

Building Sustainable Nutrition Partnerships

Leveraging Best Practices to Implement Texas HB 26 & SB 25

Implementation of Texas HB 26 & SB 25 provides an important opportunity to harness nutrition services as a tool to improve health outcomes, reduce health care expenditures and utilization, strengthen Texas's economy, and position Texas as a national leader in community care innovation.

The Problem. While a growing body of evidence demonstrates that nutrition support services can be a cost-effective approach to treating, managing, and/or preventing diet-related chronic disease, and even boosting local economies and food systems, integrating these innovative community services into health care delivery and insurance systems can be a barrier to sustainable program success. Common barriers to implementation include screening and enrollment of community providers, billing and reimbursement for nutrition services, and referral pathways.

The Solution. To increase the likelihood of successful and sustainable health care integration of nutrition services, stakeholders can consider implementing supportive structures, such as clear policy guidance, model practices, and flexibility to allow gradual compliance with health care procedures and allow payor innovation.

Summary of HB26

House Bill 26 was enacted in June 2025, effective September 1, 2025.¹ In part, it authorizes **Medicaid managed care organizations (MCOs) to offer medically appropriate, cost-effective, evidence-based nutrition counseling and instruction services in lieu of state Medicaid plan services.**² The act also authorizes a **pilot program in which MCOs may offer nutrition support services in lieu of state Medicaid plan services to recipients who are pregnant and diagnosed with a chronic health condition or disease that may contribute to a high-risk pregnancy or birth complications.**

Pilot nutrition services offered may include nutrition counselling and instruction, medically tailored meals provided with counseling and instruction, and other evidence-based nutrition support services, which may include produce prescriptions and medically tailored groceries,³ for example. The Health and Human Services Commission must collect and analyze data on the pilot services' impact on maternal and infant health outcomes.

Summary of SB25

Senate Bill 25 was enacted in June 2025, effective September 1, 2025.⁴ SB 25 establishes a **nutrition education framework for health care professionals and students across Texas.** The law requires all state-funded health-related institutions to incorporate nutrition curricula for medical students and students in other health-related fields, and mandates that licensed health professionals complete continuing medical education (CME) in nutrition and metabolic health as a condition of license renewal.

SB 25 also establishes a **Texas Nutrition Advisory Committee charged with examining the impact of nutrition and ultra-processed foods on human health, reviewing scientific evidence on the health effects of ultra-processed foods, providing related education, and developing dietary and nutritional guidelines** that the State Board of Education and health licensing boards must use when developing curricula and CME content, respectively. By linking compliance to state funding and licensure, SB 25 serves as a model for embedding nutrition education throughout the health care profession.

Medicaid Screening and Enrollment of Community Providers

The Problem. There are currently no mandatory licensure, certification, or credentialing requirements for many community providers in the United States, including many nutrition service providers. Moreover, when implementing state Medicaid provider qualification standards, it is important to balance the assurance of quality care delivery while ensuring that community providers who have already been successfully delivering nutritional interventions to Medicaid beneficiaries are not prevented from doing so by novel requirements.

The Law. Federal regulations require all “ordering or referring physicians or other professionals” providing services under the Medicaid state plan to be enrolled as participating providers and to be screened using risk-based criteria.⁵ This includes license verification, disclosures, and federal database checks, and may include site visits and criminal background checks.

Sample Approaches

Analogy to community health workers and doulas.

The integration of other community-based or non-traditional providers into Medicaid can offer insight into how states can approach screening and enrollment of nutrition providers. Analogies to community health workers and doulas might be of particular interest to stakeholders in **Texas** because HB 1575, enacted in 2023, allows for Medicaid reimbursement of Case Management for Children and Pregnant Women (CPW) services provided by community health workers (CHWs) certified by the Department of State Health Services (DSHS) and doulas certified through experience or training.⁶ As with many community providers, there are no uniform and mandatory licensure, certification, or credentialing requirements for CHWs or doulas. Following Texas’ CHW program, most states rely on more **formal training pathways**, in which independent organizations whose certification, licensure, or programming is approved by the state. Others offer multiple pathways to licensure that include both a formalized training pathway and an **experience pathway** in which providers are able to prove their competence through attestation, recommendations, testimonials, or other evidence.⁷ The selection and establishment of these pathways should be conducted with guidance from providers.⁸

Application to nutrition services providers.

In **Michigan**, in lieu of services (ILOS) providers for medically tailored meals, healthy home delivered meals, healthy food packs, and produce prescriptions must have experience and expertise with providing these or similar services, with a strong preference for locally based providers, and meals must follow the Food is Medicine Coalition nutritional standards.⁹ In addition to experience requirements, **Massachusetts** providers of medically tailored meals must employ or contract with a Registered Dietitian Nutritionist (RDN) to evaluate enrollees and authorize services.¹⁰ Similarly, **Wisconsin** ILOS providers enrolling in Medicaid must demonstrate experience providing “Food is Medicine” or similar services, have appropriate infrastructure and capacity to provide medically tailored meals, and employ or contract with registered dietitians or RDNs licensed in Wisconsin.¹¹

Billing and Reimbursement for Services

The Problem. When integrating a new service into the health care and insurance systems, the state and payors must consider how to set adequate capitation and service reimbursement rates. In doing so, states estimate both the current cost of care for target population(s) and the expected return on those investments. Providers and payors must then be able to bill and reimburse for services provided. However, community providers may have difficulty navigating health care billing requirements and may also lack the infrastructure to securely submit claims for reimbursement. Additionally, billing codes that fail to accurately describe nutrition services may pose an obstacle to timely reimbursement as well as to the collection and analysis of data on program effectiveness.

The Law. While capitation rate development does not necessarily include service level data, this information may contribute to the overall rate and to calculations regarding service pricing and reimbursement. Capitation

rates must be actuarially sound and include consideration of the utilization and actual cost of ILOS (unless explicitly otherwise required by regulation or law).¹²

Sample Approaches

Coding guidance.

States implementing Medicaid nutrition initiatives commonly adopt coding guidance. Because there are no Centers for Medicare & Medicaid Services (CMS) approved billing codes for most nutrition services, states have used modifiers to differentiate between services and to enable program evaluation (such as that required by HB26). **Massachusetts** uses five different HCPCS codes in combination with seven potential modifiers to distinguish between all ten nutrition services offered under its Medicaid 1115 demonstration. The state permits providers to use up to two modifiers at the same time to further differentiate between services.¹³

Allowing invoicing and training for claims.

Allowing providers to invoice rather than submitting electronic claims and/or mandating training on claims and reimbursement processes can alleviate the burdens associated with start-up costs, promoting successful program operationalization. **Michigan** permits providers who are unable to submit claims to submit invoices to facilitate payment where needed.¹⁴ In **Wisconsin's** medically tailored meal ILOS program, health plans are required to provide training, support, and technical assistance to providers for claim submissions and payment processes.¹⁵

Model contracts.

Health care contracting can be difficult for community providers. Model contracts can provide effective support. **Michigan** requires ILOS Standard Agreement Terms to be used in all health plan-ILOS provider contracting agreements for the provision of nutrition services offered under ILOS.¹⁶

Fee schedules.

States have adopted fee schedules to assist payors and providers with pricing and negotiations. To ensure reimbursement ranges reflect the true cost of services, **Massachusetts** has developed a fee schedule guidance based on historical data, taking into consideration the price of services (e.g., meals), staff time, delivery, meal planning, assessment and coordination, and administrative costs.¹⁷ It is also critical for fee schedules to be updated on a regular basis. **North Carolina's** fee schedule was established in 2018 and was not revised until 2024. During that period, the fee structure did not take into consideration changed circumstances that arose during the COVID-19 pandemic and did not adequately cover the cost of services or administration of the care.¹⁸ Moving forward, stakeholders have recommended the department consult with community providers and other stakeholders when setting fee schedules.

Infrastructure and capacity building funds.

Integrating new entities into the Medicaid system requires operational shifts for all parties involved. While infrastructure funds are not available for ILOS in the same way that they are available under Medicaid section 1115 demonstrations, states can provide capacity building and infrastructure funding to support technology, business development, workforce development, and outreach through executive budgets. **Michigan** allocated \$10 million for an ILOS nutrition services incentive pool in its 2025 Executive Budget.¹⁹

Referral Pathways

The Problem. Inadequate referral pathways can pose a risk to successful program implementation due to communication gaps; confusion among care managers, providers, and payors; and data inoperability. Consequences may include service delays, duplicative referrals, and increased administrative costs.

The Law. Nutrition services offered under ILOS are available only through Medicaid managed care and must be a medically appropriate and cost-effective substitute for services covered by the State plan, and delivered in a timely manner.²⁰

Sample Approaches

Standardized screening and referral workflows.

Consistent screening tools, referral protocols, and interoperable platforms can improve efficiency and reduce errors. To improve referral pathways and prepare for data collection, **Oregon** is encouraging its coordinated care organizations (CCOs) to adopt standardized workflows for collecting and reporting screening and referral data.²¹ Under this workflow, once screened, members are notified of approval by their plan within 28 days and are then referred to a nutrition service provider for service initiation.²² Similarly, **Massachusetts** uses a standardized eligibility verification system (EVS) for providers and payors to verify Medicaid eligibility in real time to reduce billing errors.²³

Member engagement and individualized care plans.

Direct member involvement, care planning, and warm handoffs enhance accountability and service success. **Oregon** allows members who may qualify for nutrition services to directly submit a Digital Nutrition request form.²⁴

Data systems and tracking.

Use of integrated data, care coordination platforms, or dashboards can assist in monitoring referrals, outcomes, and engagement. Statewide Health Information Exchanges (HIEs) or community referral platforms can be leveraged or created to incorporate referral technology platforms that can enable health care organizations and Medicaid programs to identify and refer patients to service providers. These platforms can include service provider directories, the ability to send and track referrals, privacy protection/HIPAA compliance, systems integration, case management/care coordination, screening, and reporting and analytics. States may use their own statewide platforms, use a fragmented system, or use a third party.²⁵ **North Carolina** utilizes a third-party statewide referral platform, NCCARE630, which provides community partners with access to a statewide resource directory, a data repository, a shared technology platform, and a community engagement team to create a statewide coordinated care network.²⁶ The shared technology platform enables secure electronic referrals and communication between health care and human service providers and tracking of outcomes.

Nutrition Education of Health Care Providers

The Problem. Diet-related disease remains the leading cause of death in the United States, yet most physicians receive little training in diet or metabolic health.²⁷ This educational gap leaves many health care providers feeling unequipped to counsel patients on nutrition or address diet-related illness effectively.²⁸

The Law. Texas SB 25 requires the completion of nutrition education curricula across all stages of medical training, ensuring that both future and practicing clinicians receive consistent, evidence-based instruction in nutrition and metabolic health.²⁹

Sample Approaches

Louisiana's SB 14, enacted the same week as SB 25, establishes a CME requirement in nutrition and metabolic health for physicians and advanced practice nurses across multiple specialties.³⁰

Already in practice, Gaples Institute, a physician-led educational nonprofit, developed an evidence-based nutrition curriculum that is required at ten U.S. medical schools and is available as CME for practicing clinicians.³¹ The curriculum emphasizes practical nutrition counseling skills, the role of diet in preventing and managing chronic disease, and culturally adaptable, whole-food-based dietary guidance. Evaluations

show sustained increases in residents' nutrition knowledge and a stronger belief that providing nutrition guidance is part of their role in patient care.³²

Implementation of Texas HB 26 & SB 25 provides a meaningful opportunity to operationalize nutrition services as a core component of health care. It will take coordination across state agencies, payors, and community partners to translate the promise of these laws into lasting impact.

Endnotes

- ¹ H.B. No. 26, 89th Leg., Reg. Sess. (Tex. 2025).
- ² 42 C.F.R. § 438.16.
- ³ See, e.g., Dariush Mozaffarian et al., "Food Is Medicine" Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review, 83(8) JACC 843 (Feb. 2024), <https://doi.org/10.1016/j.jacc.2023.12.023>; U.S. Department of Health and Human Services, Food Is Medicine Landscape Summary (Feb. 2025), https://odphp.health.gov/sites/default/files/2025-02/Food%20Is%20Medicine%20Landscape%20Summary%20FINAL%20508%20EO%20Compliant%202%204%202025_0.pdf.
- ⁴ S.B. No. 25, 89th Leg., Reg. Sess. (Tex. 2025).
- ⁵ 42 C.F.R. Part 455 Subpart E.
- ⁶ H.B. 1575, 88th Leg., Reg. Sess. (Tex. 2023); Texas Medicaid & Healthcare Partnership, Upcoming Changes Planned for CPW Program Providers Effective December 2024 (last updated Aug. 16, 2024), <https://www.tmhp.com/news/2024-08-16-upcoming-changes-planned-cpw-program-providers-effective-december-2024>.
- ⁷ Anoocha Hasan, State Medicaid Approaches to Doula Service Benefits (updated Apr. 16, 2024), <https://nashp.org/state-tracker/state-medicaidapproaches-to-doula-service-benefits/>; National Academy for State Health Policy, State Community Health Worker Policies (Apr. 2, 2025), <https://nashp.org/state-tracker/state-community-health-worker-policies/>.
- ⁸ See, e.g., Commonwealth of Massachusetts, Doula Initiative, <https://www.mass.gov/info-details/doula-initiative> (last visited Nov. 10, 2025).
- ⁹ Michigan Department of Health and Human Services, Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide at 5-7 (last updated Oct. 2025), <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/202410-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf>; Michigan Department of Health & Human Services, ILOS Standard Agreement Terms – Revised (Sept. 2024), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/ILOS/202409-ILOS-Standard-Agreement-Terms_Revised.pdf?rev=47e31d0a3c9b4c979efbf4ec953d939a&hash=E558B3C3B25E1EDCAA3335891ED4E58B.
- ¹⁰ Massachusetts Executive Office of Health and Human Services, Health Related Social Needs (HRSN) Service Manual – HRSN Supplemental Nutrition Services at 5 (last revised July 25, 2025), <https://www.mass.gov/doc/hrsn-supplemental-services-manual-nutrition-2/download>.
- ¹¹ Wisconsin Department of Health Services, Forward Health Update, New Wisconsin Medicaid In Lieu of Service: Medically Tailored Meals at 6 (Dec. 2024), <https://www.forwardhealth.wi.gov/kw/pdf/2024-48.pdf>.
- ¹² 42 U.S.C. § 1396b(m)(2)(A); 42 C.F.R. §§ 438.3(c), 438.4(a), 438.3(e)(2)(iv).
- ¹³ Massachusetts Executive Office of Health and Human Services, HRSN Supplemental Services Fee Schedule (updated July 2025), <https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download>.
- ¹⁴ Michigan Department of Health and Human Services, Michigan's Comprehensive Health Care Program: In Lieu of Services Policy Guide at Section VIII: Payments & Billing (last updated Oct. 2025), <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MI-Healthy-Life/202410-Michigans-Comprehensive-Health-Care-Program-In-Lieu-of-Services-Policy-Guide.pdf>.
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- ¹⁷ Massachusetts Executive Office of Health and Human Services, HRSN Supplemental Services Fee Schedule (updated July 2025), <https://www.mass.gov/doc/hrsn-supplemental-services-fee-schedule-3/download>.
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- ¹⁹ State of Michigan, Governor Gretchen Whitmer, FY 2025 Executive Budget at 50 (2024), <https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Executive-Budget/Current-Exec-Rec/FY25-Budget-Book.pdf?rev=bf49e98512144dea27be8bccd98ec08&hash=1B0C9BA59E1DE7AFD28EA088F3772B9>; Michigan Department of Health and Human Services, Capacity Connect Initiative (2025), <https://www.michigan.gov/mdhhs/mihealthylife/michigan-in-lieu-of-services/capacity-connect-initiative>.
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- ²⁵ Y. Cartier, C. Fichtenberg & L. Gottlieb, Community Resource Referral Platforms: A Guide for Health Care Organizations (SIREN 2019), <https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations>.
- ²⁶ North Carolina Department of Health and Human Services, NCCARE360, <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360> (last visited Nov. 8, 2025).
- ²⁷ US Burden of Disease Collaborators, The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States, 319 JAMA 1444, 1451 (2018).
- ²⁸ See Marion L. Vetter et al., What Do Resident Physicians Know About Nutrition? An Evaluation of Attitudes, Self-Perceived Proficiency, and Knowledge, 27 J. Am. Coll. Nutr. 287, 287-298 (2008) (finding that although 94% of residents felt responsible for providing nutrition counseling, only 14% felt prepared to do so).
- ²⁹ S.B. No. 25, 89th Leg., R.S. (Tex. 2025).
- ³⁰ S.B. No. 14, 2025 Reg. Sess. (La. 2025).
- ³¹ Gaples Institute, MedEd Nutrition Education for Medical Schools and Residency Programs, Nutrition & Lifestyle Medicine Course, <https://www.gaplesinstitute.org/nutrition-cme/meded-medical-school-nutrition-resident-nutrition/> (last visited Nov. 5, 2025); see also, David M. Eisenberg et al., Proposed Nutrition Competencies for Medical Students and Physician Trainees: A Consensus Statement, 7(9) JAMA Network Open e2435425 (2024), doi:10.1001/jamanetworkopen.2024.35425 (describing 36 nutrition competencies recommended by an expert panel for undergraduate and/or graduate medical education levels. Participants recommended that nutrition competencies be included as part of licensing and board certification examinations).
- ³² Kate Shafto et al., Impact of an Online Nutrition Course to Address a Gap in Medical Education: A Feasibility Study, PRIMER 4:5 (2020), <https://doi.org/10.22454/PRIMER.2020.368659>.