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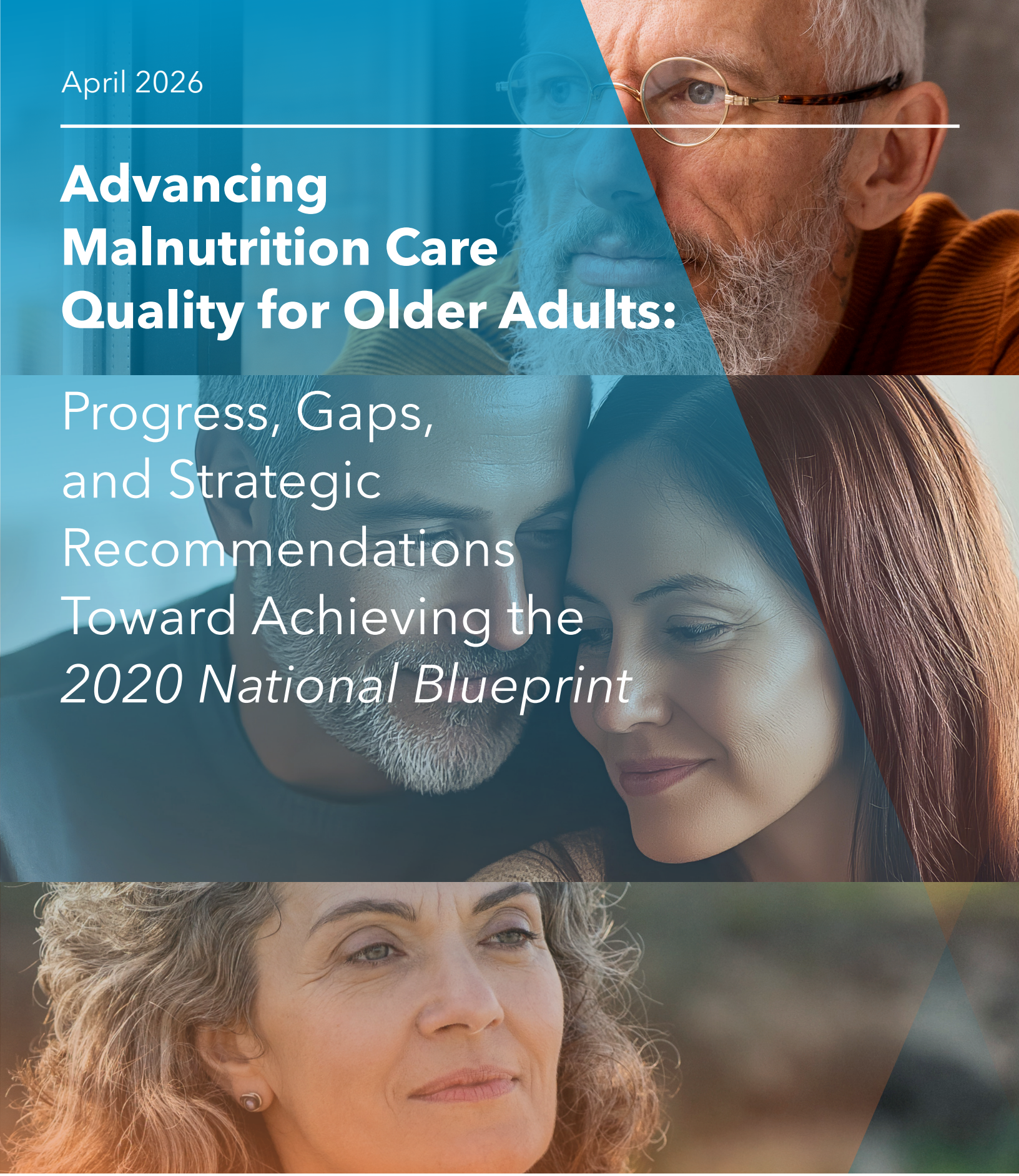
# Advancing Malnutrition Care Quality for Older Adults:

## Progress, Gaps, and Strategic Recommendations Toward Achieving the *2020 National Blueprint*



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# Executive summary

Malnutrition among older adults remains a prevalent and preventable driver of poor health outcomes, avoidable hospitalizations, and higher healthcare costs across the U.S. healthcare system.[1] Although nutrition is recognized as a critical factor for healthy aging, malnutrition remains inconsistently identified and treated, limiting progress towards population health and value-based care goals for Medicare-eligible populations.[2] Evidence increasingly demonstrates that early screening, timely identification, and coordinated nutrition interventions can prevent adverse outcomes and reduce downstream costs for older adults.[3]

In 2020, Defeat Malnutrition Today and the Malnutrition Quality Improvement Initiative (MQii), in collaboration with a multidisciplinary coalition of public and private stakeholders, released the latest iteration of the *National Blueprint for Achieving Quality Malnutrition Care for Older Adults* (2020 update).[4] This National Blueprint established a framework to improve the prevention, identification, and treatment of malnutrition across public and private payers, acute care, post-acute care, and community settings. It outlined four goals: (1) improve quality of malnutrition care practices, (2) improve access to high-quality malnutrition care and nutrition services, (3) generate clinical research on malnutrition quality of care, and (4) advance public health efforts to improve malnutrition quality of care. Five years have elapsed since the National Blueprint's goals and calls for action were issued; therefore Avalere conducted an assessment to determine where and how much progress has been made, where gaps persist, and how the current Administration's focus on nutrition, wellness, and prevention presents an opportunity to accelerate progress.

Overall, the most significant progress has occurred in the acute care setting, driven by the adoption of standardized malnutrition processes related to MQii's efforts around the integration of the Malnutrition Care Score (MCS) formerly known as the Global Malnutrition Care Score (GMCS), into Centers for Medicare and Medicaid Services (CMS) hospital quality reporting. This increased awareness, improved documentation, and embedded malnutrition care into inpatient workflows, demonstrating the value of aligned quality measurement to drive practice change.

Despite this progress, substantial gaps remain. Post-acute, community, and ambulatory settings continue to face fragmented care transitions, limited follow-through on hospital-initiated nutrition plans, data silos that inhibit measurement and accountability, and persistent nutrition workforce shortages. These challenges undermine continuity of care and prevent malnutrition interventions from delivering sustained benefits across the care continuum, particularly for older adults with complex nutrition needs.

Building on these findings, there remains a clear opportunity for CMS, the CMS Innovation Center, and other policy stakeholders to strengthen malnutrition care across settings. Actions should build on existing CMS momentum by incentivizing and expanding the use of malnutrition quality measures beyond acute care, supporting improvements in transitions of care, addressing workforce capacity, and enhancing data infrastructure. These tactical recommendations are intentionally designed to align closely with CMS priorities[1-3] related to prevention, nutrition, and wellness within a value-based framework.

*The Defeat Malnutrition Today coalition is a diverse alliance of stakeholders that share the goal of achieving the recognition of malnutrition as a key indicator and vital sign of health risk.*

*The Malnutrition Quality Improvement Initiative (MQii) is a learning collaborative led by Avalere Health that seeks to advance evidence-based, high-quality patient-driven care for adults who are malnourished or at risk for malnutrition.*

# Introduction

Malnutrition is a leading cause of poor health outcomes among older adults in the United States,[4] as it can exacerbate chronic illnesses, complicate acute disease, increase risks of infection, impair wound healing and surgical recovery, increase risk of falls, lead to functional decline, and ultimately increase mortality.[7,8] While proper nutrition plays a critical role in health outcomes across the lifespan, its importance is heightened for older adults, for whom malnutrition and limited access to nutrition services have a greater impact on health outcomes compared to younger populations.[4,6] These impacts not only diminish quality of life, but also significantly elevate healthcare utilization and costs.[5,6] Importantly, malnutrition among older adults is largely preventable through early screening, timely identification, and connection to appropriate nutrition and community-based interventions.

Recent national attention has further elevated malnutrition as a critical and preventable issue. As highlighted in a recent Washington Post analysis, deaths attributed to malnutrition have risen sharply in the United States, particularly among adults age 85 and older[7]. This is driven in part by improved recognition, reporting, and clinical diagnosis of malnutrition. This increased visibility highlights both the severity of the problem and the opportunity to intervene earlier to prevent avoidable adverse outcomes among older adults.

Recently, the Administration has also elevated nutrition and prevention as a central component of its broader health agenda, recognizing nutrition as a key lever for improving population health and advancing healthy aging. This emphasis has been reinforced through increased alignment between the U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (HHS), creating a timely opportunity to better coordinate nutrition policy, programs, and guidance across healthcare and community settings. The Administration's continued support for evidence-based Dietary Guidelines further emphasizes the role of nutrition in disease prevention, wellness, and longevity, particularly for older adults who experience the greatest burden of nutrition-related risk.[8]

In 2017, Defeat Malnutrition Today and the Malnutrition Quality Improvement Initiative (MQii) co-led a multidisciplinary group of coalition members and other stakeholders to produce the *National Blueprint for Achieving Quality Malnutrition Care for Older Adults*,[9] with an update and revision published in 2020. The 2020 update outlined specific goals for high-quality malnutrition care across the continuum of acute, post-acute, and community settings while also serving as a strategic and tactical resource for policymakers, healthcare providers, patients and caregivers, and public and private payers. Importantly, the National Blueprint also emphasized prevention-focused strategies, including screening, timely identification, strengthened transitions of care, and connections to community-based resources, to reduce adverse outcomes and support wellness and healthy aging.

**Figure 1: *The National Blueprint* outlined four primary goals for addressing malnutrition and improving outcomes in older adults:**

**1 Improve quality of malnutrition care practices across all care settings.**

High-quality prevention, identification, and treatment of malnutrition with emphasis on transitions of care will greatly reduce costs and improve malnutrition-associated outcomes. Establishing a comprehensive set of care standards to be adopted by nutrition professionals, other healthcare providers, and social services personnel in all settings of care lays the foundation to improve malnutrition care and related patient outcomes for older adults.

**2 Improve access to high-quality malnutrition care and nutrition services.**

Integration of nutrition services in payment and delivery models will align incentives and reduce access barriers to quality malnutrition care. Increased awareness and adoption of best practices are needed to ensure that older adults can access needed malnutrition care and follow-up nutrition services in a timely and efficient manner. This includes enhancing access to dietitians and other professionals trained in malnutrition care (particularly through provider referrals) and better nutrition care options in all care settings.

**3 Generate clinical research on malnutrition quality of care.**

Research is critical to address the evidence gaps in understanding the most effective methods of malnutrition prevention, identification, and treatment. Evidence generation should focus on determining the impact on health outcomes of older adults, clinical practices, program delivery, and healthcare expenditures in order to establish a stronger knowledge base for quality improvement strategies in each care setting.

**4 Advance public health efforts to improve malnutrition quality of care.**

While malnutrition is a major public health issue affecting a significant portion of the population, the prevalence and impact of malnutrition is not well known by key stakeholders in the healthcare ecosystem. Because of its prevalence as a public health issue and impact on costs, there is a need for greater awareness and action from all healthcare stakeholders, and elevation of the importance of malnutrition as a public health priority.

To understand the progress made against these goals since the 2020 publication, as well as the outstanding gaps, Avalere conducted background research and interviewed seven key experts in malnutrition care and policy, representing acute care providers, post-acute providers, community partners, payers, and researchers. Participants were selected based on their professional experience, subject-matter expertise, and direct involvement in malnutrition-related programs, policy development, research, or implementation efforts. Interviewees provided insights into progress made since the release of the 2020 National Blueprint, identified persistent gaps and barriers to high-quality malnutrition care, and offered perspectives on emerging opportunities to strengthen prevention, screening, care coordination, and access to nutrition services. Findings from these interviews were synthesized alongside background research to inform the evaluation of progress to date and shape the recommendations outlined in this report. After analyzing the findings, we have detailed our assessment, including the implications of the progress made and the current state of malnutrition care, and outlined specific tactical recommendations for providers, payers, and policymakers to leverage high-impact strategies such as quality measures, value-based payment programs, and improvement initiatives to continue progress.

Recent attention from CMS to nutrition, preventive services, and care coordination, particularly within Medicare Advantage (MA), along with broader federal efforts to support interoperability and health system transformation, reflects growing momentum and opportunity to advance access to malnutrition care for older adults.

# Progress since publication of the *2020 National Blueprint*

## Payers

Since the release of the 2020 update of the National Blueprint for Achieving Quality Malnutrition Care for Older Adults, payers have made incremental changes to better incentivize and integrate malnutrition care, primarily through quality measures and nutrition-focused benefits.[10–13] We identified growing recognition of clinical value, including increased adoption of nutrition-related supplemental benefits in MA and pilots involving medically tailored meals. Other notable progress includes integration of nutrition care through broader coverage in certain MA plans, telehealth expansion, expanded nutrition education through Medicare wellness programs, and emerging technology-driven efforts such as Humana's Nutrition & Wellness Portal[14] that illustrate potential for payer-driven nutrition innovation. As federal priorities have evolved, approaches to improving access to nutrition services have varied, and progress in addressing malnutrition through nutrition service coverage and delivery has differed across programs and settings. At the same time, inconsistent screening practices, fragmented data sharing, and variable medical nutrition therapy (MNT) coverage by state[15] continue to hinder access. The U.S. Government Accountability Office found that as of 2022, about one-third of MA plans offered newer types of supplemental benefits (such as food & produce), but data on enrollees' utilization of such benefits remain limited, reflecting challenges related to data capture and variable reporting.[16]

There also remains a need for stronger alignment between public and private payers around nutrition-focused quality measures, such as potential expansion of MCS concepts beyond the inpatient setting and for the development of interoperable data systems to enable accountability across settings. Without greater alignment on clinical nutrition-focused measures of quality and more complete encounter data, it remains difficult for payers to fully assess the impact of supplemental nutrition benefits and to identify opportunities to link malnutrition care with quality outcomes. Additionally, coordinated investment in malnutrition education resources could strengthen prevention, empower caregivers, and improve outcomes for older adults.

## Acute care providers

Acute care has seen the broadest progress since 2020, anchored by the integration of the MCS (formerly known as GMCS) into hospital quality reporting. The adoption of the MCS[12] through CMS's Inpatient Quality Reporting Program in 2024 was a major milestone that has elevated malnutrition from an underrecognized condition to a measurable component of hospital quality performance. Further reinforcing this momentum, the FY 2026 Inpatient Prospective Payment System Rule included a CMS Request for Information (RFI) seeking input on "tools and measures that assess optimal nutrition and preventive care" within hospital quality and value-based care programs.[17]

Together, these policy developments have expanded access to malnutrition screening, assessment, diagnosis, and intervention within the inpatient setting and reinforced nutrition as a core element of hospital care. Stakeholders interviewed for the assessment consistently reported increased clinical awareness of malnutrition, improved documentation workflows, and stronger integration of registered dietitian nutritionists (RDNs) into interdisciplinary hospital care teams. Interviewees described the MCS as a major driver of change, noting that malnutrition screening and assessment are now more frequently embedded into routine inpatient workflows.

These advances align with broader public health and professional initiatives led by organizations such as the Academy of Nutrition and Dietetics (Academy), the American Society for Parenteral and Enteral Nutrition (ASPEN), and the MQii, which support the standardization of evidence-based practices and dissemination of clinical guidance within hospitals. The Academy and ASPEN published malnutrition care workflows offering clinical guidance for providing evidence-based nutrition care to hospitalized patients at risk of or experiencing malnutrition, and ASPEN and MQii developed toolkits to support interdisciplinary implementation of malnutrition screening across healthcare stakeholders.[6,18]

Caregiver education resources focused on post-discharge needs have also demonstrated potential for advancing malnutrition care. For example, The Administration for Community Living (ACL) released a Caregiver Nutrition Education Toolkit in 2020 to guide nutrition care for older adults leaving acute care, while ASPEN and Area Agencies on Aging (AAA) offer complementary professional and community-based training materials.[19,20] Community-based programs further illustrate this continuum of care. In 2022, Meals on Wheels partnered with Johns Hopkins to reduce hospital readmissions by providing three months of transitional support services, including meal delivery, home safety inspections, social engagement, and medical supplies.[21]

Despite this broad progress, interviewees also emphasized that the progress will not lead to meaningful long-term impact without systematic advances in post-discharge care. Persisting gaps include variable inclusion of nutrition information in discharge planning, limited closed-loop referral pathways to post-acute and community providers, and insufficient mechanisms to track whether nutrition care plans initiated in the hospital are implemented and sustained after discharge. These challenges are worsened by differences in electronic health record (EHR) capabilities and documentation practices between hospitals and post-acute settings, as well as limited interoperability. Without parallel advances in care transitions and accountability beyond the hospital setting, gains achieved through inpatient quality improvement risk to dissipate once patients return to post-acute care or the community.[22]

## Post-acute care providers

Malnutrition care is inherently cross-continuum: to effectively treat the condition, diagnosis and care planning begun in hospitals must carry through to post-acute settings, home health, ambulatory care, and community-based services. Without shared data standards, clear accountability for transitions, and aligned incentives, care plans can be lost at handoffs and reduce the likelihood that older adults receive timely and adequate nutrition interventions after discharge.[14,15,16]

Post-acute care, particularly skilled nursing facilities and home health, was consistently identified as the weakest link in the malnutrition care continuum. Post-acute progress was limited due to workforce shortages (especially RDN availability), inconsistent documentation systems relative to hospitals, and a lack of standardized malnutrition quality measures that could create accountability for screening, intervention, and follow-up beyond minimum requirements.

Although skilled nursing facilities are required to conduct nutrition-related patient assessments through the Minimum Data Set (MDS), validated tools like the MNA and SGA are now embedded in national guidelines, and screening is becoming more routine,[23] interviewees emphasized that these requirements alone are insufficient to drive high-quality malnutrition care. In the absence of standardized malnutrition quality reporting requirements or aligned payment incentives, post-acute providers lack clear incentives to focus on comprehensive nutrition-related patient assessments, individualized care planning, and ongoing reassessment.

Workforce constraints worsen these challenges; stakeholders noted that dietitians are often not available on a daily basis in nursing facilities or home health settings, limiting the ability to conduct timely assessments or adjust care plans as patients' conditions change. This is important because direct care workforce shortages have caused the average length-of-stay in post-acute

care to increase by 20% for hospital patients being sent to these settings.[24] Such delays are associated with poor health outcomes and stem from shortages in both acute and post-acute care.

Operational and care coordination barriers also weaken continuity in the acute-to-post-acute care transition. Post-acute care facilities may lack the staffing, training, or clinical infrastructure needed to conduct comprehensive nutrition assessments, and nutrition diagnoses or goals established during hospitalizations are not always effectively communicated or translated into post-acute care plans. For example, although an estimated 20-50% of patients are malnourished when they are admitted to hospitals, less than 9% have a malnutrition diagnosis when they are discharged, exposing a gap in discharge documentation and communication for malnutrition.[25,26] These gaps are exacerbated by limited systems interoperability between hospitals and post-acute providers.

Without targeted policy action to address workforce capacity, documentation standards, and accountability mechanisms in post-acute settings, gains achieved through hospital-based quality initiatives are unlikely to translate into sustained improvements in outcomes for older adults.

## Community providers

Community-based organizations and public health programs have made some progress in addressing malnutrition among older adults, driven by advocacy and expanded efforts in education, malnutrition risk screening, caregiver supports such as home-delivered meals, and counseling. These efforts, often supported by programs administered through the Administration for Community Living (ACL) within the U.S. Department of Health and Human Services (HHS) and community nutrition networks, play a critical role in supporting access to nutrition services, addressing functional limitations, and managing nutrition risk beyond the clinical setting. Notably, the 2020 reauthorization of the Older Americans Act (OAA) explicitly added malnutrition to the purpose of the Act and requires state and area plans on aging to address malnutrition, with an emphasis on malnutrition screening and intervention.[27]

ACL administers and disseminates a range of public resources, including guides, presentations, and research materials on malnutrition care. These resources explain the impact of malnutrition and provide actionable steps for providers, individuals, and caregivers. Through the Nutrition and Aging Resource Center, ACL offers targeted toolkits and technical assistance to support OAA nutrition programs, including guidance on implementing malnutrition risk screening.[19,28] ACL also provides resources to community-based organizations like AAAs and Aging and Disability Resource Centers (ADRC), which play a key role in helping older adults move from institutional settings back into their communities. AAAs connect older adults with essential services such as home-delivered and congregate meals, while ADRCs acts as a central point of entry to a wide range of long-term services and supports, including nutrition services, by providing information and referrals to appropriate providers.[4,29,30]

Other organizations such as the Academy and ASPEN have developed evidence-based guidelines for the prevention and treatment of malnutrition in older adults. These guidelines endorse using validated screening tools like the Malnutrition Universal Screening Tool (MUST), Malnutrition Screening Tool (MST), and Mini Nutrition Assessment (MNA-SF) for older adults in community settings.[31,32] Community-based organizations such as AAA connect older adults to programs like congregate meal programs, Meals on Wheels, and Supplemental Nutrition Assistance Program (SNAP).[33]

Despite these advances, community-based nutrition efforts frequently operate outside of clinical data systems and are weakly integrated with healthcare delivery. Limited interoperability, inconsistent communication, and lack of closed-loop communication and interoperable electronic referral systems between clinical settings and community-based organizations (CBOs) create significant barriers to effective malnutrition care

between healthcare providers and community-based interventions.[34] ACL's Innovations in Nutrition (INNU) grant program has begun to address these gaps, including projects focused on continuity of nutrition care for individuals with malnutrition, such as a FY 2023 study examining cross-setting coordination.[4]

Workforce and capacity challenges further impede comprehensive and high-quality community-based malnutrition care. Interviewees highlighted variability in staffing capacity, training, and reimbursement mechanisms across community organizations, which can limit consistent implementation of evidence-based nutrition interventions. These challenges are particularly pronounced in communities with limited access to care and rural communities, where resource limitations coincide with higher rates of malnutrition risk. Additionally, shortages of community-based RDNs limit access to medical nutrition therapy, a specialized area of nutrition practice that involves the use of individualized nutrition interventions to treat or manage medical conditions and diseases, in many areas. Expansion of telehealth services represents an opportunity to help address these gaps and strengthen continuity of nutrition care.[34]

Policy factors also influence the ability of community programs to meet the nutritional needs . The recently passed One Big Beautiful Bill Act[35] includes changes to SNAP funding through fiscal year 2034, which may pose ongoing challenges for maintaining access to nutrition services  or older adults at nutrition risk and other vulnerable populations.

Achieving long-term impact will require stronger clinical–community integration, including shared data standards, clearer referral pathways, and workforce development strategies that support coordinated, evidence-based care pathways for older adults at risk of malnutrition. Building on OAA requirements, ACL-supported resources, and innovation grants, stronger alignment between healthcare and community nutrition systems can enhance continuity of care, improve access, and ensure that nutrition interventions initiated in clinical settings are reinforced and sustained in the community.

## Cross-cutting themes and milestones

Across stakeholder sectors, several cross-cutting themes and milestones emerged from the assessment. Nutrition care has gained meaningful traction nationally, most notably in the acute care hospital setting, but achieving full, sustained impact will require stronger alignment across care settings, clearer accountability for results, and coordinated multi-stakeholder action.

A key milestone since the 2020 National Blueprint has been the adoption of the MCS[12] into hospital quality reporting. Stakeholders consistently identified this integration as a major achievement that has accelerated awareness, standardized workflows, and driven measurable practice change in acute care. The MCS illustrates how quality measurement can serve as a catalyst for embedding nutrition into routine clinical operations.

At the same time, stakeholders emphasized that progress in hospitals alone is insufficient to improve outcomes for older adults. Persistent challenges, particularly fragmented data systems and inconsistent care transitions, remain barriers to system-wide impact. Without shared workflows and bidirectional communication across settings, nutrition diagnoses, goals, and care plans established during hospitalization are often not carried forward into post-acute, home health, or community-based care. Addressing these gaps is essential to ensuring access, continuity, and accountability in malnutrition care across the continuum.

## Remaining Gaps and Barriers

### Policy and Payment Limitations

Policy and payment structures continue to evolve alongside advances in malnutrition care. While CMS adoption of the MCS in hospital quality reporting has created an incentive for screening and intervention in acute care, comparable levers have not yet been broadly implemented in post-acute, ambulatory, and community settings.

Stakeholders have noted that payer interest in nutrition

has grown, particularly within MA, supplemental benefits, pilot programs, and emerging "food as medicine" initiatives,[36,37] but implementation remains inconsistent and fragmented. One interviewee observed that although nutrition is increasingly discussed, policy mechanisms have not fully evolved to support sustained care beyond hospitalization:

Without standardized quality measures or clear expectations for follow-up care, nutrition initiatives in post-acute and community settings often rely on discretionary plan design and can fall short.

> "Practitioners know how to do the right thing, but policy hasn't always caught up with how to deliver the services we need once you leave the hospital setting."

Further, lacking consistent coverage pathways and quality-linked incentives for nutrition services after discharge, providers can face limited motivation and resources to invest in workforce, infrastructure, and care redesign outside hospitals. This contributes to variability in access and implementation across settings and populations, undermining continuity of care and limiting the ability of malnutrition interventions to deliver sustained improvements in access and outcomes for older adults.

## Clinical Practice Challenges

Clinical practices related to malnutrition care vary widely by site of care. In hospitals, MCS-driven workflows have improved consistency and awareness. As one interviewee noted,

> "The adoption of the quality measure was a huge driver for malnutrition nationally...hospitals are now recognizing and documenting malnutrition more consistently and nutrition care is more integrated into the interdisciplinary care plan process."
>
> *– Angela Lago*

In contrast, post-acute settings struggle to operationalize comprehensive nutrition care. Although many skilled nursing facilities complete required assessments, these alone are often insufficient to trigger consistent intervention or follow-up. As one interviewee explained,

Without the regulatory or quality frameworks enforcing comprehensive actions, post-acute providers lack both the incentives and the structural support needed to move beyond minimum compliance toward proactive, evidence-based nutrition management.

> "Skilled nursing facilities are not always staffed with dietitians to perform nutrition assessments and care plans on a daily basis."
>
> *– Angela Lago*

Community-based providers face similar variability, with wide differences in screening tools, documentation practices, and access to nutrition expertise. Many community organizations deliver critical services, such as nutrition education, counseling, and meal support, but operate outside clinical workflows and data systems. Limited integration with healthcare providers and uneven workforce capacity constrain consistent application of evidence-based nutrition practices and make it difficult to sustain interventions over time. Together, these variations across settings contribute to fragmented care delivery and weaken continuity for older adults who are malnourished or at risk of malnutrition as they move through the healthcare system[38].

## Care Coordination and Transitions of Care

Breakdowns in care coordination represent one of the most persistent and consequential barriers to improving malnutrition outcomes across the continuum of care. Interviewees consistently identified transitions, particularly from hospital to post-acute or home-based care, as points where nutrition care plans are most likely to be disrupted or lost. Even as hospitals have strengthened screening, documentation, and intervention through adoption of the MCS, these improvements do not consistently translate into sustained care after discharge.[25,26] Receiving providers often lack timely access to nutrition diagnoses, care plans, or clear expectations for follow-up. Documentation may not be transmitted in a standardized or actionable format, and nutrition information may be deprioritized relative to urgent clinical concerns during transitions. One interviewee underscored this disconnect, stating:

> "It's a major accomplishment to have the Malnutrition Care Score in a hospital program, but unless that's carried through to other settings, there's not necessarily going to be significant impact."

Structural barriers further exacerbate these challenges. Post-acute providers frequently operate with more limited EHR functionality and interoperability than hospitals, reducing their ability to receive, integrate, and act on nutrition documentation generated during hospitalizations.[6]

As a result, nutrition interventions initiated during hospitalizations, such as oral nutritional supplementation, dietary modifications, or referral to nutrition services, often stall or are discontinued after discharge.[22]

## Workforce Education and Capacity Constraints

Workforce shortages and training gaps remain a central challenge to delivering consistent, high-quality malnutrition care across the continuum.[24] While hospitals have expanded dietitian involvement as part of MCS implementation, integrating RDNs more fully into interdisciplinary teams in post-acute and long-term care settings is frequently stalled by insufficient RDN coverage to support comprehensive assessment, ongoing monitoring, and care plan adjustment. Limited staffing constrains the ability of these settings to move beyond minimum screening requirements toward proactive, individualized nutrition management. As interviewee Angela Lago stated, "When dietitians are not a consistent member of the interdisciplinary team in the post-acute care setting, it makes it difficult to have timely reassessments and adjust care plans accordingly." Workforce shortages are compounded by uneven nutrition education among non-dietitian clinicians, reducing the ability of interdisciplinary teams to reinforce nutrition interventions and monitor progress.

These workforce constraints are especially acute in rural and resource-constrained settings, where shortages of qualified nutrition professionals intersect with broader access challenges.[34] Older adults in these communities may face higher malnutrition risk due to socioeconomic factors and limited service availability, yet have the least access to specialized nutrition expertise.

## Data, Measurement, and Research Gaps

Measurement and data infrastructure remain heavily concentrated in the inpatient setting. CMS collection of hospital-level MCS data will enable benchmarking and quality improvement while driving accountability within acute care. However, comparable, national-level data are largely absent in post-acute, ambulatory, and community settings, limiting visibility into malnutrition prevalence, treatment, and outcomes beyond hospitalization.[5]

Assessment interviewees repeatedly identified the lack of post-acute data as a critical barrier to policy development and evaluation. One interviewee noted the absence of recent national data on malnutrition in nursing homes and other post-acute settings, describing it as a

lingering research gap that constrains understanding of care quality and outcomes. Another highlighted that while the evidence base on malnutrition continues to grow, "there's been a lot of research done… but the translational piece into policy is missing," underscoring a disconnect between research findings and scalable policy action.

Fragmented data systems worsen these challenges by preventing longitudinal tracking of patients across care settings. Differences in documentation standards, limited interoperability, and inconsistent data capture make it difficult to follow nutrition diagnoses and interventions as individuals transition from hospitals to post-acute care, home health, or community-based services. As a result, policymakers and payers face constraints in evaluating outcomes, monitoring access, and assessing return on investment for nutrition interventions, particularly within MA and community-based programs where benefits and services are often delivered outside traditional clinical settings.[16]

## Patient, Family, and Caregiver Engagement Deficits

Caregivers play a critical role in managing nutrition after discharge, yet engagement remains inconsistent. Interviewees reported that patients and families often receive limited education about malnutrition risk, nutrition goals, or expectations for follow-up care.

Interview findings highlighted that patient and caregiver realities and preferences, such as food access, functional limitations, availability of caregiver support, and cultural and dietary considerations, are not always systematically assessed, documented, or communicated during transitions of care.[29] When these factors are not incorporated into nutrition care planning, interventions may not be aligned with patients' daily experiences, reducing adherence and effectiveness.

Community-based nutrition programs and caregiver support services can help address these gaps by providing education, meals, and other supports tailored to older adults' needs.[4,36] However, weak integration between clinical care teams and community organizations limits coordination and follow-through. Referrals may be inconsistent, feedback loops may be absent, and clinicians may lack visibility into whether community-based interventions are accessed or sustained.

## Figure 2: Top priorities

Building on progress since 2020 and recognizing the impact of the MCS in acute care, there are four near-term priorities that are essential to accelerating cross-continuum improvement and sustainingmomentum toward the goals of the *National Blueprint*.

### Top priorities moving forward

**Integrate MCS or similar measures into additional federal quality and payment programs.**

Nutrition-focused quality measurement can build on inpatient quality reporting to additional CMS-administered quality and value-based payment programs that influence provider behavior across settings. The MCS is structured on the basic components of the nutrition care process, which is not site-specific. Adapting the core MCS measure concepts of screening, assessment, diagnosis, care planning/intervention, and follow-up, for post-acute, ambulatory, and community settings would promote consistency, accountability, and continuity of malnutrition care across the continuum.

**Expand workforce capacity and training in post-acute and community settings.**

Persistent workforce shortages, particularly limited availability of RDNs in post-acute and long-term care, must be addressed through targeted workforce development strategies. These include expanding interprofessional nutrition education, supporting nutrition continuing education for non-hospital clinicians, and leveraging tele-nutrition and other scalable care models to extend expertise into resource-constrained and rural settings.

**Invest in infrastructure to support seamless nutrition care transitions and data measurement.**

Interoperability and standardized documentation must be strengthened so that nutrition diagnoses, goals, and care plans are consistently communicated during transitions of care and reliably incorporated by receiving providers. Investment in data infrastructure is also needed to enable measurement and benchmarking monitoring of malnutrition care across settings, particularly outside the hospital environment.

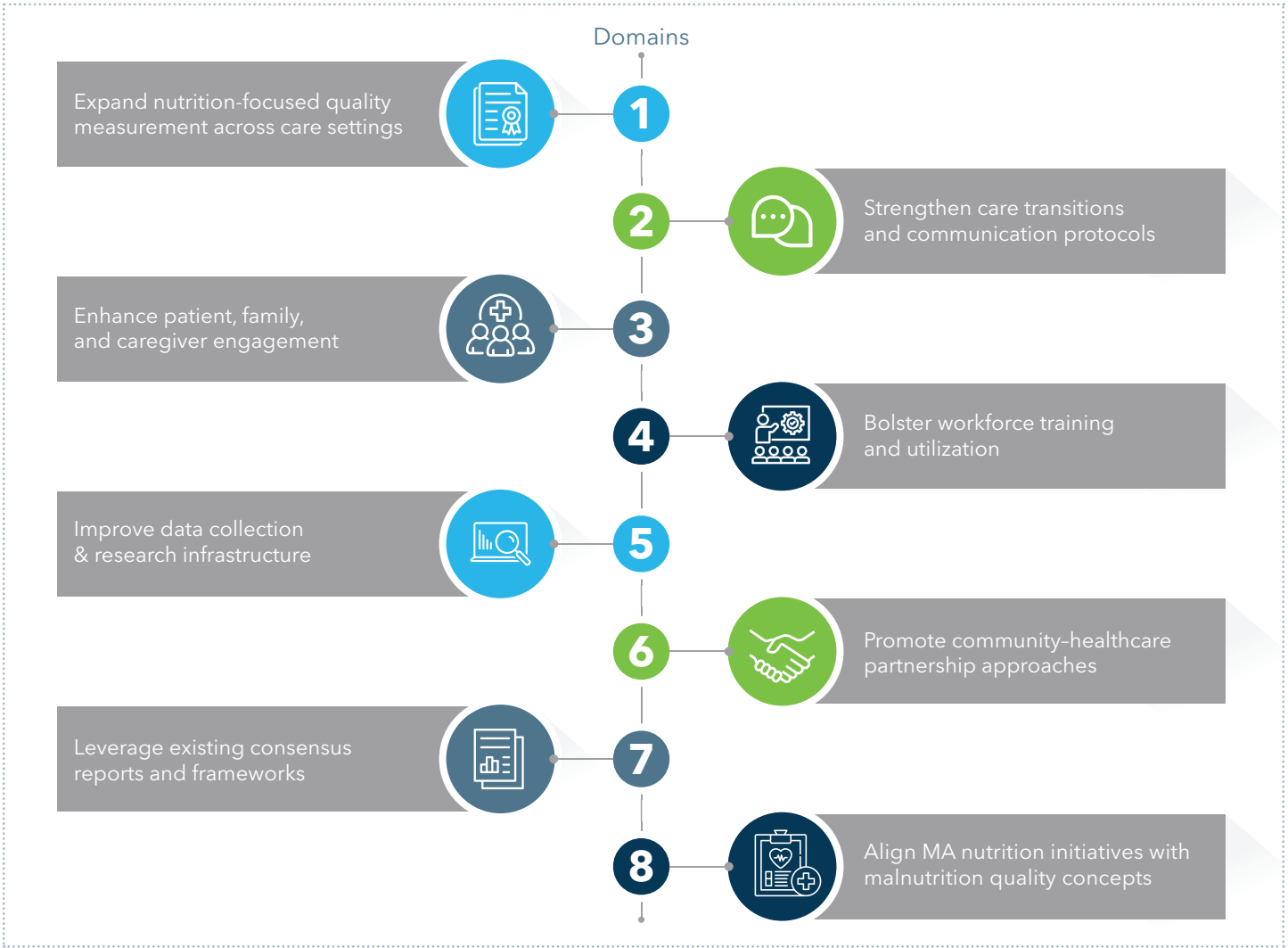
**Unite stakeholders under shared, evidence-based guidelines and frameworks.**

Stakeholders must leverage the National Blueprint and other consensus-based guidance as unifying frameworks to align payers, providers, community organizations, and policymakers around shared definitions, workflows, and accountability expectations. Coordinated adoption of evidence-based standards can reduce fragmentation, reinforce best practices, and accelerate system-wide progress in achieving quality malnutrition care for older adults.

# Recommendations for CMS and Other Regulatory and Policy Stakeholders

Progress toward filling gaps in malnutrition care requires coordinated, role-specific action that is possible with meaningful change from influential stakeholders across the healthcare continuum. The tactical recommendations outlined below, grouped into eight domains, are designed to build on existing programs and pathways, align with current administration priorities related to nutrition, and provide a way forward to incorporate consistent malnutrition care into core aspects of the patient journey, starting with quality measures and payment programs.

**Figure 3: Domains**



## Domain 1:
Expand nutrition-focused quality measurement across care settings

| Recommendations | Rationales |
|---|---|
| CMS should adapt and evolve core MCS concepts (screening, assessment, diagnosis, care planning/intervention, and follow-up) into quality measures tailored for post-acute, home health, and ambulatory settings | Experience with the MCS in hospitals demonstrates that structured, process-based quality measures can rapidly improve identification, documentation, and management of malnutrition.[12] Extending these core concepts beyond acute care promotes continuity and consistency in nutrition care and improved outcomes as patients move through post-acute, home health, and ambulatory settings. |
| CMS, in coordination with health systems and providers, should develop and test measures that explicitly assess the effectiveness of nutrition-focused communication during transitions (e.g., whether a documented malnutrition diagnosis and care plan is transmitted and acknowledged). | Without accountability for transmission and acknowledgment of malnutrition diagnoses and care plans, improvements achieved in hospitals are unlikely to translate into sustained outcomes after discharge.[39] |
| CMS should incentivize performance through value-based payment programs and public reporting where feasible, using phased implementation to balance provider burden and readiness. | Value-based payment programs provide accountability and incentivize provider investment in workforce, workflows, and data infrastructure. A phased approach, beginning with testing and reporting before advancing to performance-based incentives, supports adoption while minimizing unintended burden,[26] particularly in resource-constrained post-acute settings. |

## Domain 2:
Strengthen care transitions and communication protocols

| Recommendations | Rationales |
|---|---|
| CMS should require inclusion of malnutrition diagnoses, goals, and care plans in discharge summaries and transition documentation, with interoperability expectations aligned to broader CMS data modernization priorities. | Malnutrition diagnoses and care plans are often not consistently transmitted, or acted upon, once patients move to post-acute, home health, or community-based care.[6,39] Requiring standardized inclusion of nutrition information in discharge documentation helps ensure continuity. |
| Providers should be expected to review, update, and document nutrition care plans throughout the post-acute journey—supporting closed-loop accountability. | Closed-loop documentation reinforces nutrition as an ongoing clinical responsibility rather than a one-time inpatient intervention and supports sustained follow-up throughout the post-acute episode.[6] |
| Health systems, community partners, and payers should establish bidirectional communication standards across settings, including referral pathways to RDNs and community nutrition resources when appropriate. | Strengthening connections between clinical teams and community-based resources supports comprehensive, person-centered care.[38] |

## Domain 3:
Enhance patient, family, and caregiver engagement

| Recommendations | Rationales |
|---|---|
| Health systems and post-acute providers should document patient and caregiver preferences and goals at key transition points (hospital discharge, skilled nursing facility admission, home health start of care). | Reinforces person-centered care and helps ensure that nutrition care plans remain feasible and actionable as responsibility shifts across settings and care teams. |
| Federal agencies, health systems, and community partners should support use of shared decision-making tools/resources focused on older adult malnutrition, by leveraging existing initiatives and programs. | Shared decision-making tools can improve patient and caregiver understanding of malnutrition risk and the importance of follow-up, increasing adherence to nutrition interventions over time.[6,38] |

## Domain 4:
Bolster workforce training and utilization

| Recommendations | Rationales |
|---|---|
| Federal and state agencies should expand interprofessional education requirements and continuing education opportunities addressing malnutrition care—particularly for clinicians in post-acute and community settings. | Expanding interprofessional education equips clinicians with the skills needed to identify malnutrition risk, reinforce nutrition interventions, and support continuity of care, especially during transitions when RDNs may not be readily available.[18,40] |
| Health systems and payers should incentivize integration of RDNs into interdisciplinary teams across settings, including through telehealth models when appropriate to address rural and capacity constraints. | Incentivizing RDN integration strengthens clinical quality by ensuring that nutrition expertise is embedded within interdisciplinary teams.<br>Tele-nutrition and other virtual care models offer scalable solutions to extend RDN reach into limited access rural, and resource-constrained settings without requiring full on-site staffing.[41-43] |

## Domain 5:
Improve data collection & research infrastructure

| Recommendations | Rationales |
|---|---|
| CMS should standardize national data collection and reporting of malnutrition screening, diagnosis, and intervention across the continuum to enable benchmarking and access monitoring. | National malnutrition data are largely limited to inpatient care, constraining CMS's ability to assess performance, outcomes, and access across other settings. Standardized, cross-continuum reporting would support benchmarking, accountability, quality improvement, and monitoring of disparities among high-risk populations.[16,44] |
| Federal agencies should fund research and pilot testing of MCS-modeled measures outside acute care, emphasizing outcomes that matter to CMS programs (e.g., hospitalizations, falls, pressure injuries, total cost of care). | Research funding supports evidence generation needed to translate practice innovations into scalable policy solutions. Testing measures against CMS-relevant outcomes ensures alignment with value-based payment goals and strengthens the business case for sustained investment in nutrition care.[18,26] |

## Domain 6:
Promote community–healthcare partnership approaches

| Recommendations | Rationales |
|---|---|
| Health systems, ACL, state and local agencies, and community-based organizations should strengthen existing models that connect clinical care teams with community nutrition services (e.g., meal delivery, counseling, food access supports), particularly for limited access populations. | Strengthening partnerships between healthcare providers and community nutrition services extends care beyond the clinical setting and supports sustained intervention after discharge.[38] |
| Improve access to nutrition services by aligning screening, referral, and follow-up processes with available community capacity and coverage mechanisms. | Aligning screening and referral processes with community resources improves continuity of care, reduces unmet nutrition needs, and supports improved access for older adults.[36] |

## Domain 7:
Leverage existing consensus reports and frameworks

| Recommendations | Rationales |
|---|---|
| CMS and other federal partners should continue to reference/apply recommendations from the *National Blueprint* as an ongoing framework guiding federal action. | Using the National Blueprint as an organizing framework promotes alignment across CMS quality measurement, payment, workforce, and public health initiatives, reduces fragmentation across federal programs, and accelerates implementation by building on existing stakeholder agreement and prior investments.[45] |

## Domain 8:
Align Medicare Advantage (MA) nutrition initiatives with malnutrition quality concepts

| Recommendations | Rationales |
|---|---|
| CMS and MA organizations should encourage models that connect clinical care teams with community nutrition services (e.g., meal delivery, counseling, food access supports) particularly for limited access populations. | Malnutrition identification/treatment is foundational to preventive care, addressing it reduces risk for frailty, falls, hospitalizations/rehospitalizations, complications from chronic disease management common among MA beneficiaries.[5,37] |
| Adopt nutrition quality measures that track both process (screening / care planning / education / referral / follow-up) and outcomes into MA quality reporting | Incorporating validated measures like MCS aligns incentives for plans/ providers to deliver high-quality nutrition interventions and not just screen but act/ follow up while reducing avoidable costs.[12] |
| CMS should incentivize MA organizations through risk adjustment/ payment models that reward improvements in beneficiaries' nutrition status—recognizing downstream impact on health outcomes/costs. | Aligning payment/risk adjustment with measurable improvements incentivizes sustained investment by MA organizations.[26,37] |
| MA organizations should promote comprehensive approaches that include related wellness concepts such as physical activity, sleep hygiene, food as medicine. | |
| Support integration between clinical care teams (including RDNs), community programs (e.g., meal delivery), and digital tools to address nutrition holistically within MA populations. | |

# Implementation Considerations

## Anticipated challenges

Successful implementation will require balancing accountability with provider burden, particularly in post-acute, ambulatory, and community settings that often operate with fewer resources than hospitals. While increased expectations for nutrition screening, documentation, and follow-up are necessary to improve outcomes, interviewees cautioned that overly complex or rapidly implemented requirements could stress already constrained providers and slow adoption.

One of the most frequently cited challenges was variability in EHR capability across post-acute and community-based providers. Unlike many larger health systems and/or integrated delivery networks, many skilled nursing facilities, home health agencies, and community organizations rely on less robust or non-interoperable systems, limiting their ability to receive, integrate, and act on nutrition documentation generated during hospitalization. Inconsistent data standards and limited connectivity between acute and post-acute systems further complicate efforts to establish seamless transitions and longitudinal tracking of nutrition care.

Workforce shortages represent another significant barrier. Persistent gaps in RDN availability, particularly in post-acute, long-term care, limited access, and rural settings can constrain providers' ability to meet expanded expectations for nutrition assessment, reassessment, and care plan management. These shortages are worsened by uneven or non-existent nutrition training for the broader healthcare team, increasing the burden of implementing new requirements without investment in workforce development

Finally, the complexity of implementing closed-loop referral and follow-up processes poses challenges. Establishing workflows that ensure nutrition diagnoses and care plans are transmitted, acknowledged, acted upon, and tracked across settings requires coordination among multiple providers, payers, and community partners at both local and national levels. Without clear standards, technical support, and phased implementation, these processes may be difficult to operationalize.

To address these challenges, phased approaches combined with targeted technical assistance and infrastructure support can help lessen disruption. Providing clear guidance and resources to support provider readiness will be essential to ensuring that new malnutrition care requirements improve outcomes.

## Strategies for phased implementation and pilots

Implementation of quality malnutrition care requirements can advance through staged adoption pathways. A gradual progression, such as progressing from voluntary reporting to pay-for-reporting and (where appropriate) pay-for-performance models, allows providers time to build data infrastructure, workflows, and workforce capacity while working towards long-term implementation. This phased approach is particularly important for post-acute, ambulatory, and community settings, where readiness and resources vary widely.

Pilot testing through CMS-administered programs and the CMS Innovation Center can further support refinement at a smaller scale prior to national adoption and implementation. Demonstration models provide an opportunity to test and iterate on nutrition-focused measures, assess operational feasibility, and evaluate unintended consequences before broader adoption. Priority pilots should focus on establishing and validating data standards for nutrition documentation and care transitions, ensuring that nutrition diagnoses, goals, and care plans can be reliably transmitted and acted upon across settings. With multiple existing and newly-announced models oriented around prevention and accountability for long-term health outcomes, there

are clear opportunities to embed these nutrition-focused components in a way that benefits both the participating entities and CMS.

Pilots can also evaluate virtual care models and tele-nutrition as strategies to mitigate workforce constraints in rural and other populations where access to RDNs is limited. Testing measures in post-acute and community settings can help determine which measures are most meaningful, helpful, and aligned with CMS program goals.

Staged implementation and targeted pilot studies will enable CMS to generate evidence on effectiveness and access impacts, which can inform future rulemaking and payment policies.

## Stakeholder engagement

Meaningful stakeholder engagement will be essential to successful implementation of suggested recommendations. Collaboration among professional societies, patient and caregiver advocates, payers, post-acute provider organizations, EHR vendors, and community-based organizations can help ensure that policies are practical, accessible, and scalable across setting.

Engaging professional societies and clinical experts early in the process can support development of measures and care standards that are evidence-based, clinically relevant, and feasible to implement. Patient and caregiver advocates play a critical role in ensuring that policies reflect real-world needs, preferences, and barriers, particularly for older adults and vulnerable populations. Payers, including MA organizations and state Medicaid agencies, can provide insight into benefit design, data availability, and incentive structures that support sustained adoption.

Post-acute providers and community-based organizations can provide operational perspectives, particularly related to workforce capacity, documentation workflows, and care coordination challenges. Similarly, engagement with EHR vendors is necessary to ensure that data standards, interoperability requirements, and reporting expectations can be operationalized within existing systems.

To maximize impact, engagement strategies should prioritize alignment with existing CMS quality programs, reporting requirements, and data modernization initiatives. Reducing duplication and redundancy across programs can lower administrative burden, promote provider participation, and accelerate adoption, particularly in settings with limited resources. Ongoing stakeholder feedback mechanisms can also help CMS and other policymakers refine requirements over time, address unintended consequences, and support continuous improvement as nutrition care initiatives scale nationally.

# Conclusion

Since the release of the 2020 National Blueprint for Achieving Quality Malnutrition Care for Older Adults, measurable progress has been made to advance malnutrition care across the United States. Federal and state policy actions, including CMS's adoption of the MCS, state-level integration of nutrition into Medicaid and aging services, and the growing incorporation of nutrition concepts into value-based programs represent important milestones. Yet, older adult malnutrition remains inconsistently addressed across care settings, emphasizing the importance of building on current momentum and closing gaps in care quality and continuity.

This moment presents a critical opportunity to accelerate progress by leveraging actionable policy levers at CMS and CMMI. Embedding nutrition-focused quality measures within value-based payment programs and CMMI demonstration models can elevate malnutrition care from a supportive clinical activity to a core driver of quality, access, and outcomes. Aligning incentives for screening, intervention, workforce development, and care coordination can support sustained improvement across acute, post-acute, ambulatory, and community settings.

Achieving this vision will require coordinated, multi-stakeholder collaboration beyond federal agencies alone. Public and private payers, state governments, health systems, professional societies, and community-based organizations all have essential roles in implementing and scaling effective nutrition care. By working together to standardize measures, strengthen data sharing, expand workforce capacity, and support innovation, stakeholders can transform nutrition care delivery across the continuum.

Through decisive action now, there is a compelling opportunity to close long-standing gaps in malnutrition care, realize the goals of the National Blueprint, and ensure that older adults across the United States receive consistent, high-quality nutrition care that supports healthy aging and improved outcomes.

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## Reviewers for the Updated Blueprint (2020)

**Ainsley Malone**, MS, RDN, LD, CNSC, FAND, FASPEN, Clinical Practice Specialist, The American Society for Parenteral and Enteral Nutrition

**Jeanne Blankenship**, MS, RDN, Vice President, Policy Initiatives and Advocacy, Academy of Nutrition and Dietetics

**Julie Richards**, MS, RDN, Consultant, Health Policy and Programs, Abbott Nutrition

**Katie Jantzi**, LCSW, Director, Government Affairs, Meals on Wheels America

**Mary Beth Arensberg**, PhD, RDN, Director, Health Policy and Programs, Abbott Nutrition

**Meredith Ponder Whitmire**, JD, Policy Director, Defeat Malnutrition Today

**Sarah Ohlhorst**, MS, RDN, Senior Director, Advocacy and Science Policy, American Society for Nutrition

**Uche Akobundu**, PhD, RDN, Senior Director, Nutrition Strategy and Impact, Meals on Wheels America

## Interviewees on the Progress Made Since the 2020 Blueprint (2025)

**Angela Lago,** MS, RD, LDN, FAND, Senior Director, Quality, Standards and Interoperability

**Kenneth Nepple**, MD, Clinical Professor and Associate Chief Health Information Officer at University of Iowa Health Care

**Sarah Booth**, PhD, Center Director and Senior Scientist at Jean Mayer USDA Human Nutrition Research Center on Aging at Tufts University

**Craig Gunderson**, PhD, Snee Family Endowed Professor, Baylor University

**Bob Blancato**, MPA, National Coordinator, Defeat Malnutrition Today

**Laura Borth**, MS, RDN, CD, Policy Director, The National Association of Nutrition and Aging Services Programs and Defeat Malnutrition Today

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