



# HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

May 27, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1802-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

**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 2025 (CMS-1802-P)**

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF); Updates to the Quality Reporting Program (QRP) and Value-Based Purchasing Program (VBP) for Federal Fiscal Year (FY) 2025. HNC is an association representing manufacturers<sup>1</sup> 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 2024 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 supports the proposal to require SNFs to collect and submit through the MDS two new items for Food as standardized patient assessment data elements under the social determinants of health (SDOH) category.**
- **HNC strongly opposes CMS's proposal to decrease the Patient-Driven Payment Model (PDPM) Points in the Non-Therapy Ancillary (NTA) Component for the two classifications of parental IV feeding by 2 points, each.**

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<sup>1</sup> HNC members are Abbott Nutrition, Nestle Healthcare Nutrition, and Nutricia North America.

## **Proposal to Collect Two New Food Items as Standardized Patient Assessment Data Elements Collected as a Standardized Patient Assessment Data Element Beginning with the FY 2027 SNF QRP**

HNC supports CMS's proposal to require SNFs to collect and submit through the MDS the following two new items for Food as standardized patient assessment data elements under the SDOH category, beginning with the FY 2027 SNF QRP:

- "Within the past 12 months, you worried that your food would run out before you got money to buy more."
- "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."

The number of adults aged 65 years and older is expected to reach 77 million by 2034,<sup>1</sup> 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. Food insecurity is a risk factor for poor nutrition or malnutrition. There are several stages in the health care system where nutrition – including malnutrition – can be addressed. The Medicare-required PPS assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments. Except for the first assessment (5-day assessment), each assessment is scheduled according to the resident's length of stay in Medicare-covered Part A care. As so, if a patient that answers "yes" to either of the proposed new questions, HNC urges CMS to either require or strongly encourage SNFs to immediately trigger social services to provide patients and caregivers information on post-discharge nutrition and food services (such as meal programs and oral nutrition supplement options); as well as to start to create a post-discharge nutrition/food service plan to ensure services are provided as quickly as possible after discharge from the SNF.

The 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.<sup>2</sup> 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.

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.<sup>3</sup> 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 malnutrition screening and nutrition assessment followed by nutrition intervention can significantly improve health outcomes for adults, with studies finding:

- Decrease in avoidable readmissions by about 20%<sup>4</sup>

- 50% reduction in pressure injury incidence<sup>5,6</sup>
- Reduced overall complications<sup>7</sup>
- Reduced average length of stay of approximately two days<sup>4</sup>
- Decreased mortality<sup>8</sup>
- Improved quality of life<sup>9</sup>

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.<sup>10</sup> 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. As identified by the new proposed elements for the SNF MDS, it is important that there is attention to food and nutrition security across care settings, to promote optimal health outcomes.

### **Proposed Updates to PDPM NTA Component for Parental IV Feeding**

HNC strongly opposes CMS's proposal to decrease the PDPM Points for the two classifications of parental IV feeding by 2 points, each, as outlined below.

Condition/Extensive Service: Parenteral IV Feeding: Level High

Source: MDS Item K0510A2, K0710A2

Points: 7

*FY 2025 Proposed PDPM Points: 5*

Condition/Extensive Service: Parenteral IV feeding: Level Low

Source: MDS Item K0510A2, K0710A2, K0710B2

Points: 3

*FY 2025 Proposed PDPM Points: 1*

In order to qualify for high intensity parental IV feeding, the resident must receive 51% or more of total calories by artificial route (K0510A2 = Checked) AND (K0710A2 = 3). If the resident receives 26–50% and 501cc/day at MDS Item (K0510A2 = Checked) AND (K0710A2 = 2) AND (K0710B2 = 2), then the resident would qualify for low-intensity parenteral IV feedings. Additionally, NTA payment is determined by a base rate and separate CMI. NTA is a variable payment, paid at 300% for the first three days, and then reduced to 100% after day four. Under PDPM, payment is based on each aspect of the resident's care. Payment is still a per diem payment—however, it is adjusted to reflect varying costs throughout the resident's stay. CMS needs to take into account that more factors come into play with parental IV feeding than any other item in the NTA component; most importantly that parental IV feedings are provided to patients with comorbidities. Parenteral nutrition (PN) is the intravenous administration of nutrients directly into the systemic circulation, bypassing the gastrointestinal tract. PN requires a large intravenous tube (called a central venous catheter) which must be inserted into a large vein, such as the subclavian vein, which is located under the collarbone. PN formula is a special liquid mixture containing protein, carbohydrates, fats, vitamins, minerals, and other nutrients needed to live; as well as recover and heal from other diagnoses or surgery,

depending on the medical circumstances. Parental IV feeding requires the special formula, durable medical equipment to deliver it, and medical professionals to administer and monitor it while a patient is in a SNFs.

Previously providers might only have documented patients with severe and more costly malnutrition issues under the previous payment system. Now that they are being asked to capture all patients with malnutrition and who are at risk of malnutrition, some whose conditions cost less to treat or have earlier intervention, it could be bringing down average per-patient costs. It is good that malnutrition diagnoses are being taken more seriously in healthcare facilities, thus being captured in a timelier fashion and treated earlier than previously. However, that does not mean that the system is ideal or that the costs associated with parental IV feeding are low-cost. Parental IV feeding is usually not the provider's first choice for nutritional support when the digestive tract is functioning properly. It is used when a patient has impaired gastrointestinal function and there are contraindications to enteral nutrition. Consequently, when a patient receives parental IV feeding it typically means that all other avenues of providing adequate nutrition have been exhausted. As the PDPM system is built on a scale of 1-8 Points and reducing high level and low level parental IV feeding from 5 to 3 and 3 to 1, respectively, will have devastating negative effects on patient care, affordability and health equity for those who are more often than not already malnourished or are at the highest risk of long-term nutritional deficits developing into malnutrition.

Tragically the number of 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).<sup>11</sup> 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.<sup>12</sup> 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 patients in the U.S."<sup>13</sup> Malnutrition affects approximately 20% to 50% of admitted hospital patients.<sup>14</sup> 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.<sup>15</sup>

The estimated cost for DAM in older adults is \$51.3 billion per year.<sup>16</sup> However, this figure likely underestimates the total burden of disease-related malnutrition given the diagnosis gap in hospitalized patients.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> 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%



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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).<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> All of these findings support the need adequately cover the cost of more complex care such parenteral IV feeding, since such interventions can help prevent the poor health outcomes that can lead to an even higher toll on individual patients and healthcare institutions.

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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 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](mailto:sarnone@healthcarenutrition.org) or (202) 204-8396.

Respectfully submitted,

A handwritten signature in black ink that reads "Carla A. Saunders". The signature is written in a cursive style.

Carla Saunders  
Executive Director

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<sup>1</sup> U.S. Census Bureau. Older People Projected to Outnumber Children for First Time in U.S. History. Updated October 8, 2018. Retrieved from: <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>

<sup>2</sup> Feeding America, National Foundation to End Senior Hunger. Spotlight on Senior Health: Adverse Health Outcomes of Food Insecure Older Americans. 2014. Retrieved from: <https://www.feedingamerica.org/research/state-senior-hunger>

<sup>3</sup> 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

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