

An Analysis of Obesity Diagnosis and Treatment in Medicare and the Associated Policy Landscape

Charles River Associates

By Kirsten Axelsen, Annabelle Fowler, and Ashutosh Mishra

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1. Executive summary

Obesity is a common, serious, and costly disease that increases people's risk for morbidity and mortality.¹ It is characterized by abnormal or excessive body fat accumulation; weight loss and lifestyle changes have been shown to reduce the risk for associated negative health outcomes.²

Obesity treatment, which includes intensive behavioral therapy (IBT), anti-obesity medications (AOMs), and bariatric surgery, is underutilized, resulting in unmet potential benefits for the US health system and its patients.^{3,4} Recent advancements in AOMs showing efficacy to reduce weight beyond clinically significant thresholds have created new options for patients to achieve weight loss.^{5,6} Existing treatment guidelines recommend the use of AOMs and behavior change interventions for weight loss. However, Medicare does not cover AOMs⁷ and has limited coverage and reimbursement for IBT⁸—policies that may reduce spending in the near term at the expense of both short- and long-term health and total costs savings.⁹ Medicare Part D has statutorily excluded AOMs since it began in 2003, which implies that they were not considered essential for medical care. Clinical guidelines have since changed to recommend AOMs to treat obesity.¹⁰ Aware of these limitations, the bipartisan Treat and Reduce Obesity Act of 2021, introduced in both the Senate and House, aimed to expand Medicare's IBT benefit and allow for Medicare coverage of AOMs.¹¹

This white paper, written at the request of Eli Lilly and Company, examines the Medicare obesity diagnosis and treatment landscape to identify barriers to patients' access to obesity treatments. Our research is based on a review of the literature on Medicare policies regarding obesity diagnosis and treatment, national guidelines, incentives for providers, and patient and provider education.

We conclude that expanding access to obesity treatment in Medicare would benefit patients and the healthcare system. Such access should align with clinical best practices and national guidelines, which could lead to reduced obesity-related morbidity, mortality, and costs. Improved access to obesity treatment in Medicare would be consistent with improved access in the Federal Employees Health Benefits Program (FEHBP) and in the Veterans Health Administration (VA).

We make the following recommendations:

1. Congress should authorize the Centers for Medicare and Medicaid Services (CMS) to align coverage policies with diagnosis and treatment guidelines, and CMS should further update reimbursement practices to adequately compensate providers of obesity treatment for the value of their services.
2. CMS and contracted insurers should incorporate obesity treatments into existing performance-based incentive programs for insurers and physicians to encourage the treatment of obesity.
3. While sufficient evidence already exists to justify expanding Medicare access to obesity treatments, including new AOMs, all stakeholders should invest in real-world evidence generation to further inform policies and practices that optimize long-term effectiveness of obesity treatments at the population level.

2. Introduction and approach

Obesity is the most prevalent chronic disease among adults in the US.¹² It is expected to affect an estimated 49% of the US adult population in 2030, an increase from 42% in 2017.^{13,14} Obesity is associated with poorer health and decreased quality of life. It is a risk factor for diabetes, heart disease and stroke, musculoskeletal disorders, and certain cancers.¹⁵ In addition to producing adverse health outcomes, obesity has a direct impact on health spending. In 2016, the most recent estimate available, direct medical cost associated with obesity in the US was \$260.6 billion.¹⁶ More recently, obesity has emerged as a major risk factor for morbidity, mortality, and healthcare utilization associated with the COVID-19 virus.^{17,18}

Expanding access to obesity treatments would reduce health inequities because the burden of obesity is higher among racial and ethnic minorities and low-income adults. Obesity disproportionately affects people of color, affecting about 50% of non-Hispanic Blacks, 45% of Hispanics, and 42% of non-Hispanic whites.^{19,20} Intersectionality exacerbates health inequities, with Black and Hispanic women experiencing obesity at higher rates than other demographics (55% and 51%, respectively).²¹ Obesity prevalence is also inversely associated with household income; it affects 40% of adults under 350% of the federal poverty line and 31% of adults with higher incomes, based on 2011–2014 data.²² Maintaining the status quo of undertreating obesity perpetuates health inequities.

Current treatment options for obesity include lifestyle interventions, AOMs, and bariatric surgery. Access to modern, safe, and effective treatments has the potential to improve health, close disparity gaps, and decrease healthcare spending. AOMs historically were associated with less than 10% additional weight loss compared to a placebo.²³ However, newer AOMs, in particular glucagon-like peptide 1RA (GLP-1RA) and forthcoming combination glucose-dependent insulinotropic polypeptide (GIP) and GLP-1RA agonists, are promising treatments. They have been shown to have safer profiles and higher efficacy relative to some existing treatments, with weight loss over 20% in clinical studies.²⁴ This efficacy approaches that of bariatric surgery and is a marked improvement over lifestyle interventions alone.^{25,26,27,28} Lifestyle interventions include diet, exercise, and behavioral therapy, but their implementation and use varies.²⁹

Medicare is limited in its coverage of obesity treatments. While the US National Institutes of Health has considered obesity a chronic disease since 1998 and multiple medical societies include AOMs in their treatment recommendations, Medicare Part D, the US prescription drug plan for the elderly and disabled, excludes all AOMs from coverage.³⁰ Though both the Federal Employees Health Benefits Program (FEHBP) and the Veterans Health Administration (VA) cover AOMs, Medicare Part D, which insures 49 million people, continues to lag behind these other federally subsidized health plans in its approach to coverage.³¹ The bipartisan Treat and Reduce Obesity Act of 2021 (TROA), introduced in both the Senate and House, aims to address Medicare's limited obesity coverage by expanding its IBT benefit and allowing for Medicare coverage of AOMs.³²

At the request of Eli Lilly and Company, Charles River Associates has undertaken an assessment of key policies affecting access to obesity treatment and implications for policy change focused primarily on Medicare.

Approach

To understand the barriers to access to obesity treatment in Medicare, we first developed a research framework distinguishing between the impact on diagnosis, treatment, and follow-up. We then

conducted a literature review to understand the impact of Medicare policies, national guidelines, incentives for providers, and patient and provider education. We found 34 academic articles and 30 grey literature sources, which included non-peer-reviewed reports, government documents, and websites, among other sources.

This paper's structure reflects a focus on the challenges to access and coverage emerging from the literature review. These challenges include issues associated with diagnosis and treatment (in particular, discrepancies between clinical guidelines and Medicare policies), provider reimbursement and incentives, and gaps in provider and patient education. Drawing from the research, we outline key recommendations and conclusions.

3. Medicare obesity coverage

3.1. Diagnosis: National guidelines and Medicare diagnosis criteria

In this section, we describe the US national guidelines for obesity diagnosis and contrast those recommendations with Medicare's obesity diagnosis criteria for treatment.

3.1.1 US guidelines for obesity diagnosis

Since October 2000, the National Heart, Lung, and Blood Institute (NHLBI) has recommended that physicians consider body mass index (BMI), waist circumference, and the presence of other comorbidities and risk factors as part of their clinical decision to diagnose patients with obesity.^{33,34} These recommendations are endorsed by the Obesity Society, the Endocrine Society, the American Academy of Family Physicians, and the American Association of Clinical Endocrinologists (AACE).^{35,36,37,38}

3.1.2 Obesity diagnosis in Medicare

In Medicare, BMI is the exclusive measure used to recognize obesity to determine if a patient is eligible for treatment.³⁹ In responses to public comments on eligibility for obesity treatment in Medicare, CMS cited the 2003 US Preventive Services Task Force (USPSTF) recommendation that physicians screen for obesity and offer intensive behavioral therapy (IBT). That recommendation was based on "good evidence that body mass index (BMI) [...] is reliable and valid for identifying adults at increased risk for mortality and morbidity."⁴⁰

While BMI is a strong stand-alone indicator of potential obesity, clinical practice guidelines jointly issued by the Department of Veterans Affairs (DVA) and the Department of Defense (DoD) recommend BMI as a screening measure and as a component of an overall obesity diagnosis.⁴¹ These guidelines recognize and recommend that waist circumference, the use of obesogenic medications, patient history, and comorbidities be considered in a health care provider's diagnostic assessment of obesity.

To be consistent with scientific evidence, obesity recognition and treatment eligibility in Medicare should address limitations of the exclusive use of BMI. Waist circumference and waist-hip ratio measurements are particularly useful among Medicare patients because, compared to BMI, they may be stronger predictors of mortality and disability among aging, peri-retirement adults.⁴² In addition, changes in body composition due to aging, such as decrease in muscle mass, may lead traditional BMI thresholds to under-diagnose obesity, leaving a subset of patients with high body fat ineligible for

obesity treatment, but at higher risk for adverse health outcomes.^{43,44} These are particular issues for the population covered by Medicare and should be considered as Medicare policy is updated to reflect obesity and treatment eligibility.

Obesity diagnosis criteria: Key findings and implications

Key findings

- Medicare currently only considers BMI as a key indicator for obesity
- Clinical practice guidelines by other federal agencies recognize BMI as a component of overall physician diagnostic assessments
- Despite BMI being a straightforward and easy-to-use measure, it may under-diagnose obesity in older patients

Implication

- Updates to obesity diagnosis criteria in Medicare would prevent some patients failing to be diagnosed and treated

3.2. Treatment: National guidelines and coverage in Medicare

This subsection describes US national guidelines for obesity treatment and contrasts them to Medicare coverage decisions determining access to treatment.

3.2.1. US guidelines for obesity treatment

While several medical professional organizations in the US have published guidelines on obesity treatment, this review draws heavily from more recent publications. The 2016 guidelines by the AACE and the American College of Endocrinology (ACE) are the most recent comprehensive clinical practice guidelines by a professional organization.⁴⁵ The DVA and the DoD also issued clinical practice guidelines in 2020.⁴⁶ In late 2022, the American Gastroenterological Association (AGA) published updated pharmacological management guidelines,⁴⁷ and the American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) published updated guidance for bariatric and metabolic surgery.⁴⁸

Overall obesity treatment and management

The AACE/ACE guidelines were published before FDA approvals of more recent AOMs, including GLP-1 agonists and the expected approval of combined GLP-1 and GIP agonists. While the AACE/ACE and earlier guidelines provide BMI thresholds to inform physicians on which treatments to consider, they encourage joint patient–physician decision-making based on multiple factors, including a patient’s BMI, comorbidities, and history of failure of other treatments.^{49,50,51,52} Specifically, the AACE/ACE guidelines recommend that physicians consider treatment with lifestyle interventions (e.g., diet, exercise, and behavioral therapy) for patients with BMI ≥ 25 kg/m² and AOMs for patients who have failed to achieve $\geq 5\%$ weight loss after six months of lifestyle interventions and have a BMI ≥ 30 kg/m² or BMI ≥ 27 kg/m² with comorbidities. The ASMBS/IFSO guidelines from 2022 have lowered the BMI threshold for recommending bariatric surgery for patients who have not been able to lose weight through lifestyle interventions alone to BMI ≥ 35 kg/m² or BMI ≥ 30 kg/m² with comorbidities (previously BMI ≥ 40 kg/m² or BMI ≥ 35 kg/m² with comorbidities).^{53,54}

Pharmacological treatment

The AGA pharmacological management guidelines strongly recommend that AOMs be added to lifestyle interventions when lifestyle interventions alone lead to inadequate response.⁵⁵ The AGA and other pharmacological guidelines affirm that reducing food intake and increasing activity are initial treatments for obesity and should continue even with AOM use.^{56,57} They suggest that AOMs may improve physical function via weight loss and improved adherence to behavior changes.⁵⁸

While earlier guidelines recommended treatment with AOMs after lifestyle interventions failed through six months of application, the 2016 AACE/ACE guidelines recommend that physicians consider concurrent initiation of AOMs and lifestyle interventions for patients with weight-related complications that can be ameliorated by weight loss.^{59,60} It is unclear what the clinical rationale was for this recommendation, as the 2020 clinical practice guidelines by the DVA and DoD do not mention a requirement of failing to achieve weight loss through lifestyle intervention before AOM use.^{61,62} The 2022 AGA guidelines do not make recommendations on what defines an inadequate response to lifestyle interventions.

The AGA guidelines proposed a hierarchical treatment algorithm among AOMs, recommending semaglutide (GLP-1 agonist), liraglutide (GLP-1 agonist), phenentermine-topiramate ER, and naltrexone-bupropion ER for long-term use depending on patient clinical profiles, comorbidities, preferences, costs, and access to therapy.⁶³ While guidelines suggest that physicians should continue use only if patients lose 5% or more of their body weight after three months, they make no recommendation regarding how AOMs should be alternated or combined to ensure that patients experience long-term weight loss, and guidance on long-term AOM use is limited.⁶⁴

Telehealth services

Telehealth has emerged as a new means to expand access to provider visits for obesity diagnosis and treatment at lower costs than in-office care, and medical professional organizations are in the early stages of identifying and recommending best practices.⁶⁵ The Obesity Medicine Association (OMA) issued a clinical practice statement providing guidance on the development and implementation of telehealth services for obesity diagnosis and management.⁶⁶ The OMA recommends that telehealth should be used for assessing patients for diagnostic purposes, educating patients about obesity, providing behavioral therapy, prescribing AOMs, and referring for bariatric surgery assessment. However, the literature on implementation of these practices is nascent. Developing pilot programs for obesity diagnosis and treatment through telehealth would provide initial evidence to develop best practices and increase access to providers.

As organizations continue to develop guidelines, they should consider intentional practices to address existing health inequities. Telehealth consultations have reduced inequities in access to bariatric surgery by reducing initial consultation no-show rates by half among urban minority populations.⁶⁷ Telehealth also presents an opportunity to facilitate access to non-physician care providers (e.g., registered dietitians and providers of exercise interventions). Due to Medicare telehealth coverage expansions during the COVID-19 public health emergency, telehealth use was 63 times higher in 2020 than in 2019. There is political will to make the telehealth expansions permanent. In July 2022 when the House passed a bill to extend telehealth expansions through 2024, the vote was 416 to 12.⁶⁸

Nonetheless, though increased telehealth has improved access, Black and rural beneficiaries increased their use of telehealth at lower rates than white and urban beneficiaries.⁶⁹ Addressing health inequities through telehealth for the most impacted populations will require intentional refinement of service provision over time.

3.2.2. Obesity treatment coverage in Medicare

Since the Medicare Part D benefit was introduced in 2003, it has explicitly excluded coverage of “[a]gents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., severe obesity)),” in contrast to treatment guidelines.⁷⁰ While an explicit rationale for AOMs’ exclusion was never included in the legislation, their exclusion implies that they were not considered to be essential for medical care at that time—a clinical consensus that has since changed. Reversing this statutory exclusion would require congressional legislation, which has been proposed as a part of the bipartisan Treat and Reduce Obesity Act of 2021.

Despite the exclusion of AOMs from standard Medicare Part D formularies, Part D plans can cover AOMs as part of enhanced alternative coverage, but very few plans cover AOMs, in contrast to other federal plans:

- In 2017, just 209 people among the 42 million Medicare Part D beneficiaries were reimbursed for an AOM.^{71,72}
- A 2022 decision by the Office of Personnel Management required health plans for federal employees to cover AOMs beginning in 2023, providing AOM access to approximately 9 million people.^{73,74}
- The VA covers AOMs in addition to behavioral and lifestyle interventions.⁷⁵

As for medical treatment for obesity, original Medicare, consisting of Parts A and B, covers both IBT and bariatric surgery. Below we summarize coverage for each, including eligibility, cost sharing, and evidence that led to coverage decisions. Medicare Advantage covers these treatments and can also cover fitness memberships such as Silver Sneakers.⁷⁶

Intensive behavioral therapy in original Medicare

In Medicare, IBT for obesity involves obesity screening, a dietary assessment, and behavioral therapy to promote sustained weight loss via interventions on diet and exercise.⁷⁷ In 2003, the USPSTF recommended that physicians screen adults for obesity and offer IBT. In 2011, that recommendation, together with the rising prevalence of obesity, led CMS to cover IBT for obesity in Medicare for people with a high BMI without cost sharing, but the coverage was limited in duration, provider type, and number of visits.⁷⁸

In public comments to CMS’s proposed IBT coverage, questions were raised about why pharmacotherapy was not included as part of the benefit. CMS responded by citing the USPSTF, which in 2011 stated that interventions that combine behavioral therapy with orlistat or metformin lead to weight loss but were not recommended due to possible harms and lack of data on maintenance of improvement after medication discontinuation.⁷⁹

Despite evidence that IBT can lead to 3% weight loss, the literature identifies several critiques of the Medicare IBT benefit.⁸⁰ On the patient side, most of the evidence showing the efficacy of IBT as a treatment for obesity stems from younger populations than those typically enrolled in Medicare. Medicare patients with obesity are eligible for up to 22 IBT visits per year but must lose 6.6 pounds in the first six months to continue treatment.⁸¹ Concerns have been raised about the effectiveness of 15-minute sessions and about whether costs for patients to travel for these short sessions are prohibitive.⁸² On the provider side, a common critique is that only primary care providers (PCPs) can be reimbursed for IBT, and they generally cannot provide IBT on the same day as another office visit. Reimbursement for IBT is low (see Section 3.3), making the opportunity cost of IBT for busy PCPs

high. Some PCPs have reported that IBT is not within their expertise. These factors limit IBT use in Medicare, with fewer than 1% of eligible patients receiving treatment.⁸³

Bariatric surgery in original Medicare

The bariatric surgery benefit was introduced in 2006 for patients with a BMI ≥ 35 kg/m², an obesity-related comorbidity, and failure with obesity treatment.⁸⁴ Bariatric surgery for obesity without comorbidities is not considered “reasonable and necessary.” Initially, Medicare covered only bariatric surgery performed in approved facilities, but this restriction was removed in 2013 to increase access.⁸⁵ Patients are required to pay deductibles and cost-sharing for bariatric surgery.

CMS’s 2006 decision to cover bariatric surgery relied on it being more effective for weight loss than pharmaceuticals available at that time or diet, as well as on evidence of failure of nonsurgical treatments for weight loss and maintenance.⁸⁶ However, the effectiveness of more recent AOMs for short- and long-term weight loss since CMS’s coverage decision warrants a re-evaluation of whether pharmaceuticals should be attempted and failed before bariatric surgery. Though CMS initially expressed concern that the bariatric surgery evidence from younger populations could not be generalized to older populations due to significantly higher risks of surgery for the latter, evidence introduced during the public comment period showed that high-volume surgeons had comparable mortality outcomes for patients under and over age 65.⁸⁷ This spurred the initial coverage decision—that bariatric surgery would be covered but only if performed in high-volume certified facilities. This facility requirement was removed in 2013 to promote access to the procedure.⁸⁸ However, because surgical complications can occur, patients must have comorbidities to be eligible for bariatric surgery (such that benefits, including decreased comorbidities, outweigh risks).⁸⁹

Obesity treatment coverage: Key findings and implications

Key findings

- Current Medicare treatment coverage does not align with national guidelines that recommend the use of AOMs
- Only PCPs can be reimbursed for IBT in Medicare, and take-up is low
- The 2006 coverage decision for bariatric surgery in Medicare relied in part on it being more effective than the AOMs available at that time, which had lower effectiveness than new AOMs

Implications

- The probable large unmet need for obesity treatment in Medicare populations may be reduced by covering AOMs and expanding IBT coverage
- Beneficiaries aging into Medicare who have been successfully treated with an AOM will lose coverage

3.3. Provider reimbursement and incentives

This section outlines and discusses reimbursement and other financial incentives affecting the provision of, and in turn patients’ access to, obesity treatment. We begin with a discussion of reimbursement in Medicare for IBT and bariatric surgery. We then outline a sample of financial incentives in Medicare and in alternative payment models to assess the extent to which they would affect access to obesity treatment, including AOMs.

3.3.1. Medicare reimbursement for IBT

Medicare's low reimbursement for IBT discourages its provision. In the 2023 fee schedule, reimbursement for a 15-minute IBT sessions is \$26 (G0447), much lower than the \$57 for a 10- to 19-minute established patient office or other outpatient visit (HCPCS: 99212).⁹⁰ This rate disparity creates an opportunity cost to physicians that discourages IBT provision.⁹¹ Furthermore, IBT is permitted only for patients with BMI above 30 kg/m², which is at odds with guidelines that recommend IBT at lower BMI thresholds, as discussed above.⁹² Research has shown that administrative burdens and lack of knowledge about reimbursement has led providers to underdiagnose and undertreat obesity.⁹³

3.3.2. Financial incentives affecting diagnosis and treatment

Though financial incentives and alternative payment models in Medicare may encourage increased diagnosis and treatment of obesity, many such models do not directly incentivize treatment with AOMs. Below, we outline a subset of models that include elements that could provide incentives for increased AOM use once AOMs are covered in Medicare.

Medicare Advantage Star Ratings

Medicare Advantage provide a managed care option for Medicare beneficiaries that can also integrate drug coverage. Star Ratings measure a plan's performance relative to all other Medicare Advantage plans across 38 quality metrics considering preventative care, chronic condition management, plan responsiveness, member complaints, and customer service.⁹⁴ Changes to Star Ratings determine bonuses or penalties for the plans.

Medicare Advantage plans often offer financial incentives to providers to influence their behavior in alignment with the rating metrics.^{95,96,97,98} While the financial incentives offered by these plans have the potential to change physician behavior, it is unclear how effective they are in practice, and they affect only a subset of covered Medicare lives.^{99,100,101}

Some Star Ratings may improve with weight loss, e.g., risk of falling, adherence to diabetes and hypertension medications, blood sugar and blood pressure control, monitoring of physical activity, and osteoporosis management. The proportion of Medicare patients enrolled in Medicare Advantage plans is expected to reach 70% by 2030,¹⁰² so the Star Ratings program is a potential system for incentivizing insurers, and subsequently physicians, to diagnose and treat obesity provided they have access to coverage for the full range of treatments, including AOMs. As the prevalence of obesity rises, metrics may need to be developed that reflect quality of care for patients with obesity, such as diagnoses, treatment initiation, and weight reduction measures.

Medicare physician reimbursement

Some physicians receive payments through the Merit-Based Incentive Payment System track and are financially rewarded or penalized based on composite performance scores, including on clinical quality measures.¹⁰³ Having the option (with coverage and reimbursement) to treat patients with AOMs could enable physicians to improve quality measures for developing follow-up plans after BMI screening (Q128), trial of conservative (nonsurgical) therapy for total knee or hip replacement (Q350), and other measures related to the management of diabetes, hypertension, fall prevention, osteoporosis, and other conditions.¹⁰⁴

Center for Medicare and Medicaid Innovation Models

The Bundled Payment for Care Improvement Advanced model of the Center of Medicare and Medicaid Innovation (CMMI) is an example of a payment model that could be used to encourage treatment with AOMs if they were covered by Medicare. Another CMMI model, the Medicare Diabetes Prevention Program (MDPP), establishes a standardized lifestyle change program to reduce weight in people with prediabetes. The MDPP incentivizes patient and provider participation in obesity treatment and presents an opportunity for future concurrent AOM use.

Bundled Payment for Care Improvement Advanced model

Bundled Payment for Care Improvement Advanced is a voluntary Advanced Alternative Payment Model (APM) under Medicare that incentivizes physicians to deliver services more efficiently by fixing reimbursement for an episode of care to a target price, including for bariatric surgery.¹⁰⁵ If the true cost of care is below the target price, CMS pays physicians the difference; if it is higher than the target price, physicians owe CMS a payment.¹⁰⁶ While bundled payments are not tied to obesity metrics, physicians may financially benefit from reduced obesity prevalence, as obesity is associated with higher risks for postoperative complications, readmissions, and longer operation time.^{107, 108} Coverage for AOMs would enable physicians to treat obesity that leads to poorer health outcomes and higher costs in other episodes of care.

Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program (MDPP) model began as a CMMI pilot in 2013 that used IBT to encourage exercise and dietary change for people with moderate to high levels of obesity and prediabetes. It was expanded in 2018 after demonstrating success.¹⁰⁹ Findings from the expanded program demonstrate that it is effective at reducing weight by roughly 5% and at increasing physical activity, and that offering virtual visits increases enrollment.¹¹⁰

However, this program has faced challenges as a stand-alone weight loss treatment. The AACE/ACA guidelines recommend a weight-loss target of 10% for people with prediabetes and overweight or obesity.¹¹¹ MDPP participation by patients and providers has fallen short of expectations, with only a few thousand participating patients among an estimated eligible population of 16.4 million.^{112, 113} This is due, in part, to low awareness among patients, poor marketing, plan designations of available MDPP providers as out-of-network providers, and lack of reimbursement for complementary provider efforts to promote adherence to lifestyle changes beyond IBT sessions.¹¹⁴ Adding access to AOMs in Medicare has the potential to support greater weight loss within the MDPP program and may also make the program more attractive to potential participants.

Financial incentives: Key findings and implications

Key findings

- Medicare reimbursement for IBT is low compared to reimbursement for other types of office visits
- Current quality metrics that underlie financial incentive programs in Medicare do not directly relate to obesity treatment; if they encourage weight loss, they would do so only indirectly.

Implications

- Obesity diagnosis and treatment may increase with provider training on appropriate coding and billing practices
- Evidence linking AOM treatment to improvements in current quality metrics is needed
- Given the prevalence of obesity, the development and implementation of related quality metrics as Star Ratings may improve quality of care for patients

3.4. Provider and patient education

This section describes provider and patient education with respect to obesity knowledge and obesity treatment, factors that could hinder adequate care for populations with obesity.¹¹⁵

Provider education

Despite increased acceptance of obesity as a chronic disease, provider gaps in understanding can lead to barriers in the provision of obesity treatment.¹¹⁶ Some clinicians hold beliefs that only dietary and lifestyle changes can treat obesity, and others specifically overvalue the role of exercise and undervalue the role of AOMs in obesity management.^{117,118} Low AOM prescription rates have been linked to historic safety and efficacy concerns and to provider uncertainty regarding appropriateness of pharmaceuticals for obesity treatment.¹¹⁹

The evidence is that healthcare providers do not have a full understanding of evidence-based recommendations for obesity care, which may be due in part to the lack of obesity-focused training in medical schools and residencies.¹²⁰ In a nationally representative sample, only 16% of PCPs knew the IBT clinical guidelines and only 15% knew the appropriate criteria for AOM treatment.¹²¹

Challenges remain even among providers who are aware of obesity treatment. A 2021 study of clinicians who had provided IBT found that four difficulties surrounding obesity care can lead practices to opt out of providing treatment: (1) lack of training on obesity management; (2) the complex, multifaceted nature of obesity management, (3) low reimbursement for weight management relative to other services; and (4) obesity management requiring systemic change beyond the medical office.¹²²

Patient education

Patient education is a significant component of obesity treatment, as evidenced in guidelines recommending that providers counsel patients on lifestyle interventions, including diet and exercise. However, evidence shows that patients do not have a good understanding of their own obesity status and what constitutes “successful” obesity treatment.

Patients have been found to misrepresent the weight levels that constitute obesity. One study found that despite patient awareness of obesity as a health issue, only a third of patients with obesity perceived themselves as having obesity.¹²³ Specifically, only a third of patients with BMIs between 30 and 34.9 kg/m² and 60% of all patients with obesity perceived that they had obesity.¹²⁴

Patients appear to have expectations of weight loss following obesity treatment that do not align with clinically meaningful weight loss levels. In one study, the average post-treatment weight loss that patients with obesity considered “disappointing” was 15.6% of starting weight, whereas physicians viewed 10% as successful.¹²⁵ Evidence of new AOMs demonstrating over 20%¹²⁶ weight loss may help patients anticipate success that aligns with their high weight loss expectations if they engage in treatment.

Education: Key challenges and implications

Key findings

- Many providers still believe that obesity is a lifestyle-related disease and lack training on obesity management and the safety and efficacy of treatments
- Patients do not understand their own obesity status, and they expect high levels of weight loss with obesity treatment

Implications

- Increased education and training for providers, including on the safety and efficacy of new AOMs and their appropriate use, is needed to increase obesity treatment in Medicare
- Effectiveness of new AOMs may provide an opportunity to reframe obesity treatment and meet patient and provider expectations for weight loss

4. Recommendations and conclusion

Drawing from the analysis of Medicare diagnosis, treatment, and reimbursement for obesity, as well as research on patient and provider education, this section sets out recommendations regarding obesity diagnosis and treatment in Medicare and discusses the potential for changes in Medicare coverage.

4.1. Recommendations

Obesity diagnosis

National guidelines recommend obesity diagnosis based on BMI in addition to other factors, but Medicare coverage policy principally relies on BMI and therefore may fail to provide coverage to many patients with obesity. The emergence of obesity care through telehealth services creates opportunities for expanding access to obesity diagnostic assessments, particularly to underserved and rural populations.

Recommendations

- Given the widespread use of BMI, continue to use it as a primary diagnostic tool in the short term despite its limitations. In the medium to long term, Medicare should update its diagnosis criteria to

reflect the latest science and guidelines around obesity as well as evidence on elderly body composition rather than using BMI exclusively.

- Invest in pilot programs that examine whether the permanent expansion of telehealth can support obesity diagnosis and treatment support. Pilot programs should seek to develop greater evidence for telehealth's potential to expand diagnosis and effective treatment, particularly in rural and other underserved communities and if paired with access to AOMs.

Obesity treatment

Recent treatment guidelines in the US reflect the weight-loss advancements of newer AOMs. Medicare's treatment coverage was based on older evidence about the disease and on pharmaceuticals that were not as effective as those available now. The safety and efficacy of new AOMs support an update to the USPSTF recommendation and can be used to advocate for change in Medicare. In addition, consideration should be given to coverage in FEHBP and the VA and the justification for divergent Medicare coverage.

Recommendations

- The coverage of AOMs in the FEHBP and VA should be compared to coverage in Medicare to highlight differences in obesity treatment across these plans
- Medicare should update obesity treatment eligibility criteria to reflect the latest science and guidelines, particularly regarding coverage of AOMs and bariatric surgery, recognizing the limitations of using current BMI thresholds alone
- Medicare should provide coverage for IBT services by qualified providers beyond primary care physicians
- Develop a broad evidence base, concurrent with Medicare Part D coverage of AOMs, to support improved obesity treatment, including the following:
 - Evidence on the impact of AOMs on short- and long-term weight loss and other health conditions, particularly in combination with IBT and in comparison to IBT alone.
 - Evidence to understand how national guideline recommendations to require failure of six months of lifestyle interventions before AOM access adversely impacts outcomes and/or patient motivation to seek treatment
 - Evidence to understand how AOM use would affect adherence and outcomes for IBT, physical activity, and nutrition interventions
 - Evidence of the potential for AOM access to increase the efficacy of other CMS incentive programs, including the MDPP and Star Ratings
 - Evidence to help clinicians better understand when and how to use AOMs alongside other interventions

Reimbursement and financial incentives

The analysis uncovered low reimbursement for IBT treatment, which has been linked to low levels of use by healthcare providers. Until Medicare covers AOMs, APMs and other financial incentives will not directly lead to increased AOM utilization. However, if Medicare covers AOMs, financial incentive programs should make associated changes to quality-based payments to increase access to treatment.

Recommendations

- Engage CMS to improve adoption of IBT provision by increasing reimbursement rates, encouraging further telehealth adoption of IBT, and expanding provision by providers beyond PCPs
- To contribute to the goal of Medicare coverage, engage physician societies on the potential to improve Merit-Based Incentive Payment System quality measures with treatment of obesity using IBT and AOMs
- Concurrent with Medicare Part D coverage of AOMs, the generation of more real-world evidence is needed to understand the following:
 - The extent to which AOM and IBT access increase certain Medicare Advantage Star Ratings—this evidence may be used to engage CMS on the importance of AOM coverage to increase the efficacy of other incentive programs
 - How AOM access may reduce overall patient cost of care in bundled payment programs and Accountable Care Organizations. Since lower obesity and comorbidity prevalence can increase insurer or provider group share of cost savings, this could create an incentive for enhanced coverage plans
 - The impact of AOM access on long-term overall cost of care for different high-burden populations (e.g., elderly adults, low-income adults, certain racial and ethnic groups, rural) to counteract existing estimates of the cost of coverage to the federal government (Congressional Budget Office) and beliefs about the cost of treatment.

Patient and provider education

The availability of more effective treatments has created a renewed opportunity to educate both patients and providers on the science of the disease and the importance of treating obesity as a chronic condition.

Recommendations

- Increase education and training for providers, including PCPs, physician assistants, nurse practitioners, and obstetrician–gynecologists, on the science of obesity and new treatments, including the safety and efficacy of new AOMs
- Continue to educate patients on new AOMs and their safety and efficacy, particularly in enabling patients to follow recommended lifestyle modifications

Influence of AOM coverage beyond Medicare Part D

Weight loss and reduced prevalence of obesity, and even improvements in patient mobility, may keep them out of post-acute and long-term care settings, reducing expenditures for individuals and the health system. In addition, there is evidence that changes to CMS reimbursement for bariatric surgery has influenced physician practice patterns regarding patients beyond Medicare.¹²⁷ It is possible that if Medicare covers AOMs, that may similarly impact physician practice patterns to patients beyond Medicare by normalizing AOM prescribing. Medicare coverage of AOMs may influence commercial insurers and employers to also expand AOM coverage.

4.2. Conclusion

To improve the treatment of obesity, the mismatch between Medicare Part D's prohibition of coverage and national guidelines and current federal support of access in other plans (e.g., FEHBP) needs to be understood. If the Treat and Reduce Obesity Act of 2021 were to become law, evidence generation concurrent with increased AOM access may help to inform better use of AOMs in the Medicare population and substantiate concerns on safety, short- and long-term effectiveness, and savings to medical spending. In addition to unmet need in Medicare, there are equity concerns surrounding obesity treatment, particularly among people of color. Expanding access to obesity treatments under Medicare would progress goals of addressing these health inequities and provide continuous access to treatment for adults aging into Medicare who would otherwise lose coverage.

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