August 31, 2022

Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-4203-NC – Medicare Program; Request for Information on Medicare

On behalf of Meals on Wheels America and the programs and individuals we represent, we thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to submit public comments regarding the Request for Information (RFI) on the Medicare Advantage (MA) Program.

Meals on Wheels America is the largest and oldest national organization supporting community-based senior nutrition programs across the country that are dedicated to addressing hunger and isolation among older adults. This network serves communities throughout the United States, and, along with millions of staff and volunteers, delivers the nutritious meals, social connection and safety checks that enable older adults and individuals with disabilities to live nourished lives with independence and dignity in the comfort of their homes.

With a mission of empowering local community programs to improve the health and quality of life of the individuals they serve so that no one is left hungry or isolated, we know that a strong Medicare program that addresses the evolving and complex health needs of the growing older adult population is essential. Enhancing the administration and delivery of healthcare services for older adults that more equitably and effectively address their social determinants of health is a particularly critical component of strengthening Medicare.

Meals on Wheels America has been a longtime CMS stakeholder and partner focused on the community-dwelling older adult population and has worked with MA plans for two decades, including throughout the development of supplemental benefits. Our advocacy as a national organization aims to protect and grow programs and services, such as those administered under CMS, that help older adults age independently in their communities. We work closely with the Administration for Community Living (ACL) as the lead agency carrying out the Older Americans Act (OAA), including the Title III-C Nutrition Program (i.e., Meals on Wheels), which provides congregate and home-delivered nutrition services primarily to older adults age 60+ and individuals with disabilities. As you may know, the OAA is an efficient and effective public-private partnership with a 50-year track record through which local nutrition providers leverage multiple funding sources – from federal, state and local dollars to private donations from foundations, corporations and individuals – to address the unique nutritional, social, financial and health-related needs of a rapidly growing senior population. Given that the services that Meals on Wheels programs deliver allow older adults to remain healthier at home, avoiding more costly care settings, local organizations have also contracted with hospitals, insurers and other entities to reduce healthcare costs, enhance quality of care and improve healthcare outcomes.

Maintaining and increasing nutrition benefits through MA, and comprehensively expanding these services throughout all Medicare programs, are critical to equitably reaching unserved and underserved populations, achieving far greater impacts on health outcomes and reducing healthcare spending for beneficiaries nationwide. As current research and literature makes clear, nutrition is a cornerstone to overall health and uniquely impacts older adults, including those with multiple chronic conditions and complex care needs.

Our comments include responses to specific questions and sections within the RFI and recommendations that speak to the experience of the network of community-based senior nutrition providers and their success in supporting older individuals at risk for negative health outcomes. We value this opportunity to provide expertise on ways to support beneficiaries through Medicare with nutrition-related benefits and leveraging the existing network of Meals on Wheels providers.

Section A. Advance Health Equity

- **Question 6. For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.**

  Home- and community-based aging services that focus on social determinants of health, like those offered by Meals on Wheels programs, provide more desirable and affordable alternatives to traditional in-patient or facility-based health and long-term care options. They are also more effective in addressing the physical and mental health needs of older adults, resulting in a better quality of life. Senior nutrition programs have addressed a wide range of social determinants of health for 50 years, often leveraging the nutritious meals they provide to assess and help address factors that allow older adults to remain healthier and safer at home. As the trajectory of our current aging services and healthcare systems continue to move toward lower-cost, person-centered models of care delivery, partnerships with community-based organizations are more essential than ever because they serve the needs of older adults where they spend most of their time – in their homes.

  In the past ten years, a continually increasing number of MA plans have conducted outreach to Meals on Wheels America and the community-based senior nutrition providers in our network as they look to provide a meal related benefit to their MA plan members. Most often, the meal related offering is structured as a post-hospital discharge benefit that specifies a set number of meals that are provided to an older adult at home. Meals on Wheels America has also partnered with MA plans to provide more comprehensive services to their members who are having difficulty managing multiple chronic conditions.

Such services include a nutritious meal, friendly visit and safety and wellness check-in – offerings that are more aligned to what Meals on Wheels programs provide as part of their standard service model.

MA plans outreach to Meals on Wheels America as the national organization to leverage our network of local programs in areas that align with their respective geographic footprint. However, there are also instances in which MA plans with limited counties or a single state footprint contract with individual programs or state-based associations for the provision of meal delivery services for their members. In our experience, MA plans contract with community-based senior nutrition programs either on a per meal basis or a fixed price based on the total number of meals delivered.

- **Question 7. 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? 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.**

  Older adults who are food insecure and lack consistent access to nutritious meals experience worse health outcomes and are at increased risk for heart disease, depression and decline in cognitive function and mobility than those who are food secure.[1] Most older Americans possess at least one factor that puts them at greater risk of food insecurity, malnutrition, social isolation and/or loneliness, thereby increasing the likelihood of experiencing negative health effects. In 2020, over 9 million (12%) older adults aged 60 and older were threatened by hunger – nearly 5.2 million (7%) of whom experienced *low food security* or *very low food security*.[2] It has also been estimated that up to almost half of all older adults may be at risk of becoming or are already malnourished, which has an estimated economic cost of $51 billion annually,[3] while falls account for $50 billion in medical costs.[4,5] There is also substantial research that affirms that nutrition programs like Meals on Wheels that address food insecurity, nutritional

[1] Ziliak and Gunderson, 2021, *The Health Consequences of Senior Hunger in the United States: Evidence from the 1999-2016 NHANES,* report prepared for Feeding America available at www.feedingamerica.org/research/senior-hunger-research/senior
[2] U.S. Census Bureau, 2020, Current Population Survey (CPS) December Food Security Supplement, dataset available at https://www.census.gov/data/datasets/time-series/demo/cps/cps-supp_cps-repwgt/cps-food-security.html
[3] Kaiser et al., 2010, "Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment", *Journal of the American Geriatrics Society* 58(9):1734-8, abstract available at https://pubmed.ncbi.nlm.nih.gov/20863332/
[4] Snider et al., 2014, "Economic burden of community-based disease associated malnutrition in the United States, *Journal of Parenteral and Enteral Nutrition* 38(2 Suppl):77S-85S,
[5] Florence et al., 2018, "Medical Costs of Fatal and Nonfatal Falls in Older Adults", *Journal of the American Geriatrics Society* 66(4):693-698, available at https://www.ncbi.nlm.nih.gov/pubmed/25249028

status and social connection can improve the overall health and wellbeing for seniors participating in the programs.[6,7,8]

A rigorously designed study from 2015 found that seniors receiving home-delivered meals experienced greater improvements in health than their counterparts who did not receive services. Between baseline and follow up, the group of older adults who received home-delivered meals and safety checks were more likely to have improved physical and mental health, including reduced feelings of anxiety and loneliness, and fewer hospital admissions and falls – a major contributor of preventable hospitalizations and healthcare spending among older adults.[9] Further, the majority of seniors receiving home-delivered nutrition services consistently report that participating in the program helps them feel more secure, eat healthier foods and allows them to stay in their own home.[10] In turn, this helps avoid preventable emergency room visits, hospital admissions and readmissions, as well as extended stays in rehab, preventing premature institutionalization and ultimately reducing our nation's healthcare costs.

Beyond nutrition, human connection is an integral component specific to the Meals on Wheels delivery model and, as such, senior nutrition programs are able to help increase social connections and reduce loneliness through consistent and meaningful interactions. For many Meals on Wheels participants, staff and volunteers may be the only individual(s) she or he sees that day, providing critical occasions for socialization – which is imperative to older adults' mental and behavioral health. In fact, feelings of isolation and loneliness have been found to significantly improve among older individuals receiving daily home-delivered meals.[11] Beyond critical social connection, this is also an essential opportunity for a senior nutrition staff member or volunteer to do a safety check, to look for fall hazards, to lay eyes on a person and help them reach community resources they otherwise may not know about, such as the critical programs that further address falls prevention, and address elder abuse.

In our experience with contracting directly with MA plans and in supporting and facilitating local and regional relationships with community-based nutrition providers, MA plans may offer a set number of one-time per year general wellness and/or medically-tailored home-delivered meals as a supplemental benefit, primarily following a hospital discharge, to lessen the burdens associated with recovery. This is typically a one or two

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[6] Campbell et al., 2015, "Does Participation in Home-delivered Meals Programs Improve Outcomes for Older Adults?: Results of a Systematic Review", *Journal of Nutrition in Gerontology and Geriatrics* 34(2): 124–167, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4480596/

[7] Wright et al., 2015, "The Impact of a Home-Delivered Meal Program on Nutritional Risk, Dietary Intake, Food Security, Loneliness, and Social Well-Being", *Journal of Nutrition in Gerontology and Geriatrics,* 34(2):218-27, abstract available at https://pubmed.ncbi.nlm.nih.gov/26106989/

[8] Mathematica Policy Research, 2017, *Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality,* report prepared by Mabli et al. for the Administration for Community Living (ACL) available https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf

[9] Meals on Wheels America, 2015, *More Than a Meal Pilot Research Study*, report prepared by Thomas & Dosa, available at https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study

[10] Administration for Community Living (ACL), 2019, *National Survey of OAA Participants*, available on ACL's AGing, Independence, and Disability (AGID) Program Data Portal at https://agid.acl.gov/

[11] See footnote 9

meal-per-day limited benefit for seven to 10 days. Some MA plans have explored Value-Based Insurance Design (VBID) pilots, where they provide food- or nutrition-related services to their members with complex care needs as part of a broader social isolation, loneliness and safety and wellness check-in package. These programs, however, while impactful, are often much smaller in scale and not as prevalent as the post-hospital discharge supplemental benefit offering.

We are aware, and pleased, that food- and nutrition-related benefits are among the top supplemental benefits selected by MA plans to offer their members. In fact, the percentage of MA plan beneficiaries with meal benefit coverage grew 50% between 2018 to 2022, from approximately 20% to 71%.[12] Unfortunately, though, it has been particularly difficult to obtain data about food- or nutrition-related benefit utilization or impact from MA plans. We have found that MA plans are able and willing to share their enrolled member numbers from previous years or the number of individuals who went into a hospital in their markets. However, we have not been able to obtain utilization data about how many or what percentage of older adults who have a food- or nutrition-related benefit available to them are actually using it.

With respect to outcomes data, Meals on Wheels America often conducts follow-up satisfaction surveys with MA plan members who receive food- or nutrition-related services through contracts we serve. Through those surveys, we have received countless qualitative responses from older adults about the value of the food- or nutrition-related service and how they felt it improved their health and well-being.

Quantitative outcomes data about those seniors who used their meal-related benefits and its associated impact is much harder to obtain. We believe one of the limitations of outcomes data is a result of the popular post-hospital discharge benefit structure, which implements a short-term, one-time, set number of meals provided to an older adult following a hospitalization. Most hospitalizations among older adults are due to poor management of one or more chronic conditions. It cannot be expected that one or two meals a day for seven to 10 days, following a hospitalization, will singularly improve the health of an older adult in a significantly quantifiably measurable way. We also believe that the difficulty in assessing quantifiable outcomes information from a return-on-investment perspective is challenging because the healthcare system has not yet figured out a way to capture or identify the value of a preventative service like food- or nutrition-related services.

We believe the expansion of new ways for MA plans to offer their members services that address social determinants of health through the creation of the Special Supplemental Benefits for the Chronically Ill (SSBCI) was a step in the right direction. MA plans are allowed to provide more robust food- and nutrition-related benefits to their members, as well as more comprehensive service offerings to address their holistic needs to continue to live independently in their homes. In 2020, when MA plans were initially able to offer non-primarily health-related benefits through SSBCI, only 2% of total MA plans offered

[12] Milliman, 2022, *Prevalence of supplemental benefits in the general enrollment Medicare Advantage marketplace: 2018 to 2022*, available at https://us.milliman.com/en/insight/prevalence-of-supplemental-benefits-in-the-general-enrollment-medicare-advantage

the benefits. In 2022, the number of MA plans offering SSBCI benefits increased to 14%.[13] The share of MA enrollees who have access to SSBCI benefits is highest for food and produce (9.6% for individual plans and 35.1% for Special Needs Plans), and meals beyond a limited basis (7.8% for individual plans and 17.3% for Special Needs Plans), with non-medical transportation and pest control following.[14] This translates to nearly 4.5 million MA plan beneficiaries that have access to SSBCI benefits through their MA plan in 2022, compared to 1.2 million in 2020.[15] While we are encouraged by the growth in MA plan adoption of SSBCI benefits, there are still too many MA plans that do not yet offer these benefits, and the benefits that are offered are often too limited, contributing to greater health disparities within either the Medicare or Medicare Advantage eligible populations, representing 58.6 and 28.4 million seniors, respectively.[16]

Accordingly, we urge CMS to take the following into consideration regarding possible changes to current food- and nutrition-related benefit offerings for MA enrollees:

- Establish a clearer definition of success for MA plans that provide social determinant of health benefits – such as food- and nutrition-related benefits – to their members. The programs should also be structured to ensure success, such as allowing for greater flexibility and extended time frames for these benefits. Food insecurity is both episodic and chronic, and nutrition can be used as a preventative health measure, as well as a supportive one. Older adults who are food insecure need reliable and consistent ways to address their food- and nutrition-related needs over time. Supplemental benefits, such as those received post-hospital discharge, place arbitrary time frames on food-and nutrition-related services, which are confusing and disruptive to seniors, many of whom likely had some prior level of food insecurity and/or malnutrition prior to their hospitalization.
- Allow benefits that are meant to address social determinants of health to continue for multiple years. This would allow MA plans and their partner organizations to track and measure impact of the additional service offerings for their beneficiaries.
- Increase utilization of community-based nutrition benefits through MA plans in order for CMS to reach its goals of greater health equity. Better awareness of food insecurity, malnutrition and social isolation and their negative effects on physical and mental health have emerged recently, and it is important to note that older adults in particular – especially those who were already homebound and/or living

[13] ATI Advisory, 2022, *Growth in New, Non-Medical Benefits Since Implementation of the Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*, report available at https://atiadvisory.com/wp-content/uploads/2022/04/Data-Insight-Growth-in-New-Non-Medical-Benefits-Since-Implementation-of-the-CHRONIC-Care-Act.pdf

[14] Kaiser Family Foundation, 2022, *Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, available at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

[15] Avalere, 2022, *Enrollment in MA Plans with SSBCI Nearly Quadrupled Since 2020*, available at https://avalere.com/insights/enrollment-in-ma-plans-with-ssbci-nearly-quadrupled-since-2020

[16] Kaiser Family Foundation, 2022, *Medicare Advantage in 2022: Enrollment Update and Key Trends*, available at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

in rural areas – have long been at higher risk of hunger, isolation and loneliness and have unique challenges maintaining community connections and adequate healthcare. Through congregate and home-delivered meals, senior nutrition providers have decades of experience and success in promoting and targeting nutrition services to seniors in the greatest social and economic need – including those who are low-income; are a racial or ethnic minority; live in a rural community; have limited English proficiency; and/or are at risk of institutionalization.

Section E. Engage Partners

- **Question 1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?**

  As previously mentioned, information about current utilization rates of food- or nutrition related benefits and understanding why individuals who are eligible choose not to participate in food- or nutrition-related benefits are essential to prioritizing and coordinating services at the community level for MA plan beneficiaries.

- **Question 2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?**

  Collaboration requires time and needs to result in meaningful outcomes for all stakeholders who are being convened. Healthcare can be complicated and siloed in various cross-cutting – and not always intuitive – ways. This makes coordination difficult to foster and measure. To impact the scope of healthcare collaboration efforts in the MA space, we recommend incentivizing more locally focused partnerships, which would be better suited to address the needs of MA beneficiaries in their communities with resources that are based in those respective communities.

  Further, the current structure of social determinant of health benefits is not designed in a way that cultivates collaboration or coordination between the plans and MA stakeholders. The condensed time period and numerous steps between the initial release of the MA draft rate notice to the approved MA plan product go-live period leaves little time to develop meaningful benefit designs and partnerships with community-based organizations. MA plan case managers and care coordinators and hospital and skilled nursing facility discharge planners are key players in successful plan implementation, and they also need appropriate time and support to learn about, and ultimately work to coordinate, the various social determinant of health benefit offerings that are available for the seniors they care for.

- **Question 4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?**

Social determinants that impact health are local and reflective of the communities in which individuals reside. Senior nutrition services providers – many of whom have been operating within their communities for decades – could be further leveraged to scale the existing infrastructure and provide food- and nutrition-related benefits, as well as other services they directly provide or could refer to more individuals. Greater contracting between community-based nutrition providers and the healthcare sector will result in reduced health care spending and provide cost-effective and equitable monitoring of health in non-medical settings, such as the home. This is a step that CMS could and should encourage.

Additionally, we urge the ongoing participation and involvement of senior nutrition providers as important stakeholders that should be consulted in the planning, implementation and evaluation of the nutrition-related benefits and activities that are carried out under the Medicare Advantage program.

Thank you again for the opportunity to submit comments for this important RFI and for your consideration. The goals, objectives and proposed questions within this RFI build upon a growing foundation and will help provide direction to greatly improve the delivery, accessibility and affordability of healthcare services for older individuals through all Medicare programs. We look forward to continuing to work together toward that end. Please do not hesitate to reach out with questions; we are happy to serve as an ongoing resource.

Sincerely,

Ellie Hollander
President and CEO

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