

**PPO**

**Best Practices**

Assuring Successful  
Bariatric Surgery  
Outcomes



# **PPO Best Practices for Assuring Successful Bariatric Surgery Outcomes**

***AAPPO Issue Briefs  
and  
Case Studies***



## PPO Best Practices for Assuring Successful Bariatric Surgery Outcomes

AAPPO is pleased to bring you this Issue Brief series, "PPO Best Practices for Assuring Successful Bariatric Surgery Outcomes." The Issue Briefs were developed as part of a year long best practice initiative that also included educational webinars and launch of a robust website that includes links to patient, provider, and plan directed obesity resources.

Obesity is a growing public health problem in the U.S., and is a contributing factor to many chronic diseases including diabetes, heart disease, and joint disease. Approximately 127 million adults in the U.S. are overweight, 60 million obese, and 9 million severely obese. In the past decade, the rate of bariatric surgery has increased six fold from 13,000 performed in 1998 to 200,000 in 2007. Demand has increased as evidence accumulates about the positive health effects of surgery for people with very severe obesity.

AAPPO's Issue Brief series examines critical issues in assuring high quality outcomes for surgical treatment of obesity through bariatric surgery. This booklet includes the four Issue Briefs developed by AAPPO, along with case studies illustrating how diverse organizations have implemented effective strategies for bariatric surgical care. It offers resources to help PPO clinical leadership understand evidence based practices for bariatric surgery, and identifies PPO strategies to promote best practice.

For more information on the obesity problem in the U.S., tools and information, and links to health plan bariatric policies, visit the AAPPO web site at [www.aappo.org](http://www.aappo.org).

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For more information on AAPPO's Bariatric Surgery Best Practices Program, visit [www.aappo.org](http://www.aappo.org) or contact Liza Greenberg at [lgreenberg@healthpc.org](mailto:lgreenberg@healthpc.org).



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*All of the information provided by this initiative is the responsibility of AAPPO, not the Advisory Panel Members or funding organization. This information does not constitute medical advice.*





### Issue Brief 1

## BARIATRIC SURGERY – A FRAMEWORK FOR PPOS

### INTRODUCTION

Over the past decades obesity has emerged as one of the most significant chronic conditions in the U.S. According to the Centers for Disease Control and Prevention, one third of the adult population and 15% of children are obese (Body Mass Index greater than 30.)<sup>1</sup> Obesity is one of many underlying factors in the escalating costs of health care in the US: a July 2009 study in Health Affairs attributed \$147 billion in medical spending costs to obesity.<sup>2</sup> For fully-insured and self-insured employers, obesity is both a health care cost and productivity problem. The National Business Group on Health reports that obese adults incur annual medical expenses almost 40% higher than non-obese adults. Plus, severely obese adults have 118% more lost time from work, and also have twice as many work limitations.<sup>3</sup>

Addressing the obesity epidemic requires a multi-factorial approach undertaken by individuals, employers, communities, schools, the media and other sources of lifestyle support and information.<sup>4</sup> At the community level, recommended remedies include changing American dietary habits and increasing exercise opportunities. The health care system addresses the problem by assisting patients in maintaining normal weight, helping patients achieve medical weight loss, and supporting severely obese patients in need of weight loss surgery.

#### About AAPPO and the Best Practice Initiative

AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. It was established in 1983 to advance awareness of the benefits — greater access, choice and flexibility — that PPOs bring to

American health care. PPOs work in collaboration with the medical community respecting the doctor-patient relationship.

Currently, more than 193 million individuals are enrolled in a PPO program, which means 69 percent of Americans with health care coverage receive their health care services through a PPO delivery system. A PPO network of providers may be an embedded part of a traditional insurance program or it may be contracted as an element of a self-insured program that includes a third party administrator of claims and care management programs. PPOs also provide network services to newer types of insurance products such as consumer directed health plans. PPOs have variable access to claims data and information about quality of care.

This Issue Brief is part of a series developed by the American Association of PPOs examining bariatric surgery policy for PPOs. The Issue Briefs and the AAPPO web site on bariatric surgery ([aappo.org](http://aappo.org)) were created to provide risk and non-risk PPOs, along with their employer clients, with information on best practice considerations for bariatric surgery. The series is supported by Ethicon Endo-Surgery.

#### PPO Roles In Leveraging Bariatric Surgery Benefits And Quality

PPOs, as the dominant delivery approach to health care in the U.S., must take notice of obesity as an important cost driver to their customers. PPOs are positioned to work closely with employers and other purchasers to improve the delivery of preventive benefits, and to ensure

high quality obesity treatment. Risk-bearing PPOs can offer their clients value-added strategies such as measurement of trends, wellness programs and initiatives to promote network physician identification and intervention of early obesity. Risk-bearing PPOs may also use benefit design innovations and incentive payments to engage physicians and patients in addressing weight management and obesity.

Non-risk PPOs offer a qualified network and clinical expertise to purchasers and risk-bearing

entities. Non-risk PPOs can offer a network of high quality medical and bariatric surgery providers ensure cost effective services are available to members. These network PPOs can also position themselves to offer expert guidance to purchasers on the important trend of obesity and obesity treatment. Through their network assets, risk and non-risk PPOs can help to shape delivery and benefit options to direct patients to the highest performing services and providers and support them in engaging in healthier behaviors.

## ABOUT OBESITY

The National Institutes of Health defines overweight in terms of body mass index (BMI), a measure calculated on the basis of the patient's height and weight. A BMI of greater than 25 is considered overweight, a BMI of 30 and above is considered obese, and a BMI of 40 and above is considered severe or extreme obesity. Severe obesity has increased from 2.9% of the population in 1994 to 5.9% of the population in 2006.<sup>5</sup> Obesity is often accompanied by cardiac and metabolic co-morbidities, including hypertension, coronary heart disease, diabetes and sleep apnea. These factors increase the "absolute risk" of the patient and the chances of mortality. Obesity is also associated with other co-morbidities that do not impact risk of mortality but reduce patient quality of life and increase medical costs; these include musculoskeletal problems, gynecologic issues and gallstones.<sup>6</sup>

### Impact of Obesity Treatments Including Bariatric Surgery

Physician-developed clinical practice guidelines recommend prevention of obesity and medically supervised weight loss as the first line treatments for excess weight.<sup>7</sup> Overweight and obesity can be treated with behavioral modification, pharmacotherapy and bariatric surgery in any combination. Both the Centers for Disease Control and Prevention and the American Diabetes Association recommend structured interventions including education and counseling on improved health behaviors (such as exercise) as the first line approach to weight loss and reduction of risk for prediabetes. Behavioral intervention is only marginally effective, particularly for severely obese

people, as weight loss is often small, regaining weight is common, and there are variations in effectiveness across different racial and ethnic groups.<sup>8</sup>

A review of studies sponsored by the federal Agency for Healthcare Research and Quality (AHRQ) reported weight loss attributable to pharmacotherapy to be between approximately 3 and 6 kilograms, with weight loss up to 6% of baseline body weight.<sup>9</sup> A review of research on obesity treatment by DMAA: The Care Continuum Alliance (DMAA) also found that pharmacotherapy has modest effects, with patients in combined programs of behavioral therapy plus pharmacotherapy losing approximately 5kg of weight. Weight loss was generally greater with use of medications than for behavioral interventions alone, and can be up to 16% of excess weight when behavioral interventions, medication and supervised diet are combined.

For severe obesity physician organizations have concluded that bariatric surgery is the most effective intervention. Bariatric surgery is indicated for individuals with a BMI greater than 40, or individuals with a BMI greater than 35 plus a co-morbid condition.<sup>10,11</sup> The DMAA review concluded that there is "solid evidence" that bariatric surgery is effective at reducing weight.<sup>12</sup> Another review showed the impact of bariatric surgery on both weight and co-morbidities, finding 61% excess weight lost through surgery, a 77% reduction in diabetes, and a 61% reduction in hypertension.<sup>13</sup>

## Considerations in Assessing Bariatric Surgery Outcomes

Bariatric surgeries have increased from 13,000 in 1998 to 200,000 in 2007. The number of bariatric surgeons has increased from 250 in 1998 to 1,100 in 2003.<sup>14</sup> The number of surgeons and the number of surgeries has continued to rise since these data were published. Bariatric surgical procedures can be carried out either through open surgery or laparoscopically. The majority of procedures are being done laproscopically. Gastric restriction procedures include various types of banding of the stomach, while gastric bypass procedures cut and rearrange parts of the stomach and intestinal system to alter food intake and absorption. Each type has a slightly different profile in terms of expected weight loss, nutritional impact, follow up, and rate of complications; generally the type of surgery is determined by the expertise of the surgeon as there is no clear evidence suggesting superiority of one technique over another for specific patients.<sup>15</sup>

Two key considerations impact how PPOs should respond to the rise in bariatric surgery: the effectiveness and safety of bariatric surgery, and the cost and efficiency of bariatric surgery.

- In terms of effectiveness, guidelines and evidence reviews cited in this document conclude that bariatric surgery is the most effective treatment for severe obesity. For example, a Cochrane analysis found, "Surgery results in greater weight loss than conventional treatment in moderate (body mass index greater than 30) as well as severe obesity. Reductions in comorbidities, such as diabetes and hypertension, also occur."<sup>16</sup> As noted, there are variations in expected weight loss related to different types of bariatric surgery.
- Regarding safety, a variety of physician and insurer organizations have concluded that the rate of complications for bariatric surgery is comparable to that of other major procedures. A 2009 study concluded that the overall risk of death and other adverse outcomes after bariatric surgery is low, and should be contrasted to the risks the patient would otherwise experience from being extremely obese.<sup>17</sup> A trends review article

in 2005 found mortality rates range from 0.1% to 0.2% and the rate of unexpected re-operations for surgical complications ranges from 6% to 9%.<sup>18</sup> Bariatric procedures are getting safer. A 2009 study found a major drop in the complication rate over time; the authors attributed the decrease, which occurred as the patient population was becoming older and sicker, to an increase in volume of surgeons, and a greater use of laparoscopic surgery and banding techniques.<sup>19</sup> As a result of improved safety profile of bariatric surgery, both CMS and the Veterans Administration have recognized that the benefits of surgery outweigh the risks and approve surgery when medically necessary.

- In terms of efficiency, newer procedures have reduced length of stay and cost. The study comparing surgery in 2001 and 2006 found that hospital length of stay has decreased over time, and hospital payments for bariatric surgery patients have fallen. Rates fell from \$29,563 to \$27,905 for uncomplicated surgeries and dropped from \$41,807 to \$38,175 for patients who experienced complications.<sup>20</sup> Recent years have brought more conclusive findings about the impact of bariatric surgery to reverse costly comorbidities such as Type II diabetes. With such findings there have been new calculations of return on investment for bariatric surgery. Recent studies have found an expected ROI for surgery to be realized in a period of 2-4 years, since reversals in co-morbidities such as diabetes, hypertension and sleep apnea reduce expenditures for pharmaceuticals, office visits and hospitalizations.<sup>21</sup>

## CHANGING ENVIRONMENT FOR BARIATRIC SURGERY

An important consideration for PPOs is that the actual surgical intervention is only one component of the treatment process. Pre-operative screening and behavioral treatment are essential to ensure that patients are capable of carrying out the post operative regimen, have realistic expectations, and are motivated to succeed. Major surgical guidelines and experts in the field concur that bariatric surgery must be accompanied by behavioral and nutrition support in order to be effective. These issues will be the subject of a separate AAPPO Bariatric Best Practices Issue Brief.

### Increasing Knowledge about Best Practices

High quality bariatric surgery requires a coordinated multidisciplinary approach to behavioral and physical needs of the patients in addition to high quality technical surgical services. As with many surgical procedures, bariatric surgery outcomes are better when conducted by high volume providers in experienced facilities.<sup>22,23</sup>

Several organizations have taken the initiative on identifying and certifying best practice organizations. Centers of Excellence (COE) designation is based on standards that address among other topics:

- Volume of surgeries by the surgeon and the surgical facility
- Training and credentials of surgeons
- Facilities with equipment and experience working with severely obese populations
- Presence of trained staff to offer nutrition and surgical support, including follow up
- A track record of appropriately screening patients to identify and properly manage co-morbidities

Many insurance organizations require that bariatric surgeries be carried out in designated Centers of Excellence.

### PPO Approaches to Bariatric Surgery Policy PPOs

PPOs have three primary roles in helping to assure best practices relating to bariatric surgery: contracting with high quality physicians and hospitals, creating or supporting evidence based medical policy, and advising employer/payer clients on strategic benefit policy. These issues are discussed here:

#### *Contracting Strategy*

The case studies in this Issue Brief reflect one approach to contracting policy: many PPOs contract with COEs for bariatric surgery to ensure patient access to a systematic surgical and behavioral approach. The case studies included with this Issue Brief reflect two overlapping approaches to contracting with best practice organizations. The Surgical Review Corporation has developed evidence based certification standards for facilities and individual practitioners. The Blue Cross and Blue Shield Association has created the “Blue Distinction” program that recognizes high performing bariatric surgery centers and is in addition to certification by an independent organization such as SRC. The Blue Distinction program is a service offered to Blue Cross Blue Shield licensed plans, and enables plans to voluntarily contract with high performing organizations. Blue Distinction also includes a consumer interface so that prospective patients can identify centers with the best outcomes. Most COEs have multidisciplinary care teams prepared to manage all aspects of bariatric surgery. PPOs can promote good outcomes by contracting with COEs and by using strategic contracting to assure that patients seeking bariatric surgery have access to a multidisciplinary array of providers in network.

#### *Medical Policy*

Health plans and medical management organizations are often called upon to develop medical policy that outlines the evidence basis for determining medically necessary services. Medical policy describes when coverage will be available, required precursors to treatment, if any,

and when the service is not considered medically necessary. The AAPPO web site includes links to a number of plans that have posted bariatric surgery policy for public access. Many policies describe the underlying evidence as part of the policy. Data on effectiveness of bariatric surgery and characteristics of high quality programs continue to be published frequently. PPOs may find that it is worth revisiting the evidence for medical necessity with clients as data continues to accumulate about the impact of surgery reducing obesity and reversing expensive co-morbidities.

#### *Benefit Policy*

PPOs medical staff have an important role in guiding benefit decision-makers in employer and other customer organizations to help them arrive at an evidence based surgery policy. A 2008 Mercer survey found that approximately 57% of public and private employers offer some type of bariatric surgery benefit.<sup>24</sup> Bariatric surgery is subject to a number of state benefit mandates; in case where it is not mandated, researchers have found that many insurers exclude bariatric

surgery from benefit coverage or make denials more frequently than for other services.<sup>25</sup> Many experts suggest a rethinking of the rationale for excluding bariatric surgery based on new findings on the health impacts and improvements in both cost and quality. Major public insurers and many private insurers are offering medically necessary coverage in the context of careful management programs.

In addition to considering coverage, benefit decision makers should consider the evidence underlying aspects of benefit eligibility. Many benefit coverage decisions depend on the beneficiary navigating a number of hurdles such as sustained preoperative weight loss. While some requirements, such as a behavioral health screening and participation in nutritional counseling prior to surgery have a clinical rationale, others may adversely impact access to medically necessary surgery. Some strategies used to design effective benefit policy will be the subject of a subsequent AAPPO Issue Brief.

## EMPLOYER, PAYER AND PPO CONSIDERATIONS

PPO clinical staff are positioned to counsel employers and payers and to guide them to resources such as those cited in this Issue Brief. Employers and payers have two sources of interest in obesity and obesity treatment. One, employers are concerned with the health and productivity of their employees (and the employee's dependents, to the extent that dependent care often impacts absenteeism). Second, employers are concerned with the cost and potential cost of health care.

There are costs to providing treatment for obesity, but a growing body of research suggests that there are also costs to not treating obesity. This is due to the higher medical care utilization of obese people for obesity and related co-morbidities. For employers, determining what benefits to offer often comes down to a calculation of what benefit strategy will offer both the best contribution to health of employees and will be most cost effective. For employers, an excellent discussion of the health and productivity implications of bariatric surgery policy can be found in the publication, "Benefit Manager Guide: Bariatric Surgery," by the National Business Group on Health, a membership organization representing large employers.<sup>26</sup>

The DMAA Obesity Toolkit also contains a chapter, "Value-Based Benefit Design For Obesity And Comorbidities: A Practical Manual" that includes valuable information for employers on designing and pricing and evidence based continuum of care benefits for obesity. At minimum employers are encouraged to offer benefit design that promotes identification of obesity through regular BMI assessments and promotes counseling and behavioral interventions to promote patient weight loss.<sup>27</sup>

Some employers are concerned that offering an easily accessible bariatric surgery benefit will result in uncontrolled utilization. Although the rate of bariatric surgery has increased exponentially in the past years, researchers note that the rate of surgery is relatively low in relation to the number of adults clinically eligible. A 2005 study put the rate at 6% of the 11.5 million obese adults.<sup>28</sup> Bariatric weight loss medications were similarly under-utilized, with just 2.4% of potentially eligible adults receiving one or more of these medications, and with the average length of use below recommended levels. This could suggest a pent up demand for

both bariatric surgery and medications, but could also reflect limits to demand, as not all patients are ready to change. Nonetheless, it is clear that benefits need to be carefully constructed to ensure that the correct multidisciplinary service mix is offered to ensure proper patient selection, to meet patient needs, and to ensure access for patients committed to change.

### Future Directions

Unfortunately, the epidemic of obesity does not seem to have crested, and employers and payers can expect to see a growing prevalence of severe obesity in the general population. All employers, health plans and PPOs are encouraged to take actions to prevent obesity, ranging from offering healthier food choices at work sites to promoting more active lifestyles. In addition, PPOs should assess the adequacy of the network for expertise in preventing and managing obesity, and develop capability in this area.

From a network management perspective, PPOs should ensure that appropriate bariatric practitioners are contracted in the network, including certified Bariatric COEs and multidisciplinary bariatric specialists. PPOs will be able to deliver added value to customers by addressing obesity through multiple approaches:

- Providing innovative ideas to customers for improving beneficiary health and managing costs of obesity

- Allowing customizable benefits structures for employer customers that include integrated or well coordinated health promotion and wellness offerings
- Encouraging network providers to adopt best practices for preventing and medically managing obesity, including routine measurement of BMI
- Tracking and reporting to customers on physician performance in identification and medical management of obesity and surgical outcomes
- Negotiating with providers and COEs for comprehensive bariatric surgery services at the most competitive pricing
- Creating value-added opportunities for managing obesity and bariatric services that distinguish PPOs from competing plans, for example, by contracting with multidisciplinary bariatric professionals
- Encouraging patient accountability through education and plan design options, and steering members to programs with documented best outcomes
- Positioning the PPO to show expertise in assessing and implementing new bariatric product offerings that improve health and productivity outcomes.

As health care organizations dedicated to offering a high value network, PPOs can expect and should prepare for a greater demand in bariatric medical, pharmacologic and surgical care. Bariatric surgery offers the promise of improvement in health and productivity of patients. PPOs should stay ahead of this trend to ensure they are out front in promoting cost effective approaches with the best outcomes.

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## **CASE STUDY IN QUALITY OVERSIGHT**

### **Surgical Review Corporation**

Established in 2003, Surgical Review Corporation (SRC) is an independent, non-profit organization governed by industry stakeholders working to advance the safety, efficacy and efficiency of bariatric and metabolic surgery care worldwide. SRC is charged with developing and administering an evidence-based bariatric surgery program focused on health care quality and patient safety; supported by a centralized outcomes database which identifies processes and practices that promote patient safety and lead to excellent outcomes, improves access to quality care, protects and expands health plan coverage of bariatric surgery, and lowers medical malpractice premiums. SRC has developed integrally linked excellence initiatives to achieve this objective: ASMBS Bariatric Surgery Center of Excellence® (BSCOE) program, SRC International Center of Excellence for Bariatric Surgery (ICE) program and the Bariatric Outcomes Longitudinal Database™ (BOLD™).

The BSCOE and ICE designations are awarded to both surgeons and medical centers. Criteria for the designations require consistently excellent bariatric surgical care, and the designations are intended to assure patients of high quality bariatric surgery care.

SRC administers the BSCOE program on behalf of the American Society for Metabolic and Bariatric Surgery (ASMBS). The designation is endorsed by Centers for Medicare & Medicaid Services (CMS) and leading quality organizations and is recognized by most major health plans (see below). The SRC criteria address topics that include:

1. Documentation of organizational commitment to high quality care;
2. The expectation that the institution will perform at least 125 bariatric cases per year, or that a surgeon have performed at least 125 lifetime bariatric surgeries and at least 50 cases in the prior 12 months;
3. Having a designated physician medical director who participates in decision-making;
4. Maintaining a full complement of consultative specialists, including an on-site ACLS-qualified physician, with experience in caring for critically ill bariatric surgical patients;
5. Availability of a full line of equipment and instruments to accommodate the needs of the morbidly obese patient;
6. Having a board certified bariatric surgeon who spends a significant portion of effort in the field of bariatric surgery and who has qualified coverage and support for patient care;
7. Use of clinical pathways and orders to facilitate and standardize care and procedures;
8. Utilization of nurse or physician extenders dedicated to serving bariatric patients and who provide ongoing education to patients;
9. Documented availability of organized and supervised support groups for bariatric patients, which are led by a licensed health care professional;
10. Dedication to long-term patient follow-up and participation and reporting of all bariatric surgical patient data into BOLD.

The primary objective of the ICE program is to ensure the safest, highest quality care is delivered consistently to bariatric surgery patients regardless of where they elect to have their procedure performed. ICE establishes guidelines and criteria for evaluating bariatric surgeons and facilities worldwide, and employs a systematic approach to ensure these standards are upheld. The first centers achieved ICE designation in 2009 and numerous others are currently in the application process.

Established in 2007 to accelerate best practices development for the treatment of morbid obesity and its associated conditions, BOLD is already the world's largest and most comprehensive repository of clinical bariatric surgery patient information. It currently contains data on 160,000+ bariatric surgery patients.

According to SRC, "BOLD collects clinical data for all phases of bariatric surgical care, including demographics, procedures, medications, demographic characteristics, weight loss and maintenance, complications, and comorbidities. Bariatric surgery providers helped establish the data fields needed to best manage patient care and the bariatric surgical program."

BOLD's success is in part due to the fact that all BSCOEs surgeons are required to enter data on each bariatric surgery patient for a minimum of five years. Providers designated as a BSCOEs have access to daily reports that include data on many pertinent issues such as weight loss, intraoperative activity, complications, readmission/re-operation, and comorbidity status. In addition, national aggregate reports enable providers to compare their performance against benchmark data. Researchers working with BOLD Data reported in June that BOLD data shows better outcomes for BSCOEs than for overall reported bariatric surgery outcomes. Data from BOLD reported by SRC showed<sup>1</sup>:

- **Procedure:** The most common bariatric procedure was gastric bypass (54.8%), followed by gastric banding (39.8%), sleeve gastrectomy (2.3%) and biliopancreatic diversion (0.9%).
- **Complications:** Overall, 10.77% of patients experienced one or more complications following surgery. Most complications were considered relatively minor, with nausea/vomiting reported as the most frequent complication post-discharge.
- **Mortality:** The total mortality rate across all procedures was 0.135%, approximately one death per 1,000 patients. Rates for 90- and 30-day all-cause mortality were 0.112% and 0.089%, respectively.
- **Age:** A majority of patients were between ages 19-65 (94.08%), while a minority were younger than 19 (0.14%) or older than 65 (5.67%).
- **Gender:** Females comprised a significant majority of the study population (78.76%).
- **Race:** 78.12% of patients were identified as Caucasian, 10.52% African-American, 6.02% Hispanic, 0.2% Asian and 0.46% Native American.

More than 250 million Americans are covered by plans that endorse or require patients to receive bariatric surgical care at a BSCOEs. Health insurers such as CIGNA, Humana, Blue Cross & Blue Shield and Kaiser Permanente recognize BSCOEs distinction when making coverage decisions. The ASMBS BSCOEs designation is one component of the Blue Distinction program for Bariatric Surgery offered by the Blue Cross and Blue Shield Association.

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<sup>1</sup>[http://www.surgicalreview.org/press\\_releases\\_page.aspx?item=BOLDASMBS\\_2009\\_News\\_Release](http://www.surgicalreview.org/press_releases_page.aspx?item=BOLDASMBS_2009_News_Release)

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## **CASE STUDY IN QUALITY CONTRACTING**

### **Blue Distinction Centers for Bariatric Surgery**

The Blue Distinction program was created to encourage providers to improve quality of health care in order to provide better outcomes for patients, and to help patients identify high quality medical facilities that meet their treatment needs. The Blue Cross and Blue Shield Association created the Blue Distinction program to recognize high quality facilities in a number of important treatment categories, including bariatric surgery, heart disease, cancer treatment, and transplants. Local licensed Blue Cross Blue Shield plans often give a preference to Blue Distinction centers, but it is up to the local plans to develop policies regarding coverage for bariatric surgery at Blue Distinction or other non certified bariatric programs.

Blue Distinction Centers for Bariatric Surgery are medical centers that have demonstrated excellence in delivering quality bariatric surgery care. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. The Blue Cross and Blue Shield Association developed the designation based on criteria developed in collaboration with leading experts in the field—including the American Society for Metabolic and Bariatric Surgery (ASMBS), the Surgical Review Corporation (SRC) and the American College of Surgeons (ACS). Since its inception in 2006, the program has awarded 272 centers Blue Distinction designation.

In order to meet the program's goals of improving quality and meeting patient needs, medical centers must meet demanding process and outcome goals. Selection criteria include:

- an established bariatric surgery program, actively performing these procedures for the most recent 12-month period and performing a required minimum volume of 125 such surgeries annually
- appropriate experience of its bariatric surgery team
- an acute care inpatient facility, including intensive care and emergency services
- full accreditation by The Joint Commission, Healthcare Facilities Accreditation Program (HFAP) or national equivalent
- a comprehensive quality management program

The Blue Distinction program also relies on quality metrics: to be considered for Blue Distinction, medical centers must demonstrate acceptable re-admission, 30-day re-operation and mortality rates. In addition, centers must demonstrate a greater than 50% sustained excess weight loss (EWL) at two years. Blue Distinction centers average 5% complication rates, compared to an 8% complication rate demonstrated by non-Blue Distinction centers.

The Blue Distinction program does not specifically examine bariatric programs for cost implications to the plan or patient. According to the program description, "The goal of this program is to raise the overall quality of healthcare being delivered across this country so the national selection criteria for Blue Distinction focus on quality indicators, not costs." The total cost of a bariatric surgery depends on the prices charged by the hospital and surgeon, and the rate of complications that might necessitate more procedures. For bariatric surgery the price is negotiated with a Center of Excellence by the local Blue plan reimbursing for the surgery. It is the expectation of the Blue Distinction program that by promoting higher quality care and carefully monitoring outcomes, the cost related to complications will be minimized. Lower rates of complications also translate into better quality of life and faster return to work for patients.

<b>Quality Category</b>	<b>Blue Distinction Requirement Address:</b>
<b>Patient Results (or Patient Outcomes)</b>	<ul style="list-style-type: none"> <li>• Complication rates</li> <li>• Readmission rates</li> <li>• Mortality rate</li> </ul>
<b>Treatment Expertise</b>	<ul style="list-style-type: none"> <li>• Physician credentials</li> <li>• Dedicated team focused on providing the particular area of specialty care</li> <li>• Length of time a facility has performed a procedure</li> </ul>
<b>Procedure Volume</b>	<ul style="list-style-type: none"> <li>• Number of times a particular procedure has been completed</li> </ul>
<b>Structure</b>	<ul style="list-style-type: none"> <li>• Type of services provided (ER, diagnostic testing abilities)</li> <li>• Supporting departments (radiology, nutrition, social services, rehabilitation, etc.)</li> <li>• Use of clinical registry data systems</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Use of evidence-based care (e.g., use of beta blockers or aspirin for cardiac patients, which typically results in better outcomes)</li> <li>• Systematic follow-up of patient results after procedures</li> <li>• Quality improvement processes</li> </ul>

WEBSITE: <http://www.bcbs.com/innovations/bluedistinction/blue-distinction-bariatric/>

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### Issue Brief 2

## **BARIATRIC SURGERY – PPO STRATEGIES FOR PROMOTING MULTIDISCIPLINARY CARE MANAGEMENT**

### INTRODUCTION

This is the second in a series of Issue Briefs developed by the American Association of Preferred Provider Organizations to discuss best practices in surgical management of patients with severe obesity. As we described in Issue Brief 1, over the past few decades obesity has emerged as one of the most significant chronic conditions in the US. According to the Centers for Disease Control and Prevention, one third of the adult population and 15% of children are obese (Body Mass Index greater than 30).<sup>1</sup> Obesity is one of many underlying factors in the escalating costs of health care in the US. A July 2009 study in Health Affairs attributed \$147 billion in medical spending costs to obesity.<sup>2</sup>

Obesity is often accompanied by co-morbidities such as diabetes, hypertension and sleep apnea. According to the National Institutes of Health, bariatric surgery is an option for well-informed and motivated patients who have clinically severe obesity (BMI equal to 40) or a BMI equal to 35 and serious co-morbid conditions.<sup>3</sup> Bariatric surgery can trigger dramatic reversals of diabetes and hypertension and is the most effective approach to clinically important weight loss for people with severe obesity. However, obesity is characterized by relapses in behavior and weight regain, and must be treated as a chronic condition. The National Institutes of Health recommends that obesity treated through multidisciplinary approaches – e.g. by involving the medical, surgical, and ancillary support professionals such as dieticians – to maximize good outcomes. For the patient, treatment of obesity, even with surgery, means a lifelong commitment to behavior change through better eating and exercise.

#### About AAPPO

AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. More than 193 million individuals are enrolled in a PPO program, which means 69 percent of Americans with health care coverage receive their health care services through a PPO delivery system. A PPO network of providers may be an embedded part of a traditional insurance program or it may be contracted as an element of a self-insured program that includes a third party administrator of claims and care management programs. PPOs also provide network services to newer types of insurance products such as consumer directed health plans.

#### About the AAPPO Best Practice Initiative

This Issue Brief is part of a series developed by AAPPO examining bariatric surgery policy for PPOs. The Issue Briefs and the AAPPO web site on bariatric surgery ([www.aappo.org](http://www.aappo.org)) were created to provide risk and non-risk PPOs, along with their employer clients, information on best practice considerations for bariatric surgery.

#### PPO Roles In Leveraging Bariatric Surgery Benefits And Quality

PPOs and their employer/purchaser customers recognize obesity as a driver of lost productivity and increased health care costs. For example, the National Business Group on Health reports that obese adults incur annual medical expenses almost 40% higher than non-obese adults. Plus, adults with extreme obesity have 118% more lost time from work and also have twice as many

work limitations.<sup>4</sup> PPOs, as the dominant delivery approach to health care in the US, must take notice of obesity and the rapidly increasing rate of bariatric surgery as an important cost driver to their customers.

Creating the right network for customers and meeting the need of patients is a business imperative for all PPOs. Non-risk PPOs can offer a qualified network and clinical expertise to purchasers and risk-bearing entities. Risk-bearing PPOs offer a network and can also use benefit design innovations and incentives to engage physicians and patients in addressing weight management and obesity. With bariatric cases rising, PPOs should consider the multidisciplinary needs of patients undergoing bariatric surgery and should ensure that appropriate professionals are contracted to the network. This will ensure

customers that high quality services are provided to beneficiaries and will also meet customers' objectives for keeping medically necessary services in network and under a contracted price.

This Issue Brief discusses the roles of diverse professionals in the initial recognition and management of severe obesity, during the surgical period and in the long term post-operative phase. Case studies of organizations implementing multidisciplinary practices are also included. The purpose of this information is to illustrate to PPOs the importance of assuring a qualified network of professionals, either by working with Centers of Excellence (COEs) that have multidisciplinary professionals on staff or through a targeted contracting strategy. Specific PPO interventions are discussed in the last section of this Issue Brief.

## WHY A MULTIDISCIPLINARY STRATEGY FOR BARIATRIC SURGERY?

While severe obesity is a treatable chronic condition, experts recognize that it has many underlying causes of both biologic and psychosocial origin. Treatment of severe obesity, either medically or surgically, requires a multidisciplinary approach to assure that comprehensive behavioral and physical needs are met.<sup>5</sup> To understand why multidisciplinary interventions are recommended, consider the characteristics of severe obesity:

- **Mental health:** The relationship between obesity and mental health is complex. Persons with obesity often present for bariatric surgery with underlying mental health conditions such as depression and anxiety which have both contributed to the development of extreme obesity and are the result of it. The experience of being severely obese (particularly in a culture that over-values thinness) can have detrimental effects on self-esteem, mood, quality of life and body image, and can precipitate eating disorders.
- **Dietary Behavior:** Virtually all persons with extreme obesity have a history of dieting and weight loss, followed by regaining. Success after bariatric surgery requires that patients learn and practice a number of dietary and eating behaviors critical for long term success.

- **Exercise Behavior:** Weight gain is related to lack of exercise but being overweight itself becomes a disincentive to exercise due to discomfort.
- **Co-Morbidities:** Patients with extreme obesity often present with multiple comorbid conditions, including hypertension, diabetes, sleep apnea and endocrine disorders.

There is also a need for professional collaboration and coordination between disciplines treating the patient. A multidisciplinary approach is needed from the assessment phase through long term follow up to ensure that all aspects of obesity are managed constructively and effectively.<sup>6,7</sup>

Appropriate management of patients with severe obesity is complicated by scarcity of appropriately trained professionals. Many community physicians and other professionals do not feel comfortable addressing weight management with patients and some physicians dislike working with obese patients.<sup>8,9</sup> Overweight patients may be reluctant to seek care or follow up if they have experienced bias and/or feel stigmatized by their obesity.<sup>10,11,12</sup>

To incorporate input of each essential discipline and to ensure professionalism of staff, Centers of Excellence and bariatric programs specifically utilize physicians and multidisciplinary professionals who

want to engage in therapeutic relationships with patients who have extreme obesity, and who are qualified to treat physical and psychosocial issues related to obesity. To meet the needs of obese patients considering or undergoing bariatric surgery, PPOs should address access to the professional disciplines discussed in the following sections.

### Primary care

Primary care practitioners (PCPs) play a critical role in supporting good bariatric surgery outcomes both pre and post-operatively. Primary care practitioners are accountable for initial identification of obesity through regular measurement of body mass index (BMI). Obesity is diagnosed for patients with BMI greater than 30, and a BMI greater than 40 is diagnosed as severe obesity.

PCPs have an important role in medical management of obesity, using both behavioral and pharmaceutical treatments. PCPs are often the point of entry for therapeutic discussions of weight loss and medical weight loss management. Since many PCPs do not have great expertise in behavioral management of weight loss, it is important that PCPs are also trained to recognize obesity as a health concern and to refer patients to specialized treatment when appropriate.<sup>13</sup>

For patients with extreme obesity, PCPs are also a point of referral for a patient seeking bariatric surgery. PCPs must recognize the medical necessity of obesity surgery for patients meeting certain criteria (based on BMI or BMI plus diabetes or hypertension). In addition, bariatric experts recommend that PCPs stay up to date on the risks and benefits of bariatric surgery. Risks have fallen as techniques have improved, and Centers of Excellence are more readily available to provide comprehensive specialized services – information physicians should consider in their patient education and referral strategies.

PCP specialty societies recognize the pivotal role these physicians play in obesity management. The American College of Physicians guideline for primary care physicians recommends that surgery should be considered as a treatment options for patients with extreme obesity and for patients who present with obesity-related co-morbid conditions,

such as hypertension, impaired glucose tolerance, diabetes mellitus, hyperlipidemia and obstructive sleep apnea. The guideline goes on to recommend that patients should be referred to high volume centers with surgeons experienced in bariatric surgery.<sup>14</sup>

Patients already proceeding to surgery are often managed by PCPs during the pre-operative period, particularly if a pre-operative weight loss or weight loss attempt is required by the bariatric program or insurance company. For patients preparing for bariatric surgery, the PCP should be: supportive of the program, versed in insurance requirements for program participation including required documentation and capable of managing co-morbid conditions during this period. The Case Study of Centennial Health System shows how one bariatric program has recognized the need to fully engage PCPs to understand pre and post-operative needs of bariatric surgery patients. Centennial staff believes that this PCP engagement is one element of the good outcomes achieved by the program.

Finally, after an initial post-operative period patients often return to the PCP for medical care. PCPs should be qualified to offer supportive follow up care, manage non-obesity related co-morbidities and to refer specific behavioral or therapeutic needs to the bariatric team as necessary.

### Behavioral Health

Medical management protocols for most major health insurers require that members undergo a behavioral health assessment prior to surgery, typically with a psychologist or other mental health professional. The purpose of a behavioral health assessment – and of using behavioral health professionals with expertise in bariatric care – is to identify and treat behavioral health problems that may impact bariatric surgery outcomes. The primary purpose is not, as many patients fear, to prevent patients with psychiatric conditions from proceeding with surgery.

For the most part, behavioral health assessment serves the therapeutic function of identifying treatable conditions that may impact postoperative outcomes such as: depression, anxiety, eating or body image disorders. Mental health professional often play a psycho-educational role, educating

the patient (much like the dietitian) about the behavioral and dietary changes critical to post-operative success. Pre-operative behavioral health assessments should be conducted by mental health professionals with specific expertise with the bariatric surgery candidate population. This will ensure that they recognize the necessary assessments and conditions relevant to bariatric care.

A pre-surgical bariatric behavioral health assessment should be focused specifically on identification of conditions that may impact the outcome of surgery.<sup>15</sup> On occasion mental/behavioral health conditions are identified that do preclude a patient from having bariatric surgery because the condition interferes with the patient's ability to comply with instructions and follow up care. Examples are uncontrolled psychosis or active substance abuse. Conditions such as major depression or binge eating may not resolve spontaneously post-operatively and must be treated prospectively or concurrently.<sup>16</sup> Uncontrolled psychiatric disorders such as severe, major depression are believed to have a negative impact on surgery outcomes and controlling the condition is an important pre-operative strategy.<sup>17</sup>

Mental health follow up is a component of the long term treatment plan for individuals following bariatric surgery.<sup>18</sup> Periodic reevaluation and reinforcement can help prevent weight regain and monitor behavioral and psychological factors that may interfere with optimal outcome.

### Diet and Nutrition

Clearly, weight loss is a primary objective of bariatric surgery, and the care involvement of nutrition professionals such as nutritionists and dietitians is essential. Pre-operatively, nutritionists are involved to assess the patient's prior weight loss strategies and support the patient in preparing for surgery. Post-operatively, nutrition professionals have an important role in re-assessing patient eating behaviors, reinforcing effective strategies and correcting eating problems. Dietitians are often part of the bariatric surgery team, and if not, access to ongoing dietary counseling is an important outcomes improvement strategy.

Bariatric surgery is associated with differing nutritional requirements post-operatively depending on the type of procedure, with different

risks of malnutrition. Restrictive surgeries may have very little risk of vitamin and mineral deficiencies, while bypass procedures may create nutritional deficiencies related to malabsorption of vitamins and minerals.<sup>19</sup> Dietitians with experience in bariatric surgery are best positioned to counsel patients on appropriate intake of solid food as well as potential supplements to assure appropriate intake of nutrients, vitamins and minerals.<sup>20</sup> They are also positioned to identify maladaptive behaviors post-operatively that undermine weight loss, for example, excess consumption of high calorie liquids.

### Exercise

Exercise is a critical element of weight loss and is a long term part of bariatric surgery self management.<sup>21</sup> Patients may enter a bariatric surgery program incorrectly thinking that it is an alternative to exercise and dietary change. Patients with extreme obesity commonly have very low exercise tolerance due to shortness of breath, joint problems, reduced cardiac endurance and reduced fitness levels which are associated with a greater rate of complications.<sup>22</sup> In addition, many severely obese people have joint pain as a result of excess weight and may have difficulty identifying an appropriate exercise regimen.

It is critical that professionals with expertise in exercise programs for obese individuals discuss expectations for the patient during and after the program and ensure that the patient recognizes the need for permanent lifestyle change. Part of an effective multidisciplinary approach is to work with the patient to identify appropriate exercises that fit the patient's lifestyle and that the patient can engage in and sustain over time. This can be done by exercise therapists, physical therapists or others with training to understand the specific issues with exercise and motivation common to individuals in bariatric programs.

Post-surgical patients can be expected to start with moderate exercise of 30 to 45 minutes three to five days per week and increase with tolerance and weight loss. Consistent use of exercise after surgery is associated with greater weight loss and sustained weight loss but exercise compliance tapers off over time.<sup>23</sup> Thus, ongoing management to bolster patient adherence to post-operative exercise is an important part of long-term

management. Some bariatrics programs, such as the Geisinger Nutrition and Weight Management program discussed in the accompanying Case Study to this Issue Brief, include exercise therapists to help patients identify appropriate, sustainable forms of exercise that will not increase risk of injury.

### Surgical team support

PPO considerations around ensuring quality of surgical care were discussed extensively and covered in Case Studies attached to Issue Brief 1 of this series. As noted, availability of qualified bariatric surgeons is critical, and surgeons should adhere to evidence based guidelines for surgery.<sup>24</sup> Physician qualifications to perform bariatric surgery are determined by the American Society of Metabolic and Bariatric Surgeons and the American College of Surgeons. Generally, surgeon training and supervised experience in the

specific procedure are the most important criteria in determining qualifications.<sup>25</sup> As new surgical approaches and devices are released regularly, assuring that practitioners are trained and experienced is an important piece of quality-based contracting. Organizations that certify Centers of Excellence establish and monitor surgical training requirements in qualified COE programs.

In addition to bariatric surgeons, bariatric programs should have relationships with surgeons qualified to do revisions and plastic surgery procedures. Patients who experience significant weight loss often have excess skin folds that negatively impact their self image. Cosmetic procedures such as removing excess abdominal skin (panniculectomy) are frequently done as a follow up to bariatric surgery. While cosmetic procedures are not covered under most benefit plans, bariatric programs should counsel patients about the potential need for such surgeries and be in a position to refer them to qualified providers either in the program or affiliated.

## PPO APPROACHES TO PROMOTING A MULTIDISCIPLINARY STRATEGY

As described earlier in this Issue Brief, the primary role of a PPO is to bring a high value network to customers to maximize in-network use of services. As rates of bariatric surgery are expected to rise, PPOs should work to ensure that the network will serve the customers' benefit needs. This means contracting with providers qualified to minimize the additional cost and lost productivity of surgical complications and having providers who will address the patients physical, behavioral and psychosocial needs in order to promote the most effective weight loss.

PPO clinical experts should work with payers and purchasers to highlight the importance of directing patients to providers offering multidisciplinary care teams which monitor, report and continuously improve outcomes. Depending on the services offered, key PPO roles in assuring high quality bariatric care should include the following:

- Contract with Centers of Excellence or bariatric program that have identified a network of multidisciplinary health professionals or have them on staff;
- Ensure that mental health professionals with

specific bariatric expertise are contracted in the network and are geographically available where there is demand;

- Consult with payers/purchasers to ensure that where bariatric surgery is a covered benefit, a pre-operative assessment and multidisciplinary post-operative follow up are covered benefits as well;
- Review benefit coverage language for payers and purchasers to assist them in ensuring behavioral health coverage is aligned with requirements of the bariatric surgery benefit;
- Educate primary care providers on routine assessment of Body Mass Index (an NCQA HEDIS indicator) and on behavioral weight management interventions;
- Support coordinated handoffs and referral arrangements to ensure appropriate follow ups between PCPs and bariatric surgery program;
- Offer tools for patients and providers that will facilitate education and coordination, including web based education, personal health records for patients and electronic health records for physicians and facilities.

Case studies associated with this Issue Brief examine the Centennial Medical Center for innovations in primary care practitioner education and outreach as part of its COE approach, and the Geisinger Center for Nutrition and Weight Management, which involves a multidisciplinary care team in long term support of patients before and after weight loss surgery. Many organizations use similar approaches and techniques. We encourage PPOs to look for best practice features as they develop bariatric surgery contracting strategy.

### Future Directions

As shown in AAPPO Bariatric Surgery Issue Brief 1, there has been a rapid evolution in the safety and efficiency of bariatric surgery in the past decade. With the rate of obesity and severe obesity

increasing, the health care industry can expect to see increasing demand for bariatric surgery. As this Issue Brief has described, bariatric patients have multifaceted needs that range from behavioral to clinical. To stay ahead of this trend, PPOs must position themselves to negotiate comprehensive multidisciplinary services for patients and secure these services in network at a reasonable price. PPOs with expertise in contracting cost effectively for the most effective multidisciplinary package of services will differentiate themselves from competing organizations. Both risk and non-risk PPOs should position themselves with purchasers that are knowledgeable about trends in bariatric surgery and have the most effective strategies for care.

On behalf of AAPPO we hope this Issue Brief provides information, resources and case studies to assist PPOs in gaining that expertise.

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## **CASE STUDY: CENTENNIAL CENTER**

### **Centennial Center for the Treatment of Obesity**

Centennial Medical Center, an ASMBS/SRC Center of Excellence located in Nashville, Tennessee, offers a multidisciplinary model of treatment for patients suffering with the disease of morbid obesity. Centennial Center for the Treatment of Obesity recognizes obesity and morbid obesity as chronic, life-long, multi-factorial disease processes that must be treated on a continuum based on the individual patient's needs.

Each year, Centennial treats over 400 patients ranging in age from teenagers to senior citizens. According to Centennial, the facility is known for its all-inclusive aftercare program, which is free for the rest of a patient's life. Patients have multiple follow up visits with the surgeon during the first year. To enhance follow up opportunities Centennial offers group follow up visits for life at no cost to the patient. Additionally, Centennial expects its patients to regularly consult with the dietitians and exercise physiologists through the entire post-operative process, which extends indefinitely. This counseling is available by phone or in person at patients' convenience.

Centennial recognizes the need for multidisciplinary involvement of health care professionals. Prior to surgery, patients initially undergo a psychological evaluation, including a structured interview by a psychologist and several pencil and paper tests. Once in the program, patients have access to a wide variety of healthcare professionals, including psychologists, dietitians, and exercise physiologists, both before and after surgery, for support, coaching and counseling.

Centennial strongly emphasizes patient engagement in ongoing support groups and has developed a variety of platforms – web based and in-person to meet patient needs. Centennial offers approximately 11 psychologist led support groups and 25 patient led support groups per month. Pre-operatively, patients are asked to attend at least one meeting, and post-operatively patients are expected to attend a support group meeting monthly. Periodically Centennial contacts long term post-operative patients who do not routinely seek follow up to assess progress and health status.

Centennial has also created an outreach program to local Primary Care Providers (PCPs). Pam Davis, Program Director, routinely visits local PCPs to disseminate information about bariatric surgery. PCPs are an important component of the successful bariatric program because they interface with patients both pre- and post-operatively. Centennial believes it is important to educate PCPs on bariatric surgery as an effective treatment for individuals with severe obesity and co-morbid conditions, but also recognizes that PCPs have a significant role in managing patients' lifelong care after surgery. PCPs need to be trained to recognize issues related to bariatric surgery (such as reinforcement of nutrition and exercise programs) as well as to potentially help to manage micronutrient deficiencies.

Primary care providers may include internists, family practice physicians, nurse practitioners, and gynecologists. Centennial works to create partnership with PCPs and treating specialists as a key strategy to improving the long-term success of obesity treatment. Elements of Centennial's successful partnership with PCPs and treating specialists include:

- Educational support via CME offerings, mailed updates, provision of resource articles
- Consultative support regarding nutritional deficiencies
- Onsite visits to primary care provider and specialist offices
- Physician to physician visits to provide current information regarding the safety and efficacy of bariatric surgery
- Provision of patient education via support materials or seminars
- Facilitation of patient referral and approval process for bariatric surgery when indicated

Centennial offers ongoing education and support for specialists in the fields of cardiology, orthopedics, endocrinology, fertility and pulmonology. This education may include materials relating to obesity in general or those correlating a direct relationship between obesity and the specific specialty.

In the case of physicians who are uncomfortable referring patients for bariatric surgery, Davis brings with her information regarding the safety and efficacy of bariatric surgery; often one of Centennial's surgeons accompanies her as well. For PCPs who already feel comfortable referring patients for bariatric surgery, Davis brings articles on long-term outcomes, follow up care, and other topics in bariatric surgery. Through these personal campaigns, Centennial Center for the Treatment of Obesity educates PCPs all across the large metropolitan area of Nashville, Tennessee.

WEBSITE: <http://www.cmcwls.com/default>

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## **CASE STUDY: GEISINGER**

### **Geisinger Center for Nutrition and Weight Management**

The Geisinger Center for Nutrition and Weight Management located in Danville, Pennsylvania at the heart of Geisinger Health System, offers a team-based approach to the care of overweight and obese patients. The Geisinger Health System is a physician-led integrated health care system that serves 2.6 million patients. The Center for Nutrition and Weight Management is a Bariatric Surgery Center of Excellence that also offers non-surgical weight loss support and a variety of different bariatric procedures. It specializes in offering patients a comprehensive program of multidisciplinary care with a focus on patient support and long term engagement.

Geisinger offers team-based, comprehensive network of care that addresses medical, psychological and psychosocial needs of enrolled patients. It also provides a team coordinator and counseling on insurance access. Multidisciplinary staff members of the Geisinger program include:

- Obesity Medicine Specialist– Doctors specializing in nutrition and weight loss
- Registered Dietitians – Diet and nutrition specialists in Bariatrics and Weight Management
- Clinical Nurse Specialists – Coordinate patient medical treatment plans and education
- Nutrition Research Coordinators – Manage research data
- Exercise coordinators – Develop specialized exercise plans
- Physician Assistants – Manage patient care
- Behavioral Health Specialists – Conduct behavioral health evaluations
- Bariatric Surgeons – Perform weight loss surgeries
- Insurance coordinators
- Bariatric Surgical Nurse Coordinators – Coordinate surgical treatment plan, care and education

Throughout the bariatric surgery assessment and intervention process, Geisinger has criteria to ensure that patient needs are identified and care is managed by professionals qualified to support specific goals. For example, with the support of Geisinger’s multidisciplinary team, bariatric surgery patients are required to:

- Stop smoking
- Read a preparatory book and complete behavior modification modules
- Attend 3 educational classes
- Attend 2 patient support groups
- Determine metabolism
- Undergo a behavioral medicine evaluation
- Undergo a medical evaluation
- Undergo a surgical evaluation
- Undergo a nutritional evaluation
- Patients are also encouraged to achieve a modest preoperative weight loss

For patients entering the program, Geisinger offers an integrated approach that develops a partnership among the patient, patient’s family, doctors, nurses, and nutrition and exercise specialists. The process begins with an individual, comprehensive assessment and development of an intervention plan. The team works with patients to develop individualized meal plans for their specific lifestyle, set wellness/fitness goals, identify behavior modification techniques, and support them with weight loss medications or surgery. Behavioral health issues are a particular area of emphasis. All patients are seen at least once by a Geisinger psychologist pre-operatively and as needed post-operatively. Psychologists also play an integral role in Geisinger pre- and post-operative support groups.

Geisinger treatment is based on the premise that obesity is a long term disease – one that requires lifelong treatment. In keeping with this philosophy, Geisinger emphasizes to patients that bariatric surgery is a long

term commitment that requires the patient to be an active participant. Support groups hosted monthly are intended for patients at all stages of the bariatric surgery process, including both the early pre-operative and late post-operative patients. Support group meetings are led by a rotating multidisciplinary staff including registered dietitians, registered nurses, physician assistants, psychologists, exercise experts, internists, and surgeons. Geisinger Center reports an appreciable post-operative turn out at support groups and other non-mandatory functions.

Geisinger also offers “Back on Track classes” run by psychologists, registered dietitians and exercise experts to help redirect patients who have had bariatric surgery but are plateauing or slipping in weight loss goals or have started to gain back weight. The program motivates patients through extra accountability and education, including involvement in educational seminars and support groups.

Finally, the Geisinger Center for Nutrition and Weight Management works to educate primary care practitioners (PCPs) at the 42 primary care sites under the Geisinger umbrella. The goal is to ensure PCPs are able to identify severe obesity patients and are aware of the resources available to help this patient population. Professionals from across the spectrum of disciplines at the Geisinger Center rotate going out to various PCP sites for “meet and greets” and to offer lectures to staff at these locations. The Geisinger Center also offers an annual CME conference to educate PCPs about “state of the art” of weight management and bariatric surgery issues as well.

**Web:** <http://www.geisingerbariatrics.com/index.php>

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### Issue Brief 3

## **BARIATRIC SURGERY – PPO STRATEGIES FOR ENGAGING PATIENTS TO PROMOTE AND SUSTAIN WEIGHT LOSS**

### INTRODUCTION

This Issue Brief is the third in a series addressing issues around bariatric surgery specifically from the perspective of risk bearing and non-risk preferred provider organizations (PPOs). In each Issue Brief we discuss evidence and best practices on an aspect of bariatric surgery, and highlight key issues for PPOs. This information will support PPO executives in engaging with health plan, employer and third party administrator customers about bariatric benefit design and in adopting best practices in contracting for services.

In Issue Brief 1 we discussed the rising rates of obesity and the growing evidence on medical necessity of bariatric surgery for individuals with severe obesity. Evidence based guidelines now recommend bariatric surgery for individuals with a Body Mass Index (BMI) greater than 40 or a BMI greater than 35 and one or more serious comorbid conditions such as diabetes, hypertension or sleep apnea. Bariatric surgery has been shown to reverse diabetes and hypertension in many patients, and it is the most effective treatment that results in major weight loss. In Issue Brief 2, we discussed the importance of contracting with an appropriate panel of bariatric professionals. An effective multidisciplinary approach to surgery involves surgeons, mental health professionals, nutrition and exercise professionals in a comprehensive and ongoing treatment plan. With each Issue Brief, AAPPO includes case studies profiling best practice organizations.

In this Issue Brief, we discuss the need to engage patients long-term to manage weight and examine best practices for engaging patients in self management. While bariatric surgical procedures create a physiologic environment conducive to

major weight loss, patient self management has an essential role in achieving success. Experience of bariatric surgery programs, backed up by results of research studies, show that successful weight loss requires a long term commitment by the patient to lifestyle change that includes better eating and increased exercise. This type of engagement can be brought about through a variety of outreach and follow up strategies targeted to the patient's needs and delivered through face to face, web-based, telephonic and other modalities.

#### About the AAPPO Best Practice Initiative

This Issue Brief is part of a series developed by the American Association of Preferred Provider Organizations (AAPPO) examining bariatric surgery policy for PPOs. The Issue Briefs and the AAPPO web site on bariatric surgery ([www.aappo.org](http://www.aappo.org)) were created to provide risk and non-risk PPOs, along with their employer clients, information on best practice considerations for bariatric surgery.

#### About AAPPO

AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. More than 193 million individuals are enrolled in a PPO program, which means 69 percent of Americans with health care coverage receive their health care services through a PPO delivery system. A PPO network of providers may be an embedded part of a traditional insurance program or it may be contracted as an element of a self-insured program that includes a third party administrator of claims and care management programs. PPOs also provide network services to newer types of insurance products such as consumer directed health plans.

## PPO Roles In Leveraging Bariatric Surgery Benefits And Quality

PPOs, as the dominant delivery approach to health care in the U.S., must take notice of obesity and the rapidly increasing rate of bariatric surgery as an important cost driver to their customers. Obesity is a driver of lost productivity and increased health care costs. For example, the National Business Group on Health reports that obese adults incur annual medical expenses almost 40% higher than non-obese adults. Plus, adults with extreme obesity have 118% more lost time from work, and also have twice as many work limitations.<sup>1</sup>

To thrive in this competitive environment, PPOs need to understand how to create value products for their customers that address the pressing problem of obesity and related medical costs. With the increase in bariatric surgery, PPOs must

position themselves to guide customers towards the networks and benefit offerings most likely to drive better outcomes. Better outcomes in turn drive lower costs by avoiding complications and by achieving remissions in obesity's co-morbid conditions such as diabetes and hypertension. Creating the right network for customers and meeting the need of patients is a business imperative for all PPOs. Non-risk PPOs can offer a qualified network and clinical expertise to purchasers and risk-bearing entities. Risk-bearing PPOs offer a network and can also use benefit design innovations and incentives to engage physicians and patients in addressing weight management and obesity.

PPOs should consider what strategies are most effective at engaging surgical patients long term and should ensure that contracted bariatric programs are using all of the outreach and engagement strategies necessary to achieve the best outcomes.

## WHY PATIENT ENGAGEMENT?

Patients, providers and payers want bariatric surgery to succeed. Success is measured in excess weight loss (EWL) e.g. the expected loss based on starting BMI. When bariatric surgery is successful:

- Patients have better quality of life and longer life expectancy;
- Co-morbidities such as diabetes, hypertension and sleep apnea may resolve or improve;
- Employers benefit when patients are more productive;
- Employers/payers see a return on investment for the cost of surgery.

In order to realize these effects, patients must be successful at weight loss. Patient engagement, as measured by adherence to scheduled visits and compliance with recommended diet and exercise rules, is the most important predictor of success for patients following weight loss surgery.<sup>2,3</sup> Exercise in particular correlates to initial weight loss and long term weight management.<sup>4</sup> If eating habits go unchanged then patients are two times more likely not to lose at least half of their excess weight; and patients who do not increase physical activity are 2.3 times more likely not to lose at least half of their excess weight.<sup>5</sup>

As discussed in Issue Brief 1, bariatric surgery has been shown to have a positive return on investment.<sup>6</sup> Although medical necessity and treatment effectiveness are the primary concerns in coverage of any medical treatment, payers often also want to know the value of their health care investments and ways to maximize value. Ensuring patient engagement is one important piece of assuring the investment on bariatric surgery will generate the expected health and cost returns. PPOs should promote programs that achieve the best results with patient engagement as an essential value-added strategy to maximize both return on investment and patient health outcomes.

## The Need for Long Term Behavior Change

The majority of bariatric surgery patients achieve massive and clinically important weight loss. However, many patients fall short of their own expectations and do not lose all excess weight, and a very small percent lose no weight or actually gain weight. Up to 30% of bariatric patients with good initial loss regain at least some weight.<sup>7</sup> Obesity is a chronic condition and even with surgery, weight management is an ongoing, long term treatment goal.

Many non-obese individuals are personally familiar with the challenge of losing weight and regaining it over time. Long term behavior change is challenging in any context. Patients who go through bariatric surgery are the same – initial high motivation and compliance wanes over time and relapses can occur. Even after initial weight loss, patients are subject to relapses in old behaviors of poor dietary compliance and lack of exercise. Treatment includes both behavioral reinforcement, and in some cases, addition of weight loss medications. Patients also need long term relationships with bariatric professionals to support them in sustaining both behavioral and medical weight control approaches.

### What Do We Know About Behavior Change and Weight Loss?

To better understand how to support bariatric patients, it is helpful to understand behavioral characteristics common to patients with severe obesity. Patients who seek bariatric surgery by definition have severe obesity and virtually all of them have tried a variety of weight loss strategies. In fact, one study showed that bariatric patients averaged approximately five times each of having lost over ten pounds through dieting, but all had regained the weight.<sup>8</sup> Thus virtually all bariatric surgery patients begin the process having already unsuccessfully attempted long term behavior change. Surgery will help these patients, but they also need intensive help making necessary changes in spite of past behavior change failures.

It is helpful to know the reasons patients give for lack of weight loss. A recent study of bariatric surgery candidates found gender differences in behavioral explanations, with most falling in these categories<sup>9</sup>:

- Nonspecific explanations related to diet (25.3%)
- Physical activity (21.0%)
- Motivation (19.7%)
- Diet-related motivation (12.7%)
- Medical conditions or medications affecting physical activity (12.7%)
- Time, financial cost, social support, physical environment and knowledge (less than 4%)

These reasons show why successful bariatric programs focus heavily on diet and exercise in addition to surgical preparation, and why a long term relationship that can continually reinforce flagging motivation can help to drive the best weight loss outcomes. Best practice organizations have a variety of strategies to reach patients, understand which ones are high risk and tailor programs and treatments to their individual needs.

### Predicting High Needs Patients

Decades of experience with bariatric surgery have also revealed that some patient characteristics predict a greater likelihood of success or lack thereof. Some factors cannot be changed: people of higher socioeconomic status, women, lower BMI before surgery and Caucasians are statistically more likely to have a greater EWL. People who do not have these characteristics typically (but not always), do less well at achieving weight loss.

Some factors associated with lesser weight loss can be changed through medical treatment, proactive outreach or higher intensity care. Factors most amenable to change associated with failure to achieve EWL include: missed appointments, non-compliance with diet and exercise, depression and binge eating disorders.<sup>10,11,12</sup> Most of these factors reflect patient engagement in treatment. This information can help bariatric programs design approaches that address specific needs of higher risk patients, and perhaps target them for additional preoperative education and support to improve expected outcomes.<sup>13</sup>

For clinical reasons it is not an option to withhold treatment to high risk individuals in need of bariatric surgery. Rather, bariatric programs should demonstrate to PPOs that they will use patient risk factors to intensify engagement strategies to assure good outcomes.

## PATIENT ENGAGEMENT STRATEGIES

Bariatric professionals from all disciplines recognize the need for a long term relationship with patients. In most Centers of Excellence (COE) and best practice programs, patients are encouraged to stay engaged with a bariatric program indefinitely to support their initial and ongoing weight loss. Once surgery has been completed the bariatric programs have an ongoing therapeutic relationship with the patients to address complications and regaining of weight. Patients may need periodic behavioral reinforcement or nutritional or medical therapy. Behavioral health professionals may be needed to treat depression or eating disorders. As noted in Issue Brief 2, a multidisciplinary team is better prepared to address eating disorders, psychosocial adjustment issues and potentially, the need for pharmacologic therapy.

### Engagement Tools

A number of tools are available to support patients in meeting weight loss goals. Some of the approaches can be offered by a bariatric surgery program or COE, others are available through health plans and still others are available in communities either in person or via the internet. For example:

- Face to face meetings and support: bariatric support groups are consistently associated with improved weight loss for patient who attend.<sup>14,15</sup> Most bariatric programs offer support group meetings, and many, like the HealthPartners example offered in the Case Study, require participation both pre- and post-operatively as a condition of surgery. Many programs report fall off in support group participation over time. To keep patients engaged, some COEs and bariatric programs periodically and personally contact members to invite them to participate.
- Phone based coaching programs: phone based coaching programs are used extensively in wellness programs supporting a variety of healthy behaviors such as weight loss, exercise and smoking cessation. There is not yet a strong evidence base showing which specific elements of coaching or modalities

are most effective, so often programs use many approaches simultaneously to communicate with and engage patients.<sup>16</sup> Coaching is widely used in wellness and disease management programs. The Healthyroads program Case Study shows one “wrap around” program that coaches patients to meet the required pre-operative weight loss threshold and supports patients in maintaining healthier diet after surgery.

- Self monitoring: Self monitoring by patients – through food journaling, exercise logs and regular self-weighing is beneficial to sustaining motivation and making course corrections in a timely manner.<sup>17</sup> Effective programs should encourage continuous self monitoring during the immediate post operative period and at least intermittent self monitoring in the long term. A bariatric program should build in a review of self monitoring results and provide behavioral reinforcement to patients who are not engaged in self monitoring.
- Reminders: Mail, phone, email and text message reminders are used to communicate with patients about food and exercise maintenance and encourage follow up visit compliance. Patients are generally positive about this kind of interaction, particularly if patient preferences for the type of communication – email, phone, mail, etc. are considered. Prompts may not result in behavior change when used as stand alone interventions,<sup>18,19</sup> but they are a component of an effective long term engagement strategy.

### Specific approaches

- Internet Support groups: There is some evidence that interactive web based and other electronic approaches can engage patients and support weight loss efforts<sup>20,21</sup> and social support networks are common on the internet. Many patients are regular internet users and participate in social networks. Many bariatric programs have established support groups or refer patients to internet groups as an adjunct tool for

ongoing engagement. The effectiveness of the internet varies across different groups<sup>22</sup> and may drop off over time, suggesting that this should be one component of a multi-faceted support program.

- Food journaling (diary or internet based): Many programs suggest that patients keep an ongoing record of their food intake. The record has a dual function of helping to make patients aware of their intake and allowing dietary professionals to identify areas where the patient could fine tune intake to improve weight loss. A study conducted by the Kaiser Health Plan found that keeping a food diary doubled weight loss in a medical weight loss program.<sup>23</sup> Journals can be maintained on the internet, via a personal device such as an iPhone or in a paper record.<sup>24</sup> Since self-monitoring decreases over time, patients should be encouraged to experiment with tools and approaches that are convenient and engaging.<sup>25</sup>

As might be expected, higher “touch” and higher intensity programs are generally more costly than web based programs. Though lower cost, lower intensity programs such as internet only often achieve less sustained results.<sup>26,27</sup> Effective bariatric programs offer a variety of on site and remote follow up options, have the ability to effectively target diverse populations with diverse learning needs and proactively reach out to patients who do not continue to participate.

## Incentives

As a general strategy for improved patient engagement, a number of employers and health plans are experimenting with use of incentives to activate patients. Incentives can be in the form of a cash or gift reward for certain behaviors or can be a discount or rebate applied to medical costs. Incentives have been used most widely in the health care sector to encourage health plan members to take a health risk assessment<sup>28</sup> and sometimes, to encourage ongoing use of medications or chronic disease management. This strategy has also been adopted to incentivize medical weight loss and may be a future possibility as an adjunct to promoting surgical weight loss.

The theory behind incentives in general is to offer something that people want in order to make

palatable a less desirable activity. Some experts in bariatric care have suggested that incentives be designed around documented behaviors rather than on the actual weight loss itself. Some desirable behaviors may include:

- Preoperative selection of bariatric centers of excellence for the surgical procedure
- Maintaining a journal with consistent documentation of exercise and food intake
- Sustained bariatric program involvement as evidenced by regular participation in support groups

Some of the financial and non-financial compliance rewards suggested for bariatric patients include:

- Reduced patient self pay requirements if the patient selects a bariatric COE and completes the program;
- For continuous program involvement rewards might include:
  - » Reduced co-payments or free nutritional supplements and vitamins
  - » Discounts or free memberships to gyms or exercise programs
  - » Opportunity to earn credits towards cash payments made towards surgery
  - » Reduced price for cosmetic procedures to remove excess skin resulting from weight loss
  - » Reduced price for follow up gastric band fills
  - » Waiving copays for bariatric related follow up visits or medications

For example, the State of Maine has rolled out an incentive in its benefit design approach, offering 100% coverage to beneficiaries if they opt for medically required bariatric surgery at one of the State’s two centers of excellence. This, and other benefit design approaches will be discussed further in the fourth AAPPO Issue Brief.

Overall the evidence on the impact of financial and gift incentives on long term engagement is mixed. However, many plans and payers continue to experiment and as such PPOs may have a role in designing or implementing incentives related to bariatric surgery. As more evidence accrues on the health and economic benefits of weight loss – both for payers and patients – it is likely that more employer/purchasers will adopt incentive strategies.

## PPO APPROACHES TO INCREASING PATIENT ENGAGEMENT

PPOs have the option of contracting with a “full service” bariatric surgery provider or working with clients to coordinate multiple vendors who can support patient engagement best practices for bariatric surgery. Contracting options available to PPOs include:

- Disease management – many disease management vendors offer obesity management services among their chronic disease management offerings.
- Wellness programs – these programs can be used to both identify high risk patients through health risk assessments, and to support behavior changes on an ongoing basis. Many wellness programs offer coaching and behavior change support using the engagement tools identified above.
- Bariatric Centers of Excellence – COEs have the dedicated expertise and experience meeting the long term needs of bariatric patients.

PPOs should work with payer and employer customers to ensure that the network and benefit offerings will serve the customers’ benefit needs and deliver the most value for benefit dollars spent on bariatric surgery. This means contracting with providers qualified to deliver high quality clinical care and to engage patients long term in the exercise and dietary management behaviors needed to lose weight and keep it off.

PPO clinical experts should work with payers and purchasers to ensure that they understand the need to keep patients motivated and reinforce behaviors for the payer to gain the best return on investment. They can highlight the importance of directing patients to providers offering long term follow up or offering supplemental wellness programs to patients. Depending on the services offered, key PPO roles in assuring high quality bariatric care can include:

- Contract with Centers of Excellence or bariatric program that makes a specific contractual commitment to long term follow up with the patients;

- Review patient engagement strategies with bariatric providers to ensure that they offer reminders, prompts and other outreach tools, and that they deliver the follow up messages on diet and exercise using a variety of communications approaches, including internet, phone based, face to face support group meetings and other ways that meet the needs of the bariatric surgery populations;
- Review population specific engagement strategies with providers: providers should be capable of providing personalized or higher intensity education and self management assistance to higher risk patients, including males, those with higher BMI and persons with low socioeconomic status;
- Consult with payers/purchasers to ensure that where bariatric surgery is a covered benefit, benefits cover long term follow up from the COE or another wellness provider;
- Review benefit coverage language for payers and purchasers to ensure follow up nutrition and exercise counseling benefits are aligned with best practices in long term bariatric surgery management;
- Consider working with payers/purchasers on pilot tests for incentive programs that reward patients for ongoing participation in a follow up bariatric program and for effective behaviors that results in weight loss;
- Facilitate patient education and coordination, including offering web based education, personal health records for patients, interactive electronic food journals or other innovative tools.

Case studies associated with issue brief feature examine the Healthyroads Bariatric Surgery program, and the HealthPartners integrated program, “HealthPartners’ A Call to Change... Healthy Lifestyles, Healthy Weight – Weight Loss Surgery Edition.” HealthPartners requires a commitment to patient participation in the

weight loss process and offers intensive support to support that participation. The HealthPartners course is provided to plan members in addition to services provided by contracted COEs to ensure that all covered patients have access to the same information and support. Healthyroads is offered by a wellness organization that contracts directly with large self insured employers to support pre- and post-surgery protocols through coaching and internet based engagement tools. Many organizations and plans offer similar wrap around or support services to engage patients. We encourage PPOs to look for best practice features as they develop bariatric surgery contracting strategy.

### Future Directions

PPOs should prepare to support their clients in addressing the rising rate of obesity and bariatric

surgery. With bariatric surgery the most effective tool for massive weight loss, more patients and payers will turn to this approach to reduce weight and serious co-morbidities that accompany obesity. PPOs must help their clients maximize the impact of surgery by ensuring bariatric programs are capable of engaging patients in preliminary weight loss and are committed to supporting patients in the long term. PPOs must position themselves as expert consultants to payers. Further, they should require contacted surgery providers to demonstrate – through data – capability to fully engage and sustain engagement with bariatric surgery patients.

On behalf of AAPPO we hope this Issue Brief provides information, resources and case studies to assist PPOs in gaining that expertise.

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## CASE STUDY: HEALTH PARTNERS

HealthPartners (HP)– founded in 1957 – is a Minnesota-based, consumer-governed, nonprofit healthcare organization. HP and its related organizations provide insurance and healthcare services to its members. The group’s mission is “to improve the health of our members, our patients and the community.”

HealthPartners’ bariatric surgery program encompasses both clinical preparation and complementary telephonic support, with an increased focus on the lifestyle components that lead to a successful surgery outcome. The overall program emphasizes patient engagement through pre-operative requirements and through a post-operative support system that encourages ongoing patient support and self management.

HealthPartners incorporated telephone-based support into the overall bariatric preparation model in June, 2007 as a way to ensure that all members – regardless of where they have surgery – have the same level of baseline education. The phone course does not replace any clinic visits or requirements; rather, the intent is to supplement usual care and reinforce that information. To date, over 2600 members have participated in the program.

Program participation begins with a referral into the program by the member’s surgical team. Surgical teams are limited to HealthPartners Designated Bariatric Provider network. Providers must meet comprehensive selection criteria to be included in the network. HealthPartners maintains a high level of communication with the surgical groups, and as such, receives high satisfaction from surgeons regarding this added service.

The goals of the phone program include:

- Improve outcomes and promote patient safety for members having weight loss surgery.
- Empower members and patients for long-term success in weight loss treatment.
- Enhance member satisfaction.

Once referred for surgery, patients participate in a course titled A Call to Change... Healthy Lifestyles, Healthy Weight® Weight Loss Surgery Edition. The course is facilitated by a team of coaches, including registered dietitians and health educators with diverse backgrounds (e.g. exercise specialists, psychology/counseling), and includes five coaching calls prior to surgery. The phone program continues with at least four sessions after surgery. Topics covered in these sessions include eating before and after surgery, emotional eating, physical activity and exercise, risks and benefits of surgery, stress management, problem solving, and relapse prevention.

Patients enrolled in the course also receive a course workbook, a pedometer, a weekly weight chart, a food and activity journal, an exercise plan, and an action plan specifically designed for each patient.

Motivation for engaging in the phone program varies and is difficult to assess. Many clients want as much information and support as they can get prior to surgery and some begin the course simply because it is a component of the pre-operative checklist. However, by completion of the course, the majority of participants are impressed with the program and thankful it was available to them. Coaches meet people where they are to develop concrete strategies for successful outcomes post-operatively. The last course efficacy audit found that, on average, pre-operative course completers lost seven pounds (or about 2.5 percent of total body weight) during the course, increased body image satisfaction by 74 percent and nearly 90 percent were taking recommended daily multivitamin supplements.

Website: <http://www.healthpartners.com/portal/1.html>

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## **CASE STUDY: HEALTHYROADS (AMERICAN SPECIALTY HEALTH)**

Healthyroads, a subsidiary of American Specialty Health (ASH), contracts with health plans, disease management companies, and employer groups to provide wellness, health coaching, and prevention services. Healthyroads is often used by plans and employers to engage patients through therapeutic use of interpersonal relationships and use of incentives. Wellness programs are designed to help people manage stress, lose weight, eat healthier, quit smoking, and lead more physically active lives. For general wellness customers Healthyroads offers online tools and telephone coaching, including a personal health assessment and a customized exercise planning program. To support its roughly four million general wellness members, Healthyroads has 150 full-time health coaches on staff.

Healthyroads offers a specific wraparound program for pre and post operative coaching for patients undergoing bariatric surgery. Healthyroads coaches work individually with bariatric surgery members to develop personalized approaches to weight loss pre- and post-operatively and track progress. The organization partners with insurers and plans to support patients in the bariatric surgery pre-certification process.

In the bariatric care program, Healthyroads contracts with an insurance group and serves as a segment of the bariatric surgery process. A bariatric surgery patient works with a coach at Healthyroads for eight weeks, including time both pre- and post-operation. During this period of coaching, the patient reviews information about nutrition, exercise, and stress management specifically related to the surgery. Coaches collaboratively set weekly goals to help prepare the patient for surgery. Goals can range from practicing chewing food thoroughly to incorporating five fruits and vegetables into a daily diet. Healthyroads coaches are also in contact with the office of the patient's surgeon, to enhance communication and further support bariatric surgery patients.

Healthyroads utilizes patient incentives to keep patients actively involved in their wellness programs. For engaging in encouraged behavior—in the case of bariatric surgery, successful dieting, exercise, and smoking cessation, among other things—patients may receive American Express-branded rewards or premium discounts. Healthyroads tracks program data on program engagement and wellness results.

Website: <http://www.ashcompanies.com/aboutus/HealthyroadsWellness.aspx>

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### Issue Brief 4

## BARIATRIC SURGERY – EVIDENCE BASED BENEFIT DESIGN

### INTRODUCTION - ABOUT AAPPO AND THE BEST PRACTICE INITIATIVE

This is the fourth and final bariatric surgery Issue Brief in a series by the American Association of PPOs. Bariatric surgery rates have been increasing rapidly over the past decade, along with the rate of obesity. While the rate of complications and the cost of bariatric surgery have fallen, the rise in volume necessitates that health care executives take notice. The leadership of preferred provider organizations (PPOs) needs to understand the trends and the factors that influence use of surgery and the best outcomes. AAPPO's series examines important elements that impact outcomes, and specifically looks at the PPO's role in assuring successful weight loss. This in turn reduces extreme obesity's common co-morbidities. The four AAPPO Issue Brief topics are:

- A Bariatric Surgery Framework For PPOs
- Multidisciplinary Care for Bariatric Surgery
- Engaging Patients to Improve Bariatric Surgery Outcomes
- Benefit Design Strategies

Each AAPPO Issue Brief examines research and practical elements and identifies important considerations for PPOs and their clients. The series is based on the premise that PPOs may either be at-risk for services, and thus have an interest in identifying the highest value approaches to bariatric surgery, or as non-risk PPOs they provide a qualified network to deliver the clinical services. Non-risk

network PPOs have an important role in advising clients on high value contracting approaches and in delivering a cost effective and efficient network of providers.

This Issue Brief discusses benefit design for bariatric surgery.<sup>1</sup> While not all PPOs deliver health care benefits, PPO clinical leadership may be called upon by customers to discuss benefit design or to weigh in on medical policy supporting various approaches. Proper design and implementation of bariatric surgery benefit policy is a priority for employers and plans (referred to here as purchasers) offering benefits. This Issue Brief examines evidence for various policy design strategies where available, and notes where additional evidence is needed to guide benefit policy.

#### About AAPPO

AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. More than 193 million individuals are enrolled in a PPO program, which means 69 percent of Americans with health care coverage receive their health care services through a PPO delivery system. A PPO network of providers may be an embedded part of a traditional insurance program or it may be contracted as an element of a self-insured program that includes a third party administrator of claims and care management programs. PPOs also provide network services to newer types of insurance products such as consumer directed health plans.

### WHO PAYS FOR BARIATRIC SURGERY AND UNDER WHAT CONDITIONS?

#### Benefit Coverage and Payers

The evidence to date, described in earlier AAPPO Issue Briefs, shows that bariatric surgery is the most

effective approach to massive weight loss needed for patients with severe obesity.<sup>2</sup> Surgery results in remission of diabetes in the majority of cases.<sup>3</sup> Surgical treatment for obesity is cost effective due to its impact on co-morbid conditions such as hypertension and diabetes.<sup>4</sup> In the working age

population, bariatric surgery has been shown to promote improvements in productivity.

As noted in earlier Issue Briefs, the rate of bariatric surgery has increased dramatically over the past decade, from less than 40,000 in 2000 to over 220,000 in 2008. This is in spite of variable benefit policy and coverage and lack of uniform criteria for both medical necessity and pre-operative requirements.<sup>5</sup> Bariatric surgery is the subject of both benefit exclusions and benefit mandates in different states and different populations. The 2002 inpatient data (the most recent available) shows that private insurance coverage paid for 83% of surgeries, Medicare 6%, Medicaid 5%, other government sources 3% and self pay 3%.<sup>6</sup> This payer breakdown may have changed as government programs have added bariatric surgery as a covered benefit or changed criteria, and price reductions may have increased self pay clients.

Anecdotal reports suggest that bariatric surgery is a covered benefit in the majority of plans offered by large employers. The extent of coverage in mid and small size firms is not known. Also not known is the type of co-pay, co-insurance or deductible requirements that are imposed when bariatric surgery is covered in commercial populations. The National Business Group on Health (NBGH), an organization representing Fortune 500 large employers, indicated that coverage is typically 80% after co-pays and deductibles.<sup>7</sup> Researchers have reported other arrangements requiring up front payments by the patient. Unlike many other non-cosmetic procedures, bariatric surgery also has a high proportion of self pay clientele.

In terms of public programs, a 2004 analysis found that medically necessary weight loss surgery is covered by Medicaid in 44 states, excluded in five and not mentioned in two states (including the District of Columbia).<sup>8</sup> When medical necessity criteria are met, bariatric surgery is a covered benefit for the Medicare population. Medicare covers bariatric surgery as a treatment for severe obesity for patients with body mass index (BMI) greater than or equal to 35 and a co-morbid condition, when the medical necessity and an effort at medical weight loss has been documented in the patient record. Medicare also covers bariatric surgery as treatment for diabetes in patients with a BMI greater than or equal to 35.<sup>9</sup> The Centers for Medicare and Medicaid Services (CMS) specifies that Medicare coverage is dependent on the surgery being carried out in approved facilities.

## Benefit Design

The design of health benefits is the subject of some controversy, largely because there are no uniform clinical indicators that predict which patients will achieve medically necessary weight loss following surgery.<sup>10</sup> Health plans and employers have devised a variety of requirements around administration of the bariatric surgery benefit, many designed to assess patient motivation for surgery or control access to the benefit. Because coverage of bariatric surgery is uneven across employers and plans, many purchasers have adopted benefit design strategies aimed at controlling adverse selection that could drive up their costs disproportionately.

Proponents of bariatric surgery argue that the medical necessity of bariatric surgery for patients meeting guidelines is incontrovertible. For this reason, they argue, the surgery should be available without exclusions, benefit limitations or access barriers. Countering this is the prevailing concern by employers and plans that bariatric surgery has the potential for over-utilization, particularly for people who either do not fully meet BMI criteria, people who are unlikely to achieve or sustain clinically meaningful weight loss or for whom medical weight loss may be sufficient. There is also a concern that the early very successful weight loss results achieved in clinical trials from bariatric surgery might not be achieved if the surgery is offered to a broader population that includes less adherent, less motivated patients.

Rather than debate medical necessity over individual cases, some employers and insurers simply exclude bariatric surgery. For plans that do include bariatric surgery as a covered benefit, many require rigorous preoperative screening, medical necessity documentation and often, pre-surgery weight loss attempts.<sup>11</sup> Proponents of this strategy note that these requirements assess patient motivation, and thus ensure the benefit will be delivered to the patients with the greatest likelihood of success.

In a collaboration with Towers Perrin, NBGH examined the issue of bariatric surgery and recommended several benefit design strategies designed to maximize the beneficial outcomes of the benefit for those employers who offer it. NBGH noted that if an employer offers health benefit coverage for bariatric surgery, it should:

- Ensure that only eligible patients are approved for surgery: physicians have determined medical necessity and that the patient will benefit from the procedure;
- Require that eligible patients receive a comprehensive multidisciplinary evaluation, including a medical, nutrition, psychological and weight history assessment;
- Require that only experienced, high volume surgeons who demonstrate a minimal number of post operative hospitalizations

and mortality rate are approved to conduct the procedure, preferably at Bariatric Centers of Excellence.<sup>12</sup>

NBGH also recommends that employers examine plan design features related to bariatric surgery in the areas of provider qualifications, facility certification, member support, prior authorization and cost sharing. Several of these categories of benefits are discussed below and others have been addressed in prior AAPPO Issue Briefs.

## EVIDENCE BASED BENEFIT DESIGN

### Provider Qualifications and Facility Certification

The issues of provider qualification and facility certification were discussed and cited in AAPPO Issue Brief 1. Good surgical outcomes are associated with physician training on a specific procedure and higher volume of surgeries. Similarly, outcomes are better at facilities with specialized experience treating people with severe obesity and performing bariatric surgeries. Larger health plans have adopted policies to designate certain in-network facilities as Centers of Excellence (COE). COEs can be designated either by the plan (see the AAPPO Case Study on Blue Distinction) or by independent evaluators (see the AAPPO Case Study on the Surgical Review Corporation COE Designation).

With this Issue Brief, a case study of the State of Maine benefit design demonstrates how one large employer has used benefit design to leverage higher value bariatric surgery outcomes. State employees who meet medical necessity criteria can access bariatric surgery at designated COEs in Maine with no co-pay or deductible. Employees who select a non-COE facility are responsible for the deductible.<sup>13</sup>

### Member Support and Weight Loss Counseling

Patient engagement is an essential predictor and factor in successful weight loss following bariatric surgery. There is a strong evidence base showing that diet, exercise and follow up visit compliance are strongly associated with greater weight loss.

Timing of the benefit may also be important to its effectiveness: some studies suggest that support programs after surgery may be most meaningful to participants.<sup>14</sup> Issue Brief 3 describes the evidence and best practices associated with patient engagement and offers case studies. The case studies of Healthyroads and HealthPartners illustrate wrap-around programs that complement COE services with coaching, education and patient support.

Issues to consider in benefit design are timing, duration and mandates related to member support and counseling engagement. COE and practice guidelines recommend diet and exercise counseling as a critical component of bariatric surgery therapy.<sup>15</sup> Others have observed that mandated counseling of a prescribed length and participation rate can result in a barrier to care. For example, a 2006 study found a 50% attrition rate for patients required to participate in a preoperative dietary counseling regimen versus those who were not required to do so; at one year following surgery the non-counseling group actually had greater excess weight loss (EWL) and lower BMI than the required group. The authors concluded that there was no beneficial clinical impact resulting from screening out less motivated patients.<sup>16</sup> More flexible benefit offerings for psychosocial support may have the added value of identifying modifiable behavior that can influence weight loss after surgery.<sup>17</sup>

There is little dispute that the actual behaviors of engagement - exercise and diet compliance are essential to weight loss. The issue of contention with "support" programs is whether they in fact support the patient, or whether they impose barriers that result in program attrition detrimental to patient health. Benefits for patient

support and counseling should be constructed to rigorously promote appropriate patient selection and engagement. The burden of proof for various support interventions embedded in benefit design should be whether they increase exercise and/or diet compliance and whether they are associated with greater weight loss.

### Prior Weight Loss

Commonly found medical necessity criteria for bariatric surgery is BMI greater than or equal to 40 or BMI greater than or equal to 35 plus one or more co-morbid conditions. By definition, a patient meeting these criteria has not succeeded at long term weight loss. Many have made multiple prior weight loss attempts, but have not successfully maintained the loss.<sup>18</sup> Benefit policies tend to have requirements around three types of weight loss:

- **Weight Loss Attempts:** Most plans require documentation of prior weight loss attempts. This information may be of value in identifying eating disorders, as untreated eating disorders may impact surgery outcomes. Research shows that the vast majority of individuals seeking bariatric surgery have attempted weight loss and that prior attempts are not related to successful EWL resulting from bariatric surgery.<sup>19</sup>
- **Medically supervised weight loss for a specified period:** many plans require a medical attempt prior to surgery, often for a specific period of time. Evidence suggests this requirement does not contribute to improved surgical outcomes – for people with severe obesity, medical weight loss rarely results in needed massive sustained weight loss or resolution of co-morbidities. And as noted, most individuals regain the weight. Studies have shown that the number of weight loss attempts or maximum weight loss prior to surgery does not predict weight loss after surgery.<sup>20</sup>
- **Immediate pre-surgical weight loss to reduce surgical risks:** Unlike mandated medical weight loss of a specified period, most bariatric surgeons and many health plans require patients to undergo rapid weight loss immediately prior to surgery. This results in short term benefits of reduced liver size and slightly reduced surgical risk.<sup>21,22</sup>

This type of weight loss, an adjunct, not a substitute for bariatric surgery, is supported by evidence.

In short, peri-operative weight loss can reduce operative time and complications; evidence suggests that presurgical weight loss of 5-10% of body weight is beneficial at reducing complications.<sup>23</sup> However, there is little evidence showing that benefit requirements that the patient attempt weight loss for a specific duration of time will result in better outcomes.<sup>24</sup> Benefit policy requirements for a long term medical weight loss program may have the impact of deferring surgery, but such requirements appear unlikely to deter the need for surgery through resolution of a weight problem.

### Type of Surgery

As discussed in Issue Brief 1, there are multiple types of restrictive or malabsorption procedures. The procedures can be carried out through open or laparoscopic approaches. The field has generally evolved towards laparoscopic delivery due to lower rates of complications and faster recovery and overall cost effectiveness.<sup>25</sup> Surgeries that impact absorption of nutrients (such as Roux-en-Y) result in greater weight loss but are more complex to perform. Gastric banding has a low rate of complication but can result in lower weight loss and the need for additional follow up. Employers and insurers have an interest in the type of surgery performed as a means to ensure value for benefit dollars spent.

As with many other elements of bariatric surgery, there is controversy about the types of surgery that should be covered and the impact of coverage limitations. Few purchasers mandate a specific type of surgery, but many exclude surgeries considered to be investigational. To the extent insurers have any role directing patients to a specific type of surgery, it is indirectly, by directing patients to COEs. COEs are then accountable for ensuring that physicians are appropriately trained and qualified to recommend and perform appropriate bariatric surgeries. Evidence based guidelines are available to assist purchasers in understanding considerations in the surgical and follow up period.<sup>26</sup>

## Cost Sharing

No information was located on the types of cost sharing typically included in health plan benefits. Anecdotally it appears that the range of cost sharing alternatives vary widely. They include plans that cover 100% to plans that require patients to pay either a specified dollar amount or a specified percentage. Many plans do not cover all of the required assessments for preoperative evaluation, causing patients to bear significant out of pocket costs.

There is little evidence on the impact of cost sharing either on uptake or avoidance of surgery. It can be assumed, based on other purchasing behavior, that cost to the patient does influence demand for surgery. Of course other factors influence demand as well. Current uptake of bariatric surgery is quite low compared to the number of people who qualify based on BMI. Researchers

have attempted to quantify the demand for bariatric surgery to determine if once offered as a benefit, uptake would drive massive demand. Thus far uptake of bariatric surgery has been less than .9% of eligible individuals. Researchers in one study estimated that 9% of the full time US workforce or approximately one third of the obese workforce would qualify for bariatric surgery based on BMI. Based on a simulation of demand under various economic scenarios those researchers predicted that with an out of pocket cost of \$5000 or less the demand for surgery would increase to approximately 2% of the eligible population.<sup>27</sup>

Purchasers (employers and plans) do need to be aware that the potential use of the benefit is variable and may be hard to predict. Demand depends in part on benefit coverage, characteristics of the covered population, availability of bariatric surgery services, industry, wages, word of mouth and other factors. Benefit cost calculations should develop predictions for the purchasers based on a variety of benefit uptake scenarios.

## BENEFIT DESIGN ISSUES FOR HEALTH PLANS AND EMPLOYERS

Even when purchasers (employers or plans) recognize the medical necessity of bariatric surgery, many are concerned that offering access to an expensive benefit can result in adverse selection of the plan or employer.<sup>28</sup> That is, patients who need the benefit will migrate to the plan or employer offering the most advantageous benefits. In fact this may be true: some consumer web sites advise patients considering bariatric surgery to assess benefits available through their or their spouses' coverage and consider changing to the plan with the best surgery benefits.<sup>29</sup> There are anecdotal reports of people seeking employment specifically with employers offering generous bariatric surgery coverage for the purpose of accessing that benefit.

When it occurs, "adverse selection" causes a disproportionate expenditure on the service by a self insured employer or health plan, and can put that entity at a competitive disadvantage. Even when there is a return on investment for bariatric surgery, e.g. the patient's medical expenses are less after the surgery, the purchaser experiences a high initial outlay and may or may not retain the beneficiary for the 3 years it takes to recoup the cost. Concerns about adverse selection may be an

underlying reason that many plans or employers do not offer more generous or easily accessible bariatric benefits.

A number of purchasers have developed benefit design approaches to modulate use of bariatric surgery. Some of the approaches are consistent with best practice evidence while others are less so. Employers must use caution in developing benefit limitations to ensure that there are no violations of the Americans with Disabilities Act. Strategies include:

- **Medical Necessity and Appropriateness Assessment:** Virtually all benefit policies require a beneficiary to document medical necessity and undergo clinical and psychological screening. There are variations in how plans cover this preoperative work up, the timeframe required and requirements for which clinicians supervise the activities.
- **Step Therapy:** some plans require the patient to participate in step therapy over a period of time. This can require the patient to complete a medically supervised weight loss program, patient education and nutritional counseling sessions and behavior

modification. There are variations in the duration required for these activities, whether gaps in participation are allowed, and how much progress must be demonstrated.

- **Employment Period:** Some employers offering a bariatric benefit require an employment waiting period that specifies how long the individual must be covered/employed prior to accessing the benefit.
- **Pre-Operative Education:** Many plans and purchasers require a patient to complete a pre-operative educational program, often one that presents risks and benefits of both medical and surgical treatments of severe obesity. Organizations profiled in AAPPO case studies offer such programs.
- **Cost sharing:** Purchasers may offer bariatric surgery as a benefit rider subject to separate co-pays or deductibles – generally higher. This is generally viewed as a rate limiting approach to offering a bariatric surgery benefit. Conversely some organizations have concluded that bariatric surgery is a good investment in employee health and productivity. The State of Maine provides an example of an organization that reduces copayments for patients meeting criteria and using a Center of Excellence.
- **Cost caps:** Some plans place a total benefit limitation on the cost of bariatric surgery. This can have the intended impact of steering patients toward providers and facilities that offer more efficient procedures and having lower rates of complications. Anecdotally it is reported that COEs offer better pricing than lower volume unaffiliated practices. Cost caps can have an adverse impact on the patient if she/he experiences complications.

## Payment Strategies

The cost of bariatric surgery has fallen over the past decade as more practitioners are trained in the procedures and techniques have improved. Costly complications have also been reduced. PPO contracts are negotiated to ensure the best available pricing for specific surgical procedures. Experts in bariatric surgery also recommend examining innovative payment strategies that incorporate appropriate follow up care. Alternatives to discounted fee for service payment strategies might include:

- **Bundled payment:** PPOs contract with providers for comprehensive pre and post-operative care.
- **Discounted Aftercare:** Although cosmetic surgery is not generally a covered benefit, PPOs might negotiate discounted services for cosmetic procedures following massive weight loss. This could be used as a patient incentive to ensure ongoing patient engagement with a weight loss program.
- **Prometheus:** PPOs may want to consider new episode related payments under development for bariatric surgery. The Prometheus payment system has developed Episode Case Rates that use local data and make adjustments for potentially avoidable complications (PACs).<sup>30</sup>

As benefit packages are crafted, it is also important for payers to consider how they will address coverage of complications due to bariatric surgery in a covered beneficiary, when the surgery was not a covered benefit. Payers may also encounter late complications from surgeries performed when the patient was covered by another source of insurance.

## CONCLUSION: CONSIDERATIONS FOR PPOS

As research evidence accumulates on the effectiveness of bariatric surgery in promoting massive weight loss and its ability to reverse diabetes, there are fewer unresolved questions about medical necessity of the procedures. Questions now focus on developing appropriate medical policy and clinical processes to maximize good outcomes.<sup>31</sup> Purchasers also look to medical policy to help mitigate adverse selection, although as benefit coverage becomes increasingly common, the problem of adverse selection could be reduced.

In this environment, PPOs are asked to supply efficient and effective provider networks to deliver the bariatric surgery benefit. PPO leadership may also be asked to create or weigh in on benefit policy related to bariatric surgery. PPOs should work with their customers to assess factors that may drive use of bariatric surgery and the potential for return on investment by the employer. These factors may include overall health of the employee population, geographic environment, competition from other employers, average employee tenure, wages or

other considerations. In addition to helping clients develop benefits prospectively, PPOs are also positioned to help employers and plans rigorously evaluate the health outcomes and costs of surgery. This service is essential to helping payers assess the impact of a bariatric surgery benefit.

Clinical leadership of PPOs should be prepared to work with clients to ensure that benefits are affordable and consistent with evidence. Such benefits:

- Assure that surgical candidates are clinically ready and motivated for surgery
- Promote a multidisciplinary assessment and treatment approach
- Include evidence based medical policy for pre-surgical evaluation
- Direct patients to high quality and appropriate surgical interventions
- Ensure access to surgery for patients who meet medical necessity criteria and have a bariatric surgery benefit

- Are delivered by contracted high quality providers at competitive rates
- Reward providers and facilities for delivering both on high quality and efficient care
- Meet patient needs for follow up care for short or long term complications
- Support client needs for cost management
- Are evaluated periodically to ensure they meet patient health needs and client objectives

PPOs, their employer and plan customers, and patients all share a common desire to promote successful outcomes for medical interventions. The rise of obesity in the American population has thrust the issue of bariatric surgery to the forefront and raised important issues of how to best design and deliver an obesity surgery benefit. PPO leadership should contribute to benefit design and reimbursement discussions by advocating for evidence based practices and by assuring a high quality network to deliver that benefit.

For examples of benefit design and supporting medical policy, please review the associated Case Study on the State of Maine or visit the Bariatric Surgery Best Practices section on the AAPPO web site for links to several health plan medical policies. [http://www.aappo.org/AAPPO\\_BEST\\_PRACTICES/ABP\\_08.cfm](http://www.aappo.org/AAPPO_BEST_PRACTICES/ABP_08.cfm)

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## **CASE STUDY – STATE OF MAINE STATE EMPLOYEE HEALTH COMMISSION BARIATRIC BENEFIT CHANGE**

In May 2009 the State of Maine State Employee Health Commission announced health plan changes that would take place in July, 2009. In making the change, the State noted that after five years of relatively good claims experience and low rate increases, the State employee health plan experienced a significant jump in plan expenses. Medical claims in 2008 increased by over 10% compared to the prior year for the point-of-service plan (covering active employees and non-Medicare retirees). Payments for medical services increased by over \$16 million in 2008. The State noted that most of this increase is due to a greater use of medical services and a small group of high-cost claims. There were eight cases that exceeded \$350,000 and these eight cases alone accounted for \$4.6 million. Plan changes were implemented for members in the Point of Service PPO plan.

The State Employee Health Commission was forced to examine ways to reduce plan costs and to ensure that the plan costs did not exceed the amount budgeted. In addition to changes impacting use of emergency services (the State increased the emergency room co-payment to \$75 but increased the number of walk in centers that would provide treatment for a \$15 co-payment), the State modified its bariatric surgery benefit program to direct plan members to more efficient programs with better outcomes. For the Bariatric Surgery benefit, all deductible and copayments will be waived if members receive this procedure from “Centers of Excellence.” Through Anthem, the state insurance carrier, the State designated two major medical centers in the state as designated centers of excellence eligible for the benefit incentives.

In information provided to members, the State noted that bariatric surgery is considered to be a high risk procedure for many patients. For that reason it is important for members to have access to providers who have demonstrated quality care and outcomes. Bariatric surgery includes approved gastric bypass and laparoscopic band treatment of clinically severe obesity. Maine’s two Centers of Excellence are Blue Distinction Centers for Bariatric Care. The Blue Distinction specialty center network was developed to help consumers identify those facilities that have met or exceeded the rigorous evaluation of clinical data on the facility’s structures, processes and outcomes of care.

The State noted that Centers of Excellence tiering for bariatric surgery complements “Hospital Quality Tiering” with a benefit design tailored to bariatric hospital and surgeon services. Bariatric surgery (hospital and surgeon charges) performed at the two selected COEs are covered at the “Preferred” level of benefits. Bariatric surgery performed at all other hospitals are covered at the “Referred” level of benefits. The bariatric surgery tiering applies only to that surgery, and hospitals can continue to be Preferred for other procedures even if they are not preferred for bariatric surgery. Benefits will continue to be available for bariatric surgery at any hospital in Maine that performs the service; however the preferred level of benefits will only be available when the bariatric surgery is performed at the Blue Distinction Centers for Bariatric Care.

To educate members about benefit changes, the State encouraged its plan vendor, Anthem to post information and develop “Frequently Asked Questions.” In addition, a series of informational meetings were held at locations across the state in June and early July to go over these plan changes.

This case study was adapted from the State of Maine Web site,  
<http://www.maine.gov/beh/HealthBenefits/documents/MoreHealthPlanChanges709.doc>

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