



Academy of Nutrition
and Dietetics

www.eatright.org
www.eatrightPRO.org

120 South Riverside Plaza
Suite 2190
Chicago, Illinois 60606-6995
800.877.1600

1120 Connecticut Avenue NW
Suite 460
Washington, D.C. 20036

March 7, 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: File Code CMS-4192-P; Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure:

The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to provide comments on File Code-CMS-4192-P; Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs published in the Federal Register on January 6, 2022.

The Academy represents over 113,000 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,² under Medicare Part B and when credentialed as providers of Medicare Advantage (MA) Plans.

The Academy supports CMS’s continued goal of improving beneficiary experience with MA plans and the continued focus on addressing issues specific to social determinants of health. We respectfully offer the below comments to the proposed updates:

- Section A: Improving Experiences for Dually Eligible Individuals
- Section G: Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data

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 January 28, 2022.

Improving Experiences for Dually Eligible Individuals (Section A)

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments

Good health begins in our homes and communities and factors that influence one's overall health include eating nutritious foods, staying active, not smoking, staying current with immunizations and screening tests, and having access to health care when sick.³ Being food insecure directly impacts the health and well-being of individuals and families across generations. Limited and/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.³

Prior to the COVID-19 pandemic, more than 37 million people in the United States were affected by food insecurity; and per Feed America's Issue Brief: *The Impact of the Coronavirus on Food Insecurity in 2020 & 2021*, "many people who have been most impacted by the pandemic were food insecure or at risk of food insecurity before COVID-19 and are facing greater hardship since COVID-19,"⁴ with the largest portion of the burden felt in minority communities. A study published in the 2021 Journal of the Academy of Nutrition and Dietetics noted there is a high correlation between housing instability and food security meaning that individuals and families who experience food insecurity are also more likely to face challenges with housing instability and vice versa.⁵ In 2019, an estimated 1 in 14 seniors were dealing with hunger and food security issues⁶ and there are concerns that the COVID-19 pandemic has only amplified the number of seniors struggling with food insecurity, especially minorities and those located in rural communities. There are harsh consequences of food insecurity, such as malnutrition or the development of or exacerbation of chronic diseases,⁷ which are compounded by one's limited access to and availability of health care, that negatively impact health outcomes. **The Academy supports CMS's continued dedication to addressing healthy equity among some of our nation's most vulnerable populations, including the proposal to include standard screening questions that address social determinants of health on the Health Risk Assessment (HRA) and the decision to do so through the sub-regulatory process.**

We, too, all-too commonly have heard of individuals identified by an HRA who lack access to health care and have nutrition-related chronic diseases. For many, the result is that their chronic conditions go untreated. RDNs are an integral part of the health care team and routinely provide MNT focused on chronic disease prevention and treatment to Medicare beneficiaries. As detailed in both the MNT Systematic Review (2009) and MNT Effectiveness Projects (2015) published in the Academy's Evidence Analysis Library, MNT is an evidence-based process where the RDN will assess and identify nutrition-related concerns. When provided as part of the health care team, MNT has been shown to be cost-effective and can either prevent, delay, or in many cases is an essential part of the management of a disease or condition.⁸

³ 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 January 28, 2022.

⁴ https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf Accessed February 17, 2022.

⁵ Young Lee, C, et al. *Bidirectional Relationship Between Food Insecurity and Housing Instability*. Journal of the Academy of Nutrition and Dietetics, Jan 2021, 121(1) p 84-91.

⁶ <https://www.feedingamerica.org/hunger-in-america/senior-hunger-facts>. Accessed February 15, 2022

⁷ Ahmed T, Haboubi, N. Assessment and management of nutrition in older people and its importance to health. Clin Interv Aging. 2010; 5: 207–216.

⁸ Academy of Nutrition and Dietetics Evidence Analysis Library. Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015. Available at: <http://www.andeal.org/mnt>. Accessed March 2, 2022.

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. We believe that Medicare-Medicaid Plans (MMPs) are perfectly positioned to not only identify these individuals with unmet needs through the HRA process, but to also coordinate care and address interventions to support better health outcomes for beneficiaries, including referrals to RDNs for MNT. Additionally, 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 Supporting Older Americans Act of 2020 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, increased patient satisfaction,¹⁰ and provided guidance for their provision. **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.**

Network Adequacy

The Academy supports CMS’ proposal to require that MA Plan applicants demonstrate sufficient network adequacy of providers for all beneficiaries before CMS will approve applications for new or expanded MA Plans. Demonstration of network adequacy must include providers such as RDNs. In the 2022 Medicare Physician Fee Schedule, CMS took steps to increase access to MNT provided by RDNs under the Part B Benefit, as this service is severely underutilized by beneficiaries.¹¹ 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).¹² 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 2030.¹³ We know through member input that problems exist with adequacy of RDN networks in the commercial marketplace. Those problems could spill over into the MA space creating barriers to access to RDNs and cost-effective MNT services for MA plan members. **We believe that payer networks supporting access to a full continuum of providers and specialties will not only improve the quality of care provided, but will also improve health outcomes for our senior communities--particularly for those minority communities bearing a disproportionately higher load of chronic diseases related to socioeconomic inequities and inadequate access to health care to address them, specifically including MNT provided by RDNs.**

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

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 February 23, 2022

¹² 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

¹³ 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.

Consistency among Food Security Screening

Lastly, the Academy encourages CMS to use consistent, validated food security tools when screening for food security. One of the many challenges from the COVID-19 pandemic has been the need for organizations (*e.g.*, state, federal, and public assistance programs) to rapidly respond to an increased demand to get food to individuals in need. While a quick response was warranted, it did also complicate efforts to measure the prevalence of food security and the success in addressing food security needs. Often questions used to assess food security focus on one's length of time experiencing food insecurity and drill down 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 availability of acceptable or preferred foods.

Depending on the questions asked and the given length of time respondents indicate they experienced food security concerns, the results may provide variable estimates of the food security landscape. Moreover, without validated screening tools, it may be challenging to assess both the continued barriers to food security beneficiaries face as well as the success of interventions put in place by federal and state governments and public assistance programs.¹⁴ As a participating member of the Gravity Project, **the Academy supports CMS's proposal to align questions with the Social Determinants of Health (SDOH) Assessment data element established as part of the USCDI v2 when it is finalized and applicable.**

Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data (Section G)

Proposed Changes to Medicare MLR Reporting Regulations, Data Collection Instrument, and Regulations Authorizing Release of Part C MLR Data

The Academy supports CMS's proposal to reinstate the detailed MLR reporting requirements in effect for CYs 2014 through 2017; specifically, we support CMS collecting cost data on expanded MNT benefits and meals as 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 to ideally ameliorate, but at minimum avoid exacerbating those chronic illnesses. Over two-thirds live with multiple chronic conditions¹⁵ and many are unable to shop or cook for themselves. An inability to accomplish essential tasks of independent living creates many challenges, especially as it relates to the management of chronic disease and the possibility of increased hospital admissions. According to the research compiled and studied by the Food is Medicine Coalition, the combined treatment of providing beneficiaries both with MNT and with nutritionally sound, tailored meals results in fewer hospital admissions and a monthly reduction in beneficiary health care costs.¹⁶ To achieve this goal, **the Academy encourages CMS to expand data collection to include capturing data for Medical Nutrition Therapy beyond what is covered under the Part B Benefit and meal-related supplemental benefits.**

On average, beneficiaries enrolled in either Original Medicare or in non-SNP Medicare Advantage plans experience a similar number of chronic conditions. However, beneficiaries enrolled in Medicare Advantage

¹⁴ Poblacion, A et al. *Comparing Food Security Before and During the COVID-19 Pandemic: Considerations When Choosing Measures.* Journal of the Academy of Nutrition and Dietetics, Oct 2021, 121(10) p 1945-1947.

¹⁵ Centers for Medicare & Medicaid Services. Chronic Conditions Charts 2018. 2020. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts Accessed February 8, 2022

¹⁶ Food is Medicine Coalition. <http://www.fimcoalition.org/research1>. Accessed February 24, 2022.

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.¹⁷ According to the CDC, 90% of the nation's \$3.5 trillion annual health care expenditures is spent on managing and treating chronic and mental health conditions.^{18 19} Despite the significant spending in the Medicare program, many beneficiaries face challenges receiving quality care that is comprehensive, coordinated, or prevention-focused. RDNs are an integral part of effective coordinated care from a health care team, providing nutrition education and counseling as essential components of any preventive care plan and providing Medicare beneficiaries with MNT as treatment of any chronic disease for which it is indicated. More frequent utilization of the evidence-based process of MNT—in which the RDN assesses and identifies nutrition-related concerns and conducts nutrition interventions as part of the health care team—is essential given it has been shown to be cost-effective and can prevent, delay, or, in many cases, manage or treat a wide variety of diseases and conditions.⁸

RDNs provide MNT to Medicare beneficiaries under the Medicare Part B benefit, however coverage is limited by statute to MNT provided for the diagnoses of diabetes, non-dialysis kidney disease and beneficiaries who are 36-month post-kidney transplant. We know anecdotally that some MA plans go beyond the traditional Part B benefit and provide additional hours of covered MNT services or coverage for additional diagnoses. However, absent CMS establishing simple requirements to report such supplemental or expanded benefits, 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. **The Academy therefore requests that CMS revise the MLR data collection instrument to capture data specifying any expanded MNT benefits offered by Medicare Advantage Plans and make the data publicly available.**

Finally, the Academy stands aligned with comments submitted by the Obesity Care Advocacy Network (OCAN), of which the Academy is a member, and urges CMS to use this opportunity to re-evaluate its policy on Federal Drug Association (FDA)-approved anti-obesity medications. Federal agencies have been categorizing obesity as a disease since 1998, and it is imperative that CMS acknowledge not only the clinical complexity of obesity but also the documented therapeutic action of approved anti-obesity medications to work beyond weight loss and prevent associated morbidity and mortality. Furthermore, we agree with OCAN's assessment that the dated language in Part D impedes beneficiary access to FDA approved medications for obesity and chronic weight management as the statutory exclusion of weight loss drugs is too narrow. We concur that CMS's current interpretation of the language is not appropriately distinguishing "cosmetic" weight loss from those clinical circumstances in which drugs are being specifically prescribed for an indication of obesity or chronic weight management. We believe that this has led to the unintended consequence of further perpetuating racial and ethnic health disparities among many from communities of color that bear a disproportionately high burden of obesity, and it is having a profound impact beyond Medicare given that numerous other public and private health plans often mirror Medicare coverage.

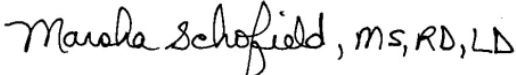
¹⁷ The Commonwealth Fund. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? <https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ>. Accessed February 24, 2022.

¹⁸ Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Santa Monica, CA: Rand Corp. 2017. https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf. Accessed February 8, 2022.

¹⁹ Centers for Medicare & Medicaid Services. National Health Expenditures 2017 Highlights. 2018. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>. Accessed February 17, 2022

Thank you for your consideration of the Academy's comments on the proposals to the 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs and for your steadfast work serving Medicare and Medicaid beneficiaries. Please do not hesitate to contact Marsha Schofield at 312-899-1762 or by email at mschofield@eatright.org with any questions or requests for additional information.

Sincerely,

A handwritten signature in black ink that reads "Marsha Schofield, MS, RD, LD". The signature is written in a cursive style.

Marsha Schofield, MS, RD, LD, FAND
Senior Director, Governance and Nutrition Services Coverage
Academy of Nutrition and Dietetics