and treatment-focused; limited direct food provision; state-authorized ILOS menu; voluntary MCO participation
New York	Medically Tailored Meals Diabetes Prevention Program (Brook+)	Adults with serious or complex health conditions to prevent emergency department visits or hospitalization; Brook+ targets adults 18–64 with prediabetes meeting program criteria	MTM is typically time-limited with extensions based on medical necessity; MCO request and state approval required; voluntary MCO participation; providers include Mom's Meals and Rethink Food
Oregon	National Diabetes Prevention Program Online Diabetes Self-Management Program	Adults with BMI ≥25 (≥23 for Asians) for prevention program; individuals with type 1 or 2 diabetes for self-management program	Education-focused ILOS; no routine meal provision; Coordinated Care Organizations (CCOs) may select to offer one ILOS per plan from state-authorized menu
Rhode Island	Home-Delivered Meals (Meals on Wheels) Nutrition Programs (e.g., weight reduction)	Individuals at risk of malnutrition; limited mobility or transportation barriers; substitute for home care/homemaking	Meal amount and duration based on medical necessity and care substitution needs; MCO request and state approval required; voluntary participation; provider primarily Meals on Wheels
Tennessee	Nutrition and Supplement Programs Weight Reduction Programs	Adults age 21+ for nutrition/supplement programs; individuals of any age with obesity for weight reduction programs	Education-focused services; limited or no routine meal provision; MCO request and state approval required; voluntary participation

Texas	Nutrition Counseling Medically Tailored Meals (Pilot Program for High-Risk Pregnancy)	Eligibility specific to MCO contract; pregnancy pilot program participants must be pregnant and high-risk due to conditions including gestational diabetes, hypertension, and obesity	Education-focused services with no meal services; pilot high-risk pregnancy program targets pregnant women with DRCCs; state-authorized ILOS menu; voluntary MCO participation
Wisconsin	Medically Tailored Meals	High-risk pregnant or postpartum individuals; individuals with diabetes discharged from a hospital in the past 90 days; and/or individuals with cardiovascular disease discharged from a hospital in the past 90 days	Eligible members receive up to two meals per day for up to 12 weeks (or up to one year if medically appropriate) with initial and follow-up visits with a registered dietitian; state-authorized ILOS menu; voluntary HMO participation

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