

October 5, 2020

Ms. Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Re: File Code- CMS-1734-P; Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (August 17, 2020)

Dear Administrator Verma:

The Academy of Nutrition and Dietetics (the “Academy”) is pleased to provide comments on File Code- CMS-1734-P published in the Federal Register on August 17, 2020. Representing over 107,000 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. RDNs independently provide professional services such as medical nutrition therapy (MNT)² under Medicare Part B and are recognized as Eligible Clinicians (ECs) and Qualified APM Participants (QPs) in Medicare’s Quality Payment Program. RDNs provide high quality, evidence-based care to patients and deliver substantial cost-savings to the health care system as a whole.

As we know all too well, Medicare beneficiaries and providers are facing unique times when it comes to accessing and delivering safe, equitable, and effective health care during a public health emergency (PHE) whose end is uncertain. We also know the PHE is having and will continue to have a significant economic impact on patients and providers and those paying for health care. The Academy appreciates efforts to date by CMS to pivot policies considering these circumstances and the continued adjustments as laid out in these proposed rules. With that in mind, the Academy offers specific comment on the following proposed rule items:

1. Telehealth and Other Services Involving Communications Technology (**Section II.D**)
 - a. Adding Services to the Medicare Telehealth Services List
 - b. Proposed Technical Amendment to Remove References to Specific Technology

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 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 May 2017. Accessed September 15, 2020.

- c. Communication Technology-Based Services (CTBS)
 - d. Continuation of Payment for Audio-only Visit (98966-8)
 - e. Direct Supervision by Interactive Telecommunication Technology
2. Remote Physiological Monitoring (RPM) Services (**Section II.E**)
3. Principal Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (**Section III.C**)
4. Comprehensive Screenings for Seniors (**Section III.E**)
5. Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (**Section III.O**)
6. CY 2021 Updates to the Quality Payment Program (**Section IV**)
 - a. Merit-based Incentive Payment System (MIPS)
 - b. MIPS Value Pathways (MVP)
7. Regulatory Impact Analysis: Changes in Relative Value Unit (RVU) Impacts (Section VIII.C.)

1. Telehealth and Other Services Involving Communications Technology (Section II.D)

Adding Services to the Medicare Telehealth Services List

The Academy requests CMS add G0271 to the list of Medicare telehealth services as this service meets the Category 1 criteria. As noted in our comments submitted to CMS on June 1, 2020 in response to CMS-1744-IFC, we believe the addition of HCPCS G0271 falls under Category 1 in accordance with section 1834(m)(4)(F)(ii) of the Social Security Act which outlines Category 1 services are “*similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services... we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter... We also look for similarities in the telecommunications system used to deliver the service.*”

The current list of Medicare telehealth services³ includes:

- CPT code 97802 – Medical nutrition therapy, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- CPT code 97803 – Medical nutrition therapy, re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- CPT code 97804 – Medical nutrition therapy, group (two or more individuals), each 30 minutes
- HCPCS code G0270 – Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen, individual, face-to-face with the patient, each 15 minutes

HCPCS code G0271 is analogous to CPT Code 97804 for group medical nutrition therapy and HCPCS code G0270 for reassessment and subsequent intervention(s) for a change in diagnosis, medical condition or treatment regimen. Therefore, we believe it meets Category 1 criteria for inclusion in the list of approved Medicare telehealth services.

³ CMS, Telehealth Services. <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. Accessed September 14, 2020.

Proposed Technical Amendment to Remove References to Specific Technology

In the proposed rule, CMS proposes a modification to the definition under §410.78(a)(3) of an “interactive telecommunication system” to remove reference to “telephones”. The Academy supports this modification to the definition to recognize the role smart phones now play in health care. We encourage CMS to consider additional opportunities to modernize Medicare policies to better support current and future use of telehealth and communication technology-based services as the field continues to evolve.

Communication Technology-Based Services (CTBS)

As stated in our June 1, 2020 response to CMS-1744-IFC, **registered dietitians and nutrition professionals should be listed as Medicare providers for use of G2061-3**. These services fall squarely within the RDN’s scope of practice and definition of their respective benefit category. Registered dietitians and nutrition professionals frequently receive inquiries from patients through a variety of communication technologies about physiological data (e.g., blood glucose self-monitoring results, blood pressure, weight, and nutrition-related serum values such as potassium), medications, physical activity, adverse symptoms and/or food intake related to their nutrition care plan. Information gathered through online communication platforms allows RDNs to make decisions about whether an MNT encounter may be necessary.

We believe the agency’s intent when listing eligible Medicare providers within the Interim Final Rule was to highlight those providers who are not eligible to provide telehealth services but can provide these communication technology-based services. The omission of RDNs from the list of eligible providers of communication technology-based services has led stakeholders (including administrators and billing staff) to interpret the policy literally and are mistakenly believing that they cannot bill for these services when provided by a registered dietitian. This has led to limited access to nutrition services for beneficiaries who would benefit most from Medical Nutrition Therapy (MNT).

The Academy urges CMS to recognize CPT codes 98970-2 in place of G2061-3. In the CY20 Medicare Physician Fee Schedule Proposed Rule, CMS noted the codes may not be utilized because the term “evaluation and management” was included in the code descriptor. Since that time the CPT Editorial Panel has revised the code descriptor language so it would behoove CMS to transition from the G codes to the CPT codes to reduce the burden and confusion of having CPT codes and HCPCS codes for the exact same service. The Academy believes it may have been CMS’s intent to do so when it noted on page 114 of the proposed rule: “We also note that in section II.K. of this proposed rule we are proposing for CY 2021 to replace the eVisit G codes with corresponding CPT codes.” Our belief is based on the fact that there is no section II.K in the proposed rule.

The Academy supports CMS’s proposal to create new HCPCS G codes for virtual check-ins for non-physician practitioners who cannot independently bill for E/M Services. **The Academy requests that RDNs and nutrition professionals be deemed eligible providers and independent billers for HCPCS G Codes: G20X0 and G20X2.** The virtual check-in offers the opportunity to make simple adjustments in a nutrition care plan that helps to avoid higher cost encounters with the health care system (e.g., hospitalizations, emergency department or urgent care center visits), allows beneficiaries to remain safely in their homes and mitigate infection risk, and/or

additional long-distance trips to health care professionals for patients located in rural areas. The Academy agrees that these codes should be valued the same as the physician versions of the codes. Furthermore, we agree that beneficiary consent and the proposed flexibility with the timing and manner of acquiring that consent is of the utmost importance.

Continuation of Payment for Audio-only Visits (98966-8)

In our June 1, 2020 response to CMS-1744-IFC,⁴ the Academy applauded CMS' decision to no longer consider CPT codes 98966-8 (telephone assessment and management services) categorically non-covered services. Since these codes were established in 2008 by the CPT Editorial Panel and valued by the RUC, the Academy has been urging CMS to cover these services to improve timely access to care with cost effective providers and decrease unnecessary care and avoidable costs. Recognition of these services within the Medicare program is important in capturing real costs to non-physician practices. Providing coverage of audio-only services improves timely access to care and keeps the beneficiary safe at home. Member feedback has highlighted that many Medicare beneficiaries prefer audio-only visits due to poor broadband connectivity and/or lack of comfort or ability to utilize audio-video technology, a finding supported by research conducted by the Better Medicare Alliance (BMA) and ATI Advisory. BMA surveyed Medicare beneficiaries about their experiences with telehealth and found that > 60% of beneficiaries preferred modality of care was audio. Video communication was perceived as invasive as beneficiaries are sensitive about their personal appearance and the cleanliness of their home, and among those with devices, the preference is for mobile devices over personal computers.⁴ Our members report improved show rates and compliance to nutrition care plans as beneficiaries have been able to keep appointments through audio-only visits under the parameters of the current flexibilities. Telephonic check-ins have also provided the opportunity for the RDN to determine if an MNT encounter is necessary or if adjustments to the nutrition care plan can be made over the phone, often preventing higher cost encounters with the health care system (e.g., hospitalizations, emergency department or urgent care center visits).

The Academy believes CMS has the authority to continue payment for audio-only visits. The definition of an interactive communication system was developed by CMS through regulations and CMS, as demonstrated in this proposed rule, can modify that definition. The current audio-only services allowed during the PHE fall within the definition of telehealth under Section 1834(m) of the Social Security Act (SSA): ““(i) IN GENERAL.—The term ‘telehealth service’ means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201– 99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.”⁵ With that said, **the Academy encourages CMS to develop coding and payment for non-physician providers for audio-only services, similar to the virtual check-ins, as a permanent payment policy.** We recommend CMS model these codes similar to the current telephone services codes (98966-8) and crosswalk payment to G2061-G2063. Doing so would provide access to such services from all Medicare provider types beyond the current geographic

⁴ Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19 <https://www.bettermedicarealliance.org/publication/telehealth-during-a-time-of-crisis-medicare-experiences-amid-covid-19/>. Accessed on September 14, 2020.

⁵ <https://www.congress.gov/106/bills/hr5661/BILLS-106hr5661ih.pdf> Accessed: September 14, 2020

limitations of the SSA. Such broad access is important to ensure beneficiary safety, improve care, and manage health care costs.

Direct Supervision by Interactive Telecommunications Technology

The Academy thanks CMS for providing clarification of direct supervision requirements in allowing the supervising physician (or other supervising practitioner) the ability to be available through audio/video communications technology and confirming “that individual practitioners were in the best position to make decisions about how to meet the requirement to provide appropriate direct supervision based on their clinical judgment in particular circumstances”⁶. The Academy believes that this will not only provide better access to care for beneficiaries but also support the delivery of timely, cost effective care. **The Academy encourages CMS to make these flexibilities permanent.**

2. Remote Physiological Monitoring (RPM) Services (Section II.E)

The Academy appreciates CMS providing the requested clarity on how the agency interprets aspects of the RPM code descriptors for CPT codes 99453, 99454, 99091, and 99457. **The Academy supports CMS’ proposal to make permanent policy allowing consent to be obtained at the time that RPM services are furnished and to allow auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician’s supervision.**

The Academy recommends CMS expand access to these codes by other Medicare provider types within their scope of practice to support a wide range of benefit categories. Specific to CPT codes 99453, 99454, and 99457, RDNs routinely monitor physiologic parameters such as weight as part of MNT services to evaluate the nutrition care plan and revise as needed per the Academy’s evidence-based nutrition practice guidelines for persons with diabetes and chronic kidney disease.^{7 8}

CMS has long interpreted “qualified healthcare professional” differently than the intent of the CPT Panel when developing CPT codes, thereby creating administrative burden for provider practices and creating access barriers for Medicare beneficiaries to quality and effective care through all qualified Medicare providers. RDNs are deemed Medicare providers by statute and as such should have access to furnish and bill for services within their scope of practice that are reasonable and necessary for the treatment of the patient’s illness and that allow understanding of a patient’s health status to develop and manage a plan of treatment. These services are squarely within the RDN’s scope of practice.⁹ **The Academy therefore asks CMS to allow RDNs to bill for these services.**

3. Principal Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Section III.C)

The Academy supports CMS’ proposal to add G2064 and G2065, Principal Care Management (PCM) Services, to the general care management code G0511 for RHCs and FQHCs and

⁶ 2021 Medicare Physician Fees Schedule, CMS-1734- P p124.

⁷ Academy of Nutrition and Dietetics. 2015 Diabetes Type 1 and 2 Evidence-Based Nutrition Practice Guidelines. <https://www.andeal.org/topic.cfm?menu=5305&cat=5595>. Accessed June 15, 2020.

⁸Academy of Nutrition and Dietetics. Chronic Kidney Disease (CKD) Guidelines. <https://www.andeal.org/topic.cfm?menu=5303>. Accessed June 15, 2020.

⁹ The Academy Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. J Acad Nutr Diet. 2018;118:141-165.

increasing the payment rate to reflect the addition of these 2 new codes. We agree with CMS that patients with a single high-risk disease or complex chronic condition may require significant resources to manage their care, including MNT services provided by RDNs. Data show that MNT provided by an RDN is linked to improved clinical outcomes and reduced costs related to physician time, medication use and hospital admissions for people with obesity, diabetes, and disorders of lipid metabolism, as well as other chronic diseases.¹⁰ RDNs are an essential part of the health care team at many RHCs and FQHCs. As a member of the team, they are well-qualified and frequently do provide care management services to patients with a single high-risk disease or complex chronic condition (including but not limited to diabetes or renal disease). Current RHC and FQHC payment systems do not include such services. These critical safety net providers deserve the opportunity to receive payment for these important services designed to improve patient outcomes and which they are currently providing without compensation.

4. Comprehensive Screenings for Seniors (Section III.E)

The Academy supports the requirement under Section 2002 of the SUPPORT Act to include screening for potential substance use disorders (SUDs) and a review of any current opioid prescriptions as part of the first and subsequent Annual Wellness Visits (AWV). We, too, are concerned about opioid risk and SUDs in Medicare beneficiaries. Screening for SUDs is an important step toward referring patients to critical MNT services provided by RDNs as these individuals frequently suffer from gastrointestinal issues, flare-ups of previously dormant autoimmune diseases, eating disorders/disordered eating and malnutrition in all its forms.¹¹ This population often also benefits from life-skills training, including grocery shopping, meal planning and preparation, for which RDNs are best qualified to provide. In comments to the Centers for Disease Control on Nutrition Interventions and Drug Overdose Response Investigation Data Collections,¹² we cited several studies documenting substandard eating patterns during drug use, including inadequate intake leading to micronutrient deficiencies^{13, 14, 15, 16, 17, 18} and

¹⁰ Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Evidence Analysis Project 2008*. <http://www.andevidencelibrary.com/mnt>.

¹¹ Academy of Nutrition and Dietetics: Revised 2018 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Mental Health and Addictions Journal of the Academy of Nutrition and Dietetics, October 2018, Volume 118, Number 10.

¹² *Drug Overdose Response Investigation (DORI) Data Collections (Docket No. CDC-2017-0055)*. <https://www.eatrightpro.org/news-center/on-the-pulse-of-public-policy/regulatory-comments/academy-comments-to-cdc-re-nutrition-interventions-and-drug-overdose-response-investigation-dori-data-collections>. Accessed September 5, 2020.

¹³ Gawad, S.S.A.E., et al., *Effects of drug addiction on antioxidant vitamins and nitric oxide levels*. J. Basic Appl. Sci. Res., 2010. 1(6): p. 485-491.

¹⁴ Hossain, K.J., et al., *Serum antioxidant micromineral (Cu, Zn, Fe) status of drug dependent subjects: Influence of illicit drugs and lifestyle*. Subst Abuse Treat Prev Policy, 2007. 2: p. 12.

¹⁵ Mannan, S.J., et al., *Investigation of serum trace element, malondialdehyde and immune status in drug abuser patients undergoing detoxification*. Biol Trace Elem Res, 2011. 140(3): p. 272-83.

¹⁶ Santolaria-Fernandez, F.J., et al., *Nutritional assessment of drug addicts*. Drug Alcohol Depend, 1995. 38(1): p. 11-8

¹⁷ Varela, P., et al., *Human immunodeficiency virus infection and nutritional status in female drug addicts undergoing detoxification: anthropometric and immunologic assessments*. Am J Clin Nutr, 1997. 191997(66): p. 504S-508S.

¹⁸ Islam, S.K.N., K.J. Hossain, and M. Ahsan, *Serum vitamin E, C and A status of the drug addicts undergoing detoxification: influence of drug habit, sexual practice and lifestyle factors*. European Journal of Clinical Nutrition, 2001. 55: p. 1022-1027.

malnutrition.^{19 20 21 22 23} We also provided extensive evidence to support the claim that nutrition can play a critical role in promoting wellness during the recovery process, thereby helping to reduce relapse and accidental overdose or death. The AWW offers an ideal opportunity for performing such screening and making appropriate referrals for services. The Academy supports the proposed increase in payments for the AWW that will offset the costs of this requirement.

5. Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

The Academy continues to support the virtual flexibilities provided to the Medicare Diabetes Prevention Program (MDPP) by CMS during the PHE. We believe that these changes have helped seniors improve their health and lower their risk for diabetes under the current circumstances. We further commend CMS for waiving the limitations for virtual make-up sessions and beneficiary's ability to maintain eligibility. The Academy supports CMS's proposal of waiving the requirement for in-person attendance at the first core-session which will allow for new cohorts to begin the program and lower their risk of diabetes. Lastly, we support CMS's proposal to make these flexibilities available during future health emergencies. Such action by CMS will allow MDPPs to quickly switch from in-person to virtual delivery of services, thus minimizing disruptions in care.

Now more than ever, the ability to provide effective and safe care to our nations seniors is of the most importance. Nearly half of all Americans suffer from preventable chronic conditions,²⁴ such as obesity, diabetes, and heart disease. It is estimated that one in five Americans aged 65 years and over (one in 11 Americans overall) have been diagnosed with type 1 or type 2 diabetes.²⁵ Research has shown that preventive health programs are highly effective in preventing chronic diseases²⁶ and that a crucial component of preventative health care programs is nutrition. There are multiple examples of virtual DPPs that appropriately leverage RDNs in their program. At the same time, there are virtual programs who do not, and we are concerned with their ability to provide patients with safe, appropriate care. Medicare beneficiaries with prediabetes may very well also have multiple co-morbidities requiring expertise beyond what non-RDN providers in the MDPP may be able to safely provide. The current CDC program recognition standards do not include any specific requirements to ensure these beneficiaries are identified and appropriately referred to necessary health care services and providers. Experience of Academy members delivering Diabetes Prevention Programs or providing MNT services to participants of such programs reveals the unfortunate frequent

¹⁹ Baptiste, F., *Drugs and diet among women street sex workers and injection drugs user in Quebec City*. Canadian Journal of Urban Research, 2009. 18(2): p. 78-95.

²⁰ Saeland, M., et al., *High sugar consumption and poor nutrient intake among drug addicts in Oslo, Norway*. Br J Nutr, 2011. 105(4): p. 618-24.

²¹ Anema, A., et al., *Hunger and associated harms among injection drug users in an urban Canadian setting*. Substance Abuse Treatment, Prevention, and Policy, 2010. 5(20).

²² Nazrul Islam, S.K., et al., *Nutritional status of drug addicts undergoing detoxification: prevalence of malnutrition and influence of illicit drugs and lifestyle*. Br J Nutr, 2002. 88(5): p. 507-13.

²³ Ross, L.J., et al., *Prevalence of malnutrition and nutritional risk factors in patients undergoing alcohol and drug treatment*. Nutrition, 2012. 28(7-8): p. 738-43.

²⁴ Wullianallur R. *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*. Int J Environ Res Public Health. 2018 Mar; 15(3): 431.

²⁵ 2017 CMS Report: *Diabetes Occurrence, Costs, and Access to Care among Medicare Beneficiaries Aged 65 Years and Over*.

²⁶ National Centers for Disease Control and Prevention. www.cdc.gov/chronicdisease/programs-impact Accessed September 14, 2020.

occurrence of participants being provided with incorrect nutrition information and advice that is detrimental to their health. Data to date on CDC recognized programs indicates some of the most successful programs use both lay coaches and health professional coaches, such as RDNs. Moving forward, either during times of public health emergencies or non-emergent times, **the Academy continues to urge CMS to require MDPP services, whether virtual or in-person, to be delivered by or under the supervision of qualified health care providers, such as an RDN, NDTR, or CDCES.**

6. CY 2021 Updates to the Quality Payment Program (Section IV)

In light of the COVID-19 public health emergency, the Academy agrees with and appreciates CMS's decision to propose only minimal changes to the Merit-based Incentive Payment System (MIPS) as well as delay the implementation of the initial MIPS Value Pathways (MVP) until at least the 2022 performance year. This will allow clinicians to remain focused on providing timely and safe care to beneficiaries without the burden of learning and adapting to new measures.

Merit-based Incentive Payment System (MIPS)

The Academy appreciates the agency's recognition of the impact of COVID-19 on the ability of MIPS eligible clinicians to complete data submission as they focus on caring for patients. We also appreciate CMS's decision to adjust performance thresholds and category weights for the 2021 performance period. Specifically, the Academy supports the following proposals for the reasons cited by CMS:

- Decrease the weight of the Quality performance category to 40% for the 2023 MIPS payment year and 30% for the 2024 MIPS payment year as required by law.
- Use performance period and not historical date benchmarks to score quality measures for the 2021 performance period due to the COVID-19 PHE impacting data submission in 2020.
- Remove the CMS Web Interface as a collection type and submission type for groups and virtual groups beginning with the 2021 performance period.
- Change the maximum number of points available for the complex patient bonus to 10 points to account for the additional complexity of treating patients during the COVID-19 Public Health Emergency.
- Establish a process for agency-nominated improvement activities.

Quality Performance Category

The Academy recommends the following changes to the quality measures:

- The Malnutrition Quality Improvement Initiative (MQii) - Malnutrition Global Composite Score (Composite Measure) has been reviewed by CMS and has been accepted to move forward on the draft Measures under Consideration List for 2020. As measure steward, the Academy of Nutrition and Dietetics will be receiving email questions, comments, and updates on the status of the Composite Measure as it is going through further CMS and HHS clearance states in the coming months. Adoption of this composite measure provides an important opportunity to address malnutrition beyond the hospital and throughout the community at-large, as described in *The National Blueprint: Achieving*

*Quality Malnutrition Care for Older Adults.*²⁷ Its inclusion will also make sure care is delivered safely, effectively, equitably, and timely.

Add the following two quality measures to the Nutrition/Dietitian Specialty Measure Set: Depression Screening (NQF#0418/Quality#134) and Tobacco Screening (NQF#0028/Quality#226).

These measures address major public health concerns that all Medicare providers should be doing their part to address. These screenings are routinely part of the comprehensive nutrition assessment performed by RDNs per evidence-based practice guidelines. Nutrition Assessment includes in the standards of practice quality indicators for RDNs in Mental Health and Addictions: “Each RDN considers other factors affecting intake, nutrition, and health status (e.g., cultural, ethnic, religious, lifestyle influencers, psychosocial and social determinants of health). Each RDN evaluates impact of substance use disorder (e.g., alcohol, tobacco, drugs) on ability to care for self.”²⁸ Beyond MNT services, RDNs may perform these screens as recognized providers of the Annual Wellness Visit (AWV). Depression, particularly in older adults, has been linked to malnutrition and food insecurity,²⁹ both of which are issues RDNs actively address to not only provide guidance and intervention but also assist in the coordination of care with other appropriate subspecialties. Smoking and poor diet are well known risk factors for the development of chronic disease. A study completed in 2017 by Shepard, et al at Bellevue Hospital Center and NYU Langone Medical Center demonstrated a negative correlation between smoking and diet quality among adults with a median age of 60 years old, who were undergoing coronary angiography. Adult smokers were noted to have reported poorer diet quality in comparison to non-smokers.³⁰

Cost Performance Category

The Academy supports the continued gradual increase in weighting of the Cost Performance category. The Academy has been participating in several of the clinical care subcommittees charged with developing new episode-based measures and looks forward to continued opportunities to do so in the future. **The Academy urges CMS to continue to include the full range of provider types in the development of such measures to fully capture the total cost of care involved in these episodes of care.**

Improvement Activities Performance Category

The Academy has completed work on Improvement Activity tools for use by RDNs. One such resource tool is the Standards of Excellence (SoE) Metric Tool. The SoE Metric Tool directly aligns with the IA component within the MIPS program. The MIPS IA component encourages providers to establish and conduct practice improvement activities best suited for their practice. The SoE Metric Tool is a self-assessment tool for RDNs to measure and evaluate their practice’s programs, services and initiatives that identify and distinguish the RDN brand as the professional expert in food and nutrition. RDNs utilizing this tool will be able to input pertinent data, identify

²⁷ The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Washington, DC: Avalere Health and Defeat Malnutrition Today; 2020.

²⁸ Academy of Nutrition and Dietetics: Revised 2018 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Mental Health and Addictions Journal of the Academy of Nutrition and Dietetics, October 2018, Volume 118, Number 10.

²⁹ Doner B, et al. *Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings.* JAND, April 2018, 118 (4) Number 4, p 724-35.

³⁰ Shepard, T. et al. Association Between Smoking Status and Diet Quality Among Patients Referred for Coronary Angiography in New York City. JAND, Sep 2017, Suppl 1., 117 (9) p A-81

gaps within performance, and ultimately generate quality improvement programs and activities. **The Academy recommends CMS incorporate the SoE tool into the IA inventory and allow RDNs to report Improvement Activities through this tool as eligible clinicians under MIPS.**

The Academy recommends CMS include in the IA Inventory under Population Management the integration of a registered dietitian onto the care team. This IA is evidence-based, aligns well with several of the existing activities under this domain, and is consistent with the existing recommendation to integrate a pharmacist into the care team to assist with medication management.

The Academy recommends development and inclusion of an IA measure on referrals to RDNs for MNT services for patients with nutrition-related chronic conditions (including chronic renal disease stage 3 and 4 and diabetes, for which Medicare Part B benefits exist and are underutilized) in accordance with clinical practice guidelines. MNT provided by RDNs for prevention, wellness and disease management improves patient health and increases productivity and satisfaction levels through decreased doctor visits, fewer hospitalizations and re-admissions, and reduced prescription drug use. RDNs' expertise and extensive training enable them to deliver coordinated, cost-effective care for a variety of chronic diseases, including obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.³¹ RDNs are recognized as the most qualified food and nutrition experts by the National Academy of Medicine (formerly IOM), most physicians, numerous clinical guidelines, and as evidenced by recommendations of the United States Preventive Services Task Force (USPSTF), providing nutrition care more effectively at a lower cost than physicians, nurse practitioners, and physician assistants.³² Given the lack of coverage for MNT services for all but a handful of disease states, it is not surprising that the service is underutilized when it might be more effective. To solve long-term problems in the Medicare program, we must aim for both earlier intervention and for prevention in cases where it is demonstrated to pay off. Nutrition-related chronic diseases and conditions, such as hypertension, obesity, and diabetes mellitus, are both costly and common in the United States. Nutrition management of multiple chronic conditions by improving overall nutrition intake is both cost-effective and an integral component of treatment. Given the low utilization of MNT when it could make a significant impact, **CMS should develop process and outcome quality measures of appropriate use that recognize the benefits of referring patients to RDNs for MNT, consistent with the explicit recommendations of the USPSTF.**

Promoting Interoperability (PI) Performance Category

CMS is proposing to continue the existing policy of reweighting the Promoting Interoperability performance category for certain types of non-physician practitioner MIPS eligible clinicians for the performance period in 2021, including registered dietitians or nutrition professionals. **The Academy supports the continued exclusion as there currently are not sufficient measures applicable and available to RDNs under this performance category.**

³¹ Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015*. <http://www.andeal.org/mnt>

³² 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).

The Academy has ongoing efforts underway to support the development and testing of nutrition content as part of the HL7 FHIR specification which includes the NutritionOrder, NutritionIntake, and NutritionProduct resources, as well as involvement in other FHIR implementation guides that include nutrition and support the care plan through inclusion of the whole care team. As the FHIR standard, implementation guides, and APIs evolve, this pathway may provide RDNs and other specialty providers more efficient ways to support electronic referral loops among MIPS eligible and non-MIPS providers. **We encourage CMS to consider creating future interoperability measures that support the adoption of Application Programming Interfaces as alternative means of demonstrating performance in this category.**

MIPS Value Pathways (MVP)

As previously noted, the Academy appreciates CMS' decision to delay implementation of the initial MIPS Value Pathways (MVP) until at least the 2022 performance year in light of the current PHE. The Academy supports CMS' updates to the MVP framework guiding principles and the proposed criteria for developing and selecting MVPs as they reflect consideration of many of the concerns raised in our comments to CMS on the CY20 Medicare Physician Fee Schedule proposed rule. Providing this information now will help stakeholders begin to develop proposed MVPs as time and resources permit during the PHE.

As CMS continues to develop the MVP concept, the Academy voices its continued concern that, like the overall design of the QPP, it is being done through the lens of physician-providers only. By using promoting interoperability measures as a foundation for the MVPs, it automatically excludes a large cadre of valuable Medicare providers, including RDNs, from participation in such pathways. **The Academy continues to encourage CMS to provide financial support (e.g., grants) and continued technical assistance to all provider types not previously included in the EHR Incentive Program to make access to health information technology and interoperability among all providers a reality.**

7. Regulatory Impact Analysis: Changes in Relative Value Unit (RVU) Impacts (Section VIII.C.)

While we support the Medicare office visit payment policy finalized for CY21, **the Academy strongly urge CMS/HHS to utilize its authority under the public health emergency declaration to preserve patient access to care and mitigate financial distress due to the pandemic by implementing the office visit increases as planned while waiving budget neutrality requirements for the new Medicare office visit payment policy.** Now is not the time to impose drastic cuts that will further strain a health care system that is already stressed by the COVID-19 pandemic. The proposed cuts, as estimated in Table 90, are devastating to health care professionals, their practices, and most importantly, to their patients. Payment reductions of this magnitude would be a major problem at any time, but to impose cuts of this magnitude during or immediately after the COVID-19 pandemic is unconscionable.

Seniors with diet-related conditions, including diabetes and chronic kidney disease, are suffering from the worst COVID-19 outcomes, including higher rates of death. Medical nutrition therapy provided by RDNs has been proven to help these patients control their blood sugar, blood pressure and weight, slow the progression of diabetes and kidney disease, lower medication use, and avoid unnecessary emergency room visits and hospitalizations. MNT by RDNs for Medicare beneficiaries with chronic kidney disease is critical to achieving the goals of the

President's Executive Order on Advancing American Kidney Health which calls for cutting the number of new cases of end-stage renal disease by 25% by 2030.^{33 34}

Primary care providers will have fewer choices when referring patients to specialists if health care professionals must close or limit their practices because of these cuts. Many of our members are small business owners hit hard financially by the PHE. The proposed cuts, on top of Medicare fee-for-service payments that have failed to keep up with inflation along with the 2% sequestration reductions, will force many to reconsider their Medicare provider enrollment status, thus severely diminishing Medicare beneficiary access to critical nutrition services. While some have pointed to the Quality Payment Program as an opportunity to offset these cuts, access to the Merit-based Incentive Payment System and Advanced Alternative Payment Models cannot be considered a meaningful or accessible offset.

It is clear that the recovery and restoration to full patient utilization of health care services will be drawn out. We foresee that providers, particularly those in rural and underserved areas, will be unable to sustain these lower payments and be forced to reduce essential staff or even close their doors as a result of this change, thus restricting Medicare and non-Medicare patient access to medically necessary services.

The Academy urges CMS to explore all avenues, including working with Congress, to prevent drastic cuts from occurring while RDNs and other Medicare providers are still trying to recover and gain their financial footing from the effects of the pandemic. For example, CMS could delay or cancel implementation of the GPC1X add-on code and apply savings to the budget neutrality calculation. Another option would be to phase-in the payment changes over several years to allow providers to recover from the financial impact of the pandemic. As recommended by the Medicare Payment Advisory Commission (MedPAC) in Chapter 3 of the Commission's June 2018 Report to Congress, adjustments to the fee schedule to address devaluation of E/M services could be phased in over multiple years to reduce the impact on other services.³⁵ We also note that there is precedent for phase-in when a proposal results in large-scale changes and shifts in payment. For example, CMS finalized a CY 2019 proposal to phase-in market-based supply and equipment pricing practice expense updates over a 4-year period *"to minimize any potential disruptive effects during the proposed transition period that could be caused by other sudden shifts in RVUs due to the high number of services that make use of these very common supply and equipment items."*³⁶

Finally, CMS routinely and inexplicably omits analysis of the impact of the proposed physician fee schedule changes for the RDN specialty; RDNs are not listed in Table 90 "CY 2021 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty." CMS's omission of RDNs in Table 90 makes it difficult for the Academy and RDN Medicare providers to recognize the impact of fee schedule changes on their practices. **Once again, the Academy urges CMS to**

³³ <https://aspe.hhs.gov/system/files/pdf/262046/AdvancingAmericanKidneyHealth.pdf>. Accessed, September 12, 2020

³⁴ <https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/> Accessed September 12, 2020

³⁵ Medicare Payment Advisory Commission Report to the Congress: Medicare and the Health Care Delivery System (June 2018). http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf

³⁶ 2019 Physician fee schedule final rule (pg. 59475). <https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

annually include the RDN specialty in this table to facilitate an analysis of fee schedule changes on this vital healthcare specialty.

Thank you for your careful consideration of the Academy's comments on the proposals for the CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at jblankenship@eatright.org or Marsha Schofield at 312-899-1762 or by email at mschofield@eatright.org with any questions or requests for additional information. The Academy looks forward to continued opportunities to work with CMS to design a health care delivery and payment system that improves the health of the nation and meets the needs of all stakeholders.

Sincerely,



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