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:
  - 21% decrease in diabetes related deaths
  - 14% decrease in heart attacks
  - 37% decrease in micro-vascular complications
- A 10% cholesterol reduction yields:
  - 30% reduction in coronary heart disease
- A 6% reduction in blood pressure yields:
  - 16% reduction in coronary heart disease
  - 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

Process

- 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