AFIMA-CMMI Meeting: Major Takeaways and Next Steps

July 31, 2026, Consultation with Sarah Downer, CMMI/CMS

Bottom Line

- **CMMI will not provide AFIMA a step-by-step roadmap.** AFIMA should return with its own technically detailed demonstration proposal and ask CMMI to critique and refine it.
- **Better clinical outcomes are not enough.** The model must identify eligible beneficiaries in CMS data, define exactly what is delivered and at what cost, use credible comparison groups, and show a plausible path to net federal savings after program costs.
- **The meeting was constructive.** Sarah Downer was supportive of the concept, but emphasized that CMMI actuarial, evaluation, and model-design staff will expect rigorous evidence and a design that can be replicated and scaled nationally.

Core CMMI Design Requirements

- **Use a claims-visible target population.** Eligibility should be identifiable through Medicare or Medicaid claims/encounter data, such as diabetes plus recent hospitalization or emergency department use, repeated diabetes-related encounters, intensive medication use, complications, or persistently high spending.
- **Define the AFIM intervention precisely.** The proposal should specify food type and quantity, frequency, duration, nutritional standards, intervention tiers, education/cooking support, monitoring, technology, provider/vendor responsibilities, and the cost of each component.
- **Build a full federal savings model.** CMMI will want baseline annual spending, intervention cost, expected enrollment, completion and attrition, utilization changes across hospital/ED/physician/drug services, gross savings, net savings, sensitivity analyses, break-even points, and expected savings if expanded.
- **Solve the selection-bias problem.** AFIM participants are likely to be motivated volunteers. CMMI will ask whether they would have improved without the intervention, so the comparison group must resemble participants clinically and in willingness to participate.
- **Use a credible control-group design.** Potential approaches include random assignment among willing participants, waitlist controls, phased implementation, matched willing controls, propensity/claims matching, or a stepped-wedge design.
- **Treat evaluation staff as essential partners.** Sarah indicated that CMMI evaluation staff could participate in the next discussion to assess whether AFIMA's comparison-group and evaluation structure is sufficiently rigorous.
- **Traditional Medicare is the simplest starting point.** A Medicare-first demonstration would be easier for CMMI to evaluate and administer. Medicaid can remain a second-stage or parallel track but would require CMS Medicaid officials, states, managed care organizations, and potentially waiver authorities.

Recommended Initial Demonstration

- **Start narrow rather than proposing multiple conditions at once.** The strongest first model is one clearly defined population receiving one standardized intervention, with additional populations added later.
- **Potential starting model:** a 12-month, claims-targeted AFIM intervention for high-risk traditional Medicare beneficiaries with type 2 diabetes, using randomization, a waitlist, or phased implementation among beneficiaries who voluntarily agree to participate.
- **Do not rely on A1C unless CMS can access it reliably and promptly.** If laboratory data are incomplete, AFIMA should use a claims-based proxy for elevated diabetes risk.

Immediate AFIMA Action Plan

- **1. Commission the actuarial and evaluation framework.** Develop a reproducible methodology for baseline costs, program costs, enrollment/completion assumptions, utilization changes, gross and net savings, sensitivity analyses, break-even points, and savings at scale.
- **2. Form a small technical working group.** Include an actuary, health economist, program evaluator, Medicare claims expert, Medicaid data expert, experienced AFIM operators, a practicing physician, food/agriculture representation, and AFIMA policy leadership.
- **3. Standardize the intervention.** Create an AFIMA intervention manual covering food benefit, duration, nutrition standards, referral/eligibility, education, cooking support, care coordination, monitoring, technology, provider/vendor responsibilities, and component costs.
- **4. Inventory AFIMA's existing evidence.** Collect standardized data from participating programs on population characteristics, enrollment/completion, clinical outcomes, hospital/ED use, total cost of care, drug utilization, intervention cost, engagement, durability of benefits, comparison methods, and CMS-replicable claims measures.
- **5. Develop the control-group proposal before returning to CMMI.** The central design question is how to compare AFIM participants with similarly motivated individuals who do not initially receive the intervention.
- **6. Prepare a formal technical concept package.** Recommended materials: a 10–15-page concept paper, actuarial appendix, one-page model diagram, proposed control-group design, standardized intervention table, evidence summary, and five to ten specific technical questions for CMMI.
- **7. Request a technical design meeting—not another general policy briefing.** Ask Sarah to include CMMI evaluation, actuarial/financial, model-design, Traditional Medicare, and—if relevant—Medicaid and nutrition/population-health staff.
- **8. Ask CMMI to identify fatal flaws.** Key questions should address whether CMS can identify the population in claims, whether the control group is credible, what additional data are needed, whether Medicare is the right initial payer, what cost assumptions are missing, what outcomes are sufficient, and what could prevent actuarial certification.

Success Test

- **AFIMA must be able to show that CMMI can:** identify the right beneficiaries; deliver a standardized and replicable intervention; separate program effects from participant motivation; measure outcomes against credible controls; calculate net federal savings; and scale the model without losing clinical or financial impact.
- **Highest-priority next move:** commission the claims-based actuarial and evaluation framework and use it as the foundation for the next technical meeting with Sarah Downer and the appropriate CMMI/CMS teams.