

June 14, 2024

120 South Riverside Plaza
Suite 2190
Chicago, Illinois 60606-6995
800.877.1600

1150 Connecticut Avenue NW
Suite 615
Washington, D.C. 20036
800.877.0877

To: Senate Finance Committee

The Academy of Nutrition and Dietetics (“the Academy”) appreciate the opportunity to submit comments related to the May 17, 2024, white paper soliciting comments to the Senate Finance Committee on *Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B*.

The Academy represents over 113,000 registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists; it is the largest association of credentialed nutrition and dietetics practitioners in the world and is committed to accelerating improvements in global health and addressing food and nutrition security and the effects it has on health and well-being. Every day, we work with Americans from all walks of life, from birth through old age, providing professional services such as Medical Nutrition Therapy (MNT). Medical Nutrition Therapy is defined by Section 1861 of the Social Security Act as Medicare Part B benefit and is paid for under the Medicare Physician Fee Schedule. The Act also recognizes registered dietitians as the qualified provider type to deliver the service.

The Academy applauds the committee’s commitment to ensuring access to high quality care so that individuals with chronic conditions can achieve better health outcomes. We remain committed to supporting meaningful payment reform that not only focuses on responsible health care spending but also implements whole-population prevention strategies and chronic disease management that includes access to evidence-based nutrition care. However, we would be remiss in our efforts if we do call attention to the fact that our nation continues to pay the prices for overlooking the importance of nutrition in both preventing and treating chronic disease. Our nation’s health policy continues to fall short when comes to focusing on disease prevention, wellness or healthy lifestyles.

Summary of America’s chronic disease crisis and access to nutrition care

The CDC’s National Diabetes Statistics Report estimates that almost 30% of Americans aged 65 or older have diabetes (diagnosed and undiagnosed)¹ and 33.7% of adults aged 65 or older have chronic kidney disease.² Furthermore, the CDC estimates that 129 million Americans have at least 1 chronic condition, and

¹ <https://www.cdc.gov/diabetes/data/statistics-report/index.html>. Accessed June 11, 2024

² <https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html>, Accessed June 11, 2024

that 5 of the leading causes of death are associated with a preventable and treatable chronic disease.³ Nutritional inadequacy and physical inactivity are major factors in chronic conditions such as cardiovascular disease and type 2 diabetes, which are leading causes of death for Americans 65 years and older.⁴ Practice guidelines for diabetes care⁵ and cardiovascular disease⁶ underscore the critical role of MNT as a cornerstone in the comprehensive management of both conditions. Multiple studies have shown that MNT provided by RDNs leads to significant improvements in HbA1c levels, ranging from 0.3% to 2.0% within six months.⁷ Additionally, multiple MNT visits provided by dietitians can improve lipids, blood pressure⁸, A1c, weight status, and quality of life, resulting in significant cost savings for adults.⁹ Despite MNT being a widely recognized component of medical guidelines for the prevention and treatment of many chronic conditions, accessing clinically appropriate nutrition care remains low. Insufficient coverage of nutrition services, ambiguous language describing nutrition services and existing physician-centric payment models in Medicare and private insurance do little to ensure that services are actually provided by those best able to provide them effectively.

Our Health Care System Fails to Fund Nutrition Care Services

There are substantial gaps in how our healthcare system addresses the role of nutrition in preventing and treating chronic conditions, particularly in Medicare. Currently, Medicare only covers outpatient MNT provided by an RDN for beneficiaries with diabetes, chronic renal insufficiency/non-dialysis kidney disease (limited to Stage 3 and 4), or post-kidney transplant, with a referral from an MD/DO. Medicare offers too little nutrition care (up to 12 hours of MNT in the first year of treatment and up to 8 hours in years two and three)¹⁰ and too late. There is no coverage for prediabetes or individuals at risk of developing diabetes. Beneficiaries must progress to diabetes to access MNT, a cornerstone of diabetes care. Medicare's coverage for obesity care is similarly problematic, requiring a diagnosis of obesity before paying for intensive behavioral therapy services, which must be delivered in a primary care setting.

Nutrition coverage for beneficiaries at risk for or who have cardiovascular disease, cancer, eating disorders, hypertension, dyslipidemia, or other conditions is non-existent. Despite the significant number of beneficiaries with diabetes and chronic kidney disease, the Medicare MNT Part B Benefit remains underutilized, with less than 2% using the benefit.¹¹ There is no incentive within the current Medicare

³[https://www.cdc.gov/pcd/issues/2024/23_0267.htm#:~:text=An%20estimated%20129%20million%20people.and%20Human%20Services%20\(2\)](https://www.cdc.gov/pcd/issues/2024/23_0267.htm#:~:text=An%20estimated%20129%20million%20people.and%20Human%20Services%20(2).). Accessed June 11, 2024.

⁴ National Vital Statistics System – Mortality Data (2022). Available at: <https://wonder.cdc.gov/controller/saved/D158/D390F347>. Accessed June 5, 2024.

⁵ Franz MJ, MacLeod J, Evert A, Brown C, Gradwell E, Handu D, Reppert A, Robinson M. Academy of Nutrition and Dietetics Nutrition Practice Guideline for Type 1 and Type 2 Diabetes in Adults: Systematic Review of Evidence for Medical Nutrition Therapy Effectiveness and Recommendations for Integration into the Nutrition Care Process. *J Acad Nutr Diet*. 2017 Oct;117(10):1659-1679. doi: 10.1016/j.jand.2017.03.022

⁶ Sarah A. Johnson, Carol F. Kirkpatrick, Nicole H. Miller, Jo Ann S. Carson, Deepa Handu, Lisa Moloney, Saturated Fat Intake and the Prevention and Management of Cardiovascular Disease in Adults: An Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guideline, *Journal of the Academy of Nutrition and Dietetics*, Volume 123, Issue 12, 2023, Pages 1808-1830, <https://doi.org/10.1016/j.jand.2023.07.017>.

⁷ Academy of Nutrition and Dietetics Evidence Analysis Library. DM: Diabetes Type 1 and 2 Systematic Review (2013-2015). <https://www.andeal.org/topic.cfm?menu=5305&pcat=5491&cat=5161>. Accessed June 10, 2024.

⁸ <https://www.sciencedirect.com/science/article/pii/S0002916524004039?dgcid=author>

⁹ Sikand G, Handu D, Rozga M, de Waal D, Wong ND. Medical Nutrition Therapy Provided by Dietitians is Effective and Saves Healthcare Costs in the Management of Adults with Dyslipidemia. *Curr Atheroscler Rep*. 2023 Jun;25(6):331-342. doi: 10.1007/s11883-023-01096-0.

¹⁰ <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=252> Accessed June 13, 2024.

¹¹ 86 FR 39259 through 39261: MNT participation remains under 2 percent of eligible beneficiaries. Based on an analysis of Medicare claims data from 2018, 2019, 2020, we identify the utilization rate of MNT services among eligible beneficiaries to be between 1.5 and 1.8 percent.

program for the use of RDNs as part of the healthcare team to deliver nutrition care. Additionally, the limitations of the Medicare Part B benefit design have led many RDNs to not accept Medicare assignment, preferring to earn a sustainable income by accepting insurance with a more comprehensive benefit or cash pay for MNT outside of Part B. This leaves a gap in the ability of beneficiaries to seek the nutrition care they are entitled to.

How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?

To improve the A-APM options, there must be a focus on model development that meaningfully incorporates non-physician providers, such as RDNs. The Quality Payment Program (including MIPS, MIPS Value Pathways, and Advanced Alternative Payment Models) was designed from the physician lens, which has made it challenging for non-physician providers to meaningfully participate. For Example, RDNs were granted eligible clinician/qualified APM participant status in 2019¹², however, many RDNs continue to face significant barriers to participating in the QPP ((CMS QPP Experience Data reported 522 RDNs participated)¹³. RDN practices were not included in the EHR Incentive Program, which was designed to make access to health information technology and interoperability among all providers a reality. Many RDN practices continue to rely on manual reporting and data collection which can make it difficult to near impossible to participate in quality reporting. Member feedback reveals that while there is interest in participating in the QPP, the complexities of the program prove to be too burdensome. In addition to technology barriers, many RDNs have expressed concerns when selecting which measures to report, and meeting participation thresholds.

Additionally, the Academy agrees with the committee's findings that the quality performance measures available to specialties are limited. In a recent publication from America's Health Insurance Plans, it was stated that the aim of integrating quality performance into a Value-Based Care (VBC) payment model is to encourage quality improvement and maintain long-term high-quality care, particularly in areas where immediate returns on investment may not be evident.¹⁴ Furthermore, the authors stress the importance of limiting administrative burden or utilizing measures that are not clinically meaningful as the incentive use resources (personnel or capital) is insufficient.¹⁵

Team-based care often provides excellent health outcomes for patients, and Medical Nutrition Therapy (MNT) by Registered Dietitian Nutritionists (RDNs), is a component of team-based care and is essential for managing chronic diseases beyond diabetes and renal disease. However, while nutrition interventions can indeed lead to measurable positive outcomes, these improvements require both time and a commitment to change.

The Nutrition/Dietitian Measure set includes nine measures, but only two are directly related to nutrition care (Hemoglobin A1C and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents). The remaining seven measures, while important, do not reflect the full scope or quality of care provided by RDNs. Without meaningful, clinically relevant measures, there is little incentive

¹² 83 FR 59452

¹³ <https://data.cms.gov/quality-of-care/quality-payment-program-experience> Accessed June 11, 2024.

¹⁴ AHIP: A playbook of voluntary best practices for VBC Payment arrangements" 2024

¹⁵ *ibid*

to fully integrate RDN services into primary and chronic care. When developing models of care addressing chronic care, consideration must be given to non-physician providers who deliver components of comprehensive care. This could include:

- Incorporate incentives that support utilization of subspecialties, such as RDNs to deliver nutrition care.
- Supporting A-APM model design that incorporates measures that allow for non-physician providers to meaningfully participate.

1. What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?

2. Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?

While the Academy recognizes the importance of improving the quality of care delivered under the Medicare Physician Fee Schedule, we suggest that the current proposal is premature regarding the provision of comprehensive nutrition care. Senate Bill 3297, the Medical Nutrition Therapy Act, aims to expand the number of conditions eligible for Medicare coverage under Medical Nutrition Therapy (MNT). Although this bill does not directly address the proposed questions, it highlights a broader issue.

Many Registered Dietitian Nutritionists (RDNs) provide MNT services for conditions not currently covered under Medicare Part B, such as obesity, hypertension, cardiovascular disease, cancer, and eating disorders. The limited scope of the Medicare MNT benefit leaves many beneficiaries needing nutrition care for conditions other than diabetes and chronic kidney disease with few options beyond paying out of pocket or foregoing necessary care altogether.

Understanding the full scope of MNT utilization and estimating its true cost and impact on high quality care is difficult.

- The Medicare program was not originally designed to support non-physician providers. While RDNs are permitted to work within this framework, it is not optimal. Medical Nutrition Therapy is the primary service offered by RDNs to Medicare beneficiaries, however there are other services that fall squarely within the scope of the RDN, such as IBT for Obesity and continuous glucose monitoring for which RDNs are not permitted to direct bill Medicare.
- Many RDNs operate outside the Medicare system. Since Medicare's MNT benefit is limited, many beneficiaries needing nutrition care for conditions other than diabetes and chronic kidney disease must either pay out of pocket or forgo necessary care. As such, relying on Medicare claims data alone would provide an incomplete picture of the use and impact RDN provided nutrition care has on beneficiaries.

To support quality care from non-physician providers, such as RDN, policies should address their unique needs and operational realities.

In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?

Are there benefit design flexibilities that would ease financial burden for ACO-attributed beneficiaries who require chronic care management?

The Academy agrees with the committee's finding that the prevalence and cost of chronic conditions for beneficiaries and the Medicare program account for a disproportionate share of service utilization and spending. While MNT is not a new service under the Medicare program, there is recognition that access to MNT services are needed beyond the diagnoses of diabetes and non-dialysis chronic kidney disease. As such, value-based payment arrangements must adequately factor the cost of providing MNT, if MNT is not eligible for a separate FFS payment. Inclusion in such payment arrangement will help to improve access to and quality of care received by beneficiaries living with chronic conditions.

- 1. Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?*
- 2. What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?*

IBT for Obesity

The Centers for Disease Control (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, making obesity an epidemic.¹⁶ In 2020, nearly 14 million Medicare beneficiaries were either overweight or obese.¹⁷ Moreover, obesity is associated with many chronic diseases, including cardiovascular disease, musculoskeletal conditions, and diabetes.¹⁸ Tailored Medical Nutrition therapy has been a long standing component of comprehensive obesity care¹⁹, and is widely recognized in obesity care guidelines as a fundamental part of lifestyle interventions.²⁰ However, significant barriers exist with the Medicare program that prohibit beneficiaries from accessing this service.

The current Intensive Behavioral Therapy (IBT) for Obesity benefit under Fee-For-Service (FFS) aims to reduce obesity rates and its associated comorbidities in the United States. However, the benefit design is based on older literature and has not kept pace with current evidence. In 2011, CMS had to use the outdated 2003 U.S. Preventive Services Task Force (USPSTF) recommendations for "Screening Obesity in Adults" as the basis for its assessment, as these were the most current at the time. These recommendations, based on literature from the 1990s, were drafted before the Task Force updated its processes and terminology to stay relevant to primary care practice.²¹ Since the publication of the NCD for

¹⁶ <https://www.cdc.gov/obesity/php/data-research/adult-obesity-prevalence-maps.html> Accessed June 13, 2024

¹⁷ <https://www.kff.org/medicare/press-release/an-estimated-1-in-4-medicare-beneficiaries-with-obesity-or-overweight-could-be-eligible-for-medicare-coverage-of-wegovy-an-anti-obesity-drug-to-reduce-heart-risk/#:~:text=Based%20on%20KFF%20research%2C%20about,risk%20of%20serious%20heart%20problems>. Accessed June 12, 2024

¹⁸ <https://stop.publichealth.gwu.edu/fast-facts/obesity-related-chronic-disease#:~:text=Obesity%20is%20associated%20with%20cardiometabolic,heart%20disease%20and%20stroke%2C%20including%3A&text=8%2C12-high%20blood%20pressure,low%20density%20lipoprotein%2C%20LDL> Accessed June 13, 2024

¹⁹ <https://www.jandonline.org/action/showPdf?pii=S2212-2672%2822%2901200-X> Accessed June 13, 2024

²⁰ <https://pubmed.ncbi.nlm.nih.gov/24239920/> Accessed June 13, 2024

²¹ Barton, Mary & Miller, Therese & Wolff, Tracy & Petitti, Diana & LeFevre, Michael & Sawaya, George & Yawn, Barbara & Guirguis-Blake, Janelle & Calonge, Ned & Harris, Russell. (2007). How to Read the New Recommendation Statement: Methods Update from the U.S. Preventive Services Task Force. *Annals of internal medicine*. 147. 123-7.

IBT for obesity, studies have been published demonstrating RDNs as effective providers of behavioral therapy for adult weight management.²²

Additionally, the IBT for obesity is covered only if Medicare beneficiaries receive the service from their physician or other primary care provider (PCP) in a primary care setting.²³ This ultimately limits the access to the service, as those providers who actually deliver the care must do so “incident to” and under direct supervision. This is also impractical and fails to reflect how modern primary care functions—by fostering an environment of collaboration and coordination without co-location that eases the burden of providing care and improves access to care for patients. Medicare beneficiary need for, and utilization of, intensive behavior therapy will continue to increase especially now with the introduction of anti-obesity medications. It is imperative that policies and rules are updated to reflect current practice guidelines and care delivery.

The Academy sincerely appreciates the opportunity to offer comments to the Senate Finance Committee. We recognize the importance and complexity of addressing physician and provider payment issues and are committed to supporting payment reform. Our goal is to align incentives that promote both preventive care and chronic disease management, ensuring inclusivity of all providers, including Registered Dietitian Nutritionists (RDNs) who serve Medicare beneficiaries.

For any questions or additional information, please contact Jeanne Blankenship at 202-775-8277 or jblankenship@eatright.org or Carly Leon at 312-899-1773 or cleon@eatright.org.

Sincerely,



Jeanne Blankenship MS RDN
Vice President, Policy, Initiatives and Advocacy
Academy of Nutrition and Dietetics



Carly Leon MS RDN
Director, Healthcare policy and payment
Academy of Nutrition and Dietetics

²² Medical Nutrition Therapy Interventions provided by Dietitians for Adult Overweight and Obesity Management: An Academy of Nutrition and Dietetics Evidence-Based Practice Guideline. *J Acad Nut Diet* 2023;23(3):520-545. doi: <https://doi.org/10.1016/j.jand.2022.11.014>

²³ <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=353>. Accessed June 13, 2024