May 31, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1785–P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Re: [CMS-1808-P] FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule

Dear Administrator Brooks-LaSure:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to provide feedback and comments on the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule for Fiscal Year (FY) 2025 [CMS-1808-P] – hereinafter referred to as "FY 2025 IPPS/LTCH PPS proposed rule". 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. We recognize this administration has prioritized health equity and supports improving patient quality care. HNC's recommendations as outlined below can help accomplish these goals.

Global Malnutrition Composite Score (GMCS)

HNC supports CMS' proposed expansion of the GMCS to adults of all ages. The expansion of the GMCS to include all adults over 18 in Hospital Inpatient Quality Reporting (IQR), and Program Medicare Promoting Interoperability Program for Eligible Hospitals and critical access hospitals (CAHs) is a commendable step towards enhancing patient care and aligning with the goals of CMS. By promoting comprehensive malnutrition screening, assessment, and care planning, the GMCS plays a crucial role in the recovery and overall well-being of patients.

CMS adopted the GMCS eCQM in the FY 2023 IPPS/LTCH PPS final rule beginning with the CY 2024 reporting period/FY 2026 payment determination (87 FR 49239 through 49246). However, CMS has proposed implementation of the modified GMCS eCQM (expanding the applicable population from hospitalized adults 65 years old or older to hospitalized adults 18 years old or older) to begin with the CY 2026 reporting period/FY 2028 payment determination. In the FY 2025 IPPS/LTCH PPS proposed rule, CMS acknowledges that the expanded GMCS eCQM would still use data collected through hospitals' electronic health records (EHRs). The

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

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measure is designed to be calculated by the hospitals' CEHRT using the patient-level data and then submitted by hospitals to CMS. **HNC strongly recommends and encourages CMS to adjust the implementation to CY 2025 reporting period/FY 2027 program year in the final rule.**

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. 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).[1] In one study, 42.5% of patients whose stay in an acute care hospital was equal to or greater than two weeks were diagnosed with malnutrition.[2] 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.[3] Malnutrition affects approximately 20% to 50% of admitted hospital patients.[4] 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.[5]

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.[6] 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).[7] 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.[8]

Making the change to fully integrate malnutrition care (screening, assessment, diagnosis, care plans and interventions) for all adults into the healthcare 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%[9]
- 50% reduction in pressure ulcer incidence[10,11]
- Reduced overall complications[12]
- Reduced average length of stay of approximately two days[13]
- Decreased mortality[14]
- Improved quality of life[15]

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In 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. 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.[16] 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.

Based on the aforementioned evidence, it is essential that CMS begin the implementation of the expanded GMCS eCQM for CY 2025 reporting period/FY 2027 program year in the final rule.

Proposal To Adopt the Hospital Harm – Falls With Injury eCQM

HNC supports CMS' proposal to adopt the Hospital Harm – Falls with Injury eCQM (CBE #4120e) beginning with the CY 2026 Reporting Period/FY 2028 Payment Determination. 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. Nutritional assessment and intervention together break the vicious cycle between malnutrition and various diseases or conditions, in which malnutrition aggravates a disease/condition, and the disease/condition, in turn, precipitates malnutrition. Breaking this cycle helps in improving clinical outcomes. Malnutrition adversely affects the health status of individuals, clinical outcomes, and overall healthcare costs.[17] 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%.[18]

Proposal to Adopt the Age Friendly Hospital Measure

HNC supports CMS' proposal to adopt the Age Friendly Hospital measure, for the Hospital IQR Program, beginning with the CY 2025 reporting period/FY 2027 payment determination. The Age Friendly Hospital measure pairs well with the GMCS eCQM, as the components measured by the GMCS compliment with the requirements under *Domain 1: Eliciting patient Healthcare Goals* and *Domain 3: Frailty Screening and Intervention* of the Age Friendly Hospital measure.

Moreover, implementing components of the GMCS would meet the requirements for the malnutrition components of the Age Friendly Hospital measure. 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.[19] 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. HNC would like to emphasize the critical component of communicating nutrition care plans in discharge instructions and post-acute transfers to ensure that the conditions identified in the hospital are appropriately managed and treated after discharge, as disease-related malnutrition is a common reason for patients to be readmitted to hospitals.[20] Communicating nutrition care plans in discharge instructions would help reduce readmission rate for patients with malnutrition.

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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 that 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 Sydni Arnone, Healthcare Nutrition Council, at sarnone@healthcarenutrition.org or (202) 204-8396.

Respectfully submitted,

Carla Saunders
Executive Director

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