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August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS–4192–P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: *RIN 0938-AV01 Medicare Program; Request for Information on Medicare*

Dear Administrator Brooks-LaSure:

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to provide input on the Centers for Medicare and Medicaid Services' (CMS's) Request for Information on Medicare (Docket number: CMS-4203-NC).

The Academy represents over 112,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists; it is the largest association of nutrition and dietetics practitioners in the world and is committed to accelerating improvements in global health and addressing food and nutrition security and the effects it has on health and well-being. RDNs independently provide professional services, such as Medical Nutrition Therapy (MNT),[2] under Medicare Part B and, when credentialed, as providers of Medicare Advantage (MA) Plans.

The Academy supports CMS's vision of elevating whole-person centered care and strengthening the MA programs to achieve health equity and improve access to quality and cost-effective health care. We respectfully offer the below comments to the following questions in this RFI:

- Advance Health Equity (Section A)
- Expand Access: Coverage and Care (Section B)

Advancing Health Equity (Section A)

What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits?

[1] The Academy has approved the optional use of the credential "registered dietitian nutritionist (RDN)" by "registered dietitians (RDs)" to more accurately convey who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

[2] Medical nutrition therapy (MNT) is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. **Academy of Nutrition and Dietetics' Definition of Terms list** updated February 2021. Accessed August 17, 2022.

What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.

Expand Data Collection of Medical Nutrition Therapy beyond the Part B Benefit and collect data specific to meal-related supplemental benefits.

The Special Supplemental Benefits for the Chronically Ill (SSBCI) was intended to enable MA plans to tailor benefit offerings, address gaps in care, and improve health outcomes for chronically ill beneficiaries. Among these flexibilities, MA plans may offer beneficiaries with chronic illnesses, such as heart disease or diabetes, the ability to receive regular meals that can be customized ideally to ameliorate, but at minimum to avoid exacerbating those chronic illnesses. On average, beneficiaries enrolled in either Traditional Medicare or in non-SNP Medicare Advantage plans experience a similar number of chronic conditions. However, beneficiaries enrolled in Medicare Advantage Special Needs Plans are much more likely to experience multiple chronic conditions: 50% of all MA Special Needs Plan enrollees have been diagnosed with six or more chronic conditions.[3] In the *Calendar Year 2023 Policy and Technical Changes to Medicare Advantage and Medicare Prescription Drug Benefit Programs Final Rule*, CMS made note that around 4.1 million dually-eligible beneficiaries receive Medicare through MA dual eligible special needs plans or D-SNP.[4] CMS further noted that many dually eligible individuals contend with multiple social risk factors such as food and housing insecurity, lack of transportation, and low levels of health literacy. Being food insecure directly impacts the health and well-being of individuals and families across generations. Limited or infrequent access to healthy, nutritious foods is also associated with costly and preventable chronic diseases, including high blood pressure, coronary heart disease, hepatitis, stroke, cancer, arthritis, chronic obstructive pulmonary disease, and kidney disease.[5]

MNT is an essential component of both the prevention and treatment of many chronic conditions. RDNs routinely provide MNT to patients as treatment of any chronic disease for which it is indicated. Medicare beneficiaries have access to MNT under the Part B benefit; however, coverage is limited by statute to MNT provided for the diagnoses of diabetes, non-dialysis dependent kidney disease, and beneficiaries who are 36-month post-kidney transplant. **We know anecdotally that some MA plans go beyond the Part B MNT coverage determination to include coverage for additional diagnoses. However, absent of CMS establishing a pathway to report utilization of supplemental or expanded benefits (specific nature of services delivered/provided), the agency is unable to accurately assess the extent and value of these benefits (e.g., improved patient outcomes, reductions in total costs of care).** The lack of reporting requirements also prevents Medicare beneficiaries seeking MNT services to address their nutrition-related chronic conditions from comparison shopping MA Plans to select the one that best meets their needs.

In Spring of 2022, the Academy responded to CMS's proposed rule**,** *CMS–4192–P; Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs*,[6] where we highlighted the need for expanded data collection, specifically data for meal-related supplemental benefits and for Medical Nutrition Therapy coverage beyond what is covered under the Medicare Part B Benefit. **The Academy reiterates this request to expand data collection for MA plans as it relates to the utilization of MNT beyond what is covered under the Part B Benefit and also to collect data specific to meal-related supplemental benefits.**

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[3] The Commonwealth Fund. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ. Accessed August 17, 2022.

[4] https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical- changes-to-the-medicare-advantage-and. Accessed August 18, 2022.

[5] Academy of Nutrition and Dietetics. Racial and Ethnic Health Disparities and Chronic Disease Issue Brief. https://www.eatrightpro.org/advocacy/legislation/health-equity Published January 2021. Accessed August 17, 2022.

[6] Academy Highlights Value of RDNs and MNT for Medicare Advantage Participants. https://www.eatrightpro.org/-/media/eatrightpro-files/news-center/on-the-pulse/regulatorycomments/medicare-program-contract-year-2023-policy-and-technical-changes.pdf?la=en&hash=26A736423D6B33D12FF60AF728293EAA6FEC3579 Accessed August 18, 2022

Establish consistency among screening and referrals to appropriate nutrition care services

Seniors continue to deal with hunger and food security issues,[7] particularly older adults who are minorities and those located in rural communities. Harsh consequences of food insecurity often include malnutrition or the development of or exacerbation of chronic diseases,[8] which are compounded by one's limited access to and availability of health care, that negatively impact health outcomes. The Academy agrees with the information submitted to Congress through the Supporting Older Americans Act of 2020, which strongly encouraged providers of congregate and home meal programs (when feasible) to adjust food offerings to meet any special dietary needs of program participants.[9] The Act further recognized the importance of nutritional counseling and educational services for individuals and their primary caregivers participating in senior meal programs as it leads to improved health outcomes, lower cost of care, and increased patient satisfaction[10] and in addition, the Act provided guidance for their provision. It is critical that food insecure beneficiaries dealing with nutrition-related chronic conditions have access to nutritionally adequate and appropriate foods and appropriate nutrition care to maintain or improve their health. **Beneficiaries, especially those with nutrition-related chronic conditions, should receive a referral to RDNs when food insecurity is identified so that correct actions can be put into place to address both food and nutrition related issues.**

One of the main tools used to identify food insecurity is screening, which is important for understanding a patient's overall nutrition status and potential etiology of malnutrition or other chronic diseases. One of the many challenges to screening is doing so in a way that truly captures the meaningful information about the prevalence of food security, the etiology of the food insecurity and what may be the best way to successfully address food security needs. Depending on the questions asked and the given length of time respondents indicate they experienced food security concerns, the results may provide variable responses that make it difficult and time consuming to both assess and intervene on food security issues. For example, one screening tool that is used to assess food security may have questions that focus on the length of time an individual is experiencing food insecurity while others may focus on different aspects of food insufficiency, such as anxiety or worry about the adequacy of the food supply, social accessibility of food sources, quality of food intake, and assessing availably of acceptable or preferred foods. The Academy supports the use of validated screening tools, through mechanisms such as the Health Risk Assessment to assess both the continued barriers to food security beneficiaries face as well as foster referrals to appropriate health care team members, such as RDNs, to address identified issues related to food and nutrition.

Academy member feedback consistently reports beneficiaries lack access to adequate nutrition care and referrals to RDNs to manage their nutrition-related chronic diseases. For many, the result is that the nutrition management for chronic conditions go under treated or even untreated. **MA plans have the capacity to expand MNT coverage for conditions beyond that of diabetes and renal disease, thus giving them the opportunity to reach more beneficiaries who are identified as food insecure and support much needed nutrition care.** The Academy believes that Medicare Advantage Plans, in particular Medicare-Medicaid Plans (MMPs), present not only the opportunity to deliver timely and appropriate care to beneficiaries, but also are integral to closing the health equity gap by fostering coordinating care and addressing critical interventions to support better health outcomes for beneficiaries, including referrals to RDNs for MNT.

Expand Access: Coverage and Care – (Section B)

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health

[7] https://www.feedingamerica.org/hunger-in-america/senior-hunger-facts. Accessed February 15, 2022

[8] Ahmed T, Haboubi, N. Assessment and management of nutrition in older people and its importance to health. Clin Interv Aging. 2010; 5: 207–216.

[9] Supporting Older Americans Act, Title 2 U.S.C. § 215 (2020). https://www.congress.gov/bill/116th-congress/house-bill/4334/text?overview=closed. Accessed March 4, 2022.

[10] Food is Medicine: The Medically Tailored Meal Program Research. http://www.fimcoalition.org/research1. Accessed March 4, 2022

services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

Network Adequacy

In both the 2022 and 2023 Medicare Physician Fee Schedule, CMS has sought ways to improve access to high value services that are currently underutilized under the Part B benefit, such as MNT, Intensive Behavioral Therapy (IBT) for Obesity and Diabetes Self-Management Training (DSMT). [11,12] As we have stated earlier in this comment, chronic conditions are commonplace among Medicare beneficiaries, with a significant share living with at least one chronic condition, including diabetes (28% of beneficiaries) and chronic kidney disease (25% of beneficiaries).[13] In 2021, the Kaiser Family Foundation estimated that nearly 42% of the Medicare population was enrolled in Medicare Advantage Plans and that market share will increase to 51% by 2030.[14]

The Academy has identified significant barriers in as many as 5 states[15] to Medicare Advantage beneficiaries' ability to timely access covered preventive services (*i.e.*, Medical Nutrition Therapy) from qualified providers.[16] It appears likely, given the information obtained by the Academy and its members to date, that questionable private payer credentialing policies are the reason otherwise-valid claims for Medical Nutrition Therapy are consistently denied. RDNs in states that do not issue professional licenses to RDNs are denied the ability to join MA plan networks that require a license number to become a credentialed provider. RDNs are even denied when submitting the same RDN-credentialed ID number that CMS accepts in lieu of a license number. Adherence to unnecessarily restrictive payer credentialing policies is thus likely a contributing factor to the lack of sufficient network adequacy for RDNs in Medicare Advantage.

By law, MA organizations must conform with the credentialing and recredentialing requirements set forth in the Social Security Act,[17] which includes items such as written application and the required verification of any *existing* license or certification from primary sources but notably does *not* include an underlying licensure requirement in order to be credentialed. Moreover, the Social Security Act specifically recognizes that the qualified providers of Medical Nutrition Therapy in certain states—currently numbering 5—lack the option to be licensed or certified by their state.[18] Unfortunately, this checkerboard of states' varying professional regulation of RDNs operates to render MA health plan credentialling policies in conflict with MA plans' obligations to cover at minimum all medically necessary services that Traditional Medicare covers. The result is a decreased choice and reduced access to MNT providers; thus, beneficiaries who are enrolled in those plans are not able to fully access their Part B MNT Benefit.

Academy example of network adequacy barriers that are negatively impacting access to nutrition care

The Academy was informed by our members located in Michigan of a Medicare Advantage payer plan that lacked sufficient RDN providers in its network. In this particular example, the plan restricted beneficiary access to MNT to local hospital facilities; while ironically, the MA plan network identified non-facility based RDNs who were located in a neighboring state with locations more than 90 miles away. Upon investigation, many of the providers could not be

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[11] https://www.federalregister.gov/documents/2021/07/23/2021-14973/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part Accessed August 17, 2022

[12] https://www.federalregister.gov/documents/2022/07/29/2022-14562/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other. Accessed August 17, 2023

[13] The Commonwealth Fund. "Managing Medicare Beneficiaries with Chronic Conditions During the COVID-19 Pandemic. https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/managing-medicare-beneficiaries-chronic-conditions-covid#5. Accessed: February 24, 2022

[14] Kaiser Family Foundation: "Medicare Advantage in 2021: Enrollment Update and Key Trends". https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/. Accessed: February 24th, 2022.

[15] Arizona, California, Colorado, Michigan, and Virginia do not regulate the practice of dietetics and nutrition or the provision of Medical Nutrition Therapy; neither a license nor certification is available in the five states for registered dietitians.

[16] Section 105 of The Benefits and Improvement Act (BIPA) of 2000 (Pub L. No. 106-554) authorized Medicare Part B coverage of the Medical Nutrition Therapy benefit, the contours of which are defined in 42 CFR § 410.132. As codified in Section 1861(vv) of Social Security Act and reiterated in regulation (42 CFR, §410.134), only RDNs or nutrition professionals are eligible to furnish and independently bill for MNT.

[17] 42 CFR § 422.204

[18] 42 U.S.C. 1395x(vv)(2)(C)(ii)

reached. There were also the added concerns that those RDNs would not have licenses for the state of reference and beneficiaries would not have coverage for MNT delivered via telehealth with the out-of-state providers unless the beneficiaries were in rural areas.

This example highlights another significant concern in that it stressed the importance of current and complete health plan directories. In the example provided, no hospital nutrition counseling department was identified in the MA policy provider directory. This will likely lead beneficiaries to conclude that there are no RDNs in the network, serving as a barrier to care and accessing covered services. Health plans, including MA policies, should be required to provide a listing of all ancillary provider services/clinics in a system or facility.

CMS must ensure that both new and current MA health Plans demonstrate sufficient network adequacy that enables timely access to cost effective preventive services and care with qualified providers. **The Academy believes that payer networks supporting access to a full continuum of providers and specialties will not only improve access to cost-effective preventive services but will also improve health outcomes for our senior communities--particularly for those seniors who are managing chronic conditions and struggling with inadequate access to health care to address their needs, specifically including MNT provided by RDNs.**

Thank you for your consideration of the Academy's comments on the RFI: RIN 0938-AV01 Medicare Program; Request for Information on Medicare. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at jblankenship@eatright.org or Carly Léon at 312-899-1773 or cleon@eatright.org with any questions or requests for additional information.

Sincerely,

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