Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

MEASURE SLATE

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Measuring and Monitoring Progress in Healthy Weight Management in Medicaid and CHIP Managed Care

Obesity is a major driver of poor health outcomes and health care costs in the United States.[1] Rates are particularly high among individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP): approximately 25 percent of children and 40 percent of adult Medicaid beneficiaries have obesity.[2,3] Addressing obesity and its underlying drivers through healthy weight management is critical to improving long-term outcomes.

As most Medicaid and CHIP beneficiaries are enrolled in managed care,[4] states have a key opportunity to advance healthy weight management through managed care plan (MCP) contracts, oversight, accountability mechanisms, and quality improvement (QI) activities. Measurement plays a central role in these efforts by enabling states and MCPs to assess performance, monitor access to and use of services, identify gaps in care, and evaluate whether interventions improve outcomes over time.

Using Measures to Support Healthy Weight Management

In Medicaid and CHIP managed care, measures translate state priorities- such as improved nutrition, physical activity, and obesity prevention- into concrete expectations. They inform how QI activities are structured and executed, including defining performance expectations in MCP contracts, tying MCP and provider payment to performance, guiding Quality Assurance and Performance Improvement (QAPI) activities, targeting and evaluating beneficiary incentive programs, and informing External Quality Review Organization (EQRO) activities.

Measures also support ongoing oversight and accountability by enabling states to consistently assess performance across MCPs, identify variation in implementation, and track progress over time. In this way, measurement serves as a key mechanism for aligning state priorities, managed care operations, and improvement efforts to drive meaningful and sustained outcomes for beneficiaries.

State Strategies to Improve Healthy Weight Management in Medicaid and CHIP Managed Care

The Centers for Medicare & Medicaid Services (CMS) has identified a set of state strategies to improve healthy weight management in Medicaid and CHIP managed care. These strategies provide additional detail and examples of how states can design and implement approaches to support improved nutrition, physical activity, and obesity prevention. This brief is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-healthy-weight-management.pdf.

The measures shared in **Table 1** of this brief can be used to support implementation of these strategies and to monitor progress over time.

[1] https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html.

[2] https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html.

[3] https://www.macpac.gov/wp-content/uploads/2022/12/MACSTATS_Dec2022_WEB-508.pdf

[4] https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/

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Measure Slate for Healthy Weight Management

Table 1 (next page) presents an example measure slate that states, MCPs, and EQROs can use to select measures to support the design, implementation, and evaluation of strategies to promote healthy weight management.

The measure slate is organized to reflect key stages of the care continuum, including:

- identifying individuals at risk,
- delivering and supporting engagement in services, and
- assessing health outcomes, while also monitoring potential effects on system capacity and beneficiary experience.

Using a combination of measures across these areas enables states and MCPs to assess performance at multiple points along the continuum. Within a given strategy (e.g., a performance improvement project [PIP]), applying multiple measures provides a more complete view of implementation and impact. Aligning measures across managed care strategies (e.g., MCP contracts, QAPI activities, and incentives) is also critical. This alignment helps reinforce priorities, promote consistency in how performance is assessed, and support ongoing monitoring and improvement over time.

The CMS quality programs are moving towards use of digital quality measures (dQMs). dQMs are designed to reduce administrative burden and costs, minimize manual data entry and interpretation errors, and support more timely quality assessments by enabling automated, standardized analysis of data from electronic sources. Many of the measures listed in the table below have digital specifications and/or rely on data drawn from electronic sources. CMS encourages states, MCPs, providers, and other partners to build the capacity to collect and report dQMs.

For More Information

CMS provides technical assistance (TA) to state Medicaid and CHIP programs and their partners to strengthen managed care quality.

Learn more about managed care QI in Medicaid and CHIP at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/managed-care-quality-improvement.

For TA, please contact ManagedCareQuality@cms.hhs.gov.

Table 1. Example Measure Slate to Advance and Monitor Healthy Weight Management Strategies in Medicaid and CHIP Managed Care

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
Screening and Risk Identification Measures			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	**Numerator:** Unduplicated number of enrolled children ages 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile • Counseling for nutrition • Counseling for physical activity **Denominator:** Children ages 3 to 17 who had an outpatient visit as of December 31 of the measurement year.	Administrative, hybrid, EHR	**Measure Steward:** NCQA. **Notes:** • Mandatory Child Core Set measure, which reports two stratified rates (Ages 3 to 11 and Ages 12 to 17) and a total rate. • Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value. • Some states have adapted this measure to support more frequent (e.g., monthly) monitoring. These adaptations often simplify the specification by assessing BMI documentation, nutrition counseling, and/or physical activity counseling within the measurement period only, rather than including a prior-year lookback. For states adapting the measure for QI monitoring, consider reporting lag times to allow time for claims to be submitted and processed. The following provides an example of monthly reporting of this measure with a 3-month lag time: On April 1, run nutrition and physical activity counseling rates for all beneficiaries in January. On May 1, run rates for all beneficiaries in February. **Spotlight:** WCC is commonly used by states in QAPI programs. For examples, see EQR Table 3 (Performance Measures) and EQR Table 6 (PIPs). States such as Alabama have also incorporated this measure into managed care quality frameworks, setting improvement targets for ongoing monitoring and accountability.

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
Adult BMI Assessment (ABA)	**Numerator:** Unduplicated number of adults ages 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year. **Denominator:** Adults ages 18 to 74 who had an outpatient visit during the measurement year or the year prior to the measurement year.	Administrative, EHR	**Measure Steward:** NCQA **Notes:** • This measure assesses whether BMI is documented, rather than evaluating BMI value or weight status. • For QI or more frequent monitoring, some states may adapt this measure to assess BMI documentation within the measurement period only. In these cases, a reporting lag (e.g., 2–3 months) may be applied to allow time for claims submission and processing.
Child and Adolescent Well-Care Visits (WCV)	**Numerator:** Unduplicated number of children and adolescents ages 3 to 21 who had at least one well-care visit with a PCP or OB/GYN practitioner during the measurement year. **Denominator:** Children and adolescents ages 3 to 21 during the measurement year.	Administrative	**Measure Steward:** NCQA **Notes:** • Mandatory Child Core Set measure. • This measure captures receipt of annual preventive care visits, which serve as key opportunities for screening, risk identification, and counseling. • While the measure does not directly assess specific healthy weight management screenings, well-care visits are the primary setting for services such as BMI assessment, and nutrition and physical activity counseling. • Some states have used this measure as a proxy for healthy weight management screenings to support more real-time monitoring. For more information, see the Texas Medicaid QAPI example included in "Promoting Healthy Weight Management in Medicaid and CHIP Managed Care" brief.
Service Delivery and Engagement			
Referral to Healthy Weight Management Services	**Numerator:** Unduplicated number of beneficiaries identified as eligible for healthy weight management services (e.g., BMI ≥85th percentile for children or BMI ≥25/30 for adults) who received a referral for nutrition, physical activity, or weight management services during the measurement period. **Denominator:** Beneficiaries identified as eligible for healthy weight management services during the measurement period.	Administrative, EHR, care management systems	**Measure Steward:** N/A **Notes:** • This measure captures whether beneficiaries identified as at risk are connected to appropriate services. • Referrals may include nutrition counseling, intensive behavioral therapy, DPP, FHWP, medically tailored meals, or other community-based services.

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
Referral Completion / Service Initiation Rate	**Numerator:** Unduplicated number of beneficiaries who received a referral for healthy weight management services and initiated at least one referred service during the measurement period. **Denominator:** Beneficiaries who received a referral for healthy weight management services during the measurement period.	Administrative, care management systems, CBO partner data	**Measure Steward:** N/A **Notes:** • This measure assesses whether referred beneficiaries successfully connect to services. It can help identify breakdowns between referral and engagement (e.g., access barriers, follow-up gaps).
Healthy Weight Management Outreach Calls	**Numerator:** Unduplicated number of eligible beneficiaries who received an outreach call to schedule healthy weight management services during the measurement period. **Denominator:** Beneficiaries eligible for healthy weight management services during the measurement period.	Care management systems, MCP/provider/partner - maintained tracking logs	**Measure Steward:** N/A **Notes:** • This measure tracks outreach calls made by MCPs, provider practices, or other sites. Outreach calls are intended to encourage scheduling of healthy weight management services for eligible beneficiaries who do not already have an appointment scheduled. • Beneficiary eligibility will vary by program; for example, CDC-Recognized Family Healthy Weight Programs are intended for children ages 2 to 18 with a BMI at or above the 85th percentile. • Depending on the organization conducting outreach, outreach call activity may be tracked through existing care management or outreach systems or may require the development of new tracking mechanisms. • Although this measure refers to “calls,” outreach may be conducted through other contact methods (for example, text messages or emails).

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
Healthy Weight Management Service Attendance After Outreach Calls	**Numerator:** Unduplicated number of eligible beneficiaries with a completed weight management service after an outreach call during the measurement period. **Denominator:** Beneficiaries who received an outreach call to schedule healthy weight management services during the measurement period.	Administrative, care management systems, MCP/provider/partner - maintained tracking logs	**Measure Steward:** N/A **Notes:** • This measure tracks attendance at weight management services after outreach calls from MCPs, practices, or other sites. It assesses whether outreach efforts result in service uptake. • Depending on the organization conducting outreach, call activity may be tracked through existing care management or outreach systems or may require the development of new tracking mechanisms. • Although this measure refers to "calls," outreach may be conducted through other contact methods (for example, text messages or emails). **Spotlight:** MCPs commonly use outreach (for example, phone calls, text messages, or other reminders) as part of PIPs or other QI initiatives to increase engagement in healthy weight management services. For an example, see the DC Medicaid QAPI example in the "Promoting Healthy Weight Management in Medicaid and CHIP Managed Care" brief. Measures like this are critical because they provide timely insight into whether outreach strategies are effective, allowing states and MCPs to quickly identify and adjust approaches that are not working or are underperforming.
Participation in Healthy Weight Management Programs	**Numerator:** Unduplicated number of eligible beneficiaries who participated in a healthy weight management program during the measurement period. **Denominator:** Number of eligible beneficiaries during the measurement period	Administrative, care management systems, MCP/provider/partner - maintained tracking logs	**Measure Steward:** N/A **Notes:** • This measure tracks participation in plan-sponsored wellness programs (such as DPP, FHWP, healthy lifestyle coaching). • Beneficiary eligibility requirements and the definition for "participation" (for example, attending a specified number of sessions during the measurement period) will vary by program.

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
Health Outcomes			
Childhood Obesity Prevalence	**Numerator:** Unduplicated number of children ages 2 to 19 with a documented BMI ≥95th percentile for age and sex in the measurement year. **Denominator:** Children ages 2 to 19 in the measurement year.	Administrative, EHR	**Measure Steward:** N/A **Notes:** • The CDC defines obesity for children ages 2 to 19 as having a BMI at or above the 95th percentile for age and sex. **Spotlight:** Some states use Medicaid claims and encounter data to calculate obesity prevalence among beneficiaries and track trends over time. For example, Louisiana Medicaid reports obesity prevalence using managed care data and requires plans to develop action plans to address identified trends.
Adult Obesity Prevalence	**Numerator:** Unduplicated number of adults age 20 and older with a documented BMI ≥30 in the measurement year. **Denominator:** Adults age 20 and older in the measurement year.	Administrative, EHR	**Measure Steward:** N/A **Notes:** • The CDC defines obesity for adults 20 years and older as having a BMI at or above 30. For adults, BMI categories are based on a person's BMI regardless of age, sex, or race. • Obesity is further divided into three classes: – Class 1: 0 to less than 35 – Class 2: 35 to less than 40 – Class 3 (severe): 40 or greater
Hypertension Control Among Members Receiving Healthy Lifestyle Counseling	**Numerator:** Unduplicated number of adults age 18 and older who had a diagnosis of hypertension and received lifestyle coaching whose blood pressure was adequately controlled during the measurement year. **Denominator:** Adults age 18 and older who had a diagnosis of hypertension and received lifestyle coaching in the measurement year.	Administrative, EHR	**Measure Steward:** N/A **Notes:** • This measure assesses whether lifestyle interventions are associated with improved blood pressure control. • Adequate control of blood pressure includes a systolic less than 140 mm Hg and a diastolic of less than 90 mm Hg.

Measure[a]	Measure Description	Data Source(s)	Measure Steward and Notes
New-Onset Type 2 Diabetes	**Numerator:** Unduplicated number of adults age 18 and older without a prior diagnosis of diabetes who received a new diagnosis of type 2 diabetes during the measurement year. **Denominator:** Adults age 18 and older without a prior diagnosis of diabetes during the measurement year.	Administrative, EHR	**Measure Steward:** N/A **Notes:** • This measure assesses the incidence of type 2 diabetes among adults. Obesity is a major risk factor for type 2 diabetes; changes in incidence over time may reflect the impact of prevention and healthy weight management efforts. • States may consider applying a lookback period (e.g., 1 to 2 years) to exclude beneficiaries with a prior diabetes diagnosis.
Overweight/Obesity Reduction Among At-Risk Population	**Numerator:** Unduplicated number of children and adolescents ages 2 to 19 with a BMI between the 85th and <95th percentile (overweight) who did not progress to a BMI ≥95th percentile (obesity) during the measurement year. **Denominator:** Children and adolescents ages 2 to 19 with a BMI between the 85th and <95th percentile during the baseline period.	Administrative, EHR	**Measure Steward:** N/A **Notes:** • This measure assesses whether children and adolescents at risk for obesity maintain or improve their weight status over time. • Implementation may require longitudinal data to track changes in BMI percentile across measurement periods.

[a] The measurement period for measures may vary depending on the purpose of the effort. For example, states conducting PIPs or other QI initiatives may use more frequent measurement periods (e.g., monthly or quarterly) to monitor progress, which may require adapting measure specifications. In contrast, measures used for VBP or accountability are typically assessed on an annual basis.

BMI = body mass index, CBO = community-based organization, CDC = Centers for Disease Control and Prevention, CHIP = Children's Health Insurance Program, DPP = Diabetes Prevention Program, EHR = electronic health record, EQR = external quality review, FHWP = Family Healthy Weight Program, N/A = not applicable, NCQA = National Committee for Quality Assurance, OB/GYN = obstetrician/gynecologist, PCP = primary care provider, PIP = performance improvement project, MCP = managed care plan, QAPI = Quality Assurance and Performance Improvement, QI = quality improvement