
**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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Executive Summary

The “*F as in Fat: 2010*”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 been addressing the obesity issue since 2001, and has been successful in improving food choices in schools and requiring physical education classes. During the 81st Legislative Session, multiple bills were introduced in the House and Senate related to childhood obesity in Texas.

S.B. 870, 81st Legislature, Regular Session, 2009, codified in Section 531.0993 of the Texas Government Code, directs 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 will begin operation November 1, 2010, and 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. HHSC has 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.

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. The report must include:

1. A summary of identified goals and strategies to achieve those goals.
2. Analysis of all data collected in the program and the capability of the data to measure achievement of identified goals.
3. A recommendation regarding continued operation of the program.
4. A recommendation regarding whether the program should be implemented statewide.

This report provides information on the collaborative work between HHSC and DSHS to develop the framework for the Medicaid Child Obesity Prevention Pilot program.

¹ Robert Wood Johnson Foundation. “F as in Fat: 2010”. June 2010.

Introduction

HHSC submits this report pursuant to S.B. 870, 81st Legislature, Regular Session, 2009, which directs HHSC in collaboration with DSHS to develop and implement a 24-month 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.

The Legislature appropriated \$1.5 million in general revenue for the pilot project. HHSC must submit a report to the Legislature on or before November 1 of each year of the pilot and a final report 3 months after the pilot ends.

Given the available funding for the pilot, HHSC decided to limit the pilot to overweight children in Medicaid in one area of the state, the Travis service delivery area. This decision was made in order to simplify pilot administration and maximize results by getting a larger study group from a single population.

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 (1998-2008). 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 of claims data from Medicaid versus private insurance, 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,

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: 2010”. June 2010.

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

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 throughout the state. Some of these activities include:

- DSHS has a comprehensive nutrition, physical activity, and obesity prevention program that promotes community policy 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.
- 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

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>.

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, assess 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 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

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.

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 to 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 were not reimbursable under the Texas Medicaid program. Claims for medical services for the diagnosis of overweight or obesity were 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.

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.

Travis County Service Delivery Area

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 because Amerigroup has:

¹² Ibid. p. 427.

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.

Project Framework

HHSC and DSHS workgroup members reviewed the option of utilizing multi-disciplinary treatment centers in Texas for this pilot project. However, these centers focus on treatment rather than prevention of childhood obesity. The workgroup, with guidance from HHSC Executive leadership, designed the pilot project around prevention strategies. The timeline for the project, as well as the service area covered is listed below:

- Start Date November 1, 2010
- End Date October 31, 2012
- Provider Amerigroup Texas, Inc. (Amerigroup)
- Service Area Travis and Williamson Counties

Project Strategies

Amerigroup will 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:

- Age 6-11 years at the time of enrollment.
- Pre-pubertal at the time of enrollment.
- Overweight based on body mass index (BMI) but with no obesity related co-morbid health conditions.

Parent/Child Screening & Readiness Assessment

Amerigroup will 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 will receive:

- Monthly visits with the primary care provider for six months for physical assessments and measurements, and 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 on-going participation and completion of the 12-month follow-up.

Care Coordination

Amerigroup will use care coordinators/case managers to maintain communication with participants and to collect and report program data.

Information/Educational Materials

Amerigroup will develop and distribute informational and educational materials to pilot participants.

Provider Recruitment and Training

Amerigroup will identify, recruit, and train providers to participate in the pilot. Amerigroup has identified high-volume pediatric Medicaid providers to target for outreach. Provider training must include information on childhood obesity, motivational interviewing techniques, and how to facilitate behavior change.

Data Collection and Reporting

Amerigroup will collect demographic information on participants and is required to submit monthly data including participant measurements, services provided, and program costs. HHSC will collect and analyze the data specific to (1) changes in body measurements, (2) nutritional choices, and (3) the physical activity levels of participants.

Pilot Project Evaluation

Project evaluation will be responsive to the legislative directives, and will measure:

- Changes in rates of obesity.
- Changes in nutritional choices.
- Changes in physical activity levels.
- Changes in overall health-care costs for participants.

Budget and Funding

HHSC received appropriations of \$1.5 million general revenue funds for the two-year pilot. The total funding was decreased in March 2010 to \$1.15 million in response to required budget reductions. Funding will be divided over the two state fiscal years as follows:

State Fiscal Year	Amount
2010	\$574,900
2011	\$570,000
Total	\$1,144,900

Conclusion

The Medicaid Child Obesity Prevention Pilot will evaluate the effectiveness of prevention efforts within primary care settings in reducing the rate of obesity, improving nutritional choices, and increasing 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 in February 2013.