



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

Submitted via Email

June 7, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1746-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022 Proposed Rule; CMS-1746-P

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) is providing comments on the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) proposed rule for fiscal year 2022. HNC is an association representing manufacturers¹ of enteral nutrition (EN) formulas and oral nutrition supplements (ONS), parenteral nutrition (PN) formulas, supplies, and equipment. Our mission is to improve health by advancing policies that address and raise awareness of nutrition and its impact on patient outcomes and healthcare costs. HNC aims to promote nutritional screening, diagnosis, assessment, appropriate and timely clinical nutrition interventions, as well as patient access to specialized nutrition support products and services throughout the continuum of care.

HNC is pleased to provide comments on SNF quality reporting requirements in response to the Centers for Medicare and Medicaid Services' (CMS) request for information relating to measures and concepts under consideration for future years in the SNF Quality Reporting Program (QRP), and additional items for use in the SNF QRP, including Standardized Patient Assessment Data Elements (SPADEs), that could be used to assess health equity in the care of SNF residents. As detailed further below, HNC:

- Supports the inclusion of frailty as a future SNF QRP quality measure, and requests consideration of malnutrition quality measures for inclusion; and
- Strongly recommends that CMS adopt a diagnosis of malnutrition as a SPADE to ensure the appropriate identification and nutritional management of malnourished patients, make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive, and to address gaps in health equity.

I. Background on the importance of addressing malnutrition.

¹ HNC members are Abbott Nutrition, Nestle Healthcare Nutrition, and Nutricia North America.



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

It is widely recognized that nutritional status plays a significant role in health outcomes and healthcare costs. Addressing malnutrition is essential to improving overall healthcare and may ultimately reduce the economic burden incurred when caring for the oldest and sickest Americans. Disease-related malnutrition can manifest in patients across all spectrums of body mass index, ranging from under to overweight individuals. Malnutrition often is associated with acute and chronic diseases and injury, such as cancer, stroke, infection, trauma, and surgical procedures. Large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-term care residents are undernourished.^{1,2,3,4}

If unaddressed, malnutrition increases the cost of care and likelihood of poor health outcomes, including increased complications, longer hospitalizations, and more readmissions. For example, malnourished patients are more likely to experience complications, such as pneumonia,⁵ pressure ulcers,⁶ nosocomial infections,⁷ and death.⁸ In addition, malnutrition is a risk factor for other severe clinical events, such as falls⁹ and worse outcomes after surgery or trauma.¹⁰ Falls are especially a concern among individuals considered frail. Malnutrition also has negative impacts on patients with specific chronic diseases and conditions, such as stroke,¹¹ heart failure,¹² cancer,¹³ and COPD.¹⁴ Malnourished patients, as well as patients at risk for malnutrition, have significantly longer hospitalizations than well-nourished patients and patients not at risk for malnutrition.¹⁵

Additionally, readmission rates, institutionalization, and ongoing healthcare services increase in patients suffering from malnutrition. In particular, disease-related malnutrition is a common reason for patients to be readmitted to hospitals.¹⁶ A study published in *HCUP Statistical Briefs*, developed by the Agency for Healthcare Research and Quality (AHRQ), in 2016 found that malnutrition in U.S. hospitalized patients is associated with a more than 50 percent higher rate of readmission within 30 days, compared to patient stays not associated with malnutrition.¹⁷ Hospitalized patients at risk of malnutrition are also more likely to be discharged to another facility or require ongoing healthcare services after being discharged from the hospital than patients who are not vulnerable to becoming malnourished.¹⁸

Beyond just the effect on utilization and outcomes, malnutrition has an outsized effect on overall cost of care. Malnutrition costs associated with older adults aged 65 years and older who are the most at risk of malnutrition, and largely depend on Medicare, are estimated at \$51.3 billion annually.¹⁹ However, this figure likely underestimates the total burden of disease-related malnutrition given the diagnosis gap in hospitalized patients.²⁰ In addition, malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital.²¹ Further, the average costs per readmission for patients with malnutrition were found to be 26-34 percent higher (\$16,900 to \$17,900) for patients with malnutrition compared to those without malnutrition (\$13,400).²² A retrospective health economic study found that providing oral nutritional supplements (ONS) to Medicare patients aged 65+ with any primary diagnosis was associated with a 16% reduction in length of stay and a 15.8% cost savings – an average of \$3,079 -- per episode.²³

Lastly, despite the impact on overall health and the prevalence of malnutrition among hospitalized patients, a patient's nutritional status is often not evaluated or diagnosed in a timely manner. In a recent study conducted by AHRQ using the Healthcare Cost and Utilization Project database, only about 7 percent of hospitalized patients are diagnosed with malnutrition.

The extremely low number of those diagnosed with malnutrition represents a screening and diagnosis gap that needs to be addressed. The COVID-19 pandemic has elevated the need to address this gap in care, as recent evidence shows the enormous impact malnutrition has on health outcomes in patients diagnosed with COVID-19. Additionally, outside of a healthcare setting, the economic and social consequences resulting from the pandemic contribute to the risk of food insecurity and malnourishment in the community.²⁴

Based on the aforementioned evidence, it is essential that CMS make nutritional status a key component in both its reimbursement policies and its efforts to improve the quality and value of care delivery. This should include being mindful of the outsized clinical value of nutritional status, despite the fact malnutrition is often only indicated as a secondary or comorbid condition for many patients. Further, CMS should continue to implement more nutritional-related items into its quality and value programs, including in the SNF Quality Reporting Program (QRP).

II. HNC supports frailty as a future SNF QRP quality measure, and in addition, strongly recommends the inclusion of malnutrition quality measures.

CMS is seeking input on the importance, relevance, appropriateness, and applicability of measures and concepts under consideration for future years in the SNF QRP. The SNF QRP currently has 13 measures for the FY 2022 program year, including Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay). Malnutrition is a risk factor for severe clinical events, such as loss of lean body mass and risk of falls, and possibly worse outcomes after surgery or trauma since proper nutrition is critical for healing and recovery. We are encouraged to see frailty included on the list of measures and concepts under consideration, since a diagnosis of frailty is linked to a risk of falls and adverse clinical events following a fall. Malnutrition is associated with frailty, and these two conditions share overlapping risk factors.²⁵ We request that any frailty measure include malnutrition as part of that measure.

Malnutrition also contributes to sarcopenia and the loss of the lean body mass, which can lead to frailty and possible falls. The prevalence of sarcopenia in intensive care unit (ICU) patients is documented at 56-71%.²⁶ Regardless of hospitalization, it is estimated that 5-13% of adults over age 60 years and approximately 50% of adults over 80 years have sarcopenia.²⁷ Adequate nutrition, and specifically adequate protein intake, can help attenuate the declines in muscle mass and function associated with sarcopenia, and reduce the risk of frailty and falls. Multiple international expert groups recommend increased protein intake for older adults, with a minimum of 1.0 to 1.2 g/kg/d for healthy older adults and even higher levels (1.2-1.5 g/kg/d) for those who are malnourished or at risk of malnutrition due to acute or chronic illness.^{28,29}

Malnutrition is a critical issue in all healthcare settings. Malnutrition screening in a SNF is necessary to ensure at-risk patients are identified and cared for before experiencing worsening, associated outcomes. In one study, almost fifty percent of patients admitted to a SNF were diagnosed as severely malnourished.³⁰

For these reasons, HNC strongly recommends that CMS also consider the inclusion of malnutrition quality measures in the SNF QRP for future years.

III. HNC strongly recommends that CMS adopt a diagnosis of malnutrition as a SPADE to ensure the appropriate identification and nutritional management of malnourished patients, make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive, and to address gaps in health equity.

CMS is seeking guidance on any additional items, including SPADEs, that could be used to assess health equity in the care of SNF residents, for use in the SNF QRP.

Nutritional status, and by consequence malnutrition, is often influenced by a variety of social determinants of health (SDH). In the SNF setting, some patients may remain in the facility long-term, and should be screened and rescreened for a diagnosis of malnutrition. Other patients may be moved to a different setting, such as an inpatient acute care hospital, and should be screened prior to transitioning to another setting to ensure continuity in care.

According to the World Health Organization (WHO), SDHs are “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”³¹ In many cases SDHs will have a drastic impact on the availability and quality of foods, how those foods can be prepared and consumed, and what foods will be commonly consumed as staple parts of the diet. As a result, SDHs shape a population’s nutritional status and may result in certain populations, such as the elderly, disabled, and the poorest segments of society, becoming malnourished.

CMS notes that significant and persistent inequities in health outcomes exist in the United States, and the COVID-19 pandemic has emphasized many longstanding health inequities, with higher rates of infection and mortality among black, Latino, and Indigenous and Native American persons relative to white persons. HNC is pleased that CMS is addressing these important and ongoing issues, and is seeking comment on the possibility of revising measure development, and the collection of other SPADEs that address gaps in health equity, to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patients.

SPADEs are an important tool to gather information about care being provided across care settings. SPADEs should incorporate all relevant aspects of patient care and outcomes, and nutritional related elements are a crucial aspect of that care.

HNC strongly recommends that CMS adopt a diagnosis of malnutrition as a standardized data element, to ensure appropriate identification and nutritional management of malnourished patients, make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive, and to address gaps in health equity.

Malnutrition continues to be a crucial component in reducing hospital-acquired conditions, lowering healthcare costs and improving the health and well-being of vulnerable Medicare



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

beneficiaries. **HNC urges CMS to prioritize policies and initiatives that identify and treat malnutrition, encourages proper nutrition and the development of cost-effective nutrition therapy products, and ensures access through adequate coverage and payment policies for nutrition therapy products.** HNC stands ready to work with CMS and all stakeholders to develop these policies as one means to improve the public health system. If you have any questions or would like additional information, please contact Justine Coffey, Healthcare Nutrition Council, at jcoffey@healthcarenutrition.org or 202-207-1109.

Sincerely,

Robert Rankin
Executive Director

¹ Robinson MK, Trujillo EB, Mogensen KM, et al: Improving nutritional screening of hospitalized patients: The role of prealbumin. *JPEN J Parenter Enteral Nutr.* 2003 27:389-395.

² Chima CS, Barco K, Dewitt MLA, et al: Relationship of nutritional status to length of stay, hospital costs, discharge status of patients hospitalized in the medicine service. *J Am Diet Assoc* 1997 97:975-978.

³ Braunschweig C, Gomez S, Sheean PM: Impact of declines in nutritional status on outcomes in adult patients hospitalized for more than 7 days. *J Am Diet Assoc* 2000 100:1316-1322.

⁴ Crogan NL, Pasvogel A: The influence of protein-calorie malnutrition on quality of life in nursing homes. *J Gerontol A Biol Sci Med Sci* 2003 58A(2):159-164.

⁵ Callahan CM, Wolinsky FD: Hospitalization for pneumonia among older adults. *J Gerontol.* 1996; 51A:M276-M282.

⁶ Mechanick JL: Practical aspects of nutritional support for wound-healing patients. *Am J Surg.* 2004;188:52S-56S.

⁷ Schneider SM, Veyres P, Pivot X, et al. Malnutrition is an independent factor associated with nosocomial infections. *Br J Nutr.* 2004; 92:105-111.

⁸ Correia MI, Waitzberg DL: The impact of malnutrition on morbidity, mortality, length of hospital stay and costs evaluated through a multivariate model analysis. *Clin Nutr.* 2003;22:235-239.

⁹ Meijers JMM, Halfens RJG, Neyens JCL, et al. Predicting falls in elderly receiving home care: the role of malnutrition and impaired mobility. *J Nutr Health Aging;* 2012; 16: 654-658.

¹⁰ Marik PE and Flemmer M. Immunonutrition in the surgical patient. *Minerva Anestesiologica.* 2012; 78: 336-342.

¹¹ Davalos A, Ricart W, Gonzalez-Huix F, et al. Effect of malnutrition after acute stroke on clinical outcome. *Stroke.* 1996;27:1028-1032.

¹² Zapatero A, Barba R, Gonzalez N, et al. Influence of obesity and malnutrition on acute heart failure. *Rev Esp Cardiol.* 2012; 65(5): 421-426.

¹³ Lis CG, Gupta D, Lammersfeld CA, et al. Role of nutritional status in predicting quality of life outcomes in cancer – a systematic review of the epidemiological literature. *Nutr J.* 2012; 11:27: 2-18.

¹⁴ A.S.P.E.N. Board of Directors and the Clinical Guidelines Task Force. Guidelines for the use of parenteral and enteral nutrition in adult and pediatric patients. *JPEN J Parenter Enteral Nutr.* 2002;26(1suppl):1SA-138SA.

¹⁵ Chima CS, Barco K, Dewitt ML, et al. Relationship of nutritional status to length of stay, hospital costs, and discharge status of patients hospitalized in the medicine service. *J Am Diet Assoc.* 1997; 97: 975-978.

¹⁶ Alvarez-Hernandez J, Planas Vila M, Leon-Sanz M, et al. Prevalence and costs of malnutrition in hospitalized patients; the PREDyCES® Study. *Nutr Hosp.* 2012; 27(4): 1049-1059.

¹⁷ Fingar K, Weiss A, Barrett M, Elixhauser A, Steiner C, Guenter P, and Hise Brown M. All-Cause Readmissions Following Hospital Stays for Patients with Malnutrition, 2013. *HCUP Statistical Brief #218.* 2018. 1-18.

¹⁸ Zapatero A, Barba R, Gonzalez N, et al. Influence of obesity and malnutrition on acute heart failure. *Rev Esp Cardiol.* 2012; 65(5): 421-426.

¹⁹ Snider J, et al: Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenter Enteral Nutr.* 2014;38:55-165.

²⁰ Snider JT, Linthicum MT, Wu Y, et al. Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenter Enteral Nutr.* 2014; 38 (Suppl 2): 77S-85S.

²¹ Braunschweig C, Gomez S, Sheean PM. Impact of declines in nutritional status on outcomes in adult patients hospitalized for more than 7 days. *J Am Diet Assoc.* 2000;100:1316-1322.

²² Fingar K, Weiss A, Barrett M, Elixhauser A, Steiner C, Guenter P, and Hise Brown M. All-Cause Readmissions Following Hospital Stays for Patients with Malnutrition, 2013. *HCUP Statistical Brief #218.* 2018. 1-18.



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

²³ Thomas DR, Zdrowski CD, Wilson MM, et al. Malnutrition in subacute care. *Am J Clin Nutr*. 2002;75:308-313.

²⁴ [Deepa Handu](#), PhD, RDN, LDN, [Lisa Moloney](#), MS, RDN, [Mary Rozga](#), PhD, RDN, and [Feon W. Cheng](#), PhD, MPH, RDN, CHTS-CP. Malnutrition Care During the COVID-19 Pandemic: Considerations for Registered Dietitian Nutritionists. *J Acad Nutr Diet* 2021; 121(5): 979-987.

²⁵ Dwyer JT, Gahche JJ, Weiler M, Arensberg MB. Screening Community-Living Older Adults for Protein Energy Malnutrition and Frailty: Update and Next Steps. *J Community Health*. 2020 Jun;45(3):640-660. doi: 10.1007/s10900-019-00739-1. PMID: 31571022; PMCID: PMC7188699.

²⁶ Goates, Scott; Kristy Du, Carol Braunschweig, and Mary Beth Arensberg. Economic Burden of Disease-Associated malnutrition at the State Level. *PLOS ONE*. 2016; 11(9): 1-15.

²⁷ Traylor, Daniel; Stefan Gorissen, and Stuart Phillips. Perspective: Protein Requirements and Optimal Intakes in Aging: Are We Ready to Recommend More Than the Recommended Daily Allowance? *Adv Nutr*. 2018; 9:171-182

²⁸ Bauer, J; Biolo, G; Cederholm, T; Cesari, M; Cruz-Jentoft, AJ; Morley, JE; Phillips, S; Sieber, C; Stehle, P; Teta, D; Visvanathan, R; Volpi, E; and Boirie, Y. Evidence-Based Recommendations for Optimal Dietary Protein Intake in Older People: A Position Paper From the PROT-AGE Study Group. *J Am Med Dir Assoc*. 2013; 14:543-559.

²⁹ Deutz, NE; Bauer, JM; Barazzoni, R; Biolo, G; Boirie, Y; Bosy-Westphal, A; Cederholm, T; Cruz-Jentoft, A; Krznarić, Z; Nair, KS; Singer, P; Teta, D; Tipton, K; and Calder, PC. Protein intake and exercise for optimal muscle function with aging: Recommendations from the ESPEN Expert Group. *Clin Nutr*. 2014; 33(6):929-936.

³⁰ Harding KM, Dyo M, Goebel JR, Gorman N, Levine J. Early malnutrition screening and low cost protein supplementation in elderly patients admitted to a skilled nursing facility. *Appl Nurs Res*. 2016 Aug;31:29-33. doi: 10.1016/j.apnr.2015.12.001. Epub 2015 Dec 9. PMID: 27397815.

³¹ World Health Organization. Social Determinants of Health. 2019. Retrieved from http://www.who.int/social_determinants/en/