June 9, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: 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 (CMS-1833-P)

Dear Administrator Oz:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the 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 (CMS-1833-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 who require or benefit from advanced and specialized nutrition. We acknowledge and appreciate how this administration has prioritized nutrition and supports improving patient quality care. HNC's recommendations can help accomplish these goals.

Nutrition is a fundamental aspect of healthcare, especially for patients who cannot consume food or enough food in the traditional manner, from a Regular Diet. For these patients to meet their nutrition needs, oral nutrition supplements, enteral nutrition, and/or parenteral nutrition are vital to avoid nutrient deficiencies. It is important for payors and providers to recognize that the term food in the standardized patient assessment data elements also applies to beneficiaries whose food must be administered via enteral or parenteral methods.

Supporting the Malnutrition Composite Score (MCS)

HNC supports continued inclusion of the age-expanded MCS (previously known as the Global Malnutrition Composite Score) electronic quality measure (eCQM) for all adults over 18 in the Hospital Inpatient Quality Reporting (IQR) Program and Medicare Promoting Interoperability Program Eligible Hospitals and critical access hospitals (CAHs) that implement the MCS are taking commendable step towards enhancing patient care and aligning with the goals of CMS.

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By promoting comprehensive malnutrition screening, assessment, care planning, and care transitions, the MCS plays a crucial role in the recovery and overall well-being of patients.

As CMS has previously acknowledged, 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 compared to patients who are not vulnerable to becoming malnourished.[8]

Making the change to fully integrate malnutrition care (screening, assessment, diagnosis, care plans, interventions, and care transitions) 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]

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

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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.

Conclusion

As CMS advances quality measurement and care, nutrition must be recognized as a clinical cornerstone – not an ancillary service. We urge CMS to make the MCS eCQM a mandatory quality measure to assure standardization of nutrition screening, assessment, diagnosis, and care planning. This evaluation of nutrition care will put an emphasis on discharge planning and transition of care for patients on ONS, EN, and PN. 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 across the continuum of care. 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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