HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

June 5, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1779–P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: [CMS–1779–P] 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 2024

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNFs) and Updates to the Quality Reporting Program (QRP) and Value-Based Purchasing (VBP) Program Proposed Rule for Federal Fiscal Year 2024. HNC is an association representing manufacturers[1] 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.

Malnutrition care remains a critical gap area that is associated with multiple poor health outcomes, including hospital readmissions and declines in functional status, psychosocial well-being, and quality of life. We know this administration has prioritized health equity and supports improving patient quality care. HNC's recommendations can help accomplish these goals. We have previously provided recommendations during the FY 2023 SNF PPS rule making process and we continue to encourage the agency to seriously consider our recommendations. HNC is pleased to provide comments on this Proposed Rule, as outlined below:

- **HNC strongly supports social determinants of health (SDOH) and health equity measures as future SNF QRP and VBP Program quality measure concepts, and strongly recommends CMS include the diagnosis of malnutrition as an indicator for a patient's need of a SDOH assessment and that CMS adopt a malnutrition quality measure to address health equity.**

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

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Importance of Addressing Malnutrition as a Key Gap Area

As we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost, high-quality nutrition and malnutrition care for older adults should be at the top of CMS' agenda. The number of adults aged 65 years and older is expected to reach 77 million by 2034,[1] and Medicare spending is projected to rise at a higher rate than overall health spending, therefore there is an urgency to secure the future of healthy aging, starting with nutrition. There are several stages in the health care system where nutrition – including malnutrition – can be addressed.

Up to one in two older adults are at risk for malnutrition,[2,3] an important nutrition-related public health concern that impacts quality of life and increases healthcare costs. Tragically the national deaths related to malnutrition have doubled from 9,300 deaths in 2018 to 20,500 deaths in 2022 according to the U.S. Centers for Disease Control and Prevention (CDC).[4] Disease-associated malnutrition (DAM) is malnutrition that occurs from disease-related causes. DAM can manifest in patients across all spectrums of body mass index, ranging from under to overweight individuals. It is often multifactorial, including inflammatory responses, which can increase metabolic demand, decreased appetite, gastrointestinal problems, and difficulty chewing and swallowing, leading to decreased nutrient intake, which can diminish immune response and wound healing, and increase infection rates.[5] Changes such as these can increase risks for functional disability, frailty, and falling. A Congressional Research Service (CRS) report documented "malnutrition affects 35% to 60% of older residents in long term care facilities and as many as 60% of hospitalized older adult patient in the U.S."[6] Malnutrition affects approximately 20% to 50% of admitted hospital patients.[7] However, this figure likely underestimates the total burden of DAM given the diagnosis gap in hospitalized patients. In an analysis by the Agency for Healthcare Research and Quality (AHRQ), malnutrition was diagnosed in only about 8% of hospital stays.[8] This is why CMS should adopt a diagnosis of malnutrition so there is better tracking and monitoring available to better meet patient needs and improve their quality of care.

The estimated cost for DAM in older adults is $51.3 billion per year.[9] However, this figure likely underestimates the total burden of disease-related malnutrition given the diagnosis gap in hospitalized patients.[10] Overall healthcare expenditure for DAM across eight major diseases was found to be $156.7 billion per year according to findings from the National Health Interview Survey, the National Health and Nutrition Examination Survey, and CDC.[11] If unaddressed, malnutrition will only continue to increase the cost of care and likelihood of poor health outcomes, including increased complications, longer hospitalizations, and more readmissions. Malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital.[12] A study published in *HCUP Statistical Briefs,* developed by AHRQ, in 2016 found that malnutrition in U.S. hospitalized patients is associated with a more than 50% higher rate of readmission within 30 days, compared to patient stays not associated with malnutrition. Further, the average costs per readmission for patients with malnutrition were found to be 26-34% higher ($16,900 to $17,900) compared to those without malnutrition ($13,400).[13] 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.[14] A retrospective health

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economic study found that providing 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.[15]

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 that Medicare requires an underlying qualifying condition for malnutrition diagnosis, coding, and reimbursement. 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 SDOH and health equity measures as future SNF QRP quality measure concepts, and in addition, strongly recommends CMS adopt that a diagnosis of malnutrition is an indicator for a patient's need of a SDOH assessment and as a measure to address health equity.**

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

SNFs continue to account for the majority of spending for post-acute care services in the United States (U.S.).[16] In the next decade there is an estimated 50% increase in the number of older (aged 65+) Americans needing SNF care, rising to about 1.9 million in 2030, up from 1.2 million in 2017.[17,18] Malnutrition impacts up to half of SNF residents; however, a recent claims analysis documented that even though malnutrition diagnosis claim rates have increased in recent years, the percent of malnutrition diagnoses was still less than 12% of claims for a specific set of Medicare SNF claims.[19] Age-related changes (appetite loss, limited ability to chew/swallow, polypharmacy, and cognitive/functional declines) commonly affect diet and nutrition. The most common form of malnutrition in older adults is protein-calorie malnutrition, which is associated with multiple poor health outcomes including decreased immunity, increased infection rates, delayed wound healing, and decreased respiratory and cardiac function, as well as increased healthcare costs.

Malnutrition also contributes to sarcopenia and the loss of the lean body mass, which can lead to frailty and possible falls. It is estimated that 5-13% of adults over age 60 years and approximately 50% of adults over 80 years have sarcopenia.[20] 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. Making the change to fully integrate malnutrition care (screening, assessment, diagnosis, care plans and interventions) into the Medicare system is a prudent investment because malnutrition care is a low-risk and low-cost solution that can help improve the quality of clinical care and decrease costs associated with negative outcomes. Timely screening and assessment followed by intervention can significantly improve health outcomes for adults, with studies finding:

- Decrease in avoidable readmissions by about 20%[21]
- 50% reduction in pressure ulcer incidence[22,23]
- Reduced overall complications[24]

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- Reduced average length of stay of approximately two days[21]
- Decreased mortality[25]
- Improved quality of life[26]

A study where one Accountable Care Organization (ACO) in Chicago implemented a nutrition-focused quality improvement program and analyzed the cost savings and patient outcomes. In this study, the total cost-savings from reduced 30-day readmissions and hospital stays associated with nutrition intervention was over $4.8 million; the net savings was over $3800 per patient treated for malnutrition.[27] The quality improvement program in this study included malnutrition risk screening at admission, prompt initiation of oral nutritional supplementation for at-risk patients, and nutrition support and education for patients during the hospital stay and post discharge.

Nutrition quality measures in SNFs are essential to ensure at-risk patients are identified and cared for before experiencing worsening, associated outcomes. Early nutrition intervention can reduce readmissions and decrease malnutrition complication rates and costs of care. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires development of quality measures. Screening, assessment, diagnosis, and intervention for malnutrition are notably missing from current CMS SNF quality measures, even though malnutrition is common among residents and associated with increased risk for infections, readmissions, falls, impaired wound healing, pressure injuries, physical limitations, and even death.[28] **HNC strongly recommends that CMS also consider the inclusion of nutrition quality measures in the SNF QRP for future years.**

CMS should consider utilizing the Global Malnutrition Composite Score (GMCS) electronic clinical quality measure (eCQM). The GMCS is the first nutrition-focused quality measure to be included in the CMS Hospital Inpatient Quality Reporting (IQR) Program in the FY 2023 Inpatient Prospective Payment System (IPPS) Final Rule. It was also endorsed by unanimous vote of the National Quality Forum (NQF) Consensus Standards Approval Committee (CSAC) in 2021. The GMCS eCQM could be implemented in other care settings such as SNFs.

Nutritional status and malnutrition are often influenced by a variety of SDOH which 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.”[29] In many cases, SDOH 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, SDOH 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. The U.S. Department Agriculture found that Black non-Hispanic households were over 2 times more likely to be food insecure than the national average (21.7% versus 10.5%, respectively), and the prevalence of food insecurity among Hispanic households was 17.2% compared with the national average of 10.5%.[30] Furthermore, Data from the Malnutrition Quality Improvement Initiative (MQii) Learning Collaborative in 2019 indicate non-Hispanic Black individuals with malnutrition have more than a 26% readmission rate compared with less than 19% among non-Hispanic White individuals.[31] The agency should

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recognize these disparities and why addressing nutrition measures would help close the gap in health equity.

Including nutrition quality measures would open the pathway to better address nutrition and food security in SDOH assessments for post discharge care. In addition to reducing re-admission rates in patients diagnosed with malnutrition, a focus on creating health equity through nutrition and food security would help decrease a myriad of healthcare costs related to nutrition-related diseases. Older adults that are food insecure are more likely to suffer from heart conditions, such as heart attacks, chest pain, and coronary heart disease than food secure older adults. The most recent report, *The State of Senior Hunger in 2021*, presents 2021 data from the Current Population Survey, the most recent year for which data are available. Findings reveal that 5.5 million seniors (7.1% or 1 in 14) were food insecure in 2021.[32] Including nutrition and food security in the SDOH assessment would help 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.

CMS Acknowledges the Links Between Malnutrition and SDOH and Health Equity

In 2022, CMS joined with health leaders in a roundtable on *Advancing Health Equity through Malnutrition Measurement (Roundtable)* to discuss connections between health equity, malnutrition care, and food insecurity. The *Roundtable* report noted that "Improving screening for and identification of malnourished patients in the acute care setting should be followed by developing appropriate interventions to address both malnutrition and food insecurity in culturally appropriate ways beyond the hospital— and these should be coordinated effectively. Such strategies can serve to avoid preventable complications, reduce overall costs, and address health equity."[33]

Roundtable participants identified two policy actions as top-ranked solutions to address malnutrition and food insecurity. The first was to "Incorporate the Global Malnutrition Composite Score (GMCS) measure into a federal quality reporting program (e.g., Hospital IQR [Inpatient Quality Reporting] Program)." CMS successfully achieved this in August 2022, when it adopted the GMCS as part of the FY 2023 IQR Program.

The *Roundtable's* second recommended policy action is to "implement value-based payment models to align incentives to screen for and address nutrition-related social needs and conditions." As previously stated, nutrition quality measures in SNFs are essential to ensure at-risk patients are identified and cared for before experiencing worsening, associated outcomes. The GMCS is fully developed, now in place in IQR, and can help address key nutrition care gaps in the SNF.

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In closing, addressing malnutrition and providing adequate nutrition care continues to be a crucial component in reducing hospital-acquired conditions, lowering healthcare costs and

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improving the health and well-being of vulnerable Medicare beneficiaries. **HNC urges CMS to prioritize policies and initiatives that identify and treat malnutrition, encourage proper nutrition and the development of cost-effective nutrition therapy products, and ensure 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 Sydni Arnone, Healthcare Nutrition Council, at sarnone@healthcarenutrition.org or (202) 204-8396.

Respectfully submitted,

Robert Rankin
Executive Director

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