May 23, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1827-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026 (CMS-1827-P)

Dear Administrator Oz:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026 (CMS-1827-P). HNC is an association representing manufacturers 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 for people that require or benefit from advanced and specialized nutrition.

The Agency has identified its continued interest in nutrition, such as in the request as part of the recent Inpatient Prospective Payment System[1] proposed rule for information on nutrition quality measure concepts for future consideration. We see a similar need to focus on nutrition in skilled nursing facility (SNF) care as well. Thus, we offer the following comments in response to the proposed changes to diagnosis code mappings and reimbursement that significantly affect malnutrition-related conditions, medical nutrition therapy, and patient access to skilled nursing facility (SNF) care.

Malnutrition Should Remain a Valid Primary Diagnosis for SNF Admission
Patients with moderate to severe malnutrition frequently require skilled nursing services that meet Medicare Part A SNF coverage criteria. These services include, but are not limited to:

- Initiation and monitoring of enteral or parenteral nutrition;

[1] Centers for Medicare & Medicaid Services. (2025, April 30). *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes*. Federal Register. Retrieved from https://www.federalregister.gov/documents/2025/04/30/2025-06271/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

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- Registered dietitian-led nutritional assessment and adjustment of feeding regimens/diet orders;
- Management of complications associated with refeeding syndrome, electrolyte imbalances, failure to heal (wound healing), sarcopenia or severe weight loss;
- Interdisciplinary care coordination to stabilize nutritional status and prevent further clinical decline.

ICD-10 codes such as E43 (unspecified severe protein-calorie malnutrition), E44.0 (moderate protein-calorie malnutrition), and E46 (unspecified protein-calorie malnutrition) are appropriately mapped to the "Medical Management" clinical category under PDPM. They reflect the clinical complexity and high level of care needed for this patient population, many of whom are frail, older adults transitioning from an acute hospital stay.

Reducing or reclassifying these codes in a way that invalidates their use as primary diagnoses would risk undermining access to medically necessary SNF care, especially for beneficiaries who require intensive nutritional support upon hospital discharge and beyond. While this proposed rule does not include a reduction or reclassification of malnutrition codes, HNC believes it is important to proactively address this issue.

Restricting Eating Disorder Diagnoses as Primary Drivers for SNF Care Ignores Medical Complications Including Severe Malnutrition

HNC is concerned by CMS's continued reclassification of eating disorder diagnoses – such as anorexia nervosa (restricting and binge/purge types), bulimia nervosa, pica, and rumination disorder – from "Medical Management" to "Return to Provider." While these conditions often involve psychiatric care in outpatient settings, the medical complications of severe eating disorders can warrant SNF-level skilled care when malnutrition reaches a clinically dangerous stage.

Patients presenting with one of the above diagnoses may experience:

- Severe protein-calorie malnutrition (E43/E44);
- Electrolyte imbalances;
- Organ dysfunction (e.g., bradycardia, renal impairment);
- Wound development or failure to heal;
- Inability to maintain adequate oral intake.

In such cases, the malnutrition diagnosis may appropriately serve as the principal diagnosis, with the underlying eating disorder coded as a secondary contributing condition. CMS should maintain clear guidance that supports the use of malnutrition ICD-10 codes as valid drivers of SNF care, even when the underlying etiology is psychiatric or behavioral in nature.

Ongoing Reductions in Reimbursement Threaten Access to Nutrition Support Therapies

CMS's continued reduction in reimbursement for malnutrition-related diagnoses and associated services undermines the provision of high-quality care and may unintentionally incentivize early discharge or denial of care. Nutrition support therapies such as EN and PN often require skilled administration and clinical monitoring that cannot be provided in lower-level settings, particularly for patients with comorbidities, cognitive impairment, or recent hospitalizations.

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Further reimbursement reductions, particularly for enteral/parenteral nutrition-related care, will:

- Disincentivize SNFs from accepting high-need patients;
- Reduce access to specialized nutrition support teams;
- Delay timely treatment of malnutrition, contributing to worse health outcomes and higher hospital readmission rates.

We strongly urge CMS to stabilize payment and preserve coverage for nutrition-related conditions and their treatments (such as EN and PN), recognizing the role of medical nutrition therapy in both recovery and rehospitalization prevention.

Predictable Reimbursement and Code Integrity Are Essential to Continuity of Nutrition Care

The shifting of diagnosis codes (e.g., from "Medical Management" to "Return to Provider") creates administrative uncertainty and can directly delay SNF admissions, interrupt continuity of care, and result in denied or postponed nutrition support interventions. This lack of predictability may prevent timely initiation of EN or PEN, despite clinical indications and risks of worsening malnutrition.

CMS must ensure that coding and payment policies:

- Align with clinical practice guidelines and established malnutrition assessment tools;
- Support medically appropriate SNF admissions;
- Avoid introducing coding barriers that interfere with patient recovery and transition of care.

Support for Quality Measures in Nutrition, Interoperability, and Well-Being

We support CMS's efforts to explore quality measures for inclusion in the SNF QRP that assess:

- Nutrition: We encourage the use of validated tools for identifying and tracking malnutrition risk, use of nutrition support therapies, and the impact of nutrition interventions on recovery and rehospitalization.
- Interoperability: Seamless exchange of clinical and nutrition-related data (e.g., nutrition risk assessments, weight trends, feeding regimens) across care settings is critical for timely care and safety.
- Well-being: Nutrition is foundational to well-being. Malnutrition, especially in older adults, affects mental health, physical function, and quality of life. We recommend integrating nutrition risk or status as a core component of any SNF well-being metric.

Conclusion

We urge CMS to reconsider the continued downgrading of malnutrition-related diagnosis codes, protect reimbursement for enteral and parenteral nutrition, and acknowledge the complex clinical needs of beneficiaries requiring skilled nutrition care. As CMS advances quality measurement and value-based care in SNFs, nutrition must be recognized as a clinical cornerstone – not an ancillary service. HNC urges CMS to ensure access through adequate coverage and payment policies for nutrition therapy products. Thank you for the opportunity to provide comments. We remain committed to partnering with CMS to ensure that all individuals have access to appropriate, skilled, and effective nutrition care in the SNF setting. If you have

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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