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Comment on Program Year 2020 of the Merit-based Incentive Payment System (MIPS) Program

Submitted electronically via PIMMSQualityMeasuresSupport@gdit.com

Defeat Malnutrition Today welcomes the opportunity to comment on new measure sets for the quality performance category for program year 2020 of the Merit-based Incentive Payment System (MIPS) program.

We are a diverse coalition of over 80 national, state, and local organizations who are committed to defeating older adult malnutrition across the continuum of care. We are focused on advancing this fight through federal and state policy and advocacy.

We strongly recommend that quality measures related to nutrition and malnutrition in older adults be adopted in program year 2020 of the Merit-based Incentive Payment System (MIPS) program. Older Americans would benefit from both preventive treatment measures such as malnutrition screening and active measures such as a nutrition care plan.

Why Malnutrition?

Older adult malnutrition is a growing crisis in America today. Up to half of all older adults are at risk of malnutrition. For example, in the acute care hospital setting, it is estimated that approximately 20 to 50 percent of admitted patients are malnourished or at-risk of malnutrition.[1][2][3][4][5]

As called for in the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults*, high-quality nutrition and malnutrition care for older adults should to be at the "top of the U.S. national agenda as we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost." This is because while good nutrition has been shown to help support a healthy and active lifestyle, improve health outcomes, and reduce healthcare costs, malnutrition—particularly the lack of adequate protein, calories, and other nutrients needed for tissue maintenance or repair—has been shown to be associated with poor health outcomes, frailty and disability, and increased healthcare costs.

Further, the *Blueprint* notes malnutrition is a significant problem for both underweight and overweight or obese individuals due to loss of lean body mass. The *Blueprint* was developed with input from a variety of sectors, including representatives from nonprofit organizations, state governments, professional organizations, and healthcare associations.

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[1] Barker LA, Gout BS, Crowe TC. Hospital malnutrition: Prevalence, identification and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011; 8(2):514-527.
[2] Bistrian BR, Blackburn GL, Hallowell E, Heddle R. Protein status of general surgical patients. JAMA. 1974;230(6):858-860.
[3] Christensen KS, Gstundtner KM. Hospital-wide screening improves basis for nutrition intervention. J Am Diet Assoc.1985;85(6):704-706.
[4] Lim SL, Ong KC, Chan YH, et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. Clin Nutr. 2012;31(3)345-350.
[5] Somanchi M, Tao X, Mullin GE. The facilitated early enteral and dietary management effectiveness trial in hospitalized patients with malnutrition. JPEN J Parenter Enteral Nutr. 2011;35(2):209-216.

In recent comments from U.S. Department of Health and Human Services (HHS) Secretary Alex Azar to the Hatch Foundation for Civility and Solutions on November 14, 2018, he stated:

> Data from the Agency for Health Research and Quality at HHS found that Americans with malnutrition are twice as costly to treat at the hospital as those who come in well-nourished. In fact, malnutrition is involved in 12 percent of non-maternal, non-neonatal hospital stays—$42 billion each year in healthcare spending.

In other words, malnutrition is pervasive, costly, and causes patients to feel worse and heal slower; however, it has not yet been addressed by a systematic, consistent approach throughout the healthcare system.

Broadly speaking, there is a general lack of awareness that malnutrition is linked to acute illness, chronic disease, and poor health outcomes. While there are malnutrition standards of care, best practices, and validated screening and diagnostic tools available, these have not been systematically adopted into routine medical care or adopted across care settings.

Further, care coordination by the clinical care team of malnourished and at-risk older adults can often be fragmented due to lack of visibility of clinically relevant malnutrition data and documentation and non-standardization of key malnutrition data elements in electronic health records. Last year, a multi-stakeholder group of health and community leaders and advocates came together for a national Dialogue to consider opportunities for advancing patient-centered malnutrition care transitions. They identified that all too often, "as patients transition from one point of care to another, their nutrition status is not evaluated, documented, or even included in patient health conversations" and specifically called for integration of nutrition status considerations into existing protocols, pathways, and models to facilitate enhanced care coordination and better outcomes for patients across care settings. Integrating nutrition status considerations into quality measure development and maintenance provides an opportunity to help achieve this.

Measures to Incorporate

Malnutrition measures have already been submitted to CMS for the Medicare Hospital Inpatient Quality Reporting Program:

- **MUC16-294: Completion of a Malnutrition Screening within 24 hours of Admission**
  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**
  A 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.[6,7] Appropriate implementation and documentation of the nutrition assessment can drive optimal malnutrition care including early intervention on those found to be malnourished.[8]

- **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.[6,9] 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**
  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.[10]

While there has been a limit on CMS adoption of new quality measures, we commend the Agency for recognizing the malnutrition quality measures in its final rule on Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals/Quality Reporting Requirements for FY2018, and commenting that "We agree that a systematic approach to quality improvement is essential and could include increasing awareness of malnutrition and improving management of nutrition in hospitals. We acknowledge the benefits and need for inclusion of malnutrition measures, as outlined by the commenters, and will consider the feasibility of implementing these measures in the Hospital IQR Program in the future."

We also commend the Agency for considering nutrition interventions (home delivered meals, food and produce) as a non-medical service for coverage under Medicare Advantage plan expansions in 2020.[11] Both of these actions, coupled with Sec. Azar's comments, speak to the Agency's acknowledgement of malnutrition identification and intervention as critical for the health of older adults.

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[6] Tappenden KA et al. Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition. JPEN J Parenter Enteral Nutr. 2013 Jul;37(4):482-97

[7] Deutz NE, Matheson EM, Matarese LE, et al. Readmission and mortality in malnourished, older, hospitalized adults treated with a specialized oral nutritional supplement: A randomized clinical trial. Clinical nutrition (Edinburgh, Scotland). 2016;35(1):18-26.

[8] Akner G, et al. Treatment of protein-energy malnutrition in chronic nonmalignant disorders. Am J Clin Nutr 2001;74:6.

[9] Mueller C, Compher C, Ellen DM, American Society for P, Enteral Nutrition Board of D. A.S.P.E.N. clinical guidelines: Nutrition screening, assessment, and intervention in adults. JPEN J Parenter Enteral Nutr. 2011;35(1):16-24.

[10] 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 2017 Rates, 81 FR 56761 (22 August 2016), pp. 1985

[11] https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-advance-notice-part-ii-and-draft-call-letter

Benefits for Our Healthcare System

CMS must recognize nutrition as the backbone of any LTSS system. And, 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.[12] Quality malnutrition care has been shown to create savings and improve patient care.

In short, adoption of malnutrition quality measures will have a meaningful impact on the health of older Americans while simultaneously leading to genuine cost savings in our nation's healthcare system.

Thank you for considering our comments, and we look forward to future comment opportunities. If you have questions about our comments, you may reach our Policy Director Meredith Whitmire at mponder@matzblancato.com.

Sincerely,

Bob Blancato
National Coordinator
Defeat Malnutrition Today

[12] Snider J, et al: Economic burden of community-based disease-associated malnutrition in the United States. JPEN J Parenteral Enteral Nutr.2014;38:55-165.