



June 24, 2019

Ms. Seema Verma, MPH  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1716-P  
P.O. Box 8016-8013  
Baltimore, MD 21244-8016

Re: File Code – CMS-1716-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals <http://www.regulations.gov>

Dear Administrator Verma:

On behalf of the Academy of Nutrition and Dietetics, the American Society for Parenteral and Enteral Nutrition, the American Society for Nutrition, and the Association of Clinical Documentation Improvement Specialists, and those parties signed on below, we would like to submit comments to the proposed rule **CMS-1716-P**. These comments represent a broad scope of health care professionals (medical physicians, registered nurses, registered dietitian nutritionists, and registered pharmacists) working together on a daily basis to improve care and outcomes for Medicare Part A beneficiaries. In particular, **we would like to address the upgrading and downgrading of malnutrition diagnostic codes E43 and E44.0. The proposed change does not make sense to us from either a data or clinical expertise perspective. We therefore urge CMS to delay finalization of any changes to these ICD-10 codes within the Hospital Inpatient Prospective Payment System until additional data analysis can be conducted. We also urge CMS to add malnutrition electronic clinical quality measures (eQMs) to the meaningful measure set of both the Inpatient and Long Term Care Hospital Quality Reporting Programs.**

#### **Comprehensive CC/MCC Analysis**

##### Background:

Malnutrition in hospitalized patients has clearly been associated with longer lengths of stay, higher mortality, higher readmissions, and higher cost. This condition, along with its associated ICD-10 diagnostic codes, was associated with \$49 billion dollars in hospital costs in 2016. Of those hospitalized

patients, 64% had Medicare as the payer.<sup>1</sup> Data from 2016 on hospital inpatient stays shows 375,435 Medicare beneficiaries were discharged from the hospital with a diagnosis of unspecified severe protein-calorie malnutrition (E43) while 219,920 Medicare beneficiaries were discharged with a diagnosis of moderate protein-calorie malnutrition (E44.0).<sup>2</sup>

#### Discussion Points:

**Unspecified severe protein-calorie malnutrition (E43) should not be downgraded from a major complication or comorbidity (MCC) to a complication or comorbidity (CC)** as proposed in the Center for Medicare & Medicaid Services (CMS) 2020 Proposed Inpatient Prospective Payment System Rule. It is not clear in this proposed rule as to the rationale for these changes that essentially are stating that a severe condition should be downgraded to a CC and a moderate condition should be upgraded to an MCC. The described methodology and data used as a basis for the proposed changes with these two malnutrition ICD-10 codes is unclear. The data in the FY 2020 NPRM Measure of Impact Use Supplementary File (lines 827-828) shows consistently higher values under C1, C2 and C3 for unspecified severe protein-calorie malnutrition as compared to moderate protein-calorie malnutrition.

**The proposed downgrade of E43 to a “CC” from a “MCC” and the upgrade of E44.0 from a “CC” to a “MCC” is inconsistent within the malnutrition diagnostic code “family”.** Downgrading E43 to a “CC” would render it equal to E44.1 or mild malnutrition reflecting inconsistency within the diagnosis code set. In addition, E43, “unspecified severe malnutrition” is the only diagnostic ICD-10 code to indicate severe malnutrition. If the rationale to downgrade E43 to a “CC” includes the lack of specificity with E43, it is important to remember there is no other ICD-10 severe malnutrition code.

#### Clinical Rationale:

In addition to mathematical constructs, the agency uses the judgement of its clinical advisors to assign a classification of MCC, CC or non-CC. **As a panel of experts in the field of nutrition and nutrition support, our clinical experience indicates more resources are used when providing care to severely malnourished patients compared to moderately malnourished individuals.** Data from two highlighted studies<sup>3,4</sup> demonstrate higher mortality risk and longer lengths of stay (LOS) in severely malnourished individuals compared to those with non-severe malnutrition. Longer LOS are one source of increased healthcare expenses. The proposed changes in malnutrition severity misalign with the clinical care environment. Our clinical experts have repeatedly commented to us that resource intensive nutrition therapies are utilized earlier and more frequently in severely vs moderately malnourished patients. These differences result in higher costs per patient and thus a higher hospitalization cost for the severely malnourished compared to the moderately malnourished patients. We are happy to provide any number of clinical experts to further provide practical rationale from patient experience for the agency.

#### Data from Published Reports and Hospital Systems:

One hospital system’s 7-month comparative malnutrition data shows a higher variable cost per case for E43 (\$7,585) vs E44.0 (\$7258). See attached de-identified report.

Published literature by Cenicolla, et al,<sup>3</sup> report on 327 ICU patients in which about 305 were malnourished, 14% of whom had severe malnutrition. The investigators found that the risk of mortality was 3.34 times higher in severely malnourished patient than in those with no malnutrition ( $p=0.0001$ ), while the risk of mortality in those with non-severe malnutrition was 2.3 times higher than with no malnutrition ( $p=0.005$ ). There is a clear difference in outcome between severe and non-severe malnutrition in this study.

In a study by Hiura, et al,<sup>4</sup> 5606 ICU patients were assessed and 13% had severe malnutrition. Hospital LOS and intensive care unit LOS were both significantly longer, more than twice as long, in the severely malnourished patients compared to those without severe malnutrition.

**We urge CMS delay making any changes in CC/MCC levels for E43 and E44.0 until other data can be analyzed to support or refute the proposed changes.** We recommend CMS obtain data from the Agency for Health Care Research and Quality HCUP 2016 NIS dataset to discern cost differences between these ICD-10 codes. This data can be filtered by age and payer and thus can be matched to the CMS dataset.

### **Inpatient Quality Reporting Program**

As already noted above, a large percentage of hospital patients are at risk of malnutrition. Malnourished patients experience longer hospital lengths of stay, increased mortality, and increased readmission rates. Last November, Secretary Azar II called attention to the very issue of malnutrition as a [social determinant of health](#), when he commented to the Hatch Foundation for Civility that:

“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 health care spending. Naturally, a number of private health providers and payers have already tried addressing this issue: One ACO in Chicago, for instance, began screening high-risk patients for malnutrition, and then supporting them after discharge from the hospital with follow-ups, referrals, and nutrition coupons. The savings were huge: more than \$3,800 per patient.”


Standards of care, tools, and best practices to address malnutrition have not been systematically adopted across care settings, and consistent coordination and transitions among care providers to manage patient nutrition needs continue to be lacking. We are encouraged that today over 250 hospitals nationwide — up from 50 hospitals just a year ago — have joined a Malnutrition Quality Improvement Initiative Learning Collaborative to voluntarily implement malnutrition electronic clinical quality measures (eQMs). We believe CMS’ addition of malnutrition eQMs to the meaningful measure set is urgently needed to help solve this problem. Thus, **we request that the following malnutrition eQMs reviewed by the National Quality Forum<sup>5</sup> be included in the hospital IQR rule and the LTCH Quality Reporting Program for FY 2020:**

- NQF #3087/MUC16-294: Completion of a Malnutrition Screening within 24 hours of Admission
- NQF #3088/MUC16-296: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening
- NQF #3089/MUC16-372: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment
- NQF #3090/MUC16-344: Appropriate Documentation of a Malnutrition Diagnosis

These are the same malnutrition eQMs included in the FY 2018 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Acute Hospital Payment Prospective Payment System Proposed Rule.

Thank you for your careful consideration of our comments on the proposals for the 2020 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System. Please do not hesitate to contact Marsha Schofield by phone at 312-899-1762 or by email at [mschofield@eatright.org](mailto:mschofield@eatright.org) or Peggi Guenter by email at [peggi@nutritioncare.org](mailto:peggi@nutritioncare.org) with any questions or requests for additional information.

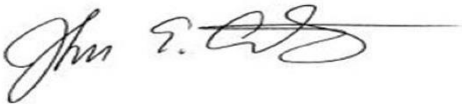
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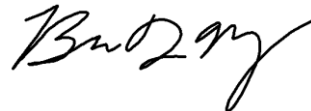
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The American Society for Parenteral and Enteral Nutrition (ASPEN) is dedicated to improving patient care by advancing the science and practice of clinical nutrition and metabolism. Founded in 1976, ASPEN is an interdisciplinary organization whose members are involved in the provision of clinical nutrition therapies, including parenteral and enteral nutrition. With more than 6,500 members from around the world, ASPEN is a community of dietitians, nurses, pharmacists, physicians, scientists, students, and other health professionals from every facet of nutrition support clinical practice, research, and education.

Representing more than 104,000 registered dietitian nutritionists (RDNs); nutrition and dietetic technicians, registered (NDTRs); and advanced-degree nutritionists, the Academy of Nutrition and Dietetics is the largest association of food and nutrition professionals in the United States and is committed to improving the nation's health through food and nutrition.

Established in 1928, the American Society for Nutrition (ASN) is the nation's preeminent nutrition research and practice organization reaching more than 35 million individuals each year with science-based nutrition information, education and advocacy activities to advance global public health.

ACDIS is a professional association representing more than 6,500 clinical documentation improvement (CDI) professionals nationwide. Their backgrounds include registered nurses (RN), health information management (HIM) professionals, case managers, quality improvement personnel, and physicians. CDI professionals work to ensure complete and accurate documentation in the medical record, which is integral to accurate assignment of ICD-10-CM diagnosis and ICD-10-PCS procedure codes and the Medicare Severity diagnosis-related groups (MS-DRG) discussed in this proposed rule. Their work also helps to ensure the accurate reporting of quality measures, medical necessity of inpatient admissions and procedures, hospital and physician profiles, and other publicly available data.

## References

1. Barrett ML, Bailey MK, Owens PL. *Non-maternal and Non-neonatal Inpatient Stays in the United States Involving Malnutrition, 2016*. ONLINE. August 30, 2018. U.S. Agency for Healthcare Research and Quality. Available: [www.hcupus.ahrq.gov/reports.jsp](http://www.hcupus.ahrq.gov/reports.jsp).
2. HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. <https://hcupnet.ahrq.gov/>. For more information about HCUP data see <http://www.hcup-us.ahrq.gov/>
3. Ceniccola G, Holanda T, Pequeno R, et al. Relevance of AND-ASPEN criteria of malnutrition to predict hospital mortality in critically ill patients: A prospective study. *J Crit Care*. 2018; 44:398-403.
4. Hiura G, Lebwohl B, Seres D. Malnutrition diagnosis in critically ill patients using 2012 Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition standardized diagnostic characteristics is associated with longer hospital and intensive care length of stay and increased in-hospital mortality. *JPEN J Parenter Enteral Nutr*. 2019. First published: 29 April 2019. <https://doi.org/10.1002/jpen.1599>.
5. <https://www.eatrightpro.org/practice/quality-management/quality-improvement/malnutrition-quality-improvement-initiative>. Accessed June 10, 2019.

## Sign-on Organizations:

Healthcare Nutrition Council  
[www.healthcarenutrition.org/](http://www.healthcarenutrition.org/)

Sodexo  
The leading employer of registered dietitians and nutrition experts committed to improving the Quality of Life.  
[www.sodexoUSA.com](http://www.sodexoUSA.com)