April 24, 2017

Ms. Seema Verma
Administrator
U.S. Centers for Medicaid & Medicare Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 2017 Transformation Ideas

Dear Administrator Verma:

Thank you for the opportunity to submit ideas to you and your staff for consideration as ways by which the delivery of services can be improved to better meet the health needs of Medicare enrollees being served under Medicare Advantage ("MA") and Part D programs. We applaud your interest in seeking potentially transformative ideas that could have a major impact on improving health and saving money, and we have several suggestions that we believe will significantly help to achieve both goals.

Meals on Wheels may not be a traditional respondent to a request like this. However, Meals on Wheels is, and for more than 45 years, has been an integral part of the healthcare continuum. In fact, Aetna Chairman and CEO Mark Bertolini said publicly at a recent conference sponsored by the Better Medicare Alliance that health plans and Meals on Wheels should be "joined at the hip." Here's why:

- Meals on Wheels seeks to enable seniors to live out their lives healthier and more safely and independently in their own homes, where they want to be. The national network of more than 5,000 Meals on Wheels programs in communities large and small, rural, suburban and urban, have worked tirelessly along with an army of over 2 million volunteers to support America's older adults with the greatest economic, social and health needs.
- Meals on Wheels has the trust and the permission to enter the homes of vulnerable seniors when most others, including health plans, cannot. We are the "eyes and ears" on these individuals—often on a daily basis—and can note changes of condition and/or fall and other safety risks that may be averted. Homes are a major factor in the social determinants of health and present untapped opportunities for healthcare prevention and remediation to happen outside of traditional medical settings.
- Meals on Wheels clients are far more vulnerable than comparably-aged Americans. The majority live alone, have limited to no mobility, suffer from multiple chronic conditions and limitations of daily living, are reliant on numerous daily medications, and are in desperate need of nutritious meals and companionship. These are the 20% of enrollees who are costing the system 80% of the healthcare spend, and Meals on Wheels is compassionately interacting with these individuals in their homes every day.

Whether meeting a long-term nutritional need or just providing a short-term intervention of meals to help someone through a care transition, Meals on Wheels is part of the healthcare solution for an aging America.

THE EVIDENCE BASE FOR MEALS ON WHEELS

The Meals on Wheels More Than a Meal model is much more than just the nutrition delivered to improve the health of high-risk seniors – it is also the socialization to reduce isolation and loneliness, the safety checks to note changes in condition and reduce risks and the connections to other community-based services that help to meet a variety of other needs that vulnerable seniors confront. The evidence clearly shows the positive impact Meals on Wheels has on improving health outcomes and reducing healthcare utilization and costs. It works, and it saves money. In fact, we can provide the full range of Meals on Wheels services for an entire year – nutrition, companionship and safety checks – for the cost of just one day in a hospital or 10 days in a nursing home.

Even before readmission rate penalties were contemplated, we conducted a five year transition care program from 2006-2010 with a large insurance company that eventually spanned 36 states covering more than 135,000 Medicare Advantage beneficiaries. The service involved a limited offering of ten frozen meals following discharge and direct telephonic connections by the local Meals on Wheels program. Analysis of a pilot study for that program indicated that the post-discharge savings for the first month were substantial, averaging approximately $1,000 for the first month on a Per Member Per Month basis, compared to matched individuals who did not receive the services. The results were significant:

- Overall healthcare savings averaging 31% per patient for the first month following hospital discharge (based on a study of the first project year);
- Fewer post-discharge costs, including fewer hospital inpatient days and inpatient admissions per 1,000;
- Referral opportunities for about 30% of recipients for ongoing meal and other community services; and
- Positive impacts for patients with higher intensity inpatient stays.

Subsequent research engagements have shown that daily meal delivery over a longer period of time (30 days – 6 months or more) produces even more favorable health outcomes and longer-term cost savings. Based on studies with five Meals and Wheels programs and hospitals in CA, KS, TX, NC, OH and ME, readmission rates were reduced to 6-7% over a 30-day period, as compared to the national readmission rate averages of 15%-33%.

Social isolation is also a big issue for seniors—where one in four is living alone—and the health implications can be severe. Studies have shown that the effects of loneliness and isolation are comparable to the impact of well-known risk factors such as obesity and substance abuse (Brigham Young), and are the equivalent of smoking 15 cigarettes a day (Holt-Lunstad, 2010). Loneliness is also associated with an increased risk of heart disease, stroke (Valtorta et al, 2016) and high blood pressure (Hawkley et al, 2010). That's why the friendly visit is such a critical component of Meals on Wheels.

The economic case for Meals on Wheels continues. Brown University, as reported in the Health Services Research Journal, found that for every additional $25 a state spends on home-delivered

meals per senior per year, it can expect a 1% decrease in the low care nursing home population. That translates to $109 million in Medicaid savings annually. Further, in a 2015 randomized control trial entitled *More Than a Meal* and conducted by Meals on Wheels America in conjunction with Brown University and AARP Foundation, home-delivered meal recipients reported reduced rates of hospitalizations, falls and fear of falling, and greater improvements in anxiety, health, isolation and loneliness, as compared to a control group. Falls alone, according to the Centers for Disease Control and Prevention, cost our nation more than $31 billion in annual Medicare expenses.

Research consistently shows that seniors receiving Meals on Wheels are able to better remain living at home and out of far more costly healthcare settings, such as hospitals and nursing homes. Based on an annual survey conducted by the Administration for Community Living, 83% and 92% of seniors who receive Meals on Wheels say that it makes them healthier and enables them to remain at home, respectively.

Today, 10.2 million seniors – or one in six – struggles with hunger – a 65% increase since the start of the recession in 2007 and a 119% increase since 2001. In 2014, funding provided through the Older Americans Act (OAA) supported the provision of meals to 2.4 million seniors nationwide. The problem – simply put – is that too many seniors who need nutritious meals are not getting them, which is contributing to poorer health and increased utilization of much more expensive healthcare options. In fact, a recent Government Accountability Office report found that about 83% of food insecure seniors and 83% of physically-impaired seniors did not receive meals [through the OAA], but likely needed them. The OAA network overall is serving 23 million fewer meals to seniors in need than it was in 2005, which is due in large part to federal funding not keeping pace with inflation or need. The trend is moving in the wrong direction at a time when the vulnerable senior population is growing exponentially.

Because Meals on Wheels can substantially help to reduce post-discharge costs and readmissions, it makes economic sense to expand our services. We hope that through programs like Medicare Advantage, you can help.

SPECIFIC RECOMMENDATIONS FOR PART C

1. **MA Plans Should Have More Flexibility in Benefit Design and in Determining Remedies to Meet the Health Needs of their Members.** Section 30.3 of the Medicare Advantage Manual provides some opportunities for meals to be incorporated as a Supplemental Benefit with limitations – for transition care purposes and for certain chronic conditions, both for a relatively short duration. There may be many other critical reasons why a senior may need nutrition services, and why such services may need to last more than 30 days. More importantly, it is not just the meals that are important – it is also the daily interaction offered by Meals on Wheels in the home, where critical and actionable health information can be ascertained – before a problem escalates to an emergency department visit or a hospital admission. Even asking simple questions about whether a senior is taking his or her medications can be insightful, and if an issue arises, it can be reported back to the person's MA plan, which will then have the opportunity to intervene more directly to potentially avoid more expensive and often unnecessary care alternatives. By providing more flexibility for nutrition services, MA plans would be encouraged to work more closely with Meals on Wheels programs so that engagement with the at-risk enrollee can be increased, and these positive results can be obtained.

Further, the requirement that a supplemental meal benefit be uniform from market to market is counterproductive to achieving the best outcomes for the enrollee. Daily hot meals delivered by Meals on Wheels programs can achieve the best outcomes for the reasons cited above. However, in rural locations, for example, where daily, hot meal service is not practical due to the transportation distances, a package of frozen meals delivered less frequently might be more appropriate. The uniformity requirement, though, forces the meal offerings to be the same – meeting the common denominator of just using frozen meals that can reach all beneficiaries, regardless of location. More flexibility to permit the delivery of daily hot meals where possible, and frozen meals elsewhere – where the nutritional values and costs are roughly the same – would magnify the benefits of utilizing Meals on Wheels services.

2. **MA Plans Can No Longer Expect Community Services to Continue to Provide Meals.** For the reasons cited above relative to supply and demand of meals provided under the Older Americans Act, community-based service organizations no longer have the automatic ability to provide meals for health plans at no cost, which stand to benefit significantly from the services provided by organizations like Meals on Wheels. Accordingly, we believe the following provision in the Medicare Manual at Section 30.3 needs to be rephrased:

   "Immediately following surgery or an inpatient hospital stay, for a temporary duration, typically a four-week period, per enrollee per year, provided they are ordered by a physician or non-physician practitioner. As discussed in 42 CFR § 422.112(b)(3), after the temporary duration, the provider should refer the enrollee to community and social services for further meals, if needed, or . . ." (Underline added).

   Severe budget constraints have forced Meals on Wheels programs to serve fewer meals to fewer seniors in need. Many Meals on Wheels programs have instituted waiting lists because they do not have the resources to meet the growing demand for services. To suggest that a health plan "should refer the enrollee to community and social services for further meals" is not only counterproductive, it places the enrollee's health in jeopardy if meals are not able to be provided by the local Meals on Wheels provider. Medicare has the resources to cover the costs of nutrition services that produce positive health outcomes, and MA plans need to have the flexibility to be able to continue to pay for meals for as long as the enrollee needs nutritional assistance. Again, the benefit to the system is not just the improvement of health due to the provision of good nutrition, but it is also the ongoing connection that the health plan has to that enrollee through the eyes and ears of Meals on Wheels, reporting back information on changes of condition – *before* a problem arises.

3. **CMS Needs to Enforce Requirements for Community and Social Services Coordination.** The Medicare Manual at Section 30.3 (and the applicable regulations) also states:

   "Note that all MA coordinated care plans are required to 'coordinate MA benefits with community and social services generally available in the area served by the MA plan (§422.112(b)(3)).'"

The Federal government, through the Older Americans Act and with the administration of CMS' sister agency, the Administration for Community Living (Administration on Aging), has built an extensive national senior infrastructure that provides a wide variety of services to millions of seniors every day. It is a very effective and comprehensive network of service providers on which seniors rely, but it is continuing to be threatened with less Federal support. CMS has appropriately and beneficially included language to require the coordination of MA benefits with these nonprofit community-based service providers. Despite this language, however, far too many MA plans contract with for-profit service providers that are in direct competition to the elaborate network of nonprofit programs and that do not, and cannot, provide a comparable service. Such contracting has the adverse effect of weakening the very system this provision was intended to support. Health plans should be leveraging this existing network of community-based service providers through contracts for the provision of services, and such actions should be more effectively encouraged – if not required – by CMS.

4. **CMS Should Review HIPAA Requirements Relative to Engagement of Community-Based Service Programs.** The Health Insurance Portability and Accountability Act ("HIPAA") states at §164.104 Applicability:

   "(a) Except as otherwise provided, the standards, requirements, and implementation specifications adopted under this part apply to the following entities:

   (1) A health plan.
   (2) A health care clearinghouse.
   (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter."

   When HIPAA was first enacted, Members of Congress may not have envisioned the role that should be played by community-based organizations in providing services. Meals on Wheels programs provide nutrition services; they are not a health plan, a clearinghouse or a healthcare provider in the traditional sense of the words. While they may inform a health plan of observations or limited information obtained from enrollees relating to conditions, they are not medical professionals as intended under the concept of a "health care provider." They do not share complex health information or records. Further, Meals on Wheels programs and other community-based service providers often do not have the staff or resources to administer and manage the labyrinth of complex regulatory requirements imposed on, or by, healthcare plans. As a result, they are often prevented from working with MA plans. This is a major obstacle for expanded engagement of community-based organizations. Short of Congressional action (which we recognize may be necessary to clarify the legislation), any action that can be undertaken by CMS to ease the regulatory burdens imposed on engagements for limited services provided by community-based organizations would help to achieve the goals for community and social service coordination.

5. **CMS Should Modify the Part C Regulations to enable Physicians for MA Plans to write Prescriptions for Meals.** This recommendation was originally proposed by the National Commission on Hunger. Doctor-prescribed meals would be different from the limited circumstances for the provision of meals under Supplemental Benefits and would

be more readily applicable to the specific needs and patient-centered care plans of the individual senior.

6. **CMS Should Improve the Discharge Planning Process to incorporate a Nutrition Assessment before Discharge.** There is no question that nutrition is a critical factor in facilitating recovery and preventing hospital readmissions. All too often, seniors discharged from the hospital return home, alone and often malnourished, to an empty refrigerator and stale food in the cupboard. Having no ability to shop, prepare, or access food, they often face further health decline and end up back in the hospital. This is when these vulnerable individuals need help the most, and Meals on Wheels, given the resources to provide services, is the intervention that can assist them most cost-effectively.

   Malnutrition among seniors is already a serious national problem. Up to 50% of older adults and 20% to 50% of patients are malnourished or at risk for malnutrition on hospital admission. Poor nutrition among older adults contributes substantially to slower healing, more infections and increased readmissions and post-discharge costs. Malnutrition causes increased hospital stays of 4-6 days; a 300% increase in healthcare costs; more complications, including falls and readmissions; and approximately $51.3B in annual healthcare costs.

   Despite its critical importance to the well-being and recovery of patients, nutrition planning is not routinely considered as part of discharge planning. It needs to be. For example, a 2014 poll taken among nurses in the Academy of Medical Surgical Nurses, found that 43.5% of the respondents do not consistently incorporate nutrition into the discharge plan, and 84% lack nutrition information in the discharge plan. Further, 55% stated that they do not have clear methods of identifying and referring at-risk patients who develop nutrition issues, and 44% of AMSN members do not have nutrition embedded into their discharge planning process.

   A comprehensive nutrition assessment needs to be part of the discharge planning process. Nutrition support (meals and/or nutrition supplements) should be available immediately upon return to the home so there is no lapse in availability. Meals on Wheels programs routinely undertake nutrition assessments as part of their intake process for new clients and stand ready to help discharge planners and hospitals with the development of nutrition assessments and protocols, as well as to coordinate, where possible, the actual delivery of nutrition services if provided the resources to do so.

7. **CMS Should Enable MA plans to freely develop Pilot Projects to Test New Services and Innovation.** One of the obstacles Meals on Wheels, and perhaps other organizations have faced in engaging with MA plans, is the reported inability for the MA Plan to undertake pilot programs to test new or innovative services that are not part of their annual bid process. This means that if a pilot program is not included in the June bid, it will have to remain on hold for another year and a half before it could be implemented. Restricted pilots involving a small geographic area and limited number of individuals for education and research purposes, such as a pilot project to assess the impact of transition care meal services to seniors being discharged from the hospital, should be permitted to begin at any time. It is detrimental to delay the exploration of practical, limited and commonsense pilots to prove their impact on the improvement of health and

the reduction of costs. CMS should establish a review system to ensure such pilots are in fact limited and potentially beneficial, but allow them to start at any time.

CONCLUSION – MORE ENGAGEMENT OF MEALS ON WHEELS WITH MEDICARE ADVANTAGE PLANS WILL LEAD TO GREATER HEALTH BENEFITS, LOWER COSTS AND GREATER SATISFACTION

Meals on Wheels America supports the efforts you and your staff are taking to identify transformative changes that will improve care and save resources. Sometimes, the best solutions may be the ones that are right before us. Nothing is more important to health, wellness, disease management and recovery than good nutrition, and Meals on Wheels has been ensuring that America's seniors get the nutrition and companionship they need and deserve. As discussed above, there are many reasons why Meals on Wheels programs need to be more fully engaged with Medicare Advantage plans, not the least of which is that our services are a proven way to reduce admissions, readmissions and post-discharge costs.

Those in the healthcare field need to better understand the services and benefits offered by our programs. Millions of older adults already rely on community-based resources to maintain health and independence, and these services need to be expanded through Medicare so improved health outcomes and greater cost savings can be achieved at greater scale.

Thank you for your consideration of our comments. We would welcome an opportunity to meet with you and your staff to provide more detail on these recommendations and the role of Meals on Wheels in protecting the health and wellness of our nation's most vulnerable seniors.

Sincerely,

Ellie Hollander
President and CEO