MEDICAID CHILD OBESITY PREVENTION PILOT

Report to the Texas Legislature

As Required by
S.B. 870, 81st Legislature, Regular Session, 2009

Health and Human Services Commission
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Table of Contents

Executive Summary

The *"F as in Fat: 2011"*[1] report ranks Texas as 7th among states in the percent of obese children 10-17 years of age (20.4 percent). Treatment methods for obesity have shown inconsistent results. In response, national experts now recommend prevention of overweight or obesity through promotion of healthy behaviors during routine well-child visits as a potential solution for our country's high rates of overweight and obesity.

The Texas Legislature has addressed the obesity issue since 2001, including improving food choices in schools and requiring physical education classes. S.B. 870, 81st Legislature, Regular Session, 2009, codified in Section 531.0993 of the Texas Government Code, directed the Health and Human Services Commission (HHSC), in coordination with the Department of State Health Services (DSHS), to establish a two-year obesity prevention pilot program. The Medicaid Child Obesity Prevention Pilot was implemented on November 1, 2010, and will conclude October 31, 2012.

The goals of the pilot are to decrease the rate of obesity, improve nutritional choices, increase physical activity levels, and achieve long-term reductions in Medicaid costs incurred as a result of obesity. Effective November 2010, HHSC contracted with one of its Medicaid managed care organizations, Amerigroup, to provide obesity prevention services to overweight Medicaid children in the Travis County service delivery area. In August 2011, HHSC amended its contract with Amerigroup to include the Dallas Service Area and allow the inclusion of children who are at high risk of developing obesity.

HHSC must submit a report to the Legislature on November 1 of each year of the pilot, and a final report three months after the completion of the pilot. This report provides information on the pilot structure, goals, strategies, and status. The final report will include analysis of the data gathered from the pilot and a recommendation on whether to continue or expand the program.

Introduction

HHSC submits this report on the pilot program designed to:

1. Decrease the rate of obesity in Children's Health Insurance Program (CHIP) enrollees and Medicaid recipients.
2. Improve nutritional choices and increase physical activity levels.
3. Achieve long-term reductions in child health plan and Medicaid program costs incurred by the state as a result of obesity.

[1] Robert Wood Johnson Foundation. "F as in Fat: 2011" Healthyamericans.org. .July 2011. 28 July 2011 http://healthyamericans.org/assets/files/TFAH2011FasInFat10.pdf.

Background

Rates of childhood obesity have been increasing for several decades in Texas and the United States and low-income and minority populations have higher prevalence rates of obesity. The statistics for Texas are as follows:

32.4%	Texas children 10-17 who are overweight or obese (2008).[2]
16.2%	Texas children age 2-4 years who are obese (2008).[3]
29.2%	Texas high school students who are overweight or obese (2009).[4]
20.4%	Obese 10-17 year olds in Texas (2007).[5]
43.5%	Obese 10-17 year olds with incomes <100% FPL (2008).[6]

A 2006 report by Thompson Medstat examined claims data from Medicaid and compared this data to private insurance, and found that children on Medicaid are almost six times more likely to be treated for a diagnosis of obesity than children covered by private insurance. The annual health-care costs for an obese child with Medicaid was about $6,700 compared to $3,700 for an obese child covered by private insurance.[7]

Childhood overweight/obesity can have lifelong implications in terms of physical health, health-care costs, work productivity, self-image, and longevity. It is generally recognized that the cause of overweight/obesity is multi-faceted. Children today tend to eat more high-calorie fast food, exercise less, and spend excessive time in sedentary activities.

Prevention must address all of these areas in a culturally appropriate way and avoid harm to the child's self-image. Texas has initiated multiple activities to address obesity. Some of these activities include the following:

- DSHS has a comprehensive nutrition, physical activity, and obesity prevention program that promote community policies and environmental changes to help make healthy eating and active living easier for Texans. In addition, DSHS has developed a multi-year strategic plan to address obesity in the state.

- The Women, Infants, and Children (WIC) program, administered by DSHS, promotes breastfeeding and has implemented a protocol for counseling overweight and obese children.

- The Texas Legislature created the Interagency Obesity Council during the 80th Legislative Session that includes the Commissioners of DSHS, the Texas Education Agency, and the Department of Agriculture.

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[2] Childhood Obesity Action Network. "Obesity Report Card", October 29, 2008.
[3] "Obesity Prevalence Among Low-Income Preschool Age Children United States 1998-2008". Morbidity and Mortality Monthly Report (MMWR)Vol. 58/No. 29. July 24, 2009. page 771.
[4] MMWR. *"Youth risk Behavior Surveillance-United States 2009"*. Vol. 59, No. SS-5. June 4, 2010.
[5] Robert Wood Johnson Foundation. "F as in Fat: 2011".July 2011. page 22
[6].Childhood Obesity Action Network. "Obesity Report Card", October 29, 2008.
[7] Thompson Medstat. "Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions". 2006. http://www.medstat.com/pdfs/childhood_obesity.pdf

- The Texas Pediatric Society has a complete obesity toolkit available on its website: http://www.txpeds.org/texas-pediatric-society-obesity-toolkit

- The Texas Department of Family and Protective Services (DFPS) has established minimum standards for well-balanced meals for children in daycare.

- The Texas Health Steps program requires Body Mass Index (BMI) measurement, nutritional counseling, and anticipatory guidance for every well-child visit for children on Medicaid.

- Texas schools are offering healthier food choices and increasing physical activity for students.

Terms and Definitions

Body Mass Index (BMI): A measure of weight in relation to height that is used to determine weight status. For children and teens, the BMI is both age and gender specific.

Obese: A BMI at or above the 95th percentile for children of the same age and sex (greater or equal to 95 percent).

Overweight: A BMI at or above the 85th percentile and lower than the 95th percentile (85-94 percent).[8]

Overweight/Obesity Treatment Guidelines

The American Academy of Pediatrics (AAP) has issued the following policies related to childhood obesity, prevention, and treatment, as well as practice guidelines for providers:

- Prevention - Recommends that all pediatric providers assess BMI, nutrition and exercise habits, and counsel on healthy lifestyle on an annual basis.

- Treatment

    1. *Stage 1-Prevention Plus:* If a child is classified as overweight or obese, the provider should provide specific guidelines on healthy eating, activity levels, decreasing television time, decreasing sugary drinks, and eating breakfast and more meals at home with the family.
    2. *Stage 2-Structured Weight Management:* This stage may include monthly visits to the provider office, structured diet, additional reduction of television time, planned physical activity, behavior change, and patient support.
    3. *Stage 3-Comprehensive Multidisciplinary Intervention:* This stage increases the intensity of interventions. Care is planned by a multi-disciplinary health-care team. The patient may be seen weekly, parents participate in behavior modification and receive

[8] Centers for Disease Control and Prevention. "Use of BMI to Screen for Overweight and Obesity in Children". http://www.cdc.gov/obesity/childhood/defining.html.

training in how to modify the home environment, and weekly eating and activity goals are set and monitored.

4. *Stage 4-Tertiary Care Intervention:* This stage should be implemented only after a patient has been unsuccessful at the previous levels of intervention and is mature enough to understand the possible risks involved. Intervention may include medications, severe calorie restriction, or surgery.[9]

Research has not produced consistent results on the long-term effectiveness of treatment options for overweight and obese children. Recently, the focus has shifted to universal assessment of obesity risk in all children.[10] AAP recommends routine assessments of eating and activity patterns in children and recognition of excessive weight gain relative to linear growth throughout childhood. AAP also suggests that anticipatory guidance, before obesity becomes severe, may be more successful.[11]

All children should have regular well-child examinations with their primary care provider. The well-child exam is an important opportunity for providers to promote healthy lifestyles. Children on Medicaid are eligible for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefits, which include regular well-child checkups. The EPSDT benefit in Texas is called Texas Health Steps. Height, weight, BMI measurements (for children 2+ years of age), health assessments, and anticipatory guidance are required elements of all Texas Health Steps examinations.

The AAP lists specific recommendations that primary care providers can undertake to help children and families develop healthy habits:

1. Identify and track those children with risk factors for overweight/obesity.
2. Calculate and plot BMI annually for children over two years of age.
3. Utilize the BMI to identify excessive weight gain relative to linear growth.
4. Encourage parents and caregivers to adopt healthy eating patterns.
5. Encourage breastfeeding.
6. Promote physical activity.
7. Limit television and video time to a maximum of two hours per day.
8. Recognize and monitor obesity-related health changes.[12]

As of the date of this report, services for overweight and obesity are not reimbursable under the Texas Medicaid program. Claims for medical services for the diagnosis of overweight or obesity are not paid by Medicaid. However, medically indicated treatment of co-morbid conditions may be covered under Medicaid. Treatment for diseases such as Type II diabetes, high cholesterol, high blood pressure, and other co-morbid diagnoses may be reimbursable under Medicaid.

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[9] Barlow, SE and the Expert Committee. "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report". Pediatrics 2007: 120; S164-S192.

[10] Ibid p. S169

[11] Committee on Nutrition, the American Academy of Pediatrics. "Prevention of Pediatric Overweight and Obesity". Pediatrics Vol. 112 No. 2 August 2003.

[12] Ibid. p. 427.

Medicaid Child Obesity Prevention Pilot Development

Collaborative work between HHSC and DSHS began in the fall of 2009 with a series of workgroup meetings that led to the development of the current pilot. Development of the project was completed in August 2010.

Pilot development meetings addressed multiple aspects of the project including:

- Project framework.
- Participant eligibility & enrollment for the pilot.
- Parent/child screening & readiness assessment.
- Benefits & services.
- Care coordination.
- Information/Educational materials for participants.
- Provider recruitment & training.
- Data collection & reporting.
- Evaluation.
- Budget & funding.

Pilot Services Provider

Both Medicaid managed care health plans in the Travis service delivery area, Amerigroup, and Superior, submitted proposals for implementing the pilot project. Amerigroup was selected to deliver pilot services due to the following qualifications:

1. Implemented a similar program in Georgia and Tennessee.
2. Already developed and utilized client education materials.
3. Experience with a model program that addresses all program requirements.
4. Submitted a budget proposal that was consistent with the funds that HHSC has available for the project.

Amerigroup's program is called Power Zone®, and combines motivational coaching and goal setting, physical activity and cooking classes, utilization of community resource programs, care coordination by a registered nurse, customized care plans, educational materials, participant incentives, and strategies to overcome barriers to a healthy lifestyle. Amerigroup's experience in Georgia and Tennessee demonstrated that participants achieved 80 percent of established goals.

HHSC amended its contract with Amerigroup on August 16, 2011, allowing Amerigroup to subcontract with Baylor's Diabetes Health and Wellness Institute (DHWI) and include the Dallas Service Area. DHWI's program is called Total Creation™, and seeks to deliver healthy clinical outcomes through sport and play, with emphasis on combating obesity, sedentary lifestyles, and chronic diseases such as type II Diabetes. DHWI will provide services in accordance with pilot requirements.

Project Timeline

The timeline for the project, as well as the service areas covered, are listed below:

- Start Date: November 1, 2010
- End Date: October 31, 2012
- Service Areas: Travis, Williamson, and Dallas counties

Project Strategies

Amerigroup and DHWI utilize the following strategies for the project:

- Targeted outreach to the Medicaid population and area providers.
- Identification and referral of participants.
- Completion of a participant pre-screening process.
- Monthly visits with a primary care provider for six months.
- Follow-up visit with the provider at 12 months.
- Additional visits with a dietician as needed.
- Referral to community programs as appropriate.
- Educational materials.
- Utilization of best practices for obesity prevention.
- Utilization of motivational interviewing techniques to facilitate behavior change.

Participant Eligibility

Pilot enrollment is limited to children on Medicaid who meet the following criteria:

- Ages 6-11 years at the time of enrollment.
- Pre-pubertal at the time of enrollment.
- Overweight based on body mass index (BMI) or at high risk of developing obesity (effective August 2011) with no weight related co-morbid health conditions.

Parent/Child Screening & Readiness Assessment

Amerigroup and DHWI screen each child for eligibility criteria, determine if the child and/or parent wants and are ready to participate in the pilot project, obtain consent to participate, collect demographic information, and identify any barriers to participation for the family.

Benefits and Services

Children who participate in the pilot receive:

- An initial assessment and a 3rd month reassessment by a primary care provider.
- Monthly visits with the primary care provider or qualified staff for six months for physical assessments and measurements, with laboratory tests as needed.
- Visits with a dietician as needed.
- Access to enhanced community services such as cooking classes and exercise programs.
- A 12-month follow-up visit with the primary care provider.
- Incentives for children (and families) that volunteer to participate in the pilot to encourage and reward completion of the program.

Care Coordination

Amerigroup uses full-time dedicated case managers to maintain communication with participants to help identify and resolve issues or obstacles to the child's ongoing participation and compliance with the treatment protocol for the pilot.

Information/Educational Materials

Amerigroup and DHWI develop and distribute program information and educational materials to pilot participants.

Provider Recruitment and Training

Amerigroup identifies, recruits, and trains providers to participate in the pilot. Amerigroup has identified high-volume pediatric Medicaid providers to target for outreach. Provider training includes information on childhood obesity, motivational interviewing techniques, and how to facilitate behavior change.

Pilot Participation

As of July 31, 2011, 59 children had enrolled in the pilot.

Pilot Enrollment Issues

Amerigroup has encountered obstacles enrolling clients into the pilot. These include: members feel their child does not have an issue with weight or do not or cannot commit to the time involved for appointments; providers who consider the pilot too time intensive and therefore do not want to participate; and members who are interested in participating but are unqualified because of the pilot's BMI requirements or co-morbid conditions. The contract amendment signed August 16, 2011 addresses some of these issues by expanding the pilot into Dallas County and allowing participants with certain co-morbidities to participate in the pilot.

Conclusion

The Medicaid Child Obesity Prevention Pilot aims to provide prevention services in primary care settings to reduce the rate of obesity, improve nutritional choices, and increase the physical activity levels of participants. The pilot evaluation will provide insight into the cost-effectiveness of this prevention strategy. A final report of the results of the pilot will be sent to the Legislature following the conclusion of the pilot.