Promoting Health: Improving Quality in Obesity Care

ICAAP 2012 Summary Report

Review of State Medicaid Policies and Quality Measures

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Introduction

This report summarizes the completion of two surveys conducted in the April - June 2012 quarter by the Illinois Chapter, American Academy of Pediatrics (ICAAP) for its Promoting Health: Improving Quality in Obesity Care (Promoting Health) initiative. The initiative is funded by a grant from the Illinois Department of Healthcare and Family Services and the Otho S.A. Sprague Memorial Institute. The activities undertaken by ICAAP identify Medicaid policies and programs outside of Illinois that should be considered for inclusion in the Illinois Medicaid program to improve the quality and delivery of care. The report also identifies quality measures addressing obesity care implemented in other states. The results of the surveys will inform anticipated ICAAP recommendations to the Illinois Department of Healthcare and Family Services about how to clarify and strengthen Illinois Medicaid policies to improve the quality of pediatric obesity care. The survey findings will also assist in the development strategies to increase provider reporting of a weight assessment quality measure in the Illinois Medicaid program.

ICAAP research activities were guided by established national clinical recommendations for the prevention, assessment, and treatment of child and adolescent overweight and obesity,1 the 2010 U.S. Preventive Services Task Force recommendation on screening for obesity in children and adolescents,2 and findings demonstrating the applicability of EPSDT coverage standards to support comprehensive, obesity-related health care interventions.3

In May 2012, the Institute of Medicine (IOM) released its extensive Recommendations on Accelerating Progress in Obesity Prevention.4 The recommendations support the current Promoting Health goal of improving pediatric obesity care in the Illinois Medicaid program. The IOM calls on public and private payers to ensure that health plan coverage, access provisions, and incentives address obesity prevention, screening, diagnosis, and treatment. The IOM suggests the following potential actions by payers to consider: (1) health plan benefit designs and programs that promote prevention; (2) innovative approaches to reimbursement for routine screenings and obesity prevention service in clinical practice; and (3) broad interpretation of the obesity-related provisions in health care reform. Finally, the IOM urges health care providers to adopt standards of practice to help children and adolescents to achieve and maintain a healthy weight and to reduce the psychosocial consequences of obesity.

II. Review and Analysis of Medicaid Policies and Programs on Pediatric Obesity from Other States

ICAAP relied on interviews with AAP Chapters, Medicaid manuals, queries to state Medicaid programs, and a literature review to complete the survey of other states’ Medicaid policies on obesity codes, coverage, and usage rates (as available). ICAAP focused on the coverage of specific codes applicable to obesity-related care: the 278.00-278.02 obesity diagnosis codes; the 97802-97804 CPT medical nutrition therapy codes; and the 96150-96155 CPT health and behavioral codes. For state Medicaid coverage, ICAAP sought to identify states that facilitated multidisciplinary care and/or designed policies and services targeting childhood obesity. ICAAP determined that Medicaid usage rates were not readily available except for those documented in several journal articles.5,6 A series of articles authored by the George Washington University Department of Health Policy were particularly valuable in highlighting those states that might have model pediatric obesity policies. (See Appendix H for a bibliography of the ICAAP literature review.)

ICAAP surveyed nine AAP chapters across the U.S. with a 100% response rate. ICAAP conducted in-depth interviews with the AAP chapter staff and/or pediatrician members in Alabama, Arizona, Maine, Massachusetts, Minnesota, North Carolina, Pennsylvania, Texas, and Washington. In the interviews, ICAAP queried chapters about Medicaid and private pay pediatric obesity programs, policies, and barriers to quality care (See Appendices I and J for a survey roster and the interview questionnaire.)

ICAAP also surveyed Medicaid program personnel and reviewed Medicaid manuals in eleven states that had been cited in the recent literature as having good evidence of EPSDT benefits covering pediatric nutrition and/or behavioral therapy. ICAAP received a 63.6% response rate to inquiries of these eleven states: Alaska, Arizona, Indiana, Iowa, Kansas, Kentucky, Michigan, Montana, New Mexico, Oklahoma, and Washington. A specific policy was reviewed in the states of Maryland, Minnesota, Nebraska, North Carolina, and Pennsylvania when research indicated that an obesity policy might be noteworthy. (See Appendix K for a summary of the Medicaid coverage by State.)

In states outside of Illinois, ICAAP identified Medicaid covered services, benefit designs, and innovative program approaches that could strengthen pediatric obesity care coverage, reimbursement, and access provisions in the Illinois Medicaid Program. These are described below.

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Nutrition Assessment and Counseling

Pennsylvania

In 2007, Pennsylvania instituted a comprehensive nutrition assessment and counseling policy that bundles nutrition weight management services. The *Child and Nutrition Weight Management Services* (CNWMS) policy was established in the Pennsylvania Medicaid Program for Medicaid recipients under age 21. CNWMS comprise physician initial assessment, re-assessment, individual/family/group weight management counseling, and nutritional counseling.

Pennsylvania Medicaid recipients are eligible for these weight management services after an initial assessment. A summary of the services are shown in the table below. Physicians may bill for a physical exam or a complete EPSDT screen and an initial assessment or re-assessment rendered to a child on the same day. Same day visits for reassessment and counseling are also permitted at an office visit for another medical issue. A child can be referred to an enrolled dietitian/nutritionist for medical nutrition therapy with up to 12 visits per year. Additionally, health/behavior intervention visits (individual, group or family) with a physician, CRNP, or RN using CPT codes 96152-154 are covered Medicaid services.

<table>
<thead>
<tr>
<th>Pennsylvania Child and Nutrition Weight Management Services (CNWMS)</th>
</tr>
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<tbody>
<tr>
<td><strong>Initial Assessment</strong></td>
</tr>
<tr>
<td><strong>Reassessment</strong></td>
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<tr>
<td><strong>Weight Management</strong></td>
</tr>
<tr>
<td><strong>Nutrition Counseling</strong></td>
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</table>

The Pennsylvania policy addresses several major barriers to care that Illinois physicians identified in the 2012 *ICAAP Survey of Physicians Providing Pediatric Obesity Care in the Illinois Medicaid Program*: (1) lack of physician time at the well child visit to thoroughly assess, counsel, and intervene with patients with overweight/obesity; (2) difficulties getting patients to return for a separate obesity care visit; and (3) no option to refer to a registered dietician for medical nutrition therapy in the Illinois Medicaid program. The CNWMS benefit design promotes patient-centered care, efficiency, and flexibility. It permits same day visits so the patient does not need to
return on a different day for an assessment or reassessment, allows for referrals to dieticians for medical nutrition therapy and interventions by various members of a patient care team, and gives the medical practice the flexibility to deliver appropriate patient weight management services to an individual, group, or family.

**Behavioral Health Services**

Mental health is linked as both a cause and consequence of obesity and impacts treatment. Psychologists, social workers, and other mental health professionals have specialized training and expertise in behavioral health interventions and in treating co-morbid mental health conditions. They are a critical part of a multi-disciplinary care team in assessing and treating youth with overweight/obesity. Even so, in some states Medicaid does not cover outpatient behavioral health services for pediatric overweight/obesity, places restrictions on those services, or does not permit behavioral health providers to bill Medicaid directly for their services. These limitations often create a shortage of providers and severely restrict access to care.

A majority of states have now opted to allow psychologists to bill directly for services rendered to adult Medicaid beneficiaries who are not also covered by Medicare. Some state Medicaid programs, such as the Public Mental Health System in Maryland, have designed a mental health service delivery system that encourages patient-centered pediatric care through open access to care and measurement of patient/caregiver satisfaction with mental health services. The Oklahoma Medicaid program discussed below additionally reimburses for CPT health and behavior codes delivered by mental health providers for a primary medical weight-related diagnosis.

**Maryland**

In July 1997, as part of the state’s Medicaid 1115 waiver reform plan, the Department of Health and Mental Hygiene initiated Maryland’s Public Mental Health System (PMHS). Through a carve-out arrangement, specialty mental health services are delivered under a single payer system. Maryland assesses and reports consumer satisfaction and outcome measures for mental health services on an annual basis.

Maryland’s Public Mental Health System enrolls physicians, psychologists, social workers, advanced practice nurses, and licensed professional counselors as contracted providers for pediatric care. The place of service includes individual and private group practice. Medicaid beneficiaries are entitled to 12 initial auto-authorized outpatient visits on an annual basis. To ensure that every beneficiary has access to mental health services in Maryland, beneficiaries can access care through self-referral as well as through provider referral.

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Oklahoma

The Oklahoma Medicaid Program covers comprehensive pediatric outpatient behavioral health services. Eligible mental health providers include psychologists, social workers (clinical specialty only), professional counselors, family therapists, and behavioral practitioners. Individual and/or interactive psychotherapy, family psychotherapy, group and/or interactive group psychotherapy can take place in a variety of outpatient settings, including an office, clinic, or other confidential setting.

In addition to coverage of services for mental health conditions, the Oklahoma Medicaid program covers health and behavior codes. Codes 96150 through 96155 are defined as “services for patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on biopsychosocial factors related to the patient’s health.” These codes have a particularly useful application in the prevention of mental health conditions associated with adolescent overweight/obesity. The codes allow for psychological services to be provided to patients that may not currently have a diagnosable mental health disorder, but already have psychosocial stressors tied to their overweight or obesity, such as stigma, bullying, social isolation, low self-esteem, negative body image, and symptoms of disordered eating that may lead to serious mental illnesses, such as depression and eating disorders.

An article documenting Medicaid reimbursement of health and behavior codes in Oklahoma was published in 2012. Oklahoma limits the use of the code to services provided by a licensed psychologist for children under 21 years of age. A primary medical weight-related diagnosis is among the most common use of the code in Oklahoma based on encounter data submitted to Medicaid between July 2010 and June 2011 for children between the ages of 5 and 12. Utilization of Health and Behavior codes for behavioral services provided by a pediatric psychologist in a hospital-based multi-disciplinary pediatric weight management clinic in Michigan was also recently reported in the *Journal of Pediatric Psychology*.

Physical Therapy/Physiologist

Orthopedic issues associated with obesity are slipped capital femoral epiphysis, Blount’s disease, altered gait biomechanics, and patellofemoral syndrome. These orthopedic issues deter children and adolescents from engaging in physical activity that is recommended by clinical guidelines. In pediatric multi-disciplinary weight management

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clinics, physical therapists and physiologists are often employed to treat the orthopedic conditions that limit physical activity and to oversee physical activity programs.

In a majority of states, Medicaid has opted to allow physical therapists to bill directly for services to adult Medicaid beneficiaries not covered by Medicare. ICAAP researchers did not assess the number of states in which physical therapy services are a covered pediatric benefit in state Medicaid programs. However, responses from state Medicaid programs and/or chapter staff in Alaska, Minnesota, and Maine indicated that physical therapy services for children are covered. In Maine, where the Medicaid program has no limits on visits or preauthorization requirements for physical therapy services, an innovative pediatric obesity program has developed between a medical practice and physical therapy clinics as described below.

**Maine**

FitforME! is a unique program to increase the ability of youth with overweight/obesity to engage in physical activity. The program was started by a physician assistant who identified musculoskeletal issues, including ankle and knee pain, as barriers to patient engagement in physical activity. The primary care practice provides medical oversight, nutrition education, and behavior management; the physical therapist at a physical therapy clinic works to address numerous orthopedic concerns associated with obesity and to engage patients in physical activity. All services are covered by Medicaid.

The FitforME! program serves patients between the ages of 6 through 18. No minimum BMI percentile is required for the physical therapy benefit. For the referral, a typical primary medical diagnosis is abnormal weight gain, which can be accompanied with a secondary orthopedic diagnosis. The physician assistant coordinates care with the physical therapist. Program components are described in the table below. FitforME! reports that patients who participated in the program had increased physical activity, weight stabilization or decline, reduction of hypertension and normalization of borderline cholesterol levels, raised confidence and self-esteems, self-awareness about nutritional choices, and interest in continuing to make improvements in health.

<table>
<thead>
<tr>
<th>FitforME! in Maine</th>
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<tbody>
<tr>
<td>Pediatric Primary Care Practice and Physical Therapy</td>
</tr>
<tr>
<td>Collaborative Care</td>
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</table>

### FitforME! Program Components

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Physical Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical weight assessment</td>
<td>Orthopedic evaluation with emphasis on flexibility, core strength, balance, gait and squat mechanics, muscular strength, soft tissue restrictions, and cardiovascular endurance</td>
</tr>
<tr>
<td>Bi-monthly visits for reassessment of medical changes, nutritional counseling, and behavioral management</td>
<td>Average of 12-15 visits over a 6-8 week period to improve musculoskeletal and cardiovascular strength, coordination and endurance</td>
</tr>
<tr>
<td>Medical weight assessment</td>
<td>Physical activity goals established for between visits</td>
</tr>
</tbody>
</table>

FitforME! is currently being utilized by a large hospital in the area as an option in their outpatient clinics for children and adolescents with overweight/obesity. Plans are also underway to expand the program to other areas of the state. This collaborative model provides fewer contact hours over a shorter duration than the U.S. Preventive Services Task Force recommendation for a moderate-to-high intensity intervention. However, the program does incorporate the recommended elements of a comprehensive intervention, including counseling for a healthy diet, counseling for physical activity or a physical activity program, and the utilization of behavioral management techniques.

### A Community-Based Medicaid Pilot Launching in Multiple States

Responding to the Patient Protection and Affordable Care Act’s Preventive Services Regulations, private payers are developing and piloting community-based programs to address the childhood obesity epidemic. The UnitedHealth Group launched its first pilot of JOIN FOR ME in Rhode Island with the Y of the USA and the YMCA of Greater Providence. The “whole family” program engaged overweight and obese youth ages 6 to 17, along with their parents, in learning sessions “to achieve healthier weights through healthier family nutrition choices, increased activity, and lifestyle tracking.” JOIN FOR ME encourages but does not incorporate physical activity into its program. A

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2012 press release from UnitedHealth Group states that JOIN FOR ME will lead to lower health care costs due to fewer doctor and hospital visits for participants.

According to UnitedHealth Group, the program has shown statistically significant improvement in weight outcomes among participants. A journal article documenting JOIN FOR ME patient outcomes is expected to be published online in *Pediatrics* in September 2012. UnitedHealth Group is now offering additional pilot programs as a covered benefit in the preventive care schedule through employer-sponsored health plans and Medicaid managed care plans in select markets. In 2012, the program is rolling out as a Medicaid managed care benefit in Rhode Island (100 enrolled families and up to 8 different sites in greater Providence starting in June 2012), in Texas (a three-year contract for up to 500 enrolled families in a number of locations), and in Louisiana (up to 500 enrolled families). The JOIN FOR ME benefit is summarized in the table below.

<table>
<thead>
<tr>
<th>UnitedHealth Group</th>
<th>JOIN FOR ME</th>
<th>Weight Management Program for Kids and Teens</th>
<th>Medicaid Managed Care Benefit in Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Source</td>
<td>Primary care providers, school nurses, community health centers, school educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility Requirements</td>
<td>Ages 6 to 17; above the 85th percentile, referred after a well-child visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program is a Medicaid Covered Medical Expense</td>
<td>Benefit includes transportation and membership at the Y throughout program attendance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Benefit</td>
<td>16 weekly classroom sessions (75 minutes) led by a trained coach/facilitator chosen by program subcontractor (such as a local Y)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Classes held at locations near patient’s neighborhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Topics Include</td>
<td>Reducing less-healthy food and drinks, getting and staying active, managing screen time, improving sleep habits, and understanding the link between moods and foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kids Group Ages 6 to 12</td>
<td>Child and one parent/caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen Group Ages 13-17</td>
<td>Parent/caregiver attend sessions 1, 2, and 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of Program per Participant</td>
<td>$750 per family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance-based Payment Model

Payment to the subcontractor (such as Ys and Boys and Girls Clubs) is tied to attendance outcomes of the child participants

Other State Medicaid Pilots

A number of states have taken the lead in launching pilot projects aimed at combating childhood obesity. One of these states is Arizona. In 2005, Arizona’s Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), developed an ambitious plan and pilot project based on the chronic care model. Some of the elements of the Arizona plan are described below. Arizona’s multi-disciplinary childhood obesity pilot utilized a phased-in approach starting in one county. Arizona estimated that its plan to comprehensively target childhood obesity could reduce its health care expenditures by approximately $40 million for the target population as child Medicaid beneficiaries reached adulthood.

More recently, Texas launched a three-year child obesity prevention pilot in Travis County with Medicaid contractor Amerigroup in November 2012. The pilot in Texas, as well as the Arizona pilot, planned to utilize care coordination/case managers to maintain continuity of care and community resources for patient physical activity and nutrition programs. The benefits and services covered in the Texas pilot include monthly visits with the primary care provider for six months for physical assessment and measurements, with laboratory tests as indicated; visits with a dietician as needed; access to community services such as cooking classes and exercise programs; and incentives for ongoing participation and completion of a 12-month follow-up visit.  

ICAAP queried AAP chapters and Medicaid staff in Arizona and Texas to obtain outcome data on the pilot prevention programs, but were unable to obtain any official reports published to date. A report to the Texas legislature is due in February 2013.

Arizona

A notable feature of the Arizona plan to combat childhood obesity is the inclusion of strategies that focus on all facets of the Medicaid health care delivery system. The plan incorporates contractor requirements, covered benefits, quality improvement, case management, provider and member education, linkages with specialists, utilization of clinical information systems for providers and member support, and member tools and incentives. The AHCCCS plan includes the following directives:

• Designate childhood obesity as a subject of the next AHCCCS medical audit
• Require Childhood Obesity initiatives and activity monitoring as a section in the annual QM/QI Plan submission and during the OFR process
• Incorporate Childhood Obesity reporting into Contractor EPSDT Quarterly Submissions
• Establish a childhood obesity registry to provide feedback and to report activities and outcomes of interventions and generate reminders and tools for patients
• Develop and implement a process to build effective case management to assure continuity and regular follow up
• Establish linkages with key specialists to assure that primary care providers have access to expert support
• Collaborate on methods to involve community fitness centers in the initiative
• Develop an incentive-based rewards programs for member participants triggered by periodic monitoring visits with primary care physicians

For the pilot, the Arizona Medicaid program proposed utilization of the following codes as evidence-based services to prevent and to treat childhood obesity:

Nutrition
• S9470 – Nutrition counseling, dietitian (open code – using for ALTCS)
• 97802 – Initial face-to-face encounter with nutritionist, 15 minute segments (open code)
• 97803 – Re-assessment by nutritionist, 15 minute segments (open code – AHCCCS fee schedule)

Physiotherapy
• S9451 - Exercise classes, non-physician provider, per session (closed code – recommend opening for specific provider type)

Health Education (purpose behavior modification)
• S0315 Disease management program; initial assessment and initiation of the program
• S0316 – Follow-up/reassessment

Integrated Care Services (Psychologists, Registered Nurse Practitioners, Certified Independent Social Workers, Social Workers, Certified Marriage/Family Therapists, and Certified Professional Counselors)
• 96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires) minute increment)
• 96151 re-assessment
• 96152 Health and behavior intervention
• 96153 group – 2 or more patients
• 96154 family with the patient present
• 96155 family without the patient present
Lessons Learned from ICAAP State Survey

With the rising tide of obesity and associated economic costs across the U.S. over the past several decades, it is in the interest of state Medicaid programs to develop health care benefits, reimbursement models, quality measures, and health care delivery systems that aggressively target childhood obesity. Yet, relatively few states have integrated comprehensive obesity prevention and management programs into their Medicaid programs.

Many states have an incomplete hodgepodge of Medicaid covered services with varying levels of access and availability for recommended multidisciplinary pediatric obesity care. Often, key disciplines that provide multidisciplinary care, such as psychologists, social workers, and dieticians, are either (1) excluded from Medicaid covered services for pediatric overweight/obesity; (2) limited in their availability to consumers because of state Medicaid restrictions on practice settings; or (3) restricted in their ability to bill Medicaid directly for their services. Medical practices have patched together innovative partnerships, like the FitforME! partnership with a physical therapy clinic, because state Medicaid programs do not adequately cover and reimburse for comprehensive multidisciplinary care.

The responses from numerous pediatricians who participated in AAP state chapter interviews, as well as the results of ICAAP’s 2012 Survey of Physicians Providing Pediatric Care in the Illinois Medicaid program, demonstrate that providers are generally confused about which pediatric obesity benefits are covered in their state Medicaid programs. Clearly delineated covered services for pediatric obesity care, such as Pennsylvania’s bundled Child and Nutrition Weight Management Service described in this report, as well as increased provider guidance on billing and coding, would be a way to clarify obesity coverage and reimbursement.

Finally, the lessons learned from Arizona’s comprehensive and commendable efforts to develop a pediatric obesity prevention and management program in its Medicaid system can be instructive to Medicaid programs in other states. Although not a formal evaluation of the program, The Early Childhood Task Force, Arizona Chapter, AAP, has developed recommendations about how the Medicaid childhood obesity pilot program in Arizona could be improved.15 Not surprisingly, the Task Force proposed the allocation of more resources towards prevention with emphasis on children from 0-5 years of age, where the Task Force indicates that the impact is most likely to have the greatest effect. Several key recommendations made by the Task Force should be considered by Illinois and other states when implementing obesity prevention programs:

• Develop incentives and interventions that target physical activity and health promotion, including member incentives and provider incentives for best practices and completion of obesity prevention training;

• Explore alternative reimbursement strategies and alternative models of care such as a multidisciplinary team approach similar to that used in the Arizona Early Intervention Program (AzEIP), or group interventions that would afford healthcare providers the opportunity to spend adequate time with patients to prevent, diagnose, and treat obesity; and

• Ensure providers can use and be reimbursed for codes recommended in the Expert Committee Recommendations for Obesity-Related Preventive Care.
III. Review and Analysis of Implementation of Quality Measures from Other States

Obesity Quality Measures

In order to review and analyze the implementation of a quality measure in other states, ICAAP conducted interviews with AAP chapters, worked with our partners on the CHIPRA demonstration project, connected with several healthcare policy and quality agencies, and completed a literature review. Generally, information about the implementation of state-wide quality measures is not widely available. The National Committee for Quality Assurance (NCQA) does not track the implementation of specific quality measures by individual states. ICAAP requested data (through CMS Technical Assistance) from other states participating in the CHIPRA demonstration grant around the country but was only able to obtain data from Illinois and Florida.

A policy brief from 2006 produced by a team from the George Washington University Medical Center School of Public Health and Health Services, entitled “Strategies for Improving Access to Comprehensive Obesity Prevention and Treatment Service for Medicaid-Enrolled Children,” obtained and reviewed “managed care contracts from 24 of the 43 states with comprehensive Medicaid managed care programs.” At that time, only New Mexico required obesity-related performance measures.

Physician documentation weight status category and providing behavior change counseling have been included in Healthcare Effectiveness Data and Information Set (HEDIS) measures since 2009. The NCQA Medicaid Managed Care Toolkit for 2012 notes that as of February 2012, 29 Medicaid programs use or require NCQA Accreditations (Illinois is not among those 29). Illinois is among the 39 states requiring reporting of the HEDIS measures, which allows states to make “comparisons of plan quality and set high performance standards in managed care contracts,” and includes the BMI Assessment for Children/Adolescents measure.

A review of Illinois’ 2011 Annual Report of The Children’s Health Insurance Plans provides baseline rates of BMI Assessment for Children and Adolescents during the 2010 and 2011 Fiscal Years. Though the HEDIS measurement includes documentation of BMI and counseling, the measurement data assessed for CHIPRA

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pertain only to documentation of BMI. This is calculated by assessing the percentage of children (ages 3 - 17) whose weight is classified based on BMI percentile for age and gender. The rate of documentation for both years was 0.4% for 2010 and 0.6% for 2011. The actual rate of documentation of BMI may be much higher, due to the fact that the data was based on administrative claims to calculate the measure.

Policy experts suggest that states may want to consider using pay-for-performance techniques that tie higher reimbursement rates to performance measures that show providers are adhering to best practices in obesity treatment and prevention”.16, pg 49

Incentives for Quality Measures

In order to improve performance rates on quality measures, implementation is often accompanied by a pay-for-performance project in which providers are incentivized to complete the measure. The Center for Health Care Strategies released a report entitled “Physician Pay-for-Performance in Medicaid: A Guide for States,” which provides a valuable description of the implementation of Pay-for-Performance (P4P) programs and an outline of incentive models (both financial and non-financial) for quality improvement projects.20 Also provided is a review of states that were, at the time the report was written, seeking to “implement strategies to improve the quality of care delivered to the Medicaid population through the use of incentives at the physician level.”16, pg 4

Non-financial incentive models include performance profiling, public recognition and technical assistance. Several financial incentive models were described; those which seem to be most promising for application in the current project include (1) pay-for-process (in which the PCP receives an automatic payment each time a particular screening/assessment is completed), (2) a bonus for either demonstration of improvement or achievement of a predetermined threshold, or (3) a tiered bonus for achievement of various thresholds. Some states (Michigan, New York, and Rhode Island) have implemented programs using a complimentary model of both financial and non-financial incentives.

Review of Individual States: Quality Measures and Pay-for-Performance

Alabama

As of February of 2012, Alabama did not have any specific quality measures in place for pediatric obesity, and there were no provider incentives in place at Alabama Medicaid.21

Alaska

According to the Operations Manager of Health Care Services, Alaska has no quality measures in place.22

21 Phone Interview with Linda Lee, Alabama AAP Executive Director.
22 Email interview conducted with Cindy Christensen, Operations Manager, Alaska Health Care Services.
Florida

Florida is part of the CHIPRA demonstration project as well. Though the HEDIS measurement related to pediatric obesity requires BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, CHIPRA only requires reporting on BMI. An initial data review revealed that all three age categories (3-11, 12-27, and Total) fall within the 50-75% HEDIS benchmark percentile.

Massachusetts

In Massachusetts, the state collects BMI in schools, but this data is not necessarily linked to Medicaid. Pay for Performance programs in Massachusetts have been focused on clinical and structure measures eliminating health disparities, rather than to a specific disease focus such as obesity.

Michigan

The Michigan Department of Community Health established a performance bonus in 2009 based on the BMI HEDIS measure (the percentage of members who had evidence of BMI percentile, counseling for nutrition, or counseling for physical activity). Eventually, these measures became the subject of the performance improvement project for all health plans.

Minnesota

Minnesota is currently working on developing pediatric preventive care measures with Minnesota Community Measurement. This effort will include a BMI snapshot for clinics throughout the state.

New Mexico

New Mexico was the only state with a contract reviewed by the George Washington University researchers in 2006 that required obesity-related performance measures. The New Mexico Managed Care Organizations report on pediatric obesity through HEDIS measures.

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23 Florida Agency for Health Care Administration. Results: Mandatory Hybrid Measures. Florida CHIPRA Demonstration Project.
24 Phone interview conducted with Cathleen Haggerty, Executive Director of the Massachusetts Chapter, AAP, Erin T. Rhodes, MD, MPH, Children’s Hospital Boston, and Alan F. Meyers, MD, Boston Medical Center.
26 Email interview conducted with Shelia Embry, Manager of Quality Improvement and Program Development Section, State of Michigan.
27 Phone interview conducted with Katherine Cairns, Executive Director, Minnesota Chapter, AAP.
28 Email interview conducted with Maria Varela, Medical Assistance Division, Human Services Department, New Mexico.
New York

New York’s Medicaid Managed Care plans implemented a number of pediatric obesity initiatives as part of their 2009 - 2010 Performance Improvement Project. A summary of each of the 19 related projects revealed an emphasis on early identification of overweight and obesity through provider assessment and documentation of BMI, though none of the 19 projects implemented a quality measure related to this goal.

North Carolina

The North Carolina Healthcare Quality Alliance (NCHQA) provides a forum for leaders to work towards statewide improvements in the quality of care. This is achieved by bringing together private providers, payers, employers and state agencies. In 2012, NCHQA came to an agreement on a set of quality measures linked to five common and costly chronic diseases: diabetes, asthma, congestive heart failure, hypertension, and post-myocardial infarction care. Most of the focus from this project will be on creating a comprehensive system of care.

Pennsylvania

The state of Pennsylvania has an extensive pay-for-performance program, including several quality measures. “Since 2005, Medicaid health plans in Pennsylvania have participated in a P4P [pay-for-performance] program. They report performance information for 10 HEDIS measures, which the state publicly reports.” To participate, Managed Care Organizations (MCOs) were required to choose “two of the following three topic areas: (1) increasing dental service utilization for children and adolescents, (2) reducing racial and/or ethnic disparities related to specified healthcare services rendered to members with diabetes, and (3) coordination between physical health and behavioral health services,” according to a 2012 report. Based on a phone interview with the director of the Pennsylvania Chapter, American Academy of Pediatrics, several of the managed care plans have chosen to address pediatric obesity as part of their priorities (as

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31 Phone Interview conducted with Suzanne Yunghans, Executive Director, Pennsylvania Chapter, AAP and Amy Wishner, Director of Pediatric Obesity Evaluation, Treatment, and Prevention in Community Settings, Pennsylvania Chapter, AAP.  
part of topic areas two and three), though outcome data are not yet available from these projects.31

**Virginia**

The Virginia Premier Health Plan, Inc. (VPHP) initiated a HEDIS Primary Care Physician Quality Incentive Program in January of 2010.34 The Quality Incentive Program was designed to “create a collaborative, quality centered partnership with … physicians and Members to align incentives and reward quality of care improvements.” Additionally, the Quality Incentive Program was “designed to incorporate NCQA’s HEDIS methodology and information set to measure performance.” Included in the “programs to encourage members to improve care” was a section described as “Disease Management Programs - case management covering asthma, diabetes, maternal/infant, COPD, obesity and heart disease”.

**Washington**

Through phone35 and email interviews,36 ICAAP learned that Washington state uses HEDIS scores to measure quality, and though plotting BMI is encouraged, there is no financial incentive provided by Medicaid to physicians for meeting this standard.

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35 Phone interview conducted with Toni Nunes, Executive Director, Washington AAP.

36 Email interview conducted with Toni Nunes, Executive Director, Washington AAP; Beth Harvey, MD, FAAP, Immediate Past President WCAAP; Kristi Rice, MD, WCAAP Volunteer.