

**Strategies for Improving Access to Comprehensive Obesity
Prevention and Treatment Services for Medicaid-Enrolled
Children**

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I. Background: Childhood Obesity

- Current estimates show more than 33% of children and adolescents (approximately 25 million) are overweight or obese.
 - Ogden CL, et al. *Prevalence of Overweight and Obesity in the United States, 1999-2004*. Journal of the American Medical Association, 295(13): 1549-1555 (2006).
- Obese children are at higher lifetime risk for heart disease, stroke, asthma, and certain forms of cancer.
 - *Designing for Active Living Among Children*, Active Living Research – Robert Wood Johnson Foundation, Fall 2007 Research Summary.
- Obese children also are being diagnosed with illnesses previously associated with adults, such as Type 2 Diabetes and high blood pressure. As a result, obesity is associated with the early onset of conditions and diseases previously associated with adults.
 - *Id.*
- 80 percent of obese children become obese adults.
 - Patel, Deena. *Super-Sized Kids*. Family Court Review, 43 (1): 164-177 (2005)
- Childhood obesity is associated with disparities in health and health care. Low income and minority children are at greater risk for childhood obesity and are also at higher risk for inadequate access to preventive and treatment-related health care services.
 - Wilensky, Whittington, and Rosenbaum (Robert Wood Johnson Foundation, Princeton N.J. 2006) available at <http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/RWJ%20Medicaid%20Obesity%20Policy%20Brief.pdf> (accessed December 22, 2007)
- Current treatment recommendations and guidelines for appropriate prevention and treatment measures relating to pediatric obesity are varied but the general consensus is assessment of family and social history, a physical exam including BMI, identification of common symptoms, co-morbidities and laboratory testing where appropriate. Treatment involves age-appropriate strategies to change the child's environment and behavior through education, counseling and goal setting.
 - Wilensky, Whittington, and Rosenbaum (Robert Wood Johnson Foundation, Princeton N.J. 2006) available at <http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/RWJ%20Medicaid%20Obesity%20Policy%20Brief.pdf> (accessed December 22, 2007)

II. The Role of Medicaid in Providing Comprehensive Childhood Obesity Prevention and Treatment.

- Medicaid is largest single source of health insurance for children (27.1% of all children) and is particularly important for lower income and minority children groups.
 - Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage of America's Children*, 2009. Table 1: Health Insurance Coverage of Children, 2006-2007. (January 2009).
- Medicaid provides health coverage for more than one in four children (27%) at all income levels and for more than half (51%) of children in families with incomes below twice the poverty level.
 - Kaiser Commission on Medicaid and the Uninsured. *Health Coverage of Children: The Role of Medicaid and SCHIP*. November 2008. Available at http://www.kff.org/uninsured/upload/7698_02.pdf
- Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
 - Marder, William and Chang, Stella. *Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions*, Thomas Medstat Research Brief (December 2005).
- Annual healthcare costs are about \$6,700 for children treated for obesity covered by Medicaid and about \$3,700 for obese children with private insurance.
 - *Id.*
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
 - *Id.*
- Since obesity appears in higher prevalence with minority and low-income children, Medicaid's coverage is important link for them into the health care system.
 - Rosenbaum S, Wilensky S, Cox M. *Reducing Obesity Risks During Childhood: The Role of Public and Private Health Insurance* The Robert Wood Johnson Foundation (2005), Available at www.rwjf.org.
- Medicaid entitles children under 21 to benefits which are broader than those found in any other form of health insurance in the U.S through ESPDT benefit.
- Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) is a benefit that was added to address health problems affecting children's development into adolescence thus extends to age 21. Operative word *Early*.

- EPSDT benefit requires the state to provide periodic and “as needed” screening services that included unclothed physical exam, comprehensive health and developmental history (physical and mental health), immunizations, laboratory tests and health education and any “other necessary” treatment to “correct or ameliorate” the effects of “physical and mental” conditions.
 - §1905(r) of the Soc. Sec. Act; 42 U.S.C. §1396d(r).
- EPSDT has three basic purposes:
 1. States are expected to affirmatively seek out low income children in need of comprehensive health care and offer families assistance in securing care.
 2. States must cover comprehensive examinations to determine children’s overall health, growth, and development, as well as medically necessary treatment to “ameliorate” the effects of “physical and mental” conditions.
 3. EPSDT requires states to ensure that children actually receive covered services by assisting in locating sources of care.
 - Federal Rules clarify that comprehensive child health assessment in EPSDT covers the “general physical and mental health, growth, development, and *nutritional status* of infants, children and youth.”
 - 42 C.F.R. §441.56(b)(1) italics added.
 - Federal Guidelines developed by CMS in order to interpret and explain its rules provide guidelines for the health assessment for nutritional status which includes dietary practices, height and weight measurements, cholesterol screening and further assessment upon determination that suggests dietary inadequacy, obesity or other nutritional problems.
 - CMS, State Medicaid Manual State Medicaid Manual §5123.2.
Available at http://www.cms.hhs.gov/manuals/pub45/pub_45.asp.
- Thus, EPSDT is a perfect avenue to use in providing a comprehensive program for children at risk of obesity.

III. Are States Using this Access to Comprehensive Childhood Obesity Prevention and Treatment through EPSDT benefit?

- Critical Milestone: In 2004, U.S. Department of Health and Human Services removed language from Medicare Coverage Issues Manual that obesity is “not a medical condition”. This gave hope that public and private insurers would follow suit and expand coverage and finance interventions aimed at reducing childhood obesity.
 - U.S. Department of Health and Human Services. HHS Announces Revised Medicare Obesity Coverage Policy. News Release, July 15, 2004. Available at: <http://www.hhs.gov/news/press/2004pres/20040715.html>
- In an effort to investigate which health insurance resources were available to cover services related to childhood obesity, George Washington University (supported by RWJ Foundation) conducted two studies which looked at whether

Medicaid insurers' coverage and payment practices supported recommended clinical practice.

- 1st Study: 2004-2005 Report “Reducing Obesity Risks During Childhood: The Role of Public and Private Health Insurance” assessed the implications of this policy change on public and private insurance coverage for services to children at risk for obesity.
 - Researchers at GWU SPHHS analyzed whether health insurance, especially those of state Medicaid Programs could cover preventative health services for children at risk for obesity.
 - Researchers ascertained the existence of clinical consensus on broad guidelines for preventative health interventions for children who are obese or at risk for obesity. (American Academy of Pediatric Recommendations¹)
 - ❖ Providing anticipatory guidance and preventative health interventions in case of children at risk is more successful than delaying treatment until after the onset of obesity.²
 - Findings: Guidelines exist to assist providers in screening and treating obese and at-risk children. All recommended childhood obesity prevention services for children and adolescents to age 21 can be covered under Medicaid's Early & Periodic Screening & Diagnostic Treatment benefit however, few state Medicaid programs specifically describe the childhood obesity services that they support.
- 2nd Study: 2005-2006 – Policy Brief “Strategies for Improving Access to Comprehensive Obesity Prevention and Treatment Services for Medicaid-Enrolled Children”
 - Researchers built on previous study and examined the extent to which state programs used Medicaid EPSDT benefit to address and finance obesity-related services that advance best-practice standards in obesity prevention, treatment and management in children.
 - Researchers compared the guidelines to standard national medical reimbursement codes to see whether codes were available for all recommended services.
 - Researchers reviewed state Medicaid manuals to see whether they clearly explained the coverage offered as well as the reimbursement codes for providers to use.
 - Findings:

¹See attached Table 1

² Barlow, S. & Dietz, W. "Obesity Evaluation and Treatment: Expert Committee Recommendations." Pediatrics Vol. 102, No. 3. Sept. 1998; Gordon-Larsen, P. et. al. "Five-year obesity incidence in the transition period between adolescence and adulthood: the National Longitudinal Study of Adolescent Health." American Journal of Clinical Nutrition 80:569-75. American Society for Clinical Nutrition. 2004.; The Institute of Medicine. "The Health-Care Sector and Providers Can Play a Role in Preventing Childhood Obesity." Fact Sheet. September 2004. Drawn from Preventing Childhood Obesity: Health in the Balance, 2005. ; NIH Obesity Research Task Force. "Strategic Plan for NIH Obesity Research."

- Existing guidelines for childhood obesity prevention and treatment fall entirely within the classes and categories of the EPSDT benefit that cover nutritional assessment and health interventions to “ameliorate” physical and mental conditions in children.
 - State provider manuals tend to be limited to a relatively brief overview of EPSDT without specific reference to nutritional assessment or counseling and Medicaid managed care contracts suggests that contractual requirements generally do not highlight obesity prevention and treatment strategies in reference to EPSDT standards.
 - Sufficient billing codes are available to bill for recommended obesity prevention services but states are not reimbursing providers for using the codes and some states put limitation of the use of certain services hampering provider’s abilities to bill for certain obesity prevention services even though appropriate codes exist.
- In 2007-2008, George Washington University researchers (supported by Trust for America’s Health) furthered the inquiry as to whether state Medicaid programs covered and reimbursed for recommended assessment and treatment for adult and pediatric obesity by conducting a state by state analysis of Medicaid programs and found similar results. Despite the high prevalence of childhood obesity, there was evidence that only ten states would cover obesity-related treatment nutritional and behavioral therapy guidelines through EPSDT. Even fewer states published any detailed screening or treatment guidelines for childhood obesity for their providers.

IV: Strategies and Recommendations for Improving Access to Comprehensive Obesity Prevention and Treatment for Medicaid-Enrolled Children.

What did we learn?

- Medicaid, under its Early and Periodic Screening & Diagnostic Treatment (EPSDT) benefit, can cover comprehensive, obesity-related pediatric health care services. (no new legislation is needed)
- Every service needed to provide quality childhood obesity prevention services according to clinical guidelines in use as of 2005 has an existing code for provider reimbursement. (no new codes are needed)
- Most state Medicaid Manuals do not provide clear or adequate information about coverage levels and appropriate reimbursement codes for specific elements of care. Providers, therefore, remain uncertain about which services they can provide and if they can be reimbursed. (need more information about coverage level and guidelines for preventive and treatment services)
- Medicaid Managed Care contracts generally do not include obesity prevention and treatment strategies in their performance measurement requirements.

Recommendations to States:

1. Clarify the application of obesity prevention and treatment guidelines as part of the EPSDT benefit for children and adolescents.
 - Medicaid Programs communicate to providers mainly through provider manuals, fee schedules, policy updates, administrative codes and regulations, and managed care contracts.
 - To promote best practices, States should disseminate to all Medicaid-participating health providers existing professional guidelines on obesity management and treatment.
 - Available resources already in place (e.g. AAP guidelines)
2. Clarify proper coding and payment procedures for obesity prevention and treatment services.
 - States should develop billing guidelines that support appropriate billing coding and could examine other payment standards and limitations that may need to be adjusted in cases involving obesity treatment and prevention.
 - Practice guidelines are often effective when tied to specific incentivization so maybe tie higher rates to providers' ability to engage in and document adherence to best practices through a pay-for-performance program.
 - States could consider including obesity-related performance measures in their managed care contracts to encourage providers adherence to best practice guidelines.
3. Bundle obesity prevention and treatment services into single package following a disease management model.
 - Bundle already-covered Medicaid services into an obesity prevention and treatment payment system, like disease management coverage and payment arrangements (e.g. Arizona).
 - States could assign currently unused codes to their obesity program which would allow for more specific evaluation and performance measurement as well as simplified coding for providers.

Recommendation for Federal Level:

1. CMS should disseminate information about the importance of childhood obesity risks to State Medicaid Programs
2. Augment existing CMS guidelines on EPSDT with special guidance on using managed care, integrated service delivery and disease-management techniques to develop comprehensive prevention programs for children at risk of obesity.

We have all the tools (EPSDT & coding) available now need to implement them.

Table 1: Recommended Preventative Health Interventions Addressing Weight Problems in Children

1. Comprehensive assessments as part of routine preventive health care (all children)

- BMI tool for a clinical assessment of obesity, using the 95th percentile as the appropriate cut-off for initiating an in-depth medical assessment for follow-up diagnostic and ongoing intervention purposes.

2. Anticipatory Guidance (all children)

- Counseling for all families on weight monitoring in children, diet and nutrition, using objective and non-accusatory language.

3. Further Assessment and Intervention for Children with Identified Risk

- Secondary assessment, treatment and case management interventions for children whose examinations indicate a risk of obesity (BMI between 85th and 95th percentiles or children with rapid weight changes over time).
- An in-depth medical assessment that is structured to: identify exogenous causes of obesity (physical and mental); assess the degree of overweight and identify existing complications from obesity; assess the need for specialty referrals; evaluate the child's and family's readiness to make change; establish a dietary and physical activity history.
- Therapy with established goals in the areas of health behavior (eating and physical activity), medical goals to improve and resolve complications, and weight goals.
- Training in parenting skills linked to changing child and family behavior
- Links to sources of increased physical activity.
- A reduction in calorie intake and nutritional evaluation and counseling
- Counseling on cessation of tobacco use.
- Regular and ongoing assessments to measure progress and challenges




Policies, Practices and PedNSS

Applying PedNSS Data to Address Childhood Obesity in Communities


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Objectives

- Overview of PedNSS
- CA PedNSS Data: Obesity
- Using PedNSS Data: Examples

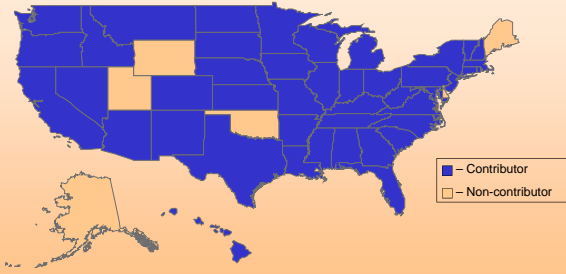


Pediatric Nutrition Surveillance System (PedNSS)

- Child-based surveillance system
- Monitors nutritional status of low-income infants and children
- Represents 8 million children < 5 years
- Data Sources: WIC, EPSDT, MCH



Contributors to the 2007 Pediatric Nutrition Surveillance Report



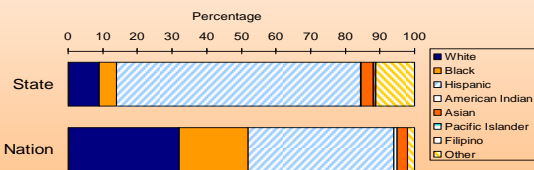
Contributors include the District of Columbia, Puerto Rico and the following ITOs: Cheyenne River Sioux Tribe (SD), the Inter Tribal Council of Arizona, Navajo Nation (AZ), Rosebud Sioux (SD), and the Three Affiliated Tribes (ND).

PedNSS Indicators

- Demographic
- Health
 - Anthropometry
 - Anemia
 - Breastfeeding
- Health Risk
 - TV/Video viewing
 - Smoking in household

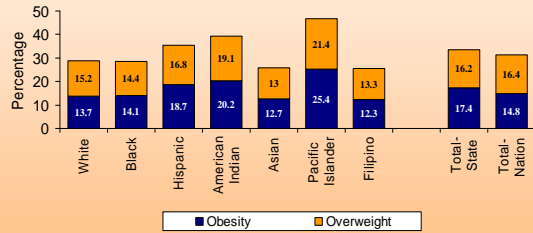


Racial and ethnic distribution among children aged <5 years



2007 CA PedNSS Table 1C

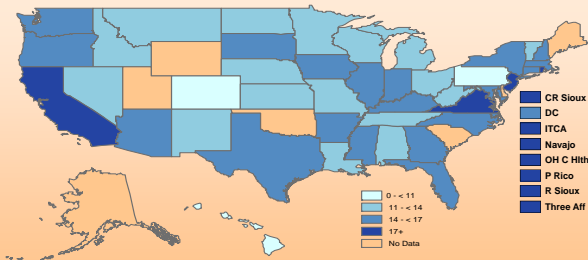
CA: Prevalence of obesity and overweight among children aged 2 to <5 years, by race and ethnicity



Overweight: \geq 95th percentile BMI-for-age; at risk of overweight: \geq 85th- $<$ 95th percentile BMI-for-age, CDC Growth Charts, 2000.

2007 CA PedNSS Table 6C

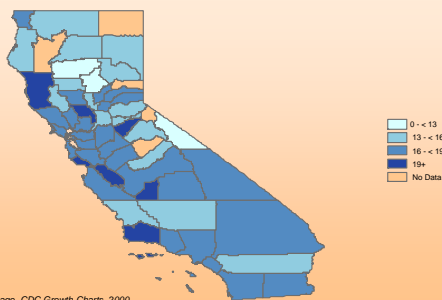
Prevalence of obesity among children aged 2 to <5 years, by contributor



* \geq 95th percentile BMI-for-age, CDC Growth Charts, 2000.
5% of children are expected to fall above the 95th percentile.

2007 National PedNSS Table 6D

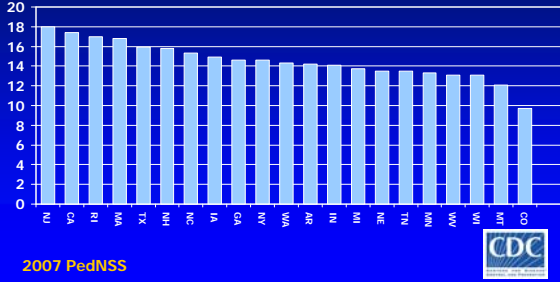
Prevalence of obesity among children aged 2 to <5 years, by county



* \geq 95th percentile BMI-for-age, CDC Growth Charts, 2000.
5% of children are expected to fall above the 95th percentile.
Year 2010 target: reduce overweight among children aged six to nineteen years to 5%.

2007 CA PedNSS Table 6B

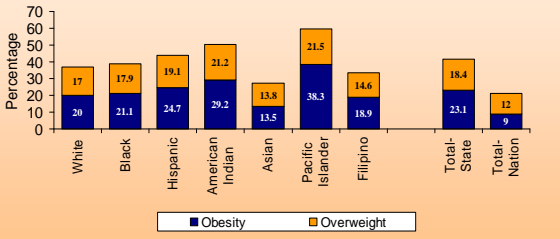
NPAO Funded States: Prevalence of Obesity for Children 2 to < 5 Years Old



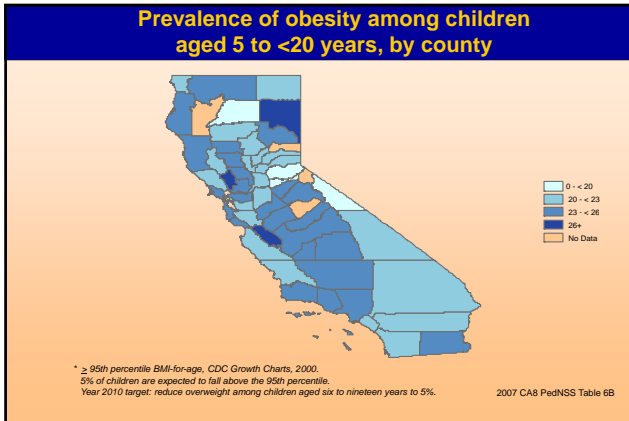
PedNSS: Children 5 through 19 Years Old



CA: Prevalence of obesity and overweight among children aged 5 to <20 years, by race and ethnicity



2007 CA8 PedNSS Table 8C



Strengths and Limitations of PedNSS

Strengths

- Comparability among states
- Measured heights and weights
- Local level analyses


Limitations

- Voluntary
- Program-based so not representative



Uses of PedNSS Data

- Monitor the *Healthy People 2010* Objectives
- Identify overweight and obesity
- Identify populations at-risk
- Monitor population trends
- Determine program priorities
- Supplement community assessment



Policy, Practices and PedNSS

- CA CHDP links PedNSS data to performance measures
- PedNSS:
 - helps target obesity issue
 - provides first step to community awareness of obesity issue



Ventura County: Example



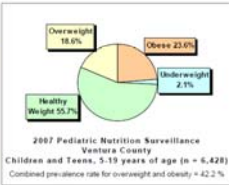
Child Health and Disability Prevention (CHDP) Program



Overweight and Obesity in Ventura County Children and Teens

In 2007, more than 2 in 5 Ventura County children and teens, 5 to 19 years of age, who received Child Health and Disability Prevention (CHDP) Program health assessments were overweight or obese. Being overweight or obese in childhood and adolescence increases the risk of early onset of serious health conditions such as diabetes, high blood pressure, high cholesterol, and heart disease. Overweight is occurring earlier in life and is an increasingly common growth pattern in children and teens. Causes of overweight and obesity are multiple and may range from individual to environmental factors. Solutions to childhood obesity will require early intervention strategies supported by community efforts.

This fact sheet summarizes California's Pediatric Nutrition Surveillance System (PedNSS) prevalence rates of overweight and obesity in Ventura County's children and teens. The



2007 Pediatric Nutrition Surveillance Ventura County Children and Teens, 5-19 years of age (n = 6,428)
Combined prevalence rate for overweight and obesity = 42.2%

American Medical Association
Weight Categories
www.ama-assn.org/speical/pednss0711.pdf

Share the Data! Influence Stakeholders and Policymakers

- Presentations
- Newsletters
- Press releases
- Community health status reports
- School districts/Wellness Policies
- Obesity Prevention Taskforce



Santa Clara County: Example

Sustainable activities as a result of sharing data

- Annual conference on obesity
- Training for community-based organizations
- Annual health fair
- Consistent provider messages



Beyond PedNSS

CDC Target Areas:

- Increase:
 - fruit and vegetable intake
 - physical activity
 - breastfeeding
- Decrease:
 - television viewing
 - consumption of sugar sweetened beverages
 - consumption of high energy dense foods



CHDP website

<http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS2007.aspx>

CDC website

www.cdc.gov/pednss/





Summary

- PedNSS data can be used to examine overweight and obesity issues in low-income children in communities
- PedNSS data provides clinical evidence that can be used to engage community leaders and policy makers

