Council for Responsible Nutrition
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June 12, 2017

Ms. Seema Verma, MPH
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 Council for Responsible Nutrition (CRN) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) FY 2018 Medicare Hospital IPPS and LTCH Prospective Payment System Proposed Rule, and Request for Information CMS-1677-P. Specifically, CRN supports CMS' *immediate* adoption of four proposed malnutrition electronic clinical quality measures (eCQMs) included in the rule and supports future adoption of a potential malnutrition composite measure in the Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

The Council for Responsible Nutrition (CRN), founded in 1973 and based in Washington, D.C., is the leading trade association representing dietary supplement and functional food manufacturers, marketers and ingredient suppliers. CRN companies produce a large portion of the functional food ingredients and dietary supplements marketed in the United States and globally. Our member companies manufacture popular national brands as well as the store brands marketed by major supermarkets, drug stores and discount chains. These products also include those marketed through natural food stores and mainstream direct selling companies. CRN represents more than 150 companies that manufacture dietary ingredients, dietary supplements and/or functional foods, or supply services to those suppliers and manufacturers. Our member companies are expected to comply with a host of federal and state regulations governing dietary supplements and food in the areas of manufacturing, marketing, quality control and safety. Our supplier and manufacturer member companies also agree to adhere to additional voluntary guidelines as well as to CRN's Code of Ethics. Learn more about us at www.crnusa.org.

Nutrient shortfalls have health consequences that can impact daily life and overall wellbeing, with national nutrition surveys consistently showing intakes below recommended levels for many nutrients. Older adults are particularly at risk for nutrient deficits, because of factors such as increased rates of chronic disease, age-associated changes, social isolation, and socioeconomic factors. Malnutrition is defined as the inadequate intake of protein and/or energy over prolonged periods of time, resulting in loss of fat stores and/or muscle wasting.[i] Malnutrition is a condition that is difficult to address for older adults, given that it often goes unrecognized and requires multi-disciplinary provider support to effectively manage.

We agree with CMS that "malnutrition is associated with many adverse outcomes." Recently published evidence analyses from the AHRQ Hospital Cost Utilization Project (HCUP) highlight the significant impact malnutrition has on patients in the hospital setting and beyond, including:

- Malnourished hospitalized patients are up to five times more likely to result in in-hospital death,[ii] and have a 54% higher likelihood of hospital 30-day readmissions than non-malnourished patients.[iii]
- Malnutrition is also associated with increased healthcare costs. Average hospital costs for all non-neonatal and non-maternal hospital stays were $12,500, while patients diagnosed with malnutrition had hospital costs averaging up to $25,200 depending on the type of malnutrition indicated.ii

- Cost per readmission for patients with malnutrition was $17,500; 26-34% higher (depending on the specific type of malnutrition) versus patients readmitted without malnutrition.[iii]

We also agree with CMS that consideration must be given to the relevance and utility of measures compared to the burden on hospitals in submitting their data. The malnutrition eCQMs were specifically designed and tested to be used with patient data already directly included in the electronic health record, thus helping to minimize the burden of data collection and reporting. Further, the malnutrition eCQMs follow the standard steps of the nutrition care process in the acute care setting, including screening, assessment, diagnosis, and development of and intervention with a patient-specific plan of care.

One of the most important questions to ask is what will occur if the malnutrition eCQMs are not immediately adopted into the hospital IQR program. We believe the answer is patients will continue to be at significant risk, their health will suffer, and healthcare costs will be further impacted. Estimates are as many as 20 to 50% of adults are at risk of or are malnourished upon admission to the hospital,[iv] yet only 7% are diagnosed.[ii] Malnutrition costs associated with older adults are estimated to have an annual economic burden of over $51 billion.[v]

The bottom line is quality care must include a focus on nutrition, but today there are no quality measures required that address malnutrition care. Thus, immediate adoption of the four malnutrition eCQMs is essential for better patient nutrition and health outcomes.

Sincerely,

Douglas MacKay, N.D.
Senior Vice President, Scientific & Regulatory Affairs

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[i] Correia MI, Waitzberg DL. The impact of malnutrition on morbidity, mortality, length of hospital stay and costs evaluated through a multivariate model analysis. *Clin Nutr.* 2003;22(3):235-239.
[ii] Weiss AJ, Fingar KR, Barrett ML, et al. Characteristics of Hospital Stays Involving Malnutrition, 2013: Statistical Brief #210. Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Rockville (MD) September 2016.
[iii] Fingar KR, Weiss AJ, Barrett ML et al. et al. Statistical Brief #281: All-Cause Readmissions Following Hospital Stays for Patients With Malnutrition, 2013. Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. December 2016.
[iv] Barker LA, Gout BS, and Crowe TC. Hospital malnutrition: prevalence, identification, and impact on patients and the healthcare system. *Int J Environ Res and Public Health*. 2011;8:514-527.
[v] Snider J, Linthicum MT, Wu Y et al: Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenteral Enteral Nutr*. 2014;38:55-165.