Health System Re-Design (HSR) Subcommittee

DHCF Medical Care Advisory Committee (MCAC)

DRAFT Recommendations to Inform Implementation of DC's Proposed 1115 Waiver Renewal

NUTRITION

DRAFT CONSENSUS RECOMMENDATIONS BASED ON MAY HSR MEETING

The following are draft recommendations for HSR Subcommittee discussion based on the May 2025 HSR meeting. The HSR Subcommittee aims to present 3-5 consensus recommendations to the MCAC in July.

This document captures the nutrition breakout discussion in response to the draft recommendations, which was held during the June 12, 2025, HSR subcommittee meeting.

1. **Provide Clarity of Services and Eligibility to Enhance Accessibility**

   Recommendation: Develop a clear and accessible definition of nutrition services and eligibility criteria. Distinguishing between medically necessary services (e.g., for chronic disease management) and social nutrition supports (e.g., food insecurity due to caregiving or housing instability) is important.

   Rationale: Participants highlighted that inconsistent eligibility guidance and unclear program descriptions create barriers to access. It was recommended that definitions be simple and widely communicated to both providers and beneficiaries.

   Feedback/Thoughts:

   Stakeholders emphasized the need for clearer definitions to prevent inconsistent interpretation of eligibility criteria across managed care organizations and service providers. It was noted that, in other states, the absence of specific examples has led to broad variation in implementation. To mitigate this, it was recommended that the final guidance incorporate illustrative examples that distinguish medically necessary services, such as those supporting chronic disease management, from social nutrition supports intended to address food insecurity arising from housing instability, caregiving responsibilities, or similar factors.

   A participant noted that examples of covered services should reflect both clinical and non-clinical interventions, including registered dietitian visits, medically tailored groceries, cooking education, group nutrition classes, and grocery-navigation support. These services were described as aligning with the waiver's intent to support needs not typically covered under standard Medicaid benefits. Providing specific examples was viewed as important to promote a shared understanding across systems.

   A participant highlighted that medical and social needs often overlap in practice, particularly in pediatric cases. It was noted that providers may prescribe nutrition supplements for a child experiencing failure to thrive, even when it is unclear whether the underlying cause is a medical condition or household food insecurity. This example illustrated the need to apply a functional lens to eligibility criteria and to design the program with flexibility to meet a range of participant needs.

It was also noted that, in the absence of clear guidance, coverage decisions may be left to interpretation by individual medical directors or provider staff. Stakeholders recommended that definitions be practical, inclusive of real-life circumstances, and broadly disseminated to ensure consistent implementation and reduce the risk of service fragmentation.

2. **Ensure Individual Navigation and Comprehensive Screening Support**

Recommendation: Implement individualized navigation services that screen for social determinants of health, assist with enrollment, help select appropriate nutrition options, and connect participants to wraparound supports (e.g., cooking tools or food storage access).

Rationale: Participants recommended building out navigation infrastructure to support enrollment and sustained engagement. Clear screening and warm handoffs were emphasized as critical to improving access, continuity of care, and maximizing effectiveness of benefits.

Feedback/Thoughts:

A participant noted that this recommendation may also serve as a cross-cutting issue, linking back to earlier discussions on service clarity and access. It was noted that assessing the effectiveness of different navigation and screening points is important to ensure participants are connected to services. The use of warm handoffs was referenced as a key strategy to support successful linkage and sustained engagement.

3. **Align New Benefits with Existing Services**

Recommendation: Ensure that new nutrition benefits are aligned and/or complementary with existing Medicare and Medicaid benefits, and/or other services, to reduce confusion, especially for dual-eligible participants. Coordinate with Managed Care Plans (MCPs), community organizations, and state agencies to prevent duplication and streamline access.

Rationale: It was recommended that benefit integration be a core component of program design, particularly for seniors and medically complex individuals who may already receive nutrition support through other programs.

Feedback/Thoughts:

A participant noted that this recommendation connects closely to earlier discussions around eligibility, emphasizing that outlining which diagnoses or conditions are covered under the program would help clarify what the nutrition benefit includes. It was also noted that in some states, policies specify that individuals cannot receive similar services through multiple programs at the same time, highlighting the need for consistency across benefit structures.

A participant emphasized that without clarity in program guidance, determinations of medical necessity may be left to individual interpretation by providers or health plan staff. The participant also referenced situations where individuals may already be receiving similar services from another organization and raised the idea of allowing them to opt out in order to participate in a different program that better meets their needs. The comment also emphasized the need to ensure that individuals are connected to the most appropriate benefit based on their specific needs.

A participant shared that greater integration of health information, particularly across clinical and community-based programs, could help clarify what services individuals are already receiving. Improved communication and data sharing were viewed as potential strategies to reduce redundancy and streamline care coordination.

A participant emphasized the importance of clearly defining the intent of the nutrition program and which diet-related conditions are eligible for support. There was a caution that eligibility design should avoid creating unintended exclusions for individuals who may qualify for both Medicaid nutrition services and other support programs such as SNAP. The comment highlighted the wide range of food insecurity and poverty levels across populations, and the importance of maintaining access for those who meet multiple criteria.

4. **Design Flexible Models to Support Varied Participant Needs**

Recommendation: Offer flexible formats for nutrition services, including home-delivered meals, grocery cards, food pickup options, and technology-based tools for nutrition education and food access, such as telehealth, SMS counseling, or app-based grocery ordering.

Rationale: Participants emphasized that mobility limitations, housing instability, and cooking capacity must be considered. It was recommended that multiple delivery methods be available to meet individuals where they are. Flexibility in service design also supports the needs of various populations, as well as diverse cultural preferences and dietary practices.

Feedback/Thoughts:

A participant noted that flexibility should include the ability to transition between different types of nutrition support based on changing needs. For example, an individual may begin with home-delivered meals following a hospitalization and later move to grocery assistance as they regain the ability to prepare food. It was noted that programs in other states often assign a fixed benefit duration (e.g., 6 to 12 weeks of meals), but do not account for transitions between service types, which may not reflect participants' evolving circumstances.

A participant emphasized the importance of distinguishing between medically necessary services and nutrition supports that function more as subsidies. From a coverage perspective, there was discussion about how to determine eligibility for individuals with chronic conditions and those without a formal diagnosis but who still experience barriers to food access, such as older adults. The duration of services was also discussed, particularly in cases where participant needs may change over time.

A participant noted that functional status should be considered when determining the appropriate service type. For example, an individual may not initially be able to cook but could regain that ability after recovery. It was shared that in many jurisdictions, participants must choose one service type or another, with no mechanism to transition between them. This was identified as a gap, since removing a meal service may leave individuals without any viable option for food access. It was also noted that Medicaid plans typically cannot offer nutrition services for food insecurity alone—there must be an accompanying need, such as a chronic condition or mobility limitation.

A participant referenced examples from other states where multiple levels of nutrition support can be authorized and adjusted over time. It was suggested that the ability to reauthorize or transition between services—such as from medically tailored meals to grocery prescriptions—could better support long-term behavior change and reduce reliance on short-term interventions.

A participant highlighted the importance of personal choice in the design of nutrition services. It was noted that services are more effective when individuals receive food they enjoy, are familiar with, and can prepare, and when options reflect their cultural preferences.

ADDITIONAL POTENTIAL NUTRITION RECOMMENDATIONS FOR CONSIDERATION:

The following are potential recommendations for HSR Subcommittee consideration, based on review of the services frameworks for nutrition. Please review and discuss whether any of these should be considered for a nutrition consensus recommendation or a cross-cutting recommendation.

1. **Broaden Eligibility Criteria to Reflect Life Stages and Health Needs:**
   Participants recommended expanding eligibility beyond nutrition-related diagnoses to include individuals with chronic or acute conditions where nutrition interventions improve health outcomes—such as lead exposure, preeclampsia, asthma, hypertension, and behavioral health conditions. They also emphasized extending eligibility to include families when appropriate, such as when a child qualifies for services.

   Feedback/Thoughts:

   A participant raised the question of how broadly eligibility should be defined, noting that conditions like lead exposure differ significantly from diet-related chronic illnesses such as preeclampsia or hypertension. It was cautioned that while food access can support many health outcomes, expanding the criteria too far may lead to challenges in implementation. The comment emphasized the importance of balancing inclusivity with clear program boundaries.

   A participant noted that high-risk maternal cases are commonly included in nutrition programs in other jurisdictions. Preeclampsia and gestational diabetes were identified as conditions where diet plays a central role in care. It was also shared that in some plans, when a high-risk maternal participant is approved for services, the benefit is extended to their children, particularly in situations where food insecurity is present in the household.

2. **Allow Up to Three Meals Per Day for Six Months with Extensions for Meal Program (Home Delivered) Services:**
   Several participants recommended allowing up to three medically tailored meals per day, seven days per week, for a standard period of six months, with the option for extensions based on continued medical necessity. Research presented highlighted that this duration is the minimum effective period to achieve measurable health improvements.

   Feedback/Thoughts:

A participant noted that approaching program design with an understanding of the potential burden of time limits is important, as fixed durations may create unnecessary barriers for participants. It was suggested that renewal over a longer period may be beneficial in certain cases, and that continuing services based on provider recommendations could help ensure appropriate care.

A participant also noted that while the specific provision of up to three meals per day may be unique to nutrition services, the extension component—based on evaluation and demonstrated need—could be applicable across other domains. The flexibility to extend services was viewed as a potentially cross-cutting strategy, depending on how other programs are structured.

3. **Invest in Infrastructure and Strengthen Cross-Sector Alignment:**
   It was emphasized that strong infrastructure is critical for scaling nutrition services effectively. Participants recommended investments in delivery logistics, kitchen storage, data tracking systems, and cross-sector collaboration with Managed Care Plans (MCPs) to streamline referrals and improve long-term sustainability.

   Feedback/Thoughts:

   There was no further discussion.

4. **Permit Clinical and Non-Clinical Providers to Identify Need:**
   Participants recommended that eligibility determinations and referrals not be limited to clinical providers. Non-clinical providers, such as community health workers, peer navigators, and social service staff, should also be able to identify individuals in need of nutrition services. This would help ensure a no-wrong-door approach and reduce delays in access to care.

   Feedback/Thoughts:

   A participant noted that these two considerations could serve as cross-cutting recommendations. The ability to invest in infrastructure and expand referral authority across clinical and non-clinical providers was seen as relevant across domains and not limited to nutrition services alone.