Academy of Nutrition and Dietetics

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

HOD Backgrounder

House of Delegates *Fall 2013*

Introduction:

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, 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. This Backgrounder sets the stage for an informed discussion of the following Mega Issue Question:

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.

Knowledge-based Strategic Governance is a mechanism for consultative leadership. It recognizes that "strategy" is the necessary and appropriate link in the Board's role to govern the organization, the House's role to govern the profession and the staff's role to manage implementation. To assist you in thinking about the issue to be addressed, four key background areas are presented as standard questions used for each Mega Issue. These questions create an environment of awareness of what we know and what is unknown. A wide range of resources has been used to provide you with what is known.

Question #1: What do we know about the current realities and evolving dynamics of our members, marketplace, industry, profession that is relevant to this decision?

Where do Academy members and RDs work? According to the *Academy's 2012 Needs Satisfaction Survey* (1), half of working RDs indicated their primary practice area as clinical practice, with 21% in inpatient, 19% in outpatient, and 9% in long term care. When asked to indicate all of the practice areas in which RDs spend at least 20% of their time, the results were as follows [Figure 4]:

- 30% acute care, inpatient
- 13% acute care, outpatient
- 15% ambulatory/outpatient care
- 16% long term/extended care
- 7% rehab facility
- 14% community/public health program
- 12% private practice
- 9% government agency
- 8% non-profit agency
- 11% college/university faculty

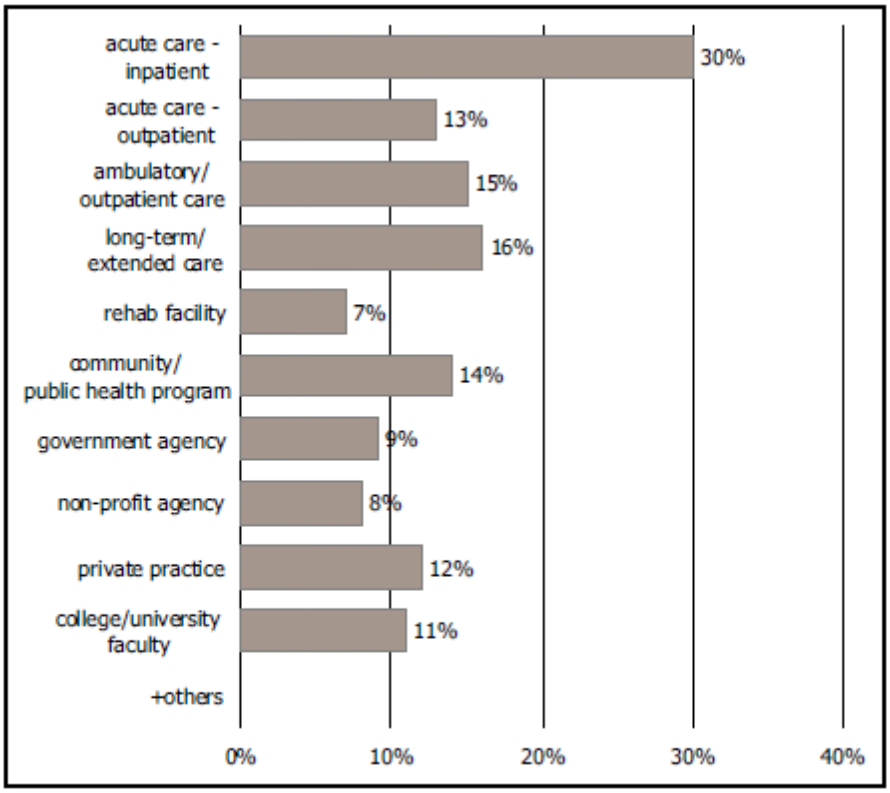

Figure 4. Primary work settings (20% or more of time) of registered dietitians working in dietetics and surveyed for 2012 Needs Satisfaction Survey (multiple answers accepted).

Traditional Delivery and Payment Methods for Nutrition Services Across Practice Settings

Health Care Delivery

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. A team approach to care was often limited to teaching hospitals, family practice residency clinics, nutrition support teams, and care team conferences in skilled nursing facilities. The patient was viewed as the recipient of care and played a limited role in setting health care goals and making decisions about their care. Health care providers often functioned in "silos" with a paper medical record serving as the primary mechanism for sharing information. The visibility of RD, RDN and DTR documentation of nutrition services varied widely, along with their participation on health care teams. 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. As a result, the relationship between RDs and RDNs in private practice and physicians has focused primarily on the referral process for nutrition services as opposed to team care planning.

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 Payment

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. For example:

- Hospital inpatient setting: approximately 40% of inpatient hospital stays are paid by the Centers for Medicare & Medicaid services (CMS), with the next major payer being private insurance (32%) (2). Medicare pays hospitals using a prospective payment system (PPS) under which payment is made on a per discharge or per case basis utilizing diagnosis-related groups (DRG). Since 2008, CMS has used the Medicare severity-diagnosis related groups (MS-DRG) system to determine payments for such stays. Under this system, patient cases are classified into 1 of 749 groups based on principal diagnoses, procedures and severity levels. The severity levels are determined according to whether patients have a complication or co-morbidity associated with the base DRG. These payment rates are then adjusted to account for local market conditions and other factors (e.g., costs of providing medical education and serving a high percentage of low-income patients) (3). Food and nutrition services, including assessment of nutritional status, diet instructions and counseling provided by RDs, for hospitalized patients (in-patients) are bundled (included in) into room and board fees under the hospital Medicare Part A "conditions of participation"(4). Hospitals therefore cannot bill Medicare separately for professional services provided by the RD, RDN or DTR. Certain ICD-9 codes for malnutrition, when documented as a diagnosis by the physician, qualify as complications/co-morbidities and can potentially enhance hospital reimbursement (5).
- Nursing care facilities: Approximately 31% of stays are paid by Medicaid and 25% by Medicare Part A (6). The nursing facility payment model is a prospective payment system (PPS) in which per diem payments for each admission are adjusted for case mix and geographic variation in wages. Case mix is classified using Resource Utilization Groups (RUGs) based on data from the MDS 3.0. Similar to hospital payment, PPS per diem payments cover all costs of furnishing covered services, including ancillary services, which by definition includes food and nutrition services (7). Therefore, nursing facilities cannot bill Medicare or Medicaid separately for professional services provided by the RD, RDN, or DTR.
- Outpatient and office based: Medical nutrition therapy (MNT) provided by RDs and RDNs is paid by public and private payers to varying degrees across the country. In addition, clients may choose to pay out of pocket for these services. In all cases, payment is made under a fee-for-service payment system. Currently, the only universal national coverage and payment guidelines in existence are under Medicare Part B, which, effective 1/1/2002, covers a limited number of hours annually for MNT services for individuals with diabetes, renal disease, and up to 36 months post-renal transplant. Medicare Part B also covers Diabetes Self-Management Training provided by RDs. Coverage and payment under Medicaid varies state-by state. Private insurance coverage for services provided by RDs and RDNs varies widely based on the specific health plan

and coverage policies. In many cases the RD or RDN can independently bill for services. Some situations exist where the payer will only pay for nutrition/MNT services when provided "incident to" the physician. In these situations, the physician must bill for the services provided by the RD or RDN. DTRs do not qualify as independent providers and billers for MNT services under any payer source.

- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): These health care facilities were established by federal law to provide outpatient services typically furnished in a physician's office in underserved rural areas and areas where there are shortages of health professionals. These facilities are paid by CMS using an all-inclusive encounter rate based on a core set of required primary and preventive health services. DSMT and MNT provided under the Medicare coverage requirements are covered services when provided in an FQHC. Other diabetes counseling or medical nutrition services provided by a RD at the FQHC may be considered incident to a visit with an FQHC provider. In the case of RHCs, while DSMT and MNT services provided in an RHC are covered, they do not constitute an RHC visit for purposes of billing. Rather, the cost of providing such services may be allowable on the cost report. Diabetes counseling or medical nutrition services provided by a RD at an RHC may be considered incident to a visit with an RHC provider provided all applicable conditions are met (8).
- WIC (Special Supplemental Nutrition Program for Women, Infants and Children): WIC is a Federal grant program under which funds are provided to WIC State agencies to pay for WIC foods, nutrition education, breastfeeding promotion and support and administrative costs. These block grant funds are used to cover the costs of the RD or RDN and DTR services.
- Home health: Medicare's payment system for home health services is an example of a global payment method. Various types of home health services are consolidated into the single payment. These services include all speech therapy, physical therapy, and occupational therapy; skilled nursing visits; home health aide visits; medical social services, and non-routine medical supplies. Professional services provided by RDs and RDNs are included as part of the administrative fee under Medicare Part A. The Medicare Part B MNT benefit can be provided as a separately billable service for patients who meet the eligibility criteria (see www.eatright.org/mnt). Private payer policies vary in terms of coverage for professional services provided by RDs and RDNs to home health clients.
- Worksite wellness: Employers have paid for programs provided by RDs, RDNs, and DTRs from the organization's budget as part of employee benefits programs to attract and retain employees and potentially reduce health insurance premiums and payments (especially self-insured companies). The Patient Protection and Affordable Care Act includes several provisions that support the establishment of such programs by small employers and expands the options to employers to offer rewards to their employees for participating in such programs and meeting certain health-related standards. The expense of an employer-provided wellness program for employees is deductible as a business expense. Some states offer tax credits to companies that establish a wellness program for their employees.

The Case for Change

The world of health care, both from the delivery side and the payment side, is undergoing massive changes. Why? Simply put, our current health care system in the United States (US) is broken, for many reasons. The US health care system is the most costly in the world, accounting for 17% of the gross domestic product with estimates that percentage will grow to nearly 20% by 2020 (9). Experts have identified the following sources of "waste" in the US health care system (10):

- Failures of care delivery
- Failures of care coordination
- Overtreatment
- Administrative complexity
- Pricing failures
- Fraud and abuse.

Despite these high health care expenditures, the quality of health care in the US in general ranks lowest among industrialized nations [see figure] (11).

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Historically, health care providers have operated in silos, working in isolation from one department or health care entity to another. Information infrastructure was not in place on a wide scale to support communication and integration of care processes across the care continuum, resulting in variation and re-work rather than process improvement that might result in lower costs. The fee-for-service system drives increased delivery of services based on consumer demand and third party payment. It does not incentivize providers to focus on disease prevention and does not translate into better quality of care.

Primary Care and Patient-Centered Care Seen as Key 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. Reports are coming out on a regular basis as different agencies and organizations explore solutions to the troubles of the US health care system. Studies have shown that a robust primary care system leads to lower costs, improved effectiveness and equity, and better quality of care. For example, in January 2013 a report issued by the Commonwealth Fund identified primary care and the patient-centered medical home (PCMH) as keys to improving health care quality and achieving billions in health care cost savings during the next decade. The report lists broad strategies and specific policies that rely heavily on primary care and the PCMH to achieve improved quality, enhanced access and cost savings. By adopting the report's recommendations, the U.S. health care system could reduce health care expenditures by more than $2 trillion (12).

After a long, long time, 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. 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 3 things:

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

Achieving the "Triple Aim"

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 (13).

Federal Solution: The Patient Protection and Affordable Care Act ("ACA")

In 2010, Congress enacted the Patient Protection and Affordable Care Act 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 (14). The ACA provides a framework for making the following changes in health care that

Member Spotlight

I first learned of patient centered medical homes in 2008 after attending a team meeting at the private practice I worked at. At this time, collaboration was in the works between a private corporation, the hospital, and individual provider practices to develop a patient centered medical home. I, like others in the room, nodded and pretended I knew what they were talking about, but I did not have a clue. Leaving the meeting I headed back to "Google" this new term. Feeling overwhelmed with the information, I wondered how I had never heard of this concept before. After updating myself on current literature, I wanted to determine how I fit into this model of care, so I approached a highly supportive endocrinologist with my concerns. At this time I developed a list of programs and opportunities to provide medical nutrition therapy for patients in the pilot program. This plan included use of evidence based data to support MNT, DSMT, diagnosis codes, and hours that should optimally be covered. Understanding the importance of the team in the medical home, I also approached the pharmacists and our diabetes educator team to discuss opportunities to develop team programs. After some review the endocrinologist took our recommendations to the leadership team and encouraged coverage of these programs. To my surprise, all programs were APPROVED, which allowed the practice to expand reimbursable services for many conditions not typically covered by commercial insurance (i.e. obesity). The success of the medical home model was adopted by the local hospital as well, and services that were approved for our initial pilot were also covered for employees and their dependents, further expanding access. My story is a little dumb luck, yet it highlights the importance of advocacy and use of evidence based data. There are endless opportunities for collaboration as an employee, contractor, or private practice. Good luck and get out there!

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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 (15-16).

Through several major provisions of the ACA, access to and affordability of overall health care services and, specifically, prevention, wellness and chronic disease management services, will expand (15, 17):

- Individual mandate: requires most Americans to maintain "minimum essential" health insurance coverage.
    - Essential Health Benefits include 10 categories of services, including "Ambulatory patient services" and "Preventive and wellness services and chronic disease management"
    - For individuals who are not exempt, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance through the new American Health Benefits Exchanges.
- Wellness/Prevention for Employees: Permits employers to offer employees rewards – in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided – for participating in a wellness program and meeting certain health-related standards. Requires a report on the effectiveness and impact of wellness programs.
- School-Based Health Clinics: Establishes new programs to support school-based health centers. Optional services include nutrition counseling, but providers are not specifically listed.
- Medicare Preventive Services:
    - Eliminates cost-sharing for Medicare covered preventive services with a Grade A or B rating[1] by the U.S. Preventive Services Task Force (includes MNT, but not DSMT).
    - Provides for an annual wellness visit that includes personalized prevention plan services with a health care assessment. RDs are listed as screening and counseling providers.
    - Authorizes the Secretary to modify or eliminate coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force (USPSTF).
- Medicaid:

[1]The USPSTF uses an evidence analysis process to conduct systematic reviews on specific topics which then serve as the scientific basis for their recommendations. Grades are used to indicate the strength of the evidence behind each recommendation. A Grade of "A" indicates "the USPSTF recommends the service. There is high certainty that the net benefit is substantial." A "B" Grade indicates "the USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial."
http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm. Accessed July 9, 2013

    - Optional program expansion to all non-Medicare eligible individuals under age 65 with incomes up to 133% Federal Poverty Level. All newly eligible adults guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.
    - Coverage for preventive services with a Grade A or B rating by the USPSTF without copayments or cost-sharing.
    - Home- and community-based waiver services to help people remain in their homes and communities.
    - Enhanced reimbursement rates for providers.
- Home Health: Establishes a demonstration program with a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams. It is designed to reduce expenditures, improve health outcomes and achieve patient satisfaction. RDs are eligible for payment if they are included in the home health practice, but are not required as part of the practice.
- Medical Homes: Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home.
- Child Obesity Demonstration Project: Funds a demonstration project aimed at reducing childhood obesity in community-based settings and schools through education, counseling, and training activities.
- Free Preventive Services: Coverage in government or group health plans without cost-sharing for preventive services with a Grade A or B rating by the USPSTF.
- Health Center Expansion: Increases funding for community health centers and establishes new programs to support nurse-managed health clinics.
- Center for Medicare and Medicaid Innovation: Provides a platform for developing new approaches to paying for health care that reward quality, efficiency and value.
- Medicare Bundled Payments for Care Improvement Initiative: The law calls for the establishment of a national pilot program on payment bundling for the Medicare program by 2013 and a Medicaid bundling demonstration program by 2012.

Member Spotlight

The Medicaid 1115 Waiver was introduced to Texas in 2011 as a way to preserve the hospital UPL (upper payment limit) funding that entities received to provide care for the underserved populations across the State. The Waiver introduces strict expectations and standards that will facilitate improving the quality and efficiency of the care the underserved populations receive. The overall goal of the Waiver is to transform the care delivery system for the most vulnerable populations through expanding coverage, changing the delivery system structure, alter benefits and cost sharing, and modify provider payments and extend coverage during an emergency.

The Waiver introduces two streams of funding:

1) UC (Uncompensated Care) pool: costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers. This is a fixed dollar amount based on the hospital's historical contributions, size, etc.
2) Delivery System Reform Incentive Payments (DSRIP) which supports coordinated care and quality improvements through completion of projects. DSRIP dollars are "at risk" and are pending achievement of project metrics and milestones.

In June 2012 due to my position as interim president of the system Diabetes Health and Wellness Institute I participated in a core team of senior leaders who designed and created DSRIP projects and associated metrics. We created 7 overarching projects at multiple hospitals and clinics in 2 geographic regions. Nutrition education is a vital component of multiple projects, particularly related to chronic disease management. Project design and protocol development is underway and expanded opportunities for RDs in case management, MNT and oversight of Community Health Workers exist.

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- Changes in hospital payments (DSH): Reduces Medicare Disproportionate Share Hospital (DSH) payments and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. Also reduces states' Medicaid DSH allotments and requires the Secretary to develop a methodology for distributing the DSH reductions.

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 (15).

Health Care Delivery Solutions:

Patient-Centered Medical Homes

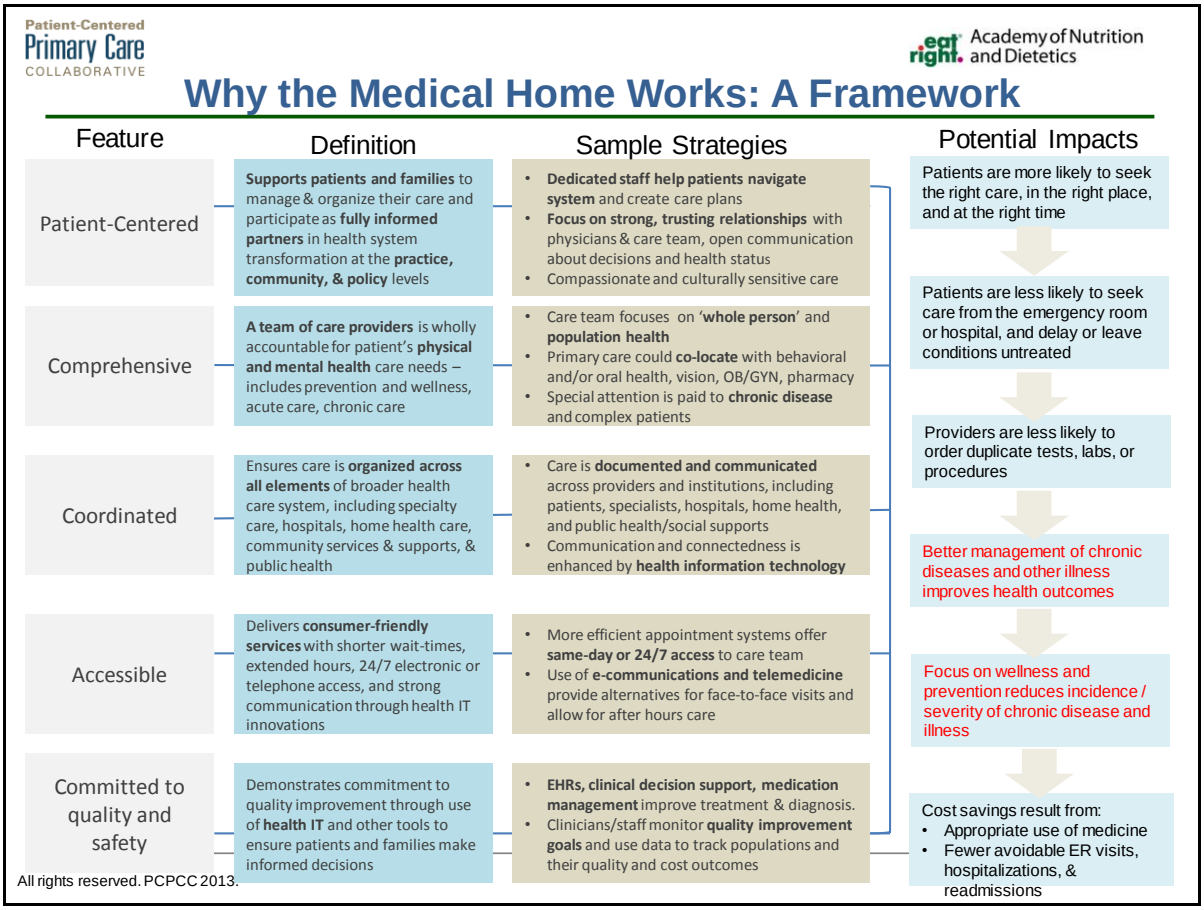
The National Committee for Quality Assurance provides the following definition of a PCMH (18):

> "A PCMH is not a house, hospital or other building and should not be confused with home-health or home-care. 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. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians."

The Patient-centered Medical Home (PCMH) model is not new. It started in 1967 in pediatrics to coordinate care of patients with special needs. In 2007, all primary care organizations developed 7 Joint Principles for the PCMH. This model of care is now seeing widespread adoption in both the public and private sectors, for both children and adults:

- More than 90 commercial insurance plans
- Employers
- 42 state Medicaid programs
- Federal agencies
- Department of Defense
- Hundreds of safety net clinics[2]
- Thousands of small and large clinical practices (19)

[2] The Institute of Medicine defines the health care safety net as: "Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients." Examples of safety net clinics include community health centers, federally qualified health centers, local health departments, school-based health programs and Ryan White AIDS programs.Institute of Medicine. 2000. America's Health Care Safety Net: Intact but Endangered. Washington, DC: National Academy Press, p.3-4):



SOURCE: The TrasforMED Patient Care Model. TransforMed 2009. Website: http://www.transformed.com/pdf/TransforMEDMedicalHomeModel-letter.pdf. Accessed May 13, 2013.

The PCMH concept has been expanded to that of a Patient Centered Medical Neighborhood (PCMN), which consists of everyone who helps the patient take care of their health. It is a community of patients, doctors, nurses, hospitals, clinics, pharmacies and more. In both concepts, the goal is great care at a lower cost (20).

In March 2009, the Academy appointed a Medical Home Workgroup. The PCMH workgroup was charged with gathering and assessing information related to RD's current involvement in this model of care and to develop a strategic plan. The workgroup sent out a survey to a random sample of 7,800 RDs and found (13.5% response rate):

- 77.3% were unfamiliar with the PCMH concept
- 16.5% were familiar with the PCMH but did not work in a PCMH setting
- 6.3% participated in a PCMH model for care in 19 different states.

The Academy PCMH Workgroup concluded that "RDs must take a more proactive approach if their role is to be fully recognized and funded by the PCMH." (21).

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Dietetic Practitioners Need to Know:

There are many places within a PCMH that the RD or RDN and DTR fit in, such as-

- **Access to Care and Information: Group Visits**
- **Practice Based Services**
- **Case Studies**
- **Care Coordination**
- **Practice Based Team-Task Designation by Skill Set**
- **Quality and Safety-Evidence Based Best Practice**

Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the patients they serve. "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" (22).

Goals of the ACO:

- Efficiency
- Quality
- Effectiveness
- Access
- Patient-centeredness
- Equitability

ACOs often focus on at-risk populations, such as diabetes, HTN, heart failure, CAD (low hanging fruit in terms of reducing costs and improving 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.

Just like PCMH, ACOs also are not a new idea. And just like PCMHs, Accountable Care Organizations are also on the rise in both the public and private sector. Growth in the public sector has been spurred by provisions in the ACA. Data from 2013 reveals:

- ACOs stretch across 49 states, Washington DC and Puerto Rico
- 428 ACOs as of January 2013
- ACO activity in the private sector outnumbers the government sector by a factor of four to one
- Majority of ACOs are found in large metropolitan regions
- Physician groups have overtaken hospital systems and have now become the largest backer of ACOs (23).

No universal model of an ACO exists, with each entity developing a design to meet its needs. These designs vary in terms of organizational structure and relationships among providers and stakeholders. ACOs are expanding beyond primary care to focus on specialty care and specific diseases. For example, Florida Blue formed two oncology ACOs in 2012. In February 2013, CMS announced its Comprehensive ESRD Care initiative, which is similar to its ACO program, but specific to end stage renal disease (24).

Member Spotlight

I currently work as a clinical project manager for the University of Michigan Ambulatory Care Services. My background as a clinical dietitian combined with the operational experience I got as the founder and director of the Diabetes Education Program here at the University have been great assets in my current role. As part of my job I support all 24 primary care clinics to meet all the requirements put in place by BCBS of Michigan to maintain "Patient Centered Medical Home" designation. Some of the implementations that I have worked on over the last couple of years include:

- Population management:
  - Development and implementation of team roles (Care Navigator, RD, RN, PharmD, social worker, panel manager, MA and clerk)
  - Management of gaps in care (in clinic or between clinic visits) for patients that need preventive care or have a chronic condition
  - Chronic care management
    - Self-management training using the empowerment approach to all the care navigators, RDs, RNs (primary care only) and PharmDs
    - Disease specific training to care navigators and nurses
  - Transition of care:
    - Calls by the primary care nurse or care navigator to connect patients that have been discharged from the hospital or the ED back with their medical home and make sure they have a follow up appointment and they know how to correctly take their medications.
    - Adult as well as pediatric patients receive these calls within 24 to 72 hours after discharge.
  - Operational Guidelines for several capabilities

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Dietetic Practitioners Need to Know:

- Who is establishing ACOs in your community?
- Identify key leaders and decision makers (Director of Managed Care, Case Manager, MDs, CNPs, etc.)
- Arrange a meeting to discuss opportunities
- Provide evidence for the benefits that an RD can bring to ACO target population
- Build relationships across the RD community

Center for Medicare & Medicaid Innovation (CMMI)

Widespread experimentation with various health care delivery and payment models is happening in both the private and public sectors as everyone strives to improve quality and control costs. The Center for Medicare & Medicaid Innovation (CMMI) was created under the ACA to fund pilot projects within the Medicare and Medicaid populations that explore new approaches to paying for health care that reward quality, efficiency and value. A project of particular interest to Academy members is the Comprehensive Primary Care Initiative (CPCI):

- Goal is to help primary care practices deliver higher quality, better coordinated, and more patient-centered care.
- Recognizes that a primary care practice is a key point of contact for patients' health care needs.
- Tests a delivery model and primary care compensation structure with the goal to drive improvements for health care quality & financial outcomes.
- Builds on existing reform efforts:
    - Patient-centered medical home (PCMH)
    - Accountable Care Organizations (ACOs)
    - Meaningful Use (MU) standards
- Blended compensation model (*denotes RD and RDN opportunities):
    - Fee-for-service
    - Risk-adjusted care coordination per-member-per-month (PMPM) payments: to support value-added non-billable practitioner time*, advanced care team functionality*, or investments in HIT utilization
    - Share in saving eligibility: practice level quality & utilization metrics
- 7 markets/500 participating practices/313,000 estimated Medicare beneficiaries:
    - **Arkansas:** Statewide
    - **Colorado:** Statewide
    - **New Jersey:** Statewide
    - **New York**: Capital District-Hudson Valley Region
    - **Ohio and Kentucky**: Cincinnati-Dayton Region
    - **Oklahoma**: Greater Tulsa Region
    - **Oregon**: Statewide
- Opportunity to integrate RDs and RDNs into primary care
    - Compared with other health care providers, RDs and RDNs have the best training for prevention and chronic care management; patient and caregiver engagement
    - Proven outcomes for MNT for obesity, diabetes, disorders of lipid metabolism, & hypertension

- PMPM fee may allow practices to pay for RD and RDN services (25)

Menu of Services RDs Can Provide to CPCI Practices

- Management of patients in the CPCI practice with "high health needs"
- Lifestyle counseling
- Collecting quality measures data
- Managing patient registries
- Conducting between-visit follow-up
- Conducting group visits
- Providing fee-for-service MNT for diabetes and renal diagnoses
- Providing "incident to" weight management services
- Participating in practice quality improvement initiatives
- Coordinating patients' care across the health system

Another demonstration project funded by the CMMI is the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration, which is assessing how the patient-centered medical home model can achieve the Triple Aim. There are 500 FQHCs participating in this demonstration, providing opportunities for RDs and RDNs to demonstrate their value (26).

Beyond PCMHs and ACOs

Additional models are evolving focusing on care management and coordination:

- Health Homes for Chronically Ill
  - A physician, other provider or team of providers may serve as a health home
  - The health home serves to integrate and coordinate all primary, acute, behavioral health, and long-term services
  - Enhanced federal funding is available for health homes under Medicaid that target beneficiaries with 2 or more chronic conditions
  - Provider payments can be "tiered" based on the severity of each individual's chronic illness
  - Requires provider investment in clinical integration and care management

- Primary Care Case Management
  - Primary care provider assumes responsibility for monitoring the care of assigned Medicaid beneficiaries, including providing prior authorization for more advanced care
  - Providers receive a monthly case management fee to supplement fee-for-service reimbursement
  - PCCM is often coupled with other programs, such as disease management
  - PCCM has been widely adopted by Medicaid programs

- Managed Care or Coordinated Care Organization (MCO / CCO)
  - MCO or CCO takes full responsibility for coordinating the care for a population for a PMPM, capitated rate
  - Plans can be provider-led, managed in partnership with a commercial insurer, or managed solely by a commercial insurer
  - HMO plans can target specific populations
  - Plan could participate in the health benefit exchanges in 2014 (if plan also licensed in commercial market)

- Plans assume all risk but have medical and care management control – closer to the premium dollar

Focus on Team-Based Care

Health care is reorganizing around the concept of high-functioning teams. Building effective team-based patient care has been shown to improve patient outcomes, improve office efficiency, and decrease health care costs (27).

The Canadian health care system recognized the benefits of team-based patient care in the report *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada.* Main messages from the report include:

- A health care system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among health care professionals.
- Successful teams recognize the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility.
- The makeup and functioning of teams vary depending on the needs of the patient. Patients and their families are important team members with important roles in decision making (28).

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 (29).

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. The role of RDs and RDNs in supermarkets is expanding beyond traditional nutrition education activities into nutrition counseling and MNT. These trends help to meet consumer needs for convenience (location, hours) and "one-stop shopping." At the same time, primary care providers often view these activities as potentially undermining the PCMH concept and creating challenges for care coordination.

Member Spotlight

Bonnie is employed as a researcher at the University of Colorado School of Medicine. Positioned in the Department of Family Medicine, she is actively involved with their practice-based research network. Her department has been working with primary care practices to assist them in adopting the key components of the Patient-Centered Medical Home (PCMH). Bonnie's expertise in nutrition and diabetes management is particularly useful for working with practices on key components of the PCMH, including engaging patients in self-management support and chronic disease management. Bonnie assists the practices by providing self-management support materials and training the providers and staff on patient-centered counseling techniques.

As a RD, Bonnie also has valuable expertise in working with other healthcare professionals as part of team-based patient care, and working across the medical neighborhood. Through these experiences, Bonnie is able to assist practices in developing practice systems to enhance team-based care, from the front office to the back office. She also works with the practices on developing systems to coordinate and communicate with specialists and other healthcare providers so that the patient's care is coordinated across all systems. She has been able to connect two of the larger physician groups with a RD to deliver MNT and services related to diabetes and chronic disease management.

As an educator, Bonnie develops curriculum around the PCMH for medical students and primary care residents.

Bonnie T. Jortberg, PhD, RD, CDE
Assistant Professor, Department of Family Medicine
University of Colorado School of Medicine

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. The growth of mHealth has been spurred by the rapid growth of mobile phone use and text messaging. mHealth is being used by all stakeholders in the health care system, including patients, providers and payers, to enhance consumer engagement, improve loyalty, achieve competitive advantage, lower costs, and improve health outcomes. Examples of mobile technologies related to nutrition services include diet and exercise logs, mobile health coaching, blood glucose and blood pressure sensors, appointment scheduling and reminders systems, and episodic care daily texts (e.g., text4baby).

For additional background, read:

Integrating Registered Dietitians into Primary Care: The Comprehensive Primary Care Initiative (CPCI) Toolkit. Available at 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. In the global payment method, there is no additional payment for higher volumes of services or more expensive or complex services. If the costs of care during the episode or timeframe are less than the bundled payment amount, the providers keep the difference. Conversely, if costs exceed payment, providers absorb the loss. In some proposed models of bundled payment, such as the accountable care organizations (ACOs) framework, savings are shared by all entities involved. Bundled payment has been proposed to address some of the shortcomings of the current fee-for-service payment system, such as overuse of well-reimbursed services and fragmented, uncoordinated care delivery. Proponents of bundled payment believe that it will lead to more judicious use of health services and improved care quality (30).

Two approaches to bundled payments are commonly seen:

- Episode bundles: Single rate for all services for a particular procedure. Single price that covers costs across the continuum of care, which could include facility costs (e.g., hospital, nursing home, clinic, outpatient rehabilitation); technical and professional fees for radiology, pathology, laboratory; professional fees for anesthesia, surgery and consultation, and home care costs. Example: Hospital and physician services for acute episodes such as hip replacement or cardiac catheterization

- Patient bundles: Combine payment for all treatments for a chronic condition for defined period of time. Example: Physician, hospital, and support services associated with the management of a patient's congestive heart failure for one year

While there is great interest in this payment reform approach, data is lacking on how to best design and administer bundled payments. Many questions remain; foremost for RDs, RDNs and DTRs is how payments for the nutrition components of care will be determined.

ACO Bundled Payment Example

Academy of Nutrition and Dietetics

Bypass surgery for patient with uncontrolled Type 2 DM:

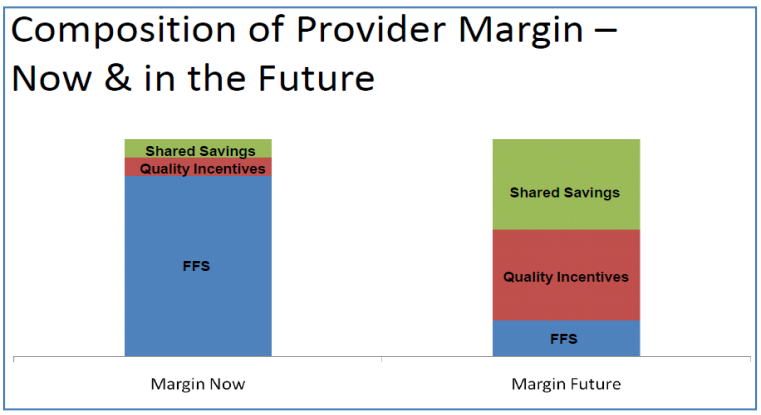
Service Total = $101,500	Fee-for-Service	Service Overall budget = $89,300	ACO Bundled Payment (Savings of $12,200)
Hospital Care	$47,500	Hospital Care	$61,000
Surgeon Fee	$15,000	Physician Fee	$13,000
Fee for uncontrolled DM	$12,000 (hospital) $2,000 (physician)	Potential avoidable costs	$15,300
Readmission for vein infection	$25,000	If readmission avoided, hospital paid additional	$12,800

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. Providers financially rewarded for good outcomes rather than number of visits. Providers bear risk of negative outcomes – complications arising afterward will not be reimbursed, nor will follow up visits. Implemented as a payment method by Medicare for hospitals beginning in Fiscal Year 2013.

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*: For discharges beginning on or after October 1, 2012, 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. A readmission is defined as an admission to an acute care hospital within 30 days of discharge from the same or another acute care hospital.
- *Hospital-Acquired Conditions (HAC):* For discharges occurring on or after October 1, 2008, hospitals do not receive additional payment for cases in which certain conditions identified by CMS was not present on admission. These conditions are high cost or high volume or both; result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines. Examples of HACs relevant to nutrition include Stage III and IV pressure ulcers and manifestations of poor glycemic control (31).
- *Hospital Value-Based Purchasing (VBP) Program*: Starting in October 2012, Medicare rewards hospitals that provide high quality care for their patients through the Hospital Value-Based Purchasing (VBP) Program. Under VBP, hospitals are paid for inpatient acute care services based on care quality, not just the quantity of the services they provide. Under the Hospital VBP Program, Medicare makes incentive payments to hospitals based on either:

  1) How well they perform on each measure, or

Member Spotlight

In the state of Rhode Island, the affiliate dietetic association (RIDA) has seized opportunities to integrate registered dietitians into PCMHs across the state. Two major PCMH initiatives have been developed in the state:

- CSI-RI (Chronic Sustainability Initiative in Rhode Island): a multi-payer program launched in 2008 with a focus on diabetes, depression and CAD.
- BCBSRI (Blue Cross Blue Shield of Rhode Island): Program focused on medically complex members utilizing a pay for performance outcomes based payment.

Starting in March 2010, RIDA members began meeting with the Medical Director of BCBSRI and physicians involved in the BCBS program. Presentations were also made to the Nurse Case Managers for the BCBS program emphasizing the role of the RD in providing MNT. As a result of these meetings, the BCBS Medical Director, as well as the physician project coordinator of the CSI-RI, delivered presentations to dietitians on the important role of the RD on the PCMH team.

RIDA leadership continuously encourages RDs in private practice to become referrals for the physician offices participating in the PCMH projects. Periodic in-services are provided to the nurse case managers and physicians involved in PCMHs to keep RDs in the forefront. As more practices qualify for PCMH status, RIDA leaders contact them to see if they have a RD as a resource and to provide them with a list of RDs in private practice. Presently 30% of the PCMH practices have RDs involved either as a referral or positioned in the offices.

Peggy O'Neill, RD, CDE
Reimbursement Representative
Rhode Island Dietetic Association

2) How much they improve their performance on each measure compared to their performance during a baseline period.

The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients as well as improve their experience of care during hospital stays (32).

Challenges Ahead

Change always comes with uncertainties and challenges, and such is the case with the changing world of health care delivery and payment. Some challenges faced by RDs, RDNs, and DTRs include:

- How to be successful in multiple simultaneous payment models: fee-for-service, bundled payments and pay-for-performance?
- Do we have enough outcomes data (individual practice as well as across the profession) to demonstrate our worth and negotiate our role within evolving care delivery and payment models?
- How do we measure "success"? Is it based on the number of patients seen or the clinical and cost savings achieved?
- Are there enough RDs, RDNs, and DTRs (numbers as well as geographic distribution) to meet demand or will other providers assume our role?
- While the ACA opens up potential opportunities for nutrition services, it does not guarantee RDs, RDNs, and DTRs as providers of these services.
- To what extent are RDs, RDNs and DTRs aware of the changes in health care delivery and payment?
- Do RDs, RDNs and DTRs have the business skills necessary to successfully integrate themselves into these models of care and negotiate for equitable payment?
- Are RDs, RDNs, and DTRs ready to accept the risk that comes with experimentation and value-based purchasing models?

Opportunities Ahead

Change also brings opportunities. As always, it is important to keep in mind that if we don't seize these opportunities, someone else will.

Opportunities Ahead: Fee-for-Service

Medicare:

- MNT and DSMT
- Annual Wellness Visit (AWV)
- Intensive Behavioral Therapy for Obesity
- Waived co-pays and deductibles
    - Includes Medical Nutrition Therapy

Patient Protection and the Affordable Care Act (PPACA):

- Grade A and B recommendations from U.S Preventive Services Task Force
    - "Healthy Diet Counseling"

    - "Obesity Screening and Counseling"
- All non-grandfathered health plans

In the private market, as result of the Affordable Care Act 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. A non-grandfathered health plan is one that was written after the passage of the ACA. Any health plans that enrolled members on or before March 23, 2010 is considered "grandfathered" and not subject to these ACA requirements. A grandfathered plan can lose this status if it makes significant changes that reduce benefits or increase costs to consumers. Health plans can determine how many visits to cover as well as who they will pay to provide these services.

Opportunities Ahead: Essential Health Benefits (EHB)

- Defines the scope of services
- Must include 10 benefit categories (per the ACA), including
    - Ambulatory patient services
    - Preventive and wellness services and chronic disease management
- The ACA requires the EHB to be similar to what is offered by a typical employer health plan.
- Each state selected a benchmark plan to be used to set the standard for defining the EHB within each state. This selection applies for 2014-2016, so opportunities continue to exist to influence inclusion of nutrition services and RDs and RDNs in the future.
- Certain provisions of the ACA do not apply to all health plans. The following table serves to assist RDs and RDNs in determining where the opportunities may lie.

Healthy diet counseling
The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by *referral to other specialists, such as nutritionists or dietitians.*
Grade B

Obesity screening and counseling: adults
The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Grade B

Obesity screening and counseling: children
The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Grade B

Health Plans and EHBs

Beginning January 1, 2014			Must Provide Essential Health Benefits	Must Limit Cost Sharing and Deductibles
Health Plans in Exchange	Small Group		Yes	Yes
	Non-Group		Yes	Yes
Other Health Plans	New Plans	Self-insured	No	No
		Large Group	No	Yes
		Small Group	Yes	Yes
		Individual	Yes	Yes
	Grandfathered Plans	Self-insured	No	No
		Large Group	No	No
		Small Group	No	No
		Individual	No	No

Opportunities Ahead: Bundled Payments

Opportunities abound for RDs, RDNs and DTRs to participate in established Medicare ACOs, private ACOs and PCMHs. In addition many PCMH and ACO pilot programs are underway, giving Academy members a great opportunity to be a part of the experiment and collect data to prove their effectiveness, value and cost-savings. 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.

The ACA also created Community Based Health Teams to coordinate and connect patients to additional health care and community resources. The ACA indicates team members may include dietitians, thus providing opportunities for RDs and RDNs working in local health departments. Opportunities might also exist for RDs and RDNs in other health care settings to contract with local health departments. Monies have not yet been appropriated for this program.

To find CMMI funded innovation opportunities in your state:
http://innovation.cms.gov/initiatives/map/index.html

Opportunities Ahead: Focus on Prevention

Medical nutrition therapy (MNT) is known to be a key component in treating many of the chronic conditions plaguing our nation. It is considered the cornerstone of treatment for diabetes, hypertension and cardiovascular disease.

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 (33).

An RD delivered lifestyle approach to diabetes and obesity improved diverse indicators of health, including:

- Weight
- HbA1c
- Health-related quality of life, use of prescription medications, productivity and total health care costs
- For every dollar invested in the RD-led lifestyle modification program there was a return of $14.58 (34-36)

The Lewin Group documented an 8.6% reduction in hospital utilization and 16.9% reduction in physician visits associated with MNT for patients with cardiovascular disease.

- The group additionally documented a 9.5% reduction in hospital utilization and 23.5% reduction in physician visits when MNT was provided to persons with diabetes mellitus (37).

Medical nutrition therapy provided by registered dietitians as part of a health plan is an effective, low-cost way of helping people safely lose weight. The cost of the MNT benefit to the health plan was $0.03 per member per month (38).

- Overweight or obese adults participating in a medical nutrition therapy benefit sponsored through their insurer were compared with individuals who did not participate. After 2 years, the adults who received the MNT benefit provided by a registered dietitian were twice as likely to achieve a clinically significant reduction in weight, experience greater average reductions in weight, and were more likely to exercise more.

Member Spotlight

We have 15 Patient-Centered Medical Home clinics here at the University of Michigan Hospitals and Health Centers (UMHHC) and we now have dietitians serving on the care team at 9 of them. I work with patients at one of the clinics and also manage the dietitians who work at the other clinics. The dietitians have all received training in the patient empowerment and self-management model and we are fully integrated into the care teams at these clinics, working closely with physicians, physician assistants, nurse practitioners, nurses, pharmacists and social workers at each site. We increased our visits by 21% in the period of July-Dec of 2012 compared to the previous year and the demand continues to grow.

Our health system is participating in a demonstration project called the Michigan Primary Care Transformation Project or MiPCT. This project was developed by CMS and Michigan BCBS to demonstrate the effectiveness of the PCMH model and provides eligible patients with coverage for unlimited dietitian visits for chronic care management regardless of the diagnosis with no co-pay for the patient. About 80% of our patients are eligible for this program so it has made our services affordable and increased the ability for us to hire more dietitians to serve our PCMH clinics. This insurance coverage has made it much easier for the dietitians to work within a patient-centered, patient empowerment framework. We can schedule short, frequent visits, phone visits and hope to be able to offer small group classes soon.

Ruth Blackburn, MPH, RD
Ambulatory Care Nutrition Services Manager
University of Michigan Hospitals and Health Centers

In addition, lifestyle risk-factor modification, including diet, is an essential component of health-promotion and disease-prevention programs. The new focus on prevention under the ACA and other efforts to reduce health care spending 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 (16).

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

Question #2: What do we know about the needs, wants and expectations of members, customers and other stakeholders related to this issue?

Members

From word-of-mouth, Academy staff and committees asking members about their wants:

- RDs, RDNs, and DTRs want to be respected members of health care team.
- Members are concerned about competition from other "nutrition professionals" and health care providers (e.g., physicians, physician assistants, nurse practitioners, pharmacists, chiropractors).
- RDs, RDNs and DTRs want to be part of a mandated component of all major health care delivery systems and afforded the respect, recognition and remuneration they feel they deserve.
- RDs, RDNs and DTRs see themselves as an essential ingredient in lowering health care costs across care settings.
- Many entry-level practitioners as well as seasoned practitioners are drawn by the independence and flexibility of operating their own business and want to go into private practice, but need an income stream.
- RDs and RDNs already in private practice, similar to their health care professional colleagues, are concerned about the viability of operating as independent business providers as PCMHs, ACOs and bundled payment systems grow.
- No matter the payment model, RDs and RDNs want nutrition counseling services delivered by RDs and RDNs to be a mandatory component of health-promotion and disease management programs. They want to provide such services without restrictions in terms of diagnosis, number of visits, length of visits, place of service, and requirements to bill "incident to" the physician.
- RDs, RDNs and DTRs want to be able to capitalize on electronic health records to demonstrate the clinical and cost-effective of their services.
- RDs and RDNs in private practice seek efficient and affordable means for access to and interoperability with electronic health records.

- RDs, RDNs and DTRs have fears about their personal future and the future of the profession and seek answers to their questions about changes in health care delivery and payment and what it means for them.
- Educators want resources to help them understand and teach students and interns about changes in health care delivery and payment.

Physicians/other health care providers

- Physicians and other health care providers face the same fears and uncertainties about their personal futures in the changing health care environment.
- Primary care clinicians are on a treadmill:
    - Payment system slanted against primary care, toward procedures, specialists, hospitals
    - Very tight financial margin
    - Have to see more and more patients to survive
    - Can't deliver the type of care needed
    - Need to have other health professionals on their care teams (RDs and RDNs) but current payment models make this difficult (for both practice & patient)
- The online RD Brand Survey conducted by the Academy in 2011 revealed (39):
    - 93% of physicians refer to RDs
    - MDs believe one of the reasons consumers do not seek the advice of an RD is because it is not covered by insurance
    - 81% believe themselves to be well-informed about nutrition
    - 61% indicate they do not have enough time during appointments to educate their patients about nutrition.
    - MDs make referrals to specific RDs based on availability/location followed by specific patient diagnosis/condition.
    - MDs strongly agree that:
        - Referring their patients to RDs usually results in a better outcome
        - RDs work best with them to improve their patient's health
        - RDs work with their patients to tailor advice/recommendations
- PCPs are not adequately trained in nutrition (40):
    - 2008-2009 study of US medical schools conducted by the University of North Carolina at Chapel Hill noted that only 27% met the National Academy of Sciences recommended minimum number of 25 hours of nutrition instruction (down from 38% in 2004)
    - Same study showed that medical students received an average of 19.6 contact hours of nutrition instruction (down from 22.3 hours in 2004)
- AAFP Nutrition Education curriculum specifically notes that family practitioners should be trained to recognize patients who are at high risk for nutrition-related complications and refer them to nutrition consultants (RDs, LDs)
- In a national cross-sectional survey of 500 primary care physicians, fewer than half (44%) thought they achieved success by helping their obese patients lose weight. Respondents identified dietitians as more qualified than primary care physicians, behavioral psychologists or nurses to help obese patients lose or maintain weight (41).
- Physician and nurse practitioner representatives from national primary care provider associations attending a meeting at the Academy in 2013 viewed RDs as an essential

part of medical practice. They identified the following benefits to having RDs on the health care team:
    - Depth and breadth of knowledge and expertise
    - As part of team, sharing of knowledge with not only patients and families but also other medical professionals
    - Different perspective
    - Management of non-food nutrition
        - Supplements
        - Tube feeding
    - How to construct diet tailored for patients with condition, mechanical needs, nutrition content, palatability
    - Improving efficiency of practice—time saving
    - RDs have more time, training for in-depth counseling
    - Patient acceptance
- The same group as above identified the following barriers to having RDs on the health care team:
    - Physician denial (of need)
    - Lack of relationship with or knowledge of RDs
    - MDs not used to having RDs on outpatient team, don't know who to refer to
    - Access to and availability of RDs
    - Expertise in specific areas
    - Coverage/cost
    - "Resources" – funding
    - Payment structure in outpatient setting
    - Lack of follow up by patients on referrals
    - Stigma of patient being identified as needing to see an RD
    - Patient denial (of need)
- The Medical Group Management Association developed a report on the medical practice of the future. This report highlights three main challenges medical practices will face:
    - Dealing with operating costs that rise more rapidly than revenues
    - Maintaining physician compensation levels in an environment of declining reimbursement.
    - Selecting and implementing an electronic health records system.
- Concerns about the impact of patient mix (low vs. high utilizers of health care) on their bottom line

Health Care Organizations

- Looking for ways to control health care costs:
    - Eliminate "waste" through process efficiency, reducing variations in care and minimizing overhead costs
    - Reduce over-utilization of high cost services
    - Strengthen data management to optimize decision support, quality, utilization and cost management
- Looking at ways to increase growth:

    - Building a more comprehensive provider network composed of high quality providers in order to drive increased patient volume and market share.
    - Diversify portfolio of value added products and services
    - Entering new markets and expanded their geographic footprint
    - Become the "provider of choice" through marketing and reputation
- Striving to manage risk by decreasing readmissions and non-emergent Emergency Department utilization and increasing savings through shared savings, episodic and global payments.
- Focusing on aligning stakeholders through increased provider accountability and increased payer-provider collaboration.
- Need to improve finances by:
    - Managing the shift from fee-for-service to value/risk based payment systems
    - Increasing margins through increased clinical value (higher quality at lower utilization and costs)
    - Optimize performance based/quality incentive payments for services
    - Introducing performance bonus incentives for new revenue streams
- New focus on population health management requires health care organizations to enhance core capabilities related to care delivery optimization, care coordination and transitions, provider and clinical integration, patient and family engagement, results and outcomes management, health information exchange, and health analytics.

Patients/clients

- Consumers are becoming more comfortable using non-physician providers for their routine care (42).
- Consumers are looking for ways to reduce their health care spending (42).
- Consumers increasingly want and expect to be able to customize their health plans (42).
- The online RD Brand Survey conducted by the Academy in 2011 revealed (39):
    - For consumers having seen an RD, 72% surveyed were referred by a doctor.
    - 17% of consumers say they are following or responsible for someone who follows a special diet for a medical condition.
    - Consumers believe they are well informed about nutrition**.** 72% of consumers rate themselves between 6 and 9 on a 10 point scale in terms of being informed about nutrition.
    - 35% of consumers say they are very likely or likely to consult an RD if they need nutritional advice.
        - Of those seeking advice from an RD, 55% are looking for guidance related to a specific medical condition, 24% want to become healthier or maintain their health, and 21% want to lose weight.
        - The main reason for not seeking an RD is that consumers feel they "can figure it out on their own."
    - Word of mouth (71%), the internet (58%) and doctors (48%) are consumers' most common sources of nutrition information compared to RDs at 9%.
- From the 2011 Nutrition Trends Survey conducted by the Academy, just over one in ten Americans are "very interested" in the services that dietitians provide. Insurance coverage would encourage nutrition service seeking (43).

- With their busy lifestyles, consumers are looking for convenient access to health care services (location, office hours).

Payers

- Insurers continue to look for ways to control health care costs.
- CMS is embracing a new paradigm that focuses on primary care.
- The relationships between payers and providers are evolving from one focused strictly on payment relationships to ones that are partnerships that focus on quality of care, clinical outcomes, patient satisfaction and cost-savings.
- Payers do not necessarily know the difference in terms of education and training between RDs, RDNs, DTRs and other providers of nutrition services.
- Payers do not necessarily know what MNT is.
- Payers want to pay for services that are proven to improve clinical outcomes and control costs.
- Payers want to manage risk; concerns about the impact of patient mix (low vs. high utilizers of health care) on their bottom line.
- New focus by private payers on marketing to consumers.
- Private payers are repositioning from insurance carriers to "health solutions" and "health and well-being" companies.

As you put forth your message, it is critical that you speak the new language of health care. You also have to be willing to take risks in order to share savings and incentives

Rethink Your Role

- Collaboration vs. referrals
- Contract/employment business models
- Care coordinator/case manager
- Transitions of care
- Population management
- Quality improvement teams (leader)
- Self-management training
- Group medical appointments
- Employee wellness programs
- Health coach
- Enhanced access
- Realign with PCPs in new ways

Build Your Skill Set

- Learn today's language of health care
- New assessment skills (Blood pressure, Blood glucose, Annual Wellness Visit)
- Informatics
- Outcomes data collection
- Motivational interviewing
- Team work
- Business
- Marketing/communications
- Leadership
- Persistence

Rethink Your Message

- Think beyond FFS
- Focus on high cost populations
- Offer pilot projects
- Focus on quality measures
- PCMH – use protocols to drive RD referrals
- Target case managers with insurance companies
- Enhanced access
- Coordinated care
- Increased safety
- Reduced readmissions
- Increased efficiency
- Self care management
- Patient satisfaction

Question #3: What do we know about the capacity and strategic position of the Academy in terms of its ability to address this issue?

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. Below are a list of Academy resources, ongoing initiatives, and current projects available for members.

Academy Resources

1. website: www.eatright.org/coverage and www.eatright.org/mnt
2. *MNT Provider* newsletter (http://www.eatright.org/mntprovider/)
3. Reimburse inbox: reimburse@eatright.org (place for members to submit questions for response from the NSC team)
4. Resources available as downloads through SHOP at www.eatright.org/shop, Nutrition Services Coverage (free to members/cost to non-members). Categories of products: MNT Advocacy, Medicare MNT Benefit, Practice Management Tools, MNT Provider newsletter
5. Reimbursement On-line Community (http://www.eatright.org/members/reimbcomm/)
6. Affiliate/DPG Reimbursement Representatives (http://www.eatright.org/members/leadershipdirectory.aspx under "Policy Initiatives and Advocacy Leader Groups")
7. Medical Nutrition Therapy MNTWorks® Kit and powerpoint (www.eatright.org/members/mntworks)
8. Third Party Payer brochure (revised in 2012) (available at www.eatright.org/shop)
9. Coding and Coverage Committee Speakers Bureau: The following presentations can be provided to affiliate/DPG conferences
    a. "Alphabet Soup: Understanding the Use of Coding/Billing Terminology"
    b. "Sign Me Up!: Getting Credentialed to Bill for Nutrition Services"
    c. "It's All About Marketing- How to Promote Billable Nutrition Services in your Practice, Facility and Community"
    d. "Documenting Severe and Non-Severe Malnutrition: A Hands on Approach"
    e. "The Skeleton's Out: A Standardized Approach to the Recognition and Documentation of Adult Malnutrition"
    f. "Aspects of Physical Assessment for Identifying Adult Malnutrition"
    g. *New this year:*
        - "Health Care Reform: Implications for Nutrition Services"
10. "What an RD Can Do For You" video: NSC worked with Strategic Communications to develop this consumer video to increase understanding of the benefits of working with an RD. Available at www.eatright.org/Public/

Key Links to Academy Resources

www.eatright.org/coverage
www.eatright.org/mnt
www.eatright.org/shop
reimburse@eatright.org
www.eatright.org/Public/ - **What is an RD?**

Ongoing initiatives:

1. Healthier Generation Benefit (HGB):
   a. Alliance for a Healthier Generation founded by the American Heart Association and the William J. Clinton Foundation to combat childhood obesity
   b. Unique collaboration between insurers, employers, and medical professional associations (Academy and AAP)
   c. Offers health benefits to children and families for the prevention, assessment and treatment of childhood obesity. At least 4 visits with their PCP and at least 4 visits with an RD per year
   d. Goal is to expand availability of HGB, increase number of RD providers, and promote stronger collaboration between RDs and pediatricians
2. American Medical Association's CPT and RUC HCPAC: Academy has representatives serving on these committees under the AMA that develop and value procedure codes (such as our MNT CPT codes) used when billing for services with public and private payers.
3. FNCE workshops and educational sessions; teleseminars through the Center for Professional Development; Public Policy Workshop session(s)
4. Academy of Nutrition and Dietetics Public Policy Priority Areas (available at http://www.eatright.org/Members/content.aspx?id=8581): Public policy and advocacy are core functions of the Academy and are critical to achieving the mission, vision, goals and strategies outlined in the Strategic Plan Roadmap. Public policy significantly influences and forms the public image of the Association and that of the nutrition and dietetics profession. To help focus and guide our policy efforts, the following priority areas and issues have been identified, many of which are relevant to this mega issue:
   a. Consumer and Community Issues
      i. Prevention and treatment of chronic disease, including health care equity
      ii. Meeting nutrition needs through the life cycle: Maternal and child nutrition to healthy aging
      iii. Quality nutrition and food through education, production, access and delivery
      iv. Nutrition monitoring and research
   b. Professional Issues
      i. Licensure: Protection of the Public
      ii. Workforce demand: Assuring the Public has access to nutrition services delivered by qualified practitioners
      iii. Outcome driven nutrition services in changing health systems
5. Efforts with CMS for MNT expansion under Medicare and to advocate for RDs as direct providers of the Intensive Behavioral Therapy for Obesity benefit (includes both regulatory and legislative efforts).

6. Support affiliate efforts related to state essential health benefits under health care reform (tools, advocacy guidance). Includes "State Health Insurance Exchange Toolkit" and "Next Steps: Essential Health Benefits" as well as several Public Policy Panel Forums on the topic.
7. RD Brand Plan: Initiative of the Academy's Marketing Team designed developed to promote the RD and RDN brand among key audiences (physicians and consumers). The goal is create awareness of the RD and RDN brand as the most credible source and to elevate and differentiate the RD and RDN from non-licensed and non-credentialed providers. Brochure developed and available free to Academy members for use with physicians to drive referrals to RDs and RDNs.

Current Projects of the Coding and Coverage Committee:

1. **Adult Malnutrition Education and Outreach Workgroup:**
   Joint workgroup with A.S.P.E.N. charged with identifying target markets for education and outreach surrounding the characteristics for identifying and documenting malnutrition in adults and proposed language presented to the National Center for Health Statistics (NCHS) along with recommended tactics and content.
2. **Pediatric Malnutrition Workgroup:**
   Joint workgroup with A.S.P.E.N. and the American Academy of Pediatrics to identify standardized characteristics for identifying and documenting pediatric malnutrition. Workgroup will also help to continue previous efforts to update diagnosis code descriptors for malnutrition in ICD code set.
3. **Marketing to Employers/Insurers Subgroup:**
   Charged with developing and implementing plan to train members on how to approach employers and insurance companies about expanding coverage for nutrition services. Subgroup's initial focus is on self-funded plans. (anticipate completion fall 2013)
4. **Educators' Toolkit Subgroup:**
   Charged with developing resources to be included in the Supervised Practice Toolkit for use by educators to demonstrate student/intern competency for the DI/CP standard: Participate in coding and billing of dietetics/nutrition services to obtain reimbursement for services from public or private insurers. (anticipate completion fall 2013)
5. **Coding Survey:** Since 2006, the Coding and Coverage Committee has conducted 2 surveys (2006, 2008) of registered dietitians related to coding practices and coverage by public and private payers for MNT services (44). Information from these surveys is used to support the Academy's efforts with the AMA RUC to maintain or increase the relative value of the MNT codes which then impacts payment rates. The survey results also inform member education/resource needs; track trends and changes in coverage, reimbursement and codes use; identify the potential need for the Academy to pursue development of new codes for nutrition services; and provides data that is essential to the Academy's advocacy work. The next iteration of the survey will be conducted summer/fall 2013.
6. **Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership**
   Electronic toolkit providing information and tools for RDs to successfully align with primary care providers to provide the Intensive Behavioral Treatment for Obesity benefit under Medicare Part B (available at www.eatright.org/shop). Teleseminar planned for October 30, 2013.
7. **PCMH/ACO Workgroup under the Coding and Coverage Committee**
   Project description: Review the Academy Medical Home Workgroup's 2009 report: "Patient-Centered Medical Home Strategic Plan" and develop recommendations for

Academy leadership (CCC, BOD and/or HLT/HOD) regarding Academy strategies for advancing RD involvement in PCMHs; Develop an Academy strategy for engaging members to take advantage of the opportunities that are presented with the PCMH and ACOs. Assess member resource needs on PCMH and ACO; and identify new resources to educate members about the PCMH and ACO concepts to position RDs as an integral component of these health care delivery models (with focus on coverage/reimbursement).

8. **Primary Care Provider Association Collaborative Meeting:**
   On February 12, 2013, the Academy convened representatives from national PCP associations for a one-day meeting at Academy headquarters to explore opportunities and challenges with integrating RDs into new PCP-led health care delivery models. The ultimate goal was to agree to collaborate on a trans-association member outreach campaign that promotes successful collaboration between RDs and PCPs. Funding for the meeting was generously provided by the Commission on Dietetic Registration as part of their goal of promoting the value of the RD. The Academy's Marketing team served as collaborators on this project.
   The group identified four potential goals for collaboration:
   - Access and Payment: Collaborate to Make Proposals for CMS Payment Policy
   - Developing Interdisciplinary Clinical Practice Guidelines (CPG)
   - Cross-Pollinating Existing Initiatives
   - Inter- or Multi-Disciplinary Symposia at National Conferences

   Academy staff from various teams reviewed the meeting report and developed a proposed roadmap for moving forward with a focus on improving access and payment to nutrition services provided by RDs and RDNs in PCMHs.
9. **Comprehensive Primary Care Collaborative Initiative (CPCI) Toolkit**
   Project description: The goal of the CPCI is to help primary care practices deliver higher quality, better coordinated, and more patient-centered care. The CPCI project was made possible by the Affordable Care Act (ACA) and recognizes that a primary care practice is a key point of contact for patients' health care needs. The purpose of this toolkit (and accompanying webinars) is to provide information to registered dietitians (RD) and primary health care providers that are participating in the CPCI about the benefits of including dietitians as part of their care teams. Available at www.eatright.org/shop. (The toolkit was released in May 2013 and a webinar for RDs was offered in June 2013 with the recording available at www.eatright.org/coverage. A webinar will also be offered to primary care provider practices in September 2013).
10. **EAL Projects:** Last year project completed on telenutrition that was partially funded by Nutrition Services Coverage (NSC). In the past NSC helped fund the MNT Effectiveness project, which is currently under revision. All EAL projects are now required to include a question on MNT effectiveness.
11. **Chronic Kidney Disease Microsite Project:** Collaborative project under the American Kidney Fund that designed an on-line continuing education program for health care professionals with the goal of increasing utilization of Medicare benefits for patients with chronic kidney disease (includes MNT and DSMT). Available at www.ckdeducation.org.
12. **MNT Business Leader Training:** 2-day in-person training event held April 21-22, 2013 for 24 selected members with the goal of creating a cadre of national experts who can assist members, affiliates and DPGs with efforts to expand coverage and reimbursement for nutrition services and pursue new opportunities in the marketplace, increase the number of Medicare providers, and enhance the business acumen of RDs providing MNT services.

Question #4: What ethical/legal implications, if any, surround the issue?

Academy/CDR Code of Ethics

Within the June 2009 American Dietetic Association and Commission on Dietetic Registration Code of Ethics, several principles are particularly germane to this mega issue (45):

> Principle #1: The dietetics practitioner conducts himself/herself with honesty, integrity, and fairness.
>
> Principle #2: The dietetics practitioner supports and promotes high standards of professional practice.
>
> Principle #4: The dietetics practitioner complies with all laws and regulations applicable or related to the profession or to the practitioner's ethical obligations as described in this Code.
>
> Principle #5: The dietetics practitioner provides professional services with objectivity and with respect for the unique needs and values of individuals.
>
> Principle #6: The dietetics practitioner does not engage in false or misleading practices or communications.
>
> Principle #9: The dietetics practitioner treats clients and patients with respect and consideration.

Providing and billing for nutrition services raises ethical issues for nutrition professionals, from the direct providers of the service through the food, administrative, community, education and/or research components that support and augment such services. The March 2012 issue of the *Journal of the Academy of Nutrition and Dietetics* features an "Ethics in Action: Elements of Ethical Billing for Nutrition Professionals" (46).

Other Items to Consider

Below are other items to consider when contemplating the shifts in health care delivery and payment models.

Fee-Splitting

Fee splitting is a state law issue that prohibits some professionals from sharing their professional fees with others who were not involved in the care of the patient. For example, if a surgeon offered to share a portion of his or her professional fee with the primary care physician who referred the patient, that would be considered fee splitting in many states. It is a type of prohibition on kickbacks. The exact nature and extent of fee splitting prohibitions varies from state to state. In general, if a professional is paid for the services he or she performs, fee splitting can be avoided. *For example, if a physician employs or has an independent contractor*

relationship with the RD (where the physician bills for the RD's services) it would not be considered fee splitting in most states. Arrangements in which an MD or RD pay money to each other in exchange for referrals could be considered prohibited fee splitting and may also violate other kickback prohibitions.

Anti-Kickback Statute

The anti-kickback statute of the Social Security Act (47) prohibits the offering of any remuneration to a Medicare or Medicaid beneficiary for the purpose of influencing the beneficiary's selection of a particular provider. The term "remuneration" has been interpreted broadly to include "anything of value," and under Section 1128A(a)(5) of the Social Security Act, remuneration includes transfers of items or services for free or for other than fair market value. Risk of violating the anti-kickback statute comes into play when RDs and RDNs consider providing free MNT services, especially to Medicare beneficiaries who qualify for DSMT and MNT benefits.

Anti-Trust Regulations

The United States Antitrust laws seek to prohibit anticompetitive behavior and unfair business practices while encouraging competition in the marketplace. As a result of the fear that monopolies dominated the market in the late 1800s, the Sherman Antitrust Act was passed in 1890, and, though it has been expanded and amended by subsequent legislation, still forms the basis of most antitrust law today(48). Anti-trust laws prevent RDs and RDNs from banding together to set fees or negotiate fees with a payer unless they are in business together as a group practice.

State Licensure Issues

State license may impact the ability of an RD or RDN to become credentialed with a third party payer for the purposes of billing under fee-for-service payment models. In addition, the growth of telehealth as a modality for delivery of health care services raises issues regarding licensure and practice across state lines. For more information on telehealth as it relates to nutrition services, visit http://www.eatright.org/Members/content.aspx?id=7341.

"Incident-To" Billing/Services

Depending on the payer source, MNT and nutrition services may be directly billed by the RD or RDN or may need to be billed as "incident to" the physician services. RDs and RDNs need to be familiar with payer policies related to such billing practices when pursuing opportunities to integrate their services into health care organizations, be it a physician office, community health program, ACO, or other model of care. Failure to do so could result in third party payer audits, allegations of fraud, requests to return payments, loss of contracts with providers and payers, and adverse legal actions. Information on "incident to" services can be found at www.eatright.org/coverage.

Scope of Practice Issues As They Relate To Transdisciplinary Care and Team Member Roles

As RDs, RDNs and DTRs look to take on new roles in some of these models of health care delivery, as well as deliver services in new settings, they need to be aware of their personal scope of practice and competencies. Scope of practice in nutrition and dietetics encompasses the range of roles, activities, and regulations within which nutrition and dietetics practitioners perform. For credentialed practitioners, scope of practice is typically established within the

practice act and interpreted and controlled by the agency or board that regulates the practice of the profession in a given state. RDs and RDNs are educated and trained in food and nutrition and are integral members and leaders of interdisciplinary teams in health care, foodservice systems, education and other practice environments. They provide services in varied settings, including health care, business and industry, communities and public health systems, schools, colleges and universities, the military, government, research, fitness centers, private practice, and communications (49).

Nutrition and dietetics practitioners are encouraged to use the Scope of Practice Decision Tool available at https://www.eatright.org/shop/product.aspx?id=6442474795.

Contract Issues (If an RD Wants To Develop Business Relationship with Provider Practice)
Whether it is an individual RD, RDN or DTR deciding to integrate their services into a health care organization (e.g., PCMH or ACO) or a manager of nutrition services in a health care or community organization doing so, it is a business decision between at least two parties. As such, the nutrition professional should consider putting a contract in place to protect their interests. Information on developing business relationships with other health care providers can be found at: http://www.eatright.org/Members/content.aspx?id=6442451325.

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

Conclusion:
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 areas of practice. Opportunities abound but, as with all opportunities, Academy members need to seize them before other health care providers and laypersons do.

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