Academy of Nutrition and Dietetics
www.eatright.org

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

May 24, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4207-NC
PO Box 8013
Baltimore, MD 21244 -8013

Re: CMS-1802-P-Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025

Dear Administrator:

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to provide comments on CMS-1802-P-Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025, published in the Federal Register on April 3, 2024.

The Academy represents over 112,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs) and other credentialed nutrition and dietetics practitioners. 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. In skilled nursing facilities, RDNs serve as integral members of the interdisciplinary team. They assess residents' nutritional status, develop individualized care plans that follow the resident through the care continuum, and offer education and counseling to both residents and caregivers. RDNs monitor residents' progress throughout their stay and actively contribute to quality improvement initiatives promoting residents' health through comprehensive nutrition support.[2]

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.[3] 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

[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] Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118(1):141-165.
[3] 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 May 15, 2024.

training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."[4] RDNs deliver nutrition care services in a variety of settings, including outpatient and inpatient, as well as short and long-term care facilities, providing high quality, evidence-based care generating cost-savings to the health care system.[5]

III. Proposed SNF PPS Rate Setting Methodology and FY 2025 Update

The Academy supports the proposed 4.1% increase in skilled nursing facility (SNF) PPS rates. As the healthcare industry continues to struggle with increasing costs[6] to provide adequate care, this adjustment is vital for ensuring SNFs can continue to deliver quality care to Medicare beneficiaries while maintaining financial stability. We appreciate CMS's recognition of this challenge and support its finalization.

Recommendation:

1. Finalize as proposed.

V. Other SNF PPS Issues

C. Technical Updates to the PDPM ICD– 10 Mappings

The Academy supports CMS's proposed changes to clinical category assignments for new ICD-10 codes, specifically the re-mapping of codes such as E88.10 (Metabolic Syndrome), E88.811 (Insulin Resistance Syndrome, Type A), E88.818 (Other Insulin Resistance), and E88.819 (Insulin Resistance, Unspecified) from "Medical Management" to "Return to Provider."

We agree with CMS's rationale that conditions like Metabolic Syndrome and Insulin Resistance typically require long-term treatment and management that is best delivered outside of a Part A SNF stay, as their root causes often involve factors such as overweight/obesity, physical inactivity, and genetic predispositions. While acknowledging the importance of these diagnoses and their impact on overall health if left untreated, we recognize that they alone may not justify a Part A SNF stay.
It is essential to ensure that Part A SNF stays are appropriately designated for conditions that necessitate skilled nursing care. However, we affirm that SNFs should continue to acknowledge and address these diagnoses during the stay, as these conditions can impact a resident's course of care. RDNs, as essential members of the interdisciplinary team in SNFs, play a crucial role in addressing metabolic health concerns such as metabolic syndrome[7] through personalized nutrition interventions. By providing tailored dietary assessments, education, and ongoing monitoring, RDNs contribute to the comprehensive management of these conditions, enhancing patient outcomes[8] and quality of care.

We appreciate CMS's consideration of these clinical category assignments and believe that the proposed changes will help maintain the integrity of Part A SNF stays while ensuring that patients receive comprehensive care tailored to their individual needs.

---

[4] 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).
[5] Centers for Medicare and Medicaid Services. IMPACT Act of 2014 & cross setting measures. https://www.cms.gov/medicare/quality/initiatives/pac-quality-initiatives/impact-act-2014-data-standardization-cross-setting-measures. Accessed May 20, 2024.
[6] 2023 Costs of Caring. Available at: https://www.aha.org/guidesreports/2024-05-01-2023-costs-caring. Accessed May 8, 2024.
[7] Medical nutrition therapy effectiveness systematic review (2013-2015) available at: https://www.andeal.org/topic.cfm?menu=5284&cat=3808. Accessed May 8, 2024.
[8] Sikand G, Cole RE, Handu D, deWaal D, Christaldi J, Johnson EQ, Arpino LM, Ekvall SM. Clinical and cost benefits of medical nutrition therapy by registered dietitian nutritionists for management of dyslipidemia: A systematic review and meta-analysis. J Clin Lipidol. 2018 Sep-Oct;12(5):1113-1122.

Recommendation:

1. Finalize as proposed.

D. Request for Information: Update to PDPM Non-Therapy Ancillary (NTA) Component

The Academy strongly opposes the elimination of malnutrition and at-risk for malnutrition from the Conditions and Extensive Services Used for NTA Classification. Malnutrition is a prevalent health issue among the Medicare population, with approximately 50 percent of older adults affected by malnutrition.[9] The Medicare population is at increased risk for malnutrition due to a higher likelihood of having multiple chronic conditions or diseases, increased risk for acute illness or need for surgery, impaired functional or cognitive status, loneliness, depression, and food insecurity.[10,11,12,13,14,15] CMS has long recognized the importance of diagnosing and subsequently treating malnutrition,[16] as evidenced by the approval of the Global Malnutrition Composite Score (GMCS)[17] (CBE #3592e), an electronic clinical quality measure (eCQM) that evaluates whether provided care was appropriate according to the patient's malnutrition risk and severity level. Appropriate care includes screening and medical nutrition therapy provided by registered dietitian nutritionists (RDNs) which entails implementation of the nutrition care process (NCP). NCP includes four main components: assessment, diagnosis, intervention and monitoring and evaluation based on best available evidence.

Screening and Diagnosis of Malnutrition

It is important for regulators and providers to recognize the distinction between malnutrition screening and assessment and acknowledge the resources that go into each step of the malnutrition identification and treatment process. Nutrition screening is the initial quick (less than ten minutes) process to identify individuals at risk of malnutrition who require further assessment. Nutrition screening entails simple and valid tools such as the Malnutrition Screening Tool (MST). The Academy advocates for the use of MST because it can be universally used for older adults, regardless of age, medical history, or setting.[18]

Individuals identified as at risk for malnutrition should be referred to an RDN for a comprehensive nutrition assessment. Nutrition assessment is a systematic approach to collect and synthesize factors needed to diagnose nutrition-related problems such as malnutrition and its related causes. Data collected includes, but is not limited to, medical history, dietary habits, anthropometric measurements, and physical examination. We emphasize the use of validated tools in the assessment and diagnosis of malnutrition. The Mini Nutritional Assessment (MNA®) is a validated tool recommended by the Academy for malnutrition assessment among patients aged 65 and older, offering standardized criteria

---

[9] Food Research & Action Center (FRAC). ''Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs.'' December 2019. https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf.

[10] Favaro-Moreira N.C., Krausch-Hofmann S. Matthys C. et al. Risk factors for malnutrition in older adults: A systematic review of the literature based on longitudinal data. Adv Nutr. 2016; 7: 507-522

[11] Porter Starr K.N. McDonald S.R. Bales C.W. Nutritional vulnerability in older adults: A continuum of concerns. Curr Nutr Rep. 2015; 4: 176-184

[12] Agarwal E. Ferguson M. Banks M. et al.Malnutrition and poor food intake are associated with prolonged hospital stay, frequent readmissions, and greater in-hospital mortality: Results from the Nutrition Care Day Survey 2010. Clin Nutr. 2013; 32: 737-745

[13] Bardon L.A. Streicher M. Corish C.A. et al. Predictors of incident malnutrition in older Irish adults from The Irish Longitudinal Study on Ageing (TILDA) cohort—A MaNuEL study [published online ahead of print September 25, 2018]. J Gerontol A Biol Sci Med Sci. https://doi.org/10.1093/gerona/gly225

[14] Valladares AF, Kilgore KM, Partridge J, et al. How a Malnutrition Quality Improvement Initiative Furthers Malnutrition Measurement and Care: Results From a Hospital Learning Collaborative. JPEN J Parenteral Enteral Nutr. 2021;45(2):366-371.

[15] Pratt, KJ, Hernandez B, Blancato R, et al. "Impact of an Interdisciplinary Malnutrition Quality Improvement Project at a Large Metropolitan Hospital." BMJ Open Quality. 2020;9:e000735.

[17] https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS986v2.html

[18] Skipper A, Coltman A, Tomesko J, et al. Position of the Academy of Nutrition and Dietetics: Malnutrition (Undernutrition) Screening Tools for All Adults. J Acad Nutr Diet.2020;120(4):709-713.

for evaluating dietary intake, anthropometry, and physical assessment. If the Mini Nutritional Assessment is not feasible for malnutrition assessment, then the Subjective Global Assessment (SGA) can be used.

The MNA® provides clear diagnostic criteria to aid RDNs in accurate malnutrition assessment and recommendation to physicians, particularly in long term care (LTC) settings. Validated assessment tools ensure precise and timely malnutrition diagnosis, allowing RDNs to develop evidence-based interventions early and decrease poor outcomes associated with malnutrition.

After malnutrition assessment, physicians review findings to inform diagnosis and treatment plans, integrating malnutrition management across care transitions. Timely identification and evidence-based treatment of malnutrition are vital across the healthcare continuum, preventing adverse outcomes during care transitions. Multidisciplinary collaboration, with RDNs at the forefront, ensures comprehensive malnutrition assessment, personalized treatment, and care continuity, ultimately enhancing patient outcomes and optimizing healthcare resource utilization.

While both screening and assessment are essential components of nutritional care, screening serves as an initial step to identify individuals at risk of malnutrition, while assessment provides a detailed diagnosis and guides the development of tailored interventions.

"At Risk for Malnutrition"

Adults at risk for malnutrition are individuals susceptible to malnutrition, which is defined as a "state of deficit, excess, or imbalance in protein, energy, or other nutrients that adversely impacts an individual's own body form, function, and clinical outcomes"[19] and can be detected by malnutrition screening. Stakeholders at the 2016 Global Leadership Conversation on Addressing Malnutrition emphasized that the initial step in evaluating nutrition status is screening for malnutrition risk, using validated tools.[20] Adults vulnerable to malnutrition, detectable through such screening, include older adults, who face heightened risk due to various factors including increased susceptibility to chronic diseases and age-related physiological, pathological, sociological, and psychological changes.[21,22, 23] Older adults may face additional risk factors such as frailty, polypharmacy, reduced physical and cognitive function, depression, poor appetite, institutionalization,[24] and social determinants such as food insecurity.[25]

Someone at risk for malnutrition necessitates a comparable level of care and resources as someone who is malnourished. Identifying and intervening with individuals at risk for malnutrition includes an initial screening using validated tools such as the MST. If malnutrition risk is identified, intervention

---

[19] The Malnutrition Quality Collaborative. (2020). National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Washington, DC: Avalere Health and Defeat Malnutrition Today. Available at https://defeatmalnutrition.today/advocacy/blueprint. Accessed May 20, 2024.

[20] Cederholm T, Jensen GL, Correia MITD, Gonzalez MC, Fukushima R, Higashiguchi T, Baptista G, Barazzoni R, Blaauw R, Coats AJS, Crivelli AN, Evans DC, Gramlich L, Fuchs-Tarlovsky V, Keller H, Llido L, Malone A, Mogensen KM, Morley JE, Muscaritoli M, Nyulasi I, Pirlich M, Pisprasert V, de van der Schueren MAE, Siltharm S, Singer P, Tappenden K, Velasco N, Waitzberg D, Yamwong P, Yu J, Van Gossum A, Compher C; GLIM Core Leadership Committee, GLIM Working Group. GLIM criteria for the diagnosis of malnutrition - A consensus report from the global clinical nutrition community. J Cachexia Sarcopenia Muscle. 2019 Feb;10(1):207-217. doi: 10.1002/jcsm.12383. PMID: 30920778; PMCID: PMC6438340.

[21] Landi F, Calvani R, Tosato M, et al. Anorexia of Aging: Risk Factors, Consequences, and Potential Treatments. Nutrients. 2016;8(2):69

[22] Evans C. Malnutrition in the elderly: a multifactorial failure to thrive. The Permanente journal. 2005;9(3):38-41.

[23] Hickson M. Malnutrition and ageing. Postgrad Med J. 2006;82(963):2-8.

[24] Fávaro-Moreira NC, Krausch-Hofmann S, Matthys C, et al. Risk Factors for Malnutrition in Older Adults: A Systematic Review of the Literature Based on Longitudinal Data. Adv Nutr. 2016;7(3):507-522.

[25] Grammatikopoulou MG, Gkiouras K, Theodoridis X, et al. Food insecurity increases the risk of malnutrition among community-dwelling older adults. Maturitas. 2019;119:8-13.

recommendations are consistent with treatment recommendations for active diagnosis malnutrition. Nutrition interventions for those at risk for malnutrition or those who are malnourished are tailored to the individual patient's needs. Appropriate interventions can include utilization of oral nutrition supplements (ONS) and food fortification for older adults in LTC settings, as part of a comprehensive individualized nutrition care plan.[26,27,28,29,30,31]

Given that individuals at risk for malnutrition encounter vulnerabilities and hurdles, it is essential for "at risk for malnutrition" status to remain on the NTA list. This acknowledgment ensures that individuals in this vulnerable state receive the necessary support and resources to prevent the progression of malnutrition and deterioration of health, particularly in institutionalized environments such as LTC, where older adults are notably susceptible. By recognizing the significance of being at risk for malnutrition, CMS incentivizes the adoption of proactive measures to address nutritional needs and enhance overall well-being effectively.

Clinical Impacts of Malnutrition

Malnutrition is associated with a higher risk of adverse outcomes, necessitating additional hospitalizations and medical interventions. Older adults suffering from malnutrition are more susceptible to infections, pressure ulcers, and other complications, leading to frequent readmissions and emergency room visits. These recurrent hospitalizations not only disrupt the continuity of care but also incur significant costs for both patients and healthcare providers. CMS recognizes the impact of malnutrition on infections and pressure ulcers, even including malnutrition as an injury risk factor in the Resident Assessment Instrument (RAI) manual.[32]

The Cost of Care & Economic Impact

Literature has established that, among older adults, malnutrition can lead to increased risk of morbidity and mortality as well as pose a significant financial burden on the health care system.[33,34] In a 2018 analysis[35] of US hospital discharges, the average cost for all hospital stays (excluding neonatal and maternal) amounted to $12,900. Patients diagnosed with malnutrition incurred significantly higher costs, averaging up to $22,200. The economic burden of disease-associated malnutrition, encompassing morbidity, mortality, and direct medical costs, is estimated at $157 billion in the United States. Of this total, $51.3 billion is attributed to individuals aged 65 and older, who are considered the most vulnerable demographic.[36]

---

[26] Deutz NE, Matheson EM, Matarese LE, et al. Readmission and mortality in malnourished, older, hospitalized adults treated with a specialized oral nutritional supplement: A randomized clinical trial. Clin Nutr. 2016;35(1):18-26.
[27] Feldblum I, German L, Castel H, Harman-Boehm I, Shahar DR. Individualized nutritional intervention during and after hospitalization: the nutrition intervention study clinical trial. J Am Geriatr Soc. 2011;59(1):10-17.
[28] Bjorkman M, Finne-Soveri H, Tilvis R. Whey protein supplementation in nursing home residents. A randomized controlled trial. Eur Geriatr Med. 2012;3:161-166.
[29] Van Wymelbeke V, Brondel L, Bon F, Martin-Pfitzenmeyer I, Manckoundia P. An innovative brioche enriched in protein and energy improves the nutritional status of malnourished nursing home residents compared to oral nutritional supplement and usual breakfast: FARINE+ project. Clin Nutr ESPEN. 2016;15:93-100.
[30] Leslie WS, Woodward M, Lean ME, Theobald H, Watson L, Hankey CR. Improving the dietary intake of under nourished older people in residential care homes using an energy enriching food approach: a cluster randomised controlled study. J Hum Nutr Diet. 2013;26(4):387-394.
[31] Smoliner C, Norman K, Scheufele R, Hartig W, Pirlich M, Lochs H. Effects of food fortification on nutritional and functional status in frail elderly nursing home residents at risk of malnutrition. Nutrition. 2008;24(11-12):1139-1144.
[32] https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf
[33] Mangels AR. CE: Malnutrition in Older Adults. Am J Nurs. 2018;118(3):34-41.
[34] Dent E, Wright ORL, Woo J, Hoogendijk EO. Malnutrition in older adults. The Lancet. 645 2023;401(10380):951-966.
[35] Barrett M.L. Bailey M.K. Owens P.L. Non-maternal and non-neonatal inpatient stays in the United States involving malnutrition, 2016. Healthcare Cost and Utilization Project. https://www.hcup-us.ahrq.gov/reports/HCUPMalnutritionHospReport_083018.pdf
[36] Snider J.T. Linthicum M.T. Wu Y. et al. Economic burden of community-based disease-associated malnutrition in the United States. JPEN J Parenter Enteral Nutr. 2014; 38: 77S-85S

The increased costs of care result from various factors, including malnutrition exacerbating existing health conditions and raising the risk of complications, which leads to extended hospital stays. Research consistently demonstrates that older adults with malnutrition experience longer hospital stays and increased use of resources compared to their well-nourished counterparts.[37] These prolonged hospitalizations not only strain hospital resources, but also escalate healthcare expenditures substantially.

The financial burdens malnutrition imposes across the continuum of care from acute hospital settings to LTC facilities and community settings, support the need for additional resources and specialized intervention that leads to appropriate management of malnutrition. Malnutrition not only exacerbates health disparities but also serves as a barrier to health equity. It contributes to the development or worsening of chronic diseases[38] further burdening healthcare systems and impeding efforts to promote equitable access to quality healthcare.

To mitigate the economic impact of malnutrition on the healthcare system, it is imperative for CMS to prioritize and incentivize evidence-based interventions targeting older adults at risk for malnutrition. Including appropriate screening, diagnosing, interdisciplinary care coordination, and community-based support services can help identify and address malnutrition early, thereby reducing hospital admissions, decreasing healthcare costs, and improving overall health outcomes for older adults.

In light of the widespread prevalence, consequential clinical ramifications,[39] and considerable financial implications associated with malnutrition, it is imperative for CMS to uphold the provision of payment models and incentives through the NTA classification list. This list facilitates systematic integration of malnutrition care best practices by supporting comprehensive screening and diagnosis protocols. CMS can offer further support through clarified guidance.

Impacts to Health Equity

Malnutrition stands not only as a health concern but also as a critical health equity issue, particularly affecting underrepresented older adults across racial and ethnic groups and rural communities[40] as noted by CMS in the CY23 Hospital Inpatient Prospective Payment Systems Proposed Rule.[41] Access to adequate nutrition and proper treatment for malnutrition is often impeded by socio-economic disparities, including poverty, food insecurity, and insufficient nutrition education. This perpetuates health inequities and results in disparate health outcomes among these populations which CMS acknowledged within the proposed rule.

By maintaining malnutrition and at-risk for malnutrition on the NTA list, CMS plays a pivotal role in addressing these disparities and advancing health equity objectives.[42] RDNs working in SNFs serve as frontline providers in assessing, diagnosing, and managing malnutrition among elderly and chronically ill individuals. However, without appropriate compensation, SNFs may face challenges in allocating

---

[37] 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

[38] Ahmed T, Haboubi, N. Assessment and management of nutrition in older people and its importance to health. Clin Interv Aging. 2010; 5: 207–216.

[39] Kramer CS, Groenendijk I, Beers S, Wijnen HH, van de Rest O, de Groot L. The Association between Malnutrition and Physical Performance in Older Adults: A Systematic Review and Meta-Analysis of Observational Studies. Curr Dev Nutr.2022;6(4):nzac007.

[40] Food Research & Action Center (FRAC). ‘‘Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs.’’ December 2019. https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf.

[41] federalregister.gov/d/2022-08268,

[42] CMS Framework for Health Equity. Available at: https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework. Accessed May 9, 2024.

resources and prioritizing malnutrition-related services effectively. The inclusion of malnutrition on the NTA list serves as a crucial incentive for SNFs to proactively identify and address malnutrition, thereby leading to improved health outcomes, reduced healthcare costs, and enhanced quality of life for patients. Furthermore, RDNs in SNFs can utilize a resident's nutrition care plan to help with transitions of care at discharge to ensure that residents with malnutrition or at risk of malnutrition due to food insecurity are connected to community-based organizations and food security programs. This work supports CMS's commitment to promoting person-centered care and addressing health disparities within the Medicare beneficiary population.

Recognizing malnutrition's multifaceted impact on health and well-being, retaining it on the NTA list signifies an acknowledgment of the interconnectedness of healthcare and the imperative to address underlying social determinants of health. By incentivizing SNFs to address malnutrition comprehensively, CMS can contribute significantly to efforts aimed at mitigating health inequities and fostering health equity for all Medicare beneficiaries.

Sub-regulatory guidance and terminology

The purpose of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual is to offer clear guidance about how to use the RAI correctly and effectively to help LTC staff develop holistic treatment plans for residents holistically. To do so involves an interdisciplinary approach in the RAI process including dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities/recreational therapy.[43]

Within the RAI manual, CMS does not provide specific examples or outline specific coding criteria for I5600 Malnutrition or at risk-of malnutrition as it does for other items such as I2300 UTI. Providing an example or outlining specific coding criteria for I5600 Malnutrition or at risk-of malnutrition within the RAI manual would greatly enhance clarity and consistency in coding practices across healthcare facilities. The absence of a standard definition of at-risk-for-malnutrition can lead to variability in coding interpretations and may lead to confusion. By offering clear guidance and specific criteria for coding malnutrition or at risk-of malnutrition, CMS can ensure that healthcare providers have a standardized framework to identify and document residents who require nutritional interventions or monitoring. This not only facilitates accurate assessment and documentation but also supports appropriate care planning and resource allocation. Moreover, standardized coding criteria enable better data collection and analysis, which are crucial for quality improvement initiatives and benchmarking efforts. Ultimately, by promoting uniformity and clarity in coding practices for malnutrition, CMS can enhance the quality of care provided to residents in long-term care facilities and improve outcomes related to nutritional health.

Recommend example:
A resident has a positive assessment for malnutrition and subsequently receives a physician diagnosis of malnutrition and is prescribed an oral nutritional supplement to address nutrient deficiencies. The resident requires regular monitoring of weight, laboratory data, and dietary intake to assess the effectiveness of the nutritional intervention and ensure improvement in nutritional status. Physician progress notes document ongoing monitoring and adjustment of the nutritional regimen.

Coding: Malnutrition item (I5600), would be checked.

[43] Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual available at: https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf. Accessed 5/8/2024.

Rationale: This would be considered an active diagnosis because of the need for continuous monitoring to evaluate the effectiveness of the nutritional intervention and ensure improvement in the resident's nutritional status.

Aligning the terminology used in the Minimum Data Set (MDS) for active diagnosis with current ICD-10 coding would also help ensure accuracy, consistency, and interoperability in the active diagnosis documentation and billing processes. Consistent terminology facilitates seamless communication among healthcare providers, reduces the risk of coding errors,[44] and enhances the reliability of data captured in patient records.[45] By aligning MDS terminology with ICD-10-CM coding, healthcare facilities can streamline documentation workflows, improve coding accuracy, and ensure compliance with regulatory requirements. This alignment also promotes interoperability between different healthcare systems and facilitates the exchange of patient information across care settings.

Nutrition Care Process and Promoting Interoperability

RDNs adhere to the NCP Framework to provide personalized care to individuals. This systematic approach involves four steps: nutrition assessment and reassessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Utilizing validated tools and markers, RDNs assess various factors including dietary intake, anthropometry, physical assessment, and signs of nutritional deficiency or excess to accurately evaluate nutrition status. The NCP allows for individualized care plans tailored to each patient's unique needs, values, and evidence-based practices, ultimately leading to more efficient and effective care. While the NCP serves to standardize the process by which RDNs deliver care, standardization is also crucial for malnutrition assessment and screening tools to ensure consistency, accuracy, and comparability across different healthcare settings.

The Academy opposes the proposed elimination of malnutrition and at-risk for malnutrition from the NTA Classification. Collaborative efforts with stakeholders, including RDNs as illustrated above, are indispensable to ensure the inclusion of malnutrition codes within CMS models, thereby bolstering the quality of care and mitigating healthcare costs associated with malnutrition-related complications.

In conclusion, the Academy adamantly contends that the elimination of malnutrition and at-risk for malnutrition from the Conditions and Extensive Services Used for NTA Classification list is not justifiable and runs counter to the principles of evidence-based healthcare practice and health equity.

Recommendation:

1. Maintain malnutrition and at risk of malnutrition on the Conditions and Extensive Services Used for NTA Classification list due to the significant prevalence and impact of malnutrition among the Medicare population, particularly older adults with multiple chronic conditions.
2. Standardize coding practices and criteria for malnutrition within the RAI manual and MDS to enhance clarity, consistency, and interoperability across healthcare facilities.
3. Further support best practices for malnutrition care through use of evidence-based tools for identifying and diagnosing malnutrition across the healthcare continuum.

Nutritional Approaches While a Resident: Feeding Tube

The Academy strongly opposes the elimination of “Nutritional Approaches While a Resident: Feeding Tube” from the Conditions and Extensive Services Used for NTA Classification List. Tube-feedings can substantially increase costs and resource utilization due to not only the cost of supplies but also cost of

[44] https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf
[45] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6486797/

the clinical treatment and expertise required to manage the tube feedings.[46] Patients relying on tube feeds necessitate specialized care, including frequent monitoring, equipment provision, and ongoing support from healthcare professionals. RDNs play a crucial role in managing and caring for patients with tube feedings, providing expertise in developing individualized feeding regimens, monitoring nutritional status, addressing complications, and ensuring optimal patient outcomes.[47] Given the lack of guidance in the RAI regarding NTA "Nutritional Approaches While a Resident: Feeding Tube," we kindly request CMS to provide clarification on the intent behind this NTA. Specifically, is this NTA intended to address increased supply costs, clinical support, or both.

Recommendation:

1. Clarify if this NTA is intended to address increased supply costs, clinical support, or both.
2. Provide additional guidance in the RAI manual regarding appropriate criteria for signifying "*Nutritional Approaches While a Resident: Feeding Tube" on the MDS.*

Parenteral IV Feeding NTA Point Changes

CMS should retain the current NTA points allocation for parenteral IV feeding due to the complex medical requirements of patients necessitating this form of nutrition support, many of whom are malnourished[48] or have dementia.[49] The substantial costs associated with parenteral nutrition in individuals with dementia syndromes underscore the critical need for adequate reimbursement to support their care. Skilled nursing facilities play a pivotal role in delivering direct medical services to these individuals, including administering parenteral nutrition to patients with dementia. With significantly higher rates of SNF stays among Medicare beneficiaries with dementia compared to those without,[50] it is evident that this population requires intensive and specialized care. Clinical guidelines are consistent in recommending parenteral nutrition when enteral is not possible or is insufficient.[51,52] We support the rationale and comments submitted by the Healthcare Nutrition Council that also link the need to preserve parenteral nutrition IV feeding points as it relates to malnutrition. Availability of NTA points ensures appropriate resource allocation to cover costs associated with parenteral nutrition solutions, specialized equipment and skilled nursing care, essential for managing patients with complex medical needs. Maintaining current NTA points acknowledges the significant impact of parenteral IV feeding on patient outcomes and healthcare utilization, warranting adequate reimbursement to support optimal care delivery.

Recommendation:

1. No change to the Parenteral IV Feeding NTA Points.

---

[46] Majka AJ, Wang Z, Schmitz KR. et al. Care coordination to enhance management of long-term enteral tube feeding: a systematic review and meta-analysis. JPEN J Parenter Enteral Nutr 2014; 38: 40-52 DOI: 10.1177/0148607113482000.
[47] Corrigan, Mandy L. et al. Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Revised 2021 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Nutrition Support. Journal of the Academy of Nutrition and Dietetics, Volume 121, Issue 10, 2071 - 2086.e59. Accessed May 20, 2024.
[48] Singer P., Blaser A.R., Bischoff S.C. ESPEN guidelines on clinical nutrition in the intensive care unit. Clin. Nutr. 2019;38:48–79. doi: 10.1016/j.clnu.2018.08.037.
[49] Hyeda A, Costa ÉSMD. Economic analysis of costs with enteral and parenteral nutritional therapy according to disease and outcome. Einstein (Sao Paulo). 2017 Apr-Jun;15(2):192-199. doi: 10.1590/S1679-45082017GS4002. PMID: 28767918; PMCID: PMC5609616.
[50] Alzheimer's Association. 2022 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2022;18. Available at: https://www.alz.org/media/Documents/2022-Facts-and-Figures-Report_1.pdf. Accessed May 20, 2024.
[51] Elke G., van Zanten A.R.H., Heyland D.K. Enteral versus parenteral nutrition in critically ill patients: An updated systemic review and meta-analysis of randomized controlled trails. Crit. Care. 2016;20:117. doi: 10.1186/s13054-016-1298-1
[52] Ridley E.J., Daives A.R., McGuinness S., for the Supplemental Parenteral Nutrition Clinical Investigators Supplemental parenteral nutrition versus usual care in critically ill adults: A pilot randomized control study. Crit. Care. 2018;22:12. doi: 10.1186/s13054-018-1939-7.

Social Determinants of Health Collected as Standardized Patient Assessment Data Elements

Screening for health-related social needs 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,[53] diabetes[54] and cardiovascular diseases.[55] By tackling food insecurity, Medicare can foster better health outcomes, lower healthcare costs and enhance the quality of life for beneficiaries.[56]

We strongly support the inclusion of proposed standardized patient assessment data elements such as, "Within the past 12 months, you worried that your food would run out before you got money to buy more" and "Within 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 remain financially viable post-discharge.

Recommendation:

1. Finalize as proposed.

Thank you for your careful consideration of the Academy's comments on the CY 25 Skilled Nursing 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.

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

[53] 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. PMID: 30406007; PMCID: PMC6214863.
[54] 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
[55] 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. Epub 2020 Sep 20. PMID: 32983850; PMCID: PMC7502278.
[56] https://www.cbpp.org/research/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care-costs