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June 10, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1808-P
PO Box 8013
Baltimore, MD 21244 -8013

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator:

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to provide comments on CMS-1808-P *Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes* published in the Federal Register on May 2, 2024.

The Academy represents over 113,000 registered dietitian nutritionists (RDNs),[1] 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.

RDNs' extensive formal education and training provides expertise in all aspects of food and nutrition, enabling RDNs to play a key role in improving people's nutritional status to prevent and treat chronic diseases and conditions. RDNs are recognized for their unique ability to conduct and translate science and evidence through education, medical nutrition therapy (MNT) and intensive behavior therapy.[2] The National Academies of Sciences, Engineering, and Medicine maintains that "the registered dietitian is currently the single identifiable group of health-care practitioners with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[3]

[1] The Academy has approved the optional use of the credential "registered dietitian nutritionist (RDN)" by "registered dietitians (RDs)" to more accurately convey who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.
[2] Medical Nutrition Therapy (MNT) is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. Academy of Nutrition and Dietetics' Definition of Terms list updated September 2023. Accessed June 5, 2024.
[3] Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published).

In the inpatient and acute care settings the dietitian plays a critical role in the healthcare team by assessing and addressing the nutritional needs of hospitalized patients. They develop personalized nutrition plans to support patients' recovery, manage chronic conditions and enhance overall health. This involves conducting nutritional assessments, monitoring patients' dietary intake and adjusting meal plans based on medical conditions, treatments and individual preferences. Nutrition care plans can include management of intravenous nutrition, or enteral tube feedings for patients who cannot consume food orally. In addition to these responsibilities, inpatient dietitians provide essential patient education. They work with individuals of all ages, from newborns in neonatal intensive care to elderly patients creating personalized nutrition plans aimed to accelerate recovery, prevent disease and promote long-term health.

Proposed Refinements to Current Measures in the Hospital IQR Program Measure Set

The Academy supports CMS's proposal, as outlined beginning on page 36327 of the Federal Register, recognizing the significance of addressing malnutrition in individuals aged 18 and older, not just those 65 and older. This approach supports CMS goals by enhancing healthcare quality, improving patient safety, and reducing costs. CMS acknowledges in this proposed rule that malnutrition is prevalent among hospitalized adults, impacting clinical outcomes and healthcare expenses. Expanding the measure to include adults aged 18 and older would facilitate timely screening and intervention, likely leading to improved outcomes and cost savings in the healthcare system.[4,5] Early identification and treatment of malnutrition in adults has been shown to prevent complications, reduce hospital stays, and lower readmission rates.[6,7] Expanding the applicable age to adults 18 or older will help to ensure that nutritional needs are met across all adult age groups, enabling hospitals to achieve higher standards of care and fulfilling CMS's mission of providing effective, equitable, and patient-centered care.[8]

Additionally, the Academy recommends that CMS expedite their proposed timeline by implementing the expansion of the GCMS starting with calendar year (CY) 2025 reporting, rather than the proposed CY 2026. Reports from Academy members indicate that RDNs in acute care settings are already providing this level of care to patients of all ages and that the age element is part of routine collection. Therefore, this expansion is not expected to create a significant reporting burden for providers or institutions and would emphasize the importance of high-quality malnutrition care for adults of all ages.

Recommendation

1. Finalize as proposed modifications to the GMCS eCQM that expand the applicable population from hospitalized adults 65 or older to hospitalized adults 18 or older.
2. Implement the expansion of the expanded GCMS eCQM starting with CY 2025.

Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning with the FY 2028 LTCH QRP

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[4] Nepple KG, Tobert CM, Valladares AF, Mitchell K, Yadrick M. Enhancing Identification and Management of Hospitalized Patients Who Are Malnourished: A Pilot Evaluation of Electronic Quality Improvement Measures. J Acad Nutr Diet. 2019 Sep;119(9 Suppl 2):S32-S39. doi: 10.1016/j.jand.2019.05.023.

[5] Fitall E, Pratt KJ, McCauley SM, Astrauskas G, Heck T, Hernandez B, Johnston J, Silver HJ, Mitchell K. Improving Malnutrition in Hospitalized Older Adults: The Development, Optimization, and Use of a Supportive Toolkit. J Acad Nutr Diet. 2019 Sep;119(9 Suppl 2):S25-S31. doi: 10.1016/j.jand.2019.05.024.

[6] Schuetz P, Sulo S, Walzer S, Vollmer L, Brunton C, Kaegi-Braun N, Stanga Z, Mueller B, Gomes F. Cost savings associated with nutritional support in medical inpatients: an economic model based on data from a systematic review of randomised trials. BMJ Open. 2021 Jul 9;11(7):e046402. doi: 10.1136/bmjopen-2020-046402. PMID: 34244264; PMCID: PMC8273448.

[7] Tappenden K.A.,Quatrara B., Parkhurst M.L., Malone A.M.,Fanjiang G.,Ziegler T. Critical role of nutrition in improving quality of care: An interdisciplinary call to action to address adult hospital malnutrition. J Acad Nutr Diet. 2013; 113: 1219-1237.

[8] Quality in Motion: CMS National Quality Strategy. April 2024. Accessed June 5, 2024. Available at: https://www.cms.gov/files/document/quality-motion-cms-national-quality-strategy.pdf.

Screening for HRSNs is increasingly recognized as a needed standard in healthcare, enabling providers to identify and mitigate social and economic factors impacting individuals' health outcomes. We commend CMS for acknowledging within the proposed rule how older adults grappling with food insecurity experience lower dietary quality, placing them at nutritional risk. This underscores the importance of addressing food insecurity within Medicare, particularly for vulnerable populations like the elderly and those with chronic conditions. Inadequate access to nutritious food elevates the risk of health issues such as malnutrition,[9] diabetes,[10] and cardiovascular diseases.[11] By tackling food insecurity, Medicare can foster better health outcomes, lower healthcare costs, and enhance the quality of life for beneficiaries.[12]

We strongly support the inclusion of proposed standardized patient assessment data elements such as "[w]ithin the past 12 months, you worried that your food would run out before you got money to buy more" and "[w]ithin the past 12 months, the food you bought just didn't last and you didn't have money to get more" within the SDOH category. Additionally, we appreciate CMS's recognition of the vital role played by SNF dietitians in transitions of care, where they create nutrition care plans empowering residents and caregivers to make food choices that support medical needs and are financially feasible post-discharge.

Recommendation:

1. Finalize as proposed.

Future LTCH Star Rating System: Request for Information

The Academy appreciates CMS's initiative to seek input on criteria for selecting measures and effective presentation of star ratings information to consumers. A star rating system can significantly assist beneficiaries in selecting an LTCH that best meets their needs, aligning with the CMS Meaningful Measures framework focused on person-centered care, equity, safety, affordability, efficiency, chronic conditions, wellness and prevention, seamless care coordination and behavioral health.[13] We strongly urge CMS to collaborate with the Academy and beneficiaries[14] to develop and integrate comprehensive nutrition care measures into potential LTCH Star Ratings.

The Academy recognizes the importance of measures that reflect improvements in beneficiary health, intermediate measures indicating actions taken to enhance beneficiary health status, and process measures capturing the healthcare services provided. We further believe that incorporating nutrition care into the LTCH Star Ratings aligns with CMS's objectives of promoting health equity and enhancing value-based care.

Cardiovascular and Diabetes Measures

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

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[9] Shifler Bowers K, Francis E, Kraschnewski JL. The dual burden of malnutrition in the United States and the role of non-profit organizations. Prev Med Rep. 2018 Oct 18;12:294-297. doi: 10.1016/j.pmedr.2018.10.002.
[10] Ronli Levi, Sara N. Bleich, Hilary K. Seligman; Food Insecurity and Diabetes: Overview of Intersections and Potential Dual Solutions. Diabetes Care 1 September 2023; 46 (9): 1599–1608. https://doi.org/10.2337/dci23-0002.
[11] Leung CW, Kullgren JT, Malani PN, Singer DC, Kirch M, Solway E, Wolfson JA. Food insecurity is associated with multiple chronic conditions and physical health status among older US adults. Prev Med Rep. 2020 Dec;20:101211. doi: 10.1016/j.pmedr.2020.101211.
[12] https://www.cbpp.org/research/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care-costs
[13] Meaningful measures 2.0: Moving from measure reduction to modernization. Available at: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/meaningful-measures-20. Accessed June 5, 2024.
[14] Rowan, Patricia, et al. Medicaid and CHIP Payment and Access Commission, 2021, Quality Rating Systems in Medicaid Managed Care Final Report, https://www.mathematica.org/publications/quality-rating-systems-in-medicaid-managed-care. Accessed 10 June 2024.

and older.[15] Practice guidelines for diabetes care[16] and cardiovascular disease[17] underscore the critical role of MNT as a cornerstone in the comprehensive management of both conditions. RDNs support individuals in achieving and sustaining optimal blood sugar levels through dietary adjustments and lifestyle interventions, aiding in the attainment of controlled A1c levels. 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.[18] Additionally, multiple MNT visits provided by dietitians can improve lipids, blood pressure, A1c, weight status, and quality of life, resulting in significant cost savings for adults.[19] Through personalized counseling, RDNs help beneficiaries adopt healthier eating habits, maintaining good cardiovascular health and improving overall health outcomes.

Malnutrition Screening and Assessment Measure

Adding a malnutrition screening and assessment measure to a CMS star rating program for LTCHs, particularly under categories such as mortality or patient safety, is crucial given the alarming trends and significant impact of malnutrition-related deaths among older adults in medical and long-term care facilities.[20] The sharp increase in malnutrition-related deaths nationwide, more than doubling from approximately 9,300 in 2018 to around 20,500 in 2022 ,[21] underscores the urgent need for effective interventions. Malnutrition mortality rates in the US, are especially prominent in demographics aged 85 and older and African Americans.[22]

Integrating malnutrition screening and assessment into CMS star ratings for LTCHs would incentivize facilities to prioritize and enhance their efforts in identifying and addressing malnutrition risk among older adults. This initiative aligns with broader efforts to improve patient safety and outcomes[23] by ensuring timely nutritional interventions and support.

Requiring LTCH's to measure and publicly report on malnutrition screening and assessment as part of the CMS star rating program, would incentivize LTCHs to implement robust protocols for early detection and intervention, thereby potentially reducing malnutrition-related mortality rates. This approach not only supports the goals of enhancing healthcare quality and patient safety but also promotes transparency and accountability in LTCH care. Integrating malnutrition screening and assessment into CMS star ratings for LTCHs is a critical step towards mitigating the alarming rise in malnutrition-related deaths among older adults. This proactive measure will empower LTCHs to prioritize nutritional care, ultimately improving patient outcomes and advancing overall healthcare quality in the long-term care setting.

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[15] National Vital Statistics System – Mortality Data (2022). Available at: https://wonder.cdc.gov/controller/saved/D158/D390F347. Accessed June 5, 2024.
[16] 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.
[17] 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.
[18] 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 23, 2022.
[19] 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.
[20] Mostafa, N., Sayed, A., Rashad, O. et al. Malnutrition-related mortality trends in older adults in the United States from 1999 to 2020. BMC Med 21, 421 (2023). https://doi.org/10.1186/s12916-023-03143-8.
[21] Reese, Phillip. "The Rate of Older Californians Dying of Malnutrition Has Accelerated." KFF Health News, 14 Apr. 2023. Available at: https://kffhealthnews.org/news/article/the-rate-of-older-californians-dying-of-malnutrition-has-accelerated/
[22] Guenter P, Abdelhadi R, Anthony P, et al. Malnutrition diagnoses and associated outcomes in hospitalized patients: United States 2018. Nutr. Clin. Pract. 2021, 36, 957–969.
[23] Quality in Motion: CMS National Quality Strategy. April 2024. Accessed June 5, 2024. Available at: https://www.cms.gov/files/document/quality-motion-cms-national-quality-strategy.pdf.

Recommendation:

1. Incorporation of nutrition related measures into Star Quality ratings for LTCH with specific consideration for conditions such as cardiovascular disease, diabetes, and malnutrition.

Proposed Transforming Episode Accountability Model

Transforming Episode Accountability Model Collaborator Definition

The Academy appreciates the opportunity to provide input on the definition for Transforming Episode Accountability Model (TEAM) collaborators. Noted as potential team collaborators are nonphysician practitioners. The Academy requests that CMS clarify and define which providers are considered nonphysician practitioners for this model, as was specified on page 43617 of the Federal Register for the Medicare Program's Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model Proposed Rule.

We request that CMS clarify whether RDNs would be considered TEAM collaborators. Nutrition has been integrated into a multi-faceted evidence-based surgical program for nearly two decades, now recognized as the Enhanced Recovery After Surgery (ERAS) program. ERAS protocols aim to identify inadequate perioperative nutrition to mitigate surgical complications, such as delayed wound healing and infections.[24,25] Specifically, ERAS Society consensus statements for perioperative care in lumbar spinal fusion,[26] cardiac[27] and colorectal surgery[28] all strongly recommend conducting a preoperative nutritional assessment for patients undergoing surgery and offering preoperative nutritional interventions to those identified as malnourished. Addressing preoperative risk factors, including nutritional deficiencies, metabolic status and low physical activity, has also demonstrated positive outcomes for patients undergoing hip and knee replacements.[29] Postoperative nutrition plays an equally important role as[30] post-operatively, as food intake may fall short of the necessary caloric and protein intake required for proper healing and metabolic functioning due to factors including nausea, vomiting, lack of appetite and change in diet.[31,32,33] Dietitians play a crucial role in post-operative care by developing personalized nutrition interventions and care plans to meet energy and protein requirements, thereby promoting optimal recovery. They also monitor the patient's condition to assess

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[24] Moore C, Pegues J, Narisetty V, Spankovich C, Jackson L, Jefferson GD. Enhanced Recovery After Surgery Nutrition Protocol for Major Head and Neck Cancer Surgery. OTO Open. 2021 Jun 18;5(2):2473974X211021100. doi: 10.1177/2473974X211021100.

[25] Melnyk M, Casey RG, Black P, Koupparis AJ. Enhanced recovery after surgery (ERAS) protocols: Time to change practice? Can Urol Assoc J. 2011 Oct;5(5):342-8. doi: 10.5489/cuaj.11002.

[26] Debono B, Wainwright TW, Wang MY, Sigmundsson FG, Yang MMH, Smid-Nanninga H, Bonnal A, Le Huec JC, Fawcett WJ, Ljungqvist O, Lonjon G, de Boer HD. Consensus statement for perioperative care in lumbar spinal fusion: Enhanced Recovery After Surgery (ERAS®) Society recommendations. Spine J. 2021 May;21(5):729-752. doi: 10.1016/j.spinee.2021.01.001.

[27] Engelman DT, Ben Ali W, Williams JB, et al. Guidelines for Perioperative Care in Cardiac Surgery: Enhanced Recovery After Surgery Society Recommendations. *JAMA Surg.* 2019;154(8):755–766. doi:10.1001/jamasurg.2019.1153.

[28] Gustafsson, U.O., Scott, M.J., Hubner, M. et al. Guidelines for Perioperative Care in Elective Colorectal Surgery: Enhanced Recovery After Surgery (ERAS®) Society Recommendations: 2018. World J Surg 43, 659–695 (2019). https://doi.org/10.1007/s00268-018-4844-y

[29] Wainwright, T. W., Gill, M., McDonald, D. A., Middleton, R. G., Reed, M., Sahota, O. Ljungqvist, O. (2019). Consensus statement for perioperative care in total hip replacement and total knee replacement surgery: Enhanced Recovery After Surgery (ERAS®) Society recommendations. Acta Orthopaedica, 91(1), 3–19. https://doi.org/10.1080/17453674.2019.1683790.

[30] Lewis SJ, Andersen HK, Thomas S. Early enteral nutrition within 24 h of intestinal surgery versus later commencement of feeding: a systematic review and meta-analysis. J Gastrointest Surg. 2009 Mar;13(3):569-75. doi: 10.1007/s11605-008-0592-x. Epub 2008 Jul 16. PMID: 18629592.

[31] Leandro-Merhi VA, Srebernich SM, Gonçalves GM, de Aquino JL. In-hospital weight loss, prescribed diet and food acceptance. Arq Bras Cir Dig. 2015;28(1):8-12. doi: 10.1590/S0102-67202015000100003. PMID: 25861060; PMCID: PMC4739256.

[32] Aquino R de C, Philippi ST. Identification of malnutrition risk factors in hospitalized patients. Rev Assoc Med Bras. 2011;57(6):637–643.

[33] Hiesmayr M, Schindler K, Pernicka E, Schuh C, Schoeniger-Hekele A, Bauer P, Laviano A, Lovell AD, Mouhieddine M, Schuetz T, Schneider SM, Singer P, Pichard C, Howard P, Jonkers C, Grecu I, Ljungqvist O, The NutritionDay Audit Team Decreased food intake is a risk factor for mortality in hospitalized patients: the NutritionDay survey 2006. Clin Nutr. 2009;28(5):484–491.

whether adjustments to interventions are necessary.[34] Personalized nutritional plans following surgery are not only desired by patients but also ensure individualized care, enhancing patient satisfaction and adherence[35] to post-surgical recommendations.[36] This comprehensive approach ensures effective nutritional care, reduces complications and minimizes length of stay. [37,38] Overall, RDNs are integral to the success of surgical programs[39] and therefore, the TEAM model.

Recommendation:

1. Specify the non-physician practitioner types that would be included as TEAM collaborators.
2. Include RDNs as TEAM collaborators.

Thank you for your careful consideration of the Academy's comments on the Inpatient Prospective Payment Systems Proposed Rule. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at jblankenship@eatright.org or Carly Léon at 312-899-1773 or by email at cleon@eatright.org with any questions or requests for additional information.

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[34] Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist. Commission on Dietetic Registration Scope and Standards of Practice Task Force. www.cdrnet.org/scope. Accessed June 6, 2024.
[35] Jinnette R, Narita A, Manning B, McNaughton SA, Mathers JC, Livingstone KM. Does Personalized Nutrition Advice Improve Dietary Intake in Healthy Adults? A Systematic Review of Randomized Controlled Trials. Adv Nutr. 2021 Jun 1;12(3):657-669. doi: 10.1093/advances/nmaa144.
[36] Wang D, Hu Y, Liu K, et allssues in patients' experiences of enhanced recovery after surgery (ERAS) : a systematic review of qualitative evidenceBMJ Open 2023;13:e068910. doi: 10.1136/bmjopen-2022-068910.
[37] Ligthart-Melis GC, Weijs PJ, te Boveldt ND, Buskermolen S, Earthman CP, Verheul HM, de Lange-de Klerk ES, van Weyenberg SJ, van der Peet DL. Dietician-delivered intensive nutritional support is associated with a decrease in severe postoperative complications after surgery in patients with esophageal cancer. Dis Esophagus. 2013 Aug;26(6):587-93. doi: 10.1111/dote.12008. Epub 2012 Dec 13. PMID: 23237356.
[38] Williams DGA, Wischmeyer PE. Perioperative Nutrition Care of Orthopedic Surgery Patient. Tech Orthop. 2020 Mar;35(1):15-18. doi: 10.1097/bto.0000000000000412.
[39] Kalogera E, Dowdy SPrehabilitation: enhancing the Enhanced Recovery after Surgery pathwayInternational Journal of Gynecologic Cancer 2019;29:1233-1234.