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January 31, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9898-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-9898-NC Request for Information: Essential Health Benefits

Dear Administrator Brooks-LaSure:

The Academy of Nutrition and Dietetics (the "Academy") is pleased to provide comments on File Code-CMS-9898-NC published in the Federal Register on December 2, 2022. Representing more than 112,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of nutrition and dietetics practitioners committed to accelerating improvements in global health and well-being through food and nutrition.

RDNs provide high quality, evidence-based care to patients and deliver substantial cost-savings to the health care system. Additionally, RDNs' extensive formal education and training provides expertise in all aspects of food and nutrition, enabling us to play a key role in shaping the public's food choices and improving people's nutritional status to prevent and treat chronic disease. RDNs are recognized for their unique ability to conduct and translate science and evidence through education, medical nutrition therapy (MNT) and intensive behavior therapy[2] to empower consumers to make healthful choices. The National Academies of Sciences, Engineering, and Medicine maintains that "the registered dietitian is currently the single identifiable group of health-care practitioners with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[3]

Every day, RDNs provide nutrition care to individuals from all walks of life, throughout the lifecycle. We are committed to improving the nation's health through food and nutrition, and providing evidenced-based nutrition counseling services that meet the health needs of all citizens. Passage of the Affordable Care Act (ACA) brought about opportunities to expand equitable access to quality care to all Americans, but the promise of quality care continues to fall short due to the vaguely defined nature of some of the Essential Health Benefits categories. We appreciate the opportunity to submit comments regarding the scope of coverage of benefits in health plans subject to the EHB requirements of the ACA. The Academy offers the following comments.

Summary of Recommendations
A summary of our recommendations is included here, with the following pages containing the evidence and further detail to support those recommendations. An overarching goal of our response is to urge

HHS to provide better clarity and guidance for states for EHB categories for more consistent implementation for nutrition-related services.

1. The Academy agrees with the National Academy of Medicine that the appropriate distinction for determining the extent of coverage for MNT versus simple nutrition education and wellness services is whether the nutrition-related service provided is medical rather than non-medical.

2. State base benchmark health plans should have increased specificity and provide consistent coverage for MNT and other nutrition services. The Academy urges HHS to provide additional guidance to states to clarify the extent of nutrition services that HHS requires prior to approving states' EHB-benchmark plans.

3. HHS should designate the qualified, credentialed provider of nutrition care services that go beyond "wellness" and provision of general non-medical nutrition information or weight-loss services to be consistent with the Social Security Act definition to ensure clinically effective care that protects the public's health. This Act designates RDNs as the recognized providers of nutrition services, including medical nutrition therapy and nutrition counseling, because of RDNs' demonstrated competency and effectiveness.

4. HHS should issue EHB guidance on preventive and wellness services to indicate that plans are required to cover all evidence-based interventions shown to work in reducing the risks of developing chronic disease, including visits with RDNs for all nutrition-related conditions and all conditions for which nutrition care is a component of care.

5. In order to support Grade A or B USPSTF recommendations for the provision of nutrition-related care in the prevention and management of chronic diseases, the Academy supports explicitly defining at a minimum any nutrition-related preventive services in the EHB as those services encompassed by Section 2713(a) of the ACA.

6. The Academy recommends that CMS recognize obesity as a complex and chronic disease and require EHB plans to cover all evidence-based treatment services under the appropriate EHB categories.

Medical Nutrition Therapy and Nutrition Counseling

The Academy defines Medical Nutrition Therapy as "the evidenced-based application… [where] 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 and monitoring."[4] Nutrition counseling, as a component of MNT, is medically necessary for chronic disease states in which dietary adjustment has a therapeutic role, when and furnished by a qualified provider.

Both nutrition counseling and medical nutrition therapy are well-recognized as medical services, embodied as necessary preventive services by the USPSTF, covered by Medicare and private health insurance plans, and coded by the Current Procedural Terminology, CPT 97802-97804.

Health plans cover Medical Nutrition Therapy benefits differently than nutrition education, wellness programs or weight loss services. Some plans specifically exclude "weight loss services" (which are usually understood to mean programs like Weight Watchers or Nutrisystem) but include MNT or bariatric surgery as chronic disease management for obesity. Similarly, plans may include a general wellness "nutrition counseling" benefit which may be limited to two annual visits with an RDN or nutrition professional, whereas an MNT benefit for diabetes or end stage renal disease is covered to allow more frequent treatment. The Academy agrees with the National Academy of Medicine that the appropriate distinction for determining the extent of coverage for MNT versus simple nutrition education and wellness services is whether the nutrition-related service provided is medical rather than non-medical.[5]

Benefit Descriptions in EHB-Benchmark Plan Documents

The 2019 Health and Human Services Notice of Benefits and Payment Parameters aimed to provide states with greater flexibility and control over state marketplaces. States had more opportunities to customize benefit across EHB Categories to better tailor plans to meet health care needs of their respective states. As a result, and despite the fact that the ACA guarantees protection from discriminatory health care practices and of EHB coverage, people living with nutrition-related chronic conditions such as obesity or pre-diabetes are unable to access medically necessary nutrition care for their chronic condition.

The Academy remains concerned that many state health plans continue to provide ambiguous and inconsistent coverage for both MNT and nutrition services, making access to quality nutrition care at the mercy of vague and ill-defined nature of some of the Essential Health Benefit categories. For the purposes of this comment period, the Academy reviewed the 2014-2016 EHB Benchmark plans as outlined on the Center for Consumer Information and Insurance Oversight's (CCIIO) website.[i] While there are health plans that include specific benefit language related to MNT and/or nutrition counseling in their benefits, terminology and actual coverage for these nutrition services are not as consistently and explicitly detailed as that of other specialist services, such as physical, occupational and speech therapy services. This ambiguity and inconsistency continue to necessitate aggressive oversight of state base-benchmark plan selections by HHS to ensure inclusion of *each* of the various types of nutrition services that should be included in EHB-benchmark plans.

Four of the top six leading causes of death can be influenced and/or ameliorated by cost-effective nutrition and diet counseling and interventions by registered dietitian nutritionists. To support a successful health care system, the EHB must include services that demonstrably improve the nutritional status of Americans and reduce the rates of obesity, cardiovascular disease, renal disease, hypertension, diabetes, HIV, forms of cancer, celiac disease, stroke, and other medical conditions. As detailed in the MNT Effectiveness Project published in the Academy's Evidence Analysis Library, MNT and other evidence-based nutrition services, from pre-conception through end-of-life, are an essential component of comprehensive health care whether provided as frontline therapy to prevent disease, delay disease progression, or as an intervention in chronic care management.[6]

[i] Of the 50 State Benchmark plans, the Academy found that 24 plans (AZ, AR, CT, CO, DC, HI, ID, IL, LA, MD, MI, NJ, NY, ND, OH, OR, RI, TN, TX, UT, VT, VA, WA, WV) included coverage for "Nutrition Counseling," 23 plans (AL, AK, CA, DE, FL, GA, KS, MA, MN, MS, IN, KY, MO, MT, NE, NV, NM, OK, PA, SC, SD, WI, WY) excluded coverage for "Nutrition Counseling" and 2 plans (ME, NH) made no mention of nutrition counseling or nutrition therapy

The Academy believes that both health plans and consumers would benefit from greater specificity of MNT in the listed elements of the EHB and it would behoove Health and Human Services to specifically determine whether a base benchmark plan meets the required minimum coverage of MNT and other nutrition services. Thus, the Academy urges HHS to provide additional guidance to states to clarify the extent of nutrition services that HHS requires prior to approving states' EHB-benchmark plans.

Coverage and Qualified Providers Differ for Various Nutrition Services

While specific to Medicare, the Social Security Act defines MNT as "nutritional diagnostic, therapy, and counseling services for the purpose of *disease management* which are furnished by a registered dietitian or nutrition professional . . . pursuant to a referral by a physician."[7] MNT is distinctly different than mere nutrition education[8] or wellness programs and requires the advanced skill set of specialists such as RDNs rather than differently qualified nutritionists, health coaches or primary care physicians without a medical nutrition background. The most appropriate and accepted definition for qualified providers of medically necessary intensive behavioral and dietary counseling is limited to a registered dietitian, qualified nutrition professional,[9] or other qualified licensed health professional (such as nurse practitioners or physicians who are trained in nutrition) recognized under the Social Security Act.[10] HHS should take the next step to designate the qualified, credentialed provider of nutrition care services that go beyond "wellness" and provision of general non-medical nutrition information or weight-loss services as consistent with the Social Security Act definition to ensure clinically effective care that protects the public's health. RDNs should be designated as the recognized providers of nutrition services, including medical nutrition therapy and nutrition counseling, because of RDNs' demonstrated competency and effectiveness.

Recommended Changes to EHB Guidance

Preventive and Wellness Services and Chronic Disease Management
It has long been established that preventive health programs are highly effective in preventing chronic diseases[11] and that a crucial component of preventative health care programs is nutrition. The Preventive and Wellness services and Chronic Disease Management[12] is perhaps the least well-defined element of the ten EHB listed in the ACA, the National Academies of Science, Engineering and Medicine recommendations[13] and the resulting benefit designs found throughout the insurance market. In comments submitted in2012, the Academy expressed concerns over the lack of specificity surrounding coverage for intensive, multi-component behavioral interventions, including those related to nutrition care; this concern continues today. As outlined above in the Benefit Descriptions in EHB-Benchmark Plan Documents section, it is evidence that our concerns were warranted and the lack of specificity indeed resulted in unclear and variable coverage of nutrition interventions.

Since implementation of the ACA, the US Preventative Services Task Forces has published several new and updated Grade A or B recommendations for clinical preventive services.Group health plans and health insurance issuers offering group or individual health insurance coverage are required to provide any additional evidence-based items or preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a rating of A or B.

The Academy urges that the EHB guidance on preventive and wellness services be substantially revised to indicate that plans are required to cover all evidence-based interventions shown to work in reducing the risks of developing chronic disease, including behavioral interventions delivered by RDNs. Specifically, we ask HHS to require that health plans include "visits with registered dietitian nutritionists for all nutrition-related chronic conditions and all conditions for which nutrition care is a component of care."

Coverage of USPSTF Grade A and B Recommendations

Of the more than 50 recommendations graded A or B, nearly 20% of the recommendations[ii] directly call for a nutrition intervention or have implications that impact nutrition status. MNT provided by RDNs is a widely recognized component of medical guidelines for the prevention and treatment of conditions such as heart disease, pre-diabetes and diabetes, obesity, along with many other chronic diseases and conditions, as well as in the reduction of risk factors for these conditions. MNT is proven to reduce chronic disease risk, delay disease progression, enhance the efficacy of medical/surgical treatment, reduce medication use and improve patient outcomes including quality of life.[14]

Additionally, data from the US Preventative Services Task Force suggests that behavioral counseling interventions are effective in not only promoting a healthful diet and physical activity (hallmarks of preventative health), but also as it relates to adults with obesity as behavioral counseling "can lead to clinically significant improvements in weight status and reduced incidence of type 2 diabetes among adults with obesity and elevated plasma glucose levels".[15] With nearly half of all Americans, and an even higher prevalence in BIPOC populations suffering from preventable chronic conditions,[16] such as obesity, diabetes, and heart disease it is critical that American's have access to health care professionals (both physician and non-physician) and services that focus on disease prevention, wellness, and healthy lifestyles.

Despite ample evidence supporting the inclusion of nutrition-related care in both the prevention and management of chronic diseases, current EHB requirements have failed to translate that care into tangible coverage. The Academy supports explicitly defining *at a minimum* any nutrition-related preventive services in the EHB as those services encompassed by Section 2713(a) of the ACA.

RDN-Provided Comprehensive Nutrition Services Are Cost-Effective

Nutrition services provided by RDNs are affordable, cost-effective, and are part of a comprehensive package of preventive and disease management services that would help to improve our nation's

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[ii] Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy; Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after; Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors; Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons; Hypertension in Adults: Screening: adults 18 years or older without known hypertension; Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older; Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis; Osteoporosis to Prevent Fractures: Screening: women 65 years and older; Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity; Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults

health. According to the Centers for Disease Control and Prevention (CDC), the prevalence of obesity in the U.S. was nearly 42% between 2017 and March 2020, which cost the U.S. an estimated $173 billion in annual medical costs in 2019. Additionally, the CDC reports that the medical cost of care for adults with obesity were $1,861 higher than the medical costs for individuals who maintain a healthy weight.[17] Obesity is linked to many chronic conditions such as cardiovascular disease, pre-diabetes and type 2 diabetes mellitus. [18]

Including RDN-provided MNT in a health plan is not only clinically effective, but itis also cost effective. As just one example, a study conducted at Massachusetts General Hospital demonstrated a savings of $4.28 for each dollar spent on MNT.[19] Individuals who have access to MNT enjoy improved quality of life and better clinical outcomes.[20] MNT is shown to significantly lower Hemoglobin A1c by 0.3%-2.0% in adults with type 2 diabetes. The average savings for each 1% decrease in A1C is $246-$1,640 per patient per year.[21] In a Blue Cross Blue Shield Study, the additional of unlimited MNT visits to benefits packages was cited as costing $0.03 per member per month. [22] Additionally, according to Wolf, *et al*, for every dollar an employer invested in the lifestyle modification program for employees with diabetes, the employer would see a return of $2.67 in productivity. MNT provided by RDNs also impacts productivity; the study indicated the RDN-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost workdays by 64.3% and disability days by 87.2%, compared with those receiving usual medical care.[23] Nutrition interventions reduce and even eliminate the need for costly long-term medications and reduce hospitalizations. HHS and the Treasury and the Labor Departments found that nutrition services for obesity alone reduce premiums by 0.05 to 0.1 percent. [24] As such, they meet the criteria of good stewardship of resources.

Finally, the Academy aligns with other concerns and recommendations noted in comments submitted by the Obesity Care Advocacy Network (OCAN), of which the Academy is a member. The Academy recommends that CMS recognize obesity as a complex and chronic disease and require EHB plans to cover all evidence-based treatment services under the appropriate EHB categories. Additionally, we join OCAN in urging CMS to provide guidance to state EHB plans that mirrors the Office of Personal Management's language to Federal Employee Health Benefit (FEHB) which ensures coverage of FDA approved anti-obesity medications. Lasty, we agree that CMS should address the discriminatory benefit design language surrounding obesity preventative care services, and to utilize the United States Pharmacopeia (USP) drug classification as the standard for determining drug classes within state EHB benchmark plans.

Thank you for your careful consideration of the Academy's comments on the Request for Information: Essential Health Benefits. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at jblankenship@eatright.org or Carly Leon at 312-899-1773 or by email at cleon@eatright.org with any questions or requests for additional information.

Sincerely,

Jeanne Blankenship, MS, RDN
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Academy of Nutrition and Dietetics

Carly Léon, MS, RDN
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Academy of Nutrition and Dietetics

[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 is defined as nutrition care services provided for treatment or management of diseases or medical conditions.

[3] Institute of Medicine (US) Committee on Nutrition Services for Medicare Beneficiaries. The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population. Washington (DC): National Academies Press (US); 2000. 13, Providers of Nutrition Services. Available from: https://www.ncbi.nlm.nih.gov/books/NBK225306/.

[4] The Academy of Nutrition and Dietetics Definition of Terms. https://www.eatrightpro.org/practice/dietetics-resources/quality-management/definition-of-terms Accessed: January 23, 2023.

[5] Essential Health Benefits: Balancing Coverage and Cost. Institute of Medicine Report at 4-19 to 4-20. Released October 6, 2011. https://nap.nationalacademies.org/catalog/13234/essential-health-benefits-balancing-coverage-and-cost Accessed January 10, 2023

[6] Grade 1 data. AND Evidence Analysis Library, https://www.andeal.org/topic.cfm?menu=5284. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

[7] 42 U.S.C. 1395(vv)(1).

[8] The Academy defines nutrition education as "the formal process to instruct or train patient(s)/client(s) in a skill or to impart knowledge to help patient(s)/client(s) voluntarily manage or modify food choices and eating behavior to maintain or improve health." Academy of Nutrition and Dietetics. Definition of Terms List. Available at http://www.eatright.org/scope

[9] 42 U.S.C. 1395(vv)(2) ("[T]he term 'registered dietitian or nutrition professional' means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C) (i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

[10] 42 U.S.C. 1395u(c)18(C).

[11]National Centers for Disease Control and Prevention. www.cdc.gov/chronicdisease/programs-impact Accessed April 22, 2020.

[12] 42 U.S. Code § 18022 - Essential health benefits requirements

[13] Institute of Medicine. 2012. *Essential Health Benefits: Balancing Coverage and Cost*. Washington, DC: The National Academies Press. https://doi.org/10.17226/13234.

[14] Grade 1 data. Academy Evidence Analysis Library, http://andevidencelibrary.com/mnt. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

[15] US Preventative Services Task Force. Final Recommendation Statement: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions.(Grade B). Accessed January 9, 2023. https://uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions. Accessed May 22, 2020.

[16] Wullianallur R. An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health. Int J Environ Res Public Health. 2018 Mar; 15(3): 431.

[17] Centers for Disease Control and Prevention. Adult Obesity Facts. https://www.cdc.gov/obesity/data/adult.html Accesses: January 9, 2023.

[18] Academy Evidence Analysis Library: Adult Weight Management Guides (2021-2022). https://www.andeal.org/topic.cfm?menu=5276&pcat=6189&cat=6190. Accessed January 9, 2023

[19] Delahanty LM, Sonnenberg LM, Hayden D, Nathan DM. Clinical and cost outcomes of medical nutrition therapy for hypercholesterolemia: A controlled trail. J Am Diet Assoc, 2001;101:1012-1016.

[20] Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med*. 2009;51(2):139-145. doi:10.1097/jom.0b013e3181965db5.

[21] Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med*. 2009;51(2):139-145. doi:10.1097/jom.0b013e3181965db5.

[22] The Incremental Value of Medical Nutrition Therapy in Weight Management, *Managed Care*, January 2013.

[23] Wolf AM, Conaway MR, Crowther JQ, et al. Translating lifestyle intervention to practice in obese patients with type 2 diabetes: Improving Control with Activity and Nutrition (ICAN) study. *Diabetes Care*. 2004; 27:1570–6.

[24] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient protection and Affordable Care Act. Access January 23, 2023. PDF Available: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwi2usHR3d78AhW6FFkFHXfODYcQFnoECBIQAQ&url=https%3A%2F%2Fwww.govinfo.gov%2Fcontent%2Fpkg%2FFR-2010-07-19%2Fpdf%2F2010-17242.pdf&usg=AOvVaw0Z0mvK4NVYMByC1bssoyrV