The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850
(Submitted electronically to regulations.gov)

May 29, 2024

RE: CMS-4207-NC: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

On behalf of the Food Is Medicine Coalition (FIMC), we would like to thank you for this opportunity to provide a comment in response to the Centers for Medicare & Medicaid Services (CMS) Request for Information on Medicare Advantage Data.

The Food is Medicine Coalition (FIMC) is the national coalition of nonprofit organizations that provide medically tailored meals (MTMs) and groceries (MTGs), medical nutrition therapy, and nutrition counseling and education to people in communities across the country who are living with severe, complex, and chronic illnesses. FIMC agencies created the medically tailored meal intervention as a response to community need nearly 40 years ago and maintain the nutrition standards for the intervention. Importantly, MTMs and MTGs are disease treatments that fulfill a prescribed diet, targeting nutrition as a determinant of health. These interventions are not primarily designed to address social determinants of health (SDOH) nor to target food security or other health related social needs (HRSNs), though, of course, access to MTMs and MTGs can address all of these needs.

The medically tailored meal intervention is the comprehensive process of delivering medically tailored meals to individuals of all ages living with severe, complex or chronic illness(es), and often living with activities of daily living (ADLs) limitations. Clients are referred to an MTM agency with the involvement of healthcare personnel. An intake and eligibility assessment is conducted by the agency and a nutrition risk assessment is conducted if appropriate. Then the client goes through a nutrition assessment with a Registered Dietitian Nutritionist (RDN) and a meal and care plan is tailored for the specific medical circumstances of the client. Meals are prepared by the agency and home-delivered, shipped or available for pick-up for the client and the client is reassessed for eligibility and nutrition need at regular intervals. Importantly, the client experiences the ongoing Nutrition Care Process (NCP), including nutrition education, support, and reassessment of their needs throughout the course of their intervention.

Similarly, MTGs are food packages that adhere to standards informed by established nutrition guidelines for specific health conditions and are tailored to a recipient's health condition(s) by a Registered Dietitian Nutritionist (RDN). MTMs and MTGs are designed to improve health outcomes, lower the cost of care, and increase client satisfaction.

As longtime advocates for policy initiatives that address the connection between diet-related diseases and the food we eat, we are deeply appreciative of CMS's leadership and work to explore options to provide more widespread, equitable access food is medicine (FIM) interventions in both the Medicaid and Medicare programs. We recognize that an outsized portion of adverse health outcomes find their root in lack of access to good nutrition, and that lack of access is predicated on healthcare inequities – both racial and socioeconomic. FIMC agencies serve people adversely affected by the epidemic of serious and chronic illness in our country, which disproportionately affects people of color. Our experience of service has shown us the deep disparities in health outcomes that our communities face and demonstrates that good nutrition is part of the solution. Right now, whether a person has access to MTMs and MTGs depends on where they live and if their insurance provider offers this service – a situation that must change.

As a coalition focused on the intersection of nutrition and healthcare, we are encouraged by CMS' recent efforts to incorporate FIM services into the Medicare model. We urge continued momentum toward a program-wide comprehensive strategy to address unmet needs that includes screening, referral, and meaningful access to responsive services, like medically tailored meals. FIMC members appreciate the important role that data—including Medicare Advantage data—can play in achieving this goal. We therefore make the following recommendations in response to the questions posed in the Request for Information (RFI):

1. Data recommendations for specific topics/populations

A. Make New Data Publicly Available in Usable Formats to Maximize Data Utility

Currently, Medicare Advantage (MA) supplemental benefits and Special Supplemental Benefits for the Chronically Ill (SSBCI) are the only policy pathways available to provide access to FIM services for Medicare enrollees. CMS's recent expansions to MA reporting requirements for these pathways therefore present a critical—and singular—opportunity to gain insight into the use and impact of these approaches. For example, under the new *Medicare Part C Technical Specifications Document, Contract Year 2024*, CMS requires plans to submit important new data regarding eligibility, utilization, costs for meals and Medical Nutrition Therapy (MNT) provided as supplemental benefits, as well as for meals beyond a limited basis and food and produce provided as SSBCI. Further, beginning in CY 2024, CMS now requires MA organizations to submit encounter data for supplemental benefits and has provided new supplemental benefit services category codes for this purpose.

These new reporting requirements present an important opportunity to better understand current access to and impact of services. However, to achieve these goals, CMS must ensure that the data is both publicly available and formatted in a way that is usable to stakeholders. As a baseline, this includes taking steps to ensure a clear, streamlined process for researchers to access the new data to inform analyses of utilization, cost, and health impact of services. But, going beyond research access, we also urge CMS to consider taking steps to make the data accessible to other potential audiences (e.g., policymakers, advocates, and service providers) wherever possible. For example,

providing data on coverage, utilization, and/or costs via searchable databases—such as on CMS's Data.CMS.gov—could be extremely helpful to individual service providers, including FIMC agencies. By accessing such databases, service providers could both get a sense of overarching market trends and—if organization level data is made available—better identify plans most invested in increasing access to FIM services, allowing targeted outreach to build potential partnerships and increase equity of access across the country.

Further, we urge CMS to provide access to data sets/reports dedicated to specific populations, especially where knowledge of benefit utilization and costs could help drive population-specific policy or plan decision-making. For example, recent reports indicate that Special Needs Plans (SNPs) are more likely than standard MA plans to provide coverage of SSBCI, including meals beyond a limited basis or food and produce. It would be highly useful to understand not only these coverage trends, but also how utilization and costs play out for the specific populations these plans are designed to serve (e.g., dual eligibles and individuals with severe or disabling chronic conditions). Similarly, CMS could provide more specific data sets to support research examining connections between supplemental benefit use and other potential indicators of heightened need for FIM services, such as patient Risk Adjustment Factor (RAF) scores.

2. Rationale, goals, and questions that you could address with newly released data and suggestions for how such data could support new action or regulation by CMS

A. Use New Data to Inform Policymaking to Establish Equitable Access to Services

While FIMC is highly supportive of efforts to expand nutrition offerings via MA supplemental benefits, we recognize that this remains only a partial solution to the problem of service access. Currently 33.4 million Medicare beneficiaries are enrolled in Original Medicare, where there are no opportunities to access MTMs or MTGs as covered benefits. To establish a more equitable system, CMS—and its counterparts such as the Veterans Health Administration and Indian Health Service—must pursue policies that provide program-wide access to FIM screening, referral, and coverage of responsive services. We therefore urge CMS to utilize the new data from MA plans to answer key questions that can move such policymaking forward.

For example, by comparing healthcare utilization data for enrollees accessing/not accessing MTMs and MTGs, CMS could gain a deeper understanding of the impact of these services on health outcomes. Additionally, by examining how these outcomes differ based on plan coverage approaches (e.g., differences in eligible conditions, length of intervention, etc.), CMS could help to address ongoing questions – like those posed in the fieldwide Food Is Medicine Research Action Plan - regarding ideal dose, duration, and target population for these services on a scale that is currently inaccessible to researchers. These learnings could critically inform program design and policymaking at CMS (e.g., policies such as the pilot envisioned by H.R.6780 and S. 2133 The Medically Tailored Home-Delivered Meal Demonstration Pilot Act, or other efforts to address coverage gaps in Medicare Parts A and B) as well as at other federal agencies.

B. Use New Data to Identify/Address Gaps in Access within Current Coverage Pathways

In addition to informing the advancement of *new* coverage policies, we encourage CMS to use MA data to better understand where implementation of *current* policies is falling short. For example, the *Medicare Part C Technical Specifications Document, Contract Year 2024* requires plans to submit important new data on the number of enrollees eligible for each supplemental benefit *and* the utilization of those services. By sharing out these data, in particular, CMS and other stakeholders

can gain an important understanding of where implementation of services may be falling short, and where efforts may be needed to improve uptake. Additionally, if possible, stratifying such data by other key metrics (e.g., geography, race/ethnicity, etc.) could give new insight into access disparities. For example, FIMC is keenly interested in better understanding current gaps in utilization for MTM, MTG, and MNT. With better information on these gaps, FIMC members could work with their plan partners to develop strategies to improve uptake of these critical services.

3. Common challenges and experiences in the MA program for which limited data are currently available

A. Lack of More Specific Service Definitions/Standards

Currently, CMS provides limited guidance or definitions regarding services provided as supplemental benefits or SSBCI. For example, the CY 2024 reporting requirements cited above describe these nutrition supports in large categories, including "meals," "meals (beyond a limited basis)," and "food and produce." As a result, the data do not distinguish between more specific interventions within these categories (e.g., general home-delivered meals vs. MTMs), nor do they capture different scopes of service (e.g., 1 meal per week vs. 21 meals per week).

FIMC agencies have worked for nearly 40 years to create, refine, and scale the MTM intervention. We have supported this process through the establishment of specific nutrition standards, and, more recently, through the creation of a first-in-the-nation accreditation standard for medically tailored meals: The FIMC MTM Accreditation Criteria and Requirements (FIMC MTM ACR). The standard is attached to this comment as supporting documentation for your review. We see these standards as critical, as they reflect the aspects of MTM that set them apart from other, less-intensive services (e.g., integration of Registered Dietitian Nutritionists, medical tailoring according to FIMC guidelines, access to the Nutrition Care Process, minimum dose and duration of meals, etc.). This tailored approach has been supported by research, which shows that MTMs can result in benefits including: (1) improved quality of life; (2) improved mental health; (3) better diabetes management; (4) healthier eating habits; and (5) improved medication adherence, alongside robust cost savings.

The lack of definition/differentiation within the current reporting categories creates a missed opportunity for researchers, enrollees, and CMS. For example, because current data does not differentiate between meals and MTMs, research resulting from the reported data may not accurately reflect the differences in outcomes that may be achieved between these two interventions. Such muddying of data has the potential to undercut CMS's ability to use this data to inform policymaking moving forward.

Similarly, the current paucity of guidance regarding service dose (meals/week) or duration (number of weeks)—beyond meal duration guidelines for general supplemental benefits (last updated in 2016)—means that there may be significant variation in scope of meal service. This variation may again confound research efforts, and improperly skew any resulting policy. Perhaps more importantly, though, this lack of consistency may create a risk for enrollees, who may not easily be able to access this data when comparing plans. For example, CMS's plan compare tool on Medicare.gov—which is designed to assist enrollees in choosing a plan—currently provides only high-level data on whether or not plans provide coverage for meals (noting only whether the plan provides "some coverage" of meals).

In response to these challenges, we encourage CMS to consider providing more specificity regarding meal benefits in MA, including: (1) differentiating between meals and MTMs with links to clear definitions informed by implementers and the research, such as those set out at the beginning of this comment; (2) setting clearer expectations for plans regarding scope of services (e.g., setting a floor with respect to dose/duration); and (3) providing more transparency regarding scope of services on CMS's plan compare tool for enrollees.

B. Lack of Data on Service Providers

Like many community-based nonprofit nutrition providers, FIMC agencies have decades of experience in delivering services to their community members. Through these years of service, FIMC agencies have perfected the science of layering diets for maximum nutrition effect, resulting in impressive outcomes. We know that these results are only possible with nutritious food, community connection, and a client-centered approach, values that are reflected in the FIMC MTM ACR. As policies regarding FIM interventions have advanced, we have seen important acknowledgements of the value of engaging such community-based organizations in service delivery. For example, CMS has allowed states to incorporate infrastructure dollars to build capacity of community-based organizations to participate in Medicaid 1115 Waivers that seek to expand access to nutrition supports. Similarly, individual states (e.g., MI and HI) have incorporated language into Medicaid policy proposals emphasizing the importance of engaging local, community-based nutrition organizations.

Supplemental benefits and SSBCI present important opportunities for MA plans to similarly invest in the value that community-based organizations bring to patients and their communities. However, there is limited data currently available regarding trends in plan contracting, resulting in little insight into whether community-based organizations are being included in these important opportunities to scale up access to FIM interventions. We therefore encourage CMS to consider advancing policies/requirements that would create greater transparency regarding plans' network of service providers for supplemental benefits/SSBCI. In doing so, CMS can both highlight community partnership as an important value for these efforts and encourage plans to thoughtfully assess their internal approaches to identifying new partners.

C. Lack of Data on Service Denials/Appeals

As enrollment in MA has grown in recent years, so have concerns regarding plan denials of requested services. For example, a recent OIG report on MA use of prior authorization found that among requests reviewed: 13 percent of those denied met Medicare coverage rules, and 18 percent of the payment requests denied met Medicare coverage rules and plan billing rules. These trends suggest a need for greater oversight to ensure that MA enrollees receive appropriate access to care. However, this analysis did not examine whether similar issues occur within the realm of supplemental benefits. Given the critical nature of services like MTM, MTG, and MNT to many of the individuals who receive them, it is important to understand whether enrollees are facing undue barriers in access in MA plans. We therefore recommend that CMS consider gathering further data regarding: (1) appeals/grievances related to supplemental benefits/SSBCI; and (2) any trends in this data by population.

D. Lack of Pre-Approved Services within SSBCI

Finally, we recognize that the value of many of the recommendations that we have outlined above are ultimately contingent on whether plans take advantage of the opportunities presented by

supplemental benefits and SSBCI to address enrollee nutrition needs. We therefore would like to offer one final recommendation that we believe would support uptake of FIM interventions as part of SSBCI by MA Plans: the development and publication of a list of specific types of SSBCI that CMS preemptively approves as "having a reasonable expectation of improving the health or overall function of chronically ill enrollees" based on "relevant acceptable evidence," including MTM, MTG and other FIM interventions like produce prescriptions.

CMS has provided MA plans with "broad discretion" in offering Special Supplemental Benefits for the Chronically Ill (SSBCI), provided that they have "a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." Recognizing the proliferation of types of SSBCI, CMS has newly enacted a requirement that plans must "demonstrate through *relevant acceptable evidence* that the item or service has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee." Plans are now required to provide a bibliography including all "evidence published within the 10 years" prior to bid submission.

We support CMS's commitment to ensure that MA plans provide SSBCI with a strong evidence base and greatest impact on members. Given that MA plans are already struggling to implement the documentation requirements for SSBCI and are increasingly migrating to the flexibilities allowed by the Value-Based Insurance Design (VBID) Model, there is significant risk that this approach to driving greater accountability by including an across-the-board bibliography requirement will functionally debilitate SSBCI as a viable pathway for plans' provision of FIM interventions and other high-value supplemental benefits with a well-documented impact on health disparities, outcomes, utilization, and cost.

To ensure that beneficiaries have access to specific supplemental benefits to improve or maintain their health, CMS should establish and publish a list of specific types of SSBCI that preemptively meet the standard of "having a reasonable expectation of improving the health or overall function of chronically ill enrollees" based on "relevant acceptable evidence." This approach would functionally incentivize MA plans to offer these high value benefits; at the same time, MA plans should and would still be required to bear the burden of providing the relevant 10-year bibliography for all proposed SSBCI *not* on this list.

Specifically, we urge CMS to include the following items or services on a core list of SSBCI for which the requirement of a bibliography should *not* apply due to rigorous relevant acceptable evidence that the item or services below have a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee. Each of these services was also included in CMS's Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program published in November 2023; it also aligns with the CMS-approved North Carolina Healthy Opportunities Pilot Fee Schedule and Service Definitions.

Proposed List of Approved SSBCI Services

- Case management services for access to food/nutrition, including, for example:
    - Outreach and education
    - Linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
- Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example:
    - Guidance on selecting healthy food

    - Healthy meal preparation
- Medically tailored meals, tailored to health risk and eligibility criteria and/or certain nutrition-sensitive health conditions.
- Home delivered meals or pantry stocking, tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or specifically for children or pregnant individuals.
- Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example:
    - Fruit and vegetable prescriptions
    - Medically tailored groceries
    - Food pharmacies
    - Healthy food vouchers
- Grocery provisions, for high-risk individuals to avoid unnecessary acute care admission or institutionalization.

Further, in order to avoid the concerns regarding lack of definitions describe above, we encourage CMS to pair this list with: (1) clear definitions informed by implementers and the research and (2) guidance regarding acceptable dosing and duration of services.

Providing such a list of preemptively approved SSBCI would address the concern that plans may be providing unnecessary or ineffective benefits, while also incentivizing MA plans to provide supplemental benefits that "are effectively reaching enrollees and actually meeting their needs."

Conclusion

FIMC appreciates CMS's ongoing work to increase access to FIM interventions in the Medicare program. Further, we applaud CMS's actions to increase the availability of data to examine and hasten the progress of these efforts. We see all of this work as critical to establishing a Medicare program that equitably and reliably responds to patient nutrition needs, including through the provision of MTM, MTG, and MNT. Thank you for your consideration of our perspective and recommendations regarding this important work. We welcome follow up conversations or inquiries to our recommendations and can be reached at info@fimcoaliton.org.

Sincerely,

Alissa Wassung
Executive Director of the Food Is Medicine Coalition