



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

June 1, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1843-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 2027 (CMS-1843-P)

Dear Administrator Oz:

The Healthcare Nutrition Council (HNC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027 (CMS-1843-P)." 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 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, including through initiatives related to food is medicine (FIM). HNC sees 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 rule that significantly affects malnutrition-related conditions, medical nutrition therapy, and patient access to SNF care.

Malnutrition Should Remain a Valid Primary Diagnosis for SNF Admission

In the proposed rule, it is noted that CMS is monitoring certain case-mix indexes (CMIs) to ensure that payment remains aligned with patient acuity, particularly as data has indicated increases in certain CMIs, including malnutrition, which may not reflect underlying health status of patients. HNC is concerned that any potential reduction or reclassification of malnutrition codes in a way that invalidates their use as primary diagnoses would not accurately reflect patients' health conditions and would risk undermining access to medically necessary SNF care, especially for beneficiaries who require intensive nutrition support upon hospital discharge and beyond.

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;

- Registered dietitian-led nutrition 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 nutrition 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. Thus, as CMS explores any potential approach to address “case-mix creep” in PDPM, HNC strongly discourages CMS from reducing or reclassifying any malnutrition codes to ensure continued access for patients requiring nutrition interventions.

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,” which was included in the FY2026 SNF final rule. 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.

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;



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

- 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.

Conclusion

We urge CMS to 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 any questions or would like additional information, please contact Allison Cooke, Healthcare Nutrition Council, at acooke@healthcarenutrition.org or (202) 860-1008.

Respectfully submitted,

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

Carla Saunders
Executive Director

¹ HNC members include Abbott Nutrition, Nestle Health Science, and Nutricia.