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February 29, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Calendar Year (CY) 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the Advance Notice)

Dear Administrator Brooks-LaSure,

The Healthcare Nutrition Council (HNC) is providing comments on “Calendar Year (CY) 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the Advance Notice)”; specifically our comments are to address Medicare Advantage. 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.

We appreciate the Centers for Medicare & Medicaid Services (CMS) efforts to address areas in MA plans that could be expanded to improve patient access to care, especially around malnutrition. HNC supports the Academy of Nutrition and Dietetics’ comments to the Advanced Notice and asks that CMS seriously take them into consideration; as the removal of malnutrition from the CMS- Hierarchical Condition Category (HCC) model now places an undue burden on healthcare providers, requiring them to achieve more with fewer resources when caring for individuals with malnutrition.

Malnutrition Increases Cost of Care

HNC supports accurate screening and diagnosis of malnutrition along with proper treatment. 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. Malnutrition can complicate conditions and lead to frailty and risk of falling. Sarcopenia is related to malnutrition, and while common among institutionalized older adults, it is also an emerging concern among the free-living population. The prevalence of sarcopenia in intensive care unit patients is documented at 56-71%.⁴ 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.⁵

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.⁶ 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.⁷ In 2021, a draft comparative effectiveness review on malnutrition in hospitalized adults, prepared for AHRQ by the Evidence-based Practice Center, found an association between malnutrition and prolonged hospital stays as well as increased mortality among malnourished patients.⁸ 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 at risk.⁹

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 for malnutrition, and largely depending on Medicare, are estimated at \$51.3 billion annually.¹⁰ However, this figure likely underestimates the total burden of disease-related malnutrition given the diagnosis gap in hospitalized patients.¹¹ In addition, malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital.¹² 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).¹³

Adequate nutrition, and specifically adequate protein intake, can help attenuate the declines in muscle mass and function associated with sarcopenia. Importantly, current evidence indicates older adults may need higher protein intakes to support healthy musculoskeletal aging. Studies have shown that the postprandial increase in muscle protein synthesis is lower in older adults compared to younger adults.¹⁴ This reduced sensitivity to protein may be due to a variety of age-related factors such as impaired protein digestion and amino acid absorption, increased splanchnic extraction, impaired muscle perfusion, or impaired anabolic signaling.¹⁵

For those at risk of malnutrition, consumption of adequate nutrition is not always possible. Older adults especially may require enteral nutrition support and can benefit from oral nutrition supplements (ONS) to meet nutrition needs. The World Health Organization (WHO) recognizes malnutrition as a major problem affecting older adults and has published a strong recommendation that ONS with dietary advice should be recommended to older people affected by undernutrition.¹⁶ A retrospective health 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.¹⁷

Malnutrition is Associated with Health Equity and Health Disparities

CMS recognizes significant and persistent inequities 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 (SDOH). According to WHO, SDOHs 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.”¹⁸ In many cases, SDOHs 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, SDOHs 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 in MA plans to address health equity, to ensure appropriate identification and nutritional management of malnourished patients, make reporting of health disparities based on social risk factors and race and ethnicity, rurality, sexual orientation and gender identity, religion, and disability more comprehensive, and to address gaps in health equity.

Malnutrition Diagnosis as part of the Global Malnutrition Composite Score

HNC is extremely pleased that starting in 2024 CMS approved the new quality measure, Global Malnutrition Composite Score (GMCS), will be available for hospitals participating in the CMS Hospital Inpatient Quality Reporting Program (IQR). This is the first nutrition-focused quality measures in any CMS program, and it acknowledges the significant role malnutrition plays in the

health of Americans 65 years and older. Furthermore, CMS is considering the GMCS to be expanded to include individuals of the ages 18 – 64 years. For the aforementioned reasons, HNC urges CMS to include malnutrition diagnosis and the GMCS as part of the Advance Notice in MA plans.

Malnutrition Diagnosis Necessary for MA Patient Access to Nutrition Benefits

The recent enhancements of MA Special Supplemental Benefits for the Chronically Ill (SSBCI) allow payers to expand benefits to include food, produce, and meals in MA plans. There are also MA supplemental plans that provide \$150/month over-the-counter (OTC) cards that allow beneficiaries to purchase ONS and other OTC products. The current Medicare benefit of enteral nutrition coverage has a few limitations, including duration of time. Enteral nutrition for temporary impairments is not covered.¹⁹ Medicare and MA plans should allow and cover short-term use of enteral nutrition and include ONS to help prevent malnutrition. Adopting the diagnosis of malnutrition within MA plans is necessary to help ensure MA patients have access to nutrition benefits in order to treat and prevent malnutrition.

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 and MA patients. 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 that ensures access through adequate coverage and payment policies in MA plans for nutrition therapy products and services. HNC stands ready to work with CMS and all stakeholders to develop these policies as one means to improve the public health system. Thank you for reviewing these comments. Please contact Sydni Arnone at sarnone@healthcarenutrition.org if you have any questions.

Sincerely,



Robert Rankin
Executive Director

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

² The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults. Washington, DC: Avalere and Defeat Malnutrition Today. March 2017.

³ Kaiser, MJ; Bauer, JM; Ramsch, C; Ulter, W; Guigoz, Y; Cederholm, T; Thomas, DR; Anthony, PS; Charlton, KE; Maggio, M; Tsai, AC; Vellas, B; and Sieber, CC. Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *Journal of the American Geriatrics Society*. 2010; 58(9): 1734-1738.

⁴ 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.

⁵ 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.

⁶ 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.

⁷ 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.

⁸ Authors to be included in final report. Draft Comparative Effectiveness Review, Malnutrition in Hospitalized Adults, Prepared for the Agency for Healthcare Research and Quality, June 3, 2021.

⁹ 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.

¹⁰ Snider J, et al: Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenteral Enteral Nutr*. 2014;38:55-165.

¹¹ 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.

¹² 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.

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- ¹⁴ Wall, BT; Gorissen, SH; Pennings, B; Koopman, R; Groen, BB; Verdijk, LB; and van Loon, LJ. Aging is accompanied by a blunted muscle protein synthetic response to protein ingestion. *PLOS ONE*. 2015; 10(11): e0140903.
- ¹⁵ 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.
- ¹⁶ World Health Organization. Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO. Retrieved from <https://www.who.int/ageing/publications/guidelines-icope/en/>.
- ¹⁷ Thomas DR, Zdrowski CD, Wilson MM, et al. Malnutrition in subacute care. *Am J Clin Nutr*. 2002;75:308-313.
- ¹⁸ World Health Organization. Social Determinants of Health. 2019. Retrieved from http://www.who.int/social_determinants/en/
- ¹⁹ Centers for Medicare & Medicaid Services. Enteral Nutrition - Policy Article. CMS.gov. 2021. Retrieved from: <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=58833&ver=3>.