

Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

January 26, 2016

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Senators:

The Food Is Medicine Coalition (FIMC) commends the Senate Finance Committee's Bipartisan Chronic Care Working Group for highlighting the needs of individuals living with chronic diseases through their Policy Options Document (referred to hereafter as Policy Options). FIMC respectfully submits the following comments on the same.

BACKGROUND

Nutrition Plays a Vital Role in the Management of Chronic Disease

While adequate food and nutrition are essential to maintaining health for all persons, good nutrition is especially critical for the management of chronic illness. Proper nutrition is needed to increase absorption of medications, reduce side effects, and maintain healthy body weight. Good nutrition reduces the risk of or helps manage some of the most costly chronic diseases to treat: heart disease, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), HIV/AIDS and, in most cases, cancer. Food and nutrition service providers can therefore serve a key role in supporting clients throughout the trajectory of their illness, from diagnosis through treatment and maintenance.

Food security and good nutrition are linked to improved health outcomes both directly and indirectly. Poor nutritional status, including both under-nutrition and over-nutrition, can affect immune function.^{i, ii, iii} Food insecurity is a source of chronic stress that has consequences for mental health, is associated with poorer adherence to medical treatments^{iv} and also reduced control of chronic conditions such as diabetes.^v Without proper nutrition, patients may encounter food-drug interactions that can prevent medications from working effectively, or which can cause or enhance medication side effects.^{vi} Poor nutritional status can also impact immune function.^{vii}

Malnutrition can play a particularly significant role for patients who require hospitalization. Roughly one in three people in the U.S. admitted to the hospital is malnourished.^{viii} Studies show that once admitted, nutritionally compromised patients have longer hospital stays,^{ix} higher costs of hospitalization,^x and are almost twice as likely as nourished patients to be readmitted within fifteen days.^{xi} In fact, for Medicare recipients suffering from common conditions such as heart failure, pneumonia, and COPD, nutrition-related diagnosis-related groups (DRGs) are among the top ten causes of readmission.^{xii}

Medically Tailored Home-Delivered Meals Improve Health Outcomes and Reduce Costs for Individuals with Chronic Disease

Providing food and nutrition services (FNS) is a cost-effective way to improve health outcomes for patients with the greatest health needs. FNS facilitates engagement with medical care especially among vulnerable populations and dramatically reduces the cost of care for the highest-risk, highest need populations: the 5% of patients that cost 50% of our national health care budget.^{xiii} This complicated population, with multiple co-morbidities, requires more intensive treatment. Medical nutrition therapy (MNT), which covers nutritional diagnostic therapy and counseling services focused on prevention, delay or management of diseases and conditions by a licensed Registered Dietitian Nutritionist (RDN) outside

of a primary care visit, is often necessary. Along with MNT, these individuals need home-delivered meals that are medically tailored by the RDN to the special needs of the individuals served, as this population often struggles to eat meals from traditional senior meal or other food providers or needs more tailored nutrition to address their medical circumstances; they may need meals pureed or minced or have other dietary modifications depending upon their illness and medications. Medically tailored meals are customized to address a wide range of medical conditions and dietary restrictions, including inability to swallow, risk of renal failure, medication side effects, and even common food allergies.

The return on investment for medically tailored meals is clear. A recent pilot study showed a 28% drop (from \$38,937 to \$28,183) in average monthly health care costs for patients battling life-threatening illness who received medically tailored meals and medical nutrition therapy (MNT).^{xiv} When compared to similar patients who did not receive these services, study participants also experienced 50% fewer hospital admissions^{xv} and were 23% more likely to be discharged to their homes rather than another facility.^{xvi} Investing in interventions that respond to complicated health needs, while reducing costly interventions, makes good business sense.^{xvii}

Current Medicare Coverage of High-Impact FNS is Nonexistent or Extremely Limited Despite Evidence that Shows Them to be a Key Component of Cost-Effective Health Care

Medicare covers MNT very narrowly under its Part B services: only for people with non-dialysis kidney disease, diabetes, or who suffer from obesity, and those who have had a kidney transplant. All must first receive a referral from a doctor or health care provider.^{xviii}

Medicare Parts A and B do not cover home-delivered meals.^{xix} However, under Medicare Part C, Medicare Advantage (MA) plans can offer nutritional counseling to a broader array of beneficiaries by offering these services as a supplemental benefit.^{xx} MA plans may similarly provide coverage of home-delivered meals as a supplemental benefit under specific circumstances. In particular, MA plans may cover home-delivered meals “if the service is: 1) needed due to an illness; 2) consistent with established medical treatment of the illness; and 3) offered for a short duration.”^{xxi} There are two specific circumstances under which MA plans can cover meals if the above criteria are met. First, meals may be offered to individuals immediately following surgery or an inpatient hospital stay, as long as the meals are only provided for a temporary period, and are ordered by a physician or non-physician practitioner. Second, meals may be covered for individuals with chronic conditions like hypertension or diabetes, if such meals are ordered by a physician or non-physician practitioner, are provided for short period of time, and are part of a program intended to “transition the enrollee to lifestyle modifications.”^{xxii}

Additional areas of existing availability for home-delivered meals are within Medicare Advantage Special Needs Plans (SNPs) for members who are dually eligible for Medicare and Medicaid (D-SNPs).^{xxiii} D-SNPs that participate in a particular Benefits Flexibility Initiative can choose to offer home-delivered meals at no additional cost to enrollees, and without the restrictions imposed on regular MA plans.^{xxiv} SNPs are not available in every area, and states vary with regard to the types of SNPs that may be available.

RECOMMENDATIONS

We recommend that the following amendments be added to or modified in Policy Options to improve the clinical outcomes of malnourished and nutritionally at-risk chronically ill Medicare beneficiaries:

I. Allowing End Stage Renal Disease (ESRD) Beneficiaries to Choose a Medicare Advantage Plan (pp 9)

- We fully support allowing ESRD beneficiaries to choose a Medicare Advantage Plan. Specifically and in addition, we recommend allowing access to medical nutrition therapy (MNT) and medically tailored home-delivered meals (MTHDM) for all beneficiaries with Chronic Kidney Disease (CKD). Access to food and nutrition services and MNT is critical to the management of CKD. There are 5 stages of CKD: CKD stage 5 is also known as End Stage Renal Disease (ESRD). Typically, patients with ESRD have 10-15% kidney function.
- MNT slows time to dialysis and improves nutrition markers in CKD.^{xxv} Currently, MNT reimbursement through Medicare only begins at CKD stage 3. We recommend that MNT instead be reimbursed for patients at all stages of CKD.
- Access to medically appropriate food and nutrition helps CKD patients manage hypertension, edema from sodium and fluid retention, anemia, and dyslipidemia; improve bone health by ensuring adequate calcium and vitamin D; adjust electrolytes; prevent catabolism and eventual malnutrition from inadequate PO; control blood glucose; and prevent nutrient deficiency, especially of protein and water soluble vitamins due to losses in dialysis.^{xxvi}
- Access to MNT and food for CKD patients results in tremendous cost savings. The Academy of Nutrition and Dietetics summarizes cost savings in this way: “When combined with the additional costs of treating CKD, ESRD and CKD consume nearly 25 percent of the Medicare budget.^{xxvii} The annual mean expenditure for an ESRD patient treated with dialysis and transplant is \$70,000 per patient,^{xxviii} whereas Medicare costs for CKD patients in 2012 totaled \$20,162 per patient.^{xxix, xxx} Thus, it is a prudent investment to identify and encourage clinically effective and cost-effective strategies, such as MNT, for delaying dialysis and treating CKD.”^{xxxi}
- For both cost savings and quality of life reasons, the MNT and MTHDM benefits should be made available to all Medicare beneficiaries with CKD.

II. Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (pp 10)

- We fully support either the long term extension or permanent authorization of all SNPs: SNPs that enroll beneficiaries in need of institutional level of care (I-SNPs), SNPs that enroll beneficiaries eligible for both Medicare and Medicaid (D-SNPs), and SNPs that enroll beneficiaries with certain chronic diseases (C-SNPs). As noted above, only the D-SNPs currently cover MNT and MTHDM, and may be able to provide home-delivered meals without the restrictions imposed on regular MA plans.^{xxxii}
- We recommend that all SNPs targeting individuals with chronic illnesses include the flexibility to provide home-delivered meals upon a provider’s referral. The Benefits Flexibility Initiative, mentioned above, should be expanded to I-SNPs and C-SNPs.
- The Centers for Medicare and Medicaid Services (CMS) should also provide guidance to state Medicaid programs on covering these services in waiver programs and through State Plan Amendments.

III. Improving Care Management Services for Individuals with Multiple Chronic Conditions (pp 11)

- We support the creation of the new high-severity chronic care management code that clinicians could bill for under the Physician Fee Schedule.
- Registered Dietitian Nutritionists should be included on the eligible provider list for the new high-severity chronic care management code, and should be reimbursed for treating chronic conditions outside those that are currently allowed under Medicare Part B (see above).

IV. Expanding the Independence at Home Model of Care (IAH) Demonstration into a Permanent, Nationwide Program, and Better Integrating Nutrition Assessments and Interventions into this Model (pp 6-7)

- We agree that the Independence at Home (IAH) demonstration, slated to end on September 30, 2017, should be expanded into a permanent, nationwide program.
- Legislation codifying the IAH model should specify a minimum list of services that care teams must consider as part of the intake and treatment processes. This list should include a requirement that care teams include a Registered Dietitian Nutritionist and that patient access to food and nutrition services is considered.
- Legislation expanding the IAH model should require that care teams conduct malnutrition screenings upon intake and throughout the course of evaluating patient service needs. By doing so, care teams can identify patients who have a particularly acute need for food and nutrition services. Malnutrition Screening Tools are discussed below in our recommendations for Quality Measures.
- Additionally, we recommend that the legislation include a requirement that care teams not only consider, but also address any identified need to connect the patient to food and nutrition services, and reimburse for these services through their incentive payments.

V. Adapting and Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (pp 14-16)

- We agree that “non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically ill individuals.” (p 14) Although MA plans reimburse for certain nutrition services under limited circumstances, the research demonstrates that a more flexible approach could yield significant cost savings.^{xxxiii}
- Given the wide variation in severity, duration, and complexity of chronic diseases, we agree that the one-size-fits-all supplemental benefits regiment should be modified to allow MA plans “to specifically tailor their benefit package to meet the needs of chronically ill individuals.” (p 14) Nutrition benefits should be flexible enough to address the needs of a patient at any stage of a chronic illness. Expanding Medicare’s meal benefit to all beneficiaries with chronic illness and a physician or other provider’s referral due to medical necessity will ensure that these beneficiaries’ health needs are met.

VI. Maintaining ACO Flexibility to Provide Supplemental Services (p 18)

- For the reasons stated, we agree that the working group should clarify that providers participating in the Medicare Shared Savings Program and Accountable Care Organizations (ACOs) may furnish a “social service” (including home-delivered meals and/or medical nutrition therapy) for which payment is not currently made under fee-for-service Medicare. This clarification would encourage providers to use resources on a broader range of nutrition services tailored to address the needs of their chronically ill patients.

VII. Developing Quality Measures for Chronic Conditions (pp 22-23)

- The Centers for Medicare and Medicaid Services, in consultation with key stakeholders in the nutrition field, should develop a standard malnutrition screening tool (at present there are several that are in use) for the Medicare population. This would allow results to be compared over time.
- The Centers for Medicare and Medicaid Services, in consultation with key stakeholders in the nutrition field, should develop a standard menu of services that address various stages of malnutrition.
- Quality measures at the community-level should include percent of beneficiaries who are screened for malnutrition and, when found to be malnourished or at severe risk of becoming malnourished, are referred to appropriate services.

VIII. Other Policies to Improve Care for the Chronically Ill (pp 30)

We believe the following actions would significantly improve care for the chronically ill while reducing health care costs associated with high-needs, high-risk patients:

1.) Expand coverage of medical nutrition therapy (MNT) for individuals living with or at risk of severe and chronic illness.

The requirements for receipt of MNT under Medicare Part B are far too narrow, cutting out many of the nutrition sensitive diseases that are driving health care costs in our country. This cost-effective benefit must be expanded for people living with other illnesses, such as heart disease, diabetes, hypertension, COPD, HIV/AIDS and others. Even with expansion of coverage to this population, MNT would remain a limited benefit overall; physician or non-physician practitioners (in this case, we recommend adding Registered Dietitian Nutritionists (RDNs) to the list of eligible referral titles) would retain the discretion to refer a vulnerable patient for MNT only when medically necessary.

2.) Expand coverage of medically tailored home-delivered meals (MTHDM) to Medicare Parts A and B, and expand the circumstances under which MTHDM can be offered.

Home-delivered meals are currently an *optional* benefit that insurers can choose to offer in Medicare Advantage plans under limited circumstances. At present, only 31% of Medicare enrollees elect to purchase Medicare Advantage benefits,^{xxxiv} and the circumstances under which the home-delivered meal benefit can be used are narrow, further reducing eligibility. Essentially, an at-risk individual must go to the hospital in order to access a benefit that could prevent them from visiting in the first place. To achieve our health care goals, avoid unnecessary hospitalizations, and prevent costly malnutrition in the highest-risk population, this benefit must be allowed to reach all Medicare-eligible individuals in need. A physician or non-physician practitioner (including an RDN) should be able to refer a beneficiary to a food and nutrition services agency for MTHDM when the meals are deemed medically necessary by that provider.

Thank you for your consideration of these suggestions and we look forward to working with you to make these modifications a reality.

**Sincerely,
The Food is Medicine Coalition**

ABOUT THE FOOD IS MEDICINE COALITION (FIMC)

The Food Is Medicine Coalition is a national volunteer association of nonprofit, medically-tailored food and nutrition services (FNS) providers that have been managing chronic illnesses, like HIV/AIDS, cancer, cardiovascular disease, renal failure, muscular sclerosis, Alzheimer's disease and over 200 others, through nutrition for over 30 years. FIMC seeks to preserve and expand coverage of FNS for the critically and/or chronically ill clients we serve. **For more information, please email: fimc@glwd.org**

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^{vi} *Avoid Food-Drug Interactions: A Guide from the National Consumers League and U.S. Food and Drug Administration*, NAT'L CONSUMERS LEAGUE & FOOD AND DRUG ADMINISTRATION 1, available at

<http://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/GeneralUseofMedicine/UCM229033.pdf>.

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^{ix} Mark R. Corkins et al., *Malnutrition Diagnoses in Hospitalized Patients: United States, 2010*, 20 J. OF PARENTERAL AND ENTERAL NUTRITION 1, 3, 7 (2013).

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^{xi} Su Lin Lim et al., *Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality*, 31 CLINICAL NUTRITION 345, 348-350 (2012).

^{xii} Sam Beattie et al., *Reducing Readmissions with Nutrition Management: Briefing White Paper*, Mom's Meals NourishCare (2011), available at http://my.momsmeals.com/content/pdf/White_Paper_Reducing_Readmissions_with_Nutrition_Management.pdf.

^{xiii} Health Care Costs: A Primer. Kaiser Family Foundation. <http://kff.org/health-costs/issue-brief/health-care-costs-a-primer/>. (last visited Jan. 22, 2016).

^{xiv} Jill Gurvey et al., *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, 4 J. OF PRIMARY CARE & CMTY. HEALTH 311, 313-15 (2013).

^{xv} *Id.* at 315 (based upon mean monthly inpatient visits).

^{xvi} *Id.* at 315 (based upon mean percentage of individuals discharged to home).

^{xvii} Bachrach, D. Pfister, H. Wallis, K., Lipson, M. Addressing Patient's Social Needs: The Emerging Business Case for Provider Investment. May 2014. Commonwealth Fund, Skoll Foundation, and Pershing Square Foundation.

^{xviii} *Nutrition therapy services (medical)*, MEDICARE, <http://www.medicare.gov/coverage/nutrition-therapy-services.html> (last visited Dec. 1, 2013).

^{xix} Home health services, MEDICARE, <http://www.medicare.gov/coverage/home-health-services.html> (last visited Dec. 1, 2013).

^{xx} Medicare Managed Care Manual 35-37, MEDICARE, <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf> (last visited Dec. 1, 2013).

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^{xxiii} Frequently Asked Questions About Special Needs Plans, MEDICARE, <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/special-needs-plans-faq.html#collapse-3318> (last visited Dec. 1, 2013).

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