Nutrition Services Delivery and Payment: The Business of Every Academy Member

HOD Executive Summary

Academy members across practice settings are impacted directly or indirectly by the delivery of and payment for nutrition services. While we typically think of this issue in the context of clinical practice and direct providers of services, the fact is that members in a variety of practice settings touch the topic. For example:

- Management: Design and oversee programs in the acute, ambulatory care and home health settings.
- Community: Design, oversee and implement WIC, Ryan White, senior congregate meal programs and associated nutrition services, and community health programs.
- Business/Consultation: Design, oversee and implement employee wellness programs, and nutrition services in the retail market.
- Research: Design and conduct outcomes research and comparative effectiveness studies on the effectiveness of MNT and other nutrition services.
- Education: Provide education, training, and continuing education on the topic to undergraduate and graduate students, interns, and practitioners.

Massive changes are underway in health care delivery and payment systems that have implications for MNT, nutrition services, the business of dietetics across practice settings and the profession of nutrition and dietetics.

**Mega Issue Question:**
As the nation’s food and nutrition leaders in optimizing the nation’s health, what can we do to position nutrition services as an essential component of the evolving health care delivery and payment models?

**Meeting Objectives:**
Delegates and meeting participants will be able to:
1. Identify relevant stakeholders and their needs.
2. Comprehend the impact that current and evolving health care delivery and payment models will have on all areas of practice.
3. Give examples of successful integration into evolving delivery and payment models.
4. Communicate the need for nutrition and dietetics practitioners to be an essential part of evolving health care delivery and payment models.
5. Promote information to members and stakeholders and encourage members to utilize Academy resources.
6. Empower members to lead efforts and seize opportunities to provide cost-effective nutrition services to optimize the public’s health.

To obtain the full backgrounder [www.eatright.org/hod](http://www.eatright.org/hod) > Fall HOD Meeting Materials.

**Traditional Delivery and Payment Methods for Nutrition Services Across Practice Settings**
In terms of health care delivery in the United States, traditionally the majority of care has been delivered in acute-care settings through hospitals and hospital-based services. These services have been delivered with limited consideration of continuity and transition of care across practice settings. RDs and RDNs have not been integrated into physician practices to a significant extent due to limited third party reimbursement for services along with space constraints. In recent years, advances in health care along with a focus on cost-savings strategies have led to a dramatic change in the delivery of health care services. Individuals are increasingly receiving health care services in ambulatory care rather than acute-care facilities. Many former hospital-based services are now performed on an outpatient basis.
Health care is a business and, like any business, relies on payment from external sources for its survival and growth. Nutrition services have been part of the health care business in a wide variety of settings for varying lengths of time. Depending on the setting, payment for the professional services provided by RDs, RDNs and DTRs varies both in terms of payer source and methodology, with the public sector (Medicare and Medicaid) footing a significant portion of the bill. For facility-based care (e.g., hospital, nursing facilities), nutrition services are not separately billable services. In the outpatient arena, nutrition services generally are paid for under a fee-for-service system with specific coverage varying widely by specific payer and policy. For community nutrition programs, nutrition services frequently are paid for via block grant funding.

**Changes in Health Care Delivery and Payment**

The world of health care, both from the delivery side and the payment side, is undergoing massive changes, sparked by escalating costs that do not correlate with improved quality of care. Payment models are shifting from a focus on paying for individual procedures and services to a focus on paying for value and performance. The evidence shows three observations:

- Delivery system reform without payment reform does not work
- Investing in primary care works
- Cost accountability works

We are seeing a shift from a “sick care” system to one more focused on prevention and management of chronic diseases. Efforts are being made to remove silos and operate in a more team-based and collaborative manner. A major underpinning of these changes is the Triple Aim. The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement back in 2007 that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously accomplish three critical objectives:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care.

In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA) in order to increase the number of Americans covered by health insurance, improve affordability and stability of insurance, and slow the growth of health care costs. The ACA provides a framework for making the following changes in health care that could have broad implications for delivery and payment of nutrition services:

- Shift away from fee-for-service payment model
- Reorientation away from acute disease management toward a preventive care and wellness model
- Patient-centered approach to treating multiple chronic disease
- Emphasis on rural and under-served areas
- Reformed delivery service that includes more primary care providers, medical homes, and community based health centers.

While many of the provisions of the ACA relevant to RDs, RDNs and DTRs involve clinical practice, the paradigm shift directly affects most areas of practice. Also, it is important to note that the inclusion of nutrition under the ACA does not specifically designate RDs, RDNs or DTRs as providers of care. Thus, these provisions do not guarantee that any enhanced professional roles or new opportunities are reserved specifically for RDs, RDNs or DTRs.

**Health Care Delivery Solutions**

Recognizing that the traditional US health care system is not financially sustainable, new models of care are being promoted, and older models are being reinvented or receiving renewed attention in both the public and private sector. These models of care include:

- **Patient-Centered Medical Homes (PCMH)**
  - The PCMH is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.

- **Accountable Care Organizations (ACO)**
An ACO is a high-performing, organized system of care and financing that can provide the full continuum of care to a specific population over an event, episode, or a lifetime while assuming accountability for clinical and financial outcomes.

When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it gets to keep and divide the savings; providers get paid more for keeping patients healthy and out of the hospital.

ACOs are designed to be built around medical homes.

- Center for Medicare and Medicaid Innovation (CMMI) Projects of Interest to Academy Members
  - Comprehensive Primary Care Initiative
    - Tests a delivery model and primary care compensation structure with the goal to drive improvements for health care quality & financial outcomes.
    - Blended compensation model that includes three components: (1) fee-for-service, (2) per-member-per-month payment, (3) shared savings.

Beyond PCMHs and ACOs
Additional models are evolving focusing on care management and coordination:
- Health Homes for Chronically Ill
- Primary Care Case Management
- Managed Care or Coordinated Care Organization (MCO/CCO)

Health care is reorganizing around the concept of high-functioning teams as this approach has been shown to improve patient outcomes, improve office efficiency, and decrease health care costs. Integrated care teams, including RDs, RDNs and DTRs, can play a role in the provision of health services in a variety of practice settings, including acute care, ambulatory care, long-term care, and community health. As teams become high-functioning, one must be aware that the roles and scopes of practice of team members can become blurred.

Emerging Delivery Venues
New venues for providing health care services, including prevention and wellness services, are emerging as various stakeholders are seeking to control costs and capitalize on opportunities under the ACA. Private payers and hospital systems are partnering with retail establishments (e.g., pharmacies, grocery stores) to offer on-site health care clinics. Another significant trend in the delivery of health care services with implications for RDs, RDNs, and DTRs is “mHealth,” or the use of mobile technologies to improve the health of individuals and populations. These mobile technologies include health text messaging, mobile phone apps, remote monitoring and portable sensors.

For additional background, read:
Integrating Registered Dietitians into Primary Care: The Comprehensive Primary Care Initiative (CPCI) Toolkit. Available at [www.eatright.org/shop](http://www.eatright.org/shop).

“Paradigm Shift in Health Care Reimbursement: A Look at ACOs and Bundled Services Payments.” JAND 2012; 112 (7):974-976.
Health Care Payment Solutions
As noted above, research shows that delivery system reform without payment reform does not work. As a result, payers are experimenting with different payment methodologies, moving away from the traditional fee-for-service model to models that link payment to outcomes/performance. Some popular models include:

- Global Payments or Bundled Payments
  - In the global payment method, the third party payer makes one combined payment to cover the services of multiple providers who are treating a single episode of care. There is no additional payment for higher volumes of services or more expensive or complex services.
- Value-based Purchasing (VBP)
  - This payment methodology links provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide.
- Pay for Performance (P4P)
  - Bonus payment to a physician or physician group based on pre-established criteria set by the payer that commonly includes a combination of quality of care, cost of care, and patient satisfaction.

Changes in Hospital Payments
Over recent years CMS has instituted changes in hospital payment in an effort to control health care spending and drive quality improvement:

- Hospital Readmissions Reduction Program
  - An adjustment is made to the base DRG payment to account for excess readmissions (hospital performance as compared to the national average) for acute myocardial infarction, heart failure and pneumonia.
- Hospital-Acquired Conditions (HAC)
  - Hospitals do not receive additional payment for cases in which certain conditions identified by CMS was not present on admission. Examples of HACs relevant to nutrition include Stage III and IV pressure ulcers and manifestations of poor glycemic control.
- Hospital Value-Based Purchasing (VBP)
  - Hospitals are paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

Opportunities Ahead
Change always comes with uncertainties and challenges, and such is the case with the changing world of health care delivery and payment. Change also brings opportunities. As always, it is important to keep in mind that if we don’t seize these opportunities, someone else will.

- Fee-for-service
  - Medicare Part B MNT and DSMT benefit, Annual Wellness Visit, Intensive Behavioral Therapy for Obesity
  - As a result of the ACA, all non-grandfathered health plans must offer preventive services that have received a Grade A or B rating from the U.S. Preventive Services Task Force (USPSTF). This includes two diet/nutrition-related areas, “healthy diet counseling” and obesity screening and counseling for children and adults. Health plans can determine how many visits to cover as well as who they will pay to provide these services.
- Essential Health Benefits
  - Under the ACA, individual and small health plans sold in and outside of the state health insurance exchanges must cover 10 categories of services. Depending on the plans offered within each state, opportunities may exist for coverage of RD-provided services.
- Bundled Payments
  - Opportunities abound for RDs, RDNs and DTRs to participate in established Medicare ACOs, private ACOs and PCMHs, as well as the many PCMH and ACO pilot programs underway. The RD and RDN are not listed by profession for ACOs...however:
    - Institutions and providers have monetary incentives to prevent readmissions
• Including the RD and RDN as part of the health care team can be seen as an investment to prevent readmission and improve the health and wellbeing of the patient
• The RD and RDN service is positioned to save physician time which translates into lower operating costs.

• Focus on Prevention
  • Opens up opportunities for RDs, RDNs and DTRs to play a more frequent role in providing lifestyle and weight-management services as part of health-promotion and disease-prevention efforts within worksites, schools, community clinics, health clubs, social service programs, and other community settings. Medical nutrition therapy (MNT) is known to be a key component in treating many of the chronic conditions plaguing our nation and is linked to improved clinical outcomes and reduced costs.

     For additional background, read:
     Medical Nutrition Therapy MNTWorks® Kit available at www.eatright.org/shop
     Projections and Opportunities for an Increasing Demand for Dietetics Practitioners: 2011 Workforce Demand Study Results and Recommendations. J Acad Nutr Diet. March 2012 Supplement1

     For information on how members are currently involved in nutrition services delivery and payment, read the Member Spotlights section
     Available at www.eatright.org/hod > Fall HOD Meeting Materials

Academy’s Efforts to Position Nutrition Services in Evolving Delivery and Payment Models
Starting in 2009 with dialogue session in the House of Delegates on Health Care Reform and formation of an internal Patient Centered Medical Home Workgroup, the Academy has been focused on educating and supporting members so they can be successful in the changing world of health care delivery and payment. In particular, the Academy’s Nutrition Services Coverage (NSC) team and Coding and Coverage Committee work tirelessly on developing resources for members related to the changing world of health care delivery and payment. Read the full Backgrounder for details on available Academy resources, ongoing initiatives and current projects of the Coding and Coverage Committee.

Key Links to Academy Resources and Information on Academy Initiatives
www.eatright.org/coverage
www.eatright.org/mnt
www.eatright.org/shop
reimburse@eatright.org
www.eatright.org/Public/ - What is an RD?

Summary
Health care delivery and payment models are changing. Academy members need to understand these changes and proactively position themselves and their services within this evolving environment if they are to achieve the recognition, respect and remuneration they seek. Branding starts with the individual, as does the task of integrating RDs, RDNs, DTRs and nutrition services into the current and future health care system. At the end of the day, it’s about the quality of nutrition services provided by RDs or RDNs. The evolving business models impact all health care settings and all areas of practice. Opportunities abound but, as with all opportunities, Academy members need to seize them before other health care providers do.

Seize the opportunities that are waiting for you. Join the experiment. We can come out on top!

To obtain the full backgrounder www.eatright.org/hod > Fall HOD Meeting Materials.