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RE: CMS- 2024-0006 Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

The Academy of Nutrition and Dietetics (the "Academy") is pleased to provide comments on File Code-CMS-2023-0010 published in the Federal Register on January 31, 2024. Representing more than 112,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of nutrition and dietetics practitioners committed to accelerating improvements in global health and well-being through food and nutrition.

The Value of Medicare Advantage Plans

Medicare Advantage offers better health care quality and affordability to more than 32 million Americans compared to traditional Medicare[i]. It provides basic Medicare benefits at 85% of the cost, often with lower premiums and out-of-pocket expenses, easing financial strain for beneficiaries while granting access to comprehensive health care. A recent study[ii] by America's Health Insurance Plans highlights the effectiveness of Medicare Advantage plans in promoting preventive care and achieving better health outcomes.

Well-designed Medicare Advantage plans play a vital role in meeting the health care needs of diverse and vulnerable populations, especially those with lower socioeconomic status. Food insecurity and health outcomes are closely linked, as inadequate access to nutritious food can lead to malnutrition and chronic health conditions. Additionally, food insecurity often exacerbates existing health issues and impedes proper management of diseases, resulting in poorer overall health outcomes. As Medicare Advantage plans can offer extra benefits beyond that of traditional Medicare, such as medically tailored meals, these plans help overcome access barriers and advance health equity in underserved communities.

Adequacy of Medicare Advantage Rates

Medicare Advantage (MA) plans are designed to go beyond the scope of traditional fee-for-service (FFS) Medicare by offering a range of additional services and benefits. These include care coordination,

[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.

wellness programs, and supplemental nutrition support, which can take the form of tailored meals and medical nutrition therapy (MNT) services for conditions beyond just diabetes and kidney disease. Moreover, these plans address various health-related social needs and provide coverage for a wide array of health services. These extra offerings are particularly significant for enrollees dealing with nutrition-related conditions such as diabetes, obesity, kidney disease, and malnutrition, especially among low-income individuals who often encounter difficulties in accessing essential medical and support services.

The Academy shares the concerns of many colleagues regarding the adequacy of current reimbursement rates for Medicare Advantage plans. These rates rely on older and potentially incomplete data that fails to fully capture service utilization. The combination of low base rates, the omission of malnutrition from the CMS-HCC Risk adjustment model, and unanticipated rises in care costs is troubling. This situation could have a detrimental effect on the ability of MA plans to deliver the necessary level of care and coordination for patients dealing not only with nutrition-related issues but also managing other complex medical conditions.

Anecdotally, the Academy is aware that Medicare Advantage plans provide Medical Nutrition Therapy and other nutrition care services beyond the scope of the Medicare Part B Benefit. However, despite reports of coverage from Medicare Advantage plans to both enrollees and providers, providers face challenges in securing reimbursement due to a lack of transparency from MA plans, particularly for conditions beyond diabetes and kidney disease. Additionally, the lack of an Advanced Beneficiary Notice (ABN) or similar form for patients without diabetes or kidney disease complicates billing procedures as MA plans often lack transparent billing protocols, resulting in frustration among both providers and patients. These issues highlight the urgent necessity for the Centers for Medicare & Medicaid Services (CMS) to tackle network adequacy and reimbursement obstacles to guarantee fair access to care and equitable compensation for providers.

With the widespread adoption of Medicare Advantage, the Academy appreciates CMS' continued efforts to improve access to high-value care for Medicare beneficiaries. To that end, the Academy offers the following comments regarding the CMS' Advanced Notice a relating to:

- Attachment II. Section E. Location of Network Areas for Private Fee-for-Service Plans and Network Adequacy
- Attachment II. Section G. CMS-HCC Risk Adjustment Model for CY 2025
- Attachment IV. Updates for Part C and D Star Ratings

Attachment II. Section E. Location of Network Areas for Private Fee-for-Service Plans and Network Adequacy

Location of Network Areas for Private Fee-for-Service (PFFS) Plans and Network Adequacy

Current regulations mandate that Medicare Advantage Private Fee for Service plans maintain adequate provider contracts to ensure accessible care for enrollees, a commitment also shared by the Academy in enhancing the accessibility and quality of health care services. The Academy fully supports the proposed changes requiring MA plans to meet network adequacy standards through signed contracts with providers, as network adequacy plays a crucial role in health outcomes for several reasons.

Network adequacy guarantees timely access to health care providers within a reasonable distance, promoting health equity by reducing disparities in access to care among demographic groups and geographic areas. Additionally, a robust network enhances the quality of care by providing access to diverse providers with varying specialties and expertise, empowering patients to choose professionals aligning with their preferences and needs. As MA plan enrollments continue to increase, ensuring network adequacy is pivotal for achieving positive health outcomes and controlling health care costs.

However, as noted in the proposed rule, in some regions, insurers rely on payments to non-contracted providers to demonstrate network adequacy. Additionally, the Academy has observed instances where certain credentialing practices by private payers require providers to meet criteria beyond what is provided for in regulatory code 42 CFR § 422.204, or restrict certain services such as telehealth, to only certain companies that do not employ all providers. Other obstacles that impede the achievement of network adequacy are vague provider directory policies, that lead to uncertainty about which providers are in-network, causing confusion amongst beneficiaries and delaying access to care. Insurers may also have difficulty ensuring access to specialty care within their networks, particularly when there is not a designated specialty taxonomy code, or the insurer does not classify a particular specialty in directories.

The Academy continues to receive concerning feedback from members facing barriers with MA networks. For example, RDNs in Florida have reported that there is an inconsistency when beneficiaries attempt to access RDNs in MA plans as not all plans will contract with RDN providers. This has created a gap in care and has led to difficulties for beneficiaries accessing in-network providers within a reasonable distance, such as locating in-network providers within a 100-mile radius. Unfortunately, the result has been that the beneficiary is left with the option of either forgoing care or facing significant burdens (both financial and time) when attempting to access care. Furthermore, this challenge is exacerbated when hospitals attempt to locate RDNs who are in-network and able to accept referrals. Lastly, Academy members have reported significantly outdated provider listings make it difficult for beneficiaries to identify available providers who accept their plan.

The Academy reiterates network adequacy concerns outlined in our 2022 comments to CMS, *RIN 0938-AV01 Medicare Program; Request for Information on Medicare*, in which we discuss barriers faced by registered dietitian nutritionists in accessing Medicare Advantage networks, especially in states where RDNs lack professional licenses or through the restriction of telehealth services to specific companies that only employ physicians and physician extenders.

By law, MA organizations must conform with the credentialing and recredentialing requirements set forth in the Social Security Act,[17] which includes items such as written application and the required verification of any existing license or certification from primary sources, but notably does not include an underlying licensure requirement in order to be credentialed. The Social Security Act specifically recognizes that the qualified providers of medical nutrition therapy in certain states that lack the option to be licensed or certified by their state.[18] Unfortunately, this checkerboard of states' varying professional regulation of RDNs operates conflicts with MA health plan credentialling policies and MA plans' obligations to cover at minimum all medically necessary services Traditional Medicare covers. The result is a decreased choice and reduced access to MNT providers; thus, beneficiaries who are enrolled in those plans are not able to fully access their Part B MNT Benefit.[iii]

To date, we continue to hear challenges faced by RDNs attempting to access MA networks given a payer policy reliance on licensure laws to inform credentialing practices.

MNT, a preventive Medicare Part B service provided by RDNs, is crucial for individuals, especially those with chronic conditions. RDNs possess specialized expertise in nutrition and disease management, making them uniquely qualified to address complex dietary needs. The Academy believes improving RDN network adequacy in MA networks enables beneficiaries to access specialized nutrition services, enhancing health care accessibility and ensuring high-quality, patient-centered care tailored to their nutritional requirements and objectives. This step aligns with CMS' aim of advancing whole-person centered care and strengthens MA programs to promote health equity and improve access to quality, cost-effective health care. Failing to address these barriers compromises beneficiary choice and access to essential services, thereby undermining the effectiveness of MA plans in fulfilling their obligations.

Attachment II. Section G. CMS-HCC Risk Adjustment Model for CY 2025

Malnutrition remains a significant health condition that affects a considerable portion of the Medicare population and has a substantial impact on health care utilization and costs.[iv] Malnutrition is an imbalance of nutrients (either deficiency or excess) and may contribute to chronic illness, acute disease, and/or infection, and can lead to various adverse health outcomes, including impaired wound healing[v], increased risk of infections, prolonged hospital stays,[vi] and higher rates of readmissions.[vii]

Starting in 2024, the new quality measure, Global Malnutrition Composite Score (GMCS), will be available for hospitals participating in the CMS Hospital Inpatient Quality Reporting Program (IQR). This is the first nutrition-focused quality measures in any CMS program and it acknowledges the significant role malnutrition plays in the health of Americans 65 years and older. **Malnutrition, however, does not exist solely with hospital walls**. RDNs serve a key role in the identification and documentation (of the diagnosis with specificity) of malnutrition, and implementing interventions, including medical nutrition therapy, and are the most qualified professionals to assess a patient's nutritional status[viii] and develop a treatment plan in collaboration with the interdisciplinary care team.

Under Medicare Part B, access to medical nutrition therapy is limited to beneficiaries with diabetes or chronic kidney disease, restricting access to RDNs only in those settings that support their role. This raises significant concerns that under the Fee-for-Service model, malnutrition is underdiagnosed, thus creating a blind spot in the methodology utilized to update the Hierarchical Condition Category (HCC) based on utilization codes frequently used in Medicare Advantage plans compared to the Fee-for-Service payment model. The existing barriers that limit access to RDNs under FFS creates a void in claims data, obscuring the actual prevalence and underestimating the genuine cost of care necessary to address malnutrition among our nation's seniors.

In the Calendar Year 2024 Medicare Advance Notice[ix], Malnutrition was removed from the CMS-HCC Risk model risk adjustment model, principle 10, as a diagnosis that is subject to discretionary coding. This change is unfortunately the result of a flawed audit completed by the Office of the Inspector General (OIG) **which relied on inconsistent and poorly applied audit criteria**. Since 2016, and as part of a larger organizational taskforce, the Academy in good faith has repeatedly attempted to work with CMS and its auditors to address the concerns brought forth in the OIG audits. The taskforce aims to actively collaborate on efforts to help the U.S. Department of Health and Human Services, the OIG, and CMS understand the best practices for diagnosing, documenting, and coding for malnutrition. Frustratingly, we have received minimal response from the agency in nine years.

The *American Journal of Clinical Nutrition* recently published a cohort study[x] evaluating the predictive validity of the Academy and ASPEN Indicators to diagnose Malnutrition (AAIM) criteria in hospitalized adults. The AAIM criteria is a validated tool to identify both the presence of malnutrition as well as the degree of severity. The study found that the AAIM diagnostic tool is valid, with malnutrition predicted by this tool correlating with higher rates of emergency room visits, and longer length of stay and increased health care resource utilization for moderate cases. The Academy again extends our offer to assist with CMS' understanding and implementation of best practices related to malnutrition.

The Academy will continue to advocate for the inclusion of malnutrition codes within CMS models. Addressing malnutrition not only enhances health outcomes and quality of life but also reduces complications, hospital readmissions, length of stay, and overall care delivery costs[xi,xii, xiii] **The removal of malnutrition from the CMS-HCC model now places an undue burden on health care providers, requiring them to achieve more with fewer resources when caring for individuals with malnutrition**.

Attachment IV. Updates for Part C and D Star Ratings

The Academy appreciates the opportunity to provide feedback on the star rating system which was developed to evaluate the quality-of-care beneficiaries receive from Medicare Advantage plans. The star rating system plays a crucial role in helping beneficiaries select plans that best meet their needs, aligning with the CMS Meaningful Measures framework's focus on person-centered care, equity, safety, affordability, efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. **We strongly urge CMS to work collaboratively with the Academy to develop and integrate a comprehensive suite of nutrition care measures into the MA Star Ratings.**

The Academy recognizes the importance of measures reflecting improvements in beneficiary health, intermediate measures indicating actions taken to enhance beneficiary health status, and process measures capturing the health care services provided. It is through this lens that we offer the following commentary:

Measure Updates for 2025 Star Ratings:

The Advanced Notice, Table IV-1 2025 Star Rating Measures listed several metrics for calculating the 2025 Star Ratings. Some of these metrics are influenced by access to nutrition care from a registered dietitian, either directly or indirectly. However, upon reviewing the technical details of these metrics, it seems that the descriptions fail to recognize the significance of nutrition in facilitating the completion of the metric or in addressing the related health condition. We believe that incorporating nutrition care into the planning of these metrics, where applicable, aligns with CMS' objectives of promoting health equity and enhancing value-based care.

- C04 Monitoring Physical Activity (Measure Type: Process Measure)
    - **Technical guidance definition:** Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.

- **Nutrition Impact:** Nutritional inadequacy and physical inactivity are major factors in chronic conditions such as cardiovascular disease, type 2 diabetes and obesity. Evidence-based interventions[xiv] by nutrition and exercise professionals, including RDNs, increase physical activity levels and improve health outcomes for those affected. By integrating research with clinical expertise and client preferences, RDNs provide tailored, effective care across diverse settings, ensuring practical and sustainable health improvements.

- C05 Special Needs Plan (SNP) Care Management (Measure Type: Process Measure)
  - **Technical guidance definition:** Percent of members whose plan did an assessment of their health needs and risks in the past year. The results of this review are used to help the member get the care they need. (Medicare does not collect this information from all plans, only for Special Needs Plans. Special Needs Plans are a type of Medicare Advantage plan designed for certain people with Medicare. Examples include: people with certain chronic diseases and conditions; people who have both Medicare and Medicaid; and people who live in an institution such as a nursing home.)
  - **Nutrition Impact:** Nutrition plays a vital role in influencing the health needs and risks of individuals; its impact aligns closely with the goals of CMS' National Quality Strategy.[xv] For example, these assessments can reveal dietary patterns, deficiencies, and lifestyle factors linked to chronic diseases such as malnutrition, diabetes, heart disease and obesity. Integrating nutrition assessments allows RDNs to address specific needs and risks in special needs populations, enhancing health outcomes and care quality. This approach supports the National Quality Strategy by promoting prevention, treatment of chronic diseases, improving population health, and enhancing patient and family care experiences. We strongly recommend assessing nutrition-related factors as part of a comprehensive health needs assessment that can provide valuable insights into members' overall health status and risk factors; and, when appropriate care plan coordination with and RDN to provide nutrition care, such as MNT.

- C10 Diabetes Care- Blood Sugar Control (Measure Type: Intermediate Outcome Measure)
  - **Technical guidance definition**: Percent of plan members with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control.
  - **Nutrition Impact:** Practice guidelines[xvi] for diabetes care underscore the critical role of MNT as the cornerstone of comprehensive diabetes management. RDNs can 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.

- C11 Controlling Blood Pressure (Measure Type: Intermediate Outcome Measure)
  - **Technical guidance definition**: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
  - **Nutrition Impact:** Multiple studies[xvii] show that MNT and counseling on Dietary Approaches to Stop Hypertension or low sodium diets by RDNs lower blood pressure in individuals with hypertension or pre-hypertension. Through personalized counseling, RDNs help plan members adopt healthier eating habits, aiding in maintaining healthy blood pressure levels and improving health outcomes.

Recommendation: The Academy strongly advocates for CMS to prioritize evidence-based nutrition care to enhance health care efficacy and equity. Collaboration with measure stewards is crucial to ensure measures encompass the entire care spectrum. Supporting measures aligned with clinical guidelines supports accurate representation of evidence-based practices and comprehensive care. Moreover, implementing feedback mechanisms enables iterative improvements, reflecting evolving health care dynamics and patient requirements. By fostering collaboration and iterative processes, CMS and measure stewards can accurately gauge the value of services like MNT, ultimately improving patient outcomes and overall care quality.

Changes to Existing Star Ratings Measures for the 2025 Measurement Year and Beyond

Future Universal Foundation Star Ratings Measures

The Academy commends CMS for leading the development of the Universal Foundation Star measures, which aim to align outcome measures across health care payers. Integrating measures aimed at improving diabetes care and cardiovascular disease into core sets for Medicare Advantage beneficiaries is a logical step, given their significant impact. However, it's important to acknowledge potential challenges, such as reporting burdens on small practices and independent providers. While alignment aims to reduce reporting burden, addressing barriers associated with data collection and reporting for a larger set of measures is crucial for successful implementation and meaningful provider participation in improving health outcomes and lowering care costs.

Recommendation: The Academy supports CMS' proposal to continue the development of a "Universal Foundation" of quality metrics by adding the proposed measures. We also strongly encourage CMS to ensure the inclusion of all providers and evidence-based treatments in measure sets and data collection, where applicable, for a comprehensive assessment of the cost and quality of person-centered care.

C-SNP Expansion and Impact: Enhancing Care for CKD Stages 3 and 4

Recommendation: The Academy would like to offer our support for the inclusion of additional CKD stages within the scope of Chronic Special Needs Plans (C-SNPs) and echo comments submitted by the Coalition for Kidney Health (C4KH) and emphasize the importance of collaboration with the kidney care community to develop and integrate a suite of kidney health and kidney disease measures into the MA Star ratings.

Display Measures

Social Need Screening and Intervention (Part C). (130)

Screening for Social Related Health Needs (SHRNs) is crucial in health care as it allows health care providers to identify and address the underlying social and economic factors that significantly impact individuals' health outcomes. Identifying barriers to health such as food insecurity and utility insecurity allows for the identification of appropriate interventions, such as medically tailored meals or tailored nutrition care plans, to positively impact the enrollee's physical environment, medical and social aspects of well-being, ultimately leading to more effective and patient-centered care. Additionally, addressing SRHNs early can help prevent or mitigate the development of chronic conditions and reduce health care disparities among vulnerable populations.

Recommendation: The Academy fully supports the implementation and use of the Social Need Screening and Intervention (SNS-E) measure to identify unmet health needs as well as CMS' objective of reducing health disparities and recognizes the crucial role of RDNs, alongside other health care providers, Medicare Advantage organizations, and community-based organizations, in addressing beneficiaries' health-related social needs. The implementation of the Social Need Screening and Intervention measure marks an essential initial step in assessing the prevalence of health-related social needs within the Medicare Advantage population.

Continuing to refine the screening by adding utility security further displays CMS' commitment to overcoming HRSN and health inequities. However, beyond data collection, the establishment of an extensive referral network comprising social and community-based organizations is imperative to effectively address identified needs. Specifically, the Academy urges CMS to address provisions that support adequate social resources and community-based organizations so that beneficiaries can readily access necessary nutrition care, meal preparation, and food security needs. To do so, would require collaborative efforts between CMS, MA plans, and other stakeholders to enhance access to these resources and facilitate meaningful connections between beneficiaries and appropriate support services.

Furthermore, permitting RDNs to participate in the Social Need Screening and Intervention measure allows for comprehensive health care delivery. RDNs possess the expertise to identify and address various health-related social needs, such as food insecurity and access to nutritious foods, which can both be exacerbated by utility insecurity and significantly impact health outcomes. By including RDNs in the Social Need Screening and Intervention measure, health care systems can leverage their unique skill set to better assess and mitigate social determinants of health, ultimately improving the overall well-being of patients.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Health Outcomes Survey (Part C):

Considering potential Health Outcomes Survey (HOS) questions that concentrate on enrollees' perceptions of unmet needs and the effectiveness of plans' assessments and interventions can be of significant benefit to MA plans and providers. These questions provide valuable insights into areas where services may be lacking, enabling targeted improvements to enhance overall care quality. By understanding enrollees' perceptions, plans and providers such as RDNs can tailor interventions to address specific needs more effectively, leading to improved outcomes and increased satisfaction. Additionally, continuous tracking of intervention effectiveness through HOS questions allows for ongoing quality improvement efforts, ensuring responsiveness to changing needs and preferences.

Recommendation: The Academy supports the use of the HOS to capture enrollees' perceptions of unmet needs and MA plans' assessment and intervention, and we strongly recommend CMS include RDNs in helping to administer HOS questions as they can play a crucial role by offering expertise in nutrition and lifestyle interventions, contributing to comprehensive and personalized care approaches that address enrollees' diverse health needs. RDNs' expertise enables them to assess nutritional needs, provide tailored interventions, and connect individuals experiencing food insecurity with appropriate resources such as food assistance programs, community food banks, and nutrition education initiatives, thereby promoting food security and overall well-being.

Blood Pressure Control for Patients with Hypertension (Part C).

In response to CMS' request for feedback on potential new measures, the Academy supports adding "Blood Pressure Control for Patients with Hypertension (Part C)" as a new measure. With over 48% of US adults affected[xviii], hypertension is a leading cause of kidney disease, heart disease, and stroke, contributing approximately $56 billion annually to health care costs. Only 1 in 4 individuals[xix] with hypertension are well controlled. Improving dietary intake, lifestyle modifications, and medical nutrition therapy are integral to treatment for both prehypertension and hypertension, enhancing outcomes in a comprehensive care approach, which is in alignment with the 2017 American Health Association and American College of Cardiology guidelines.[xx]

Recommendation: The Academy strongly advocates for an integrated approach to this measure, encompassing evidence-based nutrition care like MNT for adults with hypertension. Developing, testing, and implementing measures addressing nutrition care is crucial, given its role in treating many chronic conditions and diseases.

Additionally, the Academy would like to offer our support for the development of the *Expansion of the Kidney Evaluation for Diabetes (KED) Measure* and echo comments submitted by the Coalition for Kidney Health (C4KH), emphasizing the importance of collaboration with the kidney care community to develop and integrate a suite of kidney health and kidney disease measures into the MA Star ratings. We would also recommend the development of a Functional Status Assessment Follow-Up for the KED Measure as it would be essential for comprehensive evaluation and management of diabetic kidney disease. This would not only enhance the holistic approach to managing diabetic kidney disease but also underscores the importance of addressing functional impairment in improving patient outcomes and quality of life.

Thank you for your careful consideration of the Academy's comments on the Medicare Advantage Advance Notice. 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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