Malnutrition Care Score®
An electronic clinical quality measure stewarded by the Academy of Nutrition and Dietetics

Malnutrition Care Score
Frequently Asked Questions
JULY 2025

For more information, visit https://www.eatrightpro.org/practice/quality-care/malnutrition-care-score or email quality@eatright.org

Common Abbreviations Used

CP – Credentialed Nutrition and Dietetics Practitioner

CMS – Centers for Medicare and Medicaid Services

DTR/NDTR – Dietetic Technician, Registered/Nutrition and Dietetic Technician, Registered

eCQM – Electronic Clinical Quality Measure

EHR – Electronic Health Record

ICD-10® – International Classification of Diseases, 10th Revision

LOINC® - Logical Observation Identifiers Names and Codes

MCS – Malnutrition Care Score

MO – Measure Observations

NCP – Nutrition Care Process

NCPT – Nutrition Care Process Terminology

RD/RDN - Registered Dietitian/Registered Dietitian Nutritionist

SNOMED-CT® - Systematized Nomenclature of Medicine - Clinical Terms

General Measure Questions

1. **What is an eCQM?**

   To learn more about eCQMs, visit CMS' eCQM webpage.

2. **What is Reporting Period, Submission Period, and Payment Period?**

   a. Reporting Period is the time CMS specifies, usually from January to December, when data is gathered

   b. Submission Period is the time CMS specifies when data is submitted, typically the last day of February of the specified calendar year

   c. Payment Period is the fiscal year that CMS specifies for payment to be received for prior year's submission of data

General Malnutrition Care Score Information

3. **Is the Malnutrition Care Score the same as the Global Malnutrition Composite Score?**

   Yes. The Global Malnutrition Composite Score measure title was updated to Malnutrition Care Score to better align with the measure's intent and improve clarity.

4. **What is the Malnutrition Care Score?**

   The Malnutrition Care Score (MCS) is an electronic clinical quality measure (eCQM) that evaluates the percentage of hospitalizations for adults aged 18 years and older at the start of the inpatient encounter, with a length of stay equal to or greater than 24 hours, who received optimal inpatient nutrition care during the current inpatient hospitalization. The MCS measure is constructed of four measure observations that are aggregated as an arithmetic average of eligible hospitalizations. Table 1 presents descriptions of the measure observations (MO) and associated calculations.

Table 1. Description of the MCS Observation Measures

Measure Observation	Description	Staff Involved	Notes
MO1: Malnutrition Risk Screening	Eligible encounters* where a Malnutrition Risk Screening was performed with an At Risk or Not At Risk Result OR a Dietitian Referral order was placed	Performed by any eligible practitioner	If this Measure Observation is not completed, measure performance stops
MO2: Nutrition Assessment	Eligible encounters where the most recent Nutrition Assessment was performed with an associated result of Well Nourished/Not Malnourished/Mildly Malnourished, Moderately Malnourished OR Severely Malnourished	Performed by an RD/RDN	Only in the setting of an At Risk screen result and/or a Dietitian Referral order
MO3: Malnutrition Diagnosis	Eligible encounters where a current Malnutrition Diagnosis was documented	Documented by a physician or other eligible provider	Only in the setting of a Moderate or Severe Malnutrition finding in MO2
MO4: Nutrition Care Plan	Eligible encounters where a current Nutrition Care Plan was documented	Performed by an RD/RDN	
MO5: Total Malnutrition Components Score	Measure Observation 1 + Measure Observation 2 + Measure Observation 3 + Measure Observation 4	Each measure observation receives a 1 if it was performed or a 0 if it was not performed	
MO6: Total Malnutrition Care Score as Percentage	$\left(\frac{\text{Total Malnutrition Component Score}}{\text{Total Malnutrition Composite Score Eligible Occurrences}} \right) \times 100$		
Facility MCS for a reporting period	$\frac{\Sigma \text{ Total Malnutrition Care Score as Percentage}}{\text{\# Eligible Hospitalizations in the Reporting Period}}$		

* An eligible encounter includes any inpatient visit with a patient aged 18 years or older, with a length of stay of 24 hours or more, as well as without a discharge disposition for hospice care or a hospice care order during the visit.

5. How is the MCS calculated?

As an electronic measure, the MCS is based on value sets that include terminology (e.g., ICD10®, SNOMED-CT®, LOINC®) and their respective codes. For each step described below to beincluded in the calculation, the selected Electronic Health Record (EHR) documentation template should be mapped or linked to a code in the value set representing the step. This is what ensures the step was documented. In addition,

the measure is built so that any of the steps can be documented in no specific order, as well as documented in an observation or emergency department visit linked to the inpatient visit or encounter. The MCS calculation is as follows:

Step 1) Determine if the visit qualifies as an eligible encounter:

- An eligible encounter is any inpatient visit that is 24 hours or more, for a patient aged 18 years or older, at the beginning of the encounter
- Any patient visit that has a discharge disposition for hospice care or with a hospice care order during the inpatient encounter, will be excluded from the calculation

Step 2) Calculate Measure Observation 1 (MO1): If the patient visit is an eligible encounter, then the measure evaluates if a malnutrition risk screening was performed and documented -OR- a Dietitian Referral was ordered for the eligible patient encounter.

- If a malnutrition risk screening was documented, with a result of Not at Risk -AND- there is NO Dietitian Referral ordered, the measure score for MO1 = 1 and the measure flow stops in MO1 (move to step 5)
- If a malnutrition risk screening was NOT documented -AND- there is NO Dietitian Referral ordered, the measure score for MO1 = 0 and the measure flow stops (move to step 5)
- If a malnutrition risk screening was documented, with a result of Not at Risk -AND- there is a Dietitian Referral ordered, the measure score for MO1 = 1 and the measure flow moves to MO2 (Step 3)
- If a malnutrition risk screening was NOT documented -AND- there is a Dietitian Referral ordered, the measure score for MO1 = 1 and the measure flow moves to MO2 (Step 3)
- If a malnutrition risk screening was documented, with a result of At Risk -AND- there is NO Dietitian Referral ordered, the measure score for MO1 = 1 and the measure flow moves to MO2 (Step 3)
- If a malnutrition risk screening was documented, with a result of At Risk -AND- there is a Dietitian Referral ordered, the measure score for MO1 = 1 and the measure flow move to MO2 (Step 3)

Step 3) Calculate Measure Observation 2 (MO2): if the patient had a malnutrition risk screening performed and the result was At Risk, and/or the patient has a Dietitian Referral (no matter the reason), the measure will require MO2. If there are multiple Nutrition Assessments during the same visit, this step will use the most recent Nutrition Assessment results and is calculated as follows.

- If there is NO Nutrition Assessment documented by a Registered Dietitian, the measure score for MO2 = 0 and the measure flow stops in MO2 (moves to step 5)
- If the most recent Nutrition Assessment documented by a Registered Dietitian has anutrition diagnosis of Well Nourished OR Not Malnourished OR Mildly Malnourished, the measure score for MO2 = 1 and the measure flow stops in MO2 (moves to step 5)
- If the most recent Nutrition Assessment documented by a Registered Dietitian has a nutrition diagnosis of Moderately Malnourished OR Severely Malnourished, measure score for MO2 = 1 and the measure flow moves to MO3 AND MO4 (step 4)

Step 4) Calculate Measure Observations 3 and 4 (MO3 and MO4, respectively): if the most recent Nutrition Assessment was documented by a Registered Dietitian with a nutrition diagnosis of Moderately Malnourished OR Severely Malnourished, the measure will require MO3 and MO4.

- MO3:
    i. If the patient has a documented Malnutrition Diagnosis, the measure score for MO3 = 1 and the measure flow moves to calculating MO4
    ii. If the patient does NOT have a documented Malnutrition Diagnosis, the measure score for MO3 = 0 and the measure flow moves to calculating MO4

- MO4:
    i. If the patient has a documented Nutrition Care Plan, the measure score for MO4 = 1 and the measure flow moves to calculating the Eligible Denominator (step 5)
    ii. If the patient does NOT have a documented Nutrition Care Plan, the score for MO4 = 0 and the measure flow moves to calculating the Eligible Denominator (step 5)
    iii. Step 5) Identify the value of the Total Malnutrition Care Score Eligible Occurrences as follows:
- If a Malnutrition Risk Screening was performed AND a Malnutrition Screening Not at Risk Result was identified AND Dietitian Referral was not ordered, then the Total Malnutrition Care Score Eligible Occurrences equals 1
- If an At Risk screening result OR a Dietitian Referral Order was present AND a "Nutrition Status of Well Nourished or Not Malnourished or Mildly Malnourished" was present, then the "Total Malnutrition Care Score Eligible Occurrences equals 2
- If an At Risk screening result OR a Dietitian Referral Order is present AND a Nutrition Assessment was not completed, then the Total Malnutrition Care Score Eligible Occurrences is 2
- If none of the above criteria are met, then the Total Malnutrition Care Score Eligible Occurrences is 4

Step 6) Calculate Measure Observation 5 (MO5) by adding the values calculated for Measure Observation 1 + Measure Observation 2 + Measure Observation 3 + Measure Observation 4. This step will result in a number between 0 and 4.

Step 7) Calculate Measure Observation 6 (MO6) by dividing the result of step 6 by the identified value in step 5 as follows:

- Total Malnutrition Care Score as Percentage (MO6) = Total Malnutrition ComponentsScore (MO5) ÷ Total Malnutrition Care Score Eligible Occurrences x 100
- This calculation will result in a percentage value of 0%, 50%, 75%, or 100%.
- This calculation is per qualifying patient encounter or visit and is what will be reported as a compilation of scores.

Step 8) To calculate the facility-wide aggregate score, the facility will need to add all the values for Total Malnutrition Care Score as Percentage in step 7 (MO6) and divide by the number of eligible encounters included in the report as shown below.

$$\frac{(\Sigma \text{ Total Malnutrition Care Score as Percentage})}{\text{\# Eligible Hospitalizations in the Reporting Period}}$$

6. **If a patient was admitted many times over a year, does each admission need to be evaluated individually?**

   Yes, for each eligible encounter during the measurement period, a new performance score is calculated.

7. **Are patients admitted under observation status included?**

   Patients admitted solely under observation status are not included. However, patients who begin their admission in observation status or the emergency department and transition to inpatient are included. Additionally, any activities completed during the emergency department and/or observation status visits are counted toward the completion of the measure observations.

8. **How do swing beds impact MCS performance?**

   Inpatient encounters with a length of stay of at least 24 hours and a patient at least 18 years of age, are included in measure performance, regardless of the patient's physical location. A swing bed admission not classified as inpatient, will not be included in the measure performance.

9. **How is the process affected by patients who are receiving hospice care?**

   This depends on what a facility defines as an inpatient encounter in its policies and procedures. Follow guidelines and regulations established by CMS and state/local agencies. Starting in CY 2026, the MCS will not include in the calculation any inpatient visit that has a documented discharge disposition for hospice care or a hospice care order.

10. **For large health systems, is this data submitted to CMS for an individual hospital or for a health system that has hospitals in numerous states?**

    Each individual facility reports quality measures independently. Reporting the MCS mirrors reporting of all other eCQMs. Consider reaching out to your local quality team for specific institutional details.

11. **How should hospitals interpret their MCS scores?**

    Higher scores indicate better performance, while lower scores indicate opportunities for improvement. Hospitals may internally monitor the performance of the MCS and four measure observations over time to facilitate quality improvement for patients who are malnourished or at risk of malnourishment.

12. How is the MCS used in CMS quality reporting?

The MCS is included in the CMS Hospital Inpatient Quality Reporting Program (Hospital IQR Program) and the Medicare Promoting Interoperability Program as one of three self-selected eCQM's for hospital reporting. The Hospital IQR Program is a voluntary, pay-for-reporting program with hospital performance tied to its Medicare Annual Payment Update (APU). To receive the full Medicare APU for the provided inpatient care, hospitals are required to report data to CMS on specific measures for high-volume and high-cost health conditions.

13. Can hospitals view their MCS performance online?

The Hospital IQR Program publicly reports quality of care data on the Medicare Care Compare website under the "Hospitals" section. Refer to the CMS Hospital IQR Program website for additional information on all aspects related to the program's use of the MCS.

14. What information is used to calculate the MCS?

Fifteen data elements are used to calculate the GMCS (Table 2), all readily available in electronic health records (EHRs). Of those 15 elements, four are used to calculate other eCQMs, leaving 11 elements unique to the MCS. Table 2 depicts several linked data elements, meaning they are collected simultaneously.

Table 2. GMCS Data Elements

GMCS Data Element & Attributes*	#1 Screen	#2 Assess	#3 Diagnose	#4 Care Plan
Encounter Type+	√	√	√	√
Inpatient Admission Time+	√	√	√	√
Inpatient Discharge Time+	√	√	√	√
Date of Birth+	√	√	√	√
Completed Malnutrition Risk Screening	√	√		
Completed Malnutrition Risk Screening Time Stamp	√	√		
Completed Malnutrition Risk Screening Result	√	√		
Dietitian Referral	√	√		
Completed Nutrition Assessment		√	√	√
Completed Nutrition Assessment Time Stamp		√	√	√
Completed Nutrition Assessment Result			√	√
Documented Malnutrition Diagnosis			√	
Completed Malnutrition Diagnosis Time Stamp			√	
Completed Nutrition Care Plan				√
Completed Nutrition Care Plan Time Stamp				√

*Readily available in the EHR | +Data elements used in other eCQMs | Same color bundle indicate linked data elements

Completion of Measure Observations

15. Can a nutrition risk screening be completed more than once during a hospital encounter? If the results differ, which screening result counts for the measure?

Screening may take place more than once in one inpatient encounter. Current measure logic or flow prioritizes a Not at Risk result at any time during the encounter, regardless of the timing. However, the presence of a Dietitian Referral Order supersedes the Not at Risk result and allows for performance measurement of additional measure observations.

16. What if malnutrition risk screening does not identify risk for malnutrition but malnutrition is identified later in the admission?

In the instance of a Not At Risk malnutrition risk screen result, MCS performance measurement stops, regardless of completion of additional measure observations, with a performance score of 100%. However, the presence of a Dietitian Referral can allow for performance measurement of additional measure observations despite the Not at Risk result. Note that performance measurement should not necessarily dictate appropriate care in this setting. Refer to local policies and procedures to ensure care provision aligns with expectations.

17. What is the role of a Dietitian Referral in calculating performance for the episode?

A Dietitian Referral has multiple functions in calculating performance for the episode as described below:

- Counts as completion of Measure Observation 1, Malnutrition Risk Screening
- Queues the RD/RDN to conduct a nutrition assessment, even in the setting of a Not At Risk Result from the Malnutrition Risk Screening

18. How is the MCS encounter performance impacted when an RD/RDN nutrition diagnosis differs from that of the physician and another eligible provider?

Assuming the presence of an At Risk Result from Malnutrition Risk Screening:

- If the RD/RDN documents a nutrition diagnosis of "Not Malnourished or Mildly Malnourished", then the physician's or eligible clinician's malnutrition diagnosis is not included in the measure performance.
- If the RD/RDN documents a nutrition diagnosis of Moderate or Severe Malnutrition, the physician or eligible clinician's documented malnutrition diagnosis is included towards completion of Measure Observation 3, regardless of the alignment of malnutrition severity.

19. What if there are multiple Nutrition Assessment documented in the same eligible encounter or visit?

For Reporting Period CY 2026, the measure will prioritize the result of the most recent documented nutrition assessment. This means that the inclusion of MO3 and MO4, and the value of the Eligible Malnutrition Care Score Occurrences, will be based on the result of the most recently documented nutrition assessment.

20. Do specific tools need to be used for completing the malnutrition risk screening and nutrition assessment?

No, the MCS does not require the use of specific malnutrition risk screening or nutrition assessment tools. However, clinicians are encouraged to use valid and reliable tools for accurate and reproducible results.

21. The Malnutrition Risk Screening Value Set contains only codes specific to the NRS 2002 screening tool, along with a few generic codes. Is there a reason only this screening tool is included there?

There is no requirement to use the NRS-2002 screening tool. Any of the codes available in the value set can be used.

22. Where are the data elements used to calculate MCS observations documented in an EHR?

The location of each observation in the EHR varies by institution. The locations of the data elements, best practices for documentation, and potential changes to the EHR build will be organization specific. Consider partnering closely with your organization's information technology staff to ensure the data elements corresponding to each observation are mapped to the correct location.

23. Some EHR systems do not have NCP terms from the value sets included. How can leaders ensure the inclusion of these codes in the EHR in a structured and easily captured format when the EHR decisions are not often made at the local level?

Mapping discrete fields to appropriate codes designated in value sets is typically completed by IT staff and is usually not visible to front-end clinical users. If discrete fields already exist as part of a malnutrition care workflow, mapping these fields is relatively straightforward. If discrete fields do not already exist, demonstrating the value of standardized terminology in these fields to leadership is key to ensuring an optimal EHR build and optimal malnutrition care.

24. Do standing orders for Dietitian Referrals count as the Dietitian Referral in Measure Observation 1 and, hence, towards completion of the Nutrition Risk Screening?

Yes. A service line standing order for a Dietitian Referral should be able to count towards MO1. For this to count, the facility needs to ensure that the service line standing order is linked to the value set assigned to Observation Measure #1 to ensure the completion of the requirement is met.

25. Are Nutrition and Dietetic Technicians, Registered (NDTRs), eligible to complete any measure observations?

Yes! NDTRs are considered eligible professionals for completion of Malnutrition Risk Screening. Other eligible clinicians that may complete the malnutrition risk screening include Certified Dietary Managers (CDMs), nursing assistants (NAs), or any other individual based on professional scope, as well as state, local, and organizational regulations, policies, and procedures.

26. Why is the diagnosis of mild malnutrition not included?

The MCS encourages the use of valid and reliable malnutrition risk screening and assessment tools to help ensure the delivery of best practices and high-quality nutrition care. There arecurrently no validated criteria to diagnose mild malnutrition in adults. Therefore, this diagnosis is not included in the composite score for measure observations 3 and 4.

27. Does the nutrition assessment need to be completed within 24 hours of the malnutrition screen?

There is no timing element for any of the measure observations. They can be completed in any order at any time during the eligible encounter. Measure observations simply must be completed during the inpatient encounter and/or during the related observation or ED encounter. The nutrition screen does not need to be completed within 24 hours of inpatient admission. However, it does need to be completed within that admission (inpatient encounter).

28. Can dietetic interns complete Measure Observations 2 and 4, if an RDN cosigns the note?

This will be based on your state regulations and facility policies. However, it is specified that the measure observations must be completed by an RDN. An intern does not qualify as a fully credentialed RDN. If the RDN is cosigning, policies and regulations should specify that the RDN has reviewed the case and agrees with the assessment and nutrition care plan.

29. Does a malnutrition diagnosis during admission and prior to the screening and assessment count towards Measure Observation 3: Malnutrition Diagnosis?

Yes, if a diagnosis is active at some point during the encounter, it counts toward measure performance regardless of the timing in relation to other measure observations. It is important to note that, for this observation to be included in the calculation, Malnutrition Risk Screening must yield a result of "At Risk" and/or a Dietitian Referral order must be present along with a result of Moderate or Severe Malnutrition from the Nutrition Assessment.

30. What sources will be used to capture the physician's diagnosis of malnutrition?

The source used to capture the physician's diagnosis is the location of the physician's note or documentation that contains the diagnosis that has been identified by the mapped data element during the implementation process. Therefore, it is important that the diagnosis codes are mapped to the correct value set code in your EHR. Please work with your documentation/IT specialist to understand how your facility will map each observation.

31. What exactly will qualify for meeting the criteria for the Nutrition Care Plan? Is there specific language that needs to be included to count towards the score?

The Nutrition Care Plan structure used to address malnutrition can be defined at the institutional level. For MCS, specific value sets define the concepts required in documentation to meet the requirements. The value sets for the care plan can be found on VSAC. Your IT team needs to ensure this RDN documentation observation is mapped to the corresponding MCS observation data element and selected value set. The corresponding LOINC® codes are intentionally broad so implementers can map other reliable and valid tools that lack specific LOINC® codes.

The Care Plan should include an individualized strategy to support the patient in improving their malnutrition status, which may or may not include local resources. The Care Plan is the NCP nutrition intervention or could be any other note template deemed appropriate to support documentation and coding. As part of the normal workflow, often the RDN completes the nutrition assessment and nutrition care plan at the same time.

32. Is there a benchmark for aggregate scores that hospitals should be looking to achieve?

Because MCS is a new eCQM, there is no established benchmark. However,higher scores indicate better performance. Individual hospitals should establish their own benchmark and use the observation scores of nutrition screening, assessment, care plan, and malnutrition diagnosis to identify quality improvement projects. One of the goals of the eCQM program is to always strive to improve upon the original score.

Reporting on the Malnutrition Care Score

33. How should hospitals support the implementation of the MCS in their EHRs?

The MCS eCQM is specified for use in EHRs. The machine-readable specifications are available on the Electronic Clinical Quality Improvement (eCQI) Resource Center. To support MCS implementation into a hospital EHR, refer to the following resources for the GMCS on the eCQI Resource Center and applicable to Reporting Period Calendar Year 2026. Specifications for the MCS applicable to Reporting Period CY 2026 can be found here.

34. Is there a monetary cost to implementers for reporting eCQM performance data to the Hospital IQR or Medicare Promoting Interoperability Programs?

CMS does not charge hospitals to report performance data for any eCQM, including MCS. However, some hospitals partner with third-party organizations or vendors to build/customize EHRs, generate performance reports, map data elements needed to calculate an eCQM, and/or report performance. Costs are typically associated with these services.

35. Because the MCS is an eCQM, will the criteria from the four observations be automatically extracted from the hospital's EHR?

No. The eCQM data elements and logic mapped into an EHR are not automatically extracted or pulled from a hospital EHR. Rather, performance data are extracted by hospitals or third-party vendors for submission to CMS based on reporting requirements and the mapping or link of the data elements to the value set.

36. If a hospital does not self-select the MCS as one of its voluntary eCQMs, will the hospital's payment determination be affected by its performance on the MCS?

Performance on the MCS will not affect hospitals' payments whether they self-select to report on the measure or not. A hospital's payment is based upon submitting the appropriate data following the mandatory timeline for the mandatory and self-selected measures. Failure to submit a data set by its corresponding due date results in failure to meet the Hospital IQR Program requirements, thereby resulting in a payment reduction.

37. What gaps in care for malnutrition may still exist even after implementing the MCS? How can CPs help improve these gaps?

Reporting on the MCS does not necessarily imply high performance or comprehensive nutrition care for patients with malnutrition in the hospital. Therefore, implementing quality improvement (QI) processes prior to reporting on the measure can help to optimize performance. Following the steps presented in the MQii Toolkit can help inform the causes of gaps in care and offer steps to fill them. Additional information can also be found here.

38. What impact will this measure have on Joint Commission surveys?

Reporting on the MCS specifically does not tie directly to the Joint Commission or other regulatory body surveys. However, providing high-quality, standardized malnutrition care is likely to aid facilities in meeting specific regulatory standards related to nutrition screening and assessment.

Resources

39. What resources are available for learning more about the MCS and how to calculate the score?

The MCS page, under the MCS Implementation Resources section, has the following resources applicable to each Annual Update Cycle:

- CMS Specifications and Value set link from the eCQI Resource Center
- Specification Manual
- Frequently Asked Questions
- Process map for a visual depiction of the measure progression based on measure observations completed and documented, and their respective results.
- Possible Combinations Table for clinical scenarios and corresponding performance scores.
- Measure Score Calculator (for Reporting Period Calendar Year 2025)

40. Where can I go to find out more about eCQMs?

This website provides more information regarding eCQMs: Latest News | eCQI Resource Center (healthit.gov)

41. How do I get access to the Value Sets?

Value set access requires a UMLS account to access the Value Set Authority Center (VSAC). It can be requested here: https://uts.nlm.nih.gov/uts/signup-login.

42. If I have feedback or recommendations for future Annual Updates, where can I share them?

Anyone can submit JIRA tickets asking questions or recommending changes to any measure.

43. What if I have additional questions?

- Quality/Process improvement support: https://www.eatrightpro.org/practice/quality-care/quality-management or quality@eatright.org
- Nutrition Care Process and Terminology support: https://www.eatrightpro.org/practice/nutrition-care-process/ncp-terminology or ncp@eatright.org
- Interoperability and Health Information Standards: https://www.eatrightpro.org/practice/dietetics-resources/interoperability-and-health-information-standards/hlf-fhir or ncp@eatright.org
- MCS implementation support: https://www.eatrightpro.org/practice/quality-care/malnutrition-care-score or quality@eatright.org