January 26, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013 Baltimore, MD 21244

Submitted via regulations.gov

Re: ATA Action Response to Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P)

On behalf of ATA Action, the American Telemedicine Association's affiliated trade organization, we appreciate the opportunity to submit comments in response to this year's Medicare Advantage (MA) proposed rule. We commend CMS for providing MA plans with broad flexibility to integrate telehealth and digital health into their offerings.

Below, we outline specific recommendations to enhance the MA program's access, quality, and support for all enrollees.

Telehealth Network Adequacy Credit

CMS currently allows Medicare Advantage plans to receive a network adequacy credit when they include telehealth-capable providers in their network for certain specialties. This credit assists plans in meeting network adequacy requirements, ensuring that enrollees have reasonable access to needed care. Plans can receive up to a 10-percentage-point credit toward network adequacy calculations when contracting with eligible telehealth providers.

ATA Action strongly supports this telehealth credit and urges CMS to continue expanding it. As the nation faces ongoing practitioner and specialty shortages, telehealth represents a vital tool for improving access to care. We encourage CMS to continue identifying ways to integrate digital care into the Medicare Advantage program, thereby enhancing access, affordability, and patient choice.

Ensure Appropriate Access to Innovative Medicines

As CMS considers future policies and incentives to incorporate well-being and nutrition into the MA program, it is important that access to evidence-based therapies that have demonstrated meaningful improvements in health outcomes remain in place. Taken together, these comprehensive policies have the potential to transform function and quality of life for millions of Medicare patients and better position MA organizations to manage their long-term financial risk.

This would be a stark shift from what we see today, where cost-containment tools—such as restrictive utilization management and/or reimbursement that fail to reflect the long-term value of effective therapies—and coverage of low-value interventions that lack proven effectiveness prevail.

To ensure Medicare Advantage beneficiaries can access appropriate digital therapeutic tools that support well-being and whole-person care, CMS should issue HPMS guidance clarifying the circumstances under which MA organizations (MAOs) may furnish prescription digital therapeutics (PDTs) as supplemental benefits.

CMS's establishment of coverage pathways for certain digital mental health treatment (DMHT) services in the CY 2025 Medicare Physician Fee Schedule (PFS) Final Rule—where DMHT devices and related services were finalized as Medicare-covered when furnished incident to professional behavioral health services—provides an important example of digital tools that fall within an existing Medicare benefit category.

At the same time, many PDTs do not fall within any Medicare benefit category and thus remain non-covered and eligible for supplemental benefit coverage under the longstanding statutory and regulatory framework, which permits MAOs to offer supplemental benefits only when the item or service is not a Medicare-covered benefit.

To support consistent and appropriate plan adoption of PDTs, we urge CMS to provide clear guidance both affirming MAOs' ability to cover PDTs that fall outside any Medicare benefit category and clarifying how to distinguish Medicare-covered DMHT services from other PDTs that remain non-covered. Offering this clarification would not expand MA authority, but it would reduce operational uncertainty, promote integration of evidence-based digital tools, and improve access to interventions that support sleep health, behavioral health, chronic condition management, and overall beneficiary well-being.

Risk Adjustment

The Hierarchical Condition Category (HCC) adjustment model determines how much Medicare Advantage plans are paid for each patient. ATA Action recommends that CMS update the HCC risk adjustment model to include codes for malnutrition (E43–E46) and food insecurity (Z59.41), including care delivered virtually or with remote support. Updating the model in this way will ensure that plan payments reflect the additional care required by populations at nutritional risk. Additionally, providing separate coding and payment for foodcare services ensures that plans are reimbursed for high-acuity interventions, whether delivered in person or virtually.

Quality Bonus Payments

We applaud CMS' efforts to simplify and refocus the measure set on clinical care, outcomes, and patient experience of care measures and appreciate the opportunity to provide feedback on modifying the Star Ratings methodology to further incentivize quality improvement and suggesting new outcomes measures to promote prevention and wellness more aligned with MAHA efforts related to healthy aging, such as nutrition and patient well-being.

ATA Action proposes the following:

- **Enhance Measures Beyond Process-Based Metrics:** To enhance the Medicare Part C Star Ratings for Medical Nutrition Therapy (MNT), Nutrition Interventions, and Food as Medicine (FAM), new measures should move beyond existing process-based metrics. Current Star Ratings primarily use nutrition as a secondary (indirect) driver for intermediate outcomes (like HbA1C control)

rather than measuring nutrition care directly. The table below provides an example of shifting from indirect to direct quality measures related to nutrition care.

Category	Current Star Measures (Indirect)	Proposed New Measures (Direct)
Diabetes	A1c Control (<9.0%)	Medical Nutrition Therapy (MNT) Referral & Completion Rate
Social Needs	SNS-E (Screening only)	Food Insecurity Intervention/Resolution
General Health	BMI Assessment	Nutritious Food Benefit Engagement (virtual or in-person)
Acute Care	Readmission Rates	Post-Discharge Malnutrition Care, including virtual follow up

- **Introduce a Nutrition-Adjusted Quality Bonus:** ATA Action suggests adding a "Nutrition-Adjusted Quality Bonus" within the Star Rating Outcome Domain that will drive plan behavior toward high-value interventions. For example, plans that demonstrate measurable reductions in HbA1c or Blood Pressure levels through documented MNT and FAM interventions should receive a specific weighting bonus. This may include assigning a higher weight to "Outcome Domain" measures where clinical improvement (HbA1c < 7.0 or BP < 130/80) is documented in conjunction with MNT visits. In addition, CMS could categorize foodcare related digital health tools/apps and beneficiary incentives as "Activities that Improve Health Care Quality" in the medical loss ratio numerator (42 CFR § 422.2430).
- **Advance Outcome-Based Care and Reimbursement:** CMS should additionally consider expanding reimbursement opportunities for documented clinical outcomes—such as sustained weight loss or blood pressure control—linked to chronic disease management programs, especially those that do not fully integrate value-based care. This is similar to reimbursable coding for outcomes in the Diabetes Prevention Program.

Well-Being and Nutrition

The MA program offers a unique opportunity to bring high-value interventions designed to support overall well-being and nutrition to patients. To the extent that MA organizations are bearing financial risk related to the long-term health outcomes of the populations they serve, they have an inherent incentive to support interventions that promote health over the long term by avoiding the high costs associated with chronic conditions. Integrating comprehensive access to foodcare adds evidence-based lifestyle, nutrition, digital health tools, and outcome-based incentives into chronic disease payment policy that will improve health outcomes, reduce complications, and drive down long-term Medicare spending.

Foodcare integration recommendations include the following:

- **Allow Comprehensive, Non-Referral-Based MNT:**

ATA Action strongly supports the Medical Nutrition Therapy (MNT) Act (H.R.6199). We urge CMS to align with the goals of the bipartisan legislation by expanding MNT coverage to all chronic conditions without physician referral requirements. MNT benefit limitations should follow national standards for its respective scope of service, allowing for up to four visits per year Registered Dietitian (RD) with the ability to utilize prior authorization for additional visits as determined medically necessary based on the beneficiary's medical condition. In addition, CMS should add RDs as furnishing providers for intensive behavioral therapy for obesity.

- **Ensure Reimbursement for Evidence-Based Digital Tools and Telehealth:**

Reimbursement for evidence-based digital health tools and allowing telehealth as a modality should be included in foodcare benefits to support nutrition care plan adherence and access to care, particularly for those with mobility issues, transportation barriers, or living in rural areas. MNT should be explicitly permitted via synchronous and asynchronous digital platforms to ensure equitable access for rural and mobility-impaired enrollees. In addition, Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring RTM) in foodcare—such as smart scales, glucose monitors, clinical nutritional coaching apps should be reimbursable to expand their use. MA plans could also be rewarded for using digital health tools that export "nutrition data" directly into the patient's Electronic Health Record (EHR) to ensure physician-RD coordination.

- **Leverage Community Health Workers:**

Community Health Workers (CHWs) serve as trusted liaisons between patients and the health care system, providing less costly education and support, and care coordination that addresses barriers to care and supports patient engagement in their health. Evidence shows that integrating these providers into care management teams leads to better management of chronic conditions. CPT code 98960 is typically utilized for CHW services and should also be made permanent on the Medicare Telehealth Services List as recommended above.

- **Coverage for Medically Tailored Foods:**

Access to medically appropriate nutrition plays a crucial role in sustainably improving health outcomes, especially for individuals with chronic illnesses, recent hospitalizations, high-risk pregnancy, or malnutrition. Medically tailored foods (i.e., medically tailored meals, prescription produce, and medically tailored groceries) support nutrition care plan adherence, improving medication effectiveness, improving glycemic control, and reducing hospital readmission.

CMS should establish separate coding and payment for medically tailored foods (MTFs), particularly when integrated with medical nutrition therapy, digital health tools for supporting care plan adoption and adherence, and food benefits management, ensuring virtual modalities. In January 2025, Coding4Food stakeholders submitted HCPCS Modification Applications to request separate coding definitions for MTMs, Produce Prescriptions, Medically Tailored Groceries, and Healthy Groceries. ATA Action requests that those applications be reviewed and approved.

In the absence of that approval, we recommend an inclusive coding definition for MTFs such as:

"The provision of medically tailored meals, prescription produce, and medically tailored groceries; coordination with a registered dietitian or other clinician; and preparation and delivery of meals aligned with a patient's chronic condition and care plan."

To maintain program integrity for this service, CMS could:

- Require documentation of clinical indication and duration of need within the nutrition care plan.
- Mandate that meals meet evidence-based nutritional standards aligned with the patient's condition and nutritional needs.
- Encourage or require participation in quality reporting, such as delivery verification, dietary adherence, and patient satisfaction surveys.
- Allow use of digital health tools reporting and tracking platforms to provide visibility into service delivery and outcomes. Adherence.
- Deploy Food Benefits Management that may include rules and algorithms that help payers personalize the application of the right amount of payer-fund MTF subsidy to optimize health impact and sustained return on investment.

ATA Action appreciates the opportunity to provide feedback on the 2027 MA proposed rule. Telehealth and digital health tools are essential for expanding access, improving outcomes, and supporting patient well-being. By continuing to expand telehealth credits, modernizing risk adjustment, incentivizing nutrition and wellness outcomes, and integrating virtual care solutions, CMS can help ensure the Medicare Advantage program remains forward-thinking, inclusive, and high value.

If you have any questions, please reach out to Alexis Apple (aapple@ataaction.org).

Kind regards,

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