



## **Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program**

The Physicians Foundation appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Contract Year (CY) 2027 Medicare Advantage (MA) proposed rule, specifically the agency's Request for Information (RFI) on future directions in the MA program related to well-being and nutrition policy changes.

The Physicians Foundation is directed by the physicians and chief executives of many state and county medical societies, which are the voices of hundreds of thousands of physicians across the country, from pediatrics, primary care, and a breadth of medical specialties. For over 15 years, the Physicians Foundation has provided physicians with evidence-based research and tools to connect patients with healthy food and other lifestyle interventions that prevent and/or reverse chronic disease.

We commend CMS for recognizing that the MA program offers a unique opportunity to bring high-value interventions – particularly those that support whole-person well-being and optimal nutrition – to beneficiaries.

Currently, outdated CMS regulations block patients' access to healthy food benefits because they are *not* considered "primarily health related." As a result, MA plans can offer these benefits only through Special Supplemental Benefits for the Chronically Ill (SSBCI) – which MA members can only access *after* their health has deteriorated and plans have documented their use of expensive health care.

This fundamentally reactive and wasteful approach systematically delays access to nutrition interventions that could (1) improve health earlier, (2) drive patient participation in preventive care, and (3) avoid wasted taxpayer dollars.

A growing number of stakeholders – including front-line physicians, MA plans, and healthy food champions – have called for CMS to act. In October, the House Make America Healthy Again (MAHA) Caucus urged CMS to strengthen patients' access to healthy and nutritious food to prevent and manage chronic disease under MA. Specifically, it called on CMS to "*eliminate this bureaucratic hurdle by specifying that supplemental benefits addressing access to healthy food meet the criteria to be 'primarily health related' – and (like all such benefits) can be offered only if appropriate and medically necessary.*"<sup>i</sup>

**We physicians urge CMS to take immediate action to issue guidance recognizing that healthy and nutritious food supplemental benefits are primarily health-related and imposing meaningful guardrails on these benefits.** This approach requires no new dollars but rather prioritizes spending existing MA rebate dollars on MAHA-aligned high-value benefits over more questionable ones.

### **SSBCI is Not Working, Makes it Hard for Patients to Stay Healthy, and is Anti-MAHA**

In its RFI, CMS has recognized the important role of MA plans in ensuring individuals receive the "necessary nutrients for maintaining health, growth, and overall well-being and support beneficiaries seeking to improve their nutritional habits." Indeed, it is well-documented that high-risk patients with access to healthy food have better health outcomes,<sup>ii,iii</sup> use less healthcare,<sup>iv</sup> and save the healthcare system money.<sup>v</sup>



Currently, the only way for MA plans to cover nutritious food for chronically ill patients is SSBCI – but SSBCI is inefficient and broken. To qualify for SSBCI, MA enrollees must meet a complicated three-part statutorily defined test for “chronically ill” including: (1) have one or more complex chronic conditions; (2) be at high risk of hospitalization or other adverse outcomes; and (3) require intensive care coordination.

In practice, this definition of “chronically ill” basically *requires* government waste: Even patients diagnosed with a CMS-approved chronic condition *still* can’t access nutritious food benefits until their MA plan proves they’ve had expensive hospitalizations, reinforcing a reactive – not preventative – model of care.

**This is the antithesis of MAHA’s commitment to addressing chronic disease and CMS’s focus on prevention and combatting government waste and bureaucracy.** It frustrates physicians,<sup>vi</sup> infuriates patients, and buries plans in red tape.<sup>vii</sup> It creates enormous documentation burdens and delays in care, while providing no meaningful guardrails on the quality or value of supplemental benefits provided once patients clear this test.

### **Recommendation: Secure A Major MAHA Win by Recognizing That Healthy Food Is “Primarily Health Related” and Adding Meaningful Guardrails**

It is important that CMS take immediate action to address the inefficiencies created by SSBCI. In doing so, it can avoid wasteful taxpayer expenditures on unnecessary hospitalizations and instead prioritize spending *existing* MA rebate dollars on MAHA-aligned high-value benefits, like healthy food. This requires no change to the statutory definition of SSBCI or any additional rulemaking.

**Rather, CMS should act now to issue clarifying guidance recognizing nutritious food supplemental benefits as primarily health related via a Health Plan Management System (HPMS) memo.** This approach would enable MA plans to leverage uniformity flexibility to target members with diet sensitive conditions like diabetes, obesity, and heart disease, but with less bureaucratic hoops and delays than SSBCI. Consistent with CMS’s request for draft deregulatory language in its Medicare Regulatory Relief RFI,<sup>viii</sup> the following sample guidance language could be used in the HPMS memo:

*“CMS is issuing updated guidance specifying that supplemental benefits addressing access to healthy food meet the criteria to be “primarily health related”<sup>ix</sup> and, like all such benefits, **can be offered if medically necessary<sup>x</sup> and approved by CMS.** Specifically, CMS is building on the non-exhaustive list of allowable supplemental benefits<sup>xi</sup> it issued in 2018 after its reinterpretation of the definition of “primarily health related” and providing additional and non-exhaustive examples of allowable nutrition-related supplemental benefits, including:*

- **Healthy Food and Produce:** Food and produce to assist enrollees in meeting nutritional needs may be covered as a primarily health-related supplemental benefit. Tobacco and alcohol are not permitted. Additionally, CMS is applying the same restrictions on purchase of soft drinks and candy as included in recent Supplemental Nutrition Assistance Program (SNAP) waivers.<sup>xii</sup>
- **Meals (beyond a limited basis):** Meals may be covered as a primarily health related supplemental benefit if the meals are: 1) needed due to an illness; 2) consistent with established medical treatment of the illness. Meals may be home delivered and/or offered in a congregate setting.”



**Additionally, this guidance provides CMS with an important opportunity to implement meaningful guardrails aligned with other bold MAHA efforts across the government.** Currently, when an MA plan decides to offer a food benefit under SSBCI, there are no well-defined guardrails on the type of foods that can be offered. CMS guidance only prohibits tobacco, alcohol, “non-healthy food” (defined as “food that does not assist in meeting the nutritional needs of a chronically ill enrollee”<sup>xiii</sup>), and cannabis (as described in CY 2027 MA Proposed Rule). CMS could dial this to provide optimal nutrition and better deliver value to patients and taxpayers by dictating specific guardrails and federal standards/guidelines for the benefits to be classified as “primarily health related.”

To ensure maximal health impact and avoid fraud, waste, and abuse, CMS could require or incentivize plans to implement restrictions to only allow certain categories of food (based on SKU codes). For example, it could require that nutritious food supplemental benefits provided via restricted use cards align with existing food categories defined by other federal programs (e.g., SNAP MAHA Waivers) and/or require adherence to existing accreditation standards for medically-tailored meals<sup>xiv</sup> or produce prescriptions.<sup>xv</sup> **CMS could also leverage these guardrails to immediately activate the U.S. Department of Health and Human Services’ newly released *Dietary Guidelines for Americans*<sup>xvi</sup> at scale with the 34 million enrollees in MA.** This approach not only addresses fraud, waste, and abuse concerns, it modernizes CMS’s oversight of nutrition benefits, incentivizes participation in preventive care, and invites innovation through private-sector partnerships. In doing so, CMS would proactively leverage *existing* rebate dollars to put nutrition-focused supplemental benefits to work as a tool to prevent or mitigate chronic illness among millions of older and dually-eligible Americans – *before* their health further deteriorates and yet more healthcare dollars are wasted.

### **SSBCI and Other Federal Programs Are Not Adequate to Address the Chronic Disease Crisis**

Recognizing that nutritious food supplemental benefits are “primarily health related” supports CMS and MA plans’ use of these benefits as an important tool to enable high-risk patients to make healthy lifestyle choices – especially given that almost 9 in 10 (88%) MA members have at least one chronic condition, and more than 7 in 10 (72%) have 3 or more chronic conditions.<sup>xvii</sup>

Recognizing the crucial role that access to nutritious food plays in supporting beneficiaries to improve their nutritional habits, many MA plans, particularly D-SNPs, relied heavily on CMS’s Value-Based Insurance Design (VBID) model to provide food-related supplemental benefits to high-risk patients.<sup>xviii</sup> In 2025, a remarkable 85% of D-SNPs chose to offer food and produce benefits and 55% offered meals (beyond a limited basis) as part of their VBID benefit offerings – rather as an SSBCI – reflecting plans’ frustration with the waste and red tape associated with SSBCI.<sup>xix</sup>

CMS’s own evaluation underscores the extent to which SSBCI’s complexity has frustrated MA plans and beneficiaries and discouraged plans from using this pathway to provide high-value nutritious food supplemental benefits that support healthy lifestyle choices.<sup>xx</sup> In interviews, plan representatives consistently emphasized that SSBCI’s restrictive eligibility rules created confusion for plans and enrollees:

*We can’t just say to people, “When you enroll, we know you have diabetes. We’re going to give you this food benefit.” We have to say, “You may qualify,” and then we have to individually qualify the members. So, it’s a lot more administratively complex for us, and members don’t like it. Like, “What do you mean you can’t guarantee me I’m going to get it?” Like, “Well, how will you know?” And it’s just very hard to answer those questions.”*



Another plan highlighted the dramatic difference in reaching chronically ill patients under SSBCI:

*What VBID allowed us to do for 2023 is convert our grocery card from an SSBCI, which really only got [sic] to somewhere probably **less than 10% of the population** for the plans they were filed in. The VBID program allowed us to expand the number of members that we could reach... significantly.*

CMS’s decision to sunset VBID at the end of 2025 leaves SSBCI as the only remaining pathway for MA plans to provide important nutrition-related benefits – despite its well-documented implementation challenges that make it difficult for chronically ill patients to access medically necessary nutrition.

Other federal nutrition programs are not adequate or available to tackle the chronic disease crisis among MA members. Only 14% of Medicare members (in both Traditional Medicare and MA) are enrolled in USDA’s SNAP program.<sup>xxi</sup> SNAP is not designed to treat chronic disease, as it is based on income eligibility – unlike MA supplemental benefits, which are not an entitlement program and require medical necessity.<sup>xxii</sup> Other USDA programs such as the Gus Schumacher Nutrition Incentive Program are tied to SNAP eligibility and therefore also reach few Medicare beneficiaries. Finally, the Medicare population is not eligible for WIC, School Lunch, Breakfast, and Summer Programs, the Fresh Fruit and Vegetable Program, or the Special Milk Program.

## Conclusion

Through this Proposed Rule, CMS is boldly seeking “*policies that achieve optimal nutrition and improve preventive care in MA.*” **We call on CMS to recognize that healthy and nutritious food supplemental benefits are primarily health-related and to implement meaningful guardrails to maximize their value to patients and taxpayers. In doing so, CMS would achieve one of the most significant MAHA wins to date** – and possibly the greatest single step in fighting chronic disease through nutrition and preventive care in decades.

Physicians know that when our patients can’t access healthy food, it accelerates chronic disease. Our recent survey of front-line physicians found that 79% report that a patient’s inability to access healthy food directly interfered with chronic disease management in the past year.<sup>xxiii</sup> Empowering physicians and patients to prevent and reverse chronic disease through diet is the foundation for reversing our country’s chronic disease epidemic that burdens physicians, wastes trillions of dollars, and threatens national security and economic growth. Action is overdue.

---

<sup>i</sup> Rep. Lloyd Smucker. [Congressional MAHA Caucus Urging Improved Access to FIM](#). October 2025.

<sup>ii</sup> Wu, A., et al. [Plant-Based Family Food Packages and Weight Change in Children During the COVID-19 Pandemic](#). June 2023

<sup>iii</sup> Hager, et al. [Impact of Produce Prescriptions on Diet, Food Security, and Cardiometabolic Health Outcomes: A Multisite Evaluation of 9 Produce Prescription Programs in the United States](#). Circulation: Cardiovascular Quality and Outcomes. August 2023

- 
- iv Berkowitz S., et al. [Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries.](#) Health Affairs. April 2018
- v Ibid.
- vi The Physicians Foundation. [Request for Information \(RFI\): Ensuring Lawful Regulation and Unleashing Innovation To Make American Healthy Again – Public Comment.](#) May 2025.
- vii RAND Health Care. [Evaluation of the Medicare Advantage Value-Based Insurance Design Model Test: 2020 to 2023.](#) March 2025.
- viii Centers for Medicare & Medicaid Services. [Unleashing Prosperity Through Deregulation of the Medicare Program \(Executive Order 14192\)- Request for Information.](#) 2025.
- ix Centers for Medicare & Medicaid Services. [Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections.](#) April 2016.
- x Ibid.
- xi Centers for Medicare & Medicaid Services. [Memorandum: Reinterpretation of “Primarily Health Related” for Supplemental Benefits.](#) April 2018.
- xii U.S. Department of Agriculture. [SNAP Food Restriction Waivers.](#) August 2025.
- xiii Centers for Medicare & Medicaid Services. [Medicare and Medicaid Programs: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program.](#) Federal Register. April 2025.
- xiv Food is Medicine Coalition. [Medically Tailored Meal Intervention Accreditation Criteria and Requirements.](#) March 2024.
- xv Gretchen Swanson Center for Nutrition. [GusNIP Nutrition Incentive and Produce Prescription Project Eligible Fruits and Vegetables.](#) N.d.
- xvi U.S. Department of Health and Human Services; U.S. Department of Agriculture. [Dietary Guidelines for Americans.](#) January 2026.
- xvii Jacobson G, Cicchiello A, Sutton J, Shah A. [Medicare Advantage vs. traditional Medicare: how do beneficiaries’ characteristics and experiences differ?](#) Washington, DC: The Commonwealth Fund. October 2021.
- xviii Milliman. [State of the 2025 Medicare Advantage industry: Dual-eligible plan valuation and selected benefit offerings.](#) December 2024.
- xix Centers for Medicare & Medicaid Services. [Analysis of 2025 PBP Benefits.](#) October 2024.
- xx Centers for Medicare & Medicaid Services. [Evaluation of the MA Value-Based Insurance Design Model Test: 2020 to 2023.](#) March 2025.
- xxi KFF. [The Implications of Federal SNAP Spending Cuts on Individuals with Medicaid, Medicare and Other Health Coverage.](#) June 2025.
- xxii Food and Nutrition Act of 2008. 7 U.S.C. § 2011
- xxiii The Physicians Foundation. [Physicians Report Impact of Food Insecurity on Patient Health and Chronic Disease Management.](#) June 2025.

Respectfully submitted,

Gary Price, MD, MBA, FACS  
President, The Physicians Foundation