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

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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.
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

Employees
Beneficiaries

Providers
Healthcare Costs—Premiums

* 1999-2008 Healthcare Premiums ↑ 119%

* 2007 Healthcare Premium Costs Family of 4 = $8,824

2007 Pediatric Claims Costs

- Non-Obese Child: $1,640
- Obese Child: $2,907
- Child with Type II Diabetes: $10,789
- Adult with Type II Diabetes: $8,844
2008
Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity

✓ Clinical Recommendations for Assessment
✓ Staged Approach to Treatment

Body Mass Index

The graph illustrates the body mass index (BMI) over age, with different percentile lines for obesity, overweight, healthy weight, and underweight. The BMI increases with age, and the percentiles indicate the range for each weight category.
Staged Approach to Treatment
American Medical Association
2008

Stage 1: Preventive
BMI = 85th-94th percentile

Stage 2: Preventive Plus
BMI = 85th-94th percentile

Stage 3: Comprehensive, Multidisciplinary Intervention
BMI = 95th-98th percentile

Stage 4: Tertiary—Pharmacological and Surgical
BMI = 99th percentile

BMI: Body Mass Index

www.aafp.org/afp/200/0701/p56.pdf
www.medscape.org/viewarticle/577665
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.
2015 Guidance for Pediatricians:

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

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

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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

Employee/Beneficiary Issues

Low Use of Services

* Lack of awareness of a benefit

* Employees more apt to follow medical advice when benefits are known and available

* Parents of overweight and obese children don’t always perceive the need


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

Thomson Medstat
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 scientific evidence, under health benefits where the patient has no cost sharing, co-pays, co-insurance, or deductible.”
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 dietary counselling provided by dietician or specially trained PCC
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
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

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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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