



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

Submitted electronically via www.regulations.gov

June 2, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1779-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: [CMS-1781-P] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the Prospective Payment System (PPS) and Consolidated Billing for Inpatient Rehabilitation Facilities (IRFs) and Updates to the Quality Reporting Program (QRP) for Federal Fiscal Year 2024. 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.

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 and the Centers for Medicare & Medicaid Services (CMS) has previously recognized this. Further, 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 IRF 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 IRF QRP quality measure concepts, and in addition, strongly recommends the inclusion of nutrition quality measures. HNC urges CMS to 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.**

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

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



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should be at the top of CMS' agenda. Up to one in two older adults are at risk for malnutrition,^{1,2} an important nutrition-related public health concern that impacts health outcomes, quality of life and increases healthcare costs. The estimated cost for disease-associated malnutrition (DAM), or malnutrition that occurs from disease-related causes, in older adults is \$51.3 billion per year. A Congressional Research Service (CRS) report documented "malnutrition affects 35% to 60% of older residents in long term care facilities".³ But tragically in just the last few years, 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 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. While malnutrition affects approximately 20% to 50% of admitted hospital patients,⁶ 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.⁷ 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.

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.⁸ 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).⁹ 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.¹⁰ 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.¹¹

IRFs continue to provide vital care to patients, demonstrating resiliency during the COVID-19 pandemic as the percentage of patients discharged from the hospital to an IRF did not meaningfully change.¹² Despite the necessity of IRF care, a recent study found that 44% of IRF patients have a risk of malnutrition.¹³ 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

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approximately 50% of adults over 80 years have sarcopenia.¹⁴ 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.^{15,16} IRF settings are designed for patients to recover from acute care hospitals, such as ICU admissions, and are often where patients undergo therapy to help them recover in order to discharge home; this is why IRF settings are especially important places to address proper nutrition for healing and gaining back strength that could have been lost during an acute care inpatient hospital stay.

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%¹⁷
- 50% reduction in pressure ulcer incidence^{18,19}
- Reduced overall complications²⁰
- Reduced average length of stay of approximately two days¹⁷
- Decreased mortality²¹
- Improved quality of life²²

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.²³ 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.

Links Between Malnutrition and SDOH and Health Equity

Older adults can be at increased malnutrition risk for many reasons—including disease, poor functionality, social and mental health limitations, and hunger and food insecurity—and these malnutrition risk factors overlay each of the SDOH domains identified by Healthy People 2030.²⁴ In many cases, SDOH have a drastic impact on the availability and quality of foods, how those foods are prepared and consumed, and what foods then become part of the diet. As a result, SDOH shape a population's nutritional status and may result in certain populations, such as older adults, disabled individuals, 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%.²⁵ 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.²⁶

In 2022, CMS joined with health leaders in a roundtable on Advancing Health Equity through Malnutrition Measurement²⁷ 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.”

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 Inpatient Hospital Quality Reporting Program (IQR).

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.” Nutrition quality measures in IRFs 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 IRF 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

CMS adopting our recommendation of 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 readmission 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 older adults (7.1% or 1 in 14) were food insecure in 2021.²⁹ 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.



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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, 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.

Sincerely,

A handwritten signature in black ink that reads "Robert Rankin". The signature is written in a cursive, flowing style.

Robert Rankin
Executive Director

¹ The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults. Washington, DC: Avalere and Defeat Malnutrition Today. March 2017.

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³ Dabrowska A. Malnutrition in Older Adults. March 8, 2017. Retrieved from: https://www.defeatmalnutrition.today/sites/default/files/documents/CRS_Memo_Malnutrition_in_Older_Adults.pdf

⁴ Snider JT, Linthicum MT, Wu Y, et al. Economic burden of community-based disease-associated malnutrition in the United States. *JPEN*. 2014;38(2 Suppl):77s-85s.

⁵ Goates S, Du K, Braunschweig CA, Arensberg MB. Economic Burden of Disease-Associated Malnutrition at the State Level. *PLoS One*. 2016;11(9):e0161833-e0161833

⁶ Barker LA, Gout BS, Crowe TC. Hospital malnutrition: prevalence, identification and impact on patients and the healthcare system. *Int J Environ Res Public Health*. 2011;8(2):514-527.

⁷ Barrett ML, Bailey MK, Owens PL. Non-maternal and Non-neonatal Inpatient Stays in the United States Involving Malnutrition, 2016. U.S. Agency for Healthcare Research and Quality. Retrieved from: www.hcupus.ahrq.gov/reports.jsp.

⁸ 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.

⁹ 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.

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¹¹ Thomas DR, Zdrowski CD, Wilson MM, et al. Malnutrition in subacute care. *Am J Clin Nutr*. 2002;75:308-313.

¹² Werner RM, Bressman E. Trends in Post-Acute Care Utilization During the COVID-19 Pandemic. *J Am Med Dir Assoc*. 2021 Dec;22(12):2496-2499. doi: 10.1016/j.jamda.2021.09.001. Epub 2021 Sep 7. PMID: 34555340; PMCID: PMC8421095.

¹³ Tóth B, Dénes Z, Kudron E, Barta B, Szennai D, Terjék D. Alultápláltsághozkockázat-szűrés a rehabilitációs fekvőbeteg-ellátásban [Malnutrition risk screening in inpatient rehabilitation]. *Orv Hetil*. 2020 Jan;161(1):11-16. Hungarian. doi: 10.1556/650.2020.31601. PMID: 31884812.

¹⁴ 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

¹⁵ 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.

¹⁶ 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.



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