2025 PRMR Roundtable Measure Summary

Measure Title
Malnutrition Care Score
Measure Steward
The Academy of Nutrition and Dietetics
Administration and National Health Care Priority
Priority Topic Area: Nutrition **Rationale for Consideration:** CMS is considering this measure because it could fulfill the Administration's priorities, including those outlined under the Making America Healthy Again (MAHA) initiative. MAHA reflects a shift toward patient-centered care, emphasizing primary, secondary, and tertiary prevention; patient empowerment; nutrition and physical activity; and improvements in overall well-being and quality of life.

Measure Overview
Measure rationale: The components of this measure are supported by clinical guidance that recommends (1) malnutrition screening for patients admitted into the acute inpatient care setting; (2) nutrition assessment for patients identified at risk for malnutrition or with a dietitian referral order to form the basis for appropriate nutrition interventions; (3) appropriate recognition, diagnosis, and documentation of the nutrition status of a patient in order to (4) address their condition with an appropriate plan of care and communicate patient needs to other care providers. The process for risk identification, assessment, diagnosis, and treatment of malnutrition necessitates a multi-disciplinary care team that begins with the identification of an initial risk population for a more thorough physical assessment by registered dietitian nutritionists (RDN). The RDN in turn provides the necessary treatment recommendations to address nutritional status and the clinical indicators that inform a medical diagnosis of malnutrition completed by physician/eligible clinician. The four component measures individually will only provide a fraction of the necessary information on quality of care for patients at-risk of malnutrition. For example, knowing which patients have been assessed out of those who were initially identified as at-risk, but not knowing if the appropriate proportion of patients were screened upon admission, would be an insufficient assessment of quality of care. Implementation of this measure supports timely nursing malnutrition risk screening and hand off to RDNs for appropriate nutritional assessment for patients at-risk of malnutrition during the current hospitalization. For patients identified with a moderate or severe malnutrition status from the nutrition assessment, best practice also recommends a medical diagnosis by a physician/eligible clinician and the execution of the nutrition care plan by an RDN. Evidence demonstrates that implementing a standardized protocol for screening, assessment, diagnosis and care planning results in better identification of malnourished patients and subsequent improvements in rates of nutrition intervention for the malnourished. Outcomes modeling, and those reported in other studies, also demonstrate the benefits to patient outcomes, including reduced risk of 30-day readmissions, length of hospital stay, and complications, as well as

Measure Overview
improved quality of life after hospitalization.
Measure history: Measure currently used in a Medicare program, but the measure is undergoing substantive change. This measure is currently used in the Hospital Inpatient Quality Reporting Program and the Medicare Promoting Interoperability Program.
Numerator: As a continuous variable measure, this measure construct is called a measure observation, rather than a numerator. This measure contains five (5) different measure observations. 1. Measure Observation 1 are “Encounters with Malnutrition Risk Screening and Identified Result or a Dietitian Referral” 2. Measure Observation 2 are Encounter With Most Recent Nutrition Assessment And Identified Status” 3. Measure Observation 3 are “Encounters with Malnutrition Diagnosis” 4. Measure Observation 4 are “Encounters with Nutrition Care Plan” 5. Measure Observation Total Malnutrition Components Score which equals the sum of measure observation 1 + measure observation 2 + measure observation 3 + measure observation 4 **Exclusions:** N/A

Denominator: In a continuous variable measure, this measure construct is called the measure population, rather than the denominator. The measure population for Measure Observations 1, 2, 3, and 4 is “Inpatient hospitalizations during the measurement period with length of stay of 24 hours or more among individuals 18 years of age and older at the start of the measurement period”. “Total Malnutrition Care Score Eligible Occurrences” possible values are 1, 2, or 4. “Total Malnutrition Care Score Eligible Occurrences” is always 4 except in the following instances:
• The “Total Malnutrition Care Score Eligible Occurrences” is 1 if
  ○ A “Malnutrition Risk Screening” was performed and a “Malnutrition Screening Finding of Not At Risk Result” was identified and “Dietitian Referral” was not ordered.
• The “Total Malnutrition Care Score Eligible Occurrences” is 2
  ○ If the most recent “Nutrition Assessment” performed has a result of “Nutrition Status Finding of Well Nourished or Not Malnourished or Mildly Malnourished”.
  ○ A “Malnutrition Risk Screening” was performed and a “Malnutrition Screening Finding of Not At Risk Result” was identified and “Dietitian Referral” was ordered or a “Malnutrition Risk Screening” was performed and a “Malnutrition Screening Finding of At Risk Result” was identified but the “Nutrition Assessment” was not performed.
Exclusions: Encounters with a discharge disposition for hospice care or with a hospice care order during the inpatient qualifying encounter.
Exceptions: N/A

Measure Overview	
Measure is a composite: Yes **Measure is a paired measure:** No **Measure is a survey measure:** No **Measures is a digital measure and/or an eCQM:** Yes	**Measure type:** Intermediate Outcome
Level of analysis: Facility **Settings where measure was tested:** Hospital inpatient acute care facility	**Data source(s):** Digital-Applications: Patient-Reported Health Data or Survey Data (electronic)
CBE endorsement status: Endorsed with conditions	**CBE endorsement history:** Endorsed with conditions in Spring 2024 cycle.

Evidence

Type of evidence to support the measure: Empirical data

Summary of evidence: Nationwide analysis of hospitalizations with malnutrition diagnoses concluded that 8% of all non-neonatal and non-maternal adult hospitalizations were coded for a diagnosis of malnutrition. Furthermore, malnourished patients experienced up to 5x risk of in-hospital mortality, up to 2x higher hospital costs, up to 2x longer length of stay, and 55% higher readmissions than discharges without malnutrition (Barrett, 2018).

Research suggests that adopting malnutrition standards of care is a feasible and valuable endeavor for hospitals to undertake. Multiple studies have shown that optimal malnutrition care quality improvement programs improve care coordination between clinical disciplines responsible for nutrition care and that those improvements are associated with outcomes (Valladares, 2021; Danis, 2019; Nepple, 2019; Sriram, 2018).

A cost evaluation was conducted on one of the quality improvement programs. Savings in terms of avoided hospital readmissions and reduced adult patient length of stay for patients in the quality improvement program totaled up to $4.8 million (Sulo, 2017). Clinical evidence and best practices support the need for quality measures that incentivize early identification, diagnosis, intervention, and effective transitions of care for hospitalized patients who are at-risk or malnourished (McCauley, 2019).

Malnutrition risk identified in patients through a malnutrition screening was able to predict certain patient outcomes, including length of stay, mortality, and post-operative complications (Sauer, 2019; Silver, 2018; Allard, 2016; Khalatbari-Soltani, 2016; Kruizenga, 2016; Agarwal, 2013). A large national study understanding inpatient data from U.S. hospitals demonstrated that as many as one in three hospitalized patients are at-risk of malnutrition according to validated screening (Sauer, 2019).

The peer reviewed evidence cited for this measure also supports the assessment of patients at-risk of malnutrition via the completion of a nutrition assessment that can confirm malnutrition and initiate a care plan recommending appropriate interventions (Hudson, 2018). Ongoing research is in place to ensure that clinical standards are valid and reliable for diagnosing malnutrition in adults (Jimenez, 2022). Multiple studies have reported patient outcomes associated with malnutrition, when identified by nutrition assessment, were independently associated with higher hospital mortality, higher incidence of infection, and an increased risk of

Evidence
readmission (Hiller, 2017; Lew, 2016=7). Additional evidence demonstrated that malnourished patients were older (61 vs 58 years, P < .0001), had longer length of stay (LOS) (15 vs 12 days, P = .0067), and were more likely to be readmitted within 30 days (40% vs 23%, P < .0001). In adjusted models, 30-day readmissions (odds ratio [OR] 2.13, 95% confidence interval [CI] 1.82-2.48) and hospital mortality (OR 1.47, 95% CI 1.0-1.99) were increased in those who had >2-day stay (Hudson, 2018). Two research studies associated early nutritional care after risk identification with improved outcomes such as reduced LOS, reduction in risk of readmissions, and cost of care (Lew, 2017; Meehan, 2016). An additional study of a learning collaborative of U.S. hospitals demonstrated a statistically significant lower risk of 30-day readmission for malnourished patients who had a documented nutrition care plan (Valladares, 2021. Nutritional status and progress are often not adequately documented in the medical record. It can be difficult to tell when (or if) patients are consuming food and supplements. In addition, nutritional procedures and electronic health record (EHR)-triggered care are often lacking in the hospital. Similarly, nutritional care plans and patient issues are poorly communicated to post-acute facilities and primary care physicians (PCPs) (Corkins, 2014). Additionally, room to improve coordination between registered dietitians and physicians has also been reported (Chambers, 2019; Vest, 2018). Finally, documentation of malnutrition diagnoses has been associated with significant health care cost savings per hospital day per patient (Amaral, 2007).

Feasibility
eCQM feasibility testing/analysis conducted: Yes
Feasibility: For this measure, all elements are in defined fields in electronic sources, and some align with USCDI/USCDI+ Quality standard definitions. The eCQM was tested in three EHR systems (i.e., Epic, Cerner, and AllScripts) in 56 hospitals. The measure was highly feasible in the systems that were tested, and workflow changes were not reported as necessary for data collection.

Performance in Program

This measure was implemented in 2025; however, performance data are not yet available for analysis.

Citations (provided by developer)

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