*Submitted via regulations.gov*

September 11, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1784–P
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program; CMS–1784–P.**

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) is providing comments on the CY 2024 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program Proposed Rule. HNC is an association representing manufacturers[2] of enteral nutrition (EN) formulas and oral nutrition supplements (ONS), including those categorized as medical foods, and parenteral nutrition (PN). Our mission is to improve patient outcomes by advancing nutrition policies and actions that raise awareness and optimize access of essential nutrition support therapies across the continuum of care.

In line with our mission, we are providing comments on several areas of this year's proposed rule relating to access to nutritional therapies. As detailed further below, HNC:

- **Strongly supports the extension Medicare telehealth services and urges CMS to expand availability of telehealth to the maximum extent possible.**
- **Supports inclusion of health equity measures for Merit-Based Incentive Program (MIPS) and Advanced Alternative Payment Models (APMs).**
- **Strongly recommends that CMS integrate the Improvement Activity (IA) *Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols* to more MIPS Value Pathways (MVPs) and APMs criteria.**

[2] HNC members are Abbott Nutrition, Nestle Healthcare Nutrition, and Nutricia North America.



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**HNC strongly supports the extension Medicare telehealth services and urges CMS to expand availability of telehealth to the maximum extent possible.**

One of the most important modifications CMS made in response to COVID-19 was to expand the types of providers and types of services permitted to be provided via telehealth during the public health emergency (PHE). CMS also lifted originating site and other telehealth rules that expanded the ability of beneficiaries to quickly access needed services. This greatly benefited patients who are in need of nutrition support and related services due to a chronic condition or as they recover from an acute injury or illness.

HNC supports all of CMS' proposals to extend telehealth and telehealth-related flexibilities for the duration of CY 2024 (through December 31, 2024). However, HNC urges the agency to implement the availability of these telehealth services permanently. If CMS finds it lacks the statutory authority to make the changes fully permanent, it should extend them indefinitely or for the maximum period allowable; not just through CY 2024. In addition, CMS should seek from Congress the authority to implement all of these telehealth services permanently, as soon as possible.

CMS should be confident in the ability of these services to continue to be delivered remotely, when needed. Providers and suppliers have demonstrated they can provide a wide range of services virtually, safely and effectively. Permanent access to these telehealth services would increase Medicare beneficiaries' access to, and use of, these expanded medical nutrition therapy (MNT) services. A study published on the perspectives of Registered Dietitian Nutritionists (RDNs) on the adoption of telehealth for nutrition care highlights the fact that the use of telehealth improves clinical outcomes, reduces costs, and is positively received by patients receiving nutrition care. Furthermore, RDNs reported increased use of telehealth care during the pandemic for nutritionally at-risk patients, and "the opportunity for longer assessment time with patients and the ability to 'look in' their home environments to potentially observe their refrigerators and pantries, allowing further examination of their diet and nutrition habits."[1]

**HNC supports inclusion of health equity measures for Merit-Based Incentive Program (MIPS) and Advanced Alternative Payment Models (APMs).**

As CMS notes, belonging to a racial or ethnic minoritized group; being a member of a religious minority; living with a disability; being a member of lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) community; living in a rural area; or being near or below the poverty level is often associated with worse health outcomes. One approach being employed to reduce health inequity across CMS is the expansion of efforts to report quality measure results stratified by patient social risk factors and demographic variables. HNC supports the efforts being made by CMS to address health inequalities across the social determinants of health (SDOH) spectrum.



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**HNC strongly recommends that CMS integrate the Improvement Activity (IA) *Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols* to more MIPS Value Pathways (MVPs) and Advanced APMs criteria.**

CMS is seeking input on if they should increase the reporting requirements or require that specific measures are reported once MVPs are mandatory. HNC supports CMS' proposal to include a screening for Social Drivers of Health quality measure in all the MVPs. HNC also agrees and supports CMS' proposal to include the IA *Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols* (IA_AHE_9) to the following MVPs: Advancing Care for Heart Disease; Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes; Optimal Care for Kidney Health; Value in Primary Care; Focusing on Women's Health; Mental Health and Substance Use Disorders; and Musculoskeletal Care and Rehabilitative Support. Nevertheless, there are many factors that play into an individual's nutritional status that may not be as obvious, easy to measure, or frequently considered by most healthcare providers such as nutrition literacy and pre/post-surgical nutritional status and needs. This is not an intentional act by healthcare providers but is occurring because the system was not originally designed to take nutritional status into account. Since the system was built, the nutrition-health related scientific developments and evidence have grown drastically; however, there continues to be a significant lag in implementing and reimbursing (properly or at all) nutrition practice and patient benefits within the healthcare system. It is well known that all health insurance coverage – including private insurers – base their coverage from what Medicare covers. It is important that CMS take the important steps to ensure that nutrition services are covered, and beneficiaries get the nutrition-related benefits they need and deserve.

Malnutrition is a risk factor for severe clinical events, such as loss of lean body mass and risk of falls, and possibly worse outcomes after surgery or trauma, since proper nutrition is critical for healing and recovery. Nutritional assessment and intervention together break the vicious cycle between malnutrition and various diseases or conditions, in which malnutrition aggravates a disease/condition, and the disease/condition, in turn, precipitates malnutrition. Breaking this cycle helps in improving clinical outcomes. Malnutrition adversely affects the health status of individuals, clinical outcomes, and overall healthcare costs.[2] Below, HNC has provided scientific evidence as to why CMS should include the IA *Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols* (IA_AHE_9) the following MVPs and Advanced APMs criteria.

<u>Finalized MVPs</u>

- MVP ID: M0004 Supportive Care for Neurodegenerative Conditions
    - A systematic review of the effect of nutrition on neurodegenerative diseases showed that MeDiet, nutritional support, and calorie-controlled diets play a protective effect against cognitive decline, Alzheimer's disease (AD), Parkinson disease (PD) while malnutrition and insulin resistance represent significant risk factors. Malnutrition activates also the gut-microbiota-brain axis dysfunction that exacerbate neurogenerative process.[3]
- MVP ID: M0001 Advancing Cancer Care
    - Malnutrition in malignancies is multi-factorial. Inflammatory mediators, increased energy needs, adverse effects of drugs/therapy (like mouth ulceration, nausea, and vomiting), mental stress, anxiety, and depression can lead to deterioration of



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nutritional status. Furthermore, malnutrition can inhibit the effectiveness of therapy and worsen the prognosis of the disease.[3]

- MVP ID: G0058 Improving Care for Lower Extremity Joint Repair
  - Nutrition plays an important role in healing, including for surgical recovery following procedures such as joint repair. Unidentified and unaddressed pre-operative malnutrition is associated with worse outcomes, including increased length of stay, readmissions, re-operative rates, infections, and mortality, all of which reduce quality of care and increase healthcare costs.[4]

Nutrition care is crucial to patient care and clinical outcomes. Including IA_AHE_9 will serve to: identify and close health inequity gaps in nutrition, thus interconnected conditions that impact patient health; provide additional clinical insight to the significance of nutritional status and healthcare; and provide additional evidence – directly reported to CMS – as to why MNT services and products are vitally important to patient care, that there is a significant need for them, and that coverage of these services and products needs to be improved.

**Summary of the importance of addressing malnutrition.**

It is widely recognized that nutritional status plays a significant role in health outcomes and healthcare costs. Addressing malnutrition is essential to improving overall healthcare and may ultimately reduce the economic burden incurred when caring for the oldest and sickest Americans.[5,6] Disease-related malnutrition can manifest in patients across all spectrums of body mass index, ranging from under to overweight individuals, including those presenting with obesity. Malnutrition often is associated with acute and chronic diseases and injury, such as cancer, stroke, infection, trauma, and surgical procedures. Large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-term care residents are undernourished.[7,8,9,10]

If unaddressed, malnutrition increases the cost of care and likelihood of poor health outcomes, including increased complications, longer hospitalizations, and more readmissions. For example, malnourished patients are more likely to experience complications, such as pneumonia,[11] pressure ulcers,[12] nosocomial infections,[13] and death.[14] Malnourished patients, as well as patients at risk for malnutrition, have significantly longer hospitalizations than well-nourished patients and patients not at risk for malnutrition.[15] Additionally, readmission rates, institutionalization, and ongoing healthcare services increase in patients suffering from malnutrition. In particular, disease-related malnutrition is a common reason for patients to be readmitted to hospitals.[16] Furthermore, hospitalized patients at risk of malnutrition are also more likely to be discharged to another facility or require ongoing healthcare services after being discharged from the hospital than patients who are not at risk.[17]

Beyond just the effect on utilization and outcomes, malnutrition has an outsized effect on overall cost of care. Malnutrition costs associated with older adults aged 65 years and older who are the most at risk for malnutrition, and largely depending on Medicare, are estimated at $51.3 billion annually.[18] However, this figure likely underestimates the total burden of disease-related malnutrition given the diagnosis gap in hospitalized patients.[19] In addition, malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital.[20] Further, the average costs per readmission for patients with malnutrition were found



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to be 26-34 percent higher ($16,900 to $17,900) compared to those without malnutrition ($13,400).[1] A retrospective health economic study found that providing oral nutritional supplements (ONS) to Medicare patients aged 65+ with any primary diagnosis was associated with a 16% reduction in length of stay and a 15.8% cost savings – an average of $3,079 -- per episode.[22]

Lastly, despite the impact on overall health and the prevalence of malnutrition among hospitalized patients, a patient's nutritional status is often not evaluated or diagnosed in a timely manner. A recent study conducted by AHRQ demonstrated that only about 7 percent of hospitalized patients are diagnosed with malnutrition, indicating a screening and diagnosis gap that needs to be addressed.

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Malnutrition continues to be a crucial component in reducing hospital-acquired conditions, lowering healthcare costs and improving the health and well-being of vulnerable Medicare beneficiaries. **HNC urges CMS to prioritize policies and initiatives that identify and treat malnutrition, encourage proper nutrition and the development of cost-effective nutrition therapy products, and that ensures access through adequate coverage and payment policies for nutrition therapy products**. HNC stands ready to work with CMS and all stakeholders to develop these policies as one means to improve the public health system. If you have any questions or would like additional information, please contact Sydni Arnone, Healthcare Nutrition Council, at sarnone@healthcarenutrition.org or (202) 204-8396.

Sincerely,

Robert Rankin

Robert Rankin
Executive Director

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