April 24, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

RE: Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information

Dear Ms. Verma:

The Defeat Malnutrition Today coalition appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information contained in the Final Call Letter for CY 2018.

Defeat Malnutrition Today is a coalition with over 55 members who are committed to defeating older adult malnutrition. This is a diverse alliance of community, healthy aging, nutrition, advocacy, health care professional, faith-based, and private sector stakeholders and organizations who share the goals of achieving the recognition of malnutrition as a key indicator and vital sign of older adult health and working to achieve a greater focus on malnutrition screening and intervention through regulatory and/or legislative change across the nation's health care system.

We applaud CMS's desire for "transparency, flexibility, program simplification and innovation to transform the [Medicare Advantage] and Part D programs for Medicare enrollees to have options that fit their individual health needs."

In response to the Request for Information from the Final Call Letter, we are recommending policies to be added to improve clinical outcomes of malnourished and nutritionally at-risk chronically ill Medicare beneficiaries. Our proposals for Medicare Advantage (MA) will help ensure that older adults with chronic disease have access to the same level of malnutrition care across the healthcare continuum.

Background on the Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is a common issue in the acute care hospital setting, affecting approximately 20 to 50 percent of admitted patients.[1-5] According to the National Resource Center on Nutrition, Physical Activity and Aging, nearly 35-50 percent of older residents in long term care facilities are malnourished. Chronic disease increases the risk of malnutrition in older adults. Studies estimate the

prevalence of malnutrition in cancer patients is 30-87 percent,[6] in chronic kidney disease is 20-50 percent,[7] and in chronic obstructive pulmonary disease is 19-60 percent.[8] In addition, one of the fastest growing forms of elder abuse is self-neglect, which can be caused by the inability to maintain a proper (or any) diet, leading to malnutrition.

Because malnutrition in older adults is often linked to economic and social factors, it can lead to more health disparities. The Congressional Black Caucus Institute in their *21st Century Council 2015 Annual Report* noted that "[t]he most benefit will occur when malnutrition care becomes a priority and routine standard of medical care." One of the steps outlined to accomplish this was "[i]ntegrating malnutrition screening and treatment into the development of evidence-based care models, such as intervention strategies to improve patient care transitions."

Malnutrition is a major concern because it can cause adverse outcomes. Research documents malnourished older adults make more visits to physicians, hospitals, and emergency rooms. Malnourished patients can continue to worsen throughout an inpatient stay, which may lead to increased costs. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.[9]

Malnutrition is a patient safety risk, as those who are malnourished are more likely to experience a healthcare acquired condition. Malnutrition is linked to increased rates of morbidity, increased incidence of healthcare acquired pressure ulcers and infections, falls, delayed wound healing, decreased respiratory and cardiac function, poorer outcomes for chronic lung diseases, increased risk of cardiovascular and gastrointestinal disorders, reduced physical function, development of nosocomial infections, and impairment of non-specific and cell-mediated immunity.[10]

While malnutrition is a prevalent and potentially costly problem, it is also preventable. Effective and timely screening is essential to help providers make accurate diagnoses, and early nutrition interventions have been shown to substantially reduce readmission rates,[11-13] as well as complication rates, length of stay, cost of care, and in some cases, mortality.[10]

Malnutrition care (from screening, assessment, and diagnosis to care plans and interventions) is a low-risk and low-cost solution to help improve the quality of clinical care. Prompt nutrition intervention can significantly improve patient outcomes, with:

- 28 percent decrease in avoidable readmissions,[14]
- 25 percent reduction in pressure ulcer incidence,[15]
- 4 percent fewer overall complications,[16]
- Reduced average length of stay of approximately two days,[17-18]
- Decreased mortality,[19-24] and
- Improved quality of life.[25-30]

Recommendations

1. **Include RDNs and other clinically qualified nutrition professionals as providers in Medicare Advantage provider networks and allow them to be reimbursed for treating chronic conditions, including malnutrition**

We recommend that RDNs or other clinically qualified nutrition professionals should be included as providers in MA provider networks, including in Special Needs Plans (C-SNPs), and allow them to be reimbursed for treating chronic conditions, including malnutrition as a symptom of and a cause of these chronic illnesses.

2. **Allow nutrition social services and comprehensive malnutrition care and therapies to be offered as supplemental benefits for all Medicare Advantage plans**

We propose that social services be allowed to be offered as supplemental benefits for all MA plans, including Special Needs Plans (C-SNPs). We would particularly highlight the importance of Older Americans Act (OAA) nutrition programs or medically-tailored home delivered meal programs (which would be categorized as a "social service") to MA beneficiaries with chronic illness. These programs are essential to allowing older adults to live safely and independently in their communities.

We recommend that plans offer these benefits to ensure that patients who may not be able to prepare meals for themselves receive a proper diet. This will reduce the risk of malnutrition for these older adults, in turn reducing hospital readmissions. It will also significantly lower the chances that they will need residential care. Seventy-seven percent of congregate and 84 percent of home-delivered meal participants say they eat healthier meals because of OAA nutrition programs, and 61 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes. Further, the Administration for Community Living states that the lowest prevalence of malnutrition is found among older adults in the community.[31] By providing access to meals programs, older adults can remain in the community and also stay nourished.

Also, some older adults with chronic disease are not able to fully meet their nutrition needs with food alone. For them, oral nutrition supplements (ONS) become an important malnutrition therapy. Use of oral nutrition supplements prescribed by an RDN or other clinically qualified nutrition professional has been shown to help improve health outcomes in malnourished patients with chronic disease. For example, one recent study of older adults with a primary diagnosis of COPD compared hospitalized COPD patients who had ONS ordered for them with non-treated patients. The study attributed ONS use with a 21.5 percent reduction in length of stay (from 8.75 days among untreated patients to 6.87 days for those receiving ONS) and a reduction in episode costs of $1,570, from $12,523 to $10,953 or 12.5 percent. Among those episodes which could be tracked for follow-up, ONS use also lowered the probability of 30-day readmission by 13.1 percent. The researchers concluded: "oral nutrition supplements present an inexpensive, effective means for reducing length of stay, episode cost, and

readmission risk in hospitalized Medicare patients with COPD. As such, ONS may offer an opportunity to reduce costs to Medicare while improving quality of outcomes." [32] Thus, we recommend full coverage for these supplements as well.

Further, nutrition social services and other treatments for malnutrition that may be ordered by RDNs and other clinically qualified nutrition professionals (such as oral nutrition supplements) need to be coupled with systematic malnutrition screening, assessment, and diagnosis because beneficiaries will benefit most when malnutrition risk is quickly identified and targeted for intervention.

3. **Allow Medicare Advantage plans to include telehealth services provided by RDNs or other clinically qualified nutrition professionals as a regular benefit**

RDNs are already approved telehealth providers under traditional Medicare and can provide important services easily via videoconference or telephone calls. Nutrition plays an important role in the health of patients with chronic illness, as we have emphasized, and telehealth appointments with an RDN or other clinically qualified nutrition professional should be included as a regular benefit under MA.

We appreciate your consideration of our comments. Please feel free to contact us at info@defeatmalnutrition.today if you have any questions or if you need additional information.

Sincerely,

Bob Blancato
National Coordinator
Defeat Malnutrition Today

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