CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PUBLIC WEBINAR

Measuring What Matters

Improving Obesity Management and Outcomes

PRESENTERS:

William H Dietz MD, PhD | STOP Obesity Alliance
Tracy Zvenyach, PhD | Obesity Action Coalition

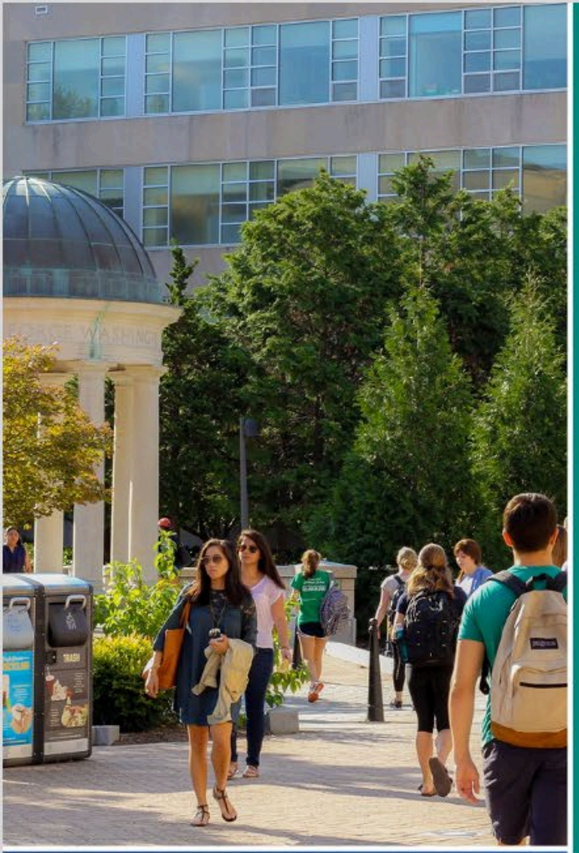
Learning Objectives

Today, we will

- Highlight the need for effective quality measures addressing obesity
- Share strategies for implementing obesity-related quality measures
- Examine current barriers to obesity care
- Discuss recommendations for next steps for developing an obesity quality measure

Today’s Presenters

- **William H Dietz MD, PhD,** STOP Obesity Alliance
- **Tracy Zvenyach, PhD,** Obesity Action Coalition



THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC

William H Dietz MD, PhD

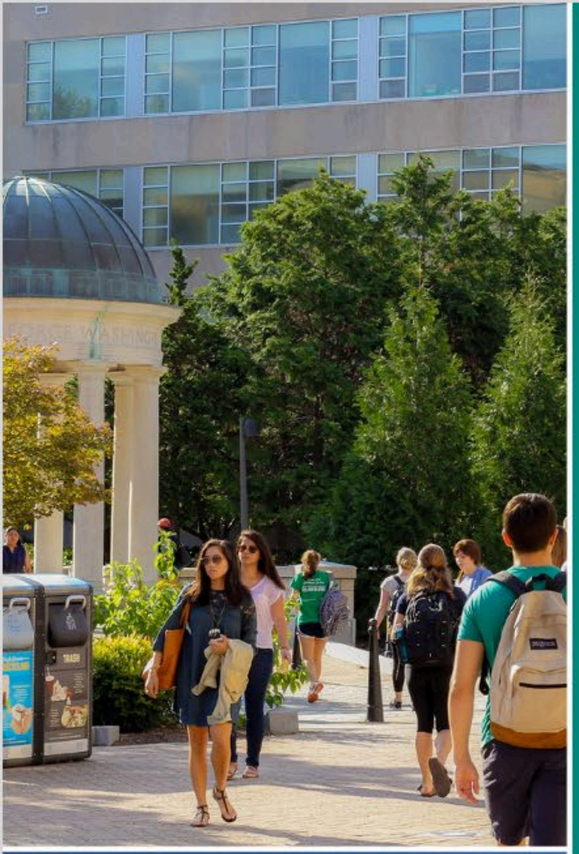
STOP Obesity Alliance

Milken Institute School of Public Health

THE GEORGE WASHINGTON UNIVERSITY

STOP OBESITY ALLIANCE

STRATEGIES TO OVERCOME & PREVENT



Meet Patty

https://stopweightbias.com/voices-and-experiences/meet-patty/

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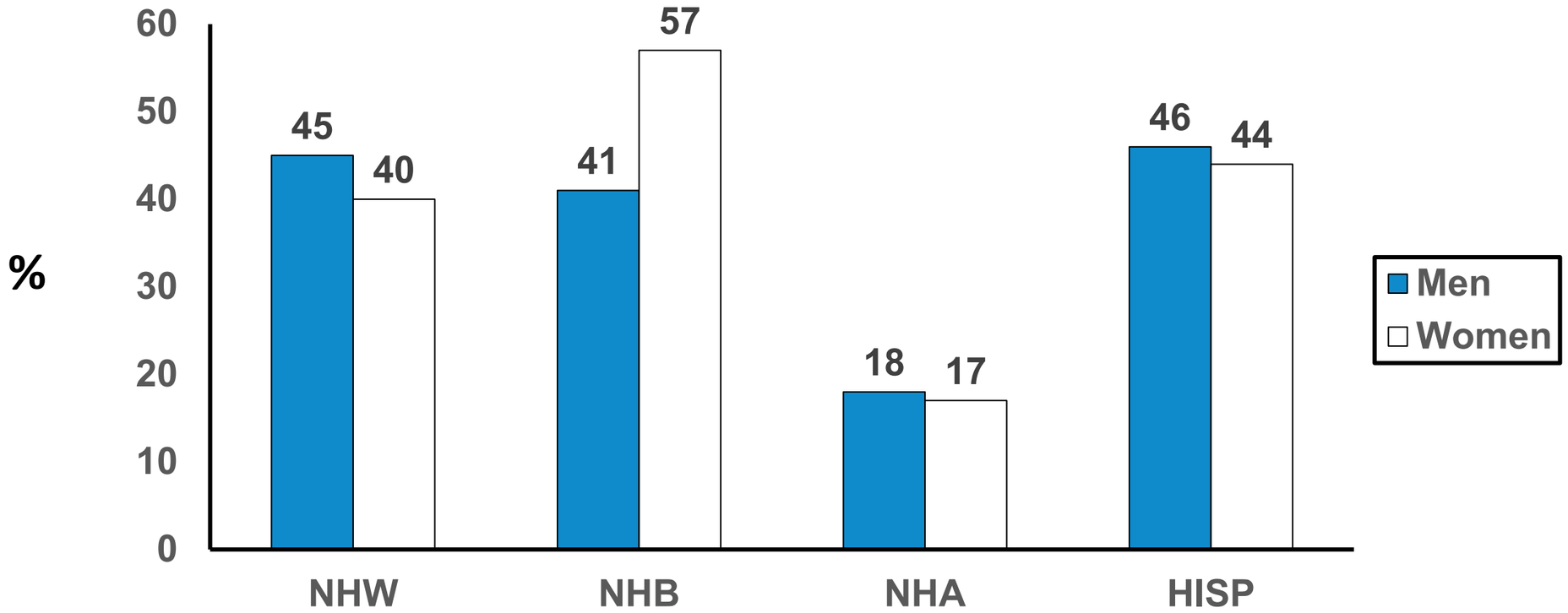
STOP OBESITY ALLIANCE
STRATEGIES TO OVERCOME & PREVENT

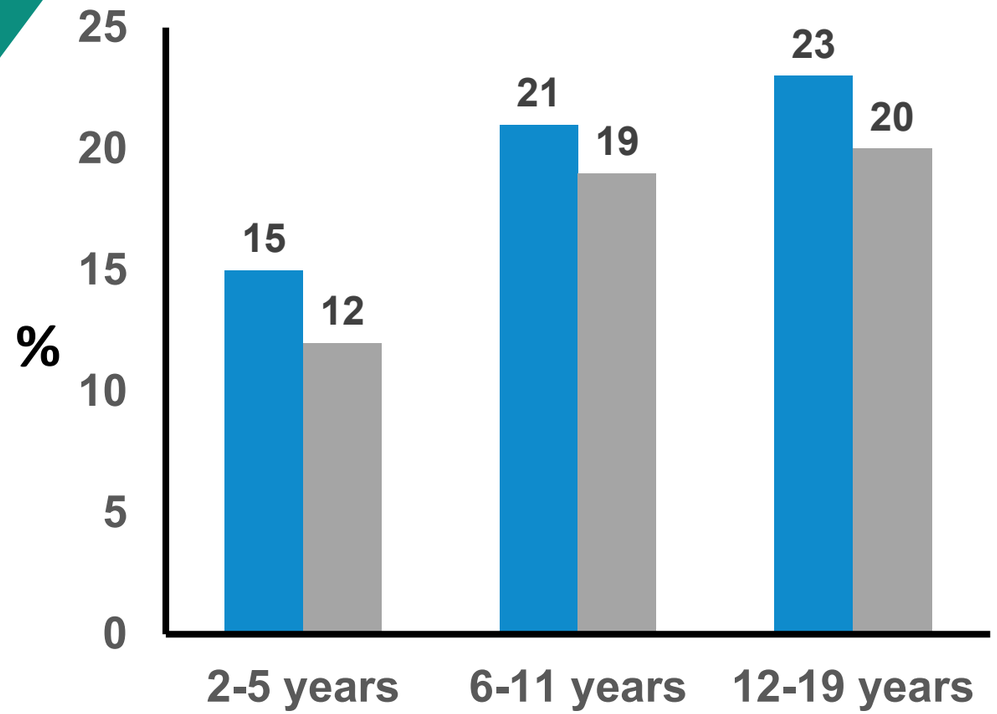
Prevalence by Race/Ethnicity in Men and Women 2017-2018

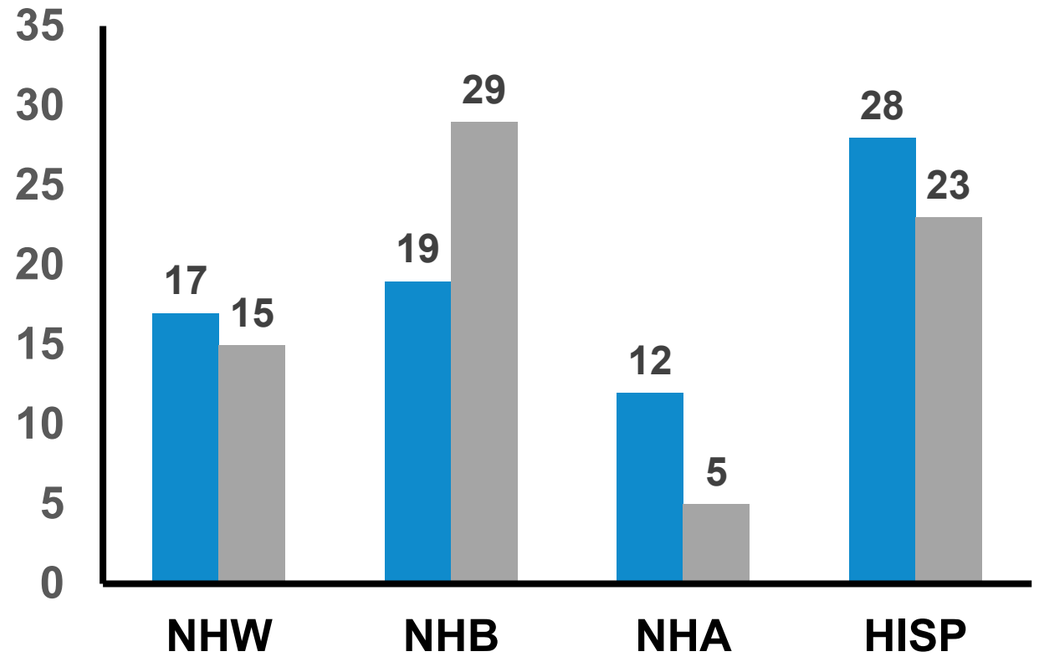


Legend:
Non-Hispanic White (NHW)
Non-Hispanic Black (NHB)
Non-Hispanic Asian (NHA)
Hispanic (HISP)

Hales CM et al. NCHS Data Brief # 360, February 2020

Prevalence of Obesity by Age, Gender, and Ethnicity in 2-19 yo; NHANES 2017-2018





Fryar CD et al. NCHS Health E-stat December 2020

Note: Prevalence in NHA sample of girls considered unreliable

Most Prevalent Co-morbidities of Obesity in 270,657 Participants in All of Us

Of patients with classes 1-3 obesity

- 45% have hypertension
- 38% have dyslipidemia
- 18% have obstructive sleep apnea
- 23% have diabetes
- 18% have metabolic dysfunction associated steatosis

Comorbidities increase with BMI. No data regarding frequency of multiple comorbidities with increasing BMI

Yao Z et al. NEJM Evidence 2025; 4(4) DOI: 10.1056/EVIDoa2400229.

Cost Savings from Weight Loss with Comorbidities in Medicare and Employer-sponsored Insurance (ESI)

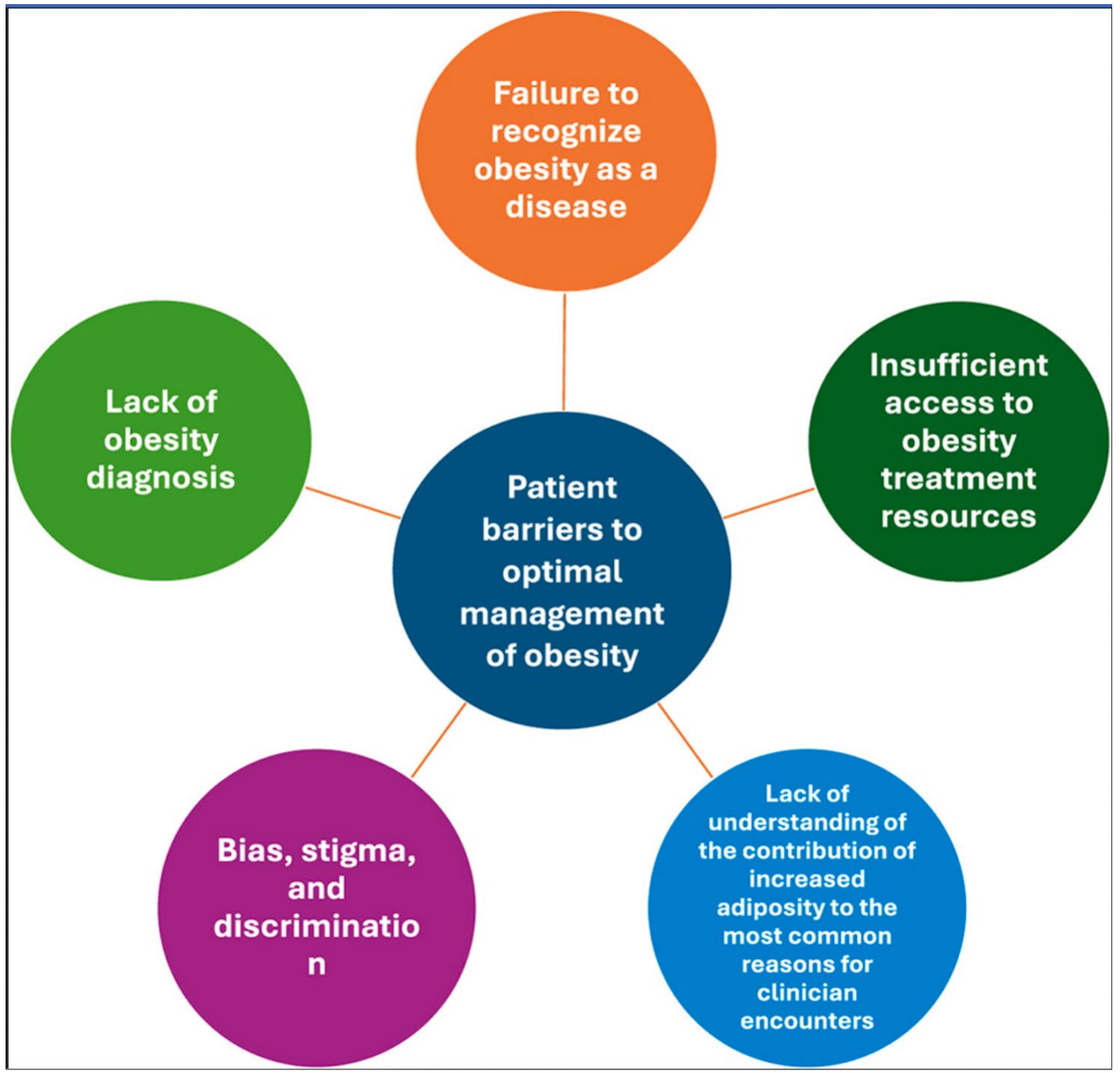
BMI	Cost Savings
30 ESI- 5% decrease	$441
30 Medicare – 5 % decrease	$834
30 ESI - 15% decrease	$1234
30 Medicare -15% decrease	$2351
45 ESI - 5% decrease	$1426
45 Medicare - 5% decrease	$2293
45 ESI – 15% decrease	$3860
45 Medicare – 15% decrease	$6271

Thorpe KE & Joski PJ. JAMA Network Open 2024; 7(12) e2449200

What Constitutes Comprehensive Obesity Treatment?

- Prevention and Screening
- Intensive Behavioral Therapy
  - Physical Activity
  - Nutrition Therapy
  - Cognitive Behavioral Therapy
- Pharmacotherapy
- Bariatric Surgery
- Weight maintenance

Barriers to Accessing Obesity Care



Pennings N et al, Obesity Pillars, 2025; 6(14), https://doi.org/10.1016/j.obpill.2025.100172.

Why Do We Need Quality Measures?

- Holds providers/payers accountable - what gets measured gets done
- Links to payment – criteria for value-based care
- Monitor quality of care delivery
- Improve outcomes
- Assess patient satisfaction
- Inform consumers

Criteria for Quality Performance Measures

Requirements

- Meaningful - firm evidence base links process to important clinical outcomes
- Feasible, reliable and suitable for application across health care systems at reasonable cost
- Assess variability so that improvements can be monitored
- Tested – no unintended adverse consequences or undue burden for patients or providers

Sampsel S et al. Am J Manag Care 2021; 27:562

Types of Quality Measures

- Process – was a step completed
- Outcome – measures the result of patient care
- Patient experiences – patient's perspective on care
- Structural – condition for care delivery like staffing
- Composite – combines multiple measures

National Quality Forum Endorsed Obesity Measures 2016*

- Adult patients with documented BMI
- Adults with serious mental illness screened for obesity with follow-up for people with obesity
- Child overweight or obesity based on parental report of height and weight
- Weight assessment and counseling for nutrition and physical activity in children and adolescence*

***All endorsements have been removed by NQF, except for the childhood measure**

(Battelle is the current consensus-based entity (CBE) for endorsement: https://p4qm.org/about)

Current Obesity Measures

Measure Name	CMS Merit-based Incentive Payment System (MIPS)	NCQA HEDIS Measures	CMS Medicaid Child Core Set (0 adult measures)
Adult measure: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	√		
Pediatric measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	√	√	√

(CMS, Explore Measures & Activities, 2022), (NCQA, HEDIS Measures, 2022) (CMS, Medicaid and CHIP Core Measure Set, 2022). (CMS, Measure Inventory Tool, 2023)

American Medical Group Association Measures - 2020

Operational tracking
- Obesity prevalence
- Prevalence of obesity related complications

Quality performance
- Obesity diagnosis
- Change in weight over time
- Anti-obesity medications
- Assessment obesity related complications

Findings

These measures were found to be feasible, provided value to participating MCOs, and demonstrated variation and differences over time.

Patient-centered outcomes
- Number of Patient Centered Reported Outcomes (PROMs) completed
- Change in score of PROM surveys

Ciemins E et al. Pop Health Mngmnt 2021; 24:482

AMGA Foundation's Obesity Management Quality Improvement Collaborative – 2025

6 AMGA member HCOs participating over 9 months with a goal to increase the number of people with obesity who receive a formal diagnosis, evidence-based comprehensive care, and education on the importance of long-term sustainable outcomes.

Measures tested through quantitative data collection:

- Prevalence of Overweight and Obesity
- Obesity Diagnosis
- Obesity Care (evidence-based weight management treatment, including lifestyle, counseling, nutritional services, obesity medication prescriptions, bariatric interventions)

Quality Improvement and Measure for Pediatric Weight Management: Project of the CDC Div of Nutrition, Physical Activity and Obesity and AllianceChicago*

KAS 3. In children 10 y and older, pediatricians and other PHCPs should evaluate for lipid abnormalities, abnormal glucose metabolism, and abnormal liver function in children and adolescents with obesity (BMI ≥95th percentile) and for lipid abnormalities in children and adolescents with overweight (BMI ≥85th - <95th percentile).

Measure Description

Percentage of patients 10-17 years of age who are eligible for and receive guideline-based metabolic screening for diabetes, hyperlipidemia AND liver disease

***AllianceChicago: A national network of Community Health Centers with a mission to improve personal, community and public health through innovative collaboration.**

Recommendations from the Lancet Commission

Diagnosis of obesity

- BMI plus as a measure of adiposity
- Adiposity measures include waist circumference, waist:hip ratio or waist height ratio

Pre-clinical obesity: obesity and no organ, tissue, or body system dysfunction

Clinical obesity

- At least one of 18 organ, tissue, or body system dysfunction for adults or one of 13 for children and adolescents
- Examples: PCOS in both adults and pediatric patients; CVD in adults, increased arterial pressure in children and adolescents

Type 2 diabetes considered as independent disease entity and not a criterion for clinical obesity

Comments on Recommendations for Adults

BMI plus is a sound measure of obesity

- Waist circumference reflects fat distribution as well as adiposity
- Adult standards for WC exist: ≥88 cm in women ≥102 cm in men
- No provider experience with waist measures
- In US, would require revisions in coding for obesity

No estimates of prevalence of clinical obesity

- 57% of adults with obesity have at least 1 of 18 comorbidities, but only about half were among the Lancet Commission's disease states

Pearson-Stuttard et al. IJO on line 9/18/2023; 47:1239

Comments on Recommendations for Children

Diagnosis of obesity

Commission did not use percentile measures for pediatric obesity

- BMI alone is a highly specific measure of body fatness in children and adolescents
- No pediatric standards exist for waist circumference or waist:hip ratio; waist:height ratio = 0.5 has been proposed but without cutpoints for morbidities
- Revised coding for obesity would be required

In a clinical study of prevalence of 12 comorbidities in pediatric patients with obesity, only elevated blood pressure and steatohepatitis were among the 13 criteria proposed by the Commission (Nussbaum et al. Clin Obesity 2021; 11e12478).

Not clear that the absence of the Commission's criteria for clinical obesity would change treatment of pediatric patients with obesity and risk factors alone

BMI Plus as a Quality Measure of Obesity

- Provides an estimate of body fat
- Consistent association with risk that has an acceptable variation with age, sex, and race
- Assesses body fat distribution

Tracy Zvenyach, PhD

Director, Policy Strategy & Alliances

June 26, 2025

OAC Obesity Action Coalition 20 YEARS SINCE 2005

Obesity treatment recommendations in progress

Open access Review

BMJ Open Diabetes Research & Care

Introduction and methodology: Standards of Care in Overweight and Obesity—2025

Raveendhara R Bannuru, ADA Professional Practice Committee (PPC)

To cite: Bannuru RR, . Introduction and methodology: Standards of Care in Overweight and Obesity—2025. BMJ Open Diab Res Care 2025;13:e004928. doi:10.1136/bmjdrc-2025-004928

Received 15 January 2025
Accepted 28 March 2025

American Diabetes Association, Arlington, Virginia, USA

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ABSTRACT

Obesity is a chronic, relapsing, and progressive disease requiring long-term, interprofessional treatment strategies to improve health outcomes. With over 40% of US adults and nearly 20% of children affected, obesity remains a significant public health concern. Despite the American Medical Association's recognition of obesity as a chronic disease, gaps persist in education, training, and access to effective treatments. These gaps contribute to inadequate obesity management and reinforce stigma and weight bias in healthcare settings.

The Standards of Care in Overweight and Obesity—2025, developed by The Obesity Association™, a division of the American Diabetes Association®, (ADA's Obesity Association), will provide evidence-based recommendations for screening, diagnosis, and management of obesity and related complications. These guidelines will emphasize a complication-centric, risk-reduction approach rather than solely focusing on weight loss. The recommendations will be intended for healthcare professionals, including but not limited to primary care physicians, endocrinologists, obesity medicine physicians, dietitians, and behavioral health specialists, as well as policymakers and insurers.

The guideline development will follow a rigorous methodology, incorporating evidence from systematic literature reviews, expert consensus, and public feedback. Recommendations will be graded based on the quality and certainty of supporting evidence, with the goal of annual updates to ensure alignment with the latest research. A stringent conflict-of-interest policy will be maintained to uphold guideline integrity.

By promoting personalized and equitable obesity care, these guidelines will aim to bridge existing gaps in clinical practice, enhance treatment accessibility, and improve long-term health outcomes for individuals with overweight or obesity.

INTRODUCTION

Obesity is a chronic, relapsing, and progressive chronic disease[1] that requires long-term, multicomponent treatment strategies to improve the health and well-being of individuals. Over 40% of US adults and nearly 20% of US children (aged 2–19 years) are currently estimated to have obesity,[2 3] and this prevalence is forecasted to increase over the coming years.[4] Substantial evidence exists to support the role of treatments, including lifestyle modification, pharmacotherapy, and metabolic-bariatric surgery, to improve outcomes. When treating overweight and obesity, a complication-centric, risk reduction, and disease burden reduction approach may be considered that incorporates managing and preventing multiple weight-related complications rather than solely focusing on achieving a specific weight reduction goal.[5 6] This strategy allows tailoring of treatment recommendations for people with overweight or obesity and identifies individuals who may best benefit from treatment.[7 8]

Despite the American Medical Association recognizing obesity as a chronic disease over two decades ago,[9 10] the available comprehensive medical evaluation and effective obesity treatments are still not implemented or always available in routine clinical practice.[11 12] The lack of education and training for healthcare professionals on obesity and its management is theorized to contribute to these care gaps.[13 14] Additionally, clinicians may not always feel confident about how to sensitively approach the topic of obesity treatment with individuals under their care,[15] particularly given the issues of weight bias and stigma.[16] Some healthcare professionals continue to erroneously believe that people living with obesity lack willpower,[17 18] rather than understanding the multitude of factors that contribute to the development of overweight and obesity.[18 19] Beyond clinicians and healthcare systems, health insurers and regulators have roles in improving obesity care by increasing capacity for and coverage of the available evidence-based treatments.[5] These changes are critical to reducing the complications and premature mortality associated with excess weight.[20]

The American Diabetes Association (ADA) and their subdivision, The Obesity Association's *Standards of Care in Overweight and Obesity*, provides clinicians, researchers, policy

Accepted: 15 May 2025
DOI: 10.1002/oby.24336

ORIGINAL ARTICLE

Obesity WILEY

Nutritional priorities to support GLP-1 therapy for obesity: A joint Advisory from the American College of Lifestyle Medicine, the American Society for Nutrition, the Obesity Medicine Association, and The Obesity Society

Dariush Mozaffarian[1] | Monica Agarwal[2] | Monica Aggarwal[3] | Lydia Alexander[4] | Caroline M. Apovian[5] | Shagun Bindlish[6] | Jonathan Bonnet[7] | W. Scott Butsch[8] | Sandra Christensen[9] | Eugenia Gianos[10] | Mahima Gulati[11] | Alka Gupta[12,13] | Debbie Horn[14] | Ryan M. Kane[15,16] | Jasdeep Saluja[17] | Deepa Sannidhi[18] | Fatima Cody Stanford[19,20] | Emily A. Callahan[1]

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Obesity Medicine Association

THE OBESITY SOCIETY
Professionals Collaborating to Overcome Obesity

ENDOCRINE SOCIETY

OAC Obesity Action Coalition | 20 YEARS SINCE 2005

Obesity treatment coverage landscape

Medicare
Prohibits coverage for obesity medications

Coverage updates needed for IBT and Surgery

Medicaid
Limited and variable coverage for all obesity treatments across states, some pulling back on medications

ACA Marketplace
Most plans have coverage *exclusion policies* for most treatments (medication & surgery)

Commercial & Employer Plans
Obesity treatment is *not included in the standard benefit* design

OAC Obesity Action Coalition | 20 YEARS SINCE 2005

Medicare: Obesity treatment coverage

National Coverage Determination (NCD)

NCD - Intensive Behavioral Therapy for Obesity (210.12)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Tracking Information

Publication Number

100-3

Manual Section Number

210.12

Manual Section Title

Intensive Behavioral Therapy for Obesity

Version Number

1

Effective Date of this Version

11/29/2011

Implementation Date

03/06/2012

Outdated 2011

Description Information

Benefit Category

Additional Preventive Services

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Item/Service Description

A. General

Based upon authority to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on intensive behavioral therapy for obesity. Screening for obesity in adults is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Part A and Part B.

The Centers for Disease Control (CDC) reported that "obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States." In the Medicare population over 30% of men and women are obese. Obesity is directly or indirectly associated with many chronic diseases including cardiovascular

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 417, 422, 423, and 460

[CMS–4208–P]

RIN 0938–AV40

Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Medicare cost plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations to implement changes related to Star Ratings, marketing and communications, agent/broker compensation, health equity, drug coverage, dual eligible special needs plans (D–SNPs), utilization management, network adequacy, and other programmatic areas, including the Medicare Drug Price Negotiation Program. This proposed rule also includes proposals to codify existing subregulatory guidance in the Part C and Part D programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Time on January 27, 2025.

ADDRESSES: In commenting, please refer to file code CMS–4208–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.
2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4208–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4208–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Matthania Volmy, (667) 290–8662—General Questions.

Nasreem Farooqahmed, (410) 786–0814—Part C and D Plan Issues.

Matthania Volmy, (667) 290–8662—D–SNP Issues.

Kyu Ishimoto, (206) 615–2337—Beneficiary Enrollment and Appeals Issues.

Alissa Stoneking, (410) 786–1120—Parts C and D Payment Issues.

Hunter Coohill, (720) 853–2000—Enforcement Issues.

Lauren Brandow, (410) 786–9765—PACE Issues.

Sara Klotz, (410) 786–1984—D–SNP Issues.

PartCandDStarRatings@cms.hhs.gov—Parts C and D Star Ratings Issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this proposed rule may be found at *https://www.regulations.gov/.*

I. Executive Summary

A. Purpose

The primary purpose of this proposed rule is to amend the regulations for the Medicare Advantage (Part C) program, Medicare Prescription Drug Benefit (Part D) program, Medicaid program, Medicare cost plan program, and Programs of All-Inclusive Care for the Elderly (PACE). This proposed rule includes a number of new policies that would improve these programs for contract year 2026 as well as codify existing Part C and Part D subregulatory guidance.

We note that, as with previous rules, the new marketing and communications policies in this rule are proposed to be applicable for all contract year 2026 marketing and communications, beginning October 1, 2025. However, to operationalize the proposed Format Provider Directories for Medicare Plan Finder provision at § 422.111(m), we anticipate that 2025 plan year directory data will need to be made available online for testing purposes in the summer of 2025, and 2026 plan year data would need to be available online on October 1, 2026. Therefore, we propose an applicability date of July 1, 2025, for this provision.

B. Summary of the Key Provisions

1. Vaccine Cost Sharing Changes

This proposal would implement section 11401 of the Inflation Reduction Act of 2022 (IRA), which amends section 1860D–2 of the Act to require that, effective for plan years beginning on or after January 1, 2023, the Medicare Part D deductible shall not apply to, and there is no cost-sharing for, an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP) covered under Part D.

2. Insulin Cost Sharing Changes

This proposal would implement section 11406 of the IRA, which amends section 1860D–2 of the Act to require that, effective for plan years beginning on or after January 1, 2023, the Medicare Part D deductible shall not apply to covered insulin products, and the Part D cost-sharing amount for a one-month supply of each covered insulin product must not exceed the statutorily defined "applicable copayment amount" for all enrollees. The applicable copayment amount for 2023, 2024, and 2025 is $35. For 2026 and each subsequent year, in accordance with the statute, we are proposing that, with respect to a covered insulin product covered under a prescription drug plan (PDP) or a Medicare Advantage prescription drug

Published since 2003

National Coverage Analysis (NCA) | **Decision Memo**

NCA - Bariatric Surgery for the Treatment of Morbid Obesity - Facility Certification Requirement (CAG-00250R3) - Decision Memo

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Decision Summary

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to conclude that continuing the requirement for certification for bariatric surgery facilities would not improve health outcomes for Medicare beneficiaries. Therefore, CMS has decided to remove this certification requirement.

CMS also decided that no changes be made to the bariatric surgery procedures that are deemed covered in section 100.1 of the National Coverage Determination (NCD) Manual. The evidence continues to support that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) continue to be reasonable and necessary for Medicare beneficiaries who have a body-mass index (BMI) ≥ 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.

Lastly, we decided to change the title to better reflect the scope of the NCD and to make it clear in the manual that under the existing policy the local Medicare Administrative Contractors have the authority to make coverage decisions for certain patients for any bariatric surgery procedures not specifically identified as covered or non-covered by an NCD.

In addition, to the decision above, CMS is renumbering and consolidating its manual for section 100.1. This is an administrative change only to make it easier for the public to read and understand the NCD manual. There is no change in coverage because of the renumbering and consolidation.

- The additional NCDs related to bariatric surgery will be consolidated and subsumed into section 100.1 of the NCD Manual. These include sections 40.5, 100.8, 100.11 and 100.14.

The changes to the manual are reflected in attachment Appendix C.

Outdated 2013

Decision Memo

To: Administrative File: CAG-00250R3

From: Louis Jacques, MD
Director, Coverage and Analysis Group

Tamara Syrek Jensen, JD
Deputy Director, Coverage and Analysis Group

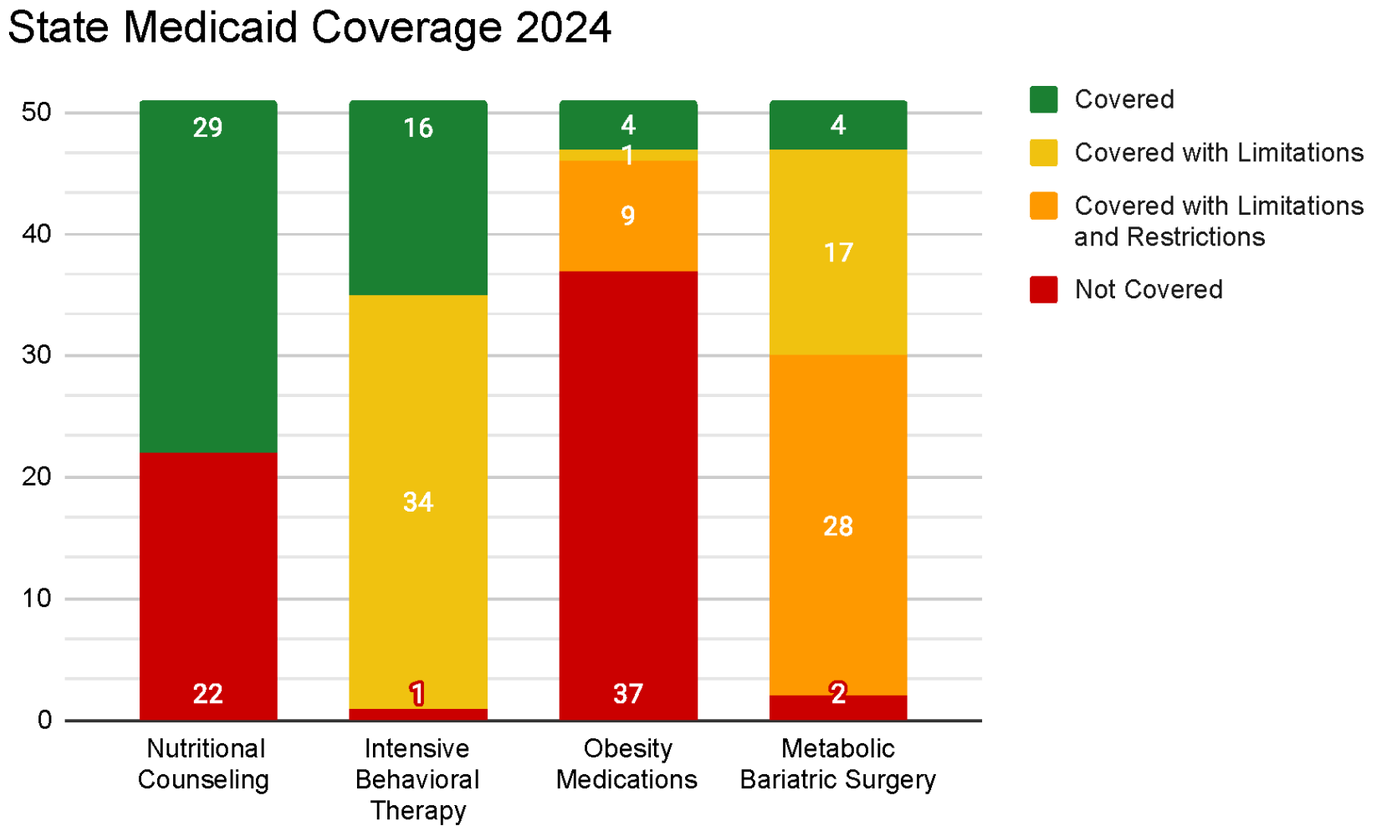
Jyme Schafer, MD, MPH
Director, Division of Medical and Surgical Services

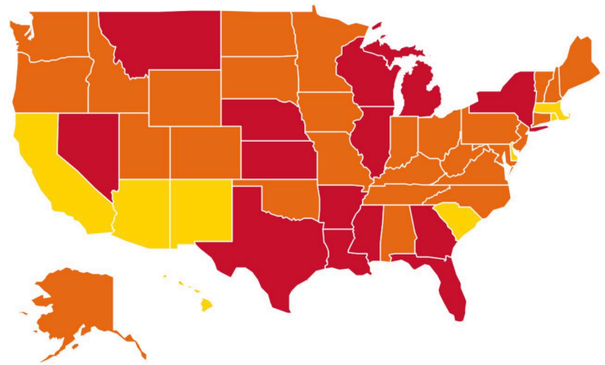
Lori Paserchia, MD
Lead Medical Officer

Obesity Action Coalition

20 YEARS SINCE 2005

Medicaid: Obesity treatment coverage





Majority of states have significant barriers and conditions of coverage for obesity care

Obesity Action Coalition

20 YEARS SINCE 2005

Other Federal Programs: Obesity treatment coverage

U.S. Department of Veterans Affairs

Get help fr

SITE MAP

Health | Benefits | Burials & Memorials | About VA | Resources | Media Room

VA » Health Care » MOVE! Weight Management Program » Veteran Materials

MOVE! Weight Management Program

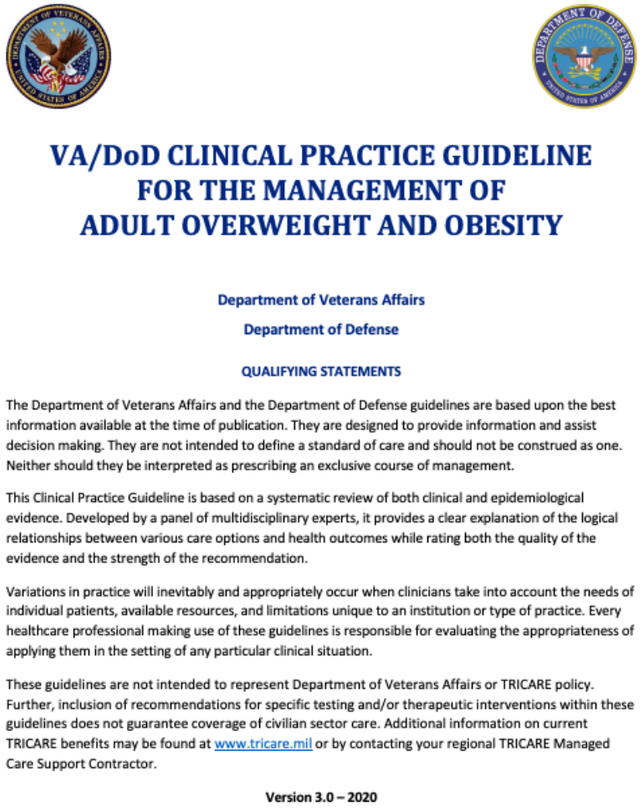
- MOVE!
  - Home
  - MOVE! Q & A
  - MOVE! Stories
  - MOVE!11
  - MOVE! Coach
  - Veteran Materials
  - Video Gallery
  - Viewer Software
  - Health Promotion and Disease Prevention
  - Site Map

MOVE! Weight Management Program for Veterans — Veteran Materials

The following materials are available to support participation in VA's MOVE! Weight Management Program for Veterans:

- Orientation Handout
- Starter Packet
- 2023 MOVE! Veteran Workbook
- 2019 MOVE! Veteran Workbook
- Food and Activity Log
- MOVE! Maintenance Booklet

Orientation Handout



VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF ADULT OVERWEIGHT AND OBESITY

Department of Veterans Affairs

Department of Defense

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent Department of Veterans Affairs or TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2020

FEHB Program Carrier Letter 2025-01

for a particular service area or when appointment wait times exceed any applicable aspects required by the regulatory bodies in which Carriers operate. As stated in Carrier Letter 2023-04, Carriers must cover services provided by out-of-network providers at in-network rates, when needed, to provide timely access to specialized care in accordance with the Carriers' accreditation standards.

Additionally, in response to MHPAEA and to support assurance of MH/SUD and M/S parity, OPM will require Carriers to provide network adequacy information from any network-related NQTL comparative analyses (Carrier Letter 2021-16). Provider network data will be instrumental in supporting these goals and ensuring that members have the necessary support from OPM in navigating their access to health care. The Technical Guidance will provide additional information on the collection of this quantitative data.

Prevention and Treatment of Obesity

OPM remains committed to ensuring Carriers offer obesity benefits that include all necessary components of current evidence-based obesity management. OPM is providing updated clarifications and expectations for Carrier obesity benefits, since the science on these interventions has evolved. OPM reminds Carriers that having an overweight or obesity diagnosis is not a lifestyle choice and increased adipose (fat) or weight gain should not be solely attributed to eating disorders. Obesity experts have advised that obesity management and treatment requires an integrated, patient-centered, and individual approach,[1] because obesity is a disease that is impacted by many different factors and causes and affects each patient differently.

Intensive Behavioral Therapy and Comprehensive Obesity Benefits

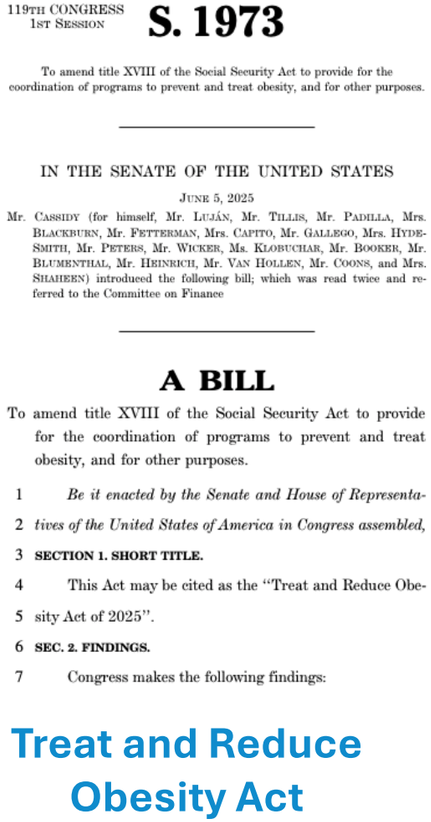
Previous Carrier Letters have encouraged Carriers to offer obesity benefits that reflect a multi-focal and chronic disease care delivery model that

[1] Obesity definition, diagnosis, bias, standard operating procedures (SOPs), and telehealth: An Obesity Medicine Association (OMA) Clinical Practice Statement (CPS) 2022 - PMC (nih.gov)

9

Obesity Action Coalition | 20 YEARS SINCE 2005

Progress Toward Access to Obesity Care



119TH CONGRESS
1ST SESSION

S. 1973

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 5, 2025

Mr. CASSIDY (for himself, Mr. LUJÁN, Mr. TILLIS, Mr. PADILLA, Mrs. BLACKBURN, Mr. FETTERMAN, Mrs. CAPITO, Mr. GALLEGO, Mrs. HYDE-SMITH, Mr. PETERS, Mr. WICKER, Ms. KLOBUCHAR, Mr. BOOKER, Mr. BLUMENTHAL, Mr. HEINRICH, Mr. VAN HOLLEN, Mr. COONS, and Mrs. SHAHEEN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

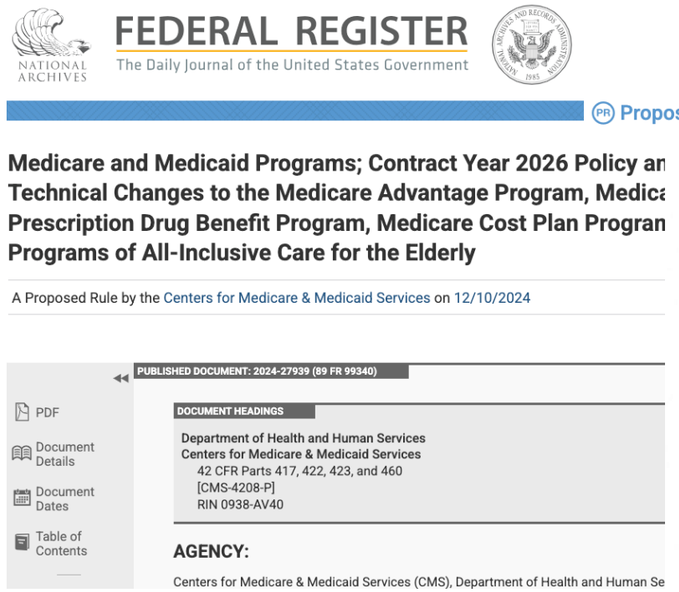
SECTION 1. SHORT TITLE.

This Act may be cited as the "Treat and Reduce Obesity Act of 2025".

SEC. 2. FINDINGS.

Congress makes the following findings:

Treat and Reduce Obesity Act



NATIONAL ARCHIVES

FEDERAL REGISTER

The Daily Journal of the United States Government

Proposed Rule

Medicare and Medicaid Programs; Contract Year 2026 Policy an Technical Changes to the Medicare Advantage Program, Medica Prescription Drug Benefit Program, Medicare Cost Plan Progran Programs of All-Inclusive Care for the Elderly

A Proposed Rule by the Centers for Medicare & Medicaid Services on 12/10/2024

PUBLISHED DOCUMENT: 2024-27939 (89 FR 99340)

PDF

Document Details

Document Dates

Table of Contents

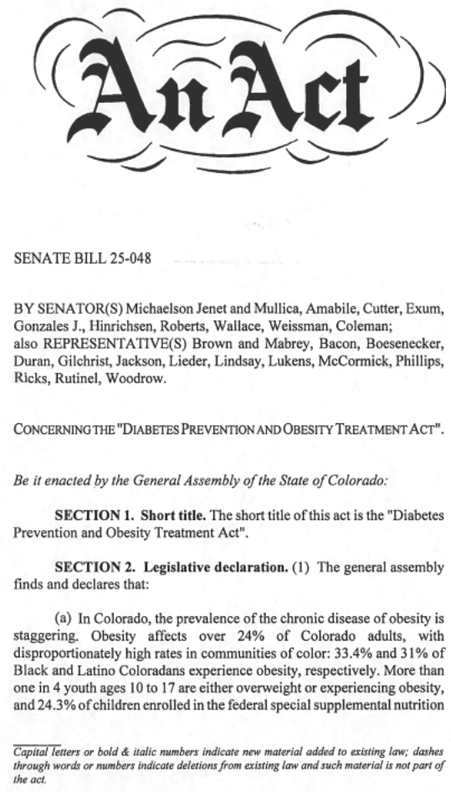
DOCUMENT HEADINGS

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 417, 422, 423, and 460
[CMS-4208-P]
RIN 0938-AV40

AGENCY:

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Se

Leadership remains open to developing a framework for coverage of obesity medications



An Act

SENATE BILL 25-048

BY SENATOR(S) Michaelson Jenet and Mullica, Amabile, Cutter, Exum, Gonzales J., Hinrichsen, Roberts, Wallace, Weissman, Coleman;
also REPRESENTATIVE(S) Brown and Mabrey, Bacon, Boesenecker, Duran, Gilchrist, Jackson, Lieder, Lindsay, Lukens, McCormick, Phillips, Ricks, Rutinel, Woodrow.

CONCERNING THE "DIABETES PREVENTION AND OBESITY TREATMENT ACT".

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Short title. The short title of this act is the "Diabetes Prevention and Obesity Treatment Act".

SECTION 2. Legislative declaration. (1) The general assembly finds and declares that:

(a) In Colorado, the prevalence of the chronic disease of obesity is staggering. Obesity affects over 24% of Colorado adults, with disproportionately high rates in communities of color: 33.4% and 31% of Black and Latino Coloradans experience obesity, respectively. More than one in 4 youth ages 10 to 17 are either overweight or experiencing obesity, and 24.3% of children enrolled in the federal special supplemental nutrition

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

CO new law to improve access to obesity care

MILLIMAN WHITE PAPER

Observational study of FlyteHealth's comprehensive obesity care program with the State of Connecticut: Year one insights

Commissioned by FlyteHealth

Briana Botros, FSA, MAAA
Julia Shelton, PharmD
Kim Ren, PhD, FSA, MAAA
AJ Ally, RPH, MBA

Milliman

Executive summary

In 2023, the State of Connecticut (SoCT) partnered with FlyteHealth to launch a pilot of FlyteHealth's Comprehensive Obesity Care (COC) program. The stated intent of the program was to address rising costs associated with anti-obesity medications (AOMs). The SoCT's employee health plan has experienced a 50% year-over-year rise in spending on glucagon-like-peptide-1 agonists (GLP-1s) used to treat obesity beginning in 2020.[1] Beginning July 1, 2023, the state required enrollees to participate in FlyteHealth's program to access coverage of these medications for treatment of all FDA approved indications. This approach aimed to ensure that GLP-1 prescriptions were coupled with comprehensive lifestyle and clinical support to maximize effectiveness and long-term success. According to FlyteHealth, their COC program provides patients with an individualized approach, directing patients to obesity treatment, which may include AOM therapy, that best matches their health profile.

Milliman was engaged by FlyteHealth to independently analyze the FlyteHealth COC program's initial observations on cost avoidance for the SoCT employee health plan. The study was performed with permission of SoCT. The timeframe of this study was insufficient to assess the total cost of care offsets; therefore, this analysis was limited to the program's impact on pharmaceutical product utilization. Other limitations to the study, which are important considerations for any of this report's users, are discussed below. It is important to note that Milliman is not endorsing FlyteHealth or its COC program.

In the context of this study with the limitations discussed below, the FlyteHealth COC program demonstrated the following:

- Approximately $430,000 to $1.2 million (1% to 3% of the total SoCT AOM pharmacy spend in the study period) was avoided based on the rejected claims and by switching eligible program participants to lower net cost therapies appropriate for each member.
- Eighty-six percent of participants who were naïve GLP-1 users from July 1, 2023 to December 31, 2023 were adherent to their GLP-1 medication. Participant adherence for GLP-1s was calculated using the proportion of days covered (PDC) calculation.[2] The PDC was defined as the number of days covered by a GLP-1 prescription divided by the number of days during the measurement period. A member was deemed adherent if their PDC rate was at least 80%.[3]
- Of the 329 naïve GLP-1 participants who enrolled within the first six months of the program, their persistence rate varied between 63% and 90% based on enrollment month in FlyteHealth. Persistence was measured by assessing if a member had a gap in therapy greater than 60 days and included all GLP-1 products, regardless of diagnosis. Naïve GLP-1 participants were defined as not having a GLP-1 prescription in the baseline claims data prior to FlyteHealth program enrollment.

This white paper presents the analytical framework Milliman used to prepare the observations about the FlyteHealth COC program, which are discussed in this report.

CT offers obesity management program to state employees

OAC Obesity Action Coalition

20 YEARS SINCE 2005

Lived experience: Access to obesity treatment barriers are real

- OAC Annual Membership Survey Data

50%
Services outright excluded from insurance coverage

36%
Issues with a provider (i.e. unable to locate someone; not open to obesity care; showed weight bias, etc.)

42%
Prescribed medication (GLP-1 or other) not covered by pharmacy benefit coverage

Obesity Action Coalition, Annual Membership Survey, 2024. Unpublished

OAC Obesity Action Coalition | 20 YEARS SINCE 2005

Quality Measures Matter

"For my entire life, I've been a target of ridicule simply because of my weight. People rarely take time to look beyond my weight to see, well, me."

- Obesity is a disease driven by **strong biology, not by choice.**
- Obesity **treatment is prevention** for other chronic diseases.
- People living with obesity want to **achieve their health goals.**
- **Americans want choice** and quality obesity care.

OAC Obesity Action Coalition | 20 YEARS SINCE 2005

ICHOM set of Patient-Centered Outcome Measures for Adults living with Obesity

ICHOM
International Consortium for Health Outcomes Measurement

Publication Submitted: The Lancet eClinical Medicine Journal

OAC Obesity Action Coalition | 20 YEARS SINCE 2005

Summary

- Tremendous progress in the science of obesity.
- Standards of obesity care are rapidly evolving.
- Long way to go in improving access to care.
- Obesity quality measures play an important role.
- *NOW* - Perfect timing for measure development and testing in obesity to fill gaps in care.

Questions & Answers

Announcement: Attend CMS MMS Information Session

- **Webinar:** “Advancing Age-Friendly Care: From the 4Ms Framework to the CMS Inpatient Quality Measure”
- **When:** 2 p.m. (ET) July 23
- **Presenter Organizations:**
  - Luminis Health
  - The John A. Hartford Foundation
  - The Institute for Healthcare Improvement (IHI)

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