Danielle Holahan
Director of New York State Health Benefit Exchange
New York State Department of Health

August 17, 2012

RE: Public Comment on the Milliman Essential Health Benefits Overview

Dear Ms. Holahan:

God's Love We Deliver is a non-sectarian, 501(c)(3) non-profit. We are the only food and nutrition services agency that provides individually tailored, life-sustaining meals and medical nutrition therapy to individuals living with life-threatening illnesses throughout the five boroughs of New York City. As the state shapes the Essential Health Benefits (EHBs) by deciding which benefits shall be included in the Medicaid Benchmark plan, God's Love strongly recommends the inclusion of food and nutrition services and medical nutritional therapy in the P*reventive and Wellness Services and Chronic Disease Management* category of this package. Research has yielded promising results demonstrating the efficacy of both of these services in producing improved health outcomes and vastly lowered healthcare costs. In addition, through HRSA, the federal government has already recognized the medical importance of the provision of medical nutrition therapy and the food that accompanies it, by deeming these services to be core medical services[i].

Medical nutritional therapy (MNT) includes nutritional diagnostic, therapy, and counseling services focused on prevention, delay or management of diseases and conditions, and involves an in-depth assessment, periodic reassessment and intervention provided by a licensed, registered dietitian outside of a primary care visit. Food and nutrition services (FNS) encompasses home delivered meals, congregate meals, food pantries and vouchers that complement and are necessary to the fulfillment of MNT.

About Us
In 1985, God's Love began as a response to the AIDS pandemic. Ten years ago, we expanded our mission to serve people living with cancer, Alzheimer's disease, Parkinson's disease, renal failure, severe diabetes, heart disease and over 200 other unique diagnoses. In FY12, we cooked and home delivered over 1,085,000 meals. Because illness affects the entire family, we also provide nutrition and meals for the children and senior caregivers of our clients. Though we serve every demographic, 90% of our clients live at or below the poverty level. In 26 years of service, we have never maintained a waiting list and we have never charged clients for our meals.

FNS and MNT are Cost-Effective
God's Love recognizes that the design of our present healthcare system results in people living with multiple, serious chronic illnesses being a significant financial drain on the healthcare system of New York State. Further, we understand that the quandary facing the decision on EHBs and Benchmark plans is how to provide maximum coverage without raising the cost of

plans in the market overall. Based on research, the inclusion of FNS and MNT as EHBs for high-cost, high-need, high-risk patients is a solution to this dilemma, as the provision of medically appropriate, nutritious food and customized nutritional support to help chronically-ill patients through difficult periods plays an integral part in accomplishing cost savings, while helping patients to be as healthy as possible for as long as possible.

Not only does good nutrition result in better health outcomes, it also enables people with chronic illnesses to remain in their homes, as opposed to in more expensive forms of care such as hospitals or nursing homes. Malnutrition is one of the greatest contributors to hospitalization, re-admission and nursing home care nationally. Medical nutrition therapy for those most at risk for malnutrition because of their illness is often forgotten as a remedy, even though it is an inexpensive treatment that addresses this root cause of hospitalization and institutionalization for the chronically ill. One can feed a person a diet designed for their unique combination of illnesses for $20/day, whereas a hospital stay is upwards of $4,000/day.

A recent study lends further support. Our sister FNS provider, MANNA (Philadelphia, PA), partnered with the OMG Center for Collaborative Learning to compare the average monthly health costs for a variety of chronic and severe illnesses before and after enrolling in the MANNA FNS program. To date, only statistics for HIV/AIDS have been released, but other data is forthcoming. For HIV/AIDS clients, over the 13-month period examined, "the average monthly health care costs in the six months following initiation of MANNA services went from an average of approximately $50,000 per month prior to receiving MANNA services, to approximately $17,000 per month following initiation of services. Costs declined most markedly during the first three months after HIV/AIDS clients started receiving MANNA services; average monthly costs fell by over 80% in the first three months, from approximately $22,000 to about $4,000.[ii]"

In a white paper entitled *The Power of Nutrition*, published by the Association of Nutrition Services Agencies, the authors conclude that available hospital cost data indicates that the provision of food and nutrition services would result in potential savings in the magnitude of billions of dollars nationally for diabetes and HIV/AIDS alone. They also find that the relatively low cost of these programs makes a strong argument for maximal implementation and utilization of nutrition services[iii].

Outcomes Associated with FNS and MNT

Research demonstrates the positive heath outcomes and cost-savings associated with provision of FNS and MNT (*please see the Appendix*). FNS and MNT, when delivered pursuant to a doctor's recommendation and furnished by a registered dietitian, increase absorption of medication, reduce side effects, and help individuals maintain a healthy body weight.

Many severe conditions, such as diabetes and obesity, can also be managed with proper nutrition. Good nutrition reduces the risk of, and/or helps manage, chronic diseases such as heart disease and cancer. Food insecurity is a source of chronic stress that has consequences for immunological functioning, as well as for mental health, and is a major factor in reduced adherence to medical treatments. Most importantly, food and nutrition services facilitate access to and engagement in medical care, especially among vulnerable populations.

After 26 years of delivering nutrition to some of the most vulnerable New Yorkers, we have learned through experience that early and reliable access to medically-appropriate food and nutrition services helps people with chronic diseases live healthy and productive lives and produces better overall health outcomes. When people are chronically ill, good nutrition is one of

the first things to deteriorate, making recovery and stabilization that much harder, if not impossible. A patient's diet can literally have life and death consequences.

FNS and MNT Success: HIV/AIDS

One can see an example of the cost/benefits and positive health outcomes produced by the provision of FNS and MNT, by looking at the comprehensive range of these services provided through the federal Ryan White program to high-cost, high-risk people living with HIV/AIDS. This range of services fulfills the needs of people living with HIV/AIDS (PLWHA) at any stage of their illness.

In the Food Need and Medical Care factsheet recently released by the CHAIN Study, conducted at the Columbia University Mailman School of Public Health, the effects of food insecurity on health outcomes for PLWHA are identified. According to CHAIN, PLWHA who are food insecure report significantly more missed appointments for primary care and significantly more emergency room visits compared to those who do not report difficulties obtaining enough and appropriate food[iv]. PLWHA who are food insecure also have poorer health outcomes; they have lower CD4 counts and are less likely to have undetectable viral loads than the food secure[v]. These differences in health functioning and outcomes are statistically significant between food secure PLWHA and food insecure PLWHA and all are controlled for gender, ethnicity, income and other factors.

The Ryan White FNS program has been designed to mitigate these negative outcomes. It is our desire to export the overwhelming success of this program to the population of high-cost, high-risk Medicaid recipients by including FNS and MNT in the Medicaid Benchmark plan.

The MLTC Program Successfully Uses FNS and MNT

Currently, the only FNS that is covered under New York State Medicaid is in managed long term care (MLTC) plans, and this program supports home-delivered meals. Within Medicaid managed care, there is no structure currently in place to support the specific, nutritional needs of individuals until they are so ill that they must be enrolled in long-term care.

And yet, MLTC plans have already recognized the value of FNS and MNT in driving down costs by managing the multiple co-morbidities of the chronically ill Medicaid population. In 2005, God's Love started our Community Partners Program, through which we provide MNT and individually tailored meals to MLTC members as a vital element of their medical care. This home delivered meal program is a growing part of our service model, having gone from 4,200 meals when we began, to 120,000 meals in the last fiscal year. Currently, we subcontract with 14 MLTC programs in the NYC metropolitan area. With the expansion of MLTC through Medicaid redesign, God's Love has been asked and has agreed to contracts with additional MLTC providers and to expand services to Westchester and Nassau Counties.

If FNS and MNT are already an allowable benefit to help manage care when clients have become the most expensive, there is much wisdom in extending this model and allowing it to be effective *before* clients reach this stage. Now is the time to take into account the benefits of providing FNS to individuals whose medical condition warrants it before their diagnosis becomes even more serious and even more expensive. Thus, we respectfully request that you include FNS and MNT, when delivered pursuant to a doctor's recommendation and furnished by a registered dietitian, in the EHB package of the Medicaid Benchmark plan.

We understand that this inclusion may require the state to file for utilization of a "Secretary-approved Plan", but we believe that the cost effectiveness of providing this service far outweighs any administrative issues in filing this request. In the next few weeks, we know that more

elaboration on the content of the 10 categories of EHBs is expected from HHS. Even if states are required to cover the costs of mandated benefits in excess of EHB provisions, and FNS and MNT are found to fall into this category, the cost of the provision of these services is small and the funds saved so great, both of which are weighty arguments in favor of inclusion.

Provision of FNS and MNT When Medically Indicated

The inclusion of FNS and MNT in the EHB package does not mean that all Medicaid recipients would receive FNS and MNT. These services are not medically indicated for all. But for those individuals in Medicaid plans whose disease is intensely responsive to nutrition management, such as serious obesity and severe diabetes, or for those individuals whose malnutrition status indicates imminent institutionalization, FNS and MNT should be permissible as allowable services. FNS remains critical to the effective management of severe chronic diseases and in the prevention of preventable institutionalization in the MLTC program. In fact, many MLTC plans have already developed sophisticated protocols, which are generalizable, that they use to indicate medical need for FNS and MNT. Allowing for the inclusion of FNS and MNT in the Medicaid Benchmark would build on the success of the MLTC program, and extend the positive effects of FNS and MNT provision to populations with conditions that could, without intervention, quickly degenerate into more costly medical conditions.

Conclusion

Because of the unique cost savings and positive health outcomes associated with provision of FNS and MNT, we respectfully propose the inclusion of FNS and MNT as Essential Health Benefits in the Medicaid Benchmark plan.

Thank you for your consideration of our request. God's Love looks forward to working with NYSDOH to incorporate the provision of FNS and MNT into the Medicaid Benchmark. Please reach out to us with any questions.

Sincerely,

Karen Pearl
President & CEO

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APPENDIX

What follows is a sampling of the research available which highlights the unique, positive medical outcomes and cost savings associated with the provision of food and nutrition services to the chronically ill.

- In a white paper entitled "The Power of Nutrition," published by the Association of Nutrition Services Agencies, the authors conclude that **available hospital cost data indicates that the provision of food and nutrition services would result in potential savings in the magnitude of billions of dollars for diabetes and HIV/AIDS alone.**

They also find that the relatively low cost of these programs makes a strong argument for maximal implementation and utilization of nutrition services[vi].

- In a review by Kyle UG, Genton L, and Pichard C., which appeared in *Current Opinion in Clinical Nutrition and Metabolic Care* and examined the recent medical literature on the association between hospital length of stay and nutritional status, the authors found that **poor nutritional status has been associated with increased rate of medical complications, increased risk of nosocomial infections, greater hospital costs, higher mortality rates, and longer length of stay (LOS) in hospitals.**[vii].
- **The Community Health Advisory & Information Network** (the CHAIN Study), a study conducted through the Mailman School of Public Health at Columbia University, recently released a white paper demonstrating that food insecurity is associated with poor medical care outcomes, and that nutrition is an essential component of care and treatment for chronic diseases such as HIV/AIDS[viii]. At a statistically significant level, CHAIN Study data show that **those people living with HIV/AIDS (PLWHA) who are food insecure have higher viral loads and lower CD4 T-cell counts than those PLWHA that are food secure, are more likely to miss medical appointments and are more likely to have visited a hospital emergency room in the past six months[ix].**
- A study by Feldblum I, German L, Bilenko N, et al., appearing in *Nutrition*, demonstrates that patients who were determined to be at nutritional risk had more diagnosed diseases, a larger number of hospitalizations, and more family physician visits before the index hospital admission. They also had significantly more days of hospitalization for the current hospital admission and had significantly more days of hospitalization in the 3 months after the current admission. **Conclusion: Greater nutritional risk increases the risk of hospital admission and length of stay[x].**
- A study by Visvanathan R, Macintosh C, Callary M, Penhall R, Horowitz M and Chapman I, appearing in the *Journal of the American Geriatric Society*, determined that **subjects who were not well nourished (NWN, with MNA <24) at baseline were more likely in the 12-month period to have been admitted to the hospital (especially as an emergency admission), to have two or more emergency admissions, to spend more than 4 weeks in the hospital, to report weight loss, and to experience falls than nourished (N, with MNA 24+) subjects[xi].**
- A study by Paddock K, and Hirdes JP, appearing in *Home Health Care Services Quarterly*, showed the greatest correlation to the probability of using acute services in the last 90 days was most associated with ADL score, self-rated health, and the Nutrition CAP. **Poor nutritional status, poor self-rated health, and ADL impairments were significantly related to the use of acute health care services by elderly home care clients in the last 90 days[xii].**
- A study by Van Nes MC, Herrmann FR, Gold G, Michel JP, Rizzoli R., appearing in *Age and Ageing*, demonstrates that **poor nutritional status, as measured by the Mini Nutritional Assessment, was closely associated with likelihood of mortality, discharge to nursing home, and longer length of stay in hospitalized patients[xiii].**
- **discharge to nursing home, and longer length of stay in hospitalized patients[xiv].**

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[i] Hopson, Deborah Farnum, PhD, RN, FAAN (14 Aug 2009). *Revised list of definitions for eligible services for the Ryan White Treatment and Modernization Act of 2006*. Rockville, MD: Department of Health and Human Services/Human Resources Services Administration: HIV/AIDS Bureau, p. 3-4

[ii] (15 May 2012). *Final Report: An Examination of Health Care Costs and Health Outcomes among MANNA Clients and a Comparison Group*. Philadelphia, PA: OMG Center for Collaborative Learning, Average Monthly Health Care Costs, for HIV/AIDS: Figure 2.

[iii] The Association of Nutrition Services Agencies (2005). *The Power of Nutrition*. Washington DC: ANSA: 28

[iv] Aidala A, Yomogida M , and the HIV Food & Nutrition Study Team (2011): 2.

[v] Aidala A, Yomogida M , and the HIV Food & Nutrition Study Team (2011): 3.

[vi] The Association of Nutrition Services Agencies. "The Power of Nutrition". 2005

[vii] Kyle UG, Genton L, Pichard C. Hospital length of stay and nutritional status. Current Opinion in Clinical Nutrition & Metabolic Care. 2005 Jul; 8(4):397-402. [Review]

[viii] Bangsberg, David R., Frongillo, Edward A. Hogg, Robert S. Ragland, Kathleen, Riley, Elise D. and Weiser, Sheri D. Food Insecurity is Associated with Incomplete HIV RNA Suppression Among Homeless and Marginally Housed HIV-infected Individuals in San Francisco. Journal of General Internal Medicine. 2008; 24 (1): 14-20

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[x] Feldblum I, German L, Bilenko N, et al. Nutritional risk and health care use before and after an acute hospitalization among the elderly. Nutrition. 2009; 25(4):415-20.

[xi] Visvanathan R, Macintosh C, Callary M, Penhall R, Horowitz M, Chapman I. The nutritional status of 250 older Australian recipients of domiciliary care services and its association with outcomes at 12 months. Journal of the American Geriatric Soc. 2003;51(7):1007-11

[xii] Paddock K, Hirdes JP. Acute health care service use among elderly home care clients. Home Health Care Services Quarterly. 2003;22(1):75-85.

[xiii] Van Nes MC, Herrmann FR, Gold G, Michel JP, Rizzoli R. Does the mini nutritional assessment predict hospitalization outcomes in older people? Age and Ageing. 2001 May; 30(3):221-6.

[xiv] Van Nes MC, Herrmann FR, Gold G, Michel JP, Rizzoli R. Does the mini nutritional assessment predict hospitalization outcomes in older people? Age and Ageing. 2001 May; 30(3):221-6.