Innovations In Medicaid: Considerations for Childhood and Adult Obesity Evidence-Based Intervention

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Integrated Health Solutions
Case Example: Missouri Medicaid

- Missouri Medicaid Population
  - Roughly 900,000 participants
  - Roughly 3/4 in managed care
  - Roughly 1/4 in fee-for-service
  - Roughly 1/3 adults
  - Roughly 2/3 children
Overview

- Missouri Medicaid Obesity Prevalence Rates
  - System Limitations
    - Claims based system
    - BMI not reported and thus not captured unless part of a claim
  - Data Sources for Modeling
    - Adults:
      - Missouri Medicaid Primary Care Health Home
        » 74% BMI >25 in 2013; 83% 2017 (eligibility change)
        » 50% with obesity in 2013; 60% in 2017 (eligibility change)
      - CDC 2010 national obesity prevalence 36%
      - MO BRFSS obesity prevalence ~30%
    - Pediatric, low-income (<130%)
      - CDC/NCHS prevalence 21.1% boys 2-19; 19.3% girls 2-19
Clinical Correlations

• 1% decrease in HbA1c yields:
  o 21% decrease in diabetes related deaths
  o 14% decrease in heart attacks
  o 37% decrease in micro-vascular complications

• A 10% cholesterol reduction yields:
  o 30% reduction in coronary heart disease

• A 6% reduction in blood pressure yields:
  o 16% reduction in coronary heart disease
  o 42% reduction in stroke

• Hennekens, C. Circulation 1998; 97:1095-1102
Overview

• Impacts
  
  – Financial

• Each Medicaid beneficiary with obesity on average costs $1,021 more than normal weight beneficiaries (Finkelstein EA, Trogdon JG, Cohen JW, Dietz W.)

• Pediatric: Missouri will expend $12 billion annually on obesity-related health care costs by 2030 (CSC Childhood Obesity Task Force Report, 2014)
Policy Considerations

• Goals
  – Follow vetted and validated guidelines and standards
  – Positively impact morbidity, mortality, quality of life
  – Maintain cost-effectiveness; awareness of budget limitations and potential impacts
  – Develop models for different methods of implementing a service
    • Assess fiscal impact of the conditions
    • Assess fiscal impact of proposed interventions/models
      – Cost-neutral or cost-saving?
      – Will it require appropriations authority?
      – Assess short- and long-term impacts- clinical, fiscal
    • Mechanism to evaluate outcomes- clinical, utilization of avoidable healthcare services, cost-savings
  – Strategic planning and collaboration to obtain approvals, appropriations to implement the policy change
Policy Considerations

- Resources and Reference Points include:
  - CMS guidance on State Plan preventive services
  - National programs (example Medicare)
  - Other state programs
  - National and state bodies of expertise (ex. ACOG for EED, USPSTF, etc)
  - Academics/research
  - National guidelines and literature
    - Application of Evidence-Based Treatment Guidelines for Pediatric and Adult Obesity
      - United States Preventive Services Task Force (USPSTF) Recommendations
        - Adults: Screen all adults (18 and older); refer to intensive, multi-component behavioral therapy for BMI 30 or greater
        - Pediatric: Screen all children 6 years and older; offer comprehensive, intensive behavioral intervention
Missouri Medicaid convened subject matter experts work group to provide input to the process

Work group includes individuals from pediatric hospitals and academic centers

Consensus process for building evidence-based program

Modeling Process

- Identify services
- Identify population
- Identify provider requirements
- Identify codes
- Identify costs/projected savings
Services, Population, and Coding

• Services
  – Intensive behavioral therapy
  – Mix of individual, family, and group sessions
  – Frequency in current modeling (following USPSTF recommendations)
    • Minimum 12 hours for adults (Medicare program)
    • Minimum 26 hours for children
  – Opportunity to continue for additional 6 months if benchmarks met

• Population
  – Adults
    • BMI 30 or greater
  – Children
    • Ages 6-18
    • Age and gender-specific BMI greater than or equal to the 95th percentile

• Coding
  – In initial modeling, identified a starter set of codes
  – Additional discussion as model continued in development
Provider Requirements

• Provider Types
  – Registered dieticians
  – Behavioral health specialists
  – Others under consideration

• Professional Certification Requirements
  – State process?
  – National certification?
  – A state process and certification should be on par with a national option (ex. Asthma Educator Certification)
  – Consider continuing education requirements, hours of work experience, mentoring relationships
Developing Models

• Steps:
  – Modeling
  – Approval and appropriations authority
  – State Plan Amendment
  – Regulation development
  – Systems work
  – Provider enrollment systems work
  – Provider recruitment
Developing Models

- Partner Programs: Diabetes Prevention Program