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National Center for Health Statistics
ICD-10 CM Coordination and Maintenance Committee
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As the leaders of the Massachusetts Food is Medicine State Plan, The Center for Health Law and Policy Innovation (CHLPI) of Harvard Law School in partnership with Community Servings write in strong support of the Vermont Blue Cross Blue Shield/Yale School of Nursing application for expanded ICD-10-CM language to create separate codes specific to patient food insecurity, water security, and related nutritional concepts:

Z59.41 Lack of adequate food

Z59.42 Food insecurity

Z59.43 Lack of safe drinking water

Z71.85 Counseling for socioeconomic factors

Z91.110 Patient's noncompliance with dietary regimen due to financial hardship

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. For a number of years, CHLPI has worked with community-based nutrition organizations across the country to address the critical link between nutrition and chronic illness by supporting the integration of medically tailored food interventions (a/k/a Food is Medicine interventions) into health care delivery and payment systems.

Community Servings is a not-for-profit food and nutrition program providing services throughout Massachusetts to individuals and families living with chronic illnesses. Community Servings has partnered with external clinical researchers to co-author three peer-reviewed journal articles published in *Health Affairs*, *JAMA-Internal Medicine*, and *The Journal of General Internal Medicine* demonstrating that its medically tailored home-delivered meals program improves health outcomes, reduces health care utilization and costs, and improves quality of life for individuals coping with complex illnesses.^{1,2,3}

Food insecurity and malnutrition are major drivers of poor health outcomes and rising health care costs, globally posing “a greater risk to morbidity and mortality than unsafe sex, alcohol, drug, and tobacco use combined.”⁴ The evidence suggests that we must identify, monitor, and address patient nutritional needs within the health care system in order to effectively address rising rates of chronic illness while controlling health care costs. The following recent research highlights this need within the US health care system:

- Total health care costs, including inpatient care, emergency care, surgeries, and drug costs, increase as food insecurity severity increases.^{5,6}
- Average inpatient hospitalization costs are 24% higher and readmission within 15 days is almost twice as likely for malnourished patients as compared to properly nourished patients.⁷
- Food insecurity is associated with increased use of health services in primary care networks among diabetic patients.⁸
- Hospitalizations for low-income, diabetic patients increase at the end of the month when nutrition benefits, finances, and food are in short supply, while hospitalizations remain stable for middle-class and upper-class households.^{9,10}



- Food-insecure individuals often have lower quality diets, including lower produce intake, than their food-secure counterparts.¹¹
- 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;^{12, 13} engaging in cost-related medication underuse;^{14, 15, 16} choosing between food and other basic needs such as utilities;^{17, 18} opting to consume low-cost, energy-dense foods;^{19, 20, 21} and/or forgoing food needed for special medical diets.²²

The Centers for Medicare and Medicaid Services (CMS), the American Academy of Pediatrics, the American Diabetes Association, the Academy of Nutrition and Dietetics, and AARP all strongly support screening patients for food insecurity and connecting patients to food resources.^{23, 24, 25} However, few health care systems in the country have implemented standardized screenings and/or automatic referrals to appropriate nutrition services. ***Current lack of specificity in ICD-10-CM language around food insecurity hampers progress in monitoring risks associated with food insecurity and limits the ability of health care providers to refer patients to appropriate nutrition services available in the community.*** We also appreciate that, in addition to a code specific to food insecurity, the creation of Z91.110, *Patient's noncompliance with dietary regimen due to financial hardship*, and Z59.41, *Lack of adequate food*, acknowledge that a patient requires access to food appropriate for their medical diagnosis.

As part the Massachusetts Food is Medicine State Plan, a two-year initiative co-led by CHLPI and Community Servings, we conducted a series of surveys and listening sessions to assess screening and referral practices for food-insecure patients in Massachusetts. In surveys administered to Massachusetts health care providers, 63% stated that their organization faces barriers in implementing food insecurity screening. Similarly, a major theme during the State Plan listening sessions, including a physician-specific session organized by the Massachusetts Medical Society, was that ***the lack of an appropriate ICD-10 code limited physicians' ability to track food insecurity and integrate effective treatment plans into patient care.*** Health care providers also highlighted associated challenges, such as the inability to obtain reimbursement for screening and referrals to outside organizations that could significantly improve the health of their patients.

This code request is built upon the clear and defined concept of food insecurity and is necessary to better track and appropriately address the nutrition drivers of morbidity seen in clinic, hospital, and community settings every day. We therefore urge the ICD-10-Coordination and Maintenance Committee to accept this careful application.

Sincerely,

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on behalf of

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Community Servings
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