

Promoting Healthy Weight Management in Medicaid and Children's Health Insurance Program (CHIP) Managed Care Webinar

Recorded September 17, 2026

Carrie Hanlon:

Whether you are joining live or listening to a recording, thank you for participating in this webinar about promoting healthy weight management and Medicaid and CHIP managed care. The agenda will begin with some introductory remarks in context from the Centers for Medicare and Medicaid Services, or CMS. We will then turn to the first of two state spotlights. Kentucky will first share their healthy weight management strategies, and then we will hear from the District of Columbia about their childhood obesity management prevention performance improvement project. As Fiona mentioned, we will have some time for Q&A before CMS provides closing remarks.

With that, I'm very pleased to introduce Vishal Arora, Senior Advisor with CMS. He will provide opening remarks and important context for our focus on healthy weight management and Medicaid and CHIP. Dr. Arora.

Vishal Arora:

Thanks, Carrie. It's great to see many of you on the call for an important topic focused on weight management in the Medicaid and CHIP population. My name is Vishal Arora. I'm a Senior Advisor for the Center Director at CMCS, focused on value-based payment, as well as clinical quality and managed care oversight. So I will frame the conversation for today, and then we'll kind of dive into some of the state-specific and territory-specific examples.

Next slide, please. So I wanted to actually outline two priorities. One is kind of focused on HHS, and one is focused on CMS. As noted in a previous webinar that we've hosted on obesity management, as we kind of think about the Making America Healthy Again agenda, there's really five key areas that have been focused on: disease prevention, chronic disease management, physical activity, nutrition, and then wellness and behavioral health. So today's topic obviously focuses on chronic disease management. We'd love to support and elevate some of the topics that folks are working on within the state Medicaid programs.

Next slide. The other initiative is actually more CMS-specific. And, really, one of the things that we're focusing on right now is about how we can measurably invest dollars in outcomes-oriented measures in the Medicaid program. And, to that end, we've created a Medicaid Quality Pledge, also known as Investing in Health Outcomes. That pledge is focused on four key principles. One is around prioritizing outcome measures over process today and in the future. Two is rationalizing measure inventories, making sure we have the right measures in place that align with prevention, chronic disease management, and behavioral health.

Third is really modernizing our quality measurement enterprise towards digital to actually ensure appropriate exchange of data on outcomes-oriented measures. Finally, aligning financial accountability to those outcomes-oriented measures. So bringing this more tactically to, you know, the example of obesity,

really kind of thinking about what are the key outcomes we're trying to drive towards and when we're thinking about obesity management in Medicaid and CHIP populations. Then, also, once we have those measures, how are we ensuring that we are monitoring those measures appropriately and almost seamlessly with providers and plans? And then, also, how are we aligning financial accountability to drive provider and beneficiary behavior towards improved outcomes?

Next slide. Those are at a high-level, some of the initiatives that are coming out of HHS and CMS. But I want to ground the discussion more on what we're discussing today, which is why focus on healthy weight in Medicaid. As many of the folks on the call recognize, obesity affects both children and adults enrolled in the Medicaid population at disproportionate rates compared to commercial and Medicare. Twenty-five percent of children with Medicaid-only coverage have obesity, and it's up to 40% of the adult population. And, then, as many of you know, those high rates of obesity really can drive severe downstream health consequences for our beneficiaries, including diabetes, heart disease, asthma, as well as pregnancy complications. So the more that we can really go upstream to manage these conditions, ideally, that leads to dividends downstream for our beneficiaries.

Next slide. Now, the other thing is why is there this focus on managed care? And, really, it's become the dominant delivery system in Medicaid and CHIP. It really has now become a key lever for improving obesity management in our populations. Unlike in Medicare where penetration hasn't really broken through as much. Medicaid penetration rates can reach as high as you know 70-80%. And we know that states are partnering with their managed care organizations through contracts, you know, oversight, as well as accountability mechanisms to really drive improvements in obesity management.

These were just some initial remarks about the importance of this topic and how it relates to existing agency priorities. With that, I'll hand it back to Carrie.

Carrie Hanlon:

Thank you, Dr. Arora. As Dr. Arora alluded to, there are several managed care strategies that can collectively influence care delivery and improve outcomes. Those were listed on the previous slide and include targeted managed care contracting; quality assessment and performance improvement, or QAPI, programs; plan and provider incentives; beneficiary incentives; and external quality review organization, or EQRO, partnerships.

And this slide provides a couple of examples of how those managed care strategies can drive improvement in care and in beneficiary outcomes associated with healthy weight management. So here on the left of the slide, to help expand access to nutrition, physical activity, and behavioral interventions, states can use targeted contracting to require their managed care plans to provide, for example, multiple obesity treatment services, services authorized under an approved authority like a state plan or waiver. On the right-hand side of the slide, to strengthen care delivery through screening, counseling, referral, and follow-up, states and plans can use the QAPI performance improvement projects to improve BMI assessment and nutrition and physical activity counseling, for example, by testing new strategies for enrollee outreach, provider training, and enhanced care management.

Next slide, please. Measurement is, of course, critical to these efforts and for advancing healthy weight management. Measurement is a core driver of quality improvement in Medicaid and CHIP managed care and embedded across program design, operation, and oversight. Measures are important because they help

translate priorities like improving nutrition and physical activity into specific expectations in managed care contracts and tie to incentives.

Measures also enable states and plans to identify gaps in performance, target improvement, and track progress over time. And states and plans can stratify measures by factors like age or geography to show where there is variation and then tailor interventions to address the greatest identified gaps. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, also known as WCC, is a key measure in this space. It is included in the Child Core Set and is among the most reported quality measures in Medicaid and CHIP managed care. It assesses whether children and adolescents ages 3 to 17 received appropriate weight assessment and counseling, including BMI percentile documentation. So, with this context, I am going to turn things over to my colleague Kristen Zycherman.

Kristen Zycherman:

Thank you, Carrie. And it is my privilege to introduce our first state highlight, which is Kentucky's Healthy Weight Management Strategies. And I would like to hand it over to Angie Parker and Troy Sutherland from the Kentucky Department for Medicaid Services Division of Quality and Population Health.

Angela Parker:

Thank you, Kristen. Next slide, please. As Kristen mentioned, I am Angie Parker, Director of Quality and Population Health at the Kentucky Department for Medicaid Services. And I have with me Troy Sutherland, who's the Quality Branch Manager within the division. We so appreciate the opportunity to discuss the Commonwealth of Kentucky's Healthy Weight Management Initiatives.

And, as you can see, as far as introductory information about Kentucky Medicaid, there are around 1.4 million Medicaid enrollees, which accounts for approximately one-third of the state's population. 660,000 children are enrolled, which represents over half of the children in the state. There are 440,000 members as part of the expansion population. We have 65,000-plus providers and five managed care organizations, otherwise known as MCOs to us; and they cover nearly 90% of the Medicaid population.

Next slide, please. As one of the seven divisions within the Kentucky Medicaid, the Division of Quality and Population Health focuses primarily on improving the overall health outcomes of Medicaid members. The division has four interconnected branches: Research and Analytics, Quality Branch, Population Health Branch, and the Behavioral Health Innovation Branch. Together, these branches share overlapping responsibilities to ensure quality healthcare and data-driven results.

Next slide, please. So why does Kentucky focus on healthy weight management? I think this slide speaks for itself, unfortunately. The 2023 America's Health Rankings flagged obesity as one of Kentucky's leading health risks, prompting statewide interventions that encompasses more than just the Medicaid population. As CMS stated in their presentation, we know obesity actively worsens other conditions; and Kentucky's top six health risks are interrelated.

Next slide, please. Within our quality strategy, we prioritize a population health focus, evidence-based care, and access to preventive services, specifically targeting childhood physical activity and wellness visits. Aligning with these goals, both metrics are also key components of other programs and initiatives within the Cabinet for Health and Family Services.

Next slide, please. As shown here, our continued quality strategy goals reinforce our unified drive to boost Medicaid health outcomes with value and quality, addressing disparities, and working toward a healthier Kentucky.

Next slide, please. Kentucky has multiple levers to promote healthy weight and addressing rising rates of obesity, diabetes, and other preventable health conditions. They include an MCO value-based payment program, VBP; value-added benefits; the Rural Health Transformation Plan; state directed payments; a weight management performance improvement plan, or PIP; and Our Healthy Kentucky Home. All of these work together to promote healthy weight and improve related preventive care. We will go into detail on the next several slides.

Next slide, please. So, first, our MCO VBP. It started in 2024 with the baseline measurement year of 2022. We withhold 2% of the MCOs' capitated payment. There are six core measures and five bonus measures that fall under the HEDIS framework. The MCOs are to achieve a 3 or 4% improvement on four of the six core measures to be eligible for the bonus pool. It is pass/fail. The bonus pool is funded by pooling the unearned core measures withhold dollars from underperforming MCOs. An MCO that qualifies for the bonus pool has the opportunity to claim withhold funding originally assigned to but left unearned by another health plan. This structure serves as a strategic financial incentive to drive compliance with both core and bonus performance measures.

Next slide, please. In developing the value-based payment framework, we included two child-specific metrics to build a strong foundation for Kentucky's youth, half of whom rely on Medicaid, as I mentioned earlier. First, the Child and Adolescent Well-Care Visits for ages 3 to 21 as a core measure tracks height, weight, and body mass index. Second, the Weight Assessment and Counseling is a bonus measure evaluating BMI assessments, alongside nutrition and physical activity counseling. Because parents or caregivers typically accompany children to their appointment, prioritizing these youth-focused measures encourages healthy lifestyle habits for the entire family.

Next slide, please. So we have our first-year results for calendar year 2024. Every health plan hit the target for well-child care visits. Also, four of the five met the weight assessment and counseling goal, averaging 5.47% improvement. As the VBP is based on HEDIS measures, we do not yet have the 2025 VBP results. We do expect to have these results very soon, and we expect to see even better improvement.

Next slide, please. This slide outlines Kentucky State University Hospital and Provider Directed Payment Program. The universities are the University of Kentucky and the University of Louisville. The providers have to meet or exceed quality measures in order to receive additional funds. This initiative directly aligns with their overall quality strategy and value-based payment program, including weight management measures.

For calendar year 2024, the Adult BMI Screening and Follow-up measure, the target threshold was 71.4%. But the result was 95.3%, a significant increase over the baseline. For calendar year 2025, the BMI Screening and Follow-up for ages 12 to 17 measure was introduced with establishing a target threshold of 90.4%, and we are in the process of evaluating 2025 results. We expect it to be just as well as the adult screening. We also required Well-child Care visits as a mandatory reporting measure via the Direct Payment Program.

Next slide, please. Value-added benefits, also known as VAB, these are benefits that are extra services provided by managed care organizations that exceed standard state-required Medicaid coverage in the areas of nutrition and weight management. MCOs offer resources such as post-hospitalization tailored meals or home-delivered meals for certain conditions, gym memberships, and Weight Watchers enrollment. However, current utilization rates remain below expectations. A major barrier is access. In some cases, members must actively enroll in a care management program to be eligible for these benefits. Also, depending on the benefit, the enrollee may have to request the benefit through the MCO app, which can also be a barrier. To resolve this, we are collaborating with MCOs to streamline access and enhance utilization reporting. For the next several slides, Troy will address. Troy.

Troy Sutherland:

Thank you, Angie. Good afternoon, everyone. I'm Troy Sutherland, the Quality Branch Manager in the Division of Quality and Population Health here at the Kentucky Department for Medicaid Services (or KDMS). I'm going to briefly discuss the weight management performance improvement project (or PIP) that was conducted. According to a study performed by the National Institutes of Health, long-term foster care in general may be a risk factor for obesity. Furthermore, researchers found that obesity rates were higher than that of children when they initially entered foster care, indicating an increase in rates after entering foster care.

After detailed analysis of the internal Supporting Kentucky Youth, or SKY, data, overweight and obesity emerged as a significant area of concern. Evaluation of claims data revealed that, in the first quarter of that year, of the 25,000 foster children in Kentucky, nearly 1,000 SKY members had a claim with an ICD-10 code that would categorize them as high risk. The objective of the PIP, which was initially just focused on the SKY population in one MCO, was to improve weight assessment, counseling for nutrition and physical activity, and referrals for overweight and obesity management in children and adolescents in the SKY Program. PIP interventions were designed to effectively address the main barriers identified among the SKY population.

Other objectives of the SKY PIP included educating providers, foster parents, guardians, and caregivers regarding evidence-based guidelines for weight management and tips for healthier eating and physical activity. Additional objectives of the SKY PIP include creating gap and care reports for providers and the Department for Community-Based Services (DCBS) staff developing a plan of care for each SKY enrollee with overweight or obese status in collaboration with external stakeholders.

Next slide, please. As you can see from the slide results, three of the six PIP intervention goals were met. And considering the new-to-us approach of the PIP, with the necessity of interagency cooperation between KDMS, the MCOs, and DCBS, we felt like these were results that could be expanded and improved upon. A goal that we made was to strengthen the cooperation in improving that process moving forward, which was an important step in sustainability. One important piece that has been improved upon is the expansion of care members from the MCO that have direct contact with appropriate DCBS staff. This has supported coordination and has reduced duplication of services, and I believe that this has had an impact on the populations that did not meet the initial performance targets.

Next slide, please. After the PIP's conclusion in 2022, we felt like that there was an opportunity to expand that weight management focus to all of our MCOs. To do that, we made weight management a part of our value-based payment program; and, as highlighted by this slide, we continue to make progress with this

performance measure over the years and believe that it will continue to improve. And, with that, I will turn it back over to Angie. Thank you, everyone.

Angela Parker:

Thank you, Troy. Next slide, please. So Kentucky's Rural Health Transformation Plan. I'm sure you all heard of this, but Kentucky was awarded \$212.9 million in budget year one. The CMS-funded initiative is designed to improve access, quality, and outcomes of healthcare in rural Kentucky. CMS disburses funds annually based on achievement of performance metrics. Kentucky has launched five interrelated initiatives that support Kentucky's rural counties. Kentucky has 120 counties, and 85 of which are classified as rural. If you would like to see additional information regarding our Rural Health Transformation Plan, there is a link available.

Next slide. So, while there are five initiatives, the first one addresses obesity and diabetes prevention and management. This initiative funds statewide hubs that combine local leadership with state coordination. These hubs are empowered to develop and implement tailored interventions or programs addressing two critical chronic conditions: diabetes and obesity. The hubs will integrate nutrition, physical activity programs, and digital self-management tools.

Next slide, please. And last but not least, Our Healthy Kentucky Home. It is led by the Kentucky Department for Public Health. It is a statewide initiative addressing multiple health priorities. The Kentucky Department for Medicaid Services hosts a monthly Medicaid meeting accessible to the public that includes various topics. Our Medicaid director presents each month on the Healthy Kentucky Home Health Focus. The spotlight in September happens to be obesity awareness and prevention by providing resources for healthy habits and physical activity. But, unfortunately, you have missed this month's meeting, as it was earlier today.

This brings me to the end of the Kentucky presentation. However, it is not the end of working to improve our health rankings and to promote and invest in healthy weight management. This is and will continue to be a focus for the Commonwealth of Kentucky. I thank you for your time, and I will send it back to Kristen.

Kristen Zycherman:

Thank you so much, Angie. I am going to introduce our next state highlight. Next slide, please. The District of Columbia's childhood obesity management and prevention PIP. And I would like to introduce Araceli Simbulan and Tobi Oni with the DC Department of Health Care Finance; and Dr. Paul Manicone, Dr. Eric Levey, and Abel Tadesse with the Health Services for Children with Special Needs health plan. Take it away.

Araceli Simbulan:

Thank you, Kristen. Good afternoon, everyone. My name is Araceli from the District of Columbia Department of Health Care Finance, and we are excited for the opportunity to present to you this afternoon. DC Medicaid in collaboration with our managed care plan partner, Health Services for Children with Special Needs (HSCSN), will present on our childhood obesity management and prevention performance improvement project (or PIP). I will kick it off with a brief overview of the District's managed care program, and my colleagues will take turns in presenting.

Next slide, please. The goal of the District of Columbia's Medicaid program overall is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for District residents. To achieve this goal, the Department of Health Care Finance administers multiple managed care programs, which include the DC Healthy Families Program and the Child and Adolescent Supplemental Security Income Program, or CASSIP, via our managed care organizations. Approximately 205,000 Medicaid beneficiaries are enrolled in managed care in the District, and over 5,000 are enrolled under the CASSIP program where this PIP resides. My colleague Tobi Oni will provide some context on our CASSIP program on the next slide. Tobi.

Oluwatobi Oni:

Thank you, Araceli. Next slide, please. Thank you, everyone. My name is Tobi Oni, and I'm the Contract Administrator for the CASSIP program here in the District of Columbia. So we will be talking more about the CASSIP program, which is one of our Medicaid programs here in the District. The CASSIP program, like Araceli stated, is the Child and Adolescent Supplemental Security Income Program. And this program is dedicated to vulnerable enrollees, the children with special healthcare needs in the District. The program is designed to cater to children from the ages 0 to 20. However, enrollees that are in the program prior to turning 21 are allowed to stay in the program up until the age of 26 years old.

The program goal and services are designed to cater to our special needs population within the children group. Enrollees with Social Security Income benefits are eligible for the program, as well as our enrollees with intellectual disabilities. The District also has the capability to enroll enrollees into the program through a referral process through our QIO, or Quality Improvement Organization, that assesses the enrollees' eligibility needs using the SSA Bluebook. Like I stated earlier on, eligibility for this program is focused and targeted to children ages 0 to 21 with the goal of ensuring that we can create a focused program for this population to ensure that their healthcare needs are being met.

Our current managed care organization awarded this contract is HSCSN, and they are here with us today. And they will be presenting more about the program that we have in place, focusing on childhood obesity. I'll hand it over to HSCSN. Take it away.

Paul Manicone:

Thanks, Tobi. My name is Paul Manicone, and I serve as the Chief Quality Officer for HSCSN. You can advance to the next slide, please. So, given that HSCSN enrollees are children and young adults with chronic conditions, we're really in a unique position to address a weight management strategy that can not only address obesity but also prevent the onset and subsequent complications of obesity, such as type 2 diabetes, if we can intervene early. Using our population health analytics, we saw not only high prevalence of obesity but also high rates of associated comorbidities such as autism spectrum disorder, developmental disabilities, depression, and asthma. So, collectively, we see this as a high-impact endeavor.

Next slide. The PIP is designed to improve access and screening, access to their primary care provider, screening for BMI, and counseling for nutrition and physical activity. It's a critical first step in the care delivery continuum, which can then allow enrollees to access specialized services for weight management. And we take a broad approach to optimizing this first step through a number of

interventions shown here. And I'll turn it over to my colleague, Dr. Levey, who will go into this in more detail. Dr. Levey.

Eric Levey:

Thanks, Paul. Hi, good afternoon. This is Eric Levey, Chief Medical Officer at HSCSN. I'm discussing our engagement of enrollees and caregivers. Next slide, please. So our EPSDT Outreach team does systematic phone outreach to all enrollees starting 30 days prior to the due date for their well-care visit, and they assist enrollees and caregivers with scheduling the well visits and arranging transportation. And, once they've completed a well visit, enrollees receive a \$25 incentive gift card, which they can use at a variety of stores.

Every enrollee also has a care manager. The care managers work closely with primary care practices to get enrollees in for well visits, which drives screening and preventive services, including weight assessment and counseling for nutrition and physical activity. Care managers also do outreach about every 60 days. They do face-to-face assessments one, two, or three times per year based on the acuity level of the enrollee. And they include well visits in their family education and in the care plans that they develop with them.

Our Communications team sends annual birthday letters to enrollees, which remind them of well-child visits but also of immunizations and other screenings and preventive services done during those visits. Our newsletter also features the importance of well visits and preventive services, and our Communications team also sends out periodic text messages on a variety of topics including the importance of well visits.

We have a Community Outreach team that holds multiple events over the course of the year, which prominently feature the need for well-child visits. And, this Saturday we're having our Back to School Bash. So, if any of you are in D.C. this weekend, feel free to come by. We have a Children's National Mobile Van. We're owned by Children's National Hospital, and we partner with them frequently. They see about 60% of our children. And the Children's National Mobile Van is one way that we can bring primary care services into underserved neighborhoods. And they typically do this about eight times per year on our behalf, and we work closely with them to get underserved children in for care. And next we have Abel Tadesse, who's going to talk about our outcomes.

Abel Tadesse:

Thank you, Dr. Levey. Next slide, please. All right. My name is Abel Tadesse. I'm Director of Quality and Accreditation, and this is one of my favorite slides to present the results that we have seen for our performance improvement project (or PIP). The project actually started in 2021, and we have here displayed three years of data showing how we're progressing on these rates that we monitor specifically on BMI percentile, counseling for nutrition, counseling for physical activity, and then child and adolescent well-care visits.

Overall, with the exception of the BMI percentile, we have seen a significant positive improvement. And going back, even though it's not displayed here, going back to measurement year 2021, the rates were in the high 70s on majority of them, with the exception of well-child visits (or WCV). But we are seeing positive trends. As Dr. Levey and Dr. Manicone described, our interventions touch different approaches

to make sure that we are addressing enrollee, provider, and health plan barriers as we move along. The application of continuous quality improvement is something that we really push within HSCSN. What this means is identifying and putting in place a root cause analysis to identify barriers and then also closely monitor data as much as possible to make sure that the data are actually going through quality checks as well.

We also discuss and evaluate the results in a Quality Improvement (QI) Workgroup that meets monthly. This is led by myself, as well as my staff from Quality Management, and we bring in different teams from Utilization Management (UM)/ Care Management, Medical Affairs, Pharmacy, Customer Service, EPSDT. We sit around and monitor the trends of data but then also hear from the teams to make sure that there are no identified new barriers. If there is one, then we discuss it and do root cause analysis to make sure that there are no surprises that can impact us down the road, especially focusing on our stakeholders, our enrollees primarily but then also providers and our health plan staff. That basically summarizes the proactive design and implementation of our initiatives.

Next slide, please. All right. So, just to give you a summary of our lessons learned and next steps, what we learned is really the importance of identifying barriers impacting three areas: enrollees, providers and practitioners, and our managed care plan staff. You know, these can be different things: enrollee unable to get appointment, practitioner not having enough staff in their office, or open slots or providers not having access to translation services. These are examples, not necessarily true barriers that we identified. But then also managed care health plan side, what are the barriers? Are there resource restrictions? Is our data being vetted and validated within our health plan?

So we look at all aspects that can possibly impact our enrollees and then our rates. We also engage with internal and external stakeholders. This is not limited to enrollees and practitioners but then also our stakeholders from our DHCF partners or any other external stakeholders, such as our HEDIS vendor. We meet with them every month to go through our HEDIS performance tracks as well. And then interventions, really, what we plan to do is it's not a single intervention that we want to place, rather, multiple, as Dr. Levey explained in prior slides. And next steps that we can recommend to other plans that want to follow the same footsteps is really understand the population. Review survey and feedback and take action on those. That's very important.

We administer various types of satisfaction surveys to our enrollees and also to our providers. And we take those to committees and subcommittees and then talk about them. What are we doing to improve those type of feedback? We do complete analysis of population health assessment. We actually did a significant facelift of the population health assessment and gave us a true identity of our enrollees. What are the gaps? And then we drilled down to the age breakout groups, not necessarily total HEDIS rates rather than, at a high level, we try to dive into and understand any type of health disparity that we may be able to identify.

Again, assess provider engagement and create a clear feedback loop. What this means is, basically, I'm sure many of you from the health plan side distribute care gap reports. But follow up with the provider group to make sure that they did understand the care gap report that is being delivered. Also, ask if they have identified any issues with the care gap report. That way we can do an investigation on our side and then see if the care gap reports need some type of enhancement. Again, that's just an example that we are currently looking into.

And then reassess interventions post-implementation. I'm sure many of you know if you're a quality leader or a quality team, continuous quality improvement is very important. Plan-Do-Study-Act, or PDSA, is something that we implement and educate our staff on an ongoing basis. If an intervention is working, we leave it alone. But if there is a new intervention that we believe is not bringing positive impact, we go back to the drawing board and then look at it and make sure that it is making sense to our enrollees, not necessarily the health plan. But I'll turn it back to Kristen.

Kristen Zycherman:

Thank you so much. And I am going to pass it on to Stephanie Reyna from Mathematica to facilitate our Q&A.

Stephanie Reyna:

Thank you, Kristen. And thank you to all of our speakers. We can move ahead to the next slide. So, just as a reminder, you can submit your questions through the Slido Q&A function, which some of you already have; we've been seeing questions come through, which is great. To access the Q&A, click on the Slido panel in the lower right corner of your screen to open it up. And you should see that Q&A box where you can type your question. And please make sure to hit Send.

I'm going to start us off with a question for the Kentucky team. So the question is: Kentucky is using several complementary approaches: value-based payment, state directed payments, value-added benefits, and a PIP. What have you learned about how those levers can reinforce one another?

Troy Sutherland:

This is Troy Sutherland with Kentucky, and I'll take that one. I think that, at least initially, and as we've worked within the program, we've learned that the potential loss of revenue is a really great motivator for the MCOs. We've also emphasized weight management in many different ways, and I think that communicates the urgency and focus that we have on this. And I think that we've taken away from the process that the MCOs are eager to do well. They're competitive, and they can develop strategies that work. And I think that we've also learned that using the levers in isolation can create fragmented care with misaligned incentives.

Stephanie Reyna:

Thank you, Troy. Angie, anything that you'd like to add to that before we move on?

Angela Parker:

I think Troy covered it pretty well. We trying to include everything and any program we can that involves weight management or obesity strategies to combat it.

Stephanie Reyna:

Thanks, Angie. I'm going to move us to a question for the District. So the question is, could you share the specific barriers that were identified during the PIP and strategies that you employed to address them?

Abel Tadesse:

All right. I'll take this one. This is Abel Tadesse from HSCSN. Barriers. There's quite a few, but I'll focus on a few. And I'll start with, the topic I'm around looking at our barriers in three lenses. One is MCP, the managed care plan; the other one is provider; and the third one is enrollee. So, starting with MCP, one of the things that we continue to see is the care gap reports. The care gap reports are really dependent on claims and encounter data we usually look at. So we always have care gap reports that we distribute.

But, as we distribute it and send it out to the providers, again, we started getting more engagement and feedback, although we haven't received strong feedback on the care gap reports from our provider networks. There is definitely a barrier where providers may have changed, enrollees may have changed PCPs, or provider may no longer be in a location. So definitely understanding the data from that lens has been identified.

Moving on to the enrollee barriers, there's always challenges, such as being unable to reach the enrollee on time. Trying to find a time that works to enrollee. Provider offices typically are open from 8 am to 6 pm. But is there opportunity to explore weekend hours. So we're doing a pilot that started last year: a Saturday clinic day. That had a positive response that we've received from our enrollees.

And then I think the provider/practitioner barrier is that, I don't believe we have a strong relationship or strong engagement with the provider network. So building that relationship going forward, to even have someone to pick up the phone and say, you know, let me call Abel with any specific questions from the provider side is something that we want to build. So provider engagement; data accuracy and completeness on care gap reports; and then from the enrollee side, unable to reach them and finding times that fit their need for appointments and scheduling might be the three barriers I can touch on.

Stephanie Reyna:

Thank you, Abel. And I think tying into the theme of barriers nicely is this next question, which is—and I think it could go to both the District and Kentucky. Do your managed care plans provide transportation to services like healthy weight management programs, gyms, or Weight Watchers meetings?

Angela Parker:

Well, the MCOs do offer transportation to physician visits. You we have non-emergency medical transportation available as well. So I would say, in some instances, yes. That is a benefit that they could ask for and probably is promoted. I believe each MCO has its own type of obesity program. They do encourage the utilization of those benefits. But, as I said earlier, they're not probably utilized enough.

Oluwatobi Oni:

Hi. This is Tobi. And that's the same on our end. All our MCOs provide transportation services for non-medical emergency transportation-related needs. In addition to that, our MCOs also have wellness centers. And each of them has a value-added benefit that they provide around weight loss and obesity. And they offer services like training and education around healthy weight management and healthy eating habits. And, through their wellness center program, they offer transportation, as well, to specific programs within their wellness center. And that's another way they've encouraged enrollees to attend by limiting the barrier around transportation.

Stephanie Reyna:

Thank you, Tobi. My next question is about care management. I think this could go to both teams as well. But, through your work, have there been any strategies that care management has tried that have been effective in reaching beneficiaries?

Oluwatobi Oni:

So this is Tobi again from DC. One of the things that is unique with our CASSIP program is that the program is actually designed to provide case management services for all enrollees in the program. And, actually, the case management service is one of the requirements, meaning it's not optional. So each enrollee is required to participate in case management services. That's one of the conditions for participating in the program. So, as a result, we've been able to provide targeted support to each individual enrollee within the program. And that's also helped with care coordination services, which is one of the primary goals of the case management services.

Angela Parker:

So I could say that each of the MCOs is required to do a health risk assessment. And some of those questions would be to evaluate, whether it's adult or child, if there are conditions that affect their overall health. And if obesity or healthy weight management or any other social determinants of health, that they, you know, have access to food problems would be part of their care management program. I think we've all seen this with MCOs offering a program, but getting members to participate is another issue. So there are those challenges that we see. We have the program, but will enrollees participate? So that's probably part of why we have all these measures in different areas so that we can continue to push the narrative and educate where we can.

Stephanie Reyna:

Thank you, Angie, and Tobi. I'm going to move us on to another question for the Kentucky team. The question is your WCC, which is Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measure, your WCC performance continued to improve after the weight management PIP ended. What do you think helped sustain that progress?

Troy Sutherland:

So this is Troy again. I think one of the good things about this process and really built a foundation is that we started one MCO with a weight management PIP, which really allowed us to learn best practices. And then, subsequently, we could apply that to the other plans. I think it also highlighted the need to continue this course of evaluating and establishing ongoing weight management metrics into our programs, and I think that really has led to sustainability.

Stephanie Reyna:

Thank you, Troy. And I have another question for the District. Can you share an example of how data or feedback led you to adjust an intervention or approach.

Abel Tadesse:

Hi. This is Abel again. So data, I think I kind of touched this one. I'm going to go back to the same example that I provided on care gap reports. Again, care gap reports, due to claims lag, or changes in practitioner provider office locations, or enrollee changing or preferring specific provider, those things are really the feedback loop that we're exploring to make sure that our care gap reports are important. So care gap distribution is what I can classify as an intervention, care gap report being distributed to the provider's office.

One of the things that we did through our HEDIS manager starting maybe October or prior of last year, 2025, is, instead of just distributing care gap reports through a either email channel or dashboard online, what we have started to do is identify specific providers or practice groups, especially the small ones. And then the HEDIS manager, in collaboration with the provider relations rep, is actually going to the office and sitting with the office rep to walk through a specific list of care gaps. This includes making sure that the office manager understands the HEDIS specs, the guidelines, the tables, the columns, the rows, what is really important about the compliance date. Those are the things that we want to really focus on and then get feedback. So far, we have received positive feedback, and we plan to continue and expand that function within our quality department.

Stephanie Reyna:

Thank you, Abel. We did get a couple of questions about materials after the session. So, as a reminder, the slides and recording will be posted to Medicaid.gov in the coming weeks. And all registrants will receive an email when those materials become available. So thank you so much to our speakers. I'm going to close this out with one more question that can go to both teams. Looking back, what is one thing you wish you had known when you started this work? Kentucky, I'll hand it to you first.

Troy Sutherland:

Hi. This is Troy again. I think one of the biggest thing that we wish we had known was the focus on provider education and how important that would turn out to be. And it was a barrier earlier on and could have been emphasized a little bit better. We really want to look at leveraging multiple initiatives inside and outside of Medicaid to build a healthier state. And, really, as always, I think we say this a lot but it's a marathon and not a sprint. You know, it's a process. And it's just important to develop it, develop it, you know, and stick with it.

Abel Tadesse:

And, for HSCSN, and I can comment. I couldn't agree more with Troy's comment about provider engagement and provider education, because HEDIS technical specifications are a long, big book. But, when you provide that and try to align our approach and strategy with the provider's busy office, it gets a little bit complicated. So I couldn't agree more with that item.

But the other thing, I personally wish I knew, or we wish we knew, more about how enrollees truly feel about all these activities and engagement efforts and if there is a true driver or feedback that we can get from a majority of enrollees. Not surveys because, you know, if you have 10 interventions or 5 interventions, it may not apply to majority of enrollees. So it's good to really understand and hear the perspective of our enrollees to make sure that what we design and implement truly impacts 100% of our

enrollees. I know this is not realistic, but it would be nice. But that's a challenge that we continue to work on to make sure at least majority of enrollees will benefit from the activities that we do. .

Stephanie Reyna:

Thank you, Abel. I'll just pause for a moment to see if anyone else on the panel would like to share a reflection.

Oluwatobi Oni:

Hi. This is Tobi. I think one other thing to share would be the issue of unable to contact, ensuring that our MCOs have the right and the correct address and contact information. And one of the things that we've leveraged is the CRISP (a health information exchange) system. And that has enabled us to do data exchange more effectively, which enables our providers within the community as well as the hospital and the MCOs to use the same platform where they can actually go and get real-time data that reflect the most up-to-date information rather than depending on the information that we have from eligibility, which we all know most of the time is outdated based on the last time they recertified their Medicaid application.

Stephanie Reyna:

Thank you, Tobi. That is a great point, and I think we'll leave it there. Thank you so much to our panel and to our audience for your questions, and I will hand it back over to Kristen from CMS to close us out.

Kristen Zyberman:

Thanks, Stephanie. I want to give you a little visual here of our revamped promoting healthy weight management web page. Apologies, it is in the same location that our childhood obesity one was. So further down the page you will still be able to see those resources and that webinar, as well, the slides and recording of this webinar. So that'll be coming soon. Additionally, we have some new QI materials on there: state strategies to improve nutrition, physical activity, and obesity prevention in Medicaid and CHIP, a strategies brief, as well as a measure table for tracking healthy weight management outcomes.

So we encourage you to go there to look at those. And we would love to get any feedback you have, any questions you have, whether it be obesity-related, weight management-related, nutrition and physical activity-related, or any other quality improvement-related topic. We have a quality improvement mailbox, that and we encourage you to reach out to MedicaidCHIPQI@cms.hhs.gov. I want to thank all of our speakers again, as well as all of our attendees. Thank you for taking time out to listen to our webinar today, and we will see you next time. Thank you very much.