Academy of Nutrition and Dietetics

Nutrition and Aging Resource Center

Medical Nutrition Therapy Works for Seniors

A Resource Guide for Registered Dietitian Nutritionists and Senior Nutrition Program Administrators

Contents

Acknowledgments

We are grateful to the Registered Dietitian Nutritionists, Community Administrators and Senior Nutrition Program staff who participated in surveys to inform the contents of this toolkit.

About the Academy of Nutrition and Dietetics

Founded in 1917 and representing more than 112,000 registered dietitian nutritionists, nutrition and dietetic technicians, and advanced-degree nutritionists, the Academy of Nutrition and Dietetics is the largest association of food and nutrition professionals in the United States working to accelerate improvements in global health and well-being through food and nutrition.

About the National Resource Center on Nutrition and Aging

The Ntional Resource Center on Nutrition and Aging (NRCNA) is funded by the Administration for Community Living (ACL). Its purpose is to build the capacity of senior nutrition programs funded by the Older Americans Act (OAA) to provide high-quality, person-centered services and to assist ACL and stakeholders in identifying current and emerging issues and opportunities that enhance program sustainability and resiliency. The center's website is designed for OAA Title III-C senior nutrition programs.

Originally prepared by Paula Ritter-Gooder, PhD, RDN, CSG, LMNT, FAND, commissioned by the National Resource Center on Nutrition and Aging, in collaboration with the Academy of Nutrition and Dietetics. Updated October 2024.

We appreciate the feedback from the following on creating this resource:

Ucheoma O. Akobundu, PhD, RD
Senior Director, Nutrition Strategy and Impact
Director, National Resource Center on Nutrition and Aging

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

Courtney Doby
Manager, Policy and Advocacy Communications
Academy of Nutrition and Dietetics

Marsha Schofield, MS, RD, LD, FAND
Senior Director,
Governance and Nutrition Services Coverage
Academy of Nutrition and Dietetics

Introduction

Welcome to the Medical Nutrition Therapy Works for Seniors Toolkit. This toolkit is the result of a collaboration between the National Resource Center on Nutrition and Aging and the Academy of Nutrition and Dietetics.

The NRCNA is funded by the Older Americans Act (OAA) as a cooperative agreement with the Administration for Community Living. Both the NRCNA and the Academy identified the need to create a practice-informed compendium of targeted guidance, resources and case studies to assist registered dietitian nutritionists and senior nutrition program administrators in understanding emerging opportunities in the provision of medical nutrition therapy to support the nutrition and health needs of community-residing older adults. Registered dietitian nutritionists have had access to the Medical Nutrition Therapy MNTWorks Kit® through the Academy, which was specifically designed to detail the varied benefits of RDN services and serves as a premier resource guide to support these professionals in promoting coverage of MNT. Senior nutrition program providers are in need of similar tools. More and more, they have been encouraged to develop relationships with Medicare Advantage plans to provide needed nutrition services for community-residing older adults, covering nutrition care services provided by registered dietitian nutritionists. Before now, limited resources existed to assist these organizations in making the business case for offering reimbursable MNT services and for establishing working partnerships with the plans.

The Medical Nutrition Therapy Works for Seniors Toolkit is a compilation of information, resources and tools that summarizes nutrition-focused health care integration opportunities for senior nutrition programs, highlights the role and impact of RDNs, and lays out the examples of promising practice and research-informed evidence regarding the clinical and cost-effectiveness of nutrition interventions. This resource guide focuses on Medicare as a key payor of health care services for many seniors, the authors acknowledge that supplemental health plans and/or other secondary coverage are also used by older Americans to cover needed services like MNT.

The goal of this toolkit is to provide resources for RDNs and senior nutrition programs to strengthen their ability to offer MNT services for coverage by Medicare and Medicare Advantage plans for older adults in community settings.

Section I:
Making the Case for Senior Nutrition Programs

Leveraging Emerging Opportunities for Future Readiness and Sustainability Through Health Care Integration

The changes created by the Patient Protection and Affordable Care Act of 2010[1] have created opportunities for providers of community nutrition services to have an impact on the social determinants of health[2] for older adults.

The 2019 position paper on Food and Nutrition Programs for Community-Residing Older Adults, authored by the Academy of Nutrition and Dietetics and the Society for Nutrition Education and Behavior, recommends a person-centered approach that utilizes both health care systems and community based programs as equal partners to promote health and well-being of community residing older adults.[3] Senior nutrition programs have a service structure in place and as trusted and proven providers, they are positioned to be a valuable partner in the expanding health care market.[4] Local senior nutrition program providers and Area Agencies on Aging are part of a national network of community-based organizations (called the Aging Network) that assist Americans to age successfully in their homes and communities. As reforms to the health care landscape continue and understanding of the impact of Social Determinants of Health, these aging services providers are increasingly sought after/seeking to partner with health care entities to further control health care costs.[5] Much of the available published literature suggests that quality of life, health and well-being for older adults can be improved by better integration and coordination with health care systems.

Medical nutrition therapy has been a Medicare benefit since 2002 and is typically offered in health care settings. RDNs and senior nutrition programs who provide nutritional support to older adults in the community should explore emerging opportunities and promising practices for offering Medicare MNT in their setting. Congregate and home-delivered meals programs funded through the Older Americans Act can be ideal settings to provide reimbursable MNT therapy for older adults who have diabetes or chronic kidney disease. Offering MNT in the community setting can slow the progression of and reduce symptoms of chronic diseases.[3] Medicare MNT provided in senior nutrition programs can improve lives and delay or prevent adverse health conditions to curb health care costs associated with hospitalizations and admissions to long term care.

Medicare reimbursement for MNT is a sustainable funding source beyond the traditional funding base for senior nutrition programs that employ RDNs. Contracting with RDNs to provide MNT in the community setting allows senior nutrition programs to partner with health care providers in their area. Interested nutrition programs can offset the startup costs of exploring reimbursable MNT service models through a number of options — including securing private grant funding to support future sustainability of nutrition programs.[4] Also, the health care system is shifting its focus to value-based payments involving providers across the health care and community settings. Senior nutrition programs are well-positioned to pitch the value proposition of offering MNT services through such new health care partnerships and secure funding these services through these value-based payments. With such services in place, it is possible for older adults enrolled in community-based senior nutrition programs, particularly those with limited resources and access/transportation for health care visits, to receive MNT within a community setting or within their own home. In this aspect, offering Medicare MNT in the home is an opportunity to improve and increase access to quality services and can be a solution for those not able to access health care services routinely from their health care provider. An increasingly competitive environment for public and private funding requires senior nutrition programs to provide more quality, client-centered, effective and efficient products and services.[4] Conducting outreach and marketing MNT as a service may serve to attract and enroll new individuals in the senior nutrition programs, expand the reach of the agency into the community, create new health care partnerships and promote the role of the agency as a provider of other services already in place.

To learn more about partnering with health care entities visit: https://www.aginganddisabilitybusinessinstitute.org/about.

Section II:
Medical Nutrition Therapy in the Changing Landscape of Medicare and Medicare Advantage

Medicare is the largest payer of health care in the United States. Since the 1970s, Medicare beneficiaries have had the option to receive benefits from private health plans instead of the federally administered Fee for Service program.

Medicare Advantage is the private Medicare health plan option that is available to beneficiaries. These plans, also known as Medicare Part C, Medicare + Choice Plans, or MA Plans, are licensed by the state, certified by the Centers for Medicare & Medicaid Services and may offer additional benefits beyond original Medicare. In 2003, due to the Medicare Prescription Drug, Improvement, and Modernization Act, enrollment in the Medicare Advantage program has been increasing. Currently, more than one-third of Medicare beneficiaries, or around 22 million, are enrolled in Medicare Advantage with 42 percent expected to be enrolled in Medicare Advantage by 2028.[6,7] The rapidly growing Medicare Advantage has the potential to improve the quality of life of beneficiaries while reducing Medicare spending.

To learn more about Medicare Advantage and funding senior nutrition programs visit: https://acl.gov/senior-nutrition. Enrollment in the Medicare Advantage market is uneven across the country. To learn where Medicare Advantage beneficiaries are enrolled, go to: https://www.bettermedicarealliance.org/about-medicare-advantage/medicare-advantage-enrollment-map.

Senior nutrition programs have an opportunity to partner with Medicare Advantage plans due to recent trends in the evolving health care landscape. Plans may provide medical nutrition therapy benefits for more conditions than available through Medicare Fee for Service. The Bipartisan Budget Act of 2018 allows Medicare Advantage to cover a wider array of benefits, which have implications for senior nutrition programs. For example, negotiation for Medicare Advantage plans to cover supplemental benefits such as home delivered hot meals benefit for chronically ill enrollees are made possible by these regulations.[8] Nutrition and aging services organizations have embarked upon identifying partnership and training opportunities to aging services providers seeking to better integrate community-based senior nutrition program services with traditional health care delivery.[9]

Medical Nutrition Therapy and RDNs

Medical nutrition therapy is an evidence-based application of the Nutrition Care Process, which is a systematic approach used to provide high quality nutrition care. The NCP consists of four distinct, interrelated steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention and Nutrition Monitoring and Evaluation. MNT utilizes all domains of nutrition intervention including food and/or nutrient delivery, nutrition education, nutrition counseling and coordination of nutrition care.[10]

MNT is not identical to nutrition education commonly provided in The Older Americans Act congregate and home-delivered meal programs. Providing MNT to a patient/client typically results in the prevention, delay or management of diseases and/or conditions. To learn more about MNT, visit: https://www.eatrightpro.org/payment/medical-nutrition-therapy.

RDNs can bill Medicare Part B for MNT for physician referred individuals with diabetes and/or renal disease. Medicare informs beneficiaries of this benefit here: https://www.medicare.gov/coverage/nutrition-therapy-services. Seniors are advised that they pay nothing for MNT as their deductible and coinsurance do not apply. The Medicare benefit allows three hours of MNT in the first referral year and two hours in each subsequent calendar year. Additional visits may be covered when there is a documented change in medical condition. Medicare Advantage plans must cover MNT services because MNT is a Part B benefit. RDNs or any organization that plans to provide MNT within a Medicare Advantage plan must first contract with Medicare and then the Medicare Advantage plan. The Centers for Medicare & Medicaid Services regulations require providers to obtain a National Provider Identifier number and use current procedural terminology codes when billing for MNT. To learn more about RDNs and MNT, please visit: https://www.eatright.org/food/resources/learn-more-about-rdns/rdns-and-medical-nutrition-therapy-services, and https://www.ncoa.org/wp-content/uploads/Tip-Sheet-Medical-Nutrition-Therapy-10.23.15.pdf.

Medical Nutrition Therapy Works for Seniors

The following resources may be used to market and educate the use and benefits of MNT to community nutrition program administrators, health professionals, consumers and managed care.

MNTWorks for Seniors

The Value of Registered Dietitians Nutritionists

RDNs are NUTRITION EXPERTS

RDNs provide vital food and nutrition services, while promoting health and well-being to the public. RDNs use their expertise to help individuals make unique, positive lifestyle changes. They work throughout the community in hospitals, private practice, physician offices, public health clinics, nursing homes, fitness centers, worksite wellness programs, schools and other locations.

RDNs provide MEDICAL NUTRITION THERAPY

RDNs are the best qualified health care professionals to deliver nutrition education and medical nutrition therapy services for prevention, wellness and disease management. Nutrition services provided by RDNs can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug coverage.

RDNs apply EVIDENCED-BASED PRACTICE

RDNs provide care by applying the Academy of Nutrition and Dietetics' Evidence-Based Nutrition Practice Guidelines. The guidelines illustrate best practice for MNT related to specific diseases or conditions to achieve positive outcomes.

RDNs are HIGHLY TRAINED PROFESSIONALS

RDNs receive extensive training that combines academic preparation with hands-on, practical patient experience. RDNs must complete a minimum of a bachelor's degree, participate in a practice program involving direct patient interaction and pass a national registration exam. Approximately 50 percent of RDNs hold advanced degrees. RDNs are also required to complete continuing professional education to maintain their credential.

RDN Services are integral to the PATIENT-CENTERED MEDICAL HOME

RDNs work hand-in-hand with referring providers and multidisciplinary health care team members to deliver care that is coordinated and cost-effective. In addition to providing MNT, RDNs address areas such as glucose monitoring and body composition analysis.

Adapted and printed by permission of the Academy of Nutrition and Dietetics from the Medical Nutrition Therapy MNTWorks Kit®.

MNTWorks for Seniors

Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guidelines

Registered Dietitians Nutritionists implement evidence-based practice, along with professional judgment, in order to achieve optimum care and positive nutrition and health outcomes. Utilizing the Academy of Nutrition and Dietetics Evidence-based Nutrition Practice Guidelines, RDNs make decisions about appropriate medical MNT interventions for specific disease states or conditions.

Several guidelines indicate the length and frequency of MNT visits for a particular disease or condition. For example, in adults with Diabetes Mellitus, the RDN should implement three to six medical nutrition therapy encounters during the first six months and determine if additional MNT encounters are needed. In studies reporting on the implementation of an initial series of RDN encounters (three to 11; total of two to 16 hours), MNT significantly lowered HbA1c by 0.3 percent to 2.0 percent in adults with type 2 diabetes and by 1.0 percent to 1.9 percent in adults with type 1 diabetes during the first six months, as well as optimization of medication therapy and improved quality of life.[1]

The following Academy nutrition practice guidelines include recommendations that are supported by evidence and describe RDN interventions that achieve best outcomes:

- Adult Weight Management
- Celiac Disease
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Critical Illness
- Diabetes Type 1 and 2
- Diabetes Type 2 Prevention
- Disorders of Lipid Metabolism
- Heart Failure
- HIV/AIDS
- Hypertension
- Oncology
- Unintended Weight Loss in Older Adults
- Malnutrition[2]

[1] Academy of Nutrition and Dietetics Evidence Analysis Library. "In adults with type 1 and type 2 diabetes, how effective is MNT provided by an RD/RDN on glycemia (A1c or glucose), medication usage and quality of life?" Accessed August 17, 2019. https://andeal.org/topic.cfm?menu=5161&cat=5596.

[2] Academy of Nutrition and Dietetics Evidence Analysis Library. "Malnutrition in Older Adults." Accessed October 1, 2024. https://andeal.org/topic. cfm?menu=6064.

Adapted and printed by permission of the Academy of Nutrition and Dietetics from the Medical Nutrition Therapy MNTWorks Kit®.

MNTWorks for Seniors

RDNs Provide Better Health Outcomes

The inclusion of nutrition interventions and counseling, when provided by a registered dietitian nutritionist as part of a health care team, results in significant improvements in weight and BMI, A1C, blood pressure and serum lipids. The following systematic reviews[1] and other studies[2] demonstrate the benefits of RDN-provided nutrition services.

Overweight/Obesity

Studies show medical nutrition therapy provided by a registered dietitian nutritionist to overweight and obese adults for less than six months yields significant weight losses of approximately one to two pounds per week. MNT provided from six to twelve months yields significant mean weight losses of up to 10 percent of body weight with maintenance of this weight loss beyond one year.[1] MNT provided by an RDN results in both statistically and clinically significant weight loss in older adults with overweight and obesity.[2]

Hypertension

MNT provided by an RDN lowers blood pressure in adults with hypertension. Studies show MNT provided for less than six months leads to significant reductions in blood pressure of approximately five mm Hg for both systolic and diastolic blood pressure. MNT provided from six to twelve months reported similar significant reductions in blood pressure with sustained reductions in blood pressure beyond one year.[1] In older adults with hypertension, MNT provided by an RDN significantly reduces dietary sodium and lowers blood pressure.[2]

Diabetes

In studies reporting on the implementation of an initial series of RDN encounters (three to 11; total of two to 16 hours), MNT significantly lowered HbA1c by 0.3 percent to 2.0 percent in adults with type 2 diabetes and by 1.0 percent to 1.9 percent in adults with type 1 diabetes during the first six months, as well as optimization of medication therapy and improved quality of life.[1]

Metabolic Syndrome/Prediabetes

MNT provided to older adults by RDNs resulted in significantly greater weight loss, improvements in serum lipid profile and reduction in prevalence of the disease.[2]

(continued on next page)

Disorders of Lipid Metabolism

Patients who attend multiple RDN visits for MNT lasting an average of 45 minutes (30-60 minutes per session) over six to twelve weeks can reduce daily dietary fat (five percent to 8 percent), saturated fat (two percent to four percent) and energy intake (232-710kcal per day). This can result in a reduction in serum total cholesterol (TC) (down 7 percent to 21 percent), LDL-C (down 7 percent to 22 percent) and triglycerides (down 11 percent to 31 percent) resulting in annual cost savings of $638–$1,456 per participant.[1] MNT provided by RDNs promote changes in dietary intake of fat and saturated fat and positively affects changes in serum lipid levels in older adults age ≥ 60 years who have disorders of lipid metabolism.[2]

HIV Infection

Studies regarding MNT report improved outcomes related to energy intake and/or symptoms (with or without oral nutritional supplementation) and cardiovascular risk indices especially with increased frequency of visits. Two studies regarding nutritional counseling (non-MNT) also report improved outcomes related to weight gain, CD4 count and quality of life.[2]

Unintended Weight Loss in Older Adults

Studies report that individualized nutrition care, directed by an RDN on the health care team, results in improved outcomes related to increased energy, protein and nutrient intakes, improved nutritional status, improved quality of life and/or weight gain.[1]

Chronic Kidney Disease

Research related to the time requirements for MNT provided by an RDN indicate that approximately two hours per month for up to one year may be required to provide an effective intervention for adults with chronic kidney disease. MNT should be initiated at least twelve months prior to the anticipation of renal replacement therapy (dialysis or transplant). Studies regarding effectiveness of MNT report significant improvements in anthropometric and biochemical measurements sustained greater than or equal to one year.[1]

Heart Failure

Research reports that MNT provided by RDNs resulted in a significant decrease in sodium intake and maintenance of body weight.[1] The impact of MNT provided by an RDN for older adults with heart failure resulted in significant reductions in sodium and fluid intake.[3]

Cancer

In older adults with cancer, MNT provided by an RDN resulted in significant improvements in energy and protein intake, quality of life, and improved outcomes of prevention of nutrition deterioration, decreased weight loss, fewer unplanned hospital admissions during treatment, and shorter length of stay during unplanned hospital admissions.[2]

---

[1] Academy of Nutrition and Dietetics Evidence Analysis Library, https://www.andeal.org/default.cfm. Accessed August 19, 2019.

[2] Rezazadeh L, Ostadrahimi A, Tutunchi H, Naemi Kermanshahi M, Pourmoradian S. Nutrition interventions to address nutritional problems in HIV-positive patients: translating knowledge into practice. J Health Popul Nutr. 2023 Sep 8;42(1):94.

[3] The Academy of Nutrition and Dietetics National Coverage Determination Formal Request. *J. Acad Nutr and Diet.* 2012;112(1):149-176.

MNTWorks for Seniors

MNT Providing Return on Investment

Data shows that medical nutrition therapy involving in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease, yields positive results. MNT is linked to improved clinical outcomes and reduced costs related to physician time, medication use and hospital admissions for people with obesity, diabetes and disorders of lipid metabolism, as well as other chronic diseases.[1]

University of Virginia School of Medicine[2] reported that an RDN case management approach to lifestyle care can improve diverse indicators of health, including weight, waist circumference, health-related quality of life and use of prescription medications, among obese persons with type 2 diabetes. These results were seen with a minimal cost of $350 per year per patient. Meta-analyses and scoping reviews have shown that nutrition interventions provided by RDNs lead to better clinical outcomes compared to those provided by other healthcare professionals and are cost-effective, reducing diabetes-related healthcare costs and hospital charges.[3]

Diabetes and obesity are associated with elevated rates of lost productivity and disability. In 2022, people with diabetes lost 17 million days of work due to diabetes, costing the U.S. economy approximately $5.4 billion.[4]

A modest-cost, RDN-led lifestyle intervention provided to people with diabetes and obesity reduced the risk of having lost work days by 64.3 percent and disability days by 87.2 percent, compared with those receiving usual medical care. For every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of $2.67 in productivity.[3]

Massachusetts General Hospital[5] reported that participants receiving group MNT in a six-month randomized trial had a six percent decrease in total and LDL-cholesterol levels, compared with the group not receiving MNT. The non-MNT group had no reduction in total cholesterol or LDL levels. The study revealed a savings of $4.28 for each dollar spent on MNT, much less than the cost of statin therapy.

The Lewin Group documented an 8.6 percent reduction in hospital utilization and 16.9 percent reduction in physician visits associated with MNT for patients with cardiovascular disease. The group additionally documented a 9.5 percent reduction in hospital utilization and 23.5 percent reduction in physician visits when MNT was provided to persons with diabetes mellitus.[6]

---

[1] Academy of Nutrition and Dietetics Evidence Analysis Library. Medical Nutrition Therapy Effectiveness (MNT) Systematic Review (2013-2015). https://www.andeal.org/default.cfm. Accessed August 19, 2019.

[2] Wolf AM, Conaway MR, Crowther JQ, et al. Translating lifestyle intervention to practice in obese patients with type 2 diabetes: Improving Control with Activity and Nutrition (ICAN) study. *Diabetes Care.* 2004;27:1570–6.

[3] Siopis G, Colagiuri S, Allman-Farinelli M. Effectiveness of dietetic intervention for people with type 2 diabetes: A meta-analysis. Clin Nutr. 2021 May;40(5):3114-3122.

[4] Emily D. Parker, Janice Lin, Troy Mahoney, Nwanneamaka Ume, Grace Yang, Robert A. Gabbay, Nuha A. ElSayed, Raveendhara R. Bannuru; Economic Costs of Diabetes in the U.S. in 2022. Diabetes Care 2 January 2024; 47 (1): 26–43.

[5] Delahanty LM, Sonnenberg LM, Hayden D, Nathan DM. Clinical and cost outcomes of medical nutrition therapy for hypercholesterolemia: A controlled trial. *J Am Diet Assoc.* 2001;101:1012–1016.

[6] Johnson, Rachel. The Lewin Group — What does it tell us, and why does it matter? *J Am Diet Assoc.* 1999;99:426–427.

MNTWorks for Seniors

Testimonials

The benefits of providing Medicare MNT within senior nutrition programs and in community settings include positive client and community program outcomes. The case for offering Medicare MNT in community-based organizations is demonstrated by these testimonials.

Our perception is that Accountable Care Organizations and physicians previously viewed us as Home Care folks, they now see us as part of managed care.

— **Area Agency on Aging Administrator**

We received very positive feedback from a physician during the referral process and feel that is building an important bridge. We feel delivering MNT will help us align with the health care community.

— **RDN Senior Nutrition Program Administrator**

Health care partners are very excited to hear that we offer this service and over time we get more and more referrals to help them reach clients they are not able to help. We have made some dramatic impacts on clients. We have helped one individual control his diabetes to the point that he lost weight and got his BG/A1C in control. He was placed on the kidney transplant list again (had been removed due to poor health management). Other clients have reported that with the new knowledge we have given them, they are now empowered to know how to manage their diabetes and their health. They feel supported and that they have someone who can help navigate their health issues.

— **Administrator of a Non-Profit Organization**

Providing MNT has been a huge impact on engagement with health care partners. It has opened up conversations with other health plans as we are a licensed Medicare provider.

— **Administrator of a Meals on Wheels Program**

Adapted and printed by permission of the Academy of Nutrition and Dietetics from the Medical Nutrition Therapy MNTWorks Kit®.

Section III:
Promising Models for Providing Medicare MNT in Community Settings

Recognizing that all community-based nutrition programs are unique to their communities, the following case studies offer insights into how a selection of programs have established Medicare MNT services. Gleaned from information interviews with key staff at each organization, the case studies provide an overview of their service models, challenges encountered, and success realized to guide you in implementing MNT services within your community.

Promising Practice Case Studies

Case Study 1

A not-for-profit organization that provides a comprehensive array of health and nutrition services to older adults and individuals living with a medical challenge and/or disability.

1. What led you to provide Medicare MNT services?

Initiated in February 2018, our original focus was to provide services to home bound individuals. We started with the goal to reduce frequent hospital readmissions, but referrals were not occurring. We had to develop multiple revenue streams to provide economy of scale. Primary focus is on MNT for diabetes.

2. What is your business model and how long have you provided Medicare MNT?

We offer MNT for Medicare beneficiaries who have diabetes, and other individuals in the community who have private insurance plans, as well as corporate wellness programs. We employ 3.5 FTE's RDNs. We offer MNT in the home and at other locations to be creative (libraries, etc.) We limit the service to in-county residents due to drive time and mileage. We expanded into wellness programs for younger clients to sustain a strong funding stream. In this venue, we partnered with other primary care providers for referrals to be able to bill insurance plans for reimbursement for MNT.

3. Describe what steps were involved in getting this model operative, what were the inputs or resources needed?

The RDN obtains the NPI and insurance billing staff assists the RDN to become credentialed with insurance plans and Medicare. It took about two-three months to accomplish these steps. Clerical support is needed to bill and process referrals and obtain all the necessary information for billing to be successful. We employ a case manager to help set up all needed requirements before the RDN calls the client to set the appointment. We need a referral and diagnosis of diabetes to bill insurance. The clinicians also want medical information and medications the client is taking.

4. How are referrals generated?

First, we used the typical approach to get referrals from primary care providers using fax and email and obtained an estimated 137 referrals in the last calendar year. Transitioning to our online secure referral portal that is encrypted for necessary HIPAA regulations accelerated referrals and broke down many barriers. We received 200 referrals from January to May 2019, by the end of July we hit 300, with 500+ referrals anticipated by end of calendar year. Referrals are building as we develop relationships within the community. Using the online portal, health care professionals can refer at any time. Additionally, we accept self-referrals through this same portal. Administrative staff obtains needed information for all referrals, the physician offices are beginning to provide all necessary information including insurance information, so the referrals are ready to go. We find it important to get back to the referral source if client denied service and report any outcomes. This was vital to demonstrate that we are responsive and a partner in providing professional services.

5. Explain your billing process.

We decided to bill the claims ourselves so we could actively and timely pursue any claims that are denied. Our billing is processed directly through the electronic health record that we use. The referral is taken with the diabetes ICD10 code, case manager assigns a client to the RDN, the RDN calls the client and sets the appointment, appointment is conducted, RDNs chart and then send billing through the EHR, the billing specialist sends the billing to the insurance companies.

6. What is your system for documenting care?

We use an electronic health record to document care and process billing (Meditouch®).

7. How have you marketed the service?

MNT is marketed on our website, word of mouth/networking.

8. Are you profitable? If yes, how? If not, why?

We are not profitable yet, and I expect that this will only be one source of revenue for our department. Going into homes has much higher costs vs. having a client come to the office. There is travel time and mileage that adds to the RDN's time. The max visits per day is estimated at three, since there is still charting that happens after the visit. We also use permanent employees for this model. Using contingent RDNs would be somewhat risky, as they would be paid an hourly rate and most of what is paid by insurance reimbursements would go to their wages and mileage. There are administrative costs that still need to be covered. Having this program as one of several lines of income seems to be the best way to offer it.

9. What were the struggles or challenges?

Know what the infrastructure expenses will be. Investigate the startup costs as revenue will not come in immediately. Getting the back-end structure in place, clients understanding the service and desiring it, determining that the client is eligible, estimating the costs of the service and compensation to the RDN to account for drive time and chart time as these are not billable expenses.

10. What factors contribute to making you successful in this endeavor?

We continue to work on evolving the model and the RDNs work in other areas that bring in income. We use grants to support those who cannot pay the deductible for other chronic conditions not currently covered.

11. What has been the impact of this service on:

a. The organization's bottom line?
It has added one new revenue stream to our department. We also do corporate work (no insurance billing needed) and receive grants for community work.

b. Engagement with health care partners?
Health care partners are very excited to hear that we offer this service and over time we get more and more referrals to help them reach clients they are not able to help.

c. Client health care outcome?
We have made some dramatic impacts on clients. We have helped one individual control his diabetes to the point that he lost weight and has improved glycemic control. He was placed on the kidney transplant list again (had been removed due to poor health management). Other clients have reported that with the new knowledge we have given them, they are now empowered to know how to manage their diabetes and their health. They feel supported and that they have someone who can help navigate their health issues.

Case Study 2

An Area Agency on Aging, a non-profit agency serving elders, and addressing needs for food, mental assistance, necessities and financial management.

1. What led you to provide Medicare MNT services?

For health promotion, use of evidence-based practices, numerous questions for RDNs at senior centers, flexibility in funding sources.

2. What is your business model and how long have you provided Medicare MNT?

The RDN is employed on staff, and per diem RDNs are contracted for languages other than English. We have provided Medicare MNT for six years. MNT is provided primarily in the home and at community centers, public housing developments, and senior centers. We have started a pilot program with Medicare Advantage Plan.

3. Describe what steps were involved in getting this model operative, what were the inputs or resources needed?

The key is to use administrative staff for appointments and obtaining needed referrals and use the RDN time for MNT.

4. How are referrals generated?

A letter describing who is eligible, description of the service, how to refer and an overview of our agency is sent to health care providers. A screening and referral form is used to obtain beneficiary information in congregate settings and other programs offered by the agency. Referral requests are submitted to the primary care provider for the needed authorization.

5. Explain your billing process.

Claims are submitted directly by our agency to National Government Connex Services

6. What is your system for documenting care?

Paper records are maintained, we are researching electronic software.

7. Are you measuring patient care outcomes or other outcomes?

Quality of Life Surveys and Food Frequencies are obtained for individual clients, but not enough data is available for health care utilization studies.

8. How have you marketed the service?

MNT is marketed as a solution, secondary resource, and complementary to the health care provider services. Case managers screen initial intakes for diabetes and kidney diagnosis.

9. Are you profitable? If yes, how? If not, why?

The last six months have been the breakeven point for us since we started the service over six years ago. The increase in referrals made this possible.

10. What were the struggles or challenges?

Working on denied claims.

11. What has been the impact of this service on:

a. The organization's bottom line?
The last six months have been the breakeven point.

b. Engagement with health care partners?
Our perception is that Accountable Care Organizations and physicians previously viewed us as home care folks, they now see us as part of managed care.

Case Study 3

A meals-on-wheels and nutrition education program for senior citizens and other individuals with chronic diseases.

1. What led you to provide Medicare MNT services?

We needed a way to sustain funding for our nutrition education and nutrition counseling services. Continued funding sources were also needed to employ the professional registered dietitian nutritionist. We wanted to be more involved in the health care arena by providing a professional service and to have a marketing niche to offer hospital systems and insurance companies.

2. What is your business model and how long have you provided Medicare MNT?

We have been providing MNT for about seven years with RDNs on staff. Our agency is a Medicare Provider for MNT. Most Medicare MNT clients have transportation problems, so we provide in-home service using a code to bill for in-home. The RDNs also work in multiple projects in addition to Medicare MNT. For example, we have a Ryan White grant (federally funded program for HIV clients) and the RDNs see many clients in our four clinics.

3. How are referrals generated?

Referral forms are sent by providers using fax or email. We get referrals from the Medicaid manager, hospitals, and other business clients who receive our education programming or meals.

4. Explain your billing process.

We bill Medicare directly as we have a biller who was already on staff to bill Medicaid Waiver meals.

5. What is the system for documenting care?

We use both electronic health records, (Epic©) and paper charts depending on what the clinic uses.

6. How have you marketed the service?

The biggest challenge has been no funds for marketing. We use presentations and conversations to get the message out.

7. Are you profitable? If yes, how? If not, why?

The Ryan White grant is helpful in supporting the cost of the overall MNT program. Our startup cost was high as we had a biller on staff who could address denials. The biller has helped with our intake process to ensure all required information is on the form prior to submitting the claim.

8. What were the struggles or challenges?

Marketing the service and getting the referral form completed has been a challenge. Getting a physician signature has been difficult in many situations. We are now reviewing telehealth opportunities as travel time is not billable. We have identified a platform that the patient and provider can both access, with a goal to have in place prior to the end of this year.

9. What has been the impact of this service on:

a. The organization's bottom line:

We do not itemize costs out for different services to determine if the revenue for providing MNT covers the cost. Our RDNs work in multiple program areas.

b. Engagement with health care partners:

This has been a huge impact as we are a licensed Medicare provider. It has opened conversations with other health plans.

c. Client health care outcomes:

We are starting the process and have applied for funding to do research on MNT outcomes. For previously related projects we have collected A1c, knowledge assessment and behavior change.

Section IV:
Tips and Resources for Getting Started

Positioning your organization or yourself to provide Medicare MNT takes multiple steps. The Academy has resources to assist with getting a Medicare MNT service initiated that are available at no cost to Academy members and available for purchase by nonmembers. To learn more, visit: https://www.eatrightpro.org/career/payment/medicare/becoming-a-medicare-provider.

Step 1. Obtaining a National Provider Identifier

The NPI is a unique 10-digit number issued by CMS to health care providers in the United States. Obtaining an NPI must be done prior to enrollment as a Medicare provider. The NPI identifies the RDN as a health care provider in standard transactions, including billing for services. To read more about the value of the NPI, go to: https://jandonline.org/article/S2212-2672(18)30746-9/fulltext.

The NPI number is good for life and the RDN may have received one while at another place of employment. Before applying for an NPI number you can search the NPI registry to learn if you already have a number. For more information, please visit: https://npiregistry.cms.hhs.gov.

If your organization has employed the RDN and will receive payment for MNT, your organization must also obtain an NPI number. Directions and application for applying for an NPI are located at https://nppes.cms.hhs.gov/#.

Step 2. Obtaining an Employee Identification Number

If you are an RDN, a sole proprietor, and will be billing Medicare directly for MNT services, obtaining an EIN will protect your Social Security Number from being disclosed on numerous documents and claims sent to health plans. For more information, visit: https://www.irs.gov/businesses/small-businesses-self-employed/how-to-apply-for-an-ein.

Step 3. Enrolling as a Medicare Provider

The RDN as the Medicare Provider

The RDN must be an approved Medicare Provider to provide Medicare MNT and directly receive payment or assign benefits to the employing agency. CMS uses an Internet Based Provider Enrollment, Chain and Ownership System to accept applications and changes in provider status. To apply directly on the CMS website to become a Medicare provider go to: https://pecos.cms.hhs.gov/pecos/login.do#headingLv1. Find more information about the benefits of becoming a Medicare provider and how to enroll in Medicare, visit: https://www.eatrightpro.org/payment/career/medicare.

Senior Nutrition Program as a Medicare Provider

If your organization employs RDNs to provide MNT, your organization must also apply as a Medicare Provider for billing purposes. Specific directions for senior nutrition programs (i.e. local service providers and Area Agencies on Aging) to complete an application for billing Medicare for MNT can be found here: https://www.ncoa.org/article/framework-change-stages-organizational-change-outcomes-key-decision-points-successful-implementation-medicare-part-b-benefits.

Step 4. Understanding Medicare Requirements for Referral and Billing

The following information is intended to support RDNs and community agencies in their understanding of complying with Medicare delivery and payment requirements. Basic information is available at: https://www.cms.gov/Medicare/Medicare.html. Dedicated administrative support is necessary to ensure Medicare MNT provided by the RDN is reimbursable and claims processing goes smoothly. Submitting accurate claims when requesting payment for Medicare-covered health care services requires a good understanding of the Medicare program. Detailed information on the ins and outs of billing and practice management resources containing sample referral forms, privacy practice for HIPAA, and other forms can be found in toolkits[11-12] that are available to Academy of Nutrition and Dietetic members at no cost at: https://www.eatrightpro.org/career/payment/coding-and-billing

Conclusion and Call to Action

Ongoing changes in health care policy have provided opportunities for senior nutrition programs and RDNs to become health care partners in the community setting.

This toolkit can be used by senior nutrition programs and RDNs to understand the framework for providing MNT within community programs. Due to increasing enrollment in Medicare Advantage, the toolkit can also serve to advocate for inclusion and expansion of nutrition services within Medicare Advantage plans. Innovative models and programs are emerging which demonstrate promising practices of providing community-based MNT. These opportunities illustrate how programs are integrating into health care delivery. By tapping into the payment stream of Medicare and Medicare Advantage, senior nutrition programs are securing additional funding streams to support their nutrition programs that serve seniors. For future sustainable programming that enhances the health of seniors, senior nutrition programs and RDNs are encouraged to be innovative and establish similar programs within their community.

References

[1] U.S. Department of Health and Human Services. The Affordable Care Act. Available at: https://www.hhs.gov/healthcare/about-the-aca/index.html.

[2] Centers for Disease Control and Prevention. Social Determinants of Health: Know what affects health. Available at: https://www.cdc.gov/socialdeterminants/index.htm.

[3] Position of the Academy of Nutrition and Dietetics and the Society for Nutrition Education and Behavior: Food and Nutrition Programs for Community-Residing Older Adults. J Acad Nutr Diet. 2019;119(7):1188-1204. Available at: https://www.eatrightpro.org/-/media/eatrightpro-files/practice/position-and-practice-papers/position-papers/pp_foodnutritionprogramsolderadults.pdf.

[4] Netterville, LL. Sustainability and Revenue Generation in an Evolving Senior Nutrition Business Environment. Available at: https://nutritionandaging.org/wp-content/uploads/2019/04/Sustainability_Brief.pdf.

[5] National Association of Area Agencies on Aging. Measuring the Value of AAA Services. Making the Case to Health Care Partners. A ROI survey of Area Agencies on Aging. Available at: https://www.n4a.org/files/n4a_ROI_Report_July2018_Final.pdf.

[6] Kaiser Family Foundation. Available at: https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage.

[7] Congressional Budget Office (2018). Medicare – Congressional Budget Office's April 2018 Baseline. Available at: https://www.cbo.gov/sites/default/files/recurringdata/51302-2018-04-medicare.pdf.

[8] Sung, J, Noel-Miller, C. AARP Public Policy Institute. Supplemental Benefits in Medicare Advantage: Recent Public Policy Changes and What they Mean for Consumers. July 2019. Available at: http://www.nasuad.org/sites/nasuad/files/medicare-supplement-series-two.doi.10.26419-2Fppi.00075.002.pdf.

[9] Meals on Wheels America. Effective Partnerships Between Community-Based Organizations and Healthcare: A Possible Path to Sustainability. Available at: https://www.mealsonwheelsamerica.org/docs/default-source/research/effective-partnerships-between-cbos-and-healthcare_full-report_final.pdf?sfvrsn=8e5fbf3b_2.

[10] Academy of Nutrition and Dietetics. Nutrition Terminology Reference Manual (eNCPT): Dietetics Language for Nutrition Care 2017. Available at http://ncpt.webauthor.com.

[11] The Complete Guide to Billing and Credentialing Essentials for RDNs. Available at: https:/-www.eatrightpro.org/career/payment/coding-and-billing/rdns-complete-guide-credentialing-billing,

[10]Amb g l e _ l b @gjjg l e F_ l b ` mm i , ? Es gbc dmp Npme p_ k Bgpcarmpq _ l b Npcacnrmpq, bgrgm l * 0 . / 5, ? t_gj_ ` jc _r8 f r r n q8 -- u u u ,c_rpge f r n pm,mpe-a_pccp-n_w k c l r-amb g l e+_ l b+ ` gjjg l e-amb g l e+ ` gjjg l e+ f _ l b ` mm i

Resources

1. Getting started with internet Based PECOS.
2. National Coverage Determination (NCD) for Medical Nutrition Therapy.
3. Malpractice insurance rationale and process for obtaining malpractice insurance.
4. MNT Provider Quarterly Newsletter.
5. Prevention and Treatment of Malnutrition in Older Adults 2023: Nutrition Care Process Flow Chart. Available on page 27.

Prevention and Treatment of Malnutrition in Older Adults 2023: Nutrition Care Process Flow Chart

EAL Evidence Analysis Library
Academy of Nutrition and Dietetics

Registered dietitian nutritionists (RDNs) should deliver nutrition assessment and interventions, however, if not feasible, RDNs should oversee or train other healthcare or community providers who provide nutrition care.

NUTRITION SCREENING

Older adults should be screened by a healthcare professional such as nutrition and dietetic technician or a community health worker using the Malnutrition Screening tool (MST).

Is the older adult at nutrition risk?

Yes

Is an RDN available for Nutrition Assessment?

Yes

No

No

Maintain current diet and activity. Rescreen at least once per year for those in the community or up to every 3 months for those in long-term care.

NUTRITION ASSESSMENT

Older adults at risk for malnutrition should be referred to an RDN for nutrition assessment using a valid nutrition assessment tool such as the full form Mini Nutrition Assessment Tool.

Older adults at risk for malnutrition should be referred to an RDN, however, if an RDN is not available, other healthcare professionals or community health workers may consider the following nutrition interventions.

Is the older adult malnourished or at risk for malnutrition?

No

Maintain current diet and activity. Rescreen at least once per year for those in the community or up to every 3 months for those in long-term care.

Yes

NUTRITION INTERVENTION

RDN to provide person centered nutrition care based on nutrition assessment. RDNs may consider the following evidence-based interventions.

- Congregate and Home-Delivered Meals
- Oral Nutrition Supplements*
- Food Fortification*

*See the MiOA Guideline for additional information on benefits vs harms and implementation considerations.