Role of Insurers in Oral Health Professionals' Efforts to Prevent Childhood Obesity and Reduce Consumption of Sugar-Sweetened Beverages

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Healthy Futures
PREVENTING CHILDHOOD OBESITY

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RWJ Disclaimer

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Purpose

To explore the role of insurers in oral health professionals' efforts to address childhood (under age 12) obesity and reduce the consumption of sugar sweetened beverages?

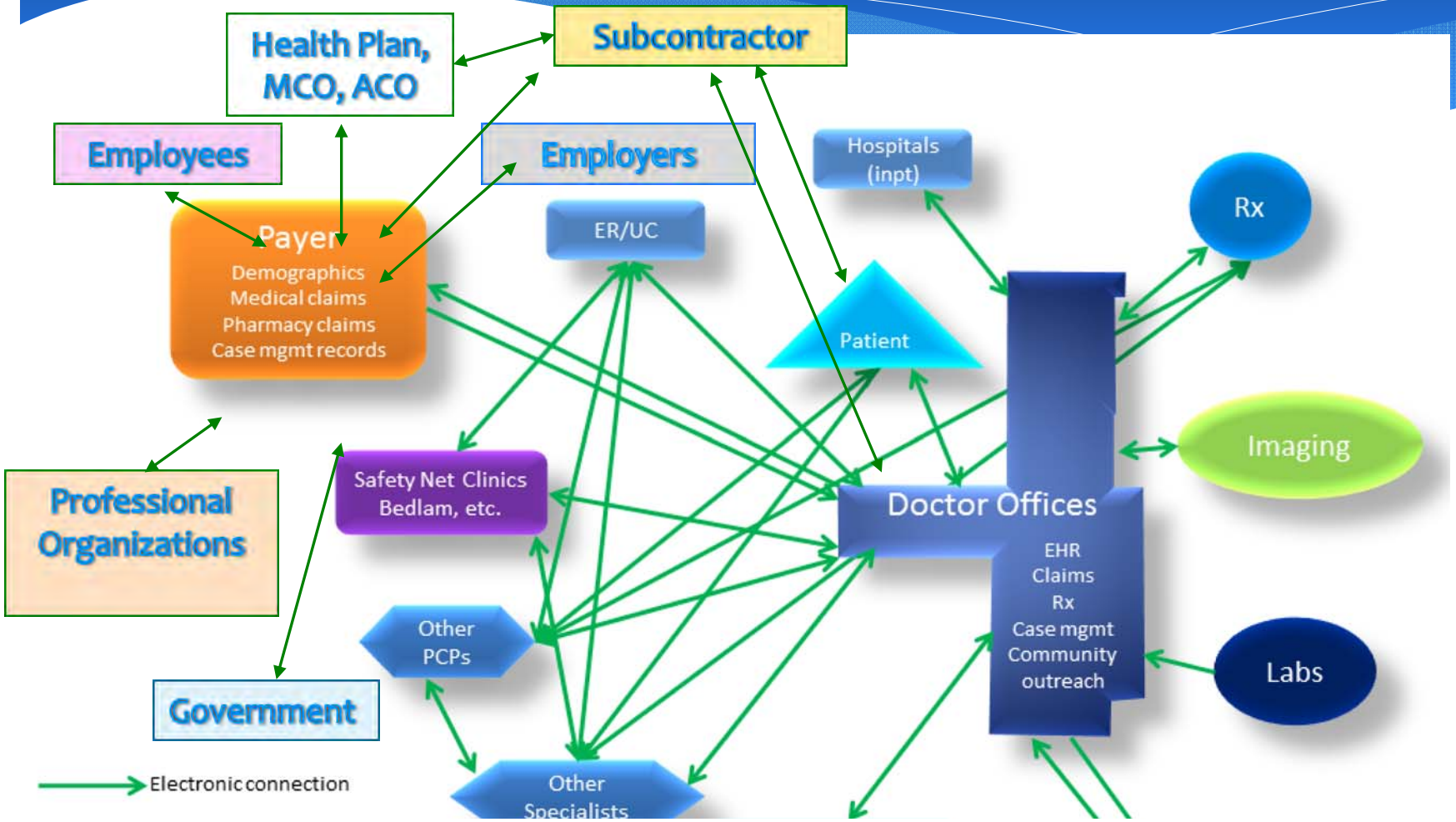
Methods

* Scoping Studies Methodology
* Literature searches via PubMed; CINAHL; and Google Scholar.
* Explored Professional Resources & Guidelines
* Investigated State Medicaid Policies and Reports
* End Point of Interest→ Impact of public/private health insurers on the delivery of professional pediatric obesity preventive and weight management services.

Results

No evidence of existing models that demonstrated the role of insurers on oral health professionals' efforts to reduce consumption of sugar sweetened beverages

Results — Complex Dynamic



Analysis of Payer Relationships

Employers

Policy Makers

- Public Health
- Delivery System
- Professional Organizations
- Government

Providers

Employees

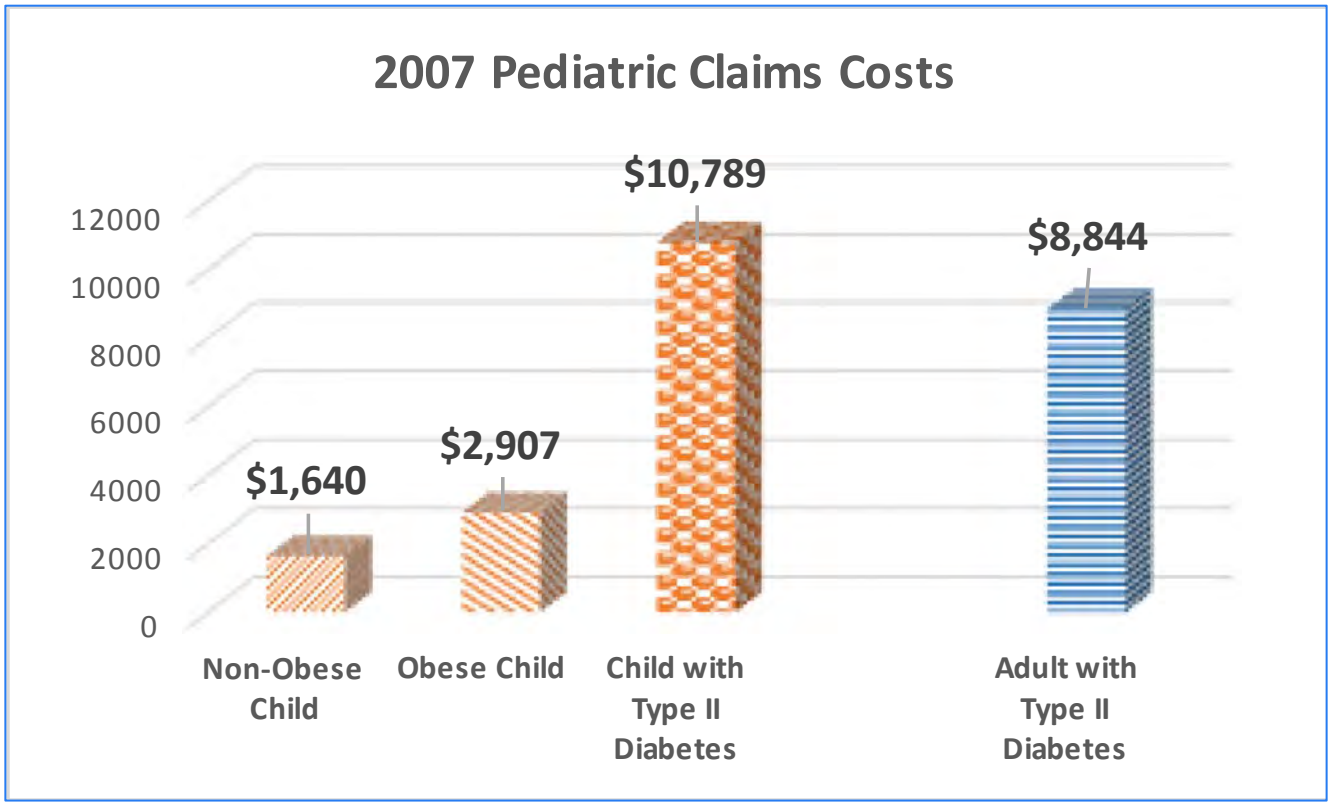
Beneficiaries

Healthcare Costs— *Premiums*

* 1999-2008 Healthcare Premiums ↑ **119%**
* 2007 Healthcare Premium Costs **Family of 4** = **$8,824**

J. Martin Sepulveda, et al. Impact of childhood obesity on employers. *Health Affair,* March 2010 vol. 29 no. 3 pp 513-521; DOI: 10.1377/hlthaff.2009.0737.

Healthcare Costs—*Claims*



American Medical Association

2008

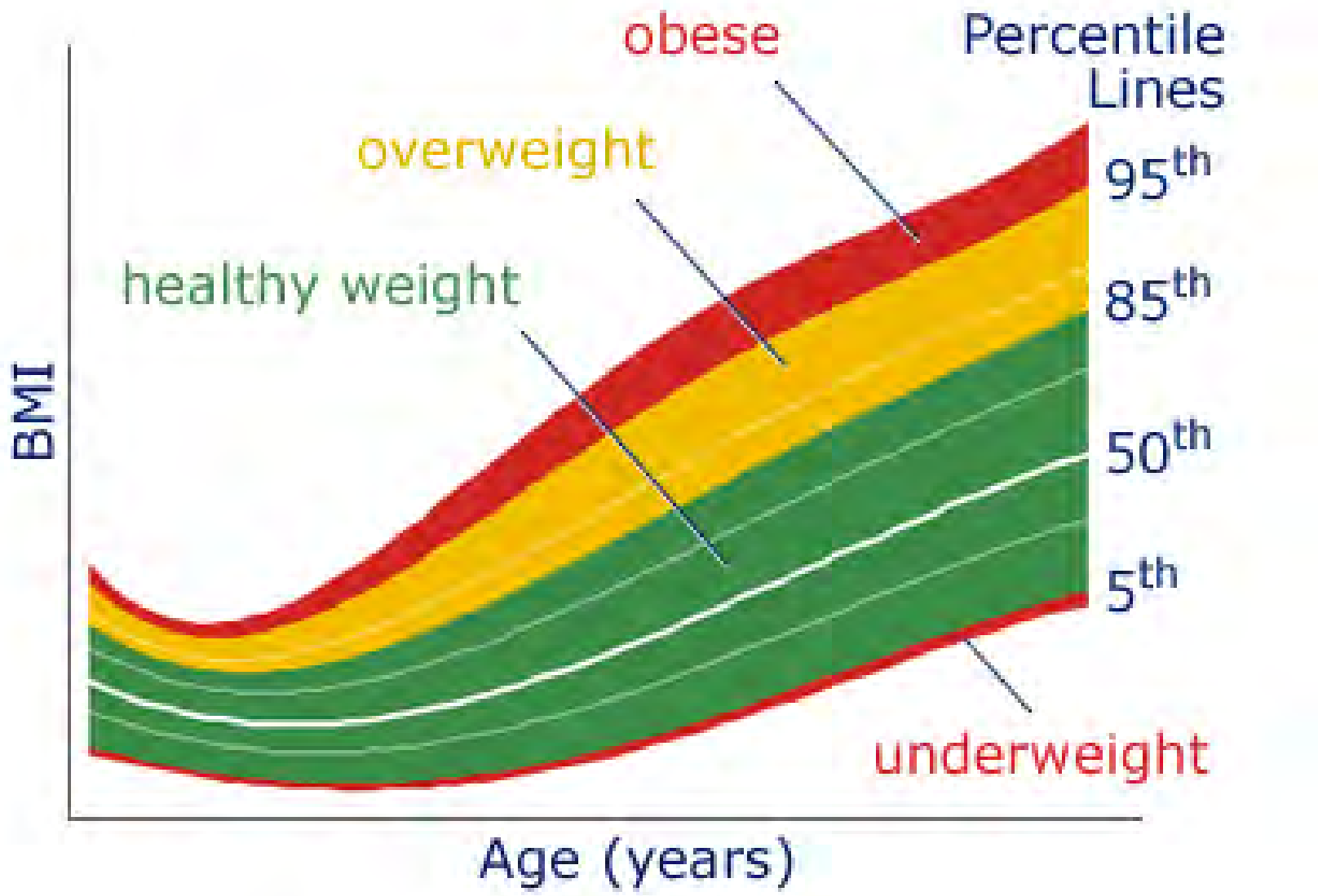
Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity

✓ **Clinical Recommendations for *Assessment***

✓ ***Staged Approach* to Treatment**

http://www.medscape.org/viewarticle/577665

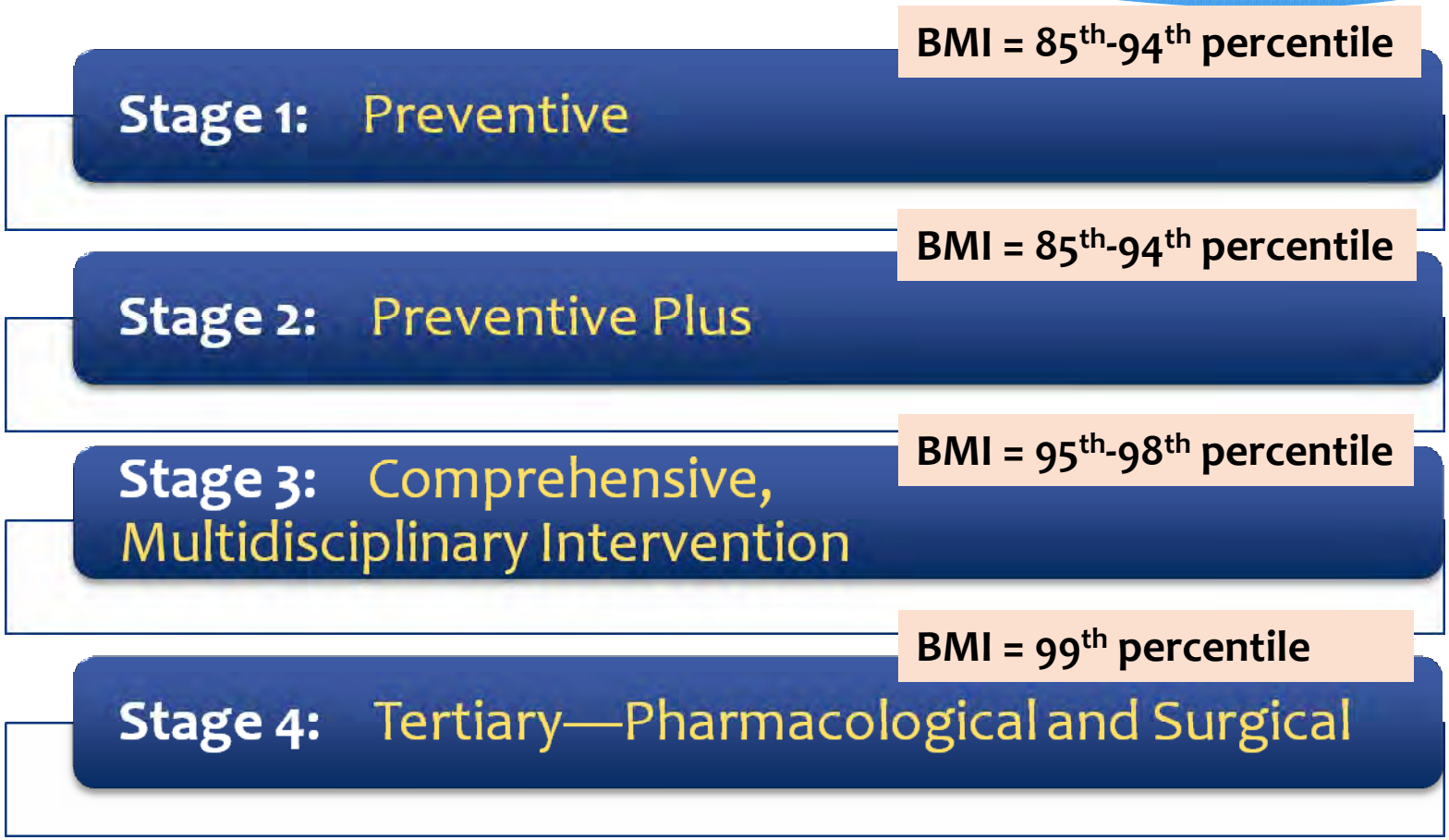
Body Mass Index



Staged Approach to Treatment

American Medical Association

2008



www.aafp.org/afp/200/0701/p56.pdf

www.medscape.org/viewarticle/577665

BMI: Body Mass Index

Centers for Disease Control and Prevention

2010

United States Preventive Task Force (USPTF)

*The USPSTS recommends that **clinicians screen** children aged 6 years and older for obesity and offer them or refer them to **comprehensive, intensive, behavioral intervention** to promote improvement in weight status.*

https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening

American Academy of Pediatrics

2015 Guidance for Pediatricians:

* Healthy behaviors
* Healthy diet choices
* Increased physical activity
* Sedentary behaviors

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Role of the Pediatrician in Primary Prevention of Obesity

Stephen R. Daniels, MD, PhD, FAAP, Sandra G. Hassink, MD, FAAP, COMMITTEE ON NUTRITION

The adoption of healthful lifestyles by individuals and families can result in a reduction in many chronic diseases and conditions of which obesity is the

abstract

Insurers' Roles

* Traditional Role = design plans, manage provider network; administer benefits, and pay claims
* Roles are changing in some settings [Government]
* Many insurers incorporate recommended staged approach to treatment in benefit plans; HOWEVER,
  * Variations in benefits and coverage
  * Eligibility requirements; i.e. age; plan
  * Coverage restrictions
  * Limited number of visits

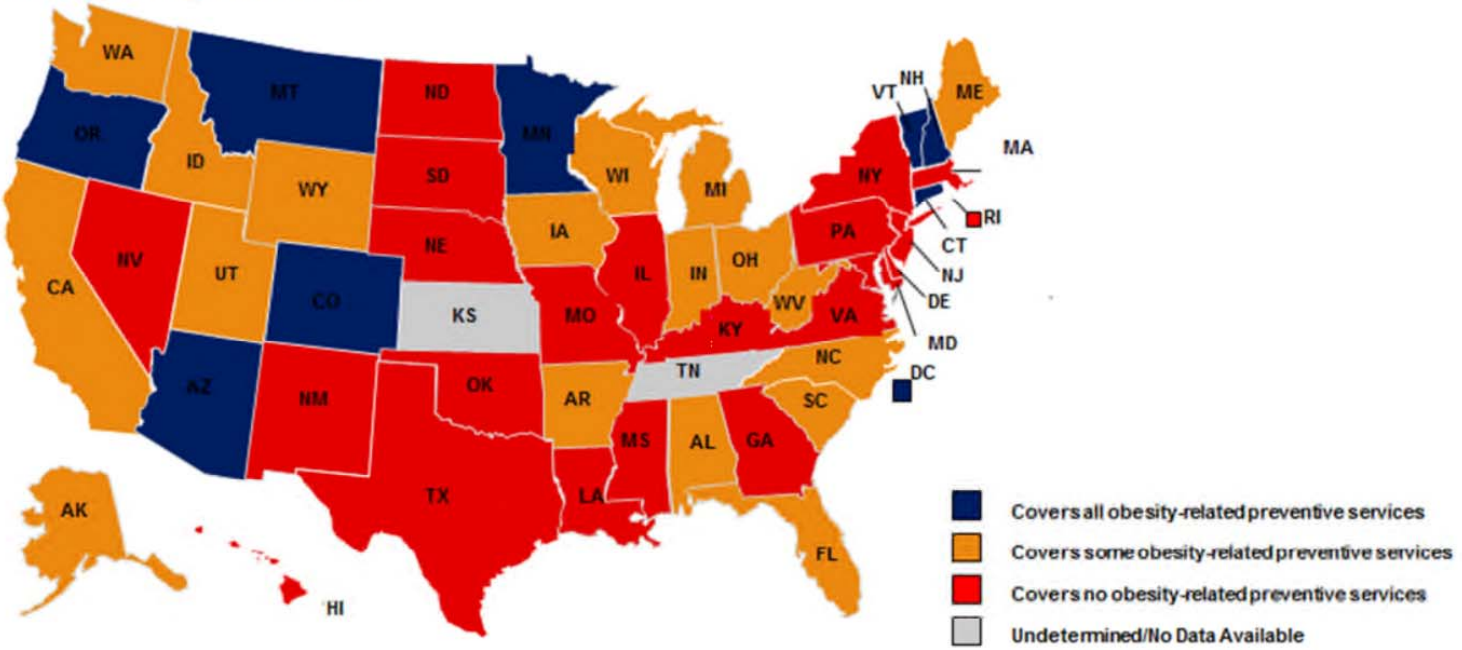
Driven by Employer and Vendor Costs

W. Slusser, K. Staten, K. Stephen, L. Liu, C. Yeh, S. Armstrong, S. DeUgarte, M. Haemer. Payment for obesity services: examples and recommendations for stage 3 comprehensive multidisciplinary intervention programs for children and adolescents. *Pediatrics, 2011, vol.128, supplement 2 S78-S85. DOI: 10:1542/peds.2011-0480H.*

Medicaid's EPSDT

"Medical Necessity"

Map 1: Medicaid Coverage of Obesity-Related Preventive Counseling Services



Source: Provider Manuals and CPT Code Search of Provider Fee Schedules
Note: Common Preventive Services are defined as CPT codes 99401-99404 and 99411-99412

Insurers' Issues

* Variability in benefit plans and structure – COST DRIVEN
* Issues with claims processing
  * Integrating BMI with claims processing
  * Dx and Tx Coding issues
* Engaging employers, providers and families
* Coordination with community wellness programs
* Lack of coordination with community obesity programs
* Enrollment requirements
* Monitoring use of services

Kimberly Rask, Julie Gazmararian et al,Journal of Obesity, Volume 2013, Article ID 379513, 7 pages
http://doi.org/10.1155/2013/379513

Variability in Treatment Guidelines -> Variability in Benefits

- No universal treatment guidelines that outline scope of a benefit
- No consistency in use / universal ICD-10 diagnostic, CPT, or HCPCS codes for reimbursement
- Obesity preventive interventions, and treatment protocols vary considerably across providers; programs; and states
- Benefits, coverage, and reimbursement differ as well
  - **Dependent upon employers; employees; policy makers' choices**
- Significant health system gaps

Health Outcomes Vary

Employer Issues

* Labor costs are high
* Health benefits account for the largest component of overall benefit costs
* Productivity impact
* MEPS data identified "Obesity" = condition contributing to workplace issues
* Few employers address obesity in employees' children
* Lack of understanding of the impact on labor
* Lack of awareness of direction or interventions to take
* Now at risk of inheriting a future obese workforce

J. Martin Sepulveda, et al. Impact of childhood obesity on employers. *Health Affair,* March 2010 vol. 29 no. 3 pp 513-521; DOI: 10.1377/hlthaff.2009.0737.

Employee/Beneficiary Issues

Low Use of Services

* Lack of awareness of a benefit
* Employees more apt to follow medical advice <u>when benefits are known and available</u>
* Parents of overweight and obese children don't always perceive the need

[1]M. Allen, R. Touger-Decker J.O'Sullivan-Mailley, B. Holland. A survey of obesity management practices in New Jersey. *Topics in Clinical Nutrition, 2003, vol. 18, no. 1, pp 3-12.*
[1] W. Slusser, K. Staten, K. Stephen, L. Liu, C. Yeh, S. Armstrong, S. DeUgarte, M. Haemer. Payment for obesity services: examples and recommendations for stage 3 comprehensive multidisciplinary intervention programs for children and adolescents. *Pediatrics, 2011, vol.128, supplement 2 S78-S85. DOI: 10:1542/peds.2011-0480H.*
Thomson Medstat

Medical Provider Issues

Low delivery of obesity treatment services

* Limited knowledge of patient's benefits and codes
* Too much variability in coverage across plans
* Insufficient interdisciplinary professional support or referral
* Lack of infrastructure to support coordination of services
* Reimbursement limitations
* Limited patient education resources
* Insufficient training
* Time constraints
* Perceived lack of parental concern and patient motivation

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Thomson Medstat

Conclusion – Unmet Need

Need to/for:

* Identify children at-risk for obesity as early as possible
* Treat and monitor obesity and related diseases during childhood and adolescence
* Train and sustain a multi-disciplinary obesity healthcare workforce
* Supportive healthcare infrastructure
* Design benefit plans to support diagnosis and treatment
* Affordable health plans
* Better informed employers; providers; beneficiaries, and payers
* Improve data to gain understanding of trends and issues

Nutrients 2009, 1(2), 197-209;doi:10.3390/nu1020197

Opportunities Exist—Patient Protection and Affordable Care Act (ACA)

Mandates Under the Law

"New commercial and individual health policies **must cover preventive services** with strong scientiific evidence, under health benefits where the patient has no cost sharing, co-pays, co-insurnace, or deductable."

Opportunities Exist—Patient Protection and Affordable Care Act (ACA)

Required Services

* **Patients with BMI >30 kg/m² :** intensive, multicomponent, counselling and behavioral interventions to support weight loss
* **Patients with diet related chronic diseases:** Intensive behavioral dietaryt counselling provided by dietician or specially trained PCC

Opportunities Exist—Patient Protection and Affordable Care Act (ACA)

Opportunities Under the Law

* **Innovative interventions** -> programs; bundled services; pay for performance; integrated multi-disciplinary services
* **Technology upgrades** -> Funding for infrastructure to support practice and population-based obesity data registries

Insurer Opportunities

Engage and train a broader workforce

- Work with employers to broaden benefits and coverage
- Design and test innovative payment models
  - Bundling
  - Pay for Performance
  - Shared savings plans
  - Report Cards
- Engage families
- Include as "Value Added Service" in Government plans
- MCOs or ACOs may **accelerate integration** at the provider and technology levels

Kimberly Rask, Julie Gazmararian et al,Journal of Obesity, Volume 2013, Article ID 379513, 7 pages
http://doi.org/10.1155/2013/379513

Discussion

Insurers may broaden the healthcare workforce to include oral health professionals

1. OHP prepared to fill the workforce gaps
2. Deliver Stages 1 and 2 obesity screening, prevention, and counseling services
3. Insurers may also take the lead in promoting employer, provider and beneficiary engagement
4. Create the necessary infrastructure and capacity for provider communication; collaboration; coordination and cooperation

Discussion

1. Develop codes and policies that support services by OHP (codes)
2. Reimburse OHP
3. Drive obesity treatment delivery via implementing incentivized provider payment models
4. Monitor disease; interventions; and outcomes across populations, and systems of care.

Recommendations

* Develop **universal obesity practice guidelines** based on the scientific evidence, that may be integrated into healthcare policy, health plans and benefits.
* Develop ***public health*** **and** ***healthcare delivery*** **systems policies** aimed at decreasing variability in screening, treatment, access, benefits, and provider practices across states and health plans.
* Develop regulations that support **universal medical necessity rules,** promoting screening, education, prevention and comprehensive treatment when necessary.
* Develop **CDT codes** that support the provision of nutrition counseling by oral health professionals for the prevention and reduction of overweight and obese children and youth.

Recommendations

* Develop policies that support the use **of ICD-10 and CPT codes** for the diagnosis and treatment of Stages 1 and 2 overweight and obesity treatment **by oral health professionals**
* Develop a **broader integrated trained provider network**—one that includes trained oral health professionals to aid in Stage 1 and Stage 2 obesity screening, education, nutritional counseling, and referral.
* Engage and support **community-based obesity programs** and services
* Design and test **innovative payment models** that incentivize provider delivery of services

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