Obesity and Medical Nutrition Therapy

Deborah B. Munchmeyer
Program Manager, SCDHHS Coverage and Benefit Design
March 10, 2018
Obesity – What, Why and How?

Source: American Association of Clinical Endocrinologists (AACE) Obesity Resource Center
Obesity meets the three main criteria for a disease:
• The condition impairs normal function
• The condition has characteristic signs or symptoms
• The condition causes harm or morbidity

Obesity prevalence has risen steadily for several decades. The disease, its complications and comorbidities place a huge burden on patients and society.

Obesity is estimated to add $3,559 annually (adjusted to 2012 dollars) to per-patient medical expenditures as compared to patients who do not have obesity; this includes $1,372 each year for inpatient services, $1,057 for outpatient services and $1,130 for prescription drugs.

• The primary therapeutic goal of obesity management is improvement in obesity-related complications, not a preset decline in body weight.

• Lifestyle intervention is a vital component of all weight loss regimens. The choice of whether to implement lifestyle therapy alone or combine it with weight-loss medications or bariatric surgery will depend on the severity of each individual patient’s obesity and related complications.
# Chronic Disease Management of Obesity

<table>
<thead>
<tr>
<th>Intervention Phase</th>
<th>Definition and Goals</th>
<th>Method</th>
</tr>
</thead>
</table>
| **Primary Prevention** | Prevent development of overweight and obesity | • Educate the public  
• Modify obesogenic built environment  
• Promote healthy eating and regular physical activity |
| **Secondary Prevention** | Prevent future weight gain and development of weight-related complications in patients with overweight or obesity | • Screen using BMI  
• Diagnose using BMI and evaluation for complications  
• Treat with lifestyle/behavioral interventions ± weight loss medications |
| **Tertiary Prevention** | Treat with weight-loss therapy to eliminate or improve weight-related complications and prevent disease progression | • Treat with lifestyle/behavioral interventions plus weight loss medications  
• Consider bariatric surgery |

Source: American Association of Clinical Endocrinologists (AACE) Obesity Resource Center
## Obesity Meets AMA Criteria for a Disease

### Impairment of Normal Function
- Physical impairments
- Altered physiologic function (inflammation, insulin resistance, dyslipidemia, etc)
- Altered regulation of satiety in the hypothalamus

### Characteristic Signs or Symptoms
- Increased body fat mass
- Joint pain
- Impaired mobility
- Low self-esteem
- Sleep apnea
- Altered metabolism

### Harm or Morbidity
- Cardiovascular disease
- Type 2 diabetes
- Metabolic syndrome
- Cancer
- Death

---

Medical Complications of Obesity

Obesity

Biomechanical
- Dismotility/disability
- GERD
- Lung function defects
- Osteoarthritis
- Sleep apnea
- Urinary incontinence

Cardiometabolic
- Dyslipidemia
- Hypertension
- Prediabetic states
- NAFLD
- PCOS

Diabetes

Cardiovascular Disease

Other
- Androgen deficiency
- Cancer
- Gallstone disease
- Psychological disorders

GERD = gastroesophageal reflux disease; NAFLD = nonalcoholic fatty liver disease; PCOS = polycystic ovary syndrome.
Obesity Has Multiple Pathophysiologic Origins

- Epigenetic
- Genetic
- Physiologic
- Behavioral
- Sociocultural
- Environmental

• Obesity costs our nation $150 billion in health care costs every year.

• Obesity is one of America's most costly and devastating health problems. It increases risk for a host of chronic and life-threatening conditions, including high blood pressure, heart disease, type 2 diabetes, stroke, arthritis, liver disease, kidney disease, dementia, gallbladder disease, mental health issues and some forms of cancer.

• The healthcare system can play a vital role in our battle against obesity and can work in concert with community health and other sector initiatives for even stronger reinforcing impact. Healthcare providers are on the front lines of the obesity epidemic and can help implement prevention strategies, including obesity screening and nutrition and exercise counseling. Health insurance plans can also play an important role by providing coverage for obesity-related disease and incentivizing its healthcare facilities and providers to implement obesity prevention interventions.

Source: The State of Obesity: Better Policies for a Healthier America
A.M.A. Recognizes Obesity as a Disease

By ANDREW POLLACK  JUNE 18, 2013

“Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans,” Dr. Patrice Harris, a member of the association’s board, said in a statement. She suggested the new definition would help in the fight against Type 2 diabetes and heart disease, which are linked to obesity. (BMI>30)
Percent of obese adults (Body Mass Index of 30+)

- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%+

2016 US Adult Population

SC is 12th highest at 32.3%

Source: The State of Obesity: Better Policies for a Healthier America
2016 US Child Population

Combined overweight and obese rates, children ages 10 to 17

SC is 17th highest at 32.9%

Source: The State of Obesity: Better Policies for a Healthier America
2017 SC Medicaid Child Population

Rate* of SC Medicaid Children with Obesity Diagnosis

Children (0-20) with BMI >= 95% for Age

- 9% - 15%
- 7% - 8%
- 5% - 6%
- 1% - 4%
- 0%
- No Data

*Rate calculated as Children (0-20) with Obesity diagnosis in FY 2017/Children Eligible for SC Medicaid for at least one month in FY 2017

Source: SCDHHS Division of Health Informatics & Analytics
2017 SC Medicaid NCP Adult Utilization

Nutritional Counseling Program Utilization by Adults - FY 2017

Source: SCDHHS Division of Health Informatics & Analytics
Nutritional Counseling Program Utilization by Adults - FY 2017

Individuals visiting Dietitians

Adulst visiting Dietitian

6 - 22
4 - 5
2 - 3
1
0

*Adults are Ages 21+ in NCP Program

Source: SCDHHS Division of Health Informatics & Analytics - 7 February 2018
2017 SC Medicaid NCP Child Utilization

Nutritional Counseling Program Utilization by Children - FY 2017

Source: SCDHHS Division of Health Informatics & Analytics
Nutritional Counseling Program Utilization by Children - FY 2017

States visiting Physicians

Children visiting Physician

1,392 - 3,355
662 - 1,391
273 - 621
48 - 272

*Children are Ages 0 - 20 in NCP Program
2017 SC Medicaid NCP Child Utilization

Nutritional Counseling Program Utilization by Children - FY 2017

Individuals visiting Dietitians

Children* visiting Dietitians

- 66 - 225
- 36 - 65
- 15 - 35
- 1 - 14
- 0

*Children are Ages 0 - 20 in NCP Program

Source: SCDHHS Division of Health Informatics & Analytics
My Healthy Weight Pledge

• The first-ever collective initiative offering obesity prevention and treatment for individuals of all ages to provide millions of individuals nationally with consistent coverage to support healthy weight change. The Alliance for a Healthier Generation and the Bipartisan Policy Center developed this initiative with support from the Robert Wood Johnson Foundation.

• Members are committed to activities that will support the utilization of these newly covered benefits and, where applicable, move their organization towards value-based payments for obesity.
Offer intensive behavioral interventions every plan year for members with a qualifying diagnosis:

- At least 12 visits for adults with a BMI ≥ 30
- At least six contact hours for adults with a BMI ≥ 25 and one or more risk factors for cardiovascular disease
- At least 12 visits for children ages 3 years or older with a BMI ≥ 95th percentile
- At least eight visits for children ages 3 years or older with a BMI 85th – 95th percentile

Implement and/or cover one or more community-based program(s) for adults and/or children:

- Adult-focused programs: Qualifying programs should have a previously demonstrated ability to achieve at least a five percent weight loss in adult participants.
- Child-focused programs: Qualifying programs should have a previously demonstrated ability to achieve a BMI percentile decrease in child participants.

Source: The Alliance for a Healthier Generation
My Healthy Weight Founding Fathers

- Kansas City
- blue california
- CDPHP
- Connecticut Department of Social Services
- Delaware Health and Social Services
- STATE of ALASKA Department of Health and Social Services
- Nestlé

Blue Cross and Blue Shield of North Carolina

Source: The Alliance for a Healthier Generation
The 6|18 Initiative

Promote adoption of evidence-based interventions in collaboration with health care purchasers, payers and providers

High-burden health conditions 6|18 Evidence-based interventions that can improve health and save money

INITIATIVE

Six High-Burden Health Conditions

- High-burden
- Costly
- Preventable
- Scalable
- Purchasers and payers

Source: Centers for Disease Control and Prevention and Center for Health Care Strategies
18 Evidence-Based Interventions

**Reduce Tobacco Use**
- Increase access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline and the 2015 U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation statement).
- Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.
- Promote increased use of covered treatment benefits by tobacco users.

**Prevent Healthcare-Associated Infections**
- Require antibiotic stewardship programs in all hospitals and skilled nursing facilities, in accordance with CDC’s Core Elements of Hospital Antibiotic Stewardship and The Core Elements of Antibiotic Stewardship for Nursing Homes.
- Reduce inappropriate antibiotic prescribing by incentivizing providers to encourage them to closely follow CDC’s Core Elements of Outpatient Antibiotic Stewardship.

**Control High Blood Pressure**
- Implement strategies that improve adherence to blood pressure and other common chronic disease prescription medications, including lipid-lowering and smoking cessation medications. Strategies may include: low-cost medication fills and fixed dose medication combinations; calendar blister packs or other medication packaging; and care coordination by primary care teams.
- Provide to patients with known or suspected hypertension validated home blood pressure monitors and reimburse for the clinical support services required for home blood pressure monitoring.

**Prevent Unintended Pregnancy**
- Reimburse providers for the full range of contraceptive services (e.g., screening for pregnancy intention; client-centered counseling; insertion, removal, replacement, or reinsertion of long-acting reversible contraceptives [LARCs, such as intrauterine devices and implants] or other contraceptive devices, and follow-up) for women of childbearing age.
- Reimburse providers or provider systems for the actual cost of FDA-approved contraception, including LARC or other contraceptive devices in order to provide the full range of contraceptive methods.
- Reimburse for immediate postpartum insertion of long-acting reversible contraceptives (LARC) by unbundling payment for LARC from other postpartum services.
- Remove administrative and logistical barriers to LARC (e.g., remove pre-approval requirement or other unnecessary restriction and mandate high acquisition and stocking levels)

**Prevent Diabetes**
- Expand access to the National Diabetes Prevention Program (the National DPP), a lifestyle change program for preventing type 2 diabetes.

Source: Centers for Disease Control and Prevention and Center for Health Care Strategies
6|18 Participants by State

Source: Centers for Disease Control and Prevention and Center for Health Care Strategies
Why Medical Nutrition Therapy?

- 2 out of 3 South Carolina adults are overweight or obese
- The economic cost of obesity in South Carolina is estimated to be $8.5 billion per year and growing
- More than 30% of South Carolina high school students are overweight or obese
- 1 in 3 low-income children ages 2–5 years old are overweight or obese in South Carolina
- As of 2013, approximately 30% of Medicaid recipients are considered obese
- April 2013, recognition of obesity as a disease by AMA
2010 Position Statement:

“It is the position of the American Dietetic Association that medical nutrition therapy, as a part of the Nutrition Care Process, be the initial step and an integral component of medical treatment for management of specific disease states and conditions. If optimal control cannot be achieved with medical nutrition therapy alone and concurrent pharmacotherapy is required, the Association promotes a team approach and encourages active collaboration among registered dietitians and other health care team members.”

August 1, 2015: SCDHHS/Medicaid launched a nutrition counseling initiative to help change behavior and establish better food choices in our diet by pairing patients with the nutrition experts – registered/licensed dietitians!
Obesity affects more than 31.6 percent of South Carolinians. The cost of obesity related to medical treatment is **$147-$210 billion dollars.**

As part of the South Carolina Obesity Action Plan, our state has outlined targeted objectives in key settings for obesity prevention and promotes statewide changes at the environmental, policy and systems level. The objectives of the action plan are addressed through the work of the SCale Down Initiative.
SC Obesity Action Plan

WHY SHOULD I CARE ABOUT OBESITY IN SOUTH CAROLINA?

Today, two out of three South Carolina adults and one out of three children are overweight or obese. Obesity has become a major contributor to the diseases that kill the most people in our state, make the most people sick, and cost our state the most money to treat.

- **Adult Health Reasons**
  - Obesity is linked to chronic diseases like diabetes and heart disease; 80% of chronic diseases are preventable.

- **Children’s Health Reasons**
  - If current trends continue, this generation of South Carolina kids will have a shorter life expectancy than their parents.

- **Economic Reasons**
  - The economic cost of obesity in South Carolina is estimated to be $8.5 billion per year and growing.

WHAT’S IN THE ACTION PLAN?

The plan focuses on strategies to reduce and prevent obesity. Here are a few examples:

- **Communities** – Improving access to affordable, healthy produce by increasing the number of local farmers markets that accept SNAP/EBT and WIC vouchers.

- **Worksites** – Implementing healthy eating, physical activity, breastfeeding, and tobacco-free campus policies at the South Carolina Governor’s cabinet agencies.

- **Healthcare** – Increasing provider referrals to obesity counseling services for South Carolina patients.

- **Schools and Child Care** – Expanding the Farm to School program to increase access to fresh, locally-grown fruits and vegetables for South Carolina students.
As part of SCaleDown, a goal of the SC Obesity Action Plan includes the defined goal to:

- Improve patient care by enhancing the health care system’s ability to effectively diagnose, counsel and refer patients to needed obesity treatment, nutritional counseling and support services

- Population targets:
  - Those insured under Medicaid
  - Adults with a BMI ≥ 30 kg/m²
  - Children with a BMI ≥ 95th percentile

- Reimbursed services:
  - Six visits with a Primary Care Provider
  - Physician, physician assistant and/or nurse practitioner
  - Six visits with a registered, licensed dietitian
H.1.1a - Increase the number of adult Medicaid patients that receive nutritional counseling services by a physician/provider. (Goal: 340 patients)
  o Provider claims (G0447) – 390

H.1.1b - Increase the number of adult Medicaid patients that receive nutritional counseling services by a dietician. (Goal: 82 patients)
  o Initial visit claims (S9470) – 62
  o Subsequent visit claims (S9452) – 26

H.2.7a - Increase the number of pediatric Medicaid patients that receive nutritional counseling services by a physician/provider. (Goal: 3,664 patients)
  o 24,581 E&M provider claims with obesity diagnosis
  o Initial visit claims (97802) – 3,612
  o Subsequent visit claims (97803) – 94

H.2.7b - Increase the number of pediatric Medicaid patients that receive nutritional counseling services by a dietician. (Goal: 817 patients)
  o Initial visit claims (97802) – 498
  o Subsequent visit claims (97803) – 368
SC Medicaid Policy Considerations

- Frequency of visits
  - 12 per year
    - Split 6 RD/6 MD
  - 30 min too short for initial visit

- Reimbursement Rate
  - $27.82/30 min (RD)
  - Little incentive for RD enrollment

- Implement universal code set for adult and pediatric services

- Coverage for NDPP
Questions?

Contact Information:

Deborah B. Munchmeyer, MHA
Deborah.Munchmeyer@scdhhs.gov