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Academy of Nutrition and Dietetics

Avalere

Partnership for Quality Measurement
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RE: Feedback on Release of Measures Under Consideration List for 2023-2024 Review Cycle

We commend CMS' recognition of the significant impact malnutrition has on all adult patient outcomes, as well as its consideration of the benefits of the expansion of the Global Malnutrition Composite Score (GMCS) (MUC2023-114) as an eCQM when extended to all adult ages 18 years or older.

In its recent committee meeting, the Pre-Rulemaking Review (PRMR) committee identified areas for consideration with corresponding conditions for expansion of the GMCS to include all adults ages 18 and over. To best facilitate CMS' decision making, each area of concern is outlined below along with supporting evidence.

Increase involvement of more patient groups in further work in this measure, especially ensuring that certain measure components will not lead to limited patient autonomy.

During the initial measure development, a National Dialogue Event was convened to identify barriers to malnutrition care, including representation from providers, payers, and patient advocacy groups.[1] Patient representatives reported that, while the technical terminology of malnutrition may be challenging and emotionally charged, participation in shared decision making when assessing and treating malnutrition is key to preventing additional complications that may impact the patient's quality of life. Additionally, throughout the update process of the currently accepted GMCS, the Technical Expert Panel (TEP), which contains representation from patients and patient advocates, is consulted regularly to ensure any updates both reflect clinical practice and capture the patient voice. Additional patient voices will be added to future TEPs to ensure adequate consideration of this unique perspective.

This measure supports the interdisciplinary teams' focus on the patient's preferences regarding food choices, timing of meals, and/or self-feeding strategies within their individual, social and environmental circumstances. The 2024 Scope and Standards of Practice for the RDN, a guidance document with standards to guide RDN practice, emphasize the provision of person-centered care with specific standards focused on collaboration with patients and their caregivers in the planning and provision of malnutrition care.[2]

Finally, in designing measure logic and corresponding value sets, the measure steward and developer recognize the importance of patient autonomy in participating in nutrition assessment and/or care planning activities. Therefore, encounters can achieve high performance scores for each of these components even in a setting of a patient declining nutrition assessments and/or specific nutrition interventions with proper documentation.

The measure should include hospital-acquired malnutrition and high-risk nutritional practices in screening and assessment.

A significant body of literature demonstrates that a patient's nutritional status often declines during a hospitalization for a variety of reasons, including but not limited to restrictive diets, perceived poor meal quality, frequent use of fasting orders, mealtime interruptions, poor appetite, gastrointestinal symptoms, and low prioritization of nutrition by care providers.[3] Therefore, identification of malnutrition risk and malnutrition developed during a hospitalization is essential to providing high-quality malnutrition care and improving patient outcomes. The current timing of the measure observations in the expanded GMCS does not preclude screening and assessments that occur later in the hospitalization from counting toward measure performance. Most hospital inpatient screening policies include rescreening if the initial screen is negative for malnutrition risk to capture those who may experience iatrogenic malnutrition. While the current logic does prioritize the absence of malnutrition risk and malnutrition, future updates will allow the measure steward to ensure changes in nutritional status and their associated care are accurately captured.

[1] Valladares A, Jones K, Mitchell K, et al. Dialogue Proceedings / Advancing Patient Centered Malnutrition Care Transitions. https://avalere.com/insights/dialogueproceedings-advancing-patient-centered-malnutrition-care-transitions. Published 2018. Accessed January 30, 2024.
[2] CDR Scope and Standards of Practice Task Force. Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist. https://www.cdrnet.org/vault/2459/web/Scope%20Standards%20of%20Practice%202024%20RDN_FINAL.pdf
[3] Cass, A. R., & Charlton, K. E. (2022). Prevalence of hospital-acquired malnutrition and modifiable determinants of nutritional deterioration during inpatient admissions: A systematic review of the evidence. *Journal of Human Nutrition and Dietetics*, *35*(6), 1043-1058.

Expansion of the GMCS to include all adults aged 18 and over will increase burden to both implementors and patients through increased staffing needs and increased rates of billing for services.

The GMCS is intended to capture facility performance in providing high-quality malnutrition care relative to a patient's present or severity of malnutrition risk and/or malnutrition. This optional eCQM is not expected to impact hospital staffing or clinical practices, as RDNs have long been established in providing cost-effective care and leading to cost savings through reductions in complications and both hospital and intensive care length of stay (LOS).[4,5,6,7] The GMCS mirrors the well-established clinical workflows of RDNs in the provision of malnutrition care to adults in the acute care setting rather than proposing new workflows that may impact operational needs.

Because this measure expansion is proposed for the IQR, billing for eligible patients will utilize the Medicare Severity Diagnosis Related Group (MS-DRG) system.[8] Within this payment system, RDN assessments and interventions are not individually billed for; rather, they are considered a part of the bundled care provided to acute care patients.

The GMCS too closely resembles the proposed Age Friendly Hospital Measure, which will result in duplicative reporting.

The Age Friendly Hospital Measure (MUC2023-196) evaluates a hospital's commitment to improving care for adults aged 65 and older through five domains. One such domain, Frailty Screening and Intervention, requires hospitals to "screen for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition" at some point during the hospitalization with a recommendation to implement "nutrition plans where appropriate."[9] While elements of this measure may appear duplicative, there are several main differences. First, the Age Friendly Hospital measure includes only adults aged 65 and older, while the GMCS expansion will include all adults aged 18 and over. Additionally, the inclusion of nutrition screening represents only one of the four components of the GMCS; likewise, the Age Friendly Hospital measure requires only an attestation of completion of the steps, rather than true measurement and would therefore not capture malnutrition prevalence nor severity data critical to determining appropriate interventions. Therefore, while both proposed measures will allow hospitals to capture one similar element, duplicative reporting will not occur.

In addition to aligning with several CMS goals, the proposed expansion (MUC2023-114) of the age range from 65 to 18 years of age or older is not expected to result in any additional reporting burden for reporting institutions because the data element of age is already being collected.

CONCLUSION

The importance of identifying, diagnosing, and treating malnutrition continues to grow. Further, the relationship between malnutrition and food insecurity and its effects on health equity has been proven to be of importance and continues to be studied. Given the merit of the expansion of the measure age range to 18 years of age or older as described above, we strongly recommend that CMS consider adoption of the MUC 2023-114 into the Hospital IQR program.

The Academy of Nutrition and Dietetics and Avalere appreciate the continuous engagement of CMS pursuant to tackling malnutrition and improving quality care at the national level. We thank CMS for the continued engagement, and we look forward to working with you on future integration of these measures in the acute care setting and efforts to improve malnutrition quality of care across all care settings.

Sincerely,

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[4] Medical Nutrition Therapy. Academy of Nutrition and Dietetics. Accessed January 30, 2024. https://www.eatrightpro.org/career/payment/medical-nutrition-therapy

[5] Siopis G, Wang L, Colagiuri S, Allman-Farinelli M. Cost Effectiveness of Dietitian-Led Nutrition Therapy for People with Type 2 Diabetes Mellitus: A Scoping Review. Journal of Human Nutrition and Dietetics. 2021;34(1):81-93. doi:10.1111/JHN.12821

[6] Sikand G, Cole RE, Handu D, et al. Clinical and Cost Benefits of Medical Nutrition Therapy by Registered Dietitian Nutritionists for Management of Dyslipidemia: A Systematic Review and MetaAnalysis. J Clin Lipidol. 2018;12(5):1113-1122. doi:10.1016/j.jacl.2018.06.016

[7] Somanchi M, Tao X, Mullin GE. The facilitated early enteral and dietary management effectiveness trial in hospitalized patients with malnutrition. *JPEN*. 2011;35(2):209-216.

[8] Centers for Medicare & Medicaid Services. Acute Inpatient PPS. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

[9] The John A. Hartford Foundation. Age Friendly Hospital Measure. https://www.johnahartford.org/images/uploads/resources/MUC_2023_v5-1_MUC2023-196.pdf