



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

Submitted via regulations.gov

June 10, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1765-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 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels; CMS-1765-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 2023. HNC is an association representing manufacturers¹ of enteral nutrition (EN) formulas and oral nutrition supplements (ONS), including those categorized as medical foods, and parenteral nutrition (PN). Our mission is to improve patient outcomes by advancing nutrition policies and actions that raise awareness and optimize access of essential nutrition support therapies across 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 on SNF Quality Reporting Program (QRP) quality measure concepts under consideration for future years, and measures to address health equity. As detailed further below, HNC:

- **Strongly supports health equity measures as future SNF QRP quality measure concepts, and in addition, strongly recommends the inclusion of nutrition quality measures.**
- **Strongly recommends that CMS adopt a diagnosis of malnutrition as a measure to address health equity.**

Summary of the importance of addressing malnutrition:

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

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



HEALTHCARE NUTRITION COUNCIL

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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) 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).

I. HNC strongly supports health equity measures as future SNF QRP quality measure concepts, and in addition, strongly recommends the inclusion of nutrition quality measures.

CMS is seeking input on the importance, relevance, and applicability of measures and concepts under consideration for future years in the SNF QRP.

The SNF QRP currently has 15 measures for the FY 2023 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.

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%.²⁵ 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.²⁶ 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.^{27,28}

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.²⁹

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

II. HNC strongly recommends that CMS adopt a diagnosis of malnutrition as a measure to address health equity.



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

CMS recognizes significant and persistent disparities in healthcare outcomes exist in the United States. As CMS notes, belonging to an underserved community is often associated with worse health outcomes. CMS further acknowledges that social risk factors are the wide array of non-clinical drivers of health known to negatively impact patient outcomes, including socioeconomic status, housing availability, and nutrition, often inequitably affecting historically marginalized communities on the basis of race and ethnicity, rurality, sexual orientation and gender identity, religion, and disability.

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.”³⁰ 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.

HNC strongly recommends that CMS adopt a diagnosis of malnutrition as a measure to address health equity, to ensure appropriate identification and nutritional management of malnourished patients, make reporting of health disparities based on social risk factors such as race and ethnicity, rurality, sexual orientation and gender identity, religion, and disability 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 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

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