

June 12, 2017

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

RE: FY 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information, CMS-1677-P

Dear Ms. Verma,

The Defeat Malnutrition Today coalition appreciates the opportunity to comment on the FY 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, specifically on the older adult malnutrition measures discussed in the proposed rule.

Defeat Malnutrition Today is a coalition with more than 60 members who are committed to defeating older adult malnutrition across the continuum of care. 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 common goals of achieving the recognition of malnutrition as a key indicator and vital sign of health risk for older adults and working to achieve a greater focus on malnutrition screening, diagnosis, and intervention through regulatory and/or legislative change across the nation's health care system.

We applaud the CMS proposal to adopt malnutrition electronic clinical quality measures (eCQMs) into the Hospital Inpatient Quality Reporting Program (IQR). As CMS notes in the proposed rule, prevalence of malnutrition may be as high as 33 to 54% for hospitalized patients, and malnourished patients have an increased risk of complications, readmissions, and length of stay, resulting in increased costs.³² Importantly, evidence demonstrates there continues to be a gap in malnutrition risk, identification, and potentially treatment, as only 3 to 7% of hospitalized patients are diagnosed with malnutrition. **As there are currently no malnutrition quality measures, we urge CMS to immediately adopt the proposed malnutrition eCQMs into the FY 2018 Hospital IQR Program versus a future IQR program. Malnutrition is a vital sign of older adult health risk and must be addressed with great urgency.**

Background on the Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is unfortunately a common issue in the acute care hospital setting, affecting approximately 20 to 50 percent of admitted patients.¹⁻⁵ Additionally, 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.

A 2017 Administration for Community Living, Center for Policy and Evaluation report on malnutrition comments “At least 1/3 of patients of all ages in developed countries, including the U.S., are malnourished when admitted to the hospital, and, if untreated, about 2/3 will have their nutritional status decline during their hospitalization.” The report concludes: “Available evidence indicates that nutrition interventions in the community and hospital settings and nutrition services programs for older adults can help preserve health and well-being as well as prevent certain health services use...Hospitals, care transition, and other health care providers could conduct nutrition screenings, assessments, and interventions as their professional organizations recommend.”³⁷

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.” The Congressional Black Caucus Institute took this a step further in their *2017 Transition Report*, recommending policymakers “Recognize malnutrition as a preventable occurrence in acute care hospitals and support appropriate screening and treatment efforts, including the adoption of malnutrition-related quality measures in federal quality reporting programs.”

Malnutrition is a major concern because it can cause adverse and costly outcomes. Research documents that malnourished older adults make more visits to physicians, hospitals, and emergency rooms. The nutritional status of malnourished patients can continue to worsen throughout an inpatient stay, which may lead to further 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 For example, 45% of patients who fall in the hospital have malnutrition; costs for falls overall to Medicare totaled \$31 billion in 2015.^{35, 36}

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
- 14 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

Malnutrition Electronic Clinical Quality Measures

We urge CMS not to delay adoption of the malnutrition eCQM set in a future IQR program but to immediately adopt the eCQM set into the FY 2018 Hospital IQR Program. While we recognize the need to carefully assess data reporting burden versus clinical value in the adoption of additional IQR measures, the malnutrition eCQMs are clinically relevant to patients and providers, can provide meaningful and actionable data in real time, and are needed to fill a critical gap in risk identification and management to improve patient outcomes and reduce healthcare costs.

Each of the four malnutrition eCQMs serves a specific role for ensuring that a multidisciplinary care team comprised of nurses, dietitians, physicians, patients and others can coordinate risk identification and risk reduction. These malnutrition eCQMs address the first four key components in the standard nutrition care process:

- **MUC16-294: Completion of a Malnutrition Screening within 24 hours of Admission**
We support CMS' consideration of MUC16-294, focused on screening for malnutrition risk, for adoption into the Hospital IQR program. Screening upon admission with a validated tool (from which there are many to choose) is a low-burden way to identify patients at-risk for poorer outcomes due to their malnutrition and initiate appropriate care.
- **MUC16-296: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening**
We support CMS' consideration of MUC16-296 for nutrition assessment. The nutrition assessment provides the foundation for all subsequent malnutrition care a patient receives. It reflects the results of the screening, outlines patient nutrition status and recommendations to guide the care plan, and informs the provider medical diagnosis of malnutrition.^{10,33} Appropriate implementation and documentation of the nutrition assessment can drive optimal malnutrition care including early intervention on those found to be malnourished.²⁰
- **MUC16-372: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment**
Development and documentation of the nutrition care plan is driven by the nutrition assessment and is required to record vital patient care information, including nutrition status, diagnosis, monitoring recommendations, and interventions.^{10,31} Therefore, we encourage CMS to consider this measure, MUC16-372, for adoption into the IQR program. The nutrition assessment-based care plan is the communication mechanism to all clinicians who interact with the patient. Moreover, it reflects the care provided in the hospital setting and becomes the information communicated to the next-in-line provider. As such, documentation of the care plan in a standardized, structured, and consistent manner is a critical activity for quality care

provision in the acute setting and to support care transitions and appropriate nutrition support beyond the hospital.

- **MUC16-344: Appropriate Documentation of a Malnutrition Diagnosis**

We support CMS' consideration of MUC16-344 for malnutrition diagnosis. Diagnosis of malnutrition and appropriate documentation is a crucial step to confirm results of a nutrition assessment, communicate nutritional status to other providers within the hospital, and ensure malnutrition support is carried out. Documentation of malnutrition in the patient's record is of significant value for care coordination between acute and post-acute settings. CMS has stated that documentation of a malnutrition diagnosis is a key component of proper discharge planning and/or transitions of care to post-acute providers.³²

We soundly recommend CMS adopt the malnutrition eQIM measure set, since each eQIM has been tested and validated and represents a distinct part of quality malnutrition care.

Adoption of a malnutrition composite eQIM in a future Hospital IQR Program

Further, we strongly urge that CMS consider adding a malnutrition composite measure, *when available*, that incorporates these four individual components that will drive optimal nutrition care for those at-risk of malnutrition or already malnourished in the hospital.

In the interim, we recommend CMS adopt the proposed malnutrition eQIM measure set. The recommended nutrition care process established to properly identify, treat and monitor malnutrition in hospitalized patients is a set of multiple evidence-based steps.^{10, 31}

Reporting Nutrition Approach Data Elements in the Long-Term Care Hospital Quality Reporting Program

Defeat Malnutrition Today commends CMS for their recognition of the importance of identifying and treating malnutrition in the post-acute care setting. We appreciate CMS's inclusion of nutrition/malnutrition data elements in the standardized patient assessment for beneficiaries in PAC settings and specifically establishing malnutrition and malnutrition risk as condition/co-morbidity as standardized data elements for PAC settings. Nutritional status and the nutrition care plan are necessary health information to achieve patient goals of care and inclusion of these standardized elements will facilitate care coordination and safe care transitions for beneficiaries who are malnourished and at risk for malnutrition. It is important for providers and patients to understand the risks for malnutrition, what might cause it or make it worse, how to prevent it, and how to connect with community nutrition support services.

We also support CMS' proposal for nutritional approaches data elements. We recommend, however, that CMS align the definition of the therapeutic diet data element with the Academy of Nutrition and Dietetics definition below to help clarify the data to be reported and ensure consistent data collection across PAC settings:

“A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet.” *Academy of Nutrition and Dietetics: Definition of Terms, June 2017, available at:*

<http://www.eatrightpro.org/~media/eatrightpro%20files/practice/scope%20standards%20of%20practice/academydefinitionoftermslist.ashx>

Malnutrition Is A Cross-Cutting Measure

Adopting malnutrition eQMs in the Hospital IQR is a critical first step to filling performance gaps, improving patient care, and decreasing costs. In future rule-making we recommend that CMS consider expanding their proposals to fill gaps across post-acute care and community settings.

The “National Blueprint: Achieving Quality Malnutrition Care for Older Adults” (The Blueprint, accessible at <http://defeatmalnutrition.today/blueprint>) calls for a range of strategies to prevent and reduce malnutrition among older adults, including “improve access to high-quality malnutrition care and nutrition services by adopting clinically relevant malnutrition quality measures in public and private accountability programs across the care continuum.”

The Blueprint also highlights many other recommendations and actionable ways that public and private sectors can work together to fill the gaps in quality malnutrition care for older adults. The Blueprint was developed with input from the Malnutrition Quality Collaborative which included non-profit organizations, state governments, professional organizations, and healthcare associations among others.

We would welcome the opportunity to review the Blueprint with CMS and identify ways we can collaborate to prevent and reduce malnutrition among older adults across the care continuum.

Conclusions

With systematic screening, assessment, diagnosis and intervention malnutrition can be identified and addressed to effectively reduce mortality rates, readmission rates, and complication rates such as increased length of stay and cost of care. As we have noted before, in addition to the clinical benefits, implementing quality malnutrition care is a low-cost, easy intervention. At a time when public scrutiny of federal expenditures for healthcare features prominently on the national stage, CMS has good reason to focus on the lowest-cost alternatives that can achieve savings. The estimated annual cost of disease-associated malnutrition in older Americans is more than \$50 billion.³⁴ Quality malnutrition care has been shown to create savings and improve patient care.

In short, we support the CMS proposal to adopt the malnutrition eQm measure set into the Hospital IQR. Adoption of these malnutrition quality measures will have a meaningful impact on the health and nutrition of older Americans, while simultaneously leading to genuine cost savings in our nation’s healthcare system. Right now, there are hundreds of quality measures currently in place, but none are related to malnutrition. Malnutrition care is a critical gap in patient care that we can no longer afford to ignore.

We appreciate the opportunity to comment on this proposed rule, and we thank you for your consideration of immediately adopting the malnutrition eQm set into the FY 2018 IQR Hospital program.

Sincerely,
Defeat Malnutrition Today

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