Improving Payment for Obesity Care: Strategies and Advocacy Recommendations from the AAP/AHRQ Obesity Treatment & Reimbursement Conference

Webinar
February 16, 2017
Meet the Faculty

Stephen Cook, MD, MPH, FAAP
Associate Professor of Pediatrics, Golisano Children’s Hospital at University of Rochester, Associate Director, AAP Institute for Healthy Childhood Weight

Moderator: Sandra G. Hassink, MD, FAAP
American Academy of Pediatrics Past-President and Medical Director, AAP Institute for Healthy Childhood Weight
Before we begin, please note a few housekeeping details:

• Please use *6 to mute your phone; if you’re using computer speakers, please mute them to avoid feedback.

• Please do not put yourself on hold, as we will be able to hear your hold music.

• Today’s webinar will be recorded. The link to the recording will be shared ~1 week following today’s event.

• Questions will be answered at the end of the webinar.
  • Questions should be submitted in the chatbox. No questions will be taken by phone.
  • All questions from the webinar, including those that were not answered due to time constraints, will be available in a summary document that will be posted with the recording.
Today’s Webinar

• Explore potential payment models for family based behavioral pediatric obesity treatment
• Learn advocacy strategies to support improved coverage for care
• Identify resources available through AAP and others to support your advocacy work for improved coverage of care
Who is in our virtual room today?
Thank you for completing the poll!

• We are all an important part of helping children with obesity

• We all have a place within the various systems that influence effective treatment.

• After today’s webinar we hope you will see your place in these various systems and how you can become a change agent within these systems.
• **Mission:**

To *advance the translation of evidence-based treatment for childhood obesity by working collaboratively* towards the development of feasible, acceptable, effective and sustainable care delivery models supporting the USPSTF recommendations and creation of a unified strategy for policy change regarding reimbursement.
• Examine the US Preventive Services Task Force (USPSTF) recommendations for childhood obesity treatment, including the current draft USPSTF recommendations (anticipated finalization and release 2017)
• Identify essential team members for the treatment of childhood obesity
• Discuss the integrated care model and context for the clinical management of obesity
• Review and discuss a model for effective childhood obesity treatment: family-based behavioral therapy

aap.org/AHRQConf
Consensus Recommendations

• Family treatment model is critical
• Interventions need to be comprehensive and behavioral
• Treatment should consist of more than 25 hours of contact with flexibility to adjust intensity of contact based on individual family needs
• Comprehensive and consistent training for staff teams delivering obesity treatment
<table>
<thead>
<tr>
<th>TEAM ROLE</th>
<th>WHO CAN FILL IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical management</td>
<td>Physician</td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td></td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>Behavioral interventionist</td>
<td>Mental Health Specialist (e.g., Psychologist/Social Worker/Master’s Level Counselor)</td>
</tr>
<tr>
<td></td>
<td>Dietitian</td>
</tr>
<tr>
<td></td>
<td>Exercise professional</td>
</tr>
<tr>
<td></td>
<td>Health coaches/educators</td>
</tr>
<tr>
<td>Supervision</td>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
<td>Physician (specialty other than psychiatry)</td>
</tr>
<tr>
<td>Subspecialist access as needed (could be virtual)</td>
<td>Exercise Physiologist</td>
</tr>
<tr>
<td></td>
<td>Registered Dietitian</td>
</tr>
<tr>
<td></td>
<td>Medical Subspecialist</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td>Coordination</td>
<td>Interventionist</td>
</tr>
<tr>
<td></td>
<td>Navigator</td>
</tr>
<tr>
<td></td>
<td>Case worker</td>
</tr>
</tbody>
</table>
Conclusions

- Access to payment for childhood obesity is inconsistent and insufficient
- Demonstration projects should be conducted by all payers (Medicaid & private)
- Providers should work with states to develop state and regional strategies for appropriate payment models & to develop alternative payment strategies

Universal Assessment of Obesity Risk and Steps to Prevention and Treatment

Identification
Calculate and plot BMI at every well child visit

BMI 5th-84th percentile
- Child history & exam
- Child growth
- Parental obesity
- Family history

BMI 85th-94th percentile
- Child history & exam
- Child growth
- Parental obesity
- Family history
- Laboratory, as needed

BMI ≥ 95th percentile
- Child history & exam
- Child growth
- Parental obesity
- Family history
- Laboratory

Assessment

Medical Risk
- Eating

Behavior Risk
- Sedentary time
- Physical activity

Attitudes
- Family and patient concern and motivation

Prevention

Target behavior
- Identify problem behaviors
- If no problem behaviors, praise current practice

Patient/family counseling
- Review any risks (e.g., DM)
- Use patient-directed techniques to encourage behavior change (see algorithm table)

Intervention for Treatment
(Advance through stages based on age and BMI)

Stage 1 Prevention Plus
Primary care office

Stage 2 Structured Weight Management
Primary care office with support

Stage 3 Comprehensive Multidisciplinary Intervention
Pediatric weight management center

Stage 4 Tertiary Care Intervention (select patients)
Tertiary care center

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Barlow S E Pediatrics 2007;120:S164-S192
Universal Assessment of Obesity Risk and Steps to Prevention and Treatment

Intervention for Treatment
(Advance through stages based on age and BMI)

- **BMI 5th-84th percentile**
  - Stage 1 Prevention Plus
  - Primary care office

- **BMI 85th-94th percentile**
  - Stage 2 Structured Weight Management
  - Primary care office with support

- **BMI ≥ 95th percentile**
  - Stage 3 Comprehensive Multidisciplinary Intervention
  - Pediatric weight management center

- **Stage 4 Tertiary Care Intervention (select patients)**
  - Tertiary care center

Patient/family counseling
Review any risks (eg DM)
Use patient-directed techniques to encourage behavior change (see algorithm table)

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Barlow S E Pediatrics 2007;120:S164-S192
<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Type</th>
<th>Location</th>
<th>Visit Length (mins)</th>
<th>Total Visits</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Consultation, moderate-high severity</td>
<td>MD</td>
<td>Clinic</td>
<td>60</td>
<td>1</td>
<td>Start of program</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>Psych PhD</td>
<td>Clinic</td>
<td>45</td>
<td>3</td>
<td>Once every 2 weeks at start of program</td>
</tr>
<tr>
<td>Medical Follow Up Visit, Moderate severity</td>
<td>MD</td>
<td>Clinic</td>
<td>25</td>
<td>4</td>
<td>Week 4 then once every 2 months</td>
</tr>
<tr>
<td>Medical nutrition therapy; initial assessment &amp; intervention</td>
<td>RD</td>
<td>Clinic</td>
<td>30</td>
<td>1</td>
<td>During 1st month of program</td>
</tr>
<tr>
<td>Physical therapy evaluation</td>
<td>PT</td>
<td>Offsite</td>
<td>60</td>
<td>1</td>
<td>During 1st month of program</td>
</tr>
<tr>
<td>Psychotherapy with patient and/or family member</td>
<td>Psych MS</td>
<td>Offsite</td>
<td>45</td>
<td>20</td>
<td>Every week for months 2-5, bimonthly month after</td>
</tr>
<tr>
<td>Physical therapy re-evaluation</td>
<td>PT</td>
<td>Offsite</td>
<td>60</td>
<td>8</td>
<td>Every 2-4 weeks after 1st month</td>
</tr>
<tr>
<td>Medical nutrition therapy; Reassessment &amp; Intervention, 15 minutes</td>
<td>RD</td>
<td>Clinic</td>
<td>30</td>
<td>3</td>
<td>Once every 2-3 months after 1st month</td>
</tr>
<tr>
<td><strong>Total visits</strong></td>
<td></td>
<td></td>
<td></td>
<td>41</td>
<td></td>
</tr>
</tbody>
</table>
Why is this important for me?

- **PCP** – you need to know what your hospital, health system, ACO will support. Can you refer to community, tertiary care, or have health coach in your office.

- **Hospital Director/Lead** – you want to know how to deliver Fee-for-Service but also bundled care &/or alternative payments w/ Community-based Organization

- **RD or MSW or MHC** – where can I provide this care/be part of a team, either FFS or bundled
Reimbursement Models & Considerations for Childhood Obesity
AHRQ Pre-Conference Survey

3 Primary Barriers to Implementation of Evidence-based Childhood Obesity Treatment*

- **77%** Lack of insurance/coverage
- **74%** Costs to implement the intervention
- **66%** Lack of adequate training for providers

*% of respondents who rated the factor as important or very important
Evolution of Delivery & Payment

SOURCE: Author’s analysis.

Miller, Health Affairs, 2009.
Five Factors Driving Total Health Care Costs

1. **Prevalence** of health conditions in the population
2. Number of episodes of care required per condition
3. Number and type of health care services a person receives in each episode
4. *Number and type of processes, devices, and drugs involved in each service*
5. *The price for each of those individual processes, devices, and drugs*
Prevalence of obesity and severe obesity in US children, 1999-2014

6.3% = Class II: >120% of Obesity

2.4% = Class III: >140% of Obesity

Obesity Volume 24, Issue 5, p 1116-1123, APR 2016
## Treatment of Obesity in Children and Adolescents

*About 15% of 2-19 yr olds*

<table>
<thead>
<tr>
<th>Stage</th>
<th>Delivery</th>
<th>Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 – Prevention Plus</strong></td>
<td>Office-based support, with scheduled follow-up</td>
<td>5 fruits and vegetables&lt;br&gt; &lt; 2 hrs of screen time&lt;br&gt; &gt; 1 hr of physical activity</td>
</tr>
<tr>
<td><strong>Stage 2 – Structured Weight Management</strong></td>
<td>Specially-trained staff in office with support from referrals (RD)</td>
<td>Reduced-calorie eating plan&lt;br&gt; &lt; 1 hr of screen time&lt;br&gt; Monitoring</td>
</tr>
<tr>
<td><strong>Stage 3 – Comprehensive Multidisciplinary Intervention</strong></td>
<td>Dedicated weight management program or registered dietician referral; weekly follow-up for 8-12 weeks</td>
<td>More frequent contact, more f 1/3rdstructured monitoring, goal-setting</td>
</tr>
<tr>
<td><strong>Stage 4 – Tertiary Care</strong></td>
<td>Pediatric weight management center with multidisciplinary team; clinical or research protocol</td>
<td>Medication, surgery, meal replacement, ongoing behavior change</td>
</tr>
</tbody>
</table>

Adapted from Barlow 2007

Evidence-based Childhood Obesity Treatment: Improving Access and Systems of Care
Chicago, Illinois
July 9th-10th, 2015
## Treatment of Obesity in Children and Adolescents

### About 15% of 2-19 yr olds

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<tr>
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<th>Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 – Prevention Plus</strong></td>
<td>Office-based support, with scheduled follow-up</td>
<td>About 7.5% of 2-19 yr olds</td>
</tr>
<tr>
<td><strong>Stage 2 – Structured Weight Management</strong></td>
<td>Specially-trained staff in office with support from referrals (RD)</td>
<td>If 1/4th w/ Ob come / follow up ~4% monitoring</td>
</tr>
<tr>
<td><strong>Stage 3 – Comprehensive Multidisciplinary Intervention</strong></td>
<td>Dedicated weight management program or registered dietician referral; weekly follow-up for 8-12 weeks</td>
<td>More frequent contact, more frequent Med, ~1% (&gt;6yr)</td>
</tr>
<tr>
<td><strong>Stage 4 – Tertiary Care</strong></td>
<td>Pediatric weight management center with multidisciplinary team; clinical or research protocol</td>
<td>If 1/4th continue, then ~ 0.2% change</td>
</tr>
</tbody>
</table>

**About 7.5% of 2-19 yr olds**

If 1/4th w/ obesity come / follow up, then ~4%

If 1/4th continue, then ~ 1% (>6yr)

If 1/4th continue, then ~ 0.2%

Evidence-based Childhood Obesity Treatment: Improving Access and Systems of Care  
Chicago, Illinois  
July 9th-10th, 2015

Adapted from Barlow 2007
Four Factors that Drive Payment Decisions

1. Challenge in bundling payment
2. Negotiating the payment amount
3. Assuring quality health care for patients
4. Aligning incentives through multiple payers
<table>
<thead>
<tr>
<th></th>
<th>Fee-For-Service</th>
<th>Episode-Of-Care Payment</th>
<th>Condition Adjusted Capitation</th>
<th>Traditional Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discourages unnecessary services in an episode?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pays for all necessary services in an episode?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Encourages coordination of multiple providers?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Facilitates comparison of costs of different providers?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Encourages providing high-quality services?</td>
<td>No</td>
<td>Yes, if quality measures are tied to payment</td>
<td>Yes, if quality measures are tied to payment</td>
<td>Yes/Maybe</td>
</tr>
<tr>
<td>Avoids penalty for taking sicker patients?</td>
<td>Yes</td>
<td>Yes, if payment is adjusted for severity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Discourages unnecessary episodes?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Application to Childhood Obesity Treatment</td>
<td>Fee-For-Service</td>
<td>Episode of Care Payment</td>
<td>Condition Adjusted Capitation</td>
<td>Traditional Capitation</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------</td>
<td>-------------------------</td>
<td>-------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Current national data shows services not being covered. FFS presents a high level of risk to insurers from high volume &amp; over-utilization.</td>
<td>Limits treatment during a defined episode, and not in chronic care model. Might be applicable in cases of adolescent bariatric surgery.</td>
<td>Encourages coordination and innovation in care delivery. Incentivizes high-quality and efficiency.</td>
<td>Puts a hard cap on reimbursement. Leads to lemon dropping and cherry picking. Places a high level of risk on providers.</td>
<td></td>
</tr>
</tbody>
</table>

Where is Risk?  
100% Payer  
100% Provider
Payment reform

Bundled payments for acute care episodes (Hip replacement)
Value-based payment (Pay for Quality P4Q)
Patient-centered medical home (Health Home)
Accountable Care Organizations (Adult vs Child Focus)

Accepts *performance risk* for quality and cost

Medicaid (Medicare)

Commercial Plan

Large Employer Groups
Joint Replacement as Bundled Episode

Volume & Variations – Major Joint Replacement

Total Episodes: 257

SNF Rehab

Payments reflect actual payments excluding IME, DSH, and Capital, are neutralized for wage adjustments, are prorated, and are not trimmed for episode outliers.

Data Source: 2011, 2012 100% Medicare Standard Analytic Files
Overview of Payers & Their Priorities

• Who is Licensed & Scope of Practice
• Commercial & Large Employer group plans
  – Tide is changing to provide coverage for weight management to children and families
  – EMPLOYERS: Want more productive work force
• Accountable Care Organizations (ACOs)
  – Initial focus on patients in poverty, and the socio-economic barriers they face, and on high cost services, admissions/ED visits
  – Focus on systems of care & care management for patients with complex, chronic conditions
• Medicaid / Medicaid Managed Care
  – State-by-state priorities
• Approximately 50% of children nationwide are covered by employer-sponsored health insurance

• All basic services including *well-child visits* and routine vaccinations are covered under these plans

• Critical Points to Make about Child Obesity Intervention
  – Not just weight loss, also general health care and prevention
  – Obesity programs are *preventive* treatments that prevent the onset of other medical issues
  – Payment should be *bundled* for the whole treatment
  – *Consistent, uniform product* that produces similar outcomes
• Adult-focused vs Child-focused (Pediatric Hospitals)
• Accountable care means responsible for the health and outcomes of defined population of patients with some risk
  – Varies based on how the population is defined, e.g., all services related to a hip replacement or full financial risk for a primary care population
  – Focus is on systems of care
  – Largely incentivized by initially focusing on the biggest drivers of poor and expensive health outcomes
    • Obesity doesn’t drive admissions or increased medical costs in short term, majority of costs as adults & in a different system
  – Investments in this population need support from other sources (e.g., employers, government) and an emphasis on the long-term payoff for the government that would result from care
Medicaid Comments

• “When you have seen 1 Medicaid plan, you have still only seen 1 Medicaid plan”

• Medicaid broadly pays for treatment services for children with obesity (“CMS has to tell us what codes”)

• Critical Points to Make about Child Obesity Intervention
  – Approach change/implementation at a state level
  – Treatment approach needs to be flexible
  – Roles needed must be considered and advocated for when necessary to ensure payment for providers other than physicians
  – Beneficial to target treatment to children who are >95\textsuperscript{th} or higher

• They don’t care about parent/adults
“Financially reward providers and plans that deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes including interventions that address underlying social determinants of health”

NYDOH, April 2015
Value-base Roadmap – moving away from Fee-For-Service toward Value-based Payment

Integrated Physical & Behavioral Primary Care
Includes social services interventions and community-based prevention activities

Fee for Service + Per Member per month

Maternity Care (including first month of baby)
Acute Stroke (incl. post-acute phase)
Depression
...

Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression...)
Hemophilia
Chronic Kidney Disease
AIDS/HIV
Multimorbid disabled / frail elderly (MLTC/FIDA population)
Severe BH/SUD conditions (HARP population)
Care for the Developmentally Disabled

Population Health focus on overall Outcomes and total Costs of Care

Sub-population focus on Outcomes and Costs within sub-population/episode of Care

How an Integrated Delivery System May Function: adapted from the DSRIP Program vision

- **Episodic**: Evidence-based, outcome-focused care pathways experienced by patients as a smooth, coordinated process

- **Continuous**: Evidence-based, outcome-focused disease management, self-management strategies, integrated care coordination

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities, such as primary care-based interventions for childhood obesity (e.g. FBT)

- Maternity care
- Acute stroke
- Depression
- Adolescent bariatric surgery
- Chronic care
- Hemophilia
- Chronic kidney disease
- AIDS/HIV
- Multimorbid disabled/frail elderly
- Severe behavioral health and substance use disorder conditions
- Developmentally disabled
- Intensive, outpatient FBT for severe childhood obesity*

*Severe obesity defined as (>120% above the 95th BMI Percentile) with at least 1 co-morbidity

**DSRIP: Delivery System Reform Incentive Payment Program

FBT: Family-based Behavioral Treatment
Upstate NY Medical Center & ACO
Value-Based Care Roadmap

From left to right, value shifts from being about volume to a different risk and reward structure.

<table>
<thead>
<tr>
<th>Current Arrangements</th>
<th>Future Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct to Employers</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Commercial / Exchange</td>
<td>Medicare</td>
</tr>
<tr>
<td>Fee-for-Service</td>
<td>P4P</td>
</tr>
</tbody>
</table>

- Medicaid: Medicaid
- Medicare: Medicare
- Commercial / Exchange: Commercial / Exchange
- Direct to Employers: Direct to Employers
- Fee-for-Service: Fee-for-Service
- P4P: P4P
- Shared Savings: Shared Savings
- Bundled Payments: Bundled Payments
- Shared Risk: Shared Risk
- Capitation Full Risk: Capitation Full Risk
- Health Plan: Health Plan
Other Key Partners/Models

- Hospitals/Health Systems will take lead on risk
- YMCA has national model for DPP
  - Developing model for kids based on MEND
  - Could be sub-contract for bundle or bill payer directly
- On-line or web-based by Employers (KURBO)
- Alliance for Healthier Generation Benefit
  - Blues and Large Employer
  - Very Broad role out in Louisiana
Outcomes / Measure / Metrics
Delivery System Reform Incentive Payment: Mapping State Programs

http://www.chcs.org/driving-health-care-innovation-through-dsrip/
What are Metrics/Outcomes to Measure?

- Avoid weight-only metrics
- Have appropriate weight change (5-10%), not cure
- Focus on patient related outcomes
- Focus/add parent parent-related
- Process measures are also important
- Advocate for measures that could be used in pay for performance or accountable care arrangements
  - Tie dollars to improvement in short-term outcomes (e.g., decrease in the percent of the pediatric population with a BMI above the 85th percentile)
  - Measure long-term savings for pediatric patients who were or are engaged in effective weight management (e.g., prevention of medical comorbidities and associated financial savings)
How to be a Champion for Obesity Treatment
Role of Healthcare Providers

Need to engage:

• parents and patients in advocating for better access to and reimbursement for childhood obesity treatment.

• Obesity Action Coalition [http://www.obesityaction.org/]

• hospital leadership like Director, Dept Chair, C-suite

• healthcare systems to assemble needed services & advocate for payment

• state organizations to advocate for (public and private) payment. (ie, AAP, Hospital Assoc.)

Together (patients/families, healthcare systems, & providers) need to work together to encourage full coverage for effective obesity treatment

## Key Advocacy Points

### Efficacy
- Scientific evidence exists supporting the efficacy of treatment for childhood obesity.
  - Biomedical and psychosocial improvements in the child and immediate family reduce the likelihood of comorbidities.
  - If applied on a population level, there is potential for a significant impact on the public health of children and parents.

### Patient-Related Variables
- This treatment would be valued by families and could boost enrollment since childhood obesity is a top health concern for parents.
- Patient-reported outcomes have been found, including improvements in:
  - Physical functioning, quality of life, self-esteem, depression, academic performance, and important cognitive skills like executive function.

### Return on Investment
- Childhood obesity incurs direct medical costs that include, but are not limited to: emergency department visits, prescription medications, and medical specialty care.
  - Reimbursing for childhood obesity treatment thus presents an opportunity to invest in treatment potentially leading to lower lifetime medical costs.
  - Costs of childhood obesity treatment may be offset in adulthood through the prevention of obesity-related comorbidities like heart disease and diabetes.
  - Positive weight outcomes extend to the caregivers, siblings, and community.
    - Children could experience fewer school absences, resulting in academic improvements, thus providing the country with a more prepared workforce.
    - Adults could reduce absenteeism and presenteeism thereby creating a more productive workforce and reduce productivity-related costs due to fewer sick days.

### Mandate
- The American Medical Association has designated obesity as a disease, and as such, medical necessity will arise for those children and adolescents suffering from severe obesity with co-morbid physical and mental health conditions.
- The USPSTF have endorsed moderate to high intensity, multicomponent, behavioral interventions for the treatment of childhood obesity with a grade B recommendation. The ACA has specifically stated that all services designated with a grade A or B from USPSTF MUST be fully covered without copayment. Therefore, childhood obesity treatment services consistent with USPSTF guidelines must be covered by insurers.
- EPSDT amendments establish new coverage requirements under Medicaid, to cover “early and periodic” screening and diagnostic services to ascertain “defects” and “chronic conditions” in children, as well as healthcare and treatment needed to “correct or ameliorate” such defects and conditions discovered during the screening examinations (see Supplement 4).
- The EPSDT benefit bars limitations and exclusions used by commercial insurers to exclude otherwise-covered treatments that promote the health of children with serious physical and mental health conditions that delay development.

**USPSTF = United States Preventive Services Task Force; EPSDT = Early and Periodic Screening, Diagnostic and Treatment**

Advocacy at State Level
Pediatric Councils

There are 39 Chapter Pediatric Councils:

Pediatric Councils are:

• A forum for chapters to meet with payers to discuss issues impacting access, quality, cost, coverage and payment
• A means to address payer policies, covered services and administrative practices affecting pediatric services
• A collaborative effort to discuss ideas for resolving issues between pediatricians and payers
• It is not a means to discuss or negotiate fees, payment, or any collective action by pediatricians

Analogue groups from Acad Nutr Diet and Amer Psych Assoc and State-level Hosp Assoc.
State Examples

- Alabama: AL CHIP
- Illinois: BCBS
- Minnesota: Obesity community treatment services
- Ohio: Children’s Hospital Association of Ohio
- Missouri: Medicaid & Wash U
MHD’s Pediatric Obesity Treatment Package Elements

- **Eligibility**: children ages ≥5 y.o. with obesity covered by MO MHD (FFS and managed care)
- **Mechanism of billing**: through a medical diagnosis
- **Approved treatment providers**: those who are currently approved to bill HBA&I codes
  - Licensed psychologists
  - Licensed professional counselors
  - Licensed clinical social workers
- **Licensed registered dietitians for MNT codes only**
Missouri Health Department’s Pediatric Obesity Treatment Package Elements

- **Treatment duration and hours**: 26 hours of behavioral treatment with 1.5 hours of MNT over 6 months
  - Additional 3 hours of treatment in the following 6 months
- **Total 29 sessions of behavioral treatment over 12 months**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Session length</th>
<th>Number of sessions</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual assessment with Behavioral Provider</td>
<td>30 minutes</td>
<td>6</td>
<td>$40 per session</td>
</tr>
<tr>
<td>Family meeting with Behavioral Provider</td>
<td>60 minutes</td>
<td>3</td>
<td>$80 per session</td>
</tr>
<tr>
<td>Group meeting with Behavioral Provider</td>
<td>60 minutes</td>
<td>20</td>
<td>$32 per patient (minimum 2 patients/families for a group)</td>
</tr>
<tr>
<td>Individual assessment with RD (MNT)</td>
<td>30 minutes</td>
<td>3</td>
<td>Unknown at this time; expected to be $40/session</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27.5 Hours</td>
<td>32 sessions</td>
<td>$750 Total Reimbursement</td>
</tr>
</tbody>
</table>
Value-Base Roadmap – Moving Away from Fee-For-Service toward Value-Based Payment

Integrated Physical & Behavioral Primary Care

- Includes social services interventions and community-based prevention activities

**Episodic**
- Maternity Care (including first month of baby)
- Acute Stroke (incl. post-acute phase)
- Depression
- ... (remaining episodic conditions)

**Continuous**
- Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression...)
- Hemophilia
- Chronic Kidney Disease
- AIDS/HIV
- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the Developmentally Disabled

Population Health focus on overall Outcomes and total Costs of Care

Sub-population focus on Outcomes and Costs within sub-population/episode of Care

Elements of a Sustainable Funding Mechanism

• Payment for value rather than volume
• Mechanisms for sharing risks and savings/benefits with reinvestment
• Options to correct the wrong pocket problem
• Braided funding from different sources
• Establish mechanism for funding continuity and certainty
Treatment options (>25hr FBT) same BUT different reasons WHY they will pay

Start(Pay) for FFS, then move to VBP
- Pre-ACA: FFS 100%, needs grants and philanthropy
- Post-ACA: FFS 30-40%, contracts & bundles 40-50%

Don’t make weight only or main metric

Payers reducing RISK, providers taking on RISK

Need to look to where both healthcare DELIVERY and PAYMENT are going

Advocacy might will be hand-to-hand combat, state by state
Conclusions

• Access to payment for childhood obesity is inconsistent and insufficient
• Demonstration projects should be conducted by all payers (Medicaid & private)
• Providers should work with states to develop state and regional strategies for appropriate payment models & to develop alternative payment strategies

Improving Access and Systems of Care for Evidence-Based Childhood Obesity Treatment: Conference Key Findings and Next Steps

Denise E. Wilfley¹*, Amanda E. Staiano², Myra Altman¹, Jeanne Lindros³, Angela Lima¹, Sandra G. Hassink³, William H. Dietz⁴, and Stephen Cook⁵*, The Improving Access and Systems of Care for Evidence-Based Childhood Obesity Treatment Conference Workgroup

Objective: To improve systems of care to advance implementation of the U.S. Preventive Services Task Force recommendations for childhood obesity treatment (i.e., clinicians offer/refer children with obesity to intensive, multicomponent behavioral interventions of >25 h over 6 to 12 months to improve weight status) and to expand payment for these services.

Methods: In July 2015, 43 cross-sector stakeholders attended a conference supported by the Agency for Healthcare Research and Quality, American Academy of Pediatrics Institute for Healthy Childhood Weight, and The Obesity Society. Plenary sessions presenting scientific evidence and clinical and payment practices were interspersed with breakout sessions to identify consensus recommendations.
Thank you!

Questions