Addressing Childhood Obesity in Medicaid and Children's Health Insurance Program (CHIP)

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Stephanie Reyna:

I want to welcome you all to today's CMS webinar "Addressing Childhood Obesity in Medicaid and CHIP." My name is Stephanie Reyna and I'm a managing consultant at Mathematica. We have an exciting agenda planned for today's event. We'll begin with an introduction from Dr. Vishal Arora with the Centers for Medicare and Medicaid Services (CMS), who will discuss how the Making America Healthy Again agenda is addressing childhood obesity in Medicaid and CHIP.

Dr. Alyson Goodman with the Centers for Disease Control and Prevention (CDC) will provide an overview of evidence-based approaches for addressing childhood obesity and how CDC is supporting implementation. Then we'll hear from Dr. Christopher Cogle with Florida Medicaid about the state's initiative focused on childhood obesity prevention and treatment. Last, Dr. Stewart Gordon with Louisiana Healthcare Connections and Dr. Amanda Staiano with Pennington Biomedical Research Center will discuss their work to further evidence-based pediatric weight management services in Louisiana.

We'll have time at the end for discussion with our speakers. Materials from today's webinar, including the recording, slides and a transcript, will be posted to medicaid.gov in the coming weeks. All registrants will receive an email when those materials are available. Next slide. And, with that, I'll turn things over to Dr. Arora with CMS.

Dr. Vishal Arora:

Thank you, Stephanie. It's great to meet everybody here, and I appreciate the invite. My name is Vishal Arora. I'm a senior adviser in the Office of the Center Director at CMS. And my work over at the agency has focused on value-based payments, managed care oversight and clinical quality. And, you know, this topic is definitely important in light of this in that portfolio. You can go to the next slide.

You know, just to level set with the group, I wanted to actually just share some data from KFF on what is really the burden of pediatric obesity by payer type. And, as you can see here, you know, disproportionately in Medicaid, the prevalence of children, this age group is 10 to 17, is about one in four. And, really, it's important for us to make sure that children who fall into this category are really getting the services that they need. And, you know, the Early and Periodic Screening, Diagnostic and Treatment benefit will obviously cover medically necessary services, but I think it's not enough to just say that we're going to cover it, it's actually ensuring that these children are getting access to the care that they need. And, hopefully, it'll be a rich discussion today with some of our participants on what they're doing in their states today. Next slide.

And so, as we think about the MAHA agenda, I think one of the things you'll see here is that [when] tackling obesity, one lever that we want to do that is obviously through the lens of primary prevention. I think at the same time it is important to recognize that, secondary, tertiary and acute care are still extremely important parts of a patient's care journey. But, hopefully, over the next several years, what we'll see from states as well as the federal government is just this focus of changing payment systems to really emphasize upstream behavior around nutrition as well as physical activity, and also just making sure that you have access to the right care team to manage obesity. You can go to the next slide.

And so, I think bringing this to a CMS level, I think what we view is that we view four stakeholder groups really as essential to advancing this agenda for pediatric obesity, but also other chronic diseases that we see both in the pediatric population as well as the adult population. And I think, obviously, you know, providers are really at the center of this because they are that touchpoint with patients. They are the ones who we hope to see will reshape their interactions to really accelerate lifestyle change and, ideally, connect with a broader support system outside of the traditional care delivery system. Payers are obviously the ones who are helping craft incentives and rewarding providers and beneficiaries for emphasizing upstream lifestyle changes. Beneficiaries, of course, are also similar to providers at the center of this relationship. And we want to ensure they have access to a connected care team as well as transparent data that can help support changes in daily behaviors and treatments that they require.

And, lastly, I think states are the ones that, at least within Medicaid, are really operationalizing their programs and ensuring that there is, you know, financing as well as quality frameworks that are emphasizing these upstream lifestyle changes. I think, at the federal government level, we can provide that guidance and that technical assistance, but it's really the states who are working with providers, payers, and beneficiaries to really make that happen on the ground. So, with that, I'm really looking forward to the discussion from some of our colleagues on the call. And, Stephanie, I'll pass it right back to you.

Stephanie Reyna:

Thanks so much, Dr. Arora. We can move to the next slide. And now I'll turn it over to Dr. Goodman with the Centers for Disease Control and Prevention.

Dr. Alyson Goodman:

Good afternoon. Thank you for having me. I'm Aly Goodman, a pediatrician and epidemiologist at CDC and lead our Obesity Branch where we work on both surveillance and monitoring of obesity, but also increasing access to evidence-based interventions. Next slide, please.

So, what is the problem? Obesity, as many of you know, is a complex, chronic and relapsing condition that starts often in childhood, but persists into adulthood. We have over 14 million, probably over 15 million, U.S. children who are now living with obesity. And, without additional intervention, our best models show that over 60% of today's two-year-olds will have obesity by age 35 years. So, we need more intervention. Right? And we need to get what works to kids efficiently and effectively. But, unfortunately, very few kids with obesity currently receive guideline-recommended evaluation and treatment. Next slide, please.

There are substantial differences in obesity prevalence in the United States by race and ethnicity. These data are from the National Survey of Children's Health from 2023 to 2024. These are parent-reported data and show substantial differences with non-Hispanic, Asian children having the lowest prevalence, then White, then American Indian and Alaskan Native followed by Native Hawaiian/Pacific Islander, then Hispanic and non-Hispanic Black children having the highest prevalence. Next slide, please.

There are also substantial differences by other characteristics including by household income with kids whose families live at 350% or above the federal poverty level having a prevalence that's almost half of those whose families live at 130% or less of the federal poverty level. Also, substantial differences by metropolitan status with those who live in rural communities having substantially higher prevalence than those who live in urban communities. Next slide.

So, what do we do? What do we know about the spectrum of prevention for child obesity? Dr. Arora mentioned, you know, the concept of primary, secondary and tertiary prevention, so I want to kind of

bring that now to obesity. We start with sort of primordial prevention, and that's thinking across communities, across the places where we all work and live and go to school. And that's thinking about issues like access to healthy food and water, access to parks, safe parks, sidewalks, healthy work and school environments. In primary prevention, what we want to see is screening, monitoring, assessing health risk and growth patterns, right, using those growth charts.

Secondary screening is now taking things up a whole other level or secondary prevention looking at lab screening, which I'm going to talk about more, monitoring growth for children who already have obesity using specialized growth charts, which are pictured here. And then tertiary prevention, which is also treatment, is using things like obesity medications or even metabolic and bariatric surgery. But, importantly, the bedrock of secondary and tertiary prevention for childhood obesity is evidence-based behavioral interventions, which we call Family Healthy Weight Programs. And we're going to talk a lot more about those today. Next slide, please.

We have a major care gap, as I mentioned. On the left, what I am showing is that we've done a good job in our field of raising rates of screening for excess weight. We now screen over 80 to 90% of children using BMI. And that's great. So, we are identifying the issue commonly. We also—on the far right here, we have a lot of evidence-based prevention and treatment that has been studied and elucidated and defined. But we have a gap in terms of the availability of evidence-based services, we have low access to those services because of many issues, but includes coverage gaps and limits. And we also have a lack of awareness of what is evidence-based child obesity care. Next slide.

So here's a study that we published last year looking at how often children are receiving the recommended laboratory screening if they have a BMI at or above the 95th percentile, which is the recommendation of the American Academy of Pediatrics, that kids get screened for dyslipidemia or high cholesterol, for fatty liver disease and for pre-diabetes. And what we showed in this paper where we looked at over 300,000 kids in a gigantic dataset from electronic health records is that only 13% of children who were eligible, in other words, 13% of kids who had obesity actually received screening for all three of those conditions annually.

So, in other words, some other kids, you know, got screened for one condition or another condition, but only 13% got all three. Seventy-four percent of kids with obesity did not receive any screening. So this represents a huge gap, especially when you consider that, of those who were screened, when they got screened, results were often positive. So over half of the kids who were screened had abnormal lipids, almost half had evidence of fatty liver disease and 14% had pre-diabetes or diabetes. So this is a major missed opportunity and, really, if we look at that from the positive sense, an opportunity for quality improvement. Next slide, please.

So our other big opportunity for quality improvement is in getting intensive health behavior and lifestyle treatment to more children. These programs have been around and really well studied. We have over 30 years of evidence from 60+ randomized controlled trials. They are guideline-recommended by the U.S. Preventive Services Task Force, by EPSDT, by the American Academy of Pediatrics. And we consider these absolutely foundational for childhood obesity treatment, as I mentioned earlier. But they are complimentary to other modes of treatment, like medical nutrition therapy, pharmacotherapy, surgery, et cetera. Next slide.

Family Healthy Weight Programs, which is what we call intensive health behavior and lifestyle treatment programs, they are a type of lifestyle change intervention. So, what is a lifestyle change intervention? They focus on physical activity and/or nutrition. They're delivered by a trained instructor or coach. They use an evidence-based curriculum. The curriculum is really important here. They build skills. This is all about behavior modification, right, so you need skills, so cooking, shopping, healthy movement. And they

are family centered. Right? They help adults or kids improve their wellness and prevent or manage their chronic disease. Next slide, please.

Family Healthy Weight Programs are not the only type of lifestyle change intervention. You might be familiar with other types, like the National Diabetes Prevention Program, or the DPP, and arthritis, physical activity programs or cardiac rehab programs. These are all lifestyle change interventions that CDC has packaged and makes available through our web pages. Next slide, please.

There's key characteristics of Family Healthy Weight Programs that are really important to keep in mind. They are safe and effective for kids aged two through 18 years with a BMI at or above the 85th percentile for age and sex, and have been very, very well studied in those populations. They are family centered, this is critical, and involve parents or caregivers. They are intensive, so they offer 26 or more contact hours over three to 12 months. And that's important that that time is offered because behavior change is hard and we all know that from our own lives. They are curriculum based. They can be done in a group setting or in individual sessions and can be done virtually or in person. Lots of models. And they can also be done in a community or a clinic setting. But the key piece is they're always delivered by trained staff. Next slide.

There are many proven benefits of Family Healthy Weight Programs including improved health behaviors, improved mental health, quality of life, parenting, family stress and coping, social connectiveness, and they've been shown to be cost effective and defer our future cost savings. So like these are all really great things, right, that we all consider super important for children and families. In addition, they've been shown to reduce the risk of having elevated metabolic markers for prediabetes, hypercholesterolemia and hypertension, and they reduce child and caregiver weight, and have been shown to have a five to 20% reduction in excess weight in both the child and the caregiver. Next slide, please.

CDC is helping to address gaps in availability of Family Healthy Weight Programs through various funding opportunities. And we now have 52 real-world implementations across 33 states through state and local health departments and community-based organizations. So we're really trying to help communities do this in real-world settings to figure out how to make this work in the real world. Next slide.

We also have a web page. Please use this QR code. It links to our page and will show you the names of CDC-recognized programs that meet these evidence-based criteria. So, on the right-hand side here, you see eight programs that meet the criteria, those key characteristics. Each of these has different kind of characteristics to them. Some are more community-based, others more clinic-based, some deliver more by behavioral interventionists, others by registered dietitians, some by trained lay providers. They each have unique characteristics, so you can go to our web page and learn more about them. Next slide.

In summary, lifestyle change interventions can make America healthy again, but only if they reach more people, are opportunities to improve reach include increasing healthcare provider referrals, and making it easier for more delivery organizations to offer these lifestyle change interventions. It's not easy, it's a lot of work, and we have to ease those barriers. We also have to make opportunities to help people enroll, including offering a variety of lifestyle change interventions with convenient locations and schedules. We have to improve awareness of the interventions and decrease the out-of-pocket costs for individuals and families. Next slide, please.

We, at CDC, are working with a lot of different states on spreading and scaling Family Healthy Weight Programs as well as other lifestyle change interventions. And you're going to hear from two of those states today, but we work with others as well that are pictured here. Next slide, please. And that is it. I thank you so much for your attention and look forward to questions. Next slide.

Stephanie Reyna:

Thank you so much, Dr. Goodman. And now I'd like to turn it over to Dr. Cogle from Florida Medicaid.

Dr. Chris Cogle:

Hi, everyone. I'm Chris Cogle. I'm a professor at the University of Florida and also the chief medical officer for Medicaid. And I want to thank Dr. Goodman and Dr. Arora for level setting. So, this is a demonstration or a discussion about some of the things that we're thinking about in Florida on how to initiate prevention of childhood obesity. And if you'd go to the next slide, please?

So, we've been thinking about this in Florida for a while and, for over a year, we've been trying to pull together an initiative. In our early design phase, we were thinking about this program called JumpStart Health where it would be a healthcare improvement initiative focused on rural Florida counties, and it would have three purposes. One is to test the feasibility of Medicaid-supported obesity prevention. Several of these items Dr. Goodman just outlined. Number two, to identify which outcome measures are most appropriate for reducing childhood obesity. Are there procedural, are there health outcomes? And then number three is to inform the design of scale, so regional statewide implementation. Next slide, please.

The first step in our thinking was to look at the prevalence of childhood obesity. And we've already seen from Dr. Goodman and Dr. Arora the focus on rural, small towns, on Medicaid recipients. And our data shows the same thing here at the state level. Now, we've partnered with an academic partner at University of Florida.

There is a data trust called OneFlorida. They have a claims plus electronic health record data trust that has coverage of 26 million individuals. And, when we use claims data in addition to electronic health data, what we find are counties with higher prevalence of childhood obesity that directly overlay our rural counties, our small towns. There was a publication a few years ago that OneFlorida helped produce that, again, showed much higher obesity and severe obesity in our rural areas. And so that's why, in Florida, we are having a special focus on our rural communities. And I want to give credit to Dr. Betsy Shenkman at OneFlorida who was able to provide the data refresh here on this slide. Next slide, please.

So the principles guiding our design in looking at childhood obesity in Florida are four-fold. And they derive a lot from what the CDC had just presented. One is connecting families to activity, local activity opportunities, so YMCA's after-school programs, 4-H, church-based fitness. We also have a state government that gives free state park passes for Medicaid recipients to make it easier. Number two principle is food, to bring healthy food within easier reach of individuals. Not paying for the food, but just working on the processes and helping community-based organizations bring themselves in reach of where families are, whether they be at schools, at medical clinics, community centers. And we're lucky to have a food network bank in Florida that has produce prescriptions, produce boxes. They drive around a mobile trailer throughout rural areas that contain fresh food. And our community also provides cooking, grocery shopping classes using seasonal Florida foods.

The third principle is to activate healthcare teams. And, for those of you that are Medicaid policymakers on the call today, you will appreciate this perspective that, when you're in an agency that does healthcare administration, we're very careful not to define the evidence or not to create new evidence, but, instead, we focus on the healthcare community and making those processes more streamlined.

And so we want to activate our pediatricians, our primary care doctors, and helping them with our Medicaid health plans in new referral workflows that are built right into electronic health records. And then the fourth principle is those habits, building them early, but reinforcing them. And it doesn't stop.

Here's a picture. So here's a life hack that I figured out with my kids many years ago when they were toddlers by putting food, fresh fruit within reach of them. They have to pass through the kitchen every day. And I thought this was a life hack here by putting it out.

And, if you can go forward a slide, but what you'll see here was one of my sons packing his lunch with what appears to be Cheetos he got somehow. I'm going to blame it on the school, but he probably got it from the pantry, which is next door to him. So, the lesson here is that we can't just teach once, we have to teach over and over again. And this is not a one-and-done initiative, this is a program that will hopefully last in perpetuity. Next slide, please.

And so, again, with a Medicaid lens, you know, we focus on health care providers and managed care plans. And so here's a list of things what do we want them to do. So we want them to screen and identify. And that was brought up with the CDC. We want them to refer effectively. We want them to counsel with confidence. And so we want CME programs that train them in nutritional counseling and motivational interviewing. And, for them, for doctors and nurses and PAs to be able to prescribe nutrition and activity right from where they work and not have to make a separate call that takes time.

And, for those of us that are in clinical practice where you only have 12 minutes per patient, streamlined access is what we're looking to establish and test and see how good of a job we're doing. And then the other side is the managed care plans. So can they bundle these services? Are there a consistent set of services? Is there streamlined access? Can they use their promotional engagement tools to set out monthly themes? And then can they help us track and show our improvement based on claims data and electronic health record data? Next slide, please.

So what we're going to examine with JumpStart Health are these managed care services. So medical nutrition therapy, there's the CPT codes. In Florida, we have a Healthy Behaviors state statute that calls for medically directed weight loss programs. And so we have monitoring around the number of individuals that are in that program and complete those programs. And then we have pediatric obesity screening and counseling. And we have codes for that. There's a lot of data sparsity. It's hard to get those Z codes on the claims records. And so there's some education going on to our doctors that says, "These Z codes are helpful to us, so please use them." Managed care plans have expanded benefits is what we call them in Florida and other states. You might know them as value-added benefits.

So these are things that the states don't pay for. It's what these managed care plans bring to the states as an added benefit of being one of the contracted providers. So our managed care plans will offer classes in meal planning, grocery shopping, cooking. They'll give out pedometers, weight scales. They'll sponsor after-school scholarships. It's so expensive to cover registration and cleats and shin guards and mouthguards.

We also, in Florida, have an effort to make sure that every child knows how to swim. And so we have coverage of swimming classes and gym membership. I mentioned the park passes. And then the telehealth coaching for nutrition education, especially for those that live in small towns where it takes a long time to travel to an urban center. Next slide, please.

We have wonderful community partnerships. I would give a shout-out to Feeding Florida who is the parent of the network of all the food banks that are in Florida. They have Fresh Access Bucks where that you can get double the value of your WIC when you go shopping at a farmers' market. They have a mobile pharmacy where they have, again, a trailer that brings whole food. They have school markets where they have very dignified access to these food lockers that Feeding Florida, the community, has.

So families can sign up and have their family member grab some fresh whole foods in a private way at the schools and then bring it home. And then we have the after-school activities. We have some local medical

clinics that are also in this partnership. And importantly we have these closed loop referral networks with our managed care plans where doctors can refer their patients to these nutrition and physical activity services through UniteUs, through FindHelp, and these other social service networks with closed loop verification back to the doctor. Next slide, please.

So what we're really adding, if you stand back and say, "What are you really doing in Florida," in this clinical workflow, really what we're adding here is we're bolstering steps four and five, which is the counseling and referring the patients to these nutrition and structured exercise programs, and then that care coordination, enhancing that at the managed care plan level, bringing them in, again, to really help to activate our health care teams. Next slide.

We work with great partners in Florida, so this is in a different department, a different agency. And, when we take an inventory of what are all the nutrition things that Florida is doing, we have 15 ways or programs that are supported by several important collaborators, like Feeding Florida, Department of Agriculture, Department of Health, Elder Affairs and our Agriculture Unit through the university. There's some early discussions now that are happening in Florida about creating a My Florida Plate with these cross-agency collaborators where, you know, we have an abundance of agriculture because of our oceans and our fields and our forests, and so there's some discussions about making a seasonal My Florida Plate to be themes that we would then reverberate with the activated healthcare network. Next slide, please.

And so we are taking a scientific approach of this so we are looking at some primary outcomes of interest, like the percentage of Medicaid enrollees that are referred for these services, the closed loop referrals, how often the provider toolkit is used, participation in these statute-mandated Healthy Behaviors programs and attendance at these community events. Now, long-term health outcomes, this is something that we'd like to study. We don't know the impact of all of these procedural outcomes on whether we're actually going to prevent the rise of BMI or whether we're going to reduce these ED visits. We're in a position of equipoise on that. And we're willing to experiment, but we really need to understand what is the connection between these procedures and these ultimate health outcomes that we hope to improve. Next slide, please.

And so, a lot of us in Medicaid that are on this call and those of you outside of it, might have heard of the Rural Health Transformation Program. All of our states and some of the territories have them. In Florida, we have four main goals, which is to support chronic disease, modernize data, leverage community partnerships, and sustain our rural health systems. That fits squarely with childhood obesity.

And so, we are looking at ways that we can animate our effort to prevent and manage childhood obesity through our support that we're getting on the Rural Health Transformation Program. And I did a quick search of some publicly accessible documents on all states in their Rural Health Program applications, and I saw at least six, there may be more. But I think, in the discussion section -- in the Q&A section, would love to hear from states if you are using your Rural Health Transformation Program and, if so, how on childhood obesity. And so thank you very much for this opportunity.

Stephanie Reyna:

Thank you so much, Dr. Cogle, for sharing the work that you're doing in Florida. And, last, I am happy to turn it over to Dr. Gordon and Dr. Staiano from Louisiana.

Dr. Stewart Gordon:

Thank you, Stephanie. And welcome to everybody that's joined from all over. Appreciate you taking the time to learn more about how we can work together to better address childhood obesity. I am the chief medical officer for Louisiana Healthcare Connections. I'm a general pediatrician and I work for a

managed care organization, LHCC, that is in the Centene family of managed care organizations. Today, I am joined by Dr. Staiano, one of my colleagues here in Baton Rouge that we worked together in the childhood obesity arena for some time. Next slide, please.

I'm actually just going to skip this slide, but to remind y'all that, after hearing Dr. Goodman's talk and the current recommendations, that FHWP, Family Health Weight Program, and IHBLT are one and the same. And so we can go on to the next slide and that'll give us a little extra time for Q&A. What this is just -- made me stop and think at my ripe young age of 61 that I've been in this world -- in this role as a general pediatrician, blessed to have been in it 32 years. The first 18 years were at a public teaching hospital where I was a general pediatrician working in a very exceptional clinic taking care of about 5,000 children. We had a multidisciplinary approach to all the children in the clinic. We had general pediatricians, we had subspecialists on one end of the hall, and we were very, very fortunate to have a child psychology graduate program on the other end of the hall.

So we had an integrated physical health/behavioral health program, it just fell into my lap. That's where my first location of practice was. And I stayed there for 18 years. The reason I say that is that, despite having all these resources, we realized that, in working with predominantly Medicaid or uninsured population, that we weren't really addressing what's now known as determinants of health. And I said, "Well, how about we superimpose or collocate a social worker in our clinic?"

So I was able to get a grant from the state Office of Public Health. And, long story short, we were able to hire a licensed clinical social worker to integrate into our practice to help us address determinants of health. And, of course, I had to kind of force this individual on my colleagues because physicians tend to be the worst types of individuals to encourage change in their behavior. And they said, "What's she going to do for us? Probably disrupt our workflow," this, that and the other. Well, as soon as she took vacation, they were all crying to me, "Can we get another one" because she was able to address a lot of things that you really, sadly, do not have time to address and attend a 10 to 12-minute visit with a child and their family.

The reason I bring this up is, at that time here in Louisiana, LCSWs, LPCs, LMFTs and LACs, all behavioral health professionals, were not allowed to bill and collect for services to Medicaid. They could if they were in a rehab center or a behavioral health site only, but, in an integrated setting, that was not allowed. Well, the facility that I practiced in was closed and I shifted into the managed care organization role that I'm in now as a chief medical officer.

So, in that transition, I said, "How else can I maybe influence how we deliver care to Medicaid recipients?" One other piece I left out, I had been in practice there at Earl K. Long in 1994 for one year, and a colleague of mine in New Orleans called me and said, "Hey, we're trying to replicate this family-based weight management program for six- to 17-year-olds outside the New Orleans market. Are you interested?" And, of course, I said, "No."

And then, 10 years later, after having delivered that program to probably three to 400 children throughout the community, and loved working with the families, basically giving IHLBT and family-based therapy to them with myself, a pediatrician, exercise physiologist, child psychology grad student, and a registered dietitian, we had some great success, but I decided that I'd rather work on the advocacy side and get involved with Medicaid policy, health policy and legislation to improve the built environment. So, advance the clock a little bit and, well, as part of that, I will say and take a little credit, that Louisiana was the first state in the Union to pass a Healthy Vending bill in 2005.

The previous year, we passed a Required Physical Activity bill in 2004. They're still on the books, but, as far as implementation and really following through on that, that's a subject for another day. But what then happened is, in this managed care role, I got much more interested in the business of medicine and

understanding the Medicaid fee schedule. As many of you probably are aware, there are 50 different states, obviously 50 different Medicaid fee schedules, and the state sets the reimbursement on those fee schedules.

So one of the roles that I've taken on in the managed care organization is in going out and visiting with physicians in their practices is to help them really understand that fee schedule. In the midst of doing that over the last 13 years, back in 2016 or '17, Amanda reached out to me and asked if I would be willing to join her and a group of colleagues for a summit at the National AAP to talk about an opportunity to get some PCORI funding to develop a study and look at childhood obesity in several states.

So, before I turn it over to her -- the reason I brought up that social worker piece and integrating that into a behavioral -- into a clinical setting is that, in March of 2012, March 1, 2012, the Medicaid policy changed in Louisiana that would allow for LCSWs, LMFTs and other behavioral health therapists to work independently. So they could be placed inside a pediatrician's practice or a family practice or a FQHC and bill and collect for their services.

So, I use that as a potential resource to help address family-based treatment. So let me turn it over to Amanda becausethe meeting that she invited me to was the beginnings of the paper that was generated in 2023 that put out the Clinical Practice Guidelines from the American Academy of Pediatrics.

Dr. Amanda Staiano:

Thank you so much. So I'm Amanda Staiano, a research professor at Pennington Biomedical Research Center, part of Louisiana State University. And I'll cover the last few years then picking up from Dr. Gordon's timeline of how we've used research studies and quality improvement projects with our Medicaid MCO partners as a way to build capacity and expand access to pediatric obesity treatment in Louisiana. Next slide.

We recently completed the TEAM UP Research Study. We randomized 730 families across 41 primary care clinics. The two treatment arms were both focused on weight management counseling and were concordant with guidelines. One treatment was entirely delivered by primary care providers. These were mostly pediatricians, but also nurses and family medicine doctors. And the other treatment also had a collocated health coach delivering IHBLT. These coaches were mostly registered dietitians, but also social workers, community health workers, and licensed counselors. TEAM UP was funded by the Patient-Centered Outcomes Research Institute, or PCORI.

We also received funding from Louisiana Healthcare Connections, the Medicaid MCO, and from a commercial insurance plan. We set up contracts and sent those funds to the clinical practices who participated in the study. Those funds helped the clinics pay the time for their dietitians and primary care providers to onboard and train. The PCP visits were billed to insurance, they used obesity diagnosis codes and preventive medicine EM codes. And the IHBLT visits were also billed to insurance using medical nutrition therapy, health and behavior or psychotherapy counseling codes. And this TEAM UP trial showed effectiveness of both treatment approaches with greater weight reduction in children who received the health coaching. We conducted additional cost analysis with our insurance partners, and we found similar utilization and costs across both treatment arms. Next slide.

The next trial is currently underway, also funded by PCORI. This is the DOSE Trial. We are, again, training primary care clinics to deliver IHBLT, this time to 900 families across Louisiana and Tennessee. All patients receive IHBLT, but we are varying the amount of contact hours they receive with the registered dietitian or health coach. The clinics bill these services to insurance, including four PCP visits and up to 16 nutritionist or health coach visits over one year. And we also include four visits with a licensed social worker to help the family with social determinants of health. So this trial is another

example of a pragmatic research study where we're building capacity and infrastructure, and clinics are billing for services. Next slide.

We are also conducting a series of quality improvement and demonstration projects with our Medicaid MCO partners. The IHBLT we have developed at Pennington is called PATH, or the Positive Actions Towards Health Program. So this is one example of an IHBLT. Next slide.

And, as you've heard from Dr. Gordon, you know, our IHBLT work started over 30 years ago. And then, about 20 years ago, our Pennington scientists began to develop and test the digital or online delivery of family weight management services. We conducted a series of trials as well for adult obesity treatment. And we've merged our pediatric and adult work into PATH, which is designed for both the parent and child to lose weight together in a healthy, sustainable way. The state of Louisiana has also invested into PATH, and we are now partnering with our Louisiana Department of Health and clinical partners throughout the state to offer PATH, and to bill insurance for these weight management and nutrition counseling services. Next slide, please.

PATH focuses on successive changes in health behaviors in children and their parents using the Traffic Light Plan and other family-friendly visual aids. And we focus on positive parenting strategies, household strategies and long-term maintenance. And then, on the next slide, you can see examples of the lesson plans that form the curriculum, family handouts and the weight path, which are all designed for low literacy.

A unique feature of our program is the wireless-enabled scale for patients to monitor their weight at home. These data are wirelessly sent to the coaches and plotted on a weight path to inform treatment delivery. There's an app to house behavioral goals and lesson content. And the family meets regularly in person or over telehealth with a trained health coach. Next slide, please.

We also recently partnered with Louisiana Healthcare Connections Medicaid MCO to test this model in a home health visitation network. The pediatricians and nurses wrote referrals to home health and we trained the home health nurses to deliver PATH. And we have shown evidence of improved weight and health outcomes. PATH was integrated within their electronic health record for both treatment delivery and evaluation. We're also working with Louisiana Department of Health on projects funded by the CDC Division of Diabetes Translation and on rural health work. And we're focusing on setting up referral pathways throughout the state. And then the third QI project is working with a federally qualified health center that provides services in schools. The startup cost for this project is funded by a Medicaid MCO.

The FQHC identified a medical assistant to complete training as a community health worker and to use the new community health worker billing codes that were recently approved in Louisiana. This individual is now delivering PATH to elementary and middle school students at school while their parents join in over telephone or video conference. We are excited to continue exploring innovative delivery and payment models with our Medicaid MCO partners in our state Medicaid office. And we are proud that Louisiana is leading the way in these efforts. So I will now turn this back to Dr. Gordon to close us out.

Dr. Stewart Gordon:

Thanks, Amanda. And, as many of you on the call deal with and understand, there are a lot of delivery challenges that exist in doing this. And it's very frustrating to look back, as many of you have in my 30 years, that we haven't made a whole lot of progress in decreasing childhood obesity. But the good news is we have the opportunity to drive the message home and get these services made available to children and families wherever they reside. I think that's been clearly demonstrated today.

And I would encourage anybody on the call to remain positive and innovative, work with your Medicaid program, work with the managed care organizations, partner with research institutions, like Amanda

described, we were able to do to help kind of get startup costs or upfront costs to help physicians and practices understand there is another way of doing and delivering this type of service, but it's got to be funded. It's got to be solvent. Everybody's got to be able to pay your staff and you have to be able to pay yourself if you're in practice. So, one thing that we should all probably focus on a little more is our respective state's Medicaid fee schedules because we have the evidence, we have the tools, one of the issues is it's not funded properly. And so we have to continue to be innovative and reach out and form partnerships to get this done.

In listening to the very early open remarks of Dr. Arora, now that we have a nice agenda to Make America Healthy Again and there's one of the core principles in that is childhood obesity and how we are going to do it. It's incumbent upon all of us to make it happen. There's a saying I like to use sometimes that says, "It takes a long time for something to suddenly happen." Well, we've got the tools, we've got the information, we know how we can do this better, and it's time for us to do it. And it's incumbent upon us to do so. If you think about Dr. Goodman's slide, about 60% of our children are going to be obese by the time they're 35, we can't afford that, not for our species nor for the cost to society. That's not what we're here for. So we can reverse that.

And I'd also encourage everybody to understand, like was pointed out earlier, if you look at childhood obesity as the ultimate chronic disease, it can be prevented. We have tools to do it, so you've got prevention, primary, secondary, tertiary prevention, and you can apply this type of family-based intervention to any disease state, whether it's asthma, diabetes, I'm not an adult doc, but COPD, any of those. And then, lastly, I'd just like to say that it's been fun taking care of patients over the years and helping families help themselves. I'll tell you one quick story and the point of this story is that you never know at what point a child and a family is going to utilize the information that you presented to them and become very successful. I was working out one day on the LSU campus, our university campus. I'm probably 40 and, obviously, the other people on campus are not that age in general in a workout room.

This young lady was in there working out on circuit training, and I kept looking at her and she was looking at me, but I'm not dare going to speak to an 18-year-old at my age unless they speak first. Anyway, long story short, she says, "Dr. Gordon?" I said, "Maggie?" She said, "Yeah." She goes, "How are you?" We gave each other a hug. She hated coming to our program. Her mom told me this story years ago. It was a one-year long program once a week for two hours, and they drove about 60 minutes to get there every Tuesday evening. And her mom told me, she goes, "I'm not going to this fat farm clinic anymore. I can't stand it."

Well, fast forward the clock, she graduated from college, she's a nutritionist. She's hung a shingle in Ireland and practiced this nutrition and wellness and health and is a beautiful young lady that's very healthy. So you've got to keep throwing the starfish back in that ocean, and you have to break down these barriers such that children and families get the information they need. And you never know at what point they are going to be the ones to make themselves successful by giving them the right tools. So time to close the gap between what we know and what we do. Thank you.

Stephanie Reyna:

Thank you so much, Dr. Gordon, and to all of our speakers for your presentations. Now we have a few minutes for some questions and discussion with our speakers. If we could move to the next slide?

Just as a reminder for folks about how you can submit a question using the Slido Q&A, which you'll find at the bottom right corner of your Webex window. And just be sure to click Send after you type it so that we receive it. We have one question that we'd like to start with that I think all of the panelists can address briefly. So we'll see how much time we have. The question is, "What short- and long-term measures do you recommend states use to assess progress in Medicaid-supported childhood obesity initiatives,

particularly when population-level outcomes may take many years to shift?" Would any of our speakers like to take that one or I can facilitate a quick round robin?

Dr. Vishal Arora:

I'm happy to start because this is actually a very relevant question as to like what we are discussing at CMS on, you know, we obviously have the Core Set measures, but, you know, to the point that was made, I mean, some of these outcome measures do take a long time. So, ultimately, we end up relying on process measures. I think what we're doing at CMS is we're actually doing an exercise right now where we're looking at all the existing quality programs that we have in Medicaid and we're trying to figure out which of these are actually aligned with where we want the system to move and where we want states and managed care plans to actually use those metrics, so that we can recommend those moving forward.

And so I think at least that's where we're starting. I will say that we don't have a perfect answer yet on what measures we should be using beyond things like, you know, like BMI, which, again, is like a flawed measure in and of itself. I know that's not a very satisfying answer, but it is just something I wanted to say that we're thinking about even right now very actively at CMS.

Dr. Amanda Staiano:

And I'll agree to that, too. And Dr. Cogle I thought presented some great metrics that Florida's considering. When we work with providers who are new to this, one of the first things we work on is just doing the diagnosis code of obesity. Some commercial plans are hinging their obesity benefits on that child being diagnosed with obesity. And then, step by step, moving towards increasing referrals to IHBLT, for example. And where we want to land is actual reductions of BMI and health improvement and attendance, as well as if we can link to the parent metrics as well since we do often see that the parents are reducing weight, getting off of medications, improving their health, too. But I think it's a step-by-step that we need to set reasonable goals and metrics as we're building capacity, and know where we're headed to, which is ultimately to reduce BMI.

Stephanie Reyna:

Thank you so much. I will move us on to our next question. Our next question is, "What recommendations or advice do you have for those of us working to scale Family Healthy Weight Programs in state Medicaid programs and to encourage managed care organizations to cover them as a value-added service?" I wonder maybe if our Louisiana speakers might want to take that one.

Dr. Stewart Gordon

Sure. Happy to help with that one. I would encourage you to look at your Medicaid fee schedule. And the sad part of Medicaid, at least in some states, is most state's Medicaid fee schedules reimbursement level is below that of Medicare. And, as we've pointed out here today, I do believe, and I think others would agree, that the Medicaid population has a lot more challenges and uphill battles to deal with which makes them a little more challenging to take care of. Many times in healthcare policy, we talk about let's get the Medicaid schedule comparable to Medicare.

Well, I've been starting to suggest that the Medicaid schedule ought to be better than the Medicare schedule because, in my opinion, Medicaid recipients are a little more challenging to care for in the right way in terms of having to figure out ways to address the social determinants of health in the office visit, hiring a social worker to help you do that, the cost of doing business in a Medicaid setting is more expensive. Yet all the states set their own Medicaid rates unlike Medicare that's set at the federal level and

has some variation. So, every four to eight years, the Medicaid schedule is tampered with, if you will, depending on the powers that be.

So funding is a key part of this. I think your managed care organizations can also -- if the funding is available, can work with individual practices and develop value-based contracts that, for that practice, can help reward them for putting together a creative program like we've described today. And so that's one opportunity while you're still working on getting that Medicaid fee schedule to at least 100% of Medicare.

Stephanie Reyna:

Thank you so much, Dr. Gordon. I think, with that, I will close us out. Since we're one minute to the top of the hour, I'm going to hand it over to Kristen Zycherman from CMS to take us through our last slides.

Kristen Zycherman:

Thank you. And I will be quick. I just wanted to point out the CMS Addressing Childhood Obesity Resources on our web page on our Medicaid.gov page. And I think we're going to drop that link into chat so that you can see it. The webinar materials will be coming to this page once they are ready for posting. We also have examples of strategies from states, and also some additional resources from CDC as well as other federal agencies. Next slide, please.

I would encourage you all to please take the survey that will pop up as soon as you exit this webinar. It helps us make better content in the future. So we really appreciate everyone that takes the time to do that. It's just a quick survey. And, if you have any further questions, I encourage you to email us at MedicaidCHIPQI@cms.hhs.gov. I want to thank again our speakers from Louisiana and Florida and the CDC and Dr. Arora from CMS. And thank you all for joining us. We had some great discussion and also a lot of people joining this call. So we appreciate everyone's time. And that's all. Thank you very much.