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Pre-Rule Making Review Hospital Committee
Battelle
Partnership for Quality Measurement

RE: Feedback on Release of Measures Under Consideration List for 2025 Review Cycle

The Academy of Nutrition and Dietetics (the Academy) appreciates the opportunity to comment on select measures included on the 2025 Measures Under Consideration (MUC) List. We commend CMS for its continued leadership in advancing interoperable, outcomes and patient-focused quality measures that promote meaningful alignment across quality programs.

The Academy offers the following measure-specific comments related to the Malnutrition Care Score (MCS) and the Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients, both of which align with CMS's focus on value-based outcomes-driven care for chronic disease populations where registered dietitian nutritionists (RDNs) play a critical role.

Malnutrition Care Score

The Academy supports CMS's consideration of expanding the Malnutrition Care Score (MUC2025-065) to the Prospective Payment System-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. CMS's emphasis on digitally enabled quality measurement, patient-centered outcomes, and alignment across reporting programs is well reflected in the design and intent of the MCS, which promotes timely identification, diagnosis, and treatment of malnutrition, and supports continuity of nutrition care.

CMS has long recognized the prevalence of malnutrition, its negative impact on patient outcomes, and the persistent barriers to high-quality malnutrition care.[1,2]

The recognition of malnutrition as a critical issue for all adults continues to support the alignment with the *Meaningful Measures 2.0 Initiative,* which strives to identify high priority areas for advancing quality of care and value-based care. Expanding the MCS to PCHQR presents an immediate opportunity for CMS to further these objectives.

The burden of malnutrition on patients in the hospital setting as detailed in a report published by the AHRQ Healthcare Cost and Utilization Project (HCUP) is of great importance as it affects all key quality domains. The report mentions that malnourished hospitalized patients are three to five times more likely to experience in-hospital death and experience a 56% higher rate of hospital 30-day readmissions compared with non-malnourished patients.[3] Furthermore, according to HCUP data malnutrition is more likely to affect certain patient populations more than others.

Malnutrition prevalence is exacerbated among patients who are already ill: chronic diseases such as

[1] Fed Register Vol. 78, No. 26, February 2013
[2] Fed Register Vol. 79, No. 91, May 12, 2014
[3] Agency for Healthcare Research and Quality. Malnutrition in Hospitalized Adults. https://effectivehealthcare.ahrq.gov/products/malnutrition-hospitalized-adults/protocol. Accessed December 4, 2023.

diabetes, cancer, and gastrointestinal, pulmonary, heart, and chronic kidney disease. Chronic disease treatments can result in changes in nutrient intake and utilization, which can lead to malnutrition. The MCS quality measure is vital to implementation of malnutrition quality improvement and advancing and standardizing nutrition care in patients across quality programs and settings. Lack of evaluation and management for malnutrition can result in negative health and financial outcomes as malnourished adults have been found to utilize more health services with more visits to physicians, hospitals, and emergency rooms. Nutrition interventions have been repeatedly shown to positively impact health status and be cost-effective in improving health outcomes among malnourished patients.

Prioritizing outcome and patient-reported measures.

Malnutrition is a patient-safety risk and has been shown to be an independent predictor of negative patient outcomes, including mortality, lengths of hospital stay, readmissions, and hospitalization costs.[4,5] Malnourished patients are also more likely to develop pressure ulcers,[6] infections,[7] post-operative complications[8,9] and experience falls.[10,11] In addition, malnutrition in the hospital is associated with increased cost of care and the economic burden of disease-associated malnutrition in the U.S. was estimated to be as high as $157 billion in 2014, with $15.5 billion directly linked to cost of treatment.[12] For cancer patients specifically, those with malnutrition had substantially higher health care utilization, including a 2.5-fold higher rate of emergency department with more than double the average emergency department costs of $10,724 vs. $4,935 per year.[13]

Furthermore, the prevalence of malnutrition in cancer patients is an estimated 30-80% and is associated with an elevated risk of all-cause mortality for all cancer patients, as well as negative clinical outcomes, such as a reduced survival rate, longer hospital length of stay, reduced ability to complete chemotherapy, and increased risk of postoperative complications. Conversely, comprehensive and proactive nutrition care, such as malnutrition screening, nutrition assessment and intervention play a critical role in not only preventing malnutrition, but lessening these adverse events by retaining muscle mass, increasing survival rate, and strengthening the immune system, to name a few.[14] Finally, the data generated from the clinical processes promoted by the MCS is critical for comprehensive discharge planning inclusive of nutrition care and helps inform patients and caregivers on how to continue improving their nutritional status after discharge.

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[4] Lim SL, Ong KC, Chan YH, Loke WC, Ferguson M, Daniels L. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. Clinical nutrition (Edinburgh, Scotland). 2012;31(3):345-350.

[5] Hiller LD, Shaw RF, Fabri PJ. Difference in Composite End Point of Readmission and Death Between Malnourished and Nonmalnourished Veterans Assessed Using Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition Clinical Characteristics. JPEN J Parenter Enteral Nutr. 2016 Sep 8. pii: 0148607116668523.

[6] Lee JY, Kim HI, Kim YN, et al. Clinical Significance of the Prognostic Nutritional Index for Predicting Short- and Long-Term Surgical Outcomes After Gastrectomy: A Retrospective Analysis of 7781 Gastric Cancer Patients. Medicine (Baltimore). 2016;95(18):e3539.

[7] Yi PH, Frank RM, Vann E, Sonn KA, Moric M, Della valle CJ. Is potential malnutrition associated with septic failure and acute infection after revision total joint arthroplasty? Clin Orthop Relat Res. 2015;473(1):175-82.

[8] Kwag SJ, Kim JG, Kang WK, Lee JK, Oh ST. The nutritional risk is a independent factor for postoperative morbidity in surgery for colorectal cancer. Ann Surg Treat Res. 2014;86(4):206-11.

[9] Choi WJ, Kim J. Nutritional Care of Gastric Cancer Patients with Clinical Outcomes and Complications: A Review. Clin Nutr Res. 2016;5(2):65-78.

[10] Vivanti A, Ward N, Haines T. Nutritional status and associations with falls, balance, mobility and functionality during hospital admission. J Nutr Health Aging. 2011;15(5):388-91.

[11] Suominen MH, Puranen TM, Jyväkorpi SK, et al. Nutritional Guidance Improves Nutrient Intake and Quality of Life, and May Prevent Falls in Aged Persons with Alzheimer Disease Living with a Spouse (NuAD Trial). J Nutr Health Aging. 2015;19(9):901-7.

[12] Snider J, et al. Economic burden of community-based disease-associated malnutrition in the United States.JPEN J Parenteral Enteral Nutr. 2014;38:55-165.

[13] Sulo S, Brunton C, Drawert S, Watson G, Hegazi R, Bastasch M. Increased Emergency Department Utilization and Costs for Medicare Cancer Patients with Malnutrition Diagnoses. J Nutr Health Aging. 2022;26(8):786-791. doi: 10.1007/s12603-022-1826-4.

[14] Hoobler, R., Herrera, M., Woodruff, K., Sanchez, A., Coletta, A. M., Chaix, A., Elizondo, J., & Playdon, M. C. (2025). Malnutrition Risk Is Associated With All-Cause Mortality and Chemotherapy Complications Among Adults Diagnosed With Diverse Cancer Types: A Retrospective Cohort Study. Journal of the Academy of Nutrition and Dietetics, 125(9), 1242–1255.e10. https://doi.org/10.1016/j.jand.2025.04.014

Transforming measures to be fully digital and incorporating all-payer data.

The MCS (MUC2025-065) has been developed to utilize digital data from all patients ages 18 years and older admitted to a hospital for 24 hours or longer and built to capture all-payer data. By leveraging an existing, digitally enabled and validated measure across multiple quality reporting programs, CMS also has an opportunity to reduce administrative burden on hospitals and clinicians by promoting alignment around shared, outcomes-based expectations rather than duplicative or payer-specific reporting requirements. Use of data in this format and applicability to all payers, aids in easing implementer burden while encouraging high-quality malnutrition care for all adult inpatients.

Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients Measure

The Academy supports CMS's consideration of a quality measure addressing chronic hyperphosphatemia among individuals receiving dialysis, as reflected in the proposed *Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients* measure, MUC2025-064.

Hyperphosphatemia is a common and clinically significant complication of chronic kidney disease and End-Stage Renal Disease (ESRD) and represents a modifiable risk factor that contributes substantially to morbidity, mortality, and health care utilization in this population. Extensive observational and clinical literature demonstrates a strong and consistent association between elevated serum phosphorus levels and adverse outcomes, including cardiovascular disease, mineral and bone disorders, fractures, hospitalizations, and increased mortality.[15,16,17,18,19,20,21]

As kidney function declines, impaired phosphate excretion becomes progressively more severe, placing individuals receiving dialysis at particularly high risk for persistent hyperphosphatemia. National data show a concerning upward trend in the proportion of dialysis patients with serum phosphorus levels ≥6.5 mg/dL between 2017 and 2023, with higher rates observed among older adults and individuals with longer dialysis duration.[22] These trends underscore the need for stronger quality oversight and targeted performance measurement to address phosphorus control in the ESRD population.

This measure provides dialysis facilities with a meaningful opportunity to strengthen team-based, outcomes-driven care by supporting early identification of patients with persistently elevated serum phosphorus and facilitating timely, coordinated interventions. Central to these efforts is medical nutrition therapy (MNT) delivered by RDNs, whose expertise enables personalized dietary phosphorus management and nutrition care plans that prioritize flexibility, patient autonomy, and the least restrictive approaches necessary to achieve clinical goals and long-term behavior change.[28] When integrated with appropriate medication management and dialysis prescription adjustments, nutrition-focused interventions can drive meaningful improvements

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[15]Qunibi WY. Consequences of hyperphosphatemia in patients with end-stage renal disease (ESRD). Kidney Int Suppl. 2004 Sep;(90):S8-S12. doi: 10.1111/j.1523-1755.2004.09004.x.

[16]Borgi L. Inclusion of Phosphorus in the Nutrition Facts Label. Clin J Am Soc Nephrol. 2019;14(1):139-140. doi:10.2215/CJN.07230618

[17]Doshi SM, Wish JB. Past, Present, and Future of Phosphate Management. Kidney Int Rep. 2022;7(4):688-698. doi:10.1016/j.ekir.2022.01.1055

[18]Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group. KDIGO clinical practice guideline for the diagnosis, evaluation, prevention, and treatment of Chronic Kidney Disease-Mineral and Bone Disorder (CKD-MBD). Kidney Int Suppl. 2009;(113):S1-130. doi:10.1038/ki.2009.188

[19]Fishbane, S.N. Nigwekar, S. Phosphate absorption and hyperphosphatemia management in kidney disease: a physiology-based review. Kidney Med. 2021; 3:1057-1064.

[20] Block, G.A. · Klassen, P.S. · Lazarus, J.M. Mineral metabolism, mortality, and morbidity in maintenance hemodialysis. J Am Soc Nephrol. 2004; 15:2208-2218

[21]Tentori, F. Blayney, M.J. Albert, J.M. Mortality risk for dialysis patients with different levels of serum calcium, phosphorus, and PTH: the dialysis outcomes and practice patterns study (DOPPS). Am J Kidney Dis. 2008; 52:519-530

[22]United States Renal Data System. (2024). Figure 3.13, serum phosphorus, 2017–2023. In End-stage renal disease: Clinical indicators and preventive care. National Institute of Diabetes and Digestive and Kidney Diseases. https://usrds-adr.niddk.nih.gov/2024/end-stage-renal-disease/3-clinical-indicators-and-preventive-care

within this population.

Incorporating a phosphorus-focused quality measure into the ESRD Quality Incentive Program would strengthen accountability for a clinically meaningful and actionable outcome, promote consistent monitoring and evidence-based management, and support improved patient outcomes.

The Academy appreciates CMS's continued commitment to advancing quality measurement that improves patient outcomes. As the burden of malnutrition and nutrition-related complications continues to grow, adopting evidence-based, outcomes-driven measures is essential to improving care and reducing avoidable costs.

The Malnutrition Care Score and the proposed hyperphosphatemia measure each address critical, actionable gaps in quality measurement. Accordingly, the Academy strongly supports adoption of MUC2025-065 into the PCHQR Program and continued advancement of MUC2025-064 within the ESRD Quality Incentive Program. We appreciate the opportunity to provide input and look forward to continued collaboration with CMS on future quality initiatives.

Sincerely,

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