March 10, 2020

Senator Cindy F. Friedman
Senate Chair, Joint Committee on Health Care Financing
Massachusetts State House, Room 208
Boston, MA 02133

Senator Harriette L. Chandler
Senate Vice Chair, Joint Committee on Health Care Financing
Massachusetts State House, Room 333
Boston, MA 02133

Representative Daniel R. Cullinane
House Vice Chair, Joint Committee on Health Care Financing
Massachusetts State House, Room 236
Boston, MA 02133

Re: An Act Relative to Establishing and Implementing a Food and Health Pilot Program (H. 4278)

Dear Senate Chair Friedman, Senate Vice Chair Chandler, and House Vice Chair Cullinane,

On behalf of the Center for Health Law & Policy Innovation of Harvard Law School (CHLPI), Community Servings, and the undersigned organizations and individuals, we are grateful for the opportunity to express our support for House Bill 4278, *An Act Relative to Establishing and Implementing a Food and Health Pilot Program*.

CHLPI advocates for legal, regulatory, and policy reforms to improve the health of underserved populations with a focus on the needs of low-income people living with chronic illnesses. Community Servings is a not-for-profit food and nutrition program with the mission to actively engage the community to provide medically tailored, nutritious, scratch-made meals to chronically and critically ill individuals and their families.

In June 2019, CHLPI and Community Servings published the *Massachusetts Food is Medicine State Plan*. The State Plan is the product of a two-year, community-driven initiative that engaged over 400 individuals from across the state to identify health and food system reforms to improve access to critical nutrition interventions and change the culture and practices of the health system, so that it is equipped to respond to individual and community-level nutrition needs. Following the release of the State Plan, CHLPI and Community Servings launched Food is Medicine Massachusetts (FIMMA), a multi-sector coalition comprised of over 50 organizations representing nutrition programs, patient advocacy groups, health care providers, health insurers, academics, and professional associations, all committed to implementing the goals of the State Plan.

Thanks to the innovative work of our state legislators and agencies, Massachusetts has long been a national leader in health care policy. We have led the way in ensuring universal access to health insurance coverage, and we continue to be at the forefront of innovative reforms such as implementing value-based payment. However, we continue to struggle with two issues that play a fundamental role in driving health outcomes and health care costs: food insecurity and diet-related disease.

Across Massachusetts the diet-related diseases of cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease "contribute to 56% of all mortality . . . and 53% of all health care expenditures."[1] Underlying these troubling trends is the fundamental issue of access to adequate nutrition. Food insecurity, or the lack of consistent access to enough food for an active, healthy life, impacts one out of every ten households in Massachusetts,[2] and results in $1.9 billion in avoidable health care costs each year.[3]

For many households, improving basic access to nutritious foods through programs like SNAP may be sufficient to improve health. However, for individuals living with or at risk for serious health conditions affected by diet, these strategies do not go far enough. These individuals not only need access to nutritious foods, but equitable access to Food is Medicine interventions—foods specifically tailored to address the impacts of their health conditions.

A growing body of evidence indicates that connecting these individuals to Food is Medicine interventions may be an effective, low-cost strategy to improve health outcomes, decrease use of expensive health care services, and improve patient quality of life. Studies show, for example, that medically tailored meals are associated with reductions in Emergency Department visits, inpatient admissions, emergency transports, admissions into skilled nursing facilities, and total health care costs,[4,5] while interventions such as medically tailored food packages can strengthen patients' ability to manage complex diet-related diseases such as diabetes.[6]

Unfortunately, despite the evidence, access to Food is Medicine interventions remains limited. Pioneering programs exist, but structural and institutional barriers—lack of integration into health care referral systems, gaps in research, and lack of sustainable funding—have historically limited the ability of these programs to scale up to meet the growing need of communities across the state.

CHLPI and Community Servings support House Bill 4278, as we believe it would help overcome these barriers, further cementing Massachusetts's role as a leader in access to care. Specifically, we believe that, if enacted, House Bill 4278 will:

- **Add to the body of evidence supporting Food is Medicine and provide valuable data on the impact of Food is Medicine interventions on health care costs and outcomes;**
- **Enhance the ability of the Massachusetts health care system to provide appropriate nutrition services based on patient need; and**
- **Expand access to Food is Medicine interventions in the state.**

House Bill 4278 Will Add to the Body of Evidence Supporting Food is Medicine and Provide Valuable Data on the Impact of Food is Medicine Interventions on Health Care Costs and Outcomes

In developing the State Plan, we had the opportunity to take a deep dive into current research on the relationship between food and health. This research clearly establishes food insecurity's role as a key driver of poor health outcomes and rising health care costs. It shows that:

- Total health care costs, including inpatient care, emergency care, surgeries, and drug costs, increase as food insecurity severity increases;[7, 8]
- Food-insecure individuals often have lower quality diets, including lower intake of produce, than their food secure counterparts, contributing to poorer health outcomes;[9] and
- To mitigate limited financial resources, food insecure individuals often adopt coping strategies that may be harmful to health such as delaying or forgoing medical care;[10, 11] engaging in cost-related medication underuse;[12, 13, 14] choosing between food and other basic needs such as utilities;[15, 16] opting to consume low-cost, energy-dense foods;[17, 18, 19] and/or forgoing food needed for special medical diets.[20]

In contrast, as noted above, research has shown that connecting individuals with diet-related disease to Food is Medicine interventions can improve health outcomes while controlling costs. For example, a 2019 Massachusetts-based study found that receipt of medically tailored meals was associated with 49% fewer inpatient admissions, 72% fewer admissions into skilled nursing facilities, and a 16% reduction in total health care costs.[21] Similarly, pilot studies of medically tailored food package and nutritious food referral programs have found improvements in key health indicators such as HbA1c for individuals living with diabetes,[22, 23] fruit and vegetable intake,[24] self-efficacy, [25] and medication adherence.[26]

Although this initial data is compelling, notable research gaps continue to limit our understanding of how Food is Medicine interventions can most effectively and efficiently be implemented in the Massachusetts health care system. First, current research focuses on the impact of single interventions (e.g., medically tailored meals *or* medically tailored food packages *or* nutritious food referrals) on health care outcomes and costs. While these focused studies are a useful starting point, they do not fully capture the lived experience of patients navigating the health care system. Every day, health care providers see patients with a range of nutritional needs. To date, though, no studies have assessed the impact of tackling that reality by offering a range of Food is Medicine services tailored to individual patient needs. House Bill 4278 proposes to do exactly this. We therefore support House bill 4278 because of its potential to provide holistic models of nutrition care services as well as data on this critical point.

Additionally, we believe that with small changes, House Bill 4278 could go even further in filling gaps in our current knowledge. For example, there is currently little research into the impact of serving a patient's entire household rather than just the individual patient. Nutrition service providers across Massachusetts often provide services at the household level, when they have the resources to do so through philanthropy or grant funding. They take this approach

because they know that in a food-insecure household, a parent or caretaker will share the food that they receive to lessen the suffering of their dependents, children, or partner. As a result, if the household is only receiving enough food for a single person, the individual patient will not receive the nutrition they truly need. However, we currently lack research on this point, making it difficult to make the case for new policies and programs to serve clients at the household level. To fill this gap, we propose that House Bill 4278 be amended to clarify that the Pilot may test the provision of services at the household level.

House Bill 4278 Will Enhance the Ability of the Massachusetts Health Care System to Provide Appropriate Nutrition Services Based on Patient Need

House Bill 4278 also presents a valuable opportunity to build upon existing programs to better meet the full range of patient nutritional needs. Just this January, MassHealth began to implement its Flexible Services program. Under the program, MassHealth Accountable Care Organizations (ACOs) receive funding that can be used to meet the housing and/or nutrition needs of certain patients. This innovative program represents an incredible leap forward in Massachusetts's ability to address the needs of some of its most vulnerable residents. However, it does face certain limitations. First the program is limited to MassHealth ACOs, leaving health care providers outside of the ACO system without funding to address the nutrition needs of their patients. Second, the Flexible Services program places particular emphasis on serving individuals with existing, significant illness, with little ability to include a focus on prevention. And third, Flexible Services dollars are limited to meeting the needs of individual eligible patients; they cannot be used to provide broader support to the patient's household.

If enacted, House Bill 4278 would give Massachusetts the opportunity to build upon the Flexible Services program, testing the impact of a comprehensive approach that fills these gaps. For example, pilot participants could include health care entities that do not currently participate in an ACO. Additionally, ACOs could use pilot funds to build upon their Flexible Services efforts, expanding the range of nutrition services provided and populations served to meet the requirements of the Food and Health Pilot. Finally, with the amendment described above, the Pilot could go further in building upon the Flexible Services program by testing the impact of providing services at the household level.

Building upon the Flexible Services program in this way would provide valuable data that could be used to refine the Flexible Services program as it moves forward. This data will be critical as the state works toward its upcoming renewal of its Medicaid Section 1115 Demonstration Waiver.

House Bill 4278 Will Expand Access to Food is Medicine Interventions

Finally, if enacted, House Bill 4278 will provide both funding and data that can be used to support the fundamental goal of the State Plan—expanding access to Food is Medicine services so that all Massachusetts residents have access to the foods they need to heal and thrive. Across the Commonwealth, many communities lack access to *any* Food is Medicine interventions. Funding remains a critical barrier to scaling Food is Medicine interventions to meet current need. In surveys conducted to develop the State Plan, almost half of responding nutrition service

organizations identified lack of funding as a barrier to providing Food is Medicine interventions. Furthermore, only 18% of these respondents said they received any funding through contracts with health insurers or health care partners, leaving the vast majority of these organizations reliant on donations and grants to support their Food is Medicine programs.

We know that health care providers and health care payers across the state are increasingly interested in addressing the role that food insecurity and diet play in the lives of their patient populations. But in order to take real action and create real partnerships to meet these needs, the health care sector continues to ask for data—proof that providing these services will accomplish their goals of cost-effectively improving patient health. While initial studies have been helpful in this regard, a large comprehensive study like the one outlined in House Bill 4278 would go significantly farther in making this case.

We therefore support House Bill 4278 because it stands to provide opportunities to improve access to Food is Medicine interventions in both the short and long-term. First, it will provide concrete, direct funds that can be used to expand current programs to new populations and geographies under the Pilot itself. But second, and perhaps more importantly, it will provide critical data that can be used as the foundation for policies and partnerships that support expansion on a much broader scale.

The Center for Health Law & Policy Innovation and Community Servings thank you for the opportunity to provide comment on House Bill 4278. For all of the reasons included here, we stand in strong support of this important legislation and the Food and Health Pilot it describes. Should you have any questions, please contact Katie Garfield at kgarfield@law.harvard.edu or Jean Terranova at JTerranova@servings.org.

Thank you for your time and consideration.

Sincerely,

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