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June 22, 2015

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Isakson and Warner:

The Academy of Nutrition and Dietetics (the "Academy") and the National Association of Nutrition and Aging Services Programs (NANASP) appreciate the opportunity to submit comments related to your May 22, 2015 letter soliciting comments to the Senate Finance Committee chronic care working group (the "letter"). The Academy more than 90,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of food and nutrition professionals in the United States and is committed to improving the nation's health through food and nutrition across the lifecycle. Every day we work with Americans in all walks of life—from birth through old age—providing professional services such as medical nutrition therapy (MNT).[2] NANASP, a 1,100-member nonpartisan, nonprofit, membership organization, represents a diverse coalition of individuals, agencies and organizations interested in senior nutrition and other programs that enhance the life quality of older Americans.

We applaud your commitment "to tackling this urgent matter head on," and look forward to working with you in developing legislative solutions that decrease costs and improve health outcomes. The Academy offers the below recommendations to achieve the working group's stated goals for both the short-term and the long term (*i.e.*, outside the Congressional Budget Office's limited ten-year scoring window). To reduce costs and improve health, any meaningful reform must include implementation of whole-population prevention strategies and specific chronic disease management that includes nutrition counseling and self-care to provide patients of all ages and medical conditions with the knowledge and tools necessary to improve their health.

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[1] The Academy recently approved the optional use of the credential "registered dietitian nutritionist (RDN)" by "registered dietitians (RDs)" to more accurately convey who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

[2] Medical nutrition therapy (MNT) is an evidence-based application of the Nutrition Care Process focused on prevention, delay or management of diseases and conditions, and involves an in-depth assessment, periodic re-assessment and intervention. [Academy of Nutrition and Dietetics' Definition of Terms list, http://www.eatrightpro.org/scope/, accessed 2 April 2014.] The term MNT is sometimes used interchangeably with, but is sometimes considered different from, nutrition counseling in health insurance plans.

I. Executive Summary

Our nation is paying the price for overlooking the importance of nutrition in preventing and treating chronic diseases. It is unrealistic to think we can ameliorate Medicare beneficiaries' chronic diseases without making significant changes to their medical care before they turn 65 years old. Similarly, it is unrealistic to think the best solution to the pervasiveness of chronic disease among Medicare beneficiaries is denying demonstrably effective medical nutrition therapy services to beneficiaries until they are already diagnosed with costly, preventable diseases.

MNT provided by RDNs is a widely recognized component of medical guidelines for the prevention and treatment of heart disease, diabetes, renal disease, obesity, cancers, and many other chronic diseases and conditions as well as in the reduction of risk factors for these conditions. America's health care system could save significant resources and improve health by preventing and treating chronic diseases with demonstrably effective nutrition care services.

However, even if there were sufficient coverage of nutrition services to prevent and treat chronic disease (which there is not), existing physician-centric payment models in Medicare and private insurance do not ensure services are actually provided by those best able to provide them effectively. In terms of specific specialties, the Academy strongly believes that RDNs must be part of any complex medical management model focused on chronic disease prevention and treatment.

II. America's Chronic Disease Crisis

For too long, our nation's health policy has failed to focus on disease prevention, wellness, or healthy lifestyles, although recent reform efforts intended to change that emphasis. Nearly half of Americans suffer from preventable chronic conditions, but relatively few resources have been committed to the broad array of potential solutions that influence whether and how individuals choose to achieve and maintain health. As a result, health care in the United States is the most expensive in the world, accounting for 17 percent of the gross national product.[3] Despite the fact that the United States spends a significant amount of money on health care, most of our citizens do not receive quality care that is comprehensive, coordinated, or prevention-focused.

A. High Cost of Chronic Disease

Our nation is paying the price for overlooking the importance of nutrition in preventing and treating chronic diseases. The Academy appreciates your recognition in the letter that the treatment of chronic disease accounts for 93 percent of Medicare spending. Costs of chronic disease places an enormous financial burden on American families, our economy and our nation's healthcare system.

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[3] Jortberg BT, Fleming MO. Registered dietitian nutritionists bring value to emerging health care delivery models. J Acad Nutr Diet. 2014;114(12):2017-22, citing Berwick D, Nolan T, Whittington J. The Triple Aim: Care, cost, and quality. Health Affairs. 2008;27(3):759-769.

In addition to helping to prevent or manage chronic conditions, adequate and proper nutrition ensures that older adults maintain an appropriate weight. Between 2007 and 2010, more than one-third (35 percent) of older adults had obesity,[4,] and although the Institute of Medicine (IOM) has cited obesity as the most common nutritional disorder in older persons, undernutrition continues to be a pervasive problem among older adults as well.[5] Undernutrition is a particularly a costly problem for older adults in community settings, with a close connection between inadequate income and food insecurity.[6] The consequences of undernutrition include increased risk of falls and subsequent injuries, which can not only impair an individual's ability to live independently but also translate into over $19 billion in health care costs for nonfatal falls nationwide.[7]

B. Our Health Care System Fails to Fund Preventive Nutrition Care Services

Virtually all prevalent chronic illnesses have a nutrition component, yet there remain huge gaps in the way our health care system addresses the important role of nutrition in preventing and treating such diseases—particularly in the Medicare program. Under current law, Medicare only covers outpatient medical nutrition therapy services provided by RDNs for beneficiaries with diabetes, chronic renal insufficiency/non-end-stage renal disease (non-dialysis) or post kidney transplant.[8] The current Medicare program offers too little nutrition care too late and does not incentivize the use of other members of the health care team with specific expertise in areas such as nutrition counseling (*i.e.*, RDNs).

For example, there is no coverage for effective and inexpensive MNT services for pre-diabetes or for individuals at risk for developing diabetes, yet once a beneficiary is diagnosed with diabetes, she has access to nutrition services that are at the cornerstone of diabetes care. Medicare's coverage of nutrition services for obesity is similarly problematic, in that beneficiaries must already be diagnosed with obesity (based on BMI) before Medicare will pay for intensive behavioral therapy services and those services are not reimbursed if provided by the most effective providers in the most effective settings. Nutrition coverage for beneficiaries at risk for cardiovascular disease (CVD) or those with cancer, eating disorders, or numerous other disease states and conditions is non-existent.

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[4] Fakhouri, T.H.I; Ogden, C.L.; Carroll, M.D.; Kit, B.K.; Flegal, K.M. (2012). Prevalence of Obesity Among Older Adults in the United States, 2007-2010. NCHS Data Brief (106):1-8. Retrieved February 4, 2013 from http://www.cdc.gov/nchs/data/databriefs/db106.pdf.

[5] Institute of Medicine (2000). The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population.

[6] National Academy of Sciences (2012). Nutrition and Healthy Aging in the Community: Workshop Summary. Sheila Moats and Julia Hoglund, Rapporteurs; Food and Nutrition Board; Institute of Medicine. P. 22.

[7] Stevens J.A., Corso P. S., Finkelstein E. A. et al. (2006). "The Costs of Fatal and Nonfatal Falls Among Older Adults," Injury Prevention. Vol. 12(5):290–95

[8] Center for Medicare and Medicaid Services National Coverage Determination (NCD) for Medical Nutrition Therapy, CMS Pub. 100-3, 180-1 (10-1-2002). Available at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=252&ncdver=1&NCAId=53&NcaName=Medical+Nutrition+Therapy+Benefit+for+Diabetes+%2526+ESRD&IsPopup=y&bc=AAAAAAAAIAAA&.

To solve long-term problems in the Medicare program, we must aim for both earlier intervention and for prevention in cases where it is demonstrated to pay off.

While some private insurance companies and some state Medicaid programs also cover MNT services, similar to the current Medicare program this coverage is often limited in terms of the variety of conditions and diseases covered, the intensity of coverage and the site of service provision. Furthermore, unlike the Medicare program, these payers may utilize physicians over nutrition experts (RDNs) and/or create barriers to access through limited provider networks.

Ensuring all Americans have access to a minimum level of effective preventive nutrition care services offers a unique opportunity to lower long-term health care costs by eliminating the often cited "free-rider" argument that one health insurer's provision of preventive services are likely to inure to another insurer years later. By eliminating the free-rider argument and guaranteeing comprehensive preventive services, overall health will be improved with less need for costly chronic disease management. Without that assurance of preventive nutrition services as a required component of coverage, plans simply will not include them despite their efficacy and role in the quality and comprehensiveness of care.

It is unrealistic to think we can ameliorate Medicare beneficiaries' chronic diseases without making significant changes to their medical care before they turn 65 years old. Similarly, it is unrealistic to think the best solution to the pervasiveness of chronic disease among Medicare beneficiaries is denying demonstrably effective medical nutrition therapy services to beneficiaries until they are already diagnosed with costly, preventable diseases. Simply put, we agree with the "inherent limitations of traditional Medicare's fee-for-service payment system" noted in your letter, but **strongly urge the Working Group to focus on perhaps the largest limitation in our pre-Medicare and post-Medicare bifurcated health care system: the focus on treating, rather than preventing, nutrition-related chronic diseases.**

C. Many Providers Lack Expertise to Provide Effective Nutrition Services

Even if there were sufficient coverage of nutrition services to prevent and treat chronic disease, existing physician-centric payment models do not ensure services are actually provided by those best able to provide them effectively. While many health plans rely on primary care physicians to provide these services, the United States Preventive Services Task Force (USPSTF) and numerous studies have found that primary care providers are limited in their time, training and skills to conduct the high-intensity interventions that are scientifically proven to be the most effective to produce the greatest results.

Research shows that "nutrition education continues to be very limited in most medical schools, a situation that casts doubt on the readiness of future physicians to effectively counsel their patients about appropriate nutrition."[9] The same evidence review also noted:

[9] Adams KM, Kohlmeier M, Zeisel SH. Nutrition education in U.S. medical schools: latest update of a national survey. Acad Med. 2010;85(9):1537-42.

> There is little dispute that a patient's dietary habits can influence chronic disease risk and treatment outcomes. Consumer surveys show that physicians are considered credible sources of nutrition information. However, more than half of graduating medical students still rate their nutrition knowledge as "inadequate," and physicians report that they have not received adequate training to counsel their patients on appropriate nutrition. Surveys of medical students and physicians alike have found suboptimal knowledge with respect to nutrition facts.
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> Several reports suggest that recent medical school graduates feel unprepared to intervene in their patients' care with regard to nutrition. Recent surveys of residents and practicing physicians support this view, especially with regard to the growing problem of obesity. This deficit in preparation is rather alarming, considering the importance of nutrition in obesity prevention and the critical role of diet in the energy balance equation.[10]

Primary care physicians themselves identify RDNs as the most qualified providers to care for patients with obesity. In a national cross-sectional survey of 500 primary care physicians, fewer than half (44 percent) thought they achieved success by helping their obese patients lose weight. Respondents identified RDNs as more qualified than primary care physicians, behavioral psychologists or nurses to help obese patients lose or maintain weight. [11] The education and training curriculum for medical students and residents would be best served by focusing on recognizing how to best utilize the other members of the health care team for their specific expertise rather than training physician providers to deliver intensive nutrition care services.

RDNs are the nutrition experts, but they have extensive training and expertise in other areas as well. Care coordination can be done by a wide variety of health care professionals, not just physicians and nurses. RDNs have the necessary skill set and many are serving in such roles within Patient Centered Medical Homes (PCMHs). Concerns about provider shortages should lead the working group to think creatively about the skill sets of providers such as RDNs and NDTRs to utilize them to the full extent of their training.

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[10] *Id*.

[11] Bleich SN, Bennett WL, Gudzune KA, et al. National survey of US primary care physicians' perspectives about causes of obesity and solutions to improve care. BMJ Open 2012;2:e001871.

III. RDNs and NDTRs Are Cost- and Clinically-Effective Solutions

The Academy agrees with you that "[l]eft unresolved, this situation will only worsen." However, there are available solutions. **The single most transformative policy to improve outcomes with patients living with four of the top six leading causes of death is cost-effective nutrition and diet counseling and interventions provided by RDNs.** Thus, any meaningful reform must include services that demonstrably improve the nutritional status of Americans and reduce the rates of obesity, cardiovascular disease, renal disease, hypertension, diabetes, HIV, forms of cancer, celiac disease, stroke, and other medical conditions. As detailed in the MNT Effectiveness Project published in the Academy's Evidence Analysis Library, MNT and other evidence-based nutrition services, from pre-conception through end-of-life, are an essential component of comprehensive health care, whether provided as frontline therapy to prevent disease, delay disease progression, or as an intervention in chronic care management.[12]

A. Overarching Recommendations

In terms of specific specialties, the Academy strongly believes that RDNs must be part of any complex medical management model focused on chronic disease prevention and treatment. MNT provided by RDNs is a widely recognized component of medical guidelines for the prevention and treatment of heart disease, diabetes, renal disease, obesity, cancers, and many other chronic diseases and conditions as well as in the reduction of risk factors for these conditions. As primary prevention, strong evidence supports optimal nutritional status as a cost-effective cornerstone in the maintenance of health, well-being, and functionality. As secondary and tertiary prevention, MNT is a cost-effective disease management strategy that reduces chronic disease risk, delays disease progression, enhances the efficacy of medical/surgical treatment, reduces medication use, and improves patient outcomes including quality of life.[13]

The working group should endorse policies that recognize nutrition as a key component of care for Medicare beneficiaries with chronic conditions; policies that allow early access to RDNs as qualified providers of such services; baseline payments that support having RDNs as part of the care team; and policies that reward changes in beneficiary behaviors that will positively impact risk factors for chronic disease (rather than just anthropometrics such as BMI). Although it is important to focus on outcomes, some process measures are needed, such as number of patients with one or more chronic diseases who receive nutrition care

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[12] Grade 1 data. ADA Evidence Analysis Library, http:www.adaevidencylibrary.com/topic.cfm?cat=3949. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

[13] Grade 1 data. Academy Evidence Analysis Library, http://andevidencelibrary.com/mnt. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

from a RDN. Nutrition and RDNs should be a required part of any care delivery model in any setting where Medicare beneficiaries receive services. The number of hours or visits per year should not artificially be limited; instead, providers should use evidence-based and expert-informed clinical practice guidelines to determine the frequency and dose of nutrition care, in collaboration with the patient. In short, the working group could effect tremendous positive change by recognizing the importance of nutrition in the prevention and treatment of chronic disease, continuing to collect data showing the benefits of RDN-provided care, and paying only for what has been shown to be effective.

B. Ensuring Patients Receive the Right Care for Chronic Diseases

Numerous national clinical practice guidelines for the management of chronic diseases such as those for cardiovascular disease, diabetes, and hypertension include a nutrition component and recommend referrals to registered dietitian nutritionists for their recognized expertise in delivering these services.[14] A lack of coverage—or ambiguous benefit categories that may permit a lack of coverage in health plans—for comprehensive nutrition counseling and behavioral interventions will simply shift care to pharmacological agents and other more invasive and costly modalities. Efforts to provide the nutrition component entirely through diet handouts without the accompanying professional service are an ineffective and poor substitute for MNT.

The Academy urges that the working group's efforts at reform ensures coverage of cost-effective preventive and wellness services that include all evidence-based interventions shown to work in reducing the risks of developing chronic disease, including referral for behavioral interventions with RDNs or other qualified specialists demonstrated to be clinically effective. Services should be covered if they are evidence-based, an otherwise covered category of service, and recommended by the primary care practitioner coordinating care for the patient. However, without ensuring coverage of nutrition care services in either a fee-for-service or an alternative payment system, no amount of improved care coordination will achieve significant improvements in patient health or reducing long- and short-term costs.

RDNs' evidence-based national practice guidelines and Evidence Analysis Library are leading, respected tools for effecting positive health outcomes. **The Academy urges the working group to support a legislative solution to ensure coverage of cost-effective**

[14] *See, e.g.,* Clinical Practice Guidelines for Chronic Kidney Diseases: Evaluation, Classification, and Stratification, National Kidney Foundation. Accessed 17 December 2012 at http://www.kidney.org/professionals/kdoqi/pdf/ckd_evaluation_classification_stratification.pdf. See also, Jensen MD, Ryan DH, Apovian CM, et al. 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation. 2013; Eckel RH, Jakicic JM, Ard JD, et al. 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013 ("The goals of the American College of Cardiology (ACC) and the American Heart Association (AHA) are to prevent cardiovascular (CV) diseases, improve the management of people who have these diseases through professional education and research, and develop guidelines, standards and policies that promote optimal patient care and CV health.").

MNT for all nutrition-related chronic diseases, including hypertension, obesity, cancer, and prediabetes, consistent with USPSTF recommendations and national clinical guidelines.

Because so many chronic diseases have associated etiologies and patients have multiple comorbidities, effective care (such as MNT) that transcends a single disease state or condition and improves various aspects of a patient's health is uniquely valuable. Research shows that community-based, point-of-testing nutrition counseling provided by registered dietitians (or a registered nurse under the supervision of a registered dietitian) may reduce risk factors for obesity and related chronic diseases among older adults.[15] Another study showed that during a 3-year intervention, individual screening and point-of-testing counseling sessions (20-40 minutes each) were offered every 6 months to 159 subjects ages 65 years and older. Significant improvements in BMI, serum LDL cholesterol, fasting blood glucose and diastolic blood pressure were noted for participants who attended three or more counseling sessions. Participants who attended all six sessions had the most favorable results for each value.[16]

RDN-provided MNT is not only clinically effective, including it in a health plan is cost effective. As just one example, a 2001 study conducted at Massachusetts General Hospital demonstrated a savings of $4.28 for each dollar spent on MNT. [17] Another study found that for every dollar invested in an RDN led lifestyle modification program there was a return of $14.58.[18] According to a recent Blue Cross Blue Shield study, "[h]ealth plans that have added these services to their benefits packages (up to unlimited visits) report the additional cost has been 3 cents per member per month." [19] Additionally, according to Wolf, *et al*, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of $2.67 in productivity. [20] MNT provided by RDNs generally impacts productivity; the study indicated the RDN-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3 percent and disability days by 87.2 percent, compared with those receiving usual medical care. [21] Nutrition interventions reduce and even eliminate the need for costly long-term medications and reduce hospitalizations. The Department of

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[15] Walker MH, Murimi MW, Kim Y, Hunt A, Erickson D, Strimbu B. Multiple point-of-testing nutrition counseling sessions reduce risk factors for chronic disease among older adults. Journal of Nutrition in Gerontology and Geriatrics, 31:2, 146-157.

[16] *Ibid*.

[17] Delahanty LM, Sonnenberg LM, Hayden D, Nathan DM. Clinical and cost outcomes of medical nutrition therapy for hypercholesterolemia: A controlled trail. J Am Diet Assoc, 2001;101:1012-1016.

[18] Wolf AM, Siadaty M, Yaeger B, et al. Effects of lifestyle intervention on health care costs: Improving Control with Activity and Nutrition (ICAN). J Am Diet Assoc. 2007;107(8):1365-73.

[19] Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The incremental value of medical nutrition therapy in weight management. Manag Care. 2013;22(1):40-5.

[20] Wolf AM, Conaway MR, Crowther JQ, et al. Translating lifestyle intervention to practice in obese patients with type 2 diabetes: Improving Control with Activity and Nutrition (ICAN) study. Diabetes Care. 2004; 27:1570–6.

[21] *Ibid*.

Health and Human Services previously found that nutrition services for obesity alone reduce premiums by 0.05 to 0.1 percent. As such, they meet the criteria of good stewardship of resources. [22]

In a review by the Academy's Evidence Analysis Library, ten studies were reviewed to evaluate the cost-effectiveness, cost benefit and economic savings of outpatient MNT involving in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. Using a variety of cost-effectiveness analyses, studies noted below affirm that MNT resulted in improved clinical outcomes and reduced costs related to physician time, medication use and/or hospital admissions for people with obesity, diabetes and disorders of lipid metabolism, as well as other chronic diseases.

1. RDNs Effectively Provide MNT for Obesity

As the Working Group is aware, chronic diseases, such as obesity and diabetes, have an enormous impact on our nation's physical and economic health. Over the last 20 years obesity rates have doubled among adults, resulting in more than 35 percent of adults living with obesity and an additional 33 percent being overweight.[23] Evidence suggests that without concerted action, roughly half the adult population will be obese by 2040.[24] These numbers are particularly troubling because one out of every eight deaths in America is caused by an illness directly related to obesity; therefore, every year millions of deaths could be prevented if patients had access to effective treatment and prevention programs.[25] Research documents the harmful health effects of excess body weight, which increases risk for conditions such as diabetes, hypertension, heart failure, dyslipidemia, sleep apnea, hip and knee arthritis, multiple cancers, renal and liver disease, musculoskeletal disease, asthma, infertility and depression.[26]

Individuals affected by obesity should have access to evidence-based covered obesity screening and referral to intensive, multi-component behavioral interventions, as these "preventive" services are recommended by the USPSTF with a B rating and are thus mandated under the ACA. Obesity is a complex, multifactorial chronic disease, which requires a multidisciplinary treatment approach. Regrettably, many private health plans have misguidedly excluded coverage for obesity treatment services because of shortsighted cost savings efforts and a false assumption that these services are either not medically

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[22] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41736 (July 19, 2010).

[23] Ogden et al. Prevalence of Obesity in the United States, 2009-2010. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. January 2012. Available at http://www.cdc.gov/nchs/data/databriefs/db82.pdf.

[24] *Id*.

[25] Carmona, Richard. The Obesity Crisis in America. Surgeon General's Testimony before the Subcommittee on Education Reform, Committee on Education and the Workforce, United States House of Representatives. 16 July 2003. Available at www.surgeongeneral.gov/news/testimony/obesity07162003.htm.

[26] NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

necessary or not in line with generally accepted standards of medical care. As a result, many Americans with obesity are effectively discriminated against because they are unable to receive the necessary care for their medical condition.

According to a recent study that implicates how important early nutrition interventions are, "[i]ncreased frequency of RD[N] visits is associated with improved BMI outcomes in obese youth participating in a [comprehensive weight management] program regardless of dietary intervention implemented."[27] Specifically, "[i]n an analysis that combined the two groups, researchers found a 28 percent increase in odds of success for each additional registered dieti[t]ian visit (P = .05), and success exceeded 78 percent when there was one or more registered dieti[t]ian visit per month compared with 43 percent success with minimal registered dieti[t]ian exposure."[28]

Another study showed that adults with overweight or obesity participating in a medical nutrition therapy benefit sponsored through their insurer were compared with individuals who did not participate. After 2 years, the adults who received the MNT benefit provided by a registered dietitian were twice as likely to achieve a clinically significant reduction in weight, experience greater average reductions in weight, and were more likely to exercise more. [29]

One simple solution to addressing the needs of adults with chronic disease is to revise the current IBT for obesity benefit under Medicare. Medicare Part D coverage must include new safe, effective, and evidence-based medications for treatment of obesity that have been recently approved by the FDA. These medications present exciting new options for medical therapy, particularly for those who do not respond to behavioral intervention or those patients for whom bariatric surgery is not indicated. The weight loss accompanying these medications has been shown to prevent progression to diabetes in high-risk patients, and to reduce the need for additional medications used to treat diabetes and hypertension.

The Academy urges CMS to enhance beneficiary access to the most qualified Medicare providers of intensive behavioral therapy (IBT) for obesity and most effective therapies, resulting in decreased healthcare costs and lower obesity rates among older adults.

2. RDNs Effectively Provide MNT for Prediabetes and Type 2 Diabetes

Type 2 Diabetes is a tremendously costly illness, both in terms of health and in terms of our nation's escalating health care costs. Unfortunately, our current health care system fails to ensure Americans at risk of diabetes can receive the medical nutrition therapy repeatedly demonstrated to reduce that risk. Twenty-nine million Americans currently have diabetes

[27] Kirk Shelley, Woo Jessica G., Jones Margaret N., and Siegel Robert M.. Childhood Obesity. April 2015, 11(2): 202-208. doi:10.1089/chi.2014.0079.

[28] *Id*.

[29] Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The incremental value of medical nutrition therapy in weight management. Managed Care. January 2013: 40-45.

and an additional 86 million Americans are estimated to have prediabetes.[30] Among Medicare beneficiaries the prevalence of diabetes is even more staggering. In 2012, over one-quarter of U.S. residents aged 65 years and older (11.2 million) had diabetes.[31] In other words, 7 out of 10 people eligible for Medicare are affected by diabetes or prediabetes.[32] For half of these individuals, however, diabetes could be prevented if they had access to a diet and exercise lifestyle intervention.[33] Therefore it is critical that there are other options for seniors with prediabetes to prevent the onset of diabetes.

We know that RDN-provided MNT for pre-diabetes has been shown to cost-effectively prevent onset of Type 2 diabetes, yet Medicare does not currently cover this service.[34] The Lewin Group documented a 9.5 percent reduction in hospital utilization and a 23.5 percent reduction in physician visits when MNT was provided to persons with diabetes mellitus.[35] A well-designed randomized controlled clinical research trial published last year by Parker, et al showed that individualized MNT provided by RDNs resulted in weight loss and improved blood glucose which are key outcomes for diabetes prevention programs.[36] The American Association of Clinical Endocrinologists/American College of Endocrinology recently issued Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan published in *Endocrine Practice* April 2015, concluding:

> Medical nutrition therapy (MNT) is recommended for all people with prediabetes and diabetes. MNT must be individualized, generally via evaluation and teaching by a trained nutritionist or registered dietitian or a physician knowledgeable in nutrition.[37]

To prevent the onset of Type 2 Diabetes and the extraordinary costs associated with the disease, the working group should endorse coverage of MNT for patients diagnosed with prediabetes, rather than simply waiting for their status to worsen before they receive the care they need.

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[30] Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and its Burden in the US, 2014. Atlanta, GA: U.S. Department of Health and Human Services; 2014.

[31] *Id*.

[32] *Id*.

[33] Diabetes Prevention Program Research Group. 10-Year Follow Up of Diabetes Incidence and Weight Loss in the DPPOS. Lancet. 2009;374(9702): 1677-1686 and Ackermann RT, Finch EA, Brizendine e, Zhou H, Marrero DG. Translating the DPP into the Community: The DEPLOY Pilot Study. American Journal of Preventive Medicine. 2008;35(4): 357-63.

[34] Diabetes Prevention Program Research Group. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program outcomes study. Lancet. 2009;374(9702): 1677-1686.

[35] Johnson R. The Lewin Group — What does it tell us, and why does it matter? *J Am Diet Assoc*. 1999;99:426–427.

[36] Parker, A., et al. Effect of Medical Nutrition Therapy by a Registered Dietitian Nutritionist in Patients with Prediabetes Participating in a Randomized Controlled Clinical Research Trial. J Acad Nutr Diet. 2014;114:1739-1748.

[37] AACE/ACE Comprehensive Diabetes Management Algorithm, Endocr Pract. 2015;21(No. 4).

3. RDNs Effectively Provide MNT for Cardiovascular Disease

The Academy supports the recent USPSTF draft recommendation of the USPSTF related to cardiovascular disease (CVD), particularly its recognition of the importance of "***referring*** overweight or obese adults who have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthy diet and physical activity for CVD prevention."[38] We agree with the USPSTF's conclusion "that for overweight or obese adults at increased risk of CVD, intensive behavioral counseling had a moderate benefit on risk for CVD, including improvements in body mass index (BMI), blood pressure, lipids, fasting glucose, and levels of physical activity [and that t]he reduction in glucose levels was sufficient to lead to a lower incidence of the diagnosis of diabetes."[39] The USPSTF's 2014 Evidence Review[40] clarifies that both medium- and high-intensity interventions improve intermediate CVD health outcomes, but that only high-intensity interventions "reduced diabetes incidence in the longer-term."[41] Findings of the Academy's Evidence Analysis Library MNT Effectiveness Project comport with the USPSTF's conclusions.[42] The Academy also supports the USPSTF's recognition that high intensity interventions provided by specialized practitioners, such as RDNs, outside of the primary care setting are usually most effective.

Lifestyle and nutrition modifications, such as those included in MNT sessions, play a crucial role in both preventing and controlling hypertension. As the USPSTF appreciates, the link between hypertension and increased risk of CVD is clear. Nutrition and lifestyle changes produced through RDN-provided MNT can improve blood pressure control and thus decrease the risk of associated health complications.[43] For patients with heart failure, research indicates that three to four visits with an RDN improves the patient's quality of

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[38] U.S. Preventive Services Task Force website. Draft Recommendation Statement: Behavioral Counseling to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Known Risk Factors. Available at http://www.uspreventiveservicestaskforce.org/draftrec.htm. Accessed May 29, 2014. (Emphasis added.)

[39] *Ibid.*

[40] USPSTF website. "Behavioral Counseling to Promote a Healthy Lifestyle for Cardiovascular Disease Prevention in Persons With Cardiovascular Risk Factors: A Systematic Evidence Review for the U.S. Preventive Services Task Force." Accessed June 4, 2014 at http://www.uspreventiveservicestaskforce.org/uspstf13/cvdhighrisk/cvdhighriskdraftrep.pdf

[41] *Ibid.* at v.

[42] Academy of Nutrition and Dietetics. Evidence Analysis Library. *Medical Nutrition Therapy Evidence Analysis Project 2008.* Accessed May 2014, https://www.adaevidencelibrary.com/topic.cfm?cat=3675. ("PrevT2DM: Coordination of Care; For individuals who are at high risk for type 2 diabetes, the registered dietitian nutritionist (RDN) should implement medical nutrition therapy (MNT) and coordinate care with a multi-disciplinary team and important others (e.g., family, friends and colleagues) in a wide variety of settings. This approach is necessary to effectively integrate MNT into overall management for individuals who are at high risk for type 2 diabetes. Rating: Strong. Imperative.")

[43] Chobanian AV et al; Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. National Heart, Lung, and Blood Institute; National High Blood Pressure Education Program Coordinating Committee. Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Hypertension. 2003 Dec;42(6):1206-52

life, decreases fatigue and edema, and most importantly decreases costly hospitalizations.[44][45][46] The Lewin Group, for example, documented an 8.6 percent reduction in hospital utilization and a 16.9 percent reduction in physician visits associated with MNT for patients with cardiovascular disease.[47]

However, when the Centers for Medicare and Medicaid Services (CMS) in 2011 decided to initiate coverage for the new preventive service of Intensive Behavioral Therapy for CVD, the substance of the covered benefit was fundamentally different from the USPSTF recommendations. Not only did this new coverage fail to cover *explicitly recommended* referrals to the most qualified, effective, and cost-effective providers of this therapy—registered dietitian nutritionists—but the limit of just one covered 15 minute "face-to-face CVD risk reduction visit every two years" is wholly irreconcilable with the USPSTF's recommendation for intensive behavioral dietary counseling.[48] **Moreover, CMS inexplicably limited provision of the IBT for CVD benefit to the primary care setting, limiting patients access to RDNs, who frequently provide care in non-primary care settings throughout the medical neighborhood.**

The 2014 Evidence Review associated with the draft recommendation concluded that "dietary counseling practices of primary care clinicians fall short of recommendations, even for patients at high risk of CVD."[49] The underlying evidence review for the 2003 Recommendation reached the same conclusion, declaring that "[a]lmost all of the effective medium- to high-intensity interventions were delivered by specially trained health educators or nurses, counselors or psychologists, dietitians or nutritionists, or exercise instructors or physiologists. Very few of these interventions involved the primary care physician at all."[50] As the USPSTF concluded, "In our review, virtually all studies achieving large effect sizes fell into the high-intensity category. . . . Low intensity counseling interventions, such as those typically used in primary care settings, . . . achieved only small

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[44]Arcand JL, Brazel S, Joliffe C et al. Education by a dietitian in patients with heart failure results in improved adherence with a sodium-restricted diet: A randomized trial. Am Heart J. 2005:150:716e1-716e65.

[45]Kuehneman T, Soulsbury D, Splett P, Chapman DB. Demonstrating the impact of nutrition intervention in a heart failure program. J Am Diet Assoc. 2002: 102:1790-1794.

[46] Ramirez EC, Martinez LC, et al. Effects of a nutritional intervention on body composition, clinical status, and quality of life in patients with heart failure. Nutrition. 2004:20:890-895.

[47] Johnson R. The Lewin Group — What does it tell us, and why does it matter? *J Am Diet Assoc*. 1999;99:426–427.

[48] Centers for Medicare and Medicaid Services. Coverage details. Accessed May 29, 2014 at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=348&ncdver=1&bc=AgAAgAAAAAAAAA%3d%3d&.

[49] USPSTF website. "Behavioral Counseling to Promote a Healthy Lifestyle for Cardiovascular Disease Prevention in Persons With Cardiovascular Risk Factors: A Systematic Evidence Review for the U.S. Preventive Services Task Force." Accessed June 4, 2014 at http://www.uspreventiveservicestaskforce.org/uspstf13/cvdhighrisk/cvdhighriskdraftrep.pdf at 4.

[50] "Behavioral Counseling in Primary Care to Promote a Healthy Diet: Recommendations and Rationale," U.S. Preventive Services Task Force2003, accessed 18 May 2014 http://www.uspreventiveservicestaskforce.org/3rduspstf/diet/dietrr.pdf

to medium effects on dietary behavior."[51] **It is critical to ensure that the specially trained practitioners able to deliver the results found in the reviewed studies demonstrating effective clinical practice are actually able to provide the interventions.**

4. Nutrition Services Effectively Improve Outcomes Related to Malnutrition

The nutrition programs in the Older Americans Act, which provide a balanced, nutritionally complete diet, are a lifeline for older adults who would otherwise go hungry and be susceptible to these consequences of undernutrition, which include being at greater risk for hospital readmission.[52] Since nutritional support of malnourished elderly individuals has been found to improve function after a hospital stay,[53] participation in OAA programs helps older adults remain independent and in their own homes rather than in a nursing home or hospital.

C. RDNs Already Demonstrate Effectiveness in Existing Payment Models

RDNs remain the most cost-effective, qualified healthcare professional to provide nutrition based lifestyle interventions, including MNT and evidence-based nutrition counseling and weight-loss management services. RDNs have demonstrated competencies and outcomes that differently trained and less qualified providers of non-medical nutrition services have been yet unable to demonstrate. The IOM found that "the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[54]

1. Medicare Part A

Under Medicare Part A, nutrition services and RDNs are often considered a requirement under conditions of participation (*e.g.*, hospital inpatient care, skilled nursing facilities, and dialysis centers). RDNs providing nutrition services in these settings have consistently proven their value in meeting the Triple Aim. For example, the End Stage Renal Disease program was revamped in 2010 for the first time since its inception in 1971 and funded a Medicare program for beneficiaries regardless of age and/or disability. This capitated program limits costs for services and medications related to the disease state while monitoring quality performance indicators to maximize patient outcomes. Cost savings to

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[51] Lin JS, O'Connor E, Whitlock EP, Beil TL. Behavioral Counseling to Promote Physical Activity and a Healthful Diet to Prevent Cardiovascular Disease in Adults: A Systematic Review for the U.S. Preventive Services Task Force. Ann Intern Med 2010;153:736-750.

[52] Friedmann J.M., Jensen G.L., Smiciklas-Wright H., McCamish M.A. (1997). Predicting early nonelective hospital readmission in nutritionally compromised older adults. The American Journal of Clinical Nutrition. Vol 65(6):1714-1720.

[53] Neelemaat F., Bosmans J. E., Thijs A. et al. (2011). Post-Discharge Nutritional Support in Malnourished Elderly Individuals Improves Functional Limitations. Journal of the American Medical Directors Association. Vol. 12(4):295–301.

[54] Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published).

the Medicare system with improved indicators of patient quality and a modest improvement in patient mortality indicate this as a potential model for other disease states.

RDNs continue to produce savings in other areas as well. CMS pre-published a final rule on May 7, 2014 that would, among other things, "Save hospitals significant resources by permitting registered dietitians to order patient diets independently, which they are trained to do, without requiring the supervision or approval of a physician or other practitioner. This frees up time for physicians and other practitioners to care for patients."[55] According to CMS in the final rule, "[t]he addition of ordering privileges enhances the ability that RDNs already have to provide timely, cost-effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team."[56] CMS made this change because it "believe[s] that RDs are the professionals who are best qualified to assess a patient's nutritional status and to design and implement a nutritional treatment plan in consultation with the patient's interdisciplinary care team."[57] All told, CMS expects this rule to improve the efficiency and efficacy of nutrition care and save up to $459 million in annual hospital costs.[58] Providing RDNs with greater ability to practice at the height of their scope of practice and providing coverage for their services will be significant cost-savers for the health care system. The Academy encourages the working group achieve additional savings by urging CMS to extend the ability to order therapeutic diets to RDNs in long term care facilities and across the continuum of care.

Building upon this experience, all alternate payments models and all policies aimed to address care of Medicare beneficiaries with nutrition-related chronic diseases in any care setting should require RDNs as part of the care team (including virtual teams, meaning RDNs should not have to be directly in a PCMH building to be a part of the team and help the patients manage their chronic conditions). **Payment models should provide funding for the nutrition services provided by the RDN, either through enhanced fee for service, enhanced Per Member Per Month fees, part of a bundled payment for chronic conditions and/or episodes of care, as well as access to shared savings and incentive programs.**

2. Coordinated Care for HIV/AIDS

The value of RDNs as Essential Community Providers (ECPs) in Federally Qualified Health Centers and elsewhere is significant. The Academy notes the success of the integration of MNT and nutrition counseling for people living with HIV infection, for example, as evidenced in an evaluation of existing evidence; seven studies were evaluated regarding MNT and/or nutrition counseling in people with HIV infection.[59] One study completed

[55] Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II, 79 Fed. Reg. 27105 (May 12, 2014).

[56] *Id*.

[57] *Id*.

[58] *Id*.

[59] Academy of Nutrition and Dietetics HIV/AIDS Nutrition Evidence Analysis Project. Available at http://www.adaevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250707 Accessed 29 July 2015.

prior to highly active ARTs stressed that early intervention may prevent progressive weight loss.[60] Four studies regarding MNT reported improved outcomes related to energy intake and/or symptoms (with or without oral nutritional supplementation) and cardiovascular risk indices, especially with increased frequency of visits.[61] Two studies regarding nutritional counseling (non-MNT) also reported improved outcomes related to weight gain, CD4 count, and quality of life.[62]

RDNs are also familiar with both nutrient-based and non-nutrient treatments to improve nutritional status and nutrient metabolism, ranging from exercise prescription and complementary/alternative medicine therapies to pharmacologic modulation.[63] RDNs provide varied nutrition care and support services as ECPs in addition to MNT, including nutrition education, evaluating nutrition and health-related psychosocial factors, and medical case management.

D. Modernize Delivery and Payment Models to Reflect Best Practices

1. Add Flexibility to Enable Effective Practitioners to Provide Care

Unlike traditional Medicare, Medicare Advantage plans, the Veterans Administration, and other federal government health plans have the flexibility to ensure beneficiaries receive the behavioral and pharmaceutical therapies they need to treat and manage their chronic diseases. RDNs and NDTRs are critical members of health care teams and are essential to delivering nutrition-focused preventive services in clinical and community settings, advocating for policy and programmatic initiatives, and leading research in disease prevention and health promotion. The Academy agrees with the American Heart Association (AHA) and the American College of Cardiology (ACC) that "[t]he ultimate decision about care of a particular patient must be made by the healthcare provider and

[60] Chlebowski RT, Grosvenor M, Lillington L, Sayre J, Beall G. Dietary intake and counseling, weight maintenance, and the course of HIV infection. J Am Diet Assoc 1995; 95(4): 428-435.

[61] Fitch KV, Anderson EJ, Hubbard JL, Carpenter SJ, Waddell WR, Caliendo AM, Grinspoon SK. Effects of a lifestyle modification program in HIV-infected individuals with the metabolic syndrome. AIDS. 2006; 20: 1843-1850. Kaiser JD, Donegan E. Complementary therapies in HIV disease. Alternative Therapies in Health and Medicine. 1996; 2(4): 42-46. Tabi M, Vogel RL. Nutritional counselling: An intervention for HIV-positive patients. Journal of Advanced Nursing. 2006; 54(6): 676-682. Topping CM, Humm DC, Fischer RB, Brayer KM. A community-based, interagency approach by dietitians to provide meals, medical nutrition therapy, and education to clients with HIV/AIDS. J Am Diet Assoc. 1995; 95: 683-686.

[62] Rabeneck L, Palmer A, Knowles JB, Seidehamel RJ, Harris CL, Merkel KL, Risser JMH, Akrabawi SS. A randomized controlled trial evaluating nutrition counseling with or without oral supplementation in malnourished HIV-infected patients. J Am Diet Assoc. 1998; 98: 434-438. Schwenk A, Steuck H, Kremer G. Oral supplements as adjunctive treatment to nutritional counseling in malnourished HIV-infected patients: randomized controlled trial. Clinical Nutrition. 1999; 18(6): 371-374.

[63] *See, e.g.*, Academy of Nutrition and Dietetics (formerly American Dietetic Association). HIV/AIDS Nutrition Evidence Analysis Project at http://www.adaevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250967. Accessed 29 July 2015.. *See also*, Liu JP, Manheimer E, Yang M. Herbal medicines for treating HIV infection and AIDS. *Cochrane Database Syst Rev*. 2005; 20:CD003937.

patient in light of the circumstances presented by that patient[,]"[64] which manifests the need for qualified, independent practitioners such as RDNs to provide more complex, individualized care when formal intervention programs or protocols may be unavailable, ineffective, or non-indicated.

The Academy recognizes that the qualifications, skills, education, training, and credentials of the practitioner delivering the service is more important in assuring effectiveness than the service location, but appreciates that both current and newer models of health care delivery affirm the importance of the primary care provider (PCP) coordinating care while recognizing that the PCP does not deliver all of the care. Instead, PCPs rely upon a team that is not bound by physical walls, but rather connected through coordination, communication, and technology.

The working group should thus endeavor to end antiquated reliance on mandated "incident to" billing models that increase costs and deny beneficiaries access to the most effective care. Reform should empower PCPs to coordinate care with effective specialists, such as RDNs, endocrinologists, and bariatricians, in their respective clinical environments. The current system simply does not facilitate patient-centered care by the right providers in the most logical care settings. Mandating "incident to" billing is impracticable and fails to reflect how a Patient Centered Medical Neighborhood best operates: fostering an environment of collaboration and coordination without co-location.

2. Develop New Payment Model for PEG Feeding Tubes

The Academy recommends that the working group encourage payers, including CMS, to adopt a procedural episode-based payment model for outpatient placement of percutaneous gastrostomy (PEG) feeding tubes. Based on Medicare claims data from 2012, this procedure (CPT code 43246) is performed 20 percent of the time in the outpatient hospital and ambulatory surgical center settings with a total claims volume of 113,807. The current payment model for this procedure only recognizes the services performed by the surgeon, gastroenterologist, or other physician provider. Placement of a PEG feeding tube represents one step in a series of services performed across the continuum of care to ensure the overall goal of this treatment modality, namely improving nutritional status and quality of life and avoiding complications requiring additional and potentially more costly care, are met. While national standards of care for enteral support of patients requiring a PEG feeding tube recommend MNT services from a registered dietitian nutritionist,[65] significant variation in delivery of MNT services exists due to lack of reimbursement for these services under current Medicare and non-Medicare payment policies. The RDN practicing in nutrition support collaborates with other health care professionals such as speech pathologists, respiratory therapists, pharmacists, nurses, and physicians to support,

[64] Eckel RH, Jakicic JM, Ard JD, et al. 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013 at 6.

[65] Kovacevich DS, Frederick A, Kelly D, Nishikawa R, Young L. Standards for Specialized Nutrition Support: Home Care Patients. Nutr Clin Practice. 2005:20:579-590.

restore, and maintain optimal nutrition health in individuals with known or potential compromise in nutrition status.

This interdisciplinary team approach has been shown to reduce cost and improve patient outcomes, and the RDN is a key resource in various aspects of nutrition support therapy[66]. Including MNT services by a RDN in such an episode-based payment model would help to prevent over- or under-feeding, and decrease complications such as dehydration, constipation, and formula intolerance. Cost savings would be realized as the associated costs of paying for emergency room and hospital visits to treat dehydration, medications and medical care needed (e.g., physician office visits, emergency room and hospital visits) to treat diarrhea/constipation, excess quantities of formulas, and other problems associated with formula intolerance would be reduced or avoided.[67]

3. Complex Managed Care Model

The Academy recommends that the working group consider defining and developing a complex medical management model by focusing on the chronic conditions known to be most prevalent in the Medicare population. As noted in CMS' "Chronic Conditions among Medicare Beneficiaries: 2012 Chartbook," more than half of Medicare beneficiaries have one or more chronic conditions, such as diabetes, hypertension, high blood cholesterol, heart disease and kidney disease.[68] Heart failure has already been identified as a condition where clinical outcomes, patient quality of life, and health care spending can all be improved with proper medical management and care coordination and thus would also be an appropriate medical condition to include in such a model. Heart failure is the primary cause of hospitalizations among the Medicare population. Hospitalizations are most often the result of non-compliance with medications or diet. Efforts to improve quality of care and control spending in these high cost, high volume populations would significantly advance efforts to achieve the Triple Aim. Studies on the patient-centered medical home model of care consistently demonstrate significant clinical and financial improvements with care coordination efforts focused on such populations.[69] [70]

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[66] Russell M, Stieber M, Brantley S, et al. American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) and American Dietetic Association (ADA): Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Nutrition Support. J Am Diet Assoc. 2007;107(10):1815-22.

[67] Kurien M, White S, Simpson G, Grant J, Sanders DS, McAlindon ME. Managing patients with gastrostomy tubes in the community: can a dedicated enteral feed dietetic service reduce hospital readmissions? Eur J Clin Nutr. 2012:66(6):757-60.

[68] Chronic Conditions among Medicare Beneficiaries: 2012 Chartbook. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf. Accessed June 15, 2015.

[69] Proof in Practice: A Compilation of Patient Centered Medical Home Pilot and Demonstration Projects, Patient-Centered Primary Care Collaborative, 2009.

[70] Higgins S, Chawla R, Colombo C, Snyder R, Nigam S. Medical homes and cost and utilization among high-risk patients. Am J Manag Care. 2014:20(3):e61-e71.

While not a new service under the Medicare program, recognition of MNT services provided by RDNs would need to expand beyond diabetes and non-dialysis renal disease to include all of the medical conditions included under this model for which such services have been proven to be of benefit and are recognized in national clinical practice guidelines. This list would include at minimum hypertension, high blood cholesterol, heart disease, heart failure, obesity, undernutrition and unintended weight loss, metabolic syndrome/pre-diabetes, celiac disease, HIV/AIDS, and COPD.[71]

These services could be paid for as a fee-for-service payment to the RDN provider or via funds designated for such use as part of a per-patient-per-month payment to the practice (primary or specialty) serving as coordinator of care for the patient's plan of care. A value-based payment model could be utilized that specifically allows the RDN provider (and other non-physician members of the patient's health care team) to share in the savings achieved by the entire care team, as well as incentive payments received by the practice for the quality outcomes achieved. Payment models continue to pose challenges as providers across practice settings who contribute to the care of an individual patient are often faced with the challenge of "carving up the pie" when it comes to bundled payments.

The working group should consider a series of critical questions: How does one determine how to allocate the bundled payment, shared savings and incentive payments across the virtual team? Which providers are considered part of the team and therefore held accountable for outcomes and eligible for payment? While providers should have the leeway to negotiate such business arrangement amongst themselves based on the unique needs of the local community and their businesses, the design of the model should recognize this challenge and be designed in ways that help to minimize it.

The payment mechanism for this model needs to recognize that health care can effectively be delivered via a medical "neighborhood" or virtual team, meaning the care team of physicians and qualified non-physician practitioners do not all need to be located within the primary care provider's office setting. The care model needs to be designed to go beyond the physical walls of any particular medical practice to allow patients to receive services where they work, live and play; in locations convenient to them; and at hours convenient to them. Payment models need to hold the team accountable for care while providing the flexibility needed to attribute payment equitably among all members of the team, no matter their practice location. While a designated "primary" care provider is essential to achieving effective care coordination, the model needs to recognize that depending on the individual patient and their needs at a particular point in time, leadership in complex chronic care management services may shift amongst members of the care team, including the registered dietitian nutritionist.

4. Revamp Antiquated Telehealth Requirements

Policies regarding telehealth services under the current Medicare program are antiquated and do not adequately address the needs of Medicare patients, providers, and the Medicare

[71] Gradwell E, Raman PR. The Academy of Nutrition and Dietetics National Coverage Determination Formal Request. *J Acad Nutr Diet.* 2012:112:149-176.

program itself. The emergence and rapid growth of telehealth and mobile technologies designed to improve the health of individuals, enhance patient engagement, and lower costs should be recognized in new payment and delivery models as they offer new opportunities to increase access to care in urban, suburban, and rural areas. Time spent by all qualified health care professionals (both physician and non-physician providers) using such technologies for assessment, treatment, evaluation and monitoring functions needs to be recognized in the payment model.

We encourage the working group to help CMS expand its current policies related to telehealth services to go beyond their current restrictions to rural Health Professional Shortage Areas (HPSA) or counties outside of a Metropolitan Statistical Area (MSA), as many Medicare beneficiaries living in urban and suburban areas have limited mobility and transportation issues. Why not enable beneficiaries to receive health care services amenable to telehealth technology in their homes, taking advantage of the wide range of emerging e-health technology. Home-based access to services becomes even more important with the population's desire to "age in place" as well as the recognition of the cost savings of keeping people at home rather than in expensive institutional settings when possible. The use of technology to help beneficiaries increase self-monitoring skills is an effective strategy to address policy categories 5, 6, and 7 as outlined in the letter.

5. Improve Transition to Electronic Health Records

Health care providers continue to struggle with achieving the universal inter-operability of electronic health records (EHR) that is critical to the success of coordinated health care delivery across the spectrum of providers and continuum of care. While this model is focused on the outpatient setting, its success relies on communication and coordination of care across physician and non-physician office practices, laboratory and imaging centers, home health agencies, durable medical equipment suppliers, pharmacies, and other community agencies/resources. Stimulus funds and incentive payments for adoption of electronic health records have been limited to physicians, creating challenges for other essential players on the health care team when it comes to timely communication and access to critical information needed to develop, implement and monitor a patient's plan of care. Even when providers have access to an electronic health record, inter-operability of these systems is not yet at the level needed for optimal support of such a model.

IV. Conclusion

The Academy sincerely appreciates the ongoing opportunity to offer comments to the Senate Finance Committee chronic care working group. Tackling this complex problem of chronic diseases head on is critical, and early and robust nutrition interventions offer an inexpensive and demonstrably effective solution. We recognize the complexity in developing legislative solutions for this vulnerable population and the Academy offers our assistance and evidence analysis regarding implicated services. Please contact either Jeanne Blankenship by telephone at 202-775-8277 ext. 1730 or by email at jblankenship@eatright.org or Pepin Tuma by telephone at 202-775-8277 ext. 6001 or by email at ptuma@eatright.org with any questions or requests for additional information.

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