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The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey

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Abstract

Poor nutrition and food insecurity are drivers of poor health, diet-related diseases, and health disparities in the US. State Medicaid Section 1115 demonstration waivers offer opportunities to pilot food-based initiatives to address health outcomes and disparities. Several states are now leveraging 1115 demonstrations, but the scope and types of utilization remain undefined. To fill this gap, we conducted a systematic analysis of state Medicaid Section 1115 applications and approvals available on Medicaid.gov through July 1, 2023. We found that 19 approved and pending 1115 waivers address nutrition, with 11 submitted or approved since 2021. Fifteen states provide or propose to provide screening for food insecurity, referral to food security programs, and/or reporting on food security as an evaluation metric. Thirteen provide or propose to provide coverage of nutrition education services. Ten provide or propose to provide direct intervention with healthy food. The primary target populations of these demonstrations are individuals with chronic diet-sensitive conditions, mental health or substance use disorders, and/or who are pregnant or postpartum. Since 2021, state utilization of Medicaid 1115 demonstrations to address nutrition has accelerated in pace, scope, and population coverage. These findings and trends have major implications for addressing diet-related health and health equity in the United States.

Key words: nutrition; food insecurity; Medicaid; social determinants of health; health-related social needs; chronic disease; health equity; health policy; health law.

Introduction

Food and nutrition insecurity are major drivers of poor health, health disparities, and preventable health care spending. Food insecurity—the condition of limited or uncertain access to adequate food[1]—is a social determinant of health that is associated with higher risk of chronic diseases and health care utilization.[2] Nutrition insecurity—inconsistent access, availability, or affordability of foods that promote well-being and prevent and treat disease—is a different, although often related, challenge.[3] Poor nutrition is a direct determinant of health, representing the leading driver of mortality in the United States and globally.[4,5] Food and nutrition insecurity cost the United States an estimated $1.1 trillion annually in health care spending and lost productivity.[6] In addition, these burdens disproportionately affect individuals based on socioeconomics, race, ethnicity, geography, and disability.[5] The COVID-19 pandemic underscored the tremendous consequences of food and nutrition insecurity, with increasing racial/ethnic disparities concomitant with diet-related illnesses such as diabetes and cardiovascular diseases as leading risk factors for COVID-19 hospitalization and death.[7-10]

Acknowledging the interconnections between access to nutritious food, health outcomes, and health disparities, health care systems, payers, and policymakers have now focused on innovative ways to address food and nutrition security.[2,11-14] These interventions increasingly take the form of "Food is Medicine" (FIM) services, treatments such as medically tailored meals, medically tailored groceries, and produce prescriptions, that are designed to respond to the nutrition needs of patients with diet-sensitive diseases.[14] However, under federal law, states are not explicitly allowed to cover the direct provision of food (beyond limited circumstances)[15-17] as an established Medicaid benefit.[18] Thus, keen to address nutrition and health inequities for Medicaid beneficiaries, the Centers for Medicare and Medicaid Services (CMS) and states have started to explore alternative strategies to integrate nutrition interventions into health care benefit packages and payment pathways.[19-22]

Medicaid Section 1115 demonstration waivers represent an appealing pathway for states seeking to update the scope of services covered to address diet-related disease. These waivers allow states to pilot coverage for nontraditional services, different payment models, and expanded eligibility criteria.[23] The demonstrations can establish sustainable statewide access to a variety of services for health-related social needs (HRSNs), including a range of nutrition interventions. Any state Medicaid agency has authority to submit Section 1115 proposals to CMS for approval if the proposed innovations

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further the objectives of the Medicaid program and are budget neutral for the federal government. The CMS can approve the waiver for up to 5 years, after which the state may apply for an extension or renewal, including requests to change aspects of the demonstration.[23]

However, the extent of utilization of these state waivers and the scope, types of interventions, and target populations of this health care tool remain undefined. States have been experimenting with Section 1115 demonstrations to provide Medicaid coverage of nutrition services only since the 2010s. Recent developments, such as the COVID-19 pandemic and the 2022 White House Conference on Hunger, Nutrition, and Health, seem to have accelerated states' current interest, use, and scope of nutrition coverage under Section 1115 demonstrations. The new Biden-Harris National Strategy on Hunger, Nutrition, and Health has committed to testing "Medicaid coverage of nutrition education and other nutrition supports using Medicaid Section 1115 demonstration projects" and issuing guidance for states seeking to take advantage of this opportunity.[24] The CMS has recently released a framework and guidance for states seeking to use Section 1115 demonstrations to address HRSNs, including nutrition.[20,21,25]

Despite increasing interest in this health care tool to address food and nutrition insecurity, diet-related diseases, and health equity, no studies to date have analyzed state utilization of Section 1115 demonstrations to meet these goals. This investigation fills this gap by evaluating the evolution and current landscape of Medicaid Section 1115 demonstration waivers used to provide coverage of nutrition services, including types of interventions and populations covered, and implications for patients, health care providers, and Medicaid programs.

Data and methods

We searched each US state's, district's, and territory's most recently approved or pending Medicaid Section 1115 waiver applications and supplemental state filings available on the Medicaid.gov State Waivers List.[26] Searches were performed using nutrition-related key words through July 1, 2023 (Appendix Methods). For approved or proposed demonstrations that included nutrition components, we extracted and recorded the following information: (1) specific terminology regarding nutrition, (2) populations targeted for services, (3) nutrition services covered, and (4) the submission date and the first date that CMS approved the demonstration containing the nutrition-related components. All original waiver documents analyzed are provided in Table S1.

In order to focus on the unique use of Section 1115 authority to expand access to nutritional interventions, we excluded waivers and services from the final analysis if they could be provided under Home and Community Based Services (HCBS) Medicaid authorities. Under these authorities, CMS has long allowed, and many states have long provided, coverage of limited nutrition services for limited populations of Medicaid beneficiaries requiring or "at risk" of requiring an institutional level of care.[27,28] Uses of Section 1115 authority to provide coverage that mirrors the services available under parallel HCBS avenues, while important, do not represent the novel and flexible application of Section 1115 authority that allows coverage of varied services for broad populations and is the focus of this article. Six Section 1115 demonstrations were excluded on this basis (Alabama, Hawaii, Minnesota, Tennessee, Texas, Vermont). In 2 other states (New Jersey, New Mexico), that portion of the nutrition interventions that could be provided under other HCBS Medicaid authorities was excluded. (See the PRISMA [Preferred Reporting Items for Systematic reviews and Meta-Analyses] flow chart of included records in Figure S1).

Each of the state Section 1115 demonstrations included in our final analysis was classified into 1 of 3 categories based on the extent to which they utilized the breadth of Section 1115 authority to provide nutrition services (based on the most intensive level of services provided as of July 1, 2023). "Screening Waivers" were defined as those providing coverage for or requiring new services limited to screening beneficiaries for food insecurity, referring to government nutrition assistance programs (eg, Supplemental Nutrition Assistance Program [SNAP]; Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), and/or measuring and utilizing rates of food insecurity as a demonstration evaluation metric. "Education Waivers" were defined as those that focused on providing coverage of new services for nutrition education. "Food is Medicine (FIM) Waivers" were defined as those that provided new coverage for services that include the direct provision of nutritious foods that support health. Definitions of these nutrition services are outlined in Table 1.

Results

Overall, our search identified 19 state Section 1115 demonstrations that provided new nutrition services uniquely available under Section 1115 authority (with detailed descriptions available in Table S2 and descriptions of excluded state demonstrations and services in Table S3). As of July 1, 2023, among the 19 state demonstrations with nutrition provisions uniquely available under Section 1115 authority, 15 were approved by CMS and 4 were pending. Four demonstrations were categorized as Screening Waivers (Georgia, Maine, Michigan, Virginia). Five were categorized as Education Waivers (Arkansas, Florida, Maryland, Rhode Island, Utah), 2 of which also include screening components. Ten were categorized as FIM Waivers (California, Massachusetts, New Jersey, North Carolina, Oregon, and Washington have been approved and Delaware, Illinois, New Mexico, and New York are pending); 8 of these include screening components, and 8 include education components.

Evolving use of Section 1115 demonstrations to address nutrition

In 2010, Georgia was the first state to distinctively incorporate nutrition services through Section 1115 authority as part of national attention to maternal mortality in high-risk populations.[29-31] (Sources for all state waiver documents are included in Table S1). Georgia's current iteration of this Screening Waiver includes referral to WIC for pregnant individuals who deliver a very-low-birth-weight newborn. In 2014, the first Education Waiver was approved in Florida, similarly focused on high-risk pregnancy, providing nutrition counseling and referral to WIC for select pregnant and postpartum individuals. Subsequent Education Waivers in Maryland (2016), Illinois (2018), New Mexico (2018), and Rhode Island (2018) also focused on nutrition education services for pregnant and postpartum beneficiaries (Figure 1).

Table 1. Definitions of nutrition services.

Category	Service	Definition
Screening	Food insecurity screening	Clinicians screen beneficiaries for the presence of food insecurity, often using validated screening tools or questions from these tools. Programs may measure food insecurity as a demonstration evaluation metric only or as a first step in referrals to existing federal food assistance programs or Food is Medicine services.
	Referral to food insecurity programs	Referrals to existing government food assistance programs such as SNAP or WIC and/or to community-based food assistance resources, such as food pantries.
Education	Nutrition education	May include medical nutrition therapy with one-on-one counseling by a registered dietitian nutritionist, behavioral education, group education, and cooking classes.
Food is Medicine	Cooking equipment	Supplies for meal preparation and nutritional welfare not available through other programs, such as pots, pans, utensils, or refrigerators.
	Medically supportive groceries	Also known as "Pantry Stocking." Packages of food items that meet general health recommendations, such as the federal Dietary Guidelines for Americans.
	Medically supportive meals	Also known as "Healthy Meals" or "Home Delivered Meals." Prepared fresh, frozen, or shelf-stable meals that meet general health recommendations, such as the federal Dietary Guidelines for Americans. Meals are typically home-delivered.
	Food pharmacy	Programs that provide access to discounted or free produce and other healthy food items in the form of a food pantry or food box. Often co-located within health care facilities and provided in combination with nutrition education.
	Produce prescriptions	Electronic benefit cards or paper vouchers redeemable at food retail, including grocery stores and farmers' markets or via home-delivery, that provide access to discounted or free healthy produce. Often in combination with nutrition education.
	Medically tailored groceries	Unprepared or lightly processed healthy food items preselected by a registered dietitian nutritionist or other qualified professional, sufficient to prepare nutritionally complete meals that are tailored to specific diagnoses and medical needs. Groceries are provided to eligible patients at distribution sites or via home delivery and are often provided in combination with nutrition education.
	Medically tailored meals	Fully prepared, home-delivered meals, tailored to the medical needs of individuals living with severe illness by a registered dietitian nutritionist through a referral from a medical professional or health care plan. Medically tailored meals are provided in combination with education in the form of nutrition counseling or medical nutrition therapy with a registered dietitian nutritionist.

Abbreviations: SNAP, Supplemental Nutrition Assistance Program; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

Illinois and New Mexico have submitted extension applications proposing to expand the nutrition services covered and populations targeted.

The first FIM Waiver—Medicaid Section 1115 demonstrations to provide direct food-based treatments—was approved in Massachusetts in 2016 and extended in 2022. The current program provides a full spectrum of FIM interventions—medically tailored and supportive meals, medically tailored and supportive groceries, produce prescriptions—as well as nutrition education and the cost of cooking equipment necessary for meal preparation. The 2022 extension is also the first to include expanded coverage for food-based nutritional support beyond the index patient to their household members in some circumstances. (Sources for all state waiver documents are included in Table S1.) This approach considers that, in households with limited resources, nutritious food provided to patients through FIM programs may be shared by family members.[32,33] Approved in 2017, Oregon's demonstration waiver allowed the state to incentivize Medicaid Coordinated Care Organizations to provide "health-related services," including FIM interventions, through various payment strategies. Oregon's demonstration was likewise extended in 2022, with significant expansion that now provides for coverage of (as opposed to incentives for) a broad spectrum of FIM interventions as well as nutrition education. (Sources for all state waiver documents are included in Table S1.)

Prior to 2021, 7 demonstrations could be categorized as Screening or Education Waivers, and only 3 as FIM Waivers. In contrast, after 2021, 4 demonstrations could be categorized as Screening or Education Waivers and 7 as FIM Waivers (including pending extensions in New Mexico and Illinois) (Figure 1).

Populations targeted

Together, the 19 states with 1115 demonstrations including nutrition services provide Medicaid coverage for over 49 million beneficiaries.[34] Based on the populations specified in each demonstration, only a percentage of beneficiaries are eligible for nutrition interventions. The most common population targeted for demonstration nutrition interventions is pregnant and/or postpartum individuals (15 states), followed by individuals with chronic diet-sensitive conditions (9 states) and/or individuals with substance use disorder or serious mental illness (8 states) (Table 2). Notably, most states only require Medicaid coverage and these medical criteria to determine eligibility. Six states (including 5 with FIM Waivers) further require a social determinant of health criterion for eligibility, such as the presence of food insecurity (5 states) and/or homelessness or risk of homelessness (5 states). Six of the 10 FIM Waivers target beneficiaries with chronic diet-sensitive conditions. In contrast, 3 of the 9 Screening and Education Waivers target beneficiaries with chronic diet-sensitive conditions (Table 2).

Scope of nutrition services

The types of specific nutrition services provided in each demonstration are outlined in Table 3. The most rapidly expanding category is the provision of coverage for FIM interventions. Nine of 10 states with approved or proposed FIM Waivers include coverage of medically tailored meals, 8 include medically supportive groceries, 7 include produce prescriptions, 7 include medically supportive meals, 6 include medically tailored groceries, 2 include cooking equipment, and 1 includes food pharmacies (Table 3). Many of these interventions are prescribed together with nutrition education.

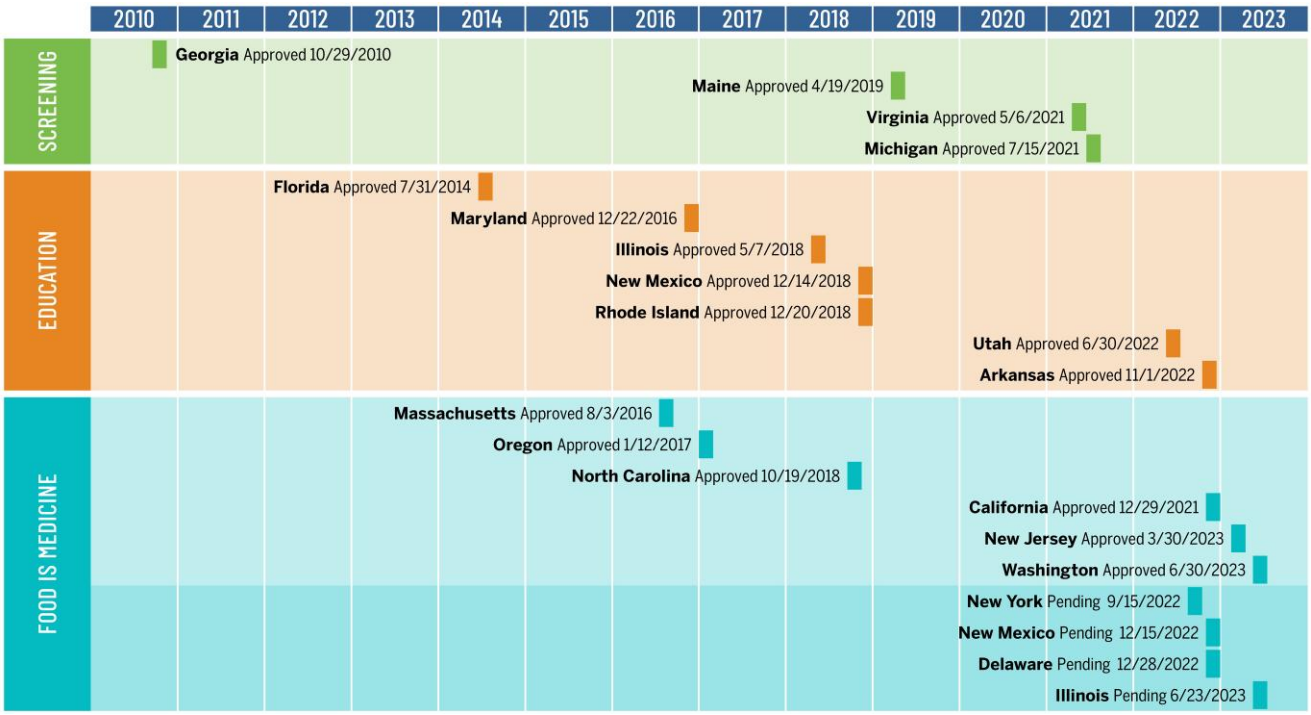

Figure 1. Timeline of first approved 1115 demonstration with nutrition components, by state. Date when nutrition components analyzed in this report were first approved by CMS (for approved demonstrations) or submitted to CMS by states (for pending requests). Section 1115 demonstration waivers with nutrition components were classified into 1 of 3 categories based on the extent to which they utilized the breadth of Section 1115 authority to provide nutrition services. For the purposes of this figure, demonstrations were categorized based on the most intensive level of services provided when first approved by CMS (for approved demonstrations) or submitted to CMS by states (for pending requests). Abbreviation: CMS, Centers for Medicare and Medicaid Services.

Table 2. Populations targeted for Medicaid Section 1115 demonstration nutrition services, by state.

Category	State demonstration waiver	Population(s) targeted					
		Health status			Social determinant		Additional populations or factors[b]
		Chronic conditions[a]	Pregnant/ postpartum	Serious mental illness/substance use disorder	Risk of homelessness	Food insecurity	
Screening	Georgia		X				
	Maine	X					
	Michigan						X
	Virginia			X			
Education	Arkansas	X	X	X			
	Florida		X				
	Maryland	X	X				
	Rhode Island		X				
	Utah[c]			X	X		
Food is Medicine	California	X	X	X			X
	Massachusetts[c]	X	X	X	X	X	X
	New Jersey		X				
	North Carolina[c]	X	X		X	X	
	Oregon[c,d]	X	X	X	X	X	X
	Washington[c,d]	X	X		X	X	X
	Delaware (pending)		X				
	Illinois (pending)[c]	X	X	X		X	
	New Mexico (pending)		X				
	New York (pending)		X	X	X		X

[a]Qualifying conditions differ by state, see Tables S1 and S2. Common conditions that may qualify include diabetes, cardiovascular disorders, HIV, and cancer.
[b]Additional populations or factors vary by state, see Tables S1 and S2. For example, Michigan's screening evaluation provision applies to all enrollees in the demonstration, Massachusetts targets individuals with complex physical health needs, and Oregon has proposed targeting individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon.
[c]Beneficiaries must meet a health needs–based criterion and have at least 1 social determinant factor.
[d]State has yet to finalize its eligibility requirements for services. Further details included in Tables S1 and S2.

Table 3. Medicaid Section 1115 demonstration nutrition services, by state.

Category	State demonstration waiver	Food insecurity screening[a]	Referral to food security programs	Nutrition education	Cooking equipment	Medically supportive groceries	Medically supportive meals	Food pharmacy	Produce prescription	Medically tailored groceries	Medically tailored meals	Infrastructure funding[b]
Screening	Georgia		X									
	Maine	X[c]										
	Michigan	X[c]										
	Virginia	X[c]										
Education	Arkansas	X		X								X
	Florida		X	X								
	Maryland			X								
	Rhode Island	X	X	X								
	Utah			X								
Food is Medicine	California[d]			X		X	X	X	X	X	X	X
	Massachusetts	X	X	X	X	X	X		X	X	X	X
	New Jersey	X	X								X	X
	North Carolina	X	X	X		X	X		X	X	X	X
	Oregon	X	X	X		X	X		X	X	X	X
	Washington	X	X	X		X	X		X	X	X	X
	Delaware (pending)[e]	X				X						
	Illinois (pending)	X	X	X	X	X	X		X	X	X	X
	New Mexico (pending)			X							X	
	New York (pending)	X	X	X		X	X		X		X	X

Abbreviations: CMS, Centers for Medicare and Medicaid Services; FIM, Food is Medicine.
Definitions for nutrition services differ by state, see Table S1. See Table 1 for definitions used for classification purposes.
[a]Although screening is typically necessary for more intensive services (eg, referral, education, and Food is Medicine services), if a state with more intensive services did not include screening provisions in its waiver documentation, we did not note that demonstration as covering "Food Insecurity Screening."
[b]Additional infrastructure investments to support the development and implementation of services. CMS allows funding for 4 categories of activities: (1) technology; (2) development of business or operational practices; (3) workforce development; and (4) outreach, education, and stakeholder convening.
[c]Food insecurity screening limited for use as a demonstration evaluation metric.
[d]California's coverage of nutrition services is provided via "in lieu of services" flexibility through a 1915(b) Medicaid managed care waiver; however, we have included it in our analysis because parts of the nutritional coverage are operationalized through the state's 1115 demonstration waiver. For example, infrastructure funds to support delivery of nutrition services are provided through the state's 1115 demonstration. See California's December 29, 2021, Approved Waiver in Table S1.
[e]Delaware's pending FIM Waiver is the first nutrition demonstration to incorporate provision of non–nutrition-related items, requesting to include diapers and wipes with its food boxes provided to postpartum individuals up to 12 weeks after birth.

Nine demonstrations, including 8 FIM Waivers and 1 Education Waiver, leverage Section 1115 authority to allocate funds toward capacity building and infrastructure development in support of nutrition services. These investments aim to address challenges of implementing HRSN programs in Medicaid—for example, providers of HRSN services may face meaningful costs when establishing health care partnerships, such as legal and technology investments to comply with patient privacy requirements.[35] These states have flexibility to determine how to use and distribute the funds within 4 categories of investment: (1) technology (including electronic referral systems, electronic health record [EHR] modifications, screening tools, case management systems, and data analytics and reporting), (2) business/operational development, (3) workforce development, and (4) outreach, education, and stakeholder convening. (Sources for all state waiver documents are included in Table S1.) Arkansas' Education Waiver that includes HRSN infrastructure funding may aim to serve as a stepping stone for a transition to a FIM Waiver in the future. (Sources for all state waiver documents are included in Table S1.)

Discussion

This analysis identified and characterized the growth and features of the provision of nutrition services to Medicaid patients under Section 1115 demonstration waivers. The findings show meaningful advances in the utilization of these demonstrations, now in 19 states, and acceleration in recent years—with 11 states' demonstrations approved or submitted since 2021. We also found that this increased pace of utilization has been accompanied by an expanded scope of services, in particular FIM interventions, which 7 states have incorporated into their demonstrations since 2021 alone.

These trends are relevant to clinicians, health systems, and payers who will need to understand in which states food and nutrition screening is required or covered, which Medicaid beneficiaries are eligible for nutrition interventions and why, how to refer beneficiaries to these new services, and how to bill Medicaid for care. These developments also require meaningful infrastructure changes and investment from health systems, including in screening tools and EHR integration, referral and clinical care pathways, and data sharing. To be most effective, these updates then require integration into medical education across the continuity of training and practice. The latter is already starting, with the American College of Lifestyle Medicine committing to free provision of Food is Medicine training to 100 000 health care providers, the American Academy of Pediatrics committing to training around nutrition insecurity for their 67 000 members, and the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education initiating plans to require mandatory nutrition education for all US residency and fellowship programs.[36]

The rapidly growing interest in and scope of state Medicaid Section 1115 demonstrations with nutrition components likely is due to several factors. This includes the US onset of the COVID-19 pandemic in March 2020, which dramatically increased the awareness of food insecurity and health disparities among at-risk populations.[7,8,37,38] Consistent with this influence, several states' demonstration documents explicitly discuss the pandemic's impact on health outcomes, racial and socioeconomic health disparities, health care delivery, and Medicaid enrollment. (Sources for all state waiver documents are included in Table S1.) The pandemic also called attention to the high rates of diet-related chronic diseases in the United States—in particular, obesity, diabetes, and hypertension, which were important determinants of COVID-19 severity, including hospitalization and death.[9,10] This can be seen in the increasing inclusion of diet-related chronic conditions in the beneficiary eligibility criteria for nutrition services in demonstrations since 2021.

A second driver of increasing state and CMS interest in nutrition services may be the accumulating scientific evidence for the health benefits and cost-effectiveness of specific FIM interventions. Since 2020, an increasing number of peer-reviewed studies—including randomized controlled trials, mixed-methods evaluations, and quasi-experimental evaluations—suggest that FIM interventions, particularly medically tailored meals and produce prescriptions, provide significant health benefits, including reduced food insecurity, increased fruit and vegetable intake, and better disease management, self-reported health status, glucose control, blood pressure, and body mass index.[39-41] Several evaluations on medically tailored meals have further linked participation with decreased health care utilization, costs, and even mortality for high-risk patients.[42-44] Recent modeling studies suggest that nationwide adoption of these treatments could generate billions in health care savings and productivity costs and be cost-effective or even cost-saving.[45,46]

A final major driver is increased attention at the federal level to the social determinants of health, poor nutrition, and health disparities. In January 2021, CMS released guidance detailing opportunities in Medicaid and the Children's Health Insurance Program (CHIP), including Section 1115 demonstration waivers, to address social determinants of health.[19] In September 2022, the Administration released a National Strategy on Hunger, Nutrition, and Health that explicitly aims to expand screening for food insecurity as well as access to FIM interventions through Section 1115 demonstrations.[22] Building on these developments, in December 2022, CMS issued a guiding framework establishing parameters for states seeking to submit Section 1115 demonstration applications aiming to address HRSNs.[25] In November 2023, CMS released further guidance and an HRSN service coverage table affirming and refining this framework for Section 1115 demonstrations as well as other Medicaid and CHIP payment authorities.[20,21] The Section 1115 CMS framework clarifies expectations for service delivery, time limits for services, and limitations on federal spending for HRSN services and infrastructure funds.[25] The framework also requires Medicaid agencies in states with approved FIM Waivers to deliver services in coordination with other state agencies that administer federal food-assistance programs such as SNAP and WIC.[20,21,25] For example, we found that CMS has required the 4 most recently approved demonstrations (Massachusetts, Oregon, New Jersey, Washington) to develop a plan for tracking and improving upon the share of Medicaid beneficiaries enrolled in SNAP and WIC. (Sources for all state waiver documents are included in Table S1.) (These states have not yet specified how they plan to fulfill this requirement.) We also found 4 older Section 1115 demonstrations (Georgia, Florida, North Carolina, Rhode Island) that explicitly address, cover, or require screening and referral to WIC and/or SNAP for eligible Medicaid beneficiaries. (Sources for all state waiver documents are included in Table S1.) These trends suggest that CMS hopes to leverage

greater enrollment in federal food programs as part of providing states with the flexibility to pilot new nutrition interventions in health care, which may create synergistic impact.

In contrast to longstanding federal food-assistance programs like SNAP or school meals, that primarily rely on income eligibility criteria, we found that the state Medicaid Section 1115 demonstrations with nutrition services largely focus on a qualifying diet-sensitive health condition to determine eligibility. This approach was reinforced by the CMS framework, which requires HRSN services provided under Section 1115 authority to be "medically appropriate."[20,21,25] This is relevant as nutrition services covered by Medicaid under Section 1115 authority are becoming situated within a health care framework as treatments to improve health for specific beneficiary populations, rather than as social benefit programs addressing poverty. The handling of nutrition interventions in this manner seamlessly falls within the legal structure of the Medicaid program, in which states can and do place limits on services based on medical necessity.[47] Additionally, CMS has taken care to note that nutrition interventions covered through Medicaid are intended to "supplement, not supplant" existing services provided by existing food-assistance programs.[25] This represents a landmark shift in the approach and authority to addressing food and nutrition within health care.

While the 2022 National Strategy on Hunger, Nutrition, and Health also commits to universal screening for food insecurity in federal health systems and to expand such screening in other health systems,[24] only 10 of the 19 states we identified include or propose screening for food insecurity as a covered or required nutrition service beyond a demonstration evaluation metric. Even in state demonstrations with more comprehensive nutrition service offerings, it was challenging to find specific screening and referral provisions in the waiver documents. For example, although California provides and New Mexico is proposing to provide coverage for FIM interventions, the states' waiver documents did not contain explicit screening or referral provisions for these services. (Sources for all state waiver documents are included in Table S1.) These and other states may provide food insecurity and/or HRSN screening in Medicaid through other pathways (such as value-based payment incentives, case management benefits, or managed care contract provisions).[48] It will be important to evaluate whether the new federal commitments to food security screening translate to increased screening by providers and increased reimbursement by payers.

A limitation of our analysis is the inability to assess the impact of these state Section 1115 demonstrations on health outcomes. While all existing state demonstrations must include an evaluation component, due to the novelty of many of these demonstrations, evaluation designs and reports are not yet available for most states. Interim evaluations that have been released (eg, Massachusetts) have not yet meaningfully assessed health outcomes. Moving forward, independent evaluation of these demonstrations' impact will be an important area for investigation, including for patient-centered outcomes, health, health equity, health care utilization, and health care system design.

Conclusion

Nineteen states have approved or pending Medicaid 1115 demonstrations that include nutrition components, with accelerating pace, scope, and population coverage of interventions since 2021. These findings and trends have major implications for addressing diet-related health and healthy equity in the United States.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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