WEST VIRGINIA FOOD IS MEDICINE COALITION

West Virginia Food is Medicine

Policy Priorities for 2026 - 2029

JUNE 2026

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POLICY SCAN

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Executive Summary

West Virginia enters 2026 with a rare convergence of policy conditions favorable to Food is Medicine (FIM): new FIM-enabling legislation, an active ILOS framework under development at the Bureau for Medical Services (BMS), a $500M+ Rural Health Transformation Program (RHTP) with FIM explicitly written in, and a Governor's Four Pillars framework that names "Clean Up the Food" as Pillar 1. These conditions are time-limited. This policy scan maps the Medicaid pathways available to WVFIMC, assesses each against West Virginia's specific landscape, and defines a sequenced 2026–2029 advocacy agenda.

Advocacy Priorities at a Glance — 2026 to 2029

2026 -->-->-->-->-->

Secure FIM in WV's ILOS framework before guidance is finalized: FIM services appear in BMS's initial ILOS pre-approval list; at least one MCO submits a FIM ILOS proposal to BMS.

Embed FIM in RHTP and Make WV Healthy Act implementation: WVFIMC seat on the Healthy Lifestyle Coalition; formal cross-agency FIM steering committee established; FIM service definitions published before first PHA grant cycle.

Build the MCO business case through VAS and quality metrics: At least one MCO offers a FIM VAS by end of SFY2026; food insecurity screening metric included in next quality strategy or withhold update.

2027 – 2028 -->-->-->-->

Advance Medicaid payment through HCBS and waiver opportunities: Health Home re-establishment under active BMS consideration; food insecurity language included in IDD waiver renewal; at least one MCO D-SNP offering a FIM-adjacent SSBCI benefit.

Deepen MCO integration through the contract renewal cycle: FIM services included in MHT contract ILOS framework; food insecurity screening required in MCO contract; at least one VBP arrangement directing payment to FIM CBOs.

Build farm-to-FIM and PRx delivery infrastructure: Extension formally designated as PRx delivery partner in at least one FIM program; farm-to-FIM procurement pilot operational in at least one region; FIM outcomes data collected against standardized metrics.

2029

Transition high-performing models toward durable Medicaid financing: At least one FIM intervention formally covered as ILOS under MHT; BMS has defined an evidence threshold for FIM Medicaid coverage; outcomes data submitted to CMS.

Monitor federal signals for 1115 and SPA windows: CMS HRSN guidance restored or nutrition-specific guidance issued; WV positioned to submit a nutrition HRSN amendment to its existing 1115 within 6 months of a federal signal.

About This Policy Scan

The mission of the West Virginia Food is Medicine Coalition (WVFIMC) is to advance and sustain the integration of Food is Medicine (FIM) interventions into West Virginia's healthcare system.

This policy scan identifies and assesses the primary Medicaid policy pathways available to support FIM services, analyzes how those pathways apply to West Virginia's specific landscape, and offers a prioritized advocacy agenda for the West Virginia Food is Medicine Coalition for 2026–2029. It also examines state and federal government programs that create complementary entry points for FIM integration alongside Medicaid financing, including the Rural Health Transformation Program (RHTP), the Make West Virginia Healthy Act, and Cooperative Extension. The scan is intended as both a reference document and a strategic planning tool. It is organized into four sections:

Section 1: Medicaid Managed Care Policy Pathways to Support Food is Medicine — a national overview of available pathways, organized by feasibility and impact

Section 2: West Virginia Medicaid Managed Care Policy Landscape — West Virginia's Medicaid structure, active waiver authorities, and a pathway-by-pathway assessment of how the national policy landscape maps to WV's specific conditions

Section 3: Policy Priorities 2026–2029 — a prioritized advocacy agenda for WVFIMC

Section 4: Appendices — primary source language from West Virginia Medicaid policy documents, waiver authorities, and government program detail

Section 1: Medicaid Managed Care Policy Pathways to Support Food is Medicine

Over the past decade, federal guidance and state-level policy innovation have significantly expanded the Medicaid pathways available to support Food is Medicine. Between 2021 and 2024, CMS issued guidance explicitly naming FIM services, including produce prescriptions, medically tailored meals, and nutrition counseling, as approvable under multiple authorities, spanning 1115 waivers, In Lieu of Services and Settings (ILOS) arrangements, Home and Community-Based Services waiver authorities, and state plan options.

In March 2025, CMS rescinded two key frameworks from 2023 and 2024 that broadly authorized those policy pathways for covering FIM services (See **Table A** for an overview of current and rescinded guidance). New state waiver applications are now reviewed case-by-case under the Social Security Act, without reference to prior guidance. Existing approved waivers remain unaffected, and states including California, Oregon, Massachusetts, and North Carolina continue to operate programs developed under the prior framework. Notably, the withdrawal raises the bar for federal approval and introduces meaningful uncertainty into planning timelines.

Against this backdrop, local context and policy change sequencing matter more than ever. Though the long-term goal is full integration of FIM into Medicaid as standard covered benefits, pursuing formal coverage mechanisms before the necessary relationships, infrastructure, and evidence are in place can be premature. Managed care plans and state agencies are more likely to invest in FIM when they have confidence in the organizations delivering these programs and data demonstrating impact.

The pathways in this section should be understood as a menu. Policy changes that incentivize clinical-community partnerships, establish screening and referral workflows, and create accountability for addressing food insecurity all advance the foundation for coverage even when they do not immediately result in Medicaid reimbursement. The right starting point depends on the maturity of the local FIM landscape, the appetite of decision-makers, and the prevailing policy environment.

Table A. Key Federal Guidance Related to Coverage of Nutrition Supports under 1115 Waivers

Year	Guidance	Summary	Status
2021	SHO 21-001: Opportunities in Medicaid & CHIP to Address SDOH	Encouraged states to address the social determinants of health (SDOH) using Medicaid authorities. Named allowable coverage pathways for home-delivered meals, nutrition counseling, and food insecurity screening.	IN EFFECT
2022	All-State Call: Addressing HRSN in Section 1115 Demonstrations (Dec. 6)	First guidance to explicitly name a spectrum of FIM services as approvable HRSN services under 1115 waivers. Set expectations for HRSN pilots in 1115 waivers: screening, care coordination, equity metrics, and evaluation.	IN EFFECT
2023	CMCS CIB: Coverage of HRSN Services in Medicaid and CHIP; CMS HRSN Coverage Table	Introduced the first federal HRSN coverage framework for Medicaid and CHIP. Outlined pathways for nutrition, housing, and other services under 1115 waivers, in-lieu of services (ILOS), home and community-based services (HCBS) waivers, and state plan authorities.	RESCINDED MARCH 2025
2024	CMCS CIB: Updates to HRSN Coverage Framework	Superseded and replaced 2023 HRSN guidance entirely. Substantially expanded detail and operational guardrails. Provided greater clarity on coverage parameters and stronger distinctions among coverage authorities.	RESCINDED MARCH 2025
2025	CMCS CIB: Rescission of HRSN Guidance (Mar. 4)	Rescinded the 2023 and 2024 CIBs. New state applications reviewed case-by-case under the Social Security Act; existing approved waivers unaffected.	IN EFFECT

The policy pathways outlined in **Table B** below vary considerably in what they achieve, how much policy investment they require, and how directly they result in Medicaid reimbursement for FIM services. To help advocates evaluate and sequence their work, each pathway below is tagged with one of three impact categories:

Clinical-Community Partnerships — Pathways that incentivize health care entities to partner with FIM providers without creating a new Medicaid-covered benefit. These do not result in direct reimbursement for FIM services, but they build the relationships, workflows, and accountability structures that make formal coverage possible. Often the most actionable starting point in early-stage FIM landscapes.

Medicaid Payment — Pathways that enable Medicaid dollars to flow directly to FIM services, through managed care plan flexibilities or formal waiver and state plan authorities. Most require state action and CMS engagement, and in many cases demonstrated cost-effectiveness or budget neutrality.

Full System Integration — Pathways that embed FIM into Medicaid's permanent architecture through state plan changes, managed care organization (MCO) contract requirements, and quality oversight mechanisms. These represent the most durable outcomes and the greatest sustained policy investment.

It is also worth noting that some of the most impactful near-term actions available to states are administrative rather than regulatory such as publishing ILOS guidance, developing pre-approved service lists, and providing technical assistance to managed care plans on how to use existing flexibilities. These **enabling infrastructure** actions do not require new authority but significantly improve the uptake of pathways that are already available, and should be pursued in parallel with any formal policy advocacy.

To learn more about the policy pathways listed in the tables below and the ways states have leveraged them, see *Mainstreaming Produce Prescriptions in Medicaid Managed Care (2023), Food is Medicine: A State Policy Toolkit (2024), The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey (2024), and States' Use Of Medicaid Managed Care 'In Lieu Of Services' Authority To Address Poor Nutrition (2025).*

Table B. Medicaid Managed Care Policy Pathways to Support Food is Medicine

Pathway	What It Does for FIM	Impact + Feasibility
General Feasibility: High		
Value-Added Services (VAS) ***Decisionmaker:*** *MCO (voluntary)*	MCOs voluntarily offer non-covered services beyond the State Plan. Not included in capitation rates (the MCO absorbs the cost) but counts toward the medical loss ratio (MLR) as a quality improvement activity. A useful bridge pathway while formal coverage is pursued; entirely discretionary and can be discontinued at any time.	**Impact:** Clinical-Community Partnerships **Feasibility: High**
MCO Contract Language ***Decisionmaker:*** *State*	Binding MCOs to SDOH screening, care coordination, CBO partnership requirements, and ILOS pre-approval. The strongest state-level tool available in non-competitive managed care states. Should be targeted 12–18 months ahead of the contract renewal cycle.	**Impact:** Depends on what mechanism is used **Feasibility: High**

Pathway	What It Does for FIM	Impact + Feasibility
Quality Strategy / Oversight Mechanisms ***Decisionmaker**: State*	State-required quality metrics, performance withholds, and bonuses tied to SDOH, food insecurity, or diet-related chronic condition benchmarks. MCOs must comply via contract. Public reporting creates additional reputational pressure on plans.	**Impact:** Clinical-Community Partnerships **Feasibility: High**
State ILOS Guidance & Technical Assistance ***Decisionmaker:** State*	States publish policy documents, pre-approved service lists, request forms, and TA resources clarifying how MCOs can use ILOS authority for FIM services. Reduces plan uncertainty and administrative burden — a primary barrier to uptake nationally. A low-cost, high-leverage state action best pursued alongside contract language changes.	**Impact:** Enabling Infrastructure **Feasibility: High**
In Lieu of Services (ILOS) ***Decisionmaker:** MCO (with State pre-approval)*	MCOs cover non-State Plan services as cost-effective substitutes for covered services. Costs count toward both capitation and the MLR numerator — the strongest financial incentive structure available at the plan level. CMS has, in the past, explicitly endorsed FIM as ILOS-eligible including preventive substitution. MCO still chooses whether to offer; members choose whether to accept.	**Impact:** Medicaid Payment **Feasibility: High**
General Feasibility: Medium		
Value-Based Payment (VBP) Requirements **Decisionmaker:** State	Contract provisions requiring MCOs to adopt VBP arrangements that can direct payments toward CBOs delivering FIM. Can include SDOH-specific goals tied to food insecurity or diet-related conditions. A key distinction: provisions must ensure payment flows to CBOs, not just referrals.	**Impact:** Clinical-Community Partnerships **Feasibility: Medium**
1915(b)(3) Waivers **Decisionmaker:** Federal (CMS approval) + State	If a state's managed care model generates documented cost savings, those savings can be redirected to fund non-covered services — including FIM supports — without new appropriations. MCO retains discretion over which services receive funds.	**Impact:** Medicaid Payment **Feasibility: Medium**
1915(c) HCBS Waivers **Decisionmaker:** Federal (CMS approval) + State	Fund home and community-based services for people who would otherwise require institutional care. CMS has historically allowed home-delivered meals; PRx is a potential expansion requiring CMS amendment. Limited to specific populations and subject to enrollment caps.	**Impact:** Medicaid Payment **Feasibility: Medium**

Pathway	What It Does for FIM	Impact + Feasibility
1915(i) HCBS SPAs/Waivers **Decisionmaker**: Federal (CMS approval) + State	Similar to 1915(c) but with broader eligibility. Individuals do not need to be at risk of institutionalization. Can cover home-delivered meals; PRx is a potential expansion. No enrollment caps. Less utilized nationally than 1915(c) with less FIM-specific precedent.	**Impact:** Medicaid Payment **Feasibility: Medium**
Dual Eligible Special Needs Plans (D-SNPs) **Decisionmaker:** Federal (Medicare Advantage) + MCO	Specialized Medicare Advantage plans for individuals enrolled in both Medicaid and Medicare. Can offer FIM services including PRx as Special Supplemental Benefits for the Chronically Ill (SSBCI) under Medicare Advantage rules — a Medicare-side pathway that does not require state Medicaid action.	**Impact:** Medicaid Payment **Feasibility: Medium**
MCO Procurement / RFP Design **Decisionmaker:** State	Competitive Request for Proposal (RPF) processes that score MCO proposals on SDOH activities and require disclosure of nutrition investments. Embeds FIM expectations before the contract is signed. Not applicable in states using non-competitive managed care models.	**Impact:** Clinical-Community Partnerships **Feasibility: Medium**
General Feasibility: Low		
Capitation Rate Social Risk Adjustment **Decisionmaker:** State (with CMS approval)	States can pay MCOs higher per-member-per-month rates for food-insecure or high-SDOH members, providing plans with additional resources that could be directed toward FIM. MCOs retain full discretion over how those additional dollars are deployed.	**Impact:** Clinical-Community Partnerships **Feasibility: Low**
Community Reinvestment Requirements **Decisionmaker:** State	Contract provisions requiring MCOs to reinvest a portion of profits into local communities. Could benefit FIM CBOs but requires active stakeholder engagement to direct funds. Without a FIM-specific carve-out, funds are unlikely to reach nutrition programs. Enforcement tends to be weak.	**Impact:** Clinical-Community Partnerships **Feasibility: Low**
1115 Demonstration Waivers **Decisionmaker:** Federal (CMS approval) + State	Allow states to test new benefit designs and delivery models not otherwise permitted. Most common FIM pathway nationally; explicitly permits nutrition supports including PRx and MTM. Budget neutral; 5-year terms. Significant federal headwinds under the current administration — CMS rescinded HRSN guidance in March 2025. Monitor for shift.	**Impact:** Medicaid Payment **Feasibility: Low**

Pathway	What It Does for FIM	Impact + Feasibility
State Plan Amendments (SPAs) **Decisionmaker:** Federal (CMS approval) + State	The most durable pathway to FIM coverage. A SPA permanently adds FIM as a covered Medicaid benefit with no cost-neutrality requirement and no renewal. CMS has not yet authorized FIM under any existing benefit category, making this a long-term national advocacy target rather than a near-term state-level ask.	**Impact:** Full System Integration **Feasibility: Low**

Section 2: West Virginia Medicaid Managed Care Policy Landscape

West Virginia's Medicaid System

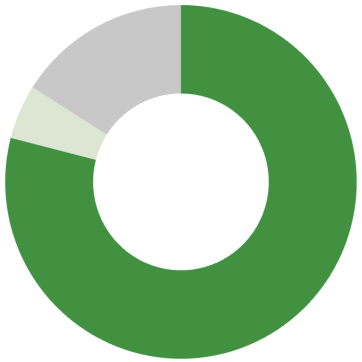
West Virginia's Medicaid program is administered by the Bureau for Medical Services (BMS) within the Department of Human Services(DoHS). The state delivers Medicaid services through two mechanisms: 1) a risk-based managed care system and 2) a fee-for-service system for populations and services not included in managed care contracts.

The managed care system operates through two programs. Mountain Health Trust (MHT) is the primary program, covering adults, children, pregnant women, SSI recipients, and CHIP enrollees — approximately 84% of WV Medicaid members as of April 2026. Four MCOs contract with BMS to deliver MHT benefits: Wellpoint, Aetna Better Health of West Virginia, The Health Plan of West Virginia, and Highmark Health Options West Virginia. Mountain Health Promise (MHP) is a specialized track for children and youth in foster care, kinship care, or adoptive placement, operated by Aetna Better Health of West Virginia. These MCOs receive a fixed capitation payment per enrollee per month and are responsible for delivering covered services, managing provider networks, and meeting quality benchmarks. **See the SFY 2026 MCO Contract here.**

West Virginia uses a non-competitive managed care model. MCOs are not selected through a Request for Proposals (RFP) process. The MCO contract renewal cycle, governed by BMS, is therefore the primary state-level entry point for advocates seeking to embed FIM expectations into managed care policy.

DELIVERY SYSTEM, APRIL 2026

How WV Medicaid members receive care

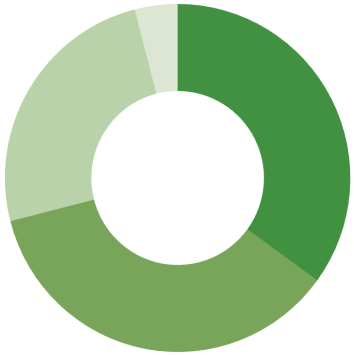


- Mountain Health Trust, 79%
- Mountain Health Promise, 5%
- Fee-for-service, 16%

Total Enrollment: 490,294

MCO ENROLLMENT, APRIL 2026

Mountain Health Trust enrollees by plan



- Wellpoint WV, 35%
- Aetna Better Health of WV, 36%
- The Health Plan of WV, 25%
- Highmark Health Options WV, 4%

Total MHT Enrollment: 385,948

Services carved out of MCO contracts

Long-term care, HCBS waiver services, point-of-sale pharmacy, and non-emergency medical transportation are delivered outside the MCO system through fee-for-service or separate waiver arrangements. FIM programs embedded in HCBS waiver populations or serving members who rely on these carved-out services will interact with a different set of payment and oversight structures than those working within managed care.

West Virginia's Medicaid program operates under a set of federal waiver authorities that govern both the managed care delivery system and services provided outside of it. **Table C** identifies the active waivers and their relevance to Food is Medicine advocacy. [See more information on BMS's Waiver Approvals webpage.]

Table C. Medicaid Waivers in West Virginia

Waiver / Authority	FIM Relevance
Section 1115 Demonstration Waivers	
Evolving WV Medicaid's Behavioral Health Continuum of Care	Active 1115 waiver. HRSN Protocol approved for housing supports (SUD population). ILOS planning language included. Template for future nutrition HRSN expansion. *See Appendix D.* **Authorized Jan 1, 2025 – Dec 31, 2029**
Section 1915(b) Waivers — Managed Care Authority	
Mountain Health Trust (MHT) WV-05	Governs the primary MCO-based managed care delivery system. Foundation for all MCO-level FIM levers including ILOS, VAS, and contract language. **No fixed expiration; annual contract cycle.**
Mountain Health Promise (MHP) WV-06	Specialized managed care track for foster care, kinship care, and adoptive care youth. Less directly relevant to FIM nutrition services but relevant for pediatric populations. **No fixed expiration; annual SFY contract cycle.**
Section 1915(c) HCBS Waivers	
WV Aged and Disabled Waiver 0134.R08.00	Most relevant to FIM. Serves elderly and disabled populations who would otherwise require institutional care. CMS has allowed home-delivered meals under 1915(c); PRx is a potential expansion requiring CMS amendment. **Expires June 30, 2030**
WV Intellectual and Developmental Disability Waiver 0133.R08.00	Serves IDD population. Lower FIM relevance. **Expires June 30, 2030**
WV Traumatic Brain Injury (TBI) Waiver 0876.R03.00	Serves TBI population. Limited direct FIM relevance. **Expires June 30, 2030**
WV Children with Serious Emotional Disorder Waiver 1646.R01.00	Serves CSED population. Limited direct FIM relevance. **Exp Jan 31, 2028**
Section 1915(i) HCBS / Health Homes	
Pilot Health Home for Pre-diabetes, Diabetes, Obesity State Plan Section 3.1-H	Health Home SPA for chronic disease population (2017–July 2024). Directly relevant population overlap with FIM. Potential for re-establishment with FIM services included. *To learn more about Health Homes, see Medicaid Health Homes: State Plan Amendment Overview (CMS, 2025). See Appendix E for WV information.* **TERMINATED July 2024**
No 1915(i) HCBS SPA/Waiver	Broader-eligibility HCBS pathway (no institutionalization requirement). Not currently used in WV for FIM-relevant services. Mid-term opportunity if BMS appetite exists. *See Food is Medicine: A State Policy Toolkit (2024) to learn more about 1915(i) HCBS SPAs/Waivers.*

West Virginia's Medicaid Policy Landscape

Table D applies the policy pathways identified in Table B to West Virginia's current Medicaid landscape, assessing each pathway's status, key findings, and near-term viability for FIM integration. Pathways are presented in the same order as Table B to facilitate cross-reference. WV status reflects conditions as of April 2026; feasibility ratings draw on the federal guidance context in Table A, WV's active waiver and contract authorities in Table C, and relevant language excerpted in **Appendices A–E.** Readers should use this table diagnostically. For advocacy priorities and recommended actions by time horizon, see **Section 3.**

Table D. West Virginia Medicaid Policy Pathways — Landscape Assessment

Pathway	WV Status	Key Finding	Feasibility / Time
General Feasibility: High			
Value-Added Services (VAS)	**Available now.** SFY26 MCO contract authorizes VAS on a bi-annual submission schedule with BMS approval.	Four MHT MCOs can propose FIM services (PRx, nutrition counseling, food pharmacy) as VAS immediately — no state action required. MCO absorbs cost but counts toward MLR as a quality improvement activity. Lowest-lift near-term entry point; entirely discretionary and can be discontinued at any time.	**Impact:** Clinical-Community Partnerships **Feasibility: High** **Time Horizon: Near-term**
MCO Contract Language	**Active planning underway.** SFY26 contract includes explicit ILOS planning language; MCOs required to collaborate with BMS on implementation.	The SFY26 contract is WV's strongest signal yet of BMS 'appetite for SDOH integration. The next contract cycle is the primary advocacy window to embed FIM-specific ILOS pre-approval, food insecurity screening requirements, and CBO partnership expectations. Target 12–18 months ahead of contract renewal (July 1). The finalized 2024–2027 Quality Strategy also formally embeds Governor Morrisey's Four Pillars framework — with "Clean Up the Food" as Pillar 1 — as a BMS commitment, giving FIM advocates direct alignment with both BMS and the Governor's office.	**Impact:** Full System Integration **Feasibility: High** **Time Horizon: Near-term**

Pathway	WV Status	Key Finding	Feasibility / Time
Quality Strategy / Oversight Mechanisms	**Active.** BMS launched a 1% quality withhold program July 1, 2025; 2024–2027 Quality Strategy in effect.	Current withhold metrics do not include food insecurity screening or diet-related chronic condition benchmarks. Advocating for inclusion of food insecurity screening rates or HbA1c/BMI improvement targets would create direct financial incentives for MCOs to invest in FIM. The five current withhold measures are FUI (SUD follow-up), OED (dental), CBP (blood pressure), APP (antipsychotics), and W30 (well-child visits). CBP and FUI are the two with direct FIM evidence. Advocate for nutrition-linked metrics in the next withhold cycle.	**Impact:** Clinical-Community Partnerships **Feasibility: High** **Time Horizon: Near-term**
State ILOS Guidance & Technical Assistance	**Pending.** BMS is in active ILOS planning per SFY26 contract; no WV-specific ILOS guidance or pre-approved FIM service list has been published.	Publishing a pre-approved FIM service list and MCO technical assistance resources would immediately reduce the administrative barriers that are the primary barrier to ILOS adoption nationally. WVFIMC must ensure FIM is included in BMS's initial ILOS framework before guidance is finalized.	**Impact:** Enabling Infrastructure **Feasibility: High** **Time Horizon: Near-term**
In Lieu of Services (ILOS)	**Enabled but not yet implemented.** SFY26 contract confirms BMS is actively planning for ILOS; no FIM services currently pre-approved.	WV's ILOS framework is under active development — the most consequential near-term opening in this scan. CMS has explicitly endorsed FIM as ILOS-eligible. Getting FIM services named in BMS's initial pre-approval list is the single highest-leverage policy ask available to WVFIMC right now. See Appendix A.	**Impact:** Medicaid Payment **Feasibility: High** **Time Horizon: Near-term**
General Feasibility: Medium			
Value-Based Payment (VBP) Requirements	**Active framework.** 2024–2027 Quality Strategy includes VBP goals; RHTP Smart Care Catalyst advances VBP models statewide.	VBP language currently focuses on utilization and quality benchmarks; food security and nutrition outcomes are not included. Advocating for SDOH-specific VBP goals tied to food insecurity or diet-related conditions (and ensuring payment flows to CBOs, not just referrals) is a medium-term priority.	**Impact:** Clinical-Community Partnerships **Feasibility: Medium** **Time Horizon: Medium-term**

Pathway	WV Status	Key Finding	Feasibility / Time
1915(b)(3) Waivers	**Theoretically available.** WV operates 1915(b) managed care under MHT (WV-05) and MHP (WV-06) on annual SFY contract cycles.	Requires documented cost savings from managed care operations redirected to non-covered services. WV has not pursued this pathway for FIM. Lower priority given that ILOS and contract language offer more direct routes to the same outcome.	**Impact:** Medicaid Payment **Feasibility: Medium** **Time Horizon: Medium-term**
1915(c) HCBS Waivers	**Partially relevant.** WV Aged and Disabled Waiver (0134.R08.00) renewed July 2025, expires June 30, 2030. IDD Waiver renewal due ~Oct 2026.	ADW is the most FIM-relevant 1915(c) waiver in WV, serving elderly and disabled populations. CMS has historically allowed home-delivered meals under 1915(c); PRx expansion would require a CMS amendment. IDD waiver renewal (~Oct 2026) is an opportunity to include food insecurity screening language.	**Impact:** Medicaid Payment **Feasibility: Medium** **Time Horizon: Medium-term**
1915(i) HCBS SPAs / Waivers	**Not currently active for FIM.** WV's Pilot Health Home for Pre-diabetes, Diabetes, and Obesity (State Plan Section 3.1–H) was terminated July 2024.	Re-establishing a Health Home SPA with FIM services embedded is a medium-term opportunity if BMS appetite exists. The terminated program's population — pre-diabetes, diabetes, obesity — has direct FIM relevance and strong clinical evidence. See Appendix E.	**Impact:** Medicaid Payment **Feasibility: Medium** **Time Horizon: Medium-term**
D-SNPs (Dual Eligible Special Needs Plans)	**Active in WV.** Dual eligibles served by MHT MCOs; D-SNP plans operate alongside Medicaid MCO contracts.	D-SNPs can offer FIM as Special Supplemental Benefits for the Chronically Ill (SSBCI) under Medicare Advantage rules — a Medicare-side pathway requiring no state Medicaid action. An underexplored near-term opportunity given WV's high dual eligible population and existing MCO relationships.	**Impact:** Medicaid Payment **Feasibility: Medium** **Time Horizon: Medium-term**
MCO Procurement / RFP Design	**Not applicable.** WV uses a non-competitive managed care model; MCOs are not selected through an RFP process.	Not available as a policy lever in WV. MCO contract language and quality strategy are the functional equivalents for embedding FIM expectations before contract periods begin.	**N/A**

Pathway	WV Status	Key Finding	Feasibility / Time
General Feasibility: Low			
Capitation Rate Social Risk Adjustment	**Not in use for FIM.** Requires CMS approval; WV has not pursued.	Would allow BMS to pay MCOs higher PMPM rates for food-insecure or high-SDOH members. High administrative complexity; MCOs retain full discretion over deployment of additional dollars. Lower priority given more direct levers are available and actionable.	**Impact:** Clinical-Community Partnerships **Feasibility: Low** **Time Horizon: Long-term**
Community Reinvestment Requirements	**Not in WV MCO contract.**	Weak enforcement track record nationally. Without a FIM-specific carve-out, funds are unlikely to reach nutrition programs. Not a priority lever for WV given the availability of stronger tools.	**Impact:** Clinical-Community Partnerships **Feasibility: Low** **Time Horizon: Long-term**
1115 Demonstration Waivers	**Active 1115 in WV** (Behavioral Health Continuum of Care, exp. Dec 29, 2029). HRSN Protocol approved for housing supports; ILOS planning language included.	WV's active 1115 is SUD/behavioral health focused. Nutrition HRSN expansion faces significant federal headwinds — CMS rescinded HRSN guidance in March 2025. The approved HRSN protocol provides a template for future nutrition expansion if federal posture shifts. Monitor closely. See Appendix C.	**Impact:** Medicaid Payment **Feasibility: Low** **Time Horizon: Long-term**
State Plan Amendments (SPAs)	**Not pursued.** CMS has not authorized FIM under any existing Medicaid benefit category nationally. *Explore WV's Medicaid State Plan.*	The most durable pathway to FIM coverage — a SPA permanently adds FIM as a covered benefit with no cost-neutrality requirement and no renewal. Requires CMS to authorize FIM under an existing benefit category. A long-term national advocacy target, not a near-term WV ask.	**Impact:** Full System Integration **Feasibility: Low** **Time Horizon: Long-term**

Government Programs with FIM Alignment

Table E provides a high-level overview of active state and federal government programs that present significant opportunities for FIM integration — through shared target populations, existing care coordination infrastructure, or

federal funding streams that FIM services could be embedded within.See **Appendix E** for full program details, decisionmaker information, and specific advocacy entry points.

Two federal policy developments shape the feasibility of all opportunities in this table and should be read as background context throughout. First, the One Big Beautiful Bill Act (OBBBA), signed July 2025, is projected to disenroll roughly 54,000 West Virginia Medicaid members and create funding shortfalls through reduced provider tax revenues. This fiscal pressure narrows BMS's appetite for new program investment but simultaneously strengthens the case for FIM interventions that can demonstrate cost savings or movement on existing HEDIS quality metrics — reframing FIM as a value-based care tool rather than a coverage expansion ask. Second, Governor Morrisey's Four Pillars of a Healthy West Virginia — with "Clean Up the Food" as Pillar 1 — has been formally embedded in the 2024–2027 Managed Care Quality Strategy as a BMS commitment, providing political cover for FIM advocacy across all of the programs below. Where the OBBBA creates fiscal headwinds, the Four Pillars framework provides a political tailwind. Advocates should use both strategically.

Table E. Healthcare-Adjacent Government Programs with FIM Alignment

Program	FIM Relevance	FIM Opportunity
Rural Health Transformation Program (RHTP) WV Office of the Governor, DoH, BMS, WVDA	A five-year ($500M+) state initiative with FIM explicitly written into the Personal Health Accelerator pillar ($107M). The primary near-term funding vehicle for building FIM clinical standards, provider networks, and administrative infrastructure.	PHA funding is deployable now. Engage DoH and the Governor's office to ensure FIM service definitions and eligibility standards are established before PHA grants are deployed at scale. Advocate for a formal cross-agency FIM steering committee (DoH + BMS + WVDA) in Phase 1. Align BMS early on reimbursement pathways so Medicaid financing is designed in from the start. See *Integrating Food is Medicine into Rural Health, A Strategy for FIM Implementation under the Rural Health Transformation Program (2026)*.
Make WV Healthy Act (HB 4982) WV Legislature, DoH (Office of Healthy Lifestyles), BMS	Signed Feb. 28, 2026 — first WV statute to explicitly authorize FIM services under Medicaid. Requires BMS to design FIM programs for Medicaid members and directs MCOs to partner with community groups.	Engage BMS and the Office of Healthy Lifestyles immediately to align FIM service definitions and MCO contract expectations with WVFIMC priorities. Advocate for WVFIMC representation on the 13-member Healthy Lifestyle Coalition. Leverage the Act's MCO partnership language to push for FIM inclusion in the next managed care contract cycle.

Program	FIM Relevance	FIM Opportunity
Cooperative Extension WVU Extension, USDA	Operates in all 55 counties with existing farmer relationships, capacity to provide nutrition education through EFNEP and other health programs, and WVFIMC founding partnership. The only statewide network that could co-deliver PRx programs where clinical access is limited. *Note: SNAP-Ed eliminated FY2026.*	Formalize Extension as a primary PRx delivery partner, leveraging SNAP Stretch infrastructure at farmers markets and retail sites through the WV Food and Farm Coalition. Engage Extension's agricultural programs to develop farm-to-FIM supply chain capacity. The loss of SNAP-Ed funding creates a compelling case for FIM investment through Extension as a replacement nutrition programming vehicle for low-income populations.
Transforming Maternal Health (TMaH) & Right From the Start WV DHHR, Office of Maternal & Child Health, CMS CMMI	CMS Innovation Center investment in whole-person perinatal care with explicit SDoH focus. The WV's TMaH is now formally named in the 2024–2027 Quality Strategy as a targeted intervention aligned with the maternal health objective. RFTS's POPRAS screening infrastructure is a ready entry point for food insecurity screening and FIM referral for pregnant and postpartum women.	Connect RFTS's POPRAS social assessment with a validated food insecurity screener and a warm referral pathway to FIM programs. Explore embedding FIM service referrals into the TMaH model's SDoH care coordination protocols. Advocate for nutrition services to be included in WV's AIM bundle implementation.
WV Birth to Three (Early Intervention) DoH (Office of Maternal, Child and Family Health), IDEA Part C	Statewide early intervention program with nutrition services authorized by statute and home-visiting infrastructure in all regions. Natural extension of the TMaH/RFTS maternal health continuum through age three.	Integrate a food insecurity screener and warm FIM referral pathway into the WVBTT Individualized Family Service Plan (IFSP) process. Engage the Office of Maternal, Child and Family Health to coordinate WVBTT, RFTS, and TMaH referral pathways — creating a continuous FIM-linked care continuum from pregnancy through early childhood.

Section 3: FIM Policy Priorities 2026–2029

Drawing on the assessment in Table D, **Table F** outlines WVFIMC's prioritized advocacy actions for 2026–2029, organized by strategic themes within each year. Unlike Table D, which assesses what exists, Table F specifies concrete actions, decision makers, and success indicators that translate the policy landscape into a coalition agenda.

Table F. FIM Policy Priorities 2026–2029

Priority Action	Action Steps	Success Indicator
2026		
Secure FIM in WV's ILOS framework before guidance is finalized BMS Office of Managed Care, WV DoH, MCO medical directors	Advocate for PRx, MTG, and MTM to be named in BMS's initial ILOS pre-approved service list. Engage DoH and BMS on FIM service definitions and MCO contracting expectations in coordination with WVFIMC. Push for a published ILOS technical assistance resource for MCOs that includes FIM as an eligible service category.	FIM services appear in BMS's initial ILOS pre-approval list; at least one MCO submits a FIM ILOS proposal to BMS.
Embed FIM in RHTP and Make WV Healthy Act implementation WV Office of the Governor, DoH (RHTP PHA, Office of Healthy Lifestyles), BMS, WVDA	Engage DoH and the Governor's office to ensure FIM service definitions and clinical eligibility standards are established before PHA grants deploy at scale. Advocate for WVFIMC representation on the 13-member Healthy Lifestyle Coalition. Push for a formal cross-agency FIM steering committee (DoH + BMS + WVDA) with decision-making authority established in RHTP Phase 1. Leverage the Make WV Healthy Act's MCO partnership language to begin MCO engagement on FIM contracting. In engaging the Governor's office specifically, advocates should use the Four Pillars framework as an accountability lever — "Clean Up the Food" is now formally embedded in the 2024-2027 Managed Care Quality Strategy as a BMS commitment, shifting the advocacy posture from requesting that BMS consider food access to holding BMS accountable for implementing its own stated priorities. This framing is most effective when directed at the Governor's office and the Office of Healthy Lifestyles, where the Four Pillars language originated.	WVFIMC seat on the Healthy Lifestyle Coalition; formal cross-agency FIM steering committee established; FIM service definitions published before first PHA grant cycle.
Build the MCO business case through VAS and quality metrics MCO medical directors, BMS Office of Quality Management	Engage MCO medical directors to propose FIM services — starting with PRx — as Value-Added Services under the current bi-annual VAS submission cycle (October 1 and April 1 submission windows). Simultaneously advocate for food insecurity screening rates and diet-related chronic condition outcomes to be included in BMS's quality withhold framework for the next Quality Strategy cycle. The most credible entry point is Controlling High Blood Pressure (CBP), which is already one of the five active withhold measures and has strong FIM evidence — making it the sharpest ask available when engaging BMS's Office of	At least one MCO offers a FIM VAS by end of SFY2026; food insecurity screening metric included in next quality strategy or withhold update.

Priority Action	Action Steps	Success Indicator
	Quality Management. Follow-Up After High-Intensity Care for SUD (FUI), also an active withhold measure, is a secondary target given the overlap between food insecurity and SUD treatment outcomes.	
2027–2028		
Advance Medicaid payment through HCBS and waiver opportunities BMS, CMS Region III, MCO D-SNP leads	Engage BMS on re-establishing a Health Home SPA targeting pre-diabetes, diabetes, and obesity populations with FIM services embedded — building on the terminated 2017–2024 program. Engage the IDD waiver renewal process (~Oct 2026) for opportunities to include food insecurity screening language. Explore D-SNP SSBCI opportunities with MCOs serving WV's dual eligible population.	Health Home re-establishment under active BMS consideration; food insecurity language included in IDD waiver renewal; at least one MCO D-SNP offering a FIM-adjacent SSBCI benefit.
Deepen MCO integration through the contract renewal cycle BMS Office of Managed Care, WV Legislature (oversight), MCOs	Target the next MHT contract renewal — beginning engagement 12–18 months ahead — to embed FIM-specific ILOS pre-approval, mandatory food insecurity screening, CBO partnership requirements, and VBP goals tied to nutrition outcomes. Leverage the Make WV Healthy Act's MCO partnership language as a statutory hook.	FIM services included in MHT contract ILOS framework; food insecurity screening required in MCO contract; at least one VBP arrangement directing payment to FIM CBOs.
Build farm-to-FIM and PRx delivery infrastructure WVDA, Cooperative Extension, DoH (PHA), BMS	Formalize Cooperative Extension as a primary PRx delivery partner, leveraging SNAP Stretch infrastructure at farmers markets and retail sites. Engage WVDA to develop farm-to-FIM procurement systems alongside clinical program deployment. Coordinate with RHTP Phase 2 evaluation to generate FIM outcomes data against standardized metrics capable of supporting Medicaid coverage decisions.	Extension formally designated as PRx delivery partner in at least one FIM program; farm-to-FIM procurement pilot operational in at least one region; FIM outcomes data collected against standardized metrics.
2029		
Transition high-performing models toward durable Medicaid financing	Work with BMS to identify FIM interventions and populations with the strongest outcomes from RHTP Phase 2 evaluation and begin moving high-performing models into managed care as ILOS or toward 1115 waiver coverage depending on federal posture. Align with BMS on the evidence threshold that would justify Medicaid coverage decisions.	At least one FIM intervention formally covered as ILOS under MHT; BMS has defined an evidence threshold for FIM

Priority Action	Action Steps	Success Indicator
BMS, CMS Region III, MCOs, DoH		Medicaid coverage; outcomes data submitted to CMS.
Monitor federal signals for 1115 and SPA windows CMS (federal), BMS, national FIM coalitions	Track shifts in CMS posture on HRSN guidance rescinded in March 2025. WV's active 1115 (exp. Dec 29, 2029) and its approved HRSN protocol provide a ready template for nutrition HRSN expansion if federal headwinds ease. Build the national advocacy case for FIM SPA authorization through NPPC and national FIM coalitions.	CMS HRSN guidance restored or nutrition-specific guidance issued; WV positioned to submit a nutrition HRSN amendment to its existing 1115 within 6 months of a federal signal.

Strategic Priorities 2026–2029

West Virginia enters 2026 with a rare convergence of policy conditions — active RHTP funding, new FIM-enabling legislation, a developing ILOS framework, and a coalition with established state agency relationships. The four-year advocacy horizon has a clear path:

2026 is about getting into the frameworks before they close. The ILOS pre-approval list, the RHTP PHA grant standards, and the Healthy Lifestyle Coalition membership are all being defined now. WVFIMC's most urgent task is ensuring FIM is named in each.

2027–2028 is about deepening what works and building toward payment. VAS pilots and quality metric wins from 2026 generate the MCO relationships and early outcomes data needed to make the contract renewal cycle and Health Home re-establishment viable asks. Farm-to-FIM infrastructure development in this window ensures supply can meet demand when Medicaid financing arrives.

2029 is about sustainability. RHTP funding is time-limited; the goal is to have moved at least one FIM intervention into sustainable Medicaid financing — through ILOS, a Health Home SPA, or a 1115 amendment —

before the grant window closes. Federal policy monitoring throughout this period ensures WV is positioned to move quickly if CMS posture on HRSN and nutrition coverage shifts.

The through-line across all four years: every near-term action should be designed to generate the clinical evidence, agency relationships, and administrative infrastructure that make long-term Medicaid coverage achievable.

Conclusion

West Virginia enters 2026 with a policy environment that is favorable for FIM. The Rural Health Transformation Program has aligned funding, infrastructure, and implementation authority around prevention and nutrition. The Make West Virginia Healthy Act has established the first statutory authorization for FIM services in Medicaid. The state's ILOS framework is under active development, and BMS has signaled appetite for SDOH integration in its managed care contracts. These conditions are the product of years of advocacy, but they are time-limited.

The analysis in this policy scan points to a clear near-term imperative: WVFIMC must engage the policy processes that are open right now — ILOS pre-approval, PHA grant standards, the Healthy Lifestyles Coalition, and the quality withhold framework. Durable FIM integration in West Virginia will require sustained alignment across Medicaid managed care, RHTP implementation, and the government program partnerships identified in this scan. The advocacy priorities outlined in Section 3 reflect that alignment, sequenced to build the clinical evidence, agency relationships, and administrative infrastructure that make long-term Medicaid coverage achievable within the RHTP funding window.

Section 4: Appendices

Appendix A. WV Medicaid Managed Care Contract, Relevant Language

All language excerpts are taken from the Mountain Health Trust SFY26 Final Contract (effective July 1, 2025).

Sections	Language	FIM Opportunity
In Lieu of Services	BMS is planning for implementation of In Lieu of Services and Settings (ILOS) that will be allowable substitutions for services or settings covered under the State Plan or otherwise covered by this Contract. The MCO shall collaborate with BMS, other MCOs, and other BMS vendors as necessary throughout the planning process. BMS will amend this Contract to incorporate the approved ILOS that MCOs may opt to offer to enrollees in accordance with 42 C.F.R. 438. (pg. 68)	The current MCO contract includes the following language indicating that BMS is actively planning for ILOS implementation. This is a significant opening for WVFIMC to advocate for FIM services to be included in the initial ILOS framework.
Value-added Services	Consistent with 42 CFR §438.3(e), the MCO may propose to offer Value-Added Services. If offered, the MCO will not receive additional compensation for the Value-Added Services from BMS. The MCO may report the costs of Value-Added Services as allowable medical or administrative costs for the purposes of MLR calculation. The cost of Value-Added Services is not included in the MCO capitation rates. The Value-Added Services are not included in the Medicaid or WVCHIP benefit package. The MCO may not offer or advertise a Value-Added Service without BMS approval. Value-Added Services must be approved by BMS. The MCO may submit the proposed Value-Added Services bi-annually on the following schedule: (1) By October 1st of each calendar year for the January 1st publishing date; and (2) By April 1st of each calendar year for the July 1st publishing date. (pg. 124–125)	The current contract authorizes MCOs to propose VAS on a bi-annual submission schedule. This is an immediate near-term opportunity for FIM programs to partner with MCOs.

Sections	Language	FIM Opportunity
Population Health	The MCO shall have an established population health approach, which includes, but is not limited to, (1) engaging enrollees across the entire care continuum, (2) promoting and incentivizing healthy behaviors and disease management, and (3) evaluating the enrollee population and coordinating prevention and wellness programs, as well as advancing evidence-based practices available to all enrollees. MCO must consider information about SDoH, as identified by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC) for its care coordination services. (pg. 125–126)	The contract includes population health requirements that create openings for FIM as an evidence-based intervention
Social Determinants of Health	The MCO shall endeavor to enhance integrated physical and behavioral health care, active local involvement, and focus on enrollees and family through proactive case management activities that support enrollees living in their homes and community, increase enrollees' self-sufficiency, and address SDoH needs. The MCO shall develop strategies to address the SDoH impacting Enrollees. The MCO should establish a Social Determinants of Health Committee to monitor and improve population health outcomes, including addressing SDoH to assess overall health plan performance. This committee should be chaired by the MCO's Social Determinants of Health Director and involve members, network providers, and stakeholders, as appropriate. Functions should include, but are not limited to: Establishing initiatives to further equitable healthcare among membership; Developing strategies to address the SDoH impacting enrollees; and Collecting and meaningfully using member-identified race, ethnicity, language, and SDoH data to identify and reduce disparities in healthcare access, services, and outcomes. The MCO's care coordination efforts shall address SDoH that identify and address enrollee access, which includes, but is not limited to, (1) employment, (2) food security, (3) housing stability..." and "The SDoH screening and referral process shall include, but not be limited to aspects such as enrollee housing and utilities status, food insecurity, transportation availability, and employment status.(pg. 125–127)	The contract requires MCOs to develop SDoH strategies and establishes a committee structure relevant to FIM advocacy Food security and food insecurity are now explicitly named mandatory screening domains.

Sections	Language	FIM Opportunity
Care Coordination with Drug Free Moms and Babies	As part of care coordination services, DFMB Care Coordinators, DFMB Community Health Workers, and the MCO's care coordination staff shall work together to provide referral sources, to re-engage DFMB participants at risk for loss of engagement, and to collaborate in addressing the findings from health-related social needs screenings. (pg. 139)	This provision links maternal care coordination, CHWs, and health-related social needs screenings in a single contractual requirement — directly relevant to the TMaH/RFTS FIM integration opportunities identified in Table E. FIM programs serving pregnant and postpartum women should be positioned as named referral destinations within this care coordination structure.

Overall Assessment:

- The ILOS planning language is the most significant opening in the current contract. BMS is explicitly building this infrastructure now. WVFIMC should engage BMS during this planning process to advocate for FIM services (PRx, nutrition counseling, MTM) to be included in the initial ILOS-approved service list.
- The VAS bi-annual submission schedule (October 1 and April 1) creates immediate near-term entry points for FIM programs to partner with individual MCOs without waiting for contract renewal.
- The SDoH Committee requirement creates a formal stakeholder engagement channel within each MCO. FIM advocates should seek seats at these tables.

Appendix B. WV Medicaid Managed Care Quality Strategy, Relevant Language

The 2024–2027 West Virginia Managed Care Quality Strategy governs BMS's approach to assessing and improving the quality of care delivered by the state's MCOs. The excerpts below highlight specific goals, objectives, and MCO requirements that are directly relevant to FIM integration. Goal 2 (reducing the burden of chronic disease) is the primary clinical hook — establishing the chronic disease performance benchmarks that FIM interventions can demonstrably move. The targeted interventions sections (Sections 6.2.1, 6.3.4, 6.3.5, and 6.3.10) establish the SDoH data collection requirements, quality withhold mechanics, and care coordination obligations that create structural openings for FIM programs to engage with MCOs. The Quality Strategy is in effect through 2027 and is updated annually, making the next update cycle a near-term advocacy target. All language excerpts are taken from the WV 2024–2027 Quality Strategy.

Goal / Topic	Language	FIM Opportunity
Social Determinants of Health Commitment	The BMS is committed to reducing health disparities that exist across the Medicaid and the WVCHIP populations. The MCOs are required to hire a SDoH director as part of their key staff. They must also establish a SDoH and Quality Committee to monitor and improve population health outcomes, including addressing the SDoH to assess overall health plan performance. This Committee is chaired by the MCO's SDoH director and involves members, network providers, and stakeholders, as appropriate. Activities include establishing initiatives to further SDoH among members, developing strategies to address the SDoH, and improving their ability to collect and use data to reduce disparities in healthcare access, services, and outcomes.(Pg. 17)	The required SoDH Director and Committee at each MCO are stakeholder engagement entry points. WVFIMC should seek participation in these structures to advocate for food insecurity screening and FIM referrals as SDoH interventions.
Goal 2: Reduce Burden of Chronic Disease	• Objective 2: Increase the number of enrollees receiving diabetes care to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 3: Increase number of enrollees receiving treatment for hypertension to meet or exceed the NCQA Quality Compass National Medicaid Average.	These objectives create a direct hook for FIM advocacy — PRx and nutrition counseling have demonstrated evidence of impact on HbA1c, blood pressure, and BMI, positioning them as interventions MCOs can use to move these metrics. Food security is explicitly named as an SDoH factor in Section 6.3.5, and MCOs are contractually required to partner with CBOs and follow up on referrals to ensure members access needed services. This creates a direct structural hook for FIM programs to position themselves as MCO community partners meeting Quality Strategy obligations — particularly for food insecurity screening and warm referral pathways.

Goal / Topic	Language	FIM Opportunity
The One Big Beautiful Bill Act / OBBBA (Section 5.1.2)	Key federal policy shifts have impacted aspects of Medicaid including funding and eligibility criteria, with potential effects on quality oversight. In July 2025, the budget reconciliation act H.R.1 was passed into law, with several key provisions related to Medicaid, including mandatory six-month redetermination and community engagement for select populations and stricter rules on health care-related provider taxes and state directed payment policies. Analyses of these policies predict the disenrollment of roughly 54,000 Medicaid enrollees in West Virginia and potential funding shortfalls due to the decreases in provider taxes. Budget constraints will underscore the need for quality monitoring and value-based care initiatives to ensure financial sustainability of the state's managed care programs and optimize reimbursement. (pg. 21)	The Quality Strategy's own framing of the post-OBBBA fiscal environment — emphasizing value-based care and financial sustainability — creates an opening for FIM advocacy grounded in cost-effectiveness rather than coverage expansion. As enrollment contracts and BMS faces funding pressure, FIM programs that can demonstrate measurable movement on HEDIS quality metrics (particularly HbA1c, blood pressure, and SUD follow-up) become more compelling to BMS and MCOs as low-cost, outcomes-linked interventions. The projected 54,000 disenrollments also mean the remaining managed care population will skew toward higher-acuity members with greater diet-related chronic disease burden — strengthening the case for FIM as a targeted intervention within the MCO quality improvement framework.
The Four Pillars of Health (Section 5.1.3)	In March 2025, West Virginia Governor Patrick Morrisey announced a series of statewide initiatives to improve the health of West Virginia, in alignment with the health priorities of the federal administration. These initiatives all aim to support Governor Morrisey's "Four Pillars of a Healthy West Virginia": (1) Clean Up the Food, (2) Find Purpose, Find Health, (3) Move Your Body, Change Your Life, (4) Reward Healthy Choices. The BMS is committed to supporting the health of West Virginia Medicaid members through interventions that align with this framework. The BMS has supported MCO-developed programs to provide fresh, healthy food to members as well as improving food access. The BMS has approved several MCO value-added services that promote physical activity and exercise among members, including healthy weight programs and gym memberships. (pg. 21)	This is the strongest political framing available for FIM advocacy within the managed care system. BMS has formally embedded the Governor's Four Pillars — with "Clean Up the Food" as Pillar 1 — into the Quality Strategy, and explicitly names MCO-developed food access programs as a current BMS commitment. This gives FIM advocates direct rhetorical and policy cover to frame produce prescriptions, medically tailored meals, and food pharmacy models as implementing BMS's own stated priorities. The Four Pillars framing should be used proactively in MCO engagement and in any advocacy targeting the next Quality Strategy update cycle or MCO contract renewal to anchor FIM as aligned with both state and federal administration health priorities.

Goal / Topic	Language	FIM Opportunity
Quality Withhold (Section 6.2.1)	In 2024, the BMS implemented a managed care quality withhold program based on HEDIS® measures of performance outcomes. The program is designed to drive quality improvement while being straightforward to administer. The BMS will withhold 1% of monthly capitation, excluding tax funding and delivery case rates. To earn back the money withheld, the MCOs will need to demonstrate year-over-year improvement. The BMS has aligned performance measures selected for the quality withhold program with those being addressed through the 2024–2027 Managed Care Quality Strategy. These measures reflect priority areas for the BMS, including SUD, chronic health conditions, and EPSDT services. Current withhold measures include: Follow-Up After High-Intensity Care for SUD (7 Days Total) (FUI); Oral Evaluation, Dental Services (OED) (Ages <1–20); Controlling High Blood Pressure (CBP); Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP – Total); Well-Child Visits in the First 30 Months of Life (W30) (0–15 Months). (pg. 34)	Two of the five current withhold measures map directly to conditions with strong FIM evidence: Controlling High Blood Pressure (CBP) and Follow-Up After High-Intensity Care for SUD (FUI). Produce prescriptions and medically tailored meals have documented evidence of impact on blood pressure; and food insecurity is a known driver of SUD relapse and treatment disruption. FIM advocates should engage BMS's Office of Quality Management to make the case for adding food insecurity screening rates or diet-related chronic condition benchmarks (HbA1c, BMI) to the withhold framework in the next Quality Strategy update cycle — creating a direct financial incentive for MCOs to contract with FIM providers. The withhold program is scheduled for annual settlement, meaning the next update window is near-term.
***Targeted Interventions:* Transforming Maternal Health Model / TMaH (Section 6.3.4)**	On January 6, 2025, the CMS announced that West Virginia was one of 15 states selected to participate in the Transforming Maternal Health Model (TMaH). West Virginia was granted a federal award of $1 million to be used over a performance period of 10 years. The model will support the BMS in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The BMS will partner with MCOs, maternal health providers, community-based organizations (CBOs), hospitals, health systems, and other agencies across the state or within designated implementation regions to carry out the core elements of the model. The TMaH implementation aligns with the Managed Care Quality Strategy objective to increase usage of timely maternal and child health services. The model's required and optional components are organized around three key focus areas: access to care, infrastructure, and workforce; quality improvement and safety; and whole-person care delivery. (pg. 36)	TMaH's explicit "whole-person care delivery" focus area and its CBO partnership requirement create a direct entry point for FIM programs serving pregnant and postpartum Medicaid members. Prenatal nutrition interventions — including produce prescriptions and medically tailored meal support — are well-aligned with TMaH's social needs mandate and the Quality Strategy's maternal health objective (increasing timely prenatal and postpartum care). WVFIMC should seek to engage BMS and MCOs during TMaH implementation planning to position FIM providers as CBO partners within TMaH referral pathways, and to advocate for food insecurity screening and nutrition support to be named as components of WV's whole-person care delivery model under the grant.

Goal / Topic	Language	FIM Opportunity
Targeted Interventions: **Social Determinants of Health (Section 6.3.5)**	The SDoH includes factors such as housing, education, income, transportation, food security, employment/workforce development, education, childhood experiences, behavior, access to care, and environment. Addressing SDoH is especially important for Medicaid and WVCHIP populations to improve long-term health outcomes and reduce disparities. The MCOs identify needs through an initial health risk assessment at enrollment and annual reassessments. The MCOs must collaborate and build partnerships with CBOs, public health departments, and/or social service providers to implement person-centered SDoH interventions. The MCOs are required to follow up on referrals to services to ensure the member has successfully accessed needed services. The BMS has contractually required MCOs to adopt a more robust approach to collecting and analyzing SDoH data. The MCOs are required to perform data analytics to identify members' disparities and report on the effectiveness of evidence-based interventions. MCOs also encourage contracted providers to use International Classification of Diseases (ICD)-10 Z-codes on provider claims. (pg. 40)	Food security is explicitly named as an SDoH factor, and MCOs are contractually required to partner with CBOs, follow up on referrals, and collect and analyze SDoH data — creating a direct structural hook for FIM programs to position themselves as MCO community partners. FIM providers, particularly those offering produce prescriptions or medically tailored meals, should seek to be named in MCO SDoH referral networks and warm handoff workflows. The ICD-10 Z-code encouragement (especially Z59.4, food insecurity) creates a data trail that can support MCO documentation of FIM referral outcomes — directly meeting the "effectiveness of evidence-based interventions" reporting requirement.
Targeted Interventions: **Value-Added Services (Section 6.3.6)**	Each MCO offers an array of VAS in addition to Medicaid covered benefits and services. These 'extra' services incentivize members to engage in their health care, including 24-hour help lines, support services for pregnant women, asthma education services, educational programs and equipment for members with diabetes, and incentives for wellness visits, dental care, smoking cessation, mammograms, and certain age-specific vaccines. The MCOs have targeted many of the VAS on the priority health conditions identified in the goals of the Managed Care Quality Strategy.	The Quality Strategy confirms MCOs are already offering VAS targeting priority health conditions. FIM programs should engage MCO medical directors to propose PRx and nutrition counseling as VAS additions aligned with existing chronic disease priorities using the bi-annual submission schedule (October 1 and April 1) as the entry point.
Targeted Interventions: **Disease Management Programs (Section 6.3.9)**	All MCOs operate disease management programs to help members with diabetes, asthma, and other chronic conditions live healthier lives. The programs incorporate self-management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination. The programs align with Goal 2: reduce burden of chronic disease. Pg. 37	All MCOs operate disease management programs for diabetes and asthma. FIM programs should seek to be integrated into existing disease management workflows as a complementary clinical intervention capable of moving the NCQA metrics MCOs are contractually required to improve.

Goal / Topic	Language	FIM Opportunity
***Targeted Interventions:* Automatic Enrollment (Section 6.3.10)**	Effective July 1, 2025, the BMS adopted automatic enrollment to an MCO for all Medicaid enrollees who are eligible for managed care. The purpose of this program is to promote better access to coordinated care and resources for members, especially those with SUDs. Previously, members who were eligible for MHT enrolled in FFS until they elected or were assigned to an MCO. Automatic member enrollment now occurs as soon as eligibility is determined, allowing the MCO to immediately coordinate care and treatment in the most appropriate setting. These initiatives align with BMS' strategic plan for SUD services and access to care as well as Goal 4 of this Managed Care Quality Strategy. (pg. 41)	Automatic MCO enrollment means that newly eligible Medicaid members — including those with SUDs, who are a key FIM target population — are immediately subject to MCO care coordination and health risk assessment upon eligibility determination. This closes the FFS gap that previously delayed MCO engagement, and it means the initial health risk assessment (through which SDoH needs including food insecurity are identified) now happens earlier in the care relationship. FIM providers seeking MCO partnerships should ensure their services are embedded in MCO onboarding and care coordination workflows, not just downstream referral networks, to capture members at the point of highest engagement.

Overall Assessment:

- The explicit inclusion of food security as an SDoH factor in Section 6.3.5, combined with the mandatory CBO partnership requirement, creates a direct hook for FIM programs to position themselves as MCO partners in meeting quality strategy obligations.
- The chronic disease objectives (diabetes, hypertension) and disease management programs align directly with FIM's evidence base. MCOs motivated to improve NCQA metrics have an evidence-based rationale to invest in FIM.
- The SDoHCommittee structure and required SDoH Director at each MCO are stakeholder engagement entry points for WVFIMC.
- WVFIMC should advocate for nutrition/food insecurity-specific metrics to be added to the Quality Strategy in the next annual update. This can be done without a waiver or contract amendment.

Appendix C. WV 1115 Waiver, Relevant Language

All language excerpts are taken from Evolving West Virginia Medicaid's Behavioral Health Continuum of Care (1115 Demonstration Waiver, Authorized January 1, 2025 – December 31, 2029). Learn more here.

Waiver Overview

West Virginia's active 1115 Demonstration Waiver (the Behavioral Health Continuum of Care waiver) focuses on SUD and behavioral health populations. While it does not currently authorize nutrition supports as covered HRSN services, it establishes HRSN infrastructure (screening, referral, care planning, CBO partnerships) and ILOS planning language that is directly relevant to FIM advocacy. The HRSN Protocol approved January 2025 covers supportive housing for individuals 18+ with SUD who are homeless or at risk.

Topic	Language	FIM Opportunity
HRSN Services Delivery Structure	HRSN services can be provided by managed care plans and paid on a nonrisk basis and must be appropriately included in contracts. This can be accomplished by either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of 'non-risk contract' at 42 CFR § 438.2) or as an amendment to a state's existing risk-based managed care plan contract to include a non-risk payment. The state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services. (pg. 30)	The waiver establishes the delivery mechanism for HRSN services, including the relationship between managed care and HRSN payment.
Capitation and Risk Structure for HRSN Services	Prior written CMS approval pursuant to STC 9.9 is required before the state moves to incorporate the HRSN services into the risk-based capitation rates in Medicaid managed care. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and may no longer utilize non-risk payments for the services included in risk-based capitation rates. (pg. 31)	This provision establishes that CMS prior approval is required before HRSN services move into risk-based capitation — meaning WV can begin with a non-risk payment structure, lowering the administrative barrier to initial implementation. For a future nutrition HRSN expansion, this confirms that the path to coverage does not require immediate actuarial risk-setting, which is a significant implementation advantage.
In Lieu of Services (ILOS)	Identification of any in lieu of services or settings (ILOSs) the state currently offers through its managed care programs and if there will be changes to those ILOSs as a result of the state moving these HRSN service(s) into risk-based managed care	The waiver explicitly links ILOS planning to HRSN service implementation — the state must identify current ILOS offerings and

Topic	Language	FIM Opportunity
	contracts.	any changes resulting from HRSN services moving into managed care. This language directly connects to the ILOS planning language in the SFY26 MCO contract (Appendix A), and both reflect active BMS planning for ILOS implementation — a critical window for WVFIMC to advocate for FIM services to be included.
HRSN Protocol Structure	• Screening criteria and clinical/social risk factors • Provider qualification and requirements • HRSN service definitions • Plan of care and care planning process • Referrals to community partners • Expectations for culturally responsive and trauma-informed care • Monitoring and evaluation parameters	The approved HRSN Protocol for this waiver outlines the implementation framework for HRSN services. While currently limited to supportive housing, the protocol structure — screening, clinical and social risk criteria, provider qualifications, care planning, CBO referrals — establishes a template that could be adapted for nutrition supports in a future waiver expansion.

Overall Assessment:

- The BH 1115 waiver establishes WV's first formal HRSN infrastructure — screening protocols, CBO referral systems, and care planning frameworks. This infrastructure is directly relevant to FIM: the same screening and referral workflows needed for housing supports are needed for nutrition supports.
- The ILOS planning language in the waiver (pg. 33) connects directly to the ILOS planning language in the MCO contract (Appendix A). Both reflect active BMS planning for ILOS implementation — a critical window for WVFIMC to advocate for FIM services to be included.
- A future waiver amendment or new 1115 application could expand HRSN coverage to include nutrition supports. The BH waiver's HRSN Protocol provides a structural template for what a nutrition HRSN protocol would need to contain.
- The non-risk payment structure described on pg. 30 is important: it means HRSN services paid under the waiver do not need to go through capitation risk-setting initially, lowering the barrier to implementation.

Appendix D. WV Health Home Program, Relevant Language

West Virginia operated a Pilot Health Home program for individuals with pre-diabetes, diabetes, and obesity under State Plan Section 3.1–H — a Health Home State Plan Amendment (SPA) authorized under Section 1945 of the Social Security Act, distinct from waiver authority. The program operated from 2017 through July 2024, when it was terminated. Although no longer active, it is directly relevant to FIM advocacy in two respects: it demonstrates that WV has previously used the Health Home SPA authority for the chronic disease populations FIM serves, and it provides a template for a future Health Home SPA that could authorize FIM services as covered Health Home activities. Understanding why the program was terminated is an important intelligence-gathering task for WVFIMC before investing advocacy effort in this pathway.

All language excerpts are taken from the West Virginia Pilot Health Home State Plan Amendment (State Plan Section 3.1–H), which was authorized under Section 1945 of the Social Security Act and operated from 2017 through July 2024.

Topic	Language	FIM Opportunity
Program Objectives	• Reduce emergency department use, hospital admissions and re-admissions, and health care costs • Reduce reliance on long-term care facilities • Improve the health care experience, quality, and outcomes for individuals and providers • Promote integration of behavioral health into primary care	The program's objectives — reducing ED use, hospitalizations, and long-term care reliance while improving chronic disease management — align directly with FIM's demonstrated outcomes. A re-established Health Home SPA with FIM services embedded could advance these same objectives through nutrition intervention, with a stronger evidence base than existed when the original program was authorized.
Eligibility	• Categorically needy individuals • Medically needy pregnant women • Medically needy children under age 18 • Members with pre-diabetes, diabetes, or obesity at risk for anxiety and/or depression	The eligible population — individuals with pre-diabetes, diabetes, or obesity — is the core FIM target population. CMS has endorsed FIM interventions including PRx and MTM as appropriate for exactly these conditions. A future Health Home SPA could authorize FIM services as covered Health Home activities delivered through CBOs in partnership with health care providers, without requiring waiver authority.

Topic	Language	FIM Opportunity

Overall Assessment:

- Although this Health Home program has been terminated, it is directly relevant to FIM advocacy in two ways:
- First, it demonstrates that WV has previously used the Health Home State Plan authority (Section 1945) for chronic disease management populations that overlap substantially with FIM's target populations — individuals with diabetes, pre-diabetes, and obesity. A new or revised Health Home SPA could include nutrition supports and FIM services as authorized Health Home services, delivered through CBOs in partnership with health care providers.
- Second, the termination of this program in July 2024 may reflect capacity or funding constraints at BMS that are worth understanding before pursuing Health Home as an advocacy target. WVFIMC should explore why the program was terminated and whether re-establishment or a modified version is feasible.
- Health Homes represent a distinct Medicaid pathway (Section 1945 SPA, not a waiver) that has been used in WV specifically for the chronic disease populations FIM serves. A future Health Home SPA could authorize FIM services as covered Health Home activities — positioning CBOs as Health Home providers or subcontractors.
- The terminated WV Health Home program should be added to the policy scan as an additional pathway row, noting its history, termination, and potential for re-establishment with FIM services included.
- Understanding the reason for termination is an important intelligence-gathering task for WVFIMC before investing advocacy effort in this pathway.

Appendix E. WV Government Programs Aligned with FIM

This appendix provides full program details, decisionmaker information, and specific coalition advocacy entry points for each program summarized in Table E. Programs are ordered by strategic priority for FIM integration. See Table E in the body of this document for a high-level summary.

Program	Details	FIM Opportunity
Rural Health Transformation Program (RHTP) WV Office of the Governor | WV Dept. of Health | Bureau for Medical	West Virginia's RHTP is a five-year, $500+ state initiative designed to build a healthy rural workforce and a self-reliant agricultural sector through innovation, prevention, and cross-agency partnership. FIM is formally embedded within the RHTP through the Personal Health Accelerator (PHA), one of seven flagship initiatives ($107M over five years), whose stated purpose includes "empower[ing] healthy living	The RHTP represents the single most significant near-term opportunity for FIM scale in West Virginia. PHA funding is deployable now and explicitly designated for FIM program development, making it the primary vehicle for building the clinical standards, provider network,

Program	Details	FIM Opportunity
Services | WV Dept. of Agriculture	through food-is-medicine programs, education, and rewards for exercise and wellness activities." PHA's explicit FIM goals include: scaling FIM to prevent obesity and diabetes; expanding locally grown produce prescriptions through FQHCs, CHCs, hospitals, and pharmacies; developing shared referral and tracking systems via EHR and community resource database integration; and partnering with CBOs to build on existing program infrastructure. Three other RHTP initiatives support the infrastructure FIM requires: the Connected Care Grid ($174M) funds closed-loop referral systems and regional care hubs; the Smart Care Catalyst ($245M) advances value-based payment models that reward HbA1c, BMI, and hypertension outcomes; and the Mountain State Care Force ($167M) builds the CHW pipeline that is the primary rural FIM delivery channel. Decisionmaker: WV Office of the Governor; WV Department of Health (PHA lead); Bureau for Medical Services (Medicaid financing); WV Department of Agriculture (supply chain)	and administrative infrastructure FIM requires before Medicaid financing is achievable. • Engage DoH and the Governor's office to ensure FIM service definitions and eligibility standards are established before PHA grants are deployed at scale • Advocate for a formal cross-agency FIM steering committee (DoH + BMS + WVDA) with decision-making authority to be established in Phase 1 • Align BMS early on reimbursement pathways (in-lieu-of services, VBP, HCBS, 1115 waiver) so Medicaid financing is designed in from Phase 1 • Leverage the Connected Care Grid's hub-and-spoke model and closed-loop referral infrastructure to integrate FIM into clinical workflows across FQHCs, rural health clinics, and critical access hospitals • Coordinate with WVDA to develop farm-to-FIM procurement systems that create stable market demand for local producers alongside clinical program deployment **Opportunity: HIGH** **Impact: High** **Feasibility: High**
Make West Virginia Healthy Act (HB 4982) WV Legislature | WV Dept. of Health (Office of Healthy Lifestyles) | Bureau for Medical Services	Signed by Governor Morrisey on February 28, 2026 (effective May 21, 2026), the Make West Virginia Healthy Act is the most significant FIM-enabling legislation in the state's history. The Act reestablishes the Office of Healthy Lifestyles within the Department of Health, creates a 13–member Healthy Lifestyle Coalition to coordinate public health and private sector wellness programs, and explicitly authorizes "Food is Medicine" services under Medicaid — including medically tailored	The Make WV Healthy Act is the direct legislative authorization for FIM in Medicaid — the first time WV statute has explicitly named and enabled FIM services as a covered intervention. This creates a durable legal and programmatic foundation for BMS to develop FIM benefit design and MCO contract language. The Act's cross-agency coordination mandate and county grant

Program	Details	FIM Opportunity
	meals, nutrition counseling, and nutrition prescriptions for members with nutrition-related chronic diseases. The Act directs the Office of Healthy Lifestyles to establish a farm-to-school program, coordinate cross-agency nutrition and physical fitness initiatives, and manage county grant programs. It requires BMS to design programs to improve health outcomes for Medicaid members with nutrition-related chronic diseases through nutrition supports and to encourage MCOs to partner with community groups and prioritize food from West Virginia farmers where feasible. Decisionmaker: WV Legislature; WV Department of Health (Office of Healthy Lifestyles); Bureau for Medical Services	authority also create new entry points for coalition engagement. • Engage BMS and the Office of Healthy Lifestyles immediately to ensure FIM service definitions, eligibility criteria, and MCO contract expectations are developed in coordination with WVFIMC and aligned with RHTP clinical standards • Advocate for WVFIMC representation on the 13-member Healthy Lifestyle Coalition and formal inclusion of the coalition in cross-agency FIM coordination • Leverage the Act's MCO partnership language to push for FIM inclusion in managed care contract requirements, building on WV's existing MCO procurement cycle as a primary advocacy entry point **Opportunity: HIGH** **Impact: High** **Feasibility: High**
WVU Cooperative Extension & Family Nutrition Program WVU Extension Service | WV Dept. of Human Services | USDA	WVU Cooperative Extension operates in all 55 West Virginia counties, providing one of the few statewide community infrastructure networks with simultaneous reach into agriculture, nutrition education, and health promotion. The Family Nutrition Program (FNP) manages SNAP Stretch and other produce incentive programs and has been an active partner in establishing the West Virginia Food is Medicine Coalition. The RHTP strategy explicitly identifies Extension as an underutilized FIM delivery asset — particularly for produce prescription programs in communities where clinical access points are limited — noting that Extension's complete geographic reach, deep community trust, and connections to local farmers cannot be replicated by any state agency. Extension's university-based agricultural research and training programs also provide technical assistance infrastructure for farm business development targeting healthcare markets.	Extension is among the most strategically important FIM delivery partners in the state — providing complete county coverage, existing farmer relationships, and trusted community presence that no FIM program can replicate independently. SNAP Stretch's produce incentive platform is a natural co-delivery vehicle for PRx programs, enabling FIM programs to reach SNAP-enrolled populations through existing channels. • Formalize WVU Extension as a primary PRx delivery partner, leveraging SNAP Stretch infrastructure at farmers markets and retail sites to co-administer produce

Program	Details	FIM Opportunity
	Note: The federal SNAP-Ed program (Nutrition Education and Obesity Prevention Grant Program) was eliminated by the One Big Beautiful Bill Act (signed July 4, 2025), ending the federal nutrition education funding stream that previously supported Extension's community nutrition outreach. States may spend residual funds through September 2026. This loss of infrastructure creates an additional case for FIM investment through Extension as a replacement vehicle for nutrition-linked programming reaching low-income populations. Decisionmaker: WVU Extension Service; WV Department of Human Services; USDA	prescription benefits for FIM-referred patients • Engage Extension's agricultural programs to develop farm-to-FIM supply chain capacity, connecting small and mid-sized farms to healthcare purchasing channels as RHTP's Department of Agriculture supply-side infrastructure develops • Position FIM program investment through Extension as a replacement vehicle for the nutrition education infrastructure lost with SNAP-Ed elimination, making the case to DoH and BMS for Extension's role in a Medicaid-adjacent FIM delivery network **Opportunity: HIGH** **Impact: High** **Feasibility: High**
Transforming Maternal Health (TMaH) Model & Right From the Start WV DHHR | Office of Maternal & Child Health | CMS Innovation Center	West Virginia was selected by CMS as a national leader in the Transforming Maternal Health (TMaH) Model — a CMS Innovation Center investment in whole-person care for pregnant and postpartum women, with explicit attention to social determinants of health. Right From the Start (RFTS) is WV's longstanding perinatal care coordination program (RWJF seed funded), operated through the DHHR Office of Maternal & Child Health. RFTS identifies high-risk pregnant women and infants using POPRAS medical/social assessments and Birth Score newborn screening, connecting them with community-based services including prenatal education and social support. WV has also been an AIM (Alliance for Innovation on Maternal Health) state since 2018, implementing evidence-based patient safety bundles for obstetric hemorrhage, severe hypertension, and perinatal mental health. Decisionmaker: WV DHHR; Office of Maternal & Child Health; CMS CMMI	The combination of TMaH's CMS Innovation funding, RFTS's established care coordination infrastructure, and WV's AIM participation creates a layered entry point for FIM — particularly medically tailored meals and produce prescriptions for pregnant and postpartum women with diet-related conditions. • Explore embedding FIM service referrals into the TMaH model's SDoH care coordination protocols • Connect RFTS's POPRAS social assessment with a validated food insecurity screener and a warm referral pathway to FIM programs • Advocate for nutrition services to be included in WV's AIM bundle implementation or perinatal care protocols

Program	Details	FIM Opportunity
		Opportunity: HIGH **Impact: High** **Feasibility: Medium**
WV SNAP Healthy Choices Waiver WV Dept. of Human Services (Bureau for Family Assistance) | USDA Food and Nutrition Service	Approved by USDA FNS on August 4, 2025 and effective January 1, 2026, West Virginia's SNAP Healthy Choices Waiver prohibits SNAP benefits from being used to purchase soda statewide — making WV one of the first states in the nation to implement a SNAP food restriction of this scope. The two-year waiver (renewable through 2027) covers approximately 300,000 West Virginia SNAP recipients and requires all SNAP-authorized retailers to update point-of-sale systems for compliance. The waiver is explicitly framed within Governor Morrisey's "Four Pillars of a Healthy West Virginia" and is paired with SNAP Stretch produce incentive programs administered through WVU Extension's Family Nutrition Program. The State Nutrition Action Council (SNAC) — a multi-agency body coordinated through Extension and including BMS, DoH, the Department of Agriculture, WIC, and multiple community partners — meets quarterly to address nutrition, obesity, and chronic disease across the state. Note: The federal SNAP-Ed program was eliminated effective FY2026 by the One Big Beautiful Bill Act; SNAC coordination and SNAP Stretch continue through Extension but without the federal SNAP-Ed funding stream. Decisionmaker: WV Department of Human Services; Bureau for Family Assistance; USDA FNS	The SNAP waiver signals strong state and federal political will to reshape nutrition purchasing behavior — creating favorable conditions for FIM program expansion and PRx alignment at retail. The waiver's two-year evaluation requirement creates an opening to link FIM outcomes data to the state's SNAP evaluation framework. • Partner with WVU Extension's Family Nutrition Program and the SNAC to align PRx program design with SNAP Stretch infrastructure, enabling dual-benefit enrollment pathways at retail sites and farmers markets • Engage DoHS and USDA FNS to incorporate FIM outcome measures into the waiver's required evaluation framework, creating shared evidence generation infrastructure **Opportunity: MEDIUM** **Impact: Medium** **Feasibility: High**
WV Birth to Three (Early Intervention) WV Dept. of Health (Office of Maternal, Child and Family Health) | Governor's Early Intervention Interagency Coordinating Council | IDEA Part C	WV Birth to Three (WVBTT) is West Virginia's federally mandated early intervention program under IDEA Part C, serving children ages birth through 35 months with developmental delays or those at risk for delay. Services are provided at no cost to families in the child's natural environment through eight regional offices statewide. WV statute explicitly lists nutrition services as an allowable early intervention service, alongside occupational therapy, nursing, social work, and speech-language pathology. WVBTT's target population overlaps substantially with the TMaH/RFTS maternal and infant health programs already active in this table. The	WVBTT's statutory inclusion of nutrition services, home-visiting infrastructure, and population overlap with TMaH and RFTS make it a natural FIM integration point for early childhood — extending nutrition support continuity from the prenatal period through age three. • Integrate a validated food insecurity screener and warm FIM referral pathway into the WVBTT Individualized Family Service Plan (IFSP) process, building on the

Program	Details	FIM Opportunity
	program's home-visiting and family coaching model and its statewide regional infrastructure create a natural delivery channel for FIM referrals and early food insecurity screening for at-risk infants and toddlers — particularly in rural counties where WVBTT regional offices often represent one of the few consistent points of professional contact with young families. Decisionmaker: WV Department of Health (Office of Maternal, Child and Family Health); Governor's Early Intervention Interagency Coordinating Council	model already being pursued for RFTS's POPRAS assessment • Engage the Office of Maternal, Child and Family Health to coordinate WVBTT, RFTS, and TMaH referral pathways, creating a continuous FIM-linked care continuum from pregnancy through early childhood **Opportunity: MEDIUM** **Impact: Medium** **Feasibility: Medium**

We are committed to leveraging the power of nutrition through strategic initiatives and community collaboration to improve health outcomes throughout the state.

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