

January 28, 2016

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

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Senators,

The DefeatMalnutrition.Today coalition appreciates the opportunity to comment on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options Document.

In response to these proposed policies, we recommend that the following policies be added to improve clinical outcomes of malnourished and nutritionally at-risk chronically ill Medicare beneficiaries:

1. Include registered dietitians (RDs) and other clinically qualified nutrition professionals as providers who should be eligible to bill a new high-severity chronic care management code under the Physician Fee Schedule;
2. Include RDs and other clinically qualified nutrition professionals as providers in Medicare Advantage provider networks and allow them to be reimbursed for treating chronic conditions, including malnutrition;
3. Allow nutrition social services (including community home delivered and center-based meals programs) and malnutrition therapies such as oral nutrition supplements, to be offered as a supplemental benefit for Medicare Advantage plans;
4. Include screening, assessment, and treatment for malnutrition and other nutrition-related chronic conditions, including nutrition social services, as part of chronic condition special needs plans (C-SNPs);
5. Allow nutrition social services and meals to be reimbursed for outpatient mental health services;
6. Include nutrition social services as a supplemental service provided with an Accountable Care Organization;
7. Allow Medicare Advantage plans to include telehealth services provided by RDNs as a regular benefit;

8. Include measurement of malnutrition as a community-level quality measure for chronic conditions;
9. Include coverage for Diabetes Self-Management Training (DSMT) for prediabetes as well as including coverage under Medicare for services analogous to DSMT for patients with malnutrition and at risk of malnutrition.

The DefeatMalnutrition.Today coalition was recently formed to address the challenges of malnutrition in older adults. Our goals are: 1) to achieve the recognition of malnutrition as a key indicator and vital sign of older adult health and 2) to achieve a greater focus on older adult malnutrition screening and intervention through regulatory and/or legislative change across the nation's health care system. We have over 30 national, state, and local member organizations.

Our detailed comments follow.

Background on the Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is a common issue in the acute care hospital setting, affecting approximately 20 to 60 percent of admitted patients.¹⁻⁵ According to the National Resource Center on Nutrition, Physical Activity and Aging, nearly 35-50 percent of older residents in long term care facilities are malnourished. Chronic disease increases the risk of malnutrition in older adults. Studies estimate the prevalence of malnutrition in cancer patients is 30-87 percent,⁶ in chronic kidney disease is 20-50 percent,⁷ and in chronic obstructive pulmonary disease is 19-60 percent.⁸ In addition, one of the fastest growing forms of elder abuse is self-neglect, which can be caused by the inability to maintain a proper (or any) diet, leading to malnutrition.

Because malnutrition in older adults is often linked to economic and social factors, it can lead to more health disparities. The Congressional Black Caucus Institute in their *21st Century Council 2015 Annual Report* noted that "[t]he most benefit will occur when malnutrition care becomes a priority and routine standard of medical care." One of the steps outlined to accomplish this was "[i]ntegrating malnutrition screening and treatment into the development of evidence-based care models, such as intervention strategies to improve patient care transitions."

Malnutrition is a major concern because it can cause adverse outcomes. Research documents malnourished older adults make more visits to physicians, hospitals, and emergency rooms. Malnourished patients can continue to worsen throughout an inpatient stay, which may lead to increased costs. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.⁹

Malnutrition is a patient safety risk, as those who are malnourished are more likely to experience a healthcare acquired condition. Malnutrition is linked to increased rates of

morbidity, increased incidence of healthcare acquired pressure ulcers and infections, falls, delayed wound healing, decreased respiratory and cardiac function, poorer outcomes for chronic lung diseases, increased risk of cardiovascular and gastrointestinal disorders, reduced physical function, development of nosocomial infections, and impairment of non-specific and cell-mediated immunity.¹⁰

While malnutrition is a prevalent and potentially costly problem, it is also preventable. Effective and timely screening is essential to help providers make accurate diagnoses, and early nutrition interventions have been shown to substantially reduce readmission rates,¹¹⁻¹³ as well as complication rates, length of stay, cost of care, and in some cases, mortality.¹⁰

Malnutrition care (from screening and assessment to care plans and interventions) is a low-risk and low-cost solution to help improve the quality of clinical care. Prompt nutrition intervention can significantly improve patient outcomes, with:

- 28 percent decrease in avoidable readmissions,¹⁴
- 25 percent reduction in pressure ulcer incidence,¹⁵
- 4 percent fewer overall complications,¹⁶
- Reduced average length of stay of approximately two days,¹⁷⁻¹⁸
- Decreased mortality,¹⁹⁻²⁴ and
- Improved quality of life.²⁵⁻³⁰

Expanding the proposed policies for Medicare beneficiaries, to include systematic malnutrition screening, assessment, and treatment as well as nutrition social services, will help ensure that older adults with chronic disease have access to the same level of malnutrition care across the healthcare continuum.

Specific Recommendations for the Policy Options Document

1. Include registered dietitians (RDs) and other clinically qualified nutrition professionals as providers who should be eligible to bill a new high-severity chronic care management code under the Physician Fee Schedule

As outlined in the Policy Options Document, the working group is considering a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule for coordinating care outside of a face-to-face encounter. We recommend that registered dietitians (RDs) or other clinically qualified nutrition professionals should be a type of provider eligible to bill the new high-severity code, as a provider who would offer “comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time.”

As the Document states, “managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, **dietitians**, nurses, and behavioral health specialists.”

2. Include RDs and other clinically qualified nutrition professionals as providers in Medicare Advantage provider networks and allow them to be reimbursed for treating chronic conditions, including malnutrition

The working group is considering adjustments to provider networks that would include new providers to treat chronic conditions and prevent their progression. We recommend that RDs or other clinically qualified nutrition professionals should be included as providers in Medicare Advantage (MA) provider networks, including in Special Needs Plans, and allow them to be reimbursed for treating chronic conditions, including malnutrition as a symptom of and a cause of these chronic illnesses.

3. Allow nutrition social services and malnutrition therapies such as oral nutrition supplements to be offered as a supplemental benefit for Medicare Advantage plans

We support the working group's proposal that social services be allowed to be offered as a supplemental benefit for Medicare Advantage plans. We would particularly highlight the importance of Older Americans Act (OAA) nutrition programs or medically-tailored home delivered meal programs (which would be categorized as a "social service") to MA beneficiaries with chronic illness. These programs are essential to allowing older adults to live safely and independently in their communities.

We recommend that plans offer these benefits to ensure that patients who may not be able to prepare meals for themselves receive a proper diet. This will reduce the risk of malnutrition for these older adults, in turn reducing hospital readmissions. It will also significantly lower the chances that they will need residential care. Seventy-seven percent of congregate and 84 percent of home-delivered meal participants say they eat healthier meals because of OAA nutrition programs, and 61 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes. Further, the Administration for Community Living states that the lowest prevalence of malnutrition is found among older adults in the community.³¹ By providing access to meals programs, older adults can remain in the community and also stay nourished.

Further, some older adults with chronic disease are not able to fully meet their nutrition needs with food alone. For them, oral nutrition supplements (ONS) become an important malnutrition therapy. Use of oral nutrition supplements prescribed by an RD or other clinically qualified nutrition professional has been shown to help improve health outcomes in malnourished patients with chronic disease. For example, one recent study of older adults with a primary diagnosis of COPD compared hospitalized COPD patients who had ONS ordered for them with non-treated patients. The study attributed ONS use with a 21.5 percent reduction in length of stay (from 8.75 days among untreated patients to 6.87 days for those receiving ONS) and a reduction in episode costs of \$1,570, from \$12,523 to \$10,953 or 12.5 percent. Among those episodes which could be tracked for follow-up, ONS use also lowered the probability of 30-day readmission by 13.1 percent. The researchers concluded: "oral nutrition supplements

present an inexpensive, effective means for reducing length of stay, episode cost, and readmission risk in hospitalized Medicare patients with COPD. As such, ONS may offer an opportunity to reduce costs to Medicare while improving quality of outcomes.”³²

4. Include screening, assessment, and treatment for malnutrition and other nutrition-related chronic conditions, including nutrition social services, as part of special needs plans for beneficiaries with chronic illness (C-SNPs)

We propose that social services be offered as a supplemental benefit for MA special needs plans for beneficiaries with chronic illness (C-SNPs). As discussed in our background section, chronic disease increases the risk of malnutrition in older adults, and these social services are incredibly important to the treatment and prevention of malnutrition. Nutrition social services and other treatments for malnutrition that may be ordered by RDs and other clinically qualified nutrition professionals (such as oral nutrition supplements) need to be coupled with systematic malnutrition screening and assessment because beneficiaries will benefit most when malnutrition risk is quickly identified and targeted for intervention. We would also highlight the need to make sure RDs and other clinically qualified nutrition professionals are covered providers under C-SNPs to treat malnutrition and nutrition-related chronic conditions, such as high blood pressure, diabetes, and heart disease.

As stated before in section 3, we would also particularly spotlight the importance of Older Americans Act (OAA) nutrition programs or medically-tailored home delivered meal programs (which would be categorized as a “social service”) to MA C-SNP beneficiaries.

5. Allow nutrition social services and meals to be reimbursed for outpatient mental health services

We propose that nutrition social services and meals should be reimbursed for outpatients using mental health services, especially including Older Americans Act (OAA) nutrition programs or medically-tailored home delivered meal programs. These nutrition services are critical to both allowing these outpatients to live independently in their homes as well as allowing proper medication treatment—without a proper diet, medications may not be taken (particularly due to lack of resources to pay for both) or may not work correctly. Many older adults struggle with these issues; more than two million older Americans suffer from some form of depression, and symptoms of clinical depression can be triggered by chronic illness, such as Alzheimer’s disease, Parkinson’s disease, heart disease, cancer and arthritis.³³ That means the importance of properly treating these patients cannot be overstated.

6. Include nutrition social services as a supplemental service provided with an Accountable Care Organization

The chronic care working group is considering clarifying that Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Plan (MSSP) may furnish a social service for which payment is not made under fee-for-service Medicare. As the paper states, a growing

body of evidence suggests that the provision of social services in conjunction with health care services can lower health care use and costs, and improve health outcomes. We recommend that nutrition social services should be supplemental services provided with ACOs, for the reasons provided under sections 3, 4, and 5.

7. Allow Medicare Advantage plans to include telehealth services provided by RDs or other clinically qualified nutrition professionals as a regular benefit

RDs are already approved telehealth providers under traditional Medicare and can provide important services easily via videoconference or telephone calls. Nutrition plays an important role in the health of patients with chronic illness, as we have emphasized, and RD or other clinically qualified nutrition professional telehealth appointments should be included as a regular benefit under MA.

8. Include measurement of malnutrition as a community-level quality measure for chronic conditions

As stated in the document, the working group is considering requiring that CMS includes in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease, as well as considering recommending that GAO conducts a report on community-level measures as they relate to chronic care management. We recommend that malnutrition be part of these community-level measures. When malnutrition is effectively measured, it can be effectively treated; further, it is important to know where the system is failing patients in this regard.

9. Include coverage for Diabetes Self-Management Training (DSMT) or the National Diabetes Prevention Program (NDPP) for prediabetes as well as including coverage under Medicare for services analogous to DSMT for patients with malnutrition and at risk of malnutrition

The working group is considering recommending that Medicare Part B provide payment for evidence-based lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes, in short allowing people with prediabetes to participate in a program similar to Diabetes Self-Management Training (DSMT). We agree with this recommendation. We also recommend that Medicare Part B cover participation by people with prediabetes in the National Diabetes Prevention Program (NDPP), a program which is recognized by the Centers for Disease Control and Prevention (CDC) and based on a clinical trial with over ten years of data from both the CDC and the National Institutes of Health. We also support the idea of patients with malnutrition and at risk of malnutrition being allowed to access services analogous to DSMT and the NDPP.

We appreciate your consideration of our comments. Please feel free to contact us at info@defeatmalnutrition.today if you have any questions or if you need additional information.

Sincerely,

DefeatMalnutrition.Today

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