Issue Brief for Academy Members

eat right. Academy of Nutrition and Dietetics

Medical Nutrition Therapy Act

(H.R.6407/ S.3297)

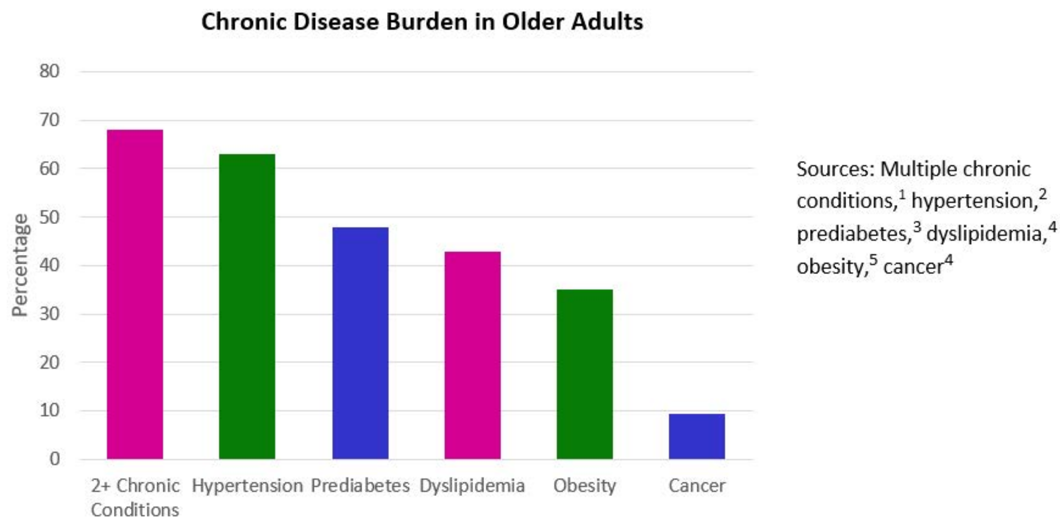
Overview

The Academy of Nutrition and Dietetics championed the introduction of the Medical Nutrition Therapy Act and is urging members of Congress to cosponsor and support passage of the bill. This bill would allow Medicare beneficiaries to access the care they need by providing coverage for Medical Nutrition Therapy for a variety of chronic conditions under Medicare Part B.[i]

The majority of Academy members work in health care and community settings that provide MNT services, and expanding coverage for MNT has been a long-held Academy policy priority. The Academy drafted legislative language with the aid of legal experts and subsequently partnered with members of Congress to introduce the MNT Act.

The Burden of Chronic Disease

Almost all Medicare beneficiaries have at least one chronic condition and over two-thirds live with multiple chronic conditions.[1] The chart below illustrates select prevalence rates from the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) for adults over 65.



Malnutrition diminishes quality of life, is a strong predictor of short-term mortality and is associated with higher health care costs.[6,7,8] It is estimated that up to one out of two older adults is either at risk of becoming or is malnourished.[9] Older adults with a chronic disease are at greater risk for malnutrition.[10]

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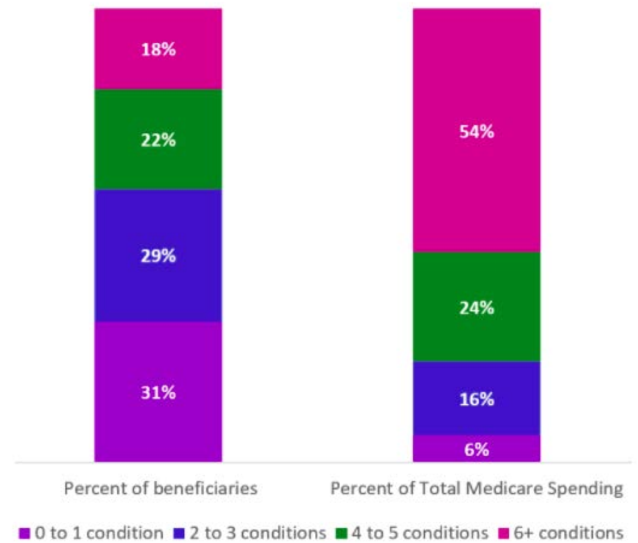
[i] To learn more about the Medicare program, visit: https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare

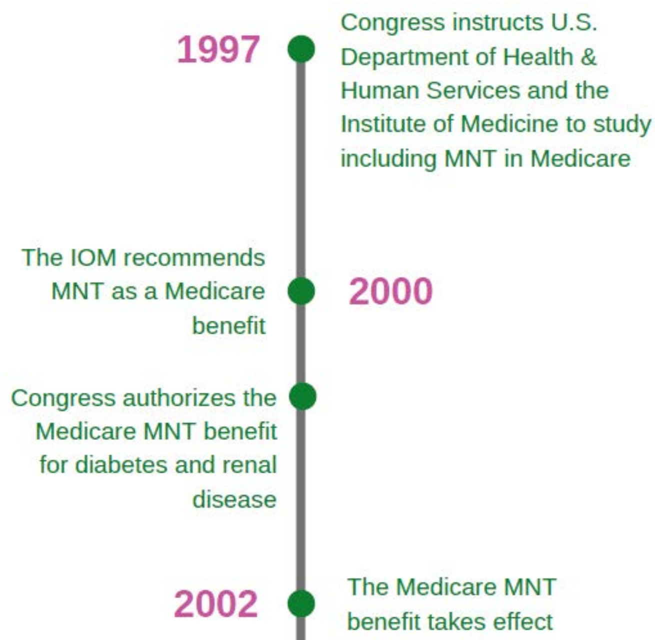
Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Spending, 2018[1]



According to the CDC's National Center for Chronic Disease Prevention and Health Promotion, 90% of the nation's $3.5 trillion annual health care expenditures is spent on treating chronic and mental health conditions.[11,12] Care for individuals with multiple chronic conditions is especially costly in the Medicare population.[1]

History of Medicare MNT Coverage

As a result of years of advocacy efforts by the Academy,[13] in the Balanced Budget Act of 1997, Congress instructed the Department of Health and Human Services and the National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine), to examine the benefits and costs associated with Medicare coverage for an expanded list of services including medical nutrition therapy.[14] The National Academies recommended that MNT should be a reimbursable benefit for Medicare beneficiaries.[15]



In 2000, these recommendations led Congress to authorize the MNT benefit for renal disease and diabetes in Medicare Part B.[16] The decision to cover only diabetes and renal disease was based on cost projections by the Congressional Budget Office. Congress specified that coverage required a referral from a physician.

The Centers for Medicare & Medicaid Services then developed regulations for the benefit, which went into effect January 1, 2002 after input from the Academy and others.[17] Using the national coverage determination process, CMS chose to cover three hours of initial MNT in the first year and two hours in subsequent years.

Additional hours were allowed if the treating physician were to determine that a change in the patient's diagnosis, medical condition or treatment regimen warranted a change in MNT. The reimbursement rate for dietitians was set at 85% of the physician rate.

MNT was added to the list of Medicare telehealth services in 2006, along with the addition of RDNs to the list of practitioners that may provide telehealth services under Medicare.[18]

Originally, MNT visits required a 20% copayment from the patient, but copayments were removed in 2011 pursuant to the Affordable Care Act's instructions to remove cost-sharing from evidence-based preventive services. Accordingly, CMS now pays for 100 percent of the service with no out-of-pocket costs for patient with Medicare Part B.[19]

Barriers to Care for Seniors

Many costly chronic conditions that affect Medicare beneficiaries could be prevented, managed or treated in part with MNT. Even with coverage limited to patients with diagnosed diabetes, renal disease and post kidney transplant, services are underutilized for a variety of reasons:

- **A referral from a physician** is required for a beneficiary to utilize MNT services under Medicare Part B.[20] Other qualified nonphysician practitioners such as nurse practitioners, physician assistants, clinical nurse specialists and psychologists are statutorily barred from directly referring their patients who have Medicare Part B to MNT services.[16] This poses a barrier to beneficiaries who may be under the care of a nonphysician practitioner who is licensed to practice as an independent provider in their state but precluded from exercising their full referral scope of practice by CMS. This especially impacts rural and medically underserved areas that rely more heavily on nonphysician practitioners.

- There are a variety of reasons why a physician **may not refer a patient to MNT services** even when medically indicated. Examples include a lack of awareness that MNT is a covered service, an inability to locate an RDN, and communication barriers or cultural competence concerns. In some parts of the country, appropriate MNT services may not be available within the travel radius of the beneficiary and—outside of the flexibilities imparted during the COVID-19 public health emergency—antiquated telehealth requirements often limit remote access to MNT services.[21]

- **Time and scheduling** pose barriers to MNT access as well. Most physician practices do not directly employ an RDN, forcing patients to make an additional appointment, often at another site on another day, to receive MNT services.[21] Transportation can pose a barrier for some older adults, which makes scheduling appointments over multiple days and locations a challenge to execute. Additionally, in the event the beneficiary has received a referral for both MNT services as well as Diabetes Self-Management Training, current coverage requires those services be received on different days.[20]

Health Equity

Communities of color have historically faced chronic disease health disparities due to systemic inequalities that have manifested in reduced access to health care, healthy food and safe places to be active. Below is a small sample of chronic disease rates and social determinants of health by race/ethnicity in the United States.

Rates of Select Chronic Diseases and Social Determinants of Health by Race/Ethnicity

Race/Ethnicity	Diabetes[22] (adults)	CKD[23] (adults)	Obesity[24] (adults)	Uninsured[25] (under age 65)	Food Insecurity[26] (households)
Non-Hispanic White	7.5%	13%	42.2%	8%	8%
Non-Hispanic Black	11.7%	16%	49.6%	11%	25%
Hispanic	12.5%	14%	44.8%	19%	20%
Asian/Native Hawaiian/Pacific Islander	9.2%[a]	12%	17.4%[a] 37.4-44.5%[b]	7%	20%[b]
American Indian/Alaska Native	14.7%	[c]	38.1%	22%	24%

[a] Asians only [b] Native Hawaiians/Pacific Islanders only [c] Data not available

The COVD-19 pandemic has magnified health disparities. The CDC lists people with obesity, diabetes and heart disease, as well as those undergoing dialysis for chronic kidney disease, as being at higher risk for severe illness from COVID-19, putting many racial and ethnic minority groups that experience health disparities at higher risk of poor COVID-19 outcomes.[27] With over a year of data from the COVID-19 pandemic, it is very clear that American Indian, Alaska Native, Hispanic, and Black communities have been hospitalized and died at significantly higher rates than Non-Hispanic White and Asian populations.[28,29,30]

The compounding impacts of systemic inequalities, food insecurity, reduced access to care and now COVID-19, underscore the need to provide equitable access to medical nutrition therapy in Medicare.

MNT is an Effective Solution

MNT has been shown to be a cost-effective component of treatment for obesity, diabetes, hypertension, dyslipidemia, HIV infection, unintended weight loss in older adults and other chronic conditions.[31-34] Counseling provided by an RDN as part of a health care team can positively impact weight, blood pressure, blood lipids and blood sugar control.[35,36] In a national survey of primary care physicians, respondents reported believing that RDNs were the most qualified health care providers to assist patients with weight loss.[37] Additionally, the National Lipid Association recommends nutritional counseling by RDNs to promote long-term adherence to an individualized, heart-healthy diet.[38]

What the MNT Act Does

The bill amends the Social Security Act to:

- Provide Medicare Part B coverage of outpatient MNT for **prediabetes, obesity, high blood pressure, high cholesterol, malnutrition, eating disorders, cancer, gastrointestinal diseases including celiac disease, HIV/AIDS, cardiovascular disease** and any other disease or condition causing **unintentional weight loss**;
- Authorize the Secretary of Health to **include other diseases based on medical necessity**; and
- Allow nurse practitioners, physician's assistants, clinical nurse specialists and psychologists to **refer their patients for MNT**.

Key Points for Legislators

- Medical nutrition therapy is nutritional diagnostic, therapy, and counseling services furnished by a registered dietitian for the purpose of disease prevention, management, or treatment;
- MNT is an evidence-based, cost-effective component of treatment that can help combat many of the nation's most prevalent and costly chronic conditions, including conditions that are contributing to poor COVID-19 outcomes;
- Access to MNT is especially critical for communities of color that suffer from chronic disease health disparities driven by reduced access to care, healthy foods and safe places to be active; and
- CMS does not have the authority to expand MNT in Medicare; passage of the MNT Act is a necessary step to providing adequate care to seniors.

For any questions on the Medical Nutrition Therapy Act, contact:

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