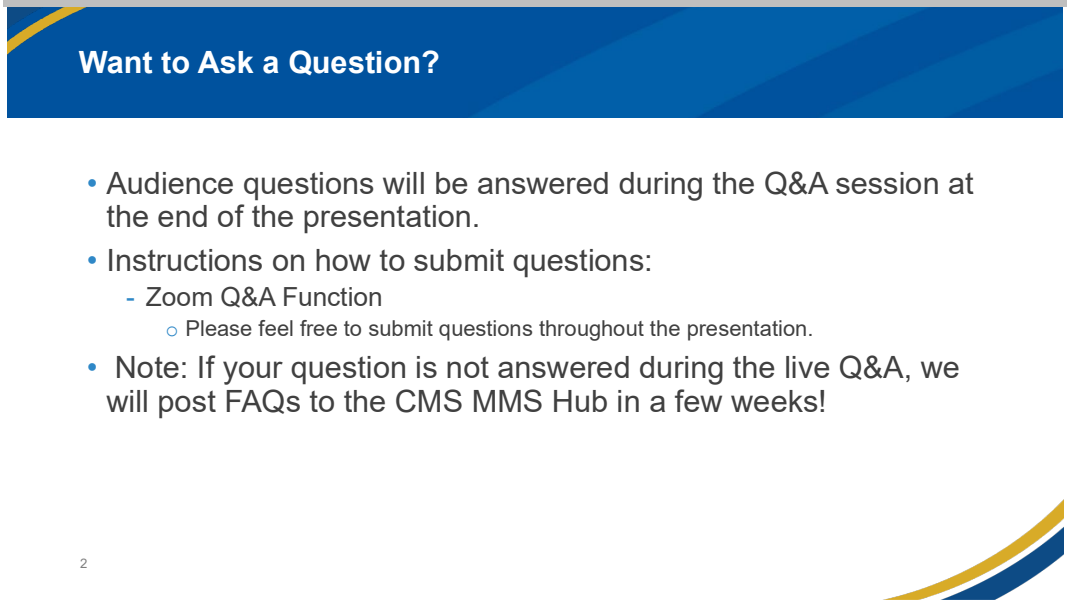
2025 MMS Public Webinar: Measuring What Matters: Improving Obesity Management and Outcomes Transcript

[SLIDE 1]

GHUNNEY: Good afternoon and thank you for joining us for today's CMS Measures Management System (MMS) public webinar: "Measuring What Matters—Improving Obesity Management and Outcomes." My name is Aya Ghunney, and I work for Battelle in support of MMS. This webinar is just one aspect of MMS education and outreach. I invite you to visit the MMS Hub website to learn more about MMS and how to get involved in quality measurement.

[SLIDE 2]



GHUNNEY: So throughout today's presentation I highly encourage you to submit questions using the Q&A feature, which is near the bottom of your screen. We'll address questions during the live Q&A at the end of the presentation, and then following the meeting we'll create a Q&A summary to answer in-scope questions we couldn't get to during today's session.

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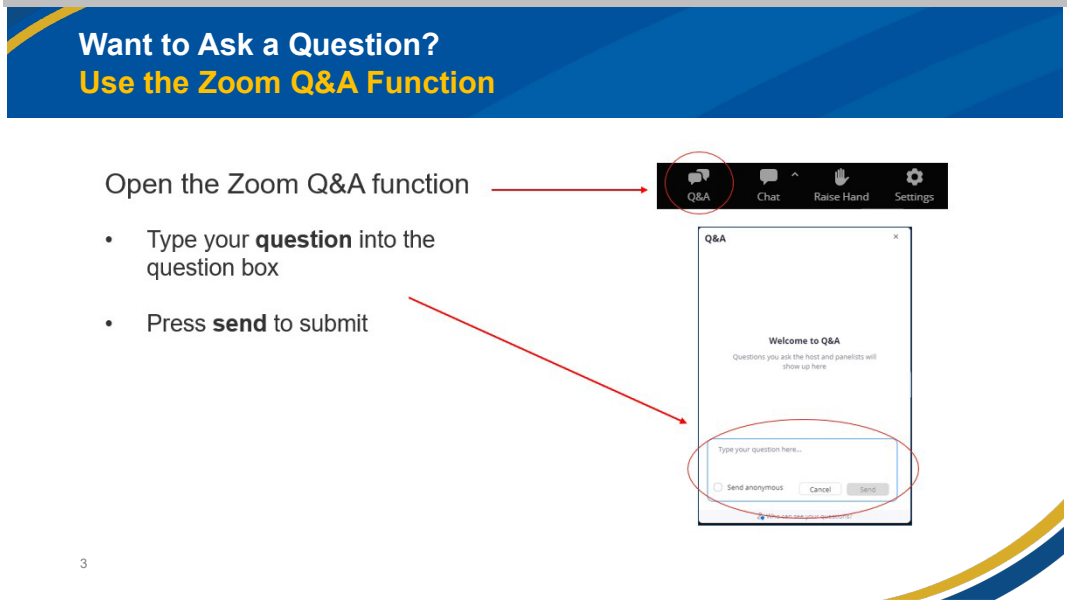


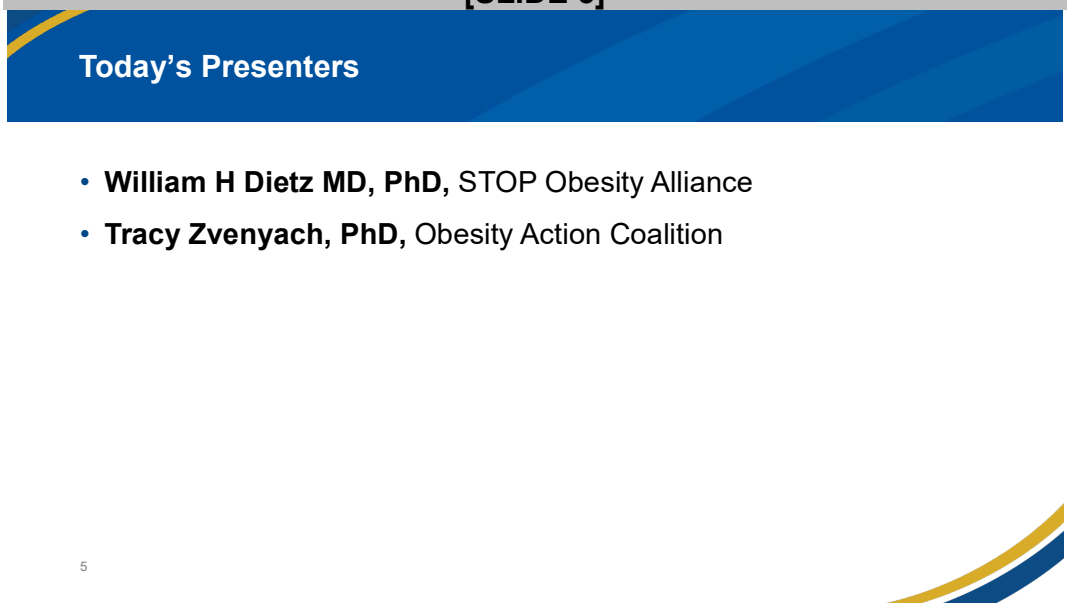
GHUNNEY: And so this is just showing you where that Q&A function is, right at the bottom of your screen. You can go ahead and type in your questions throughout the presentation, and we will answer as many as we can during that Q&A segment at the end.

[SLIDE 4]

GHUNNEY: So let's get into today's objectives. So over the course of today's webinar, we'll highlight the need for effective quality measures addressing obesity, share strategies for implementing obesity-related quality measures, examine current barriers to obesity care, and discuss recommendations for next steps for developing obesity quality measures.

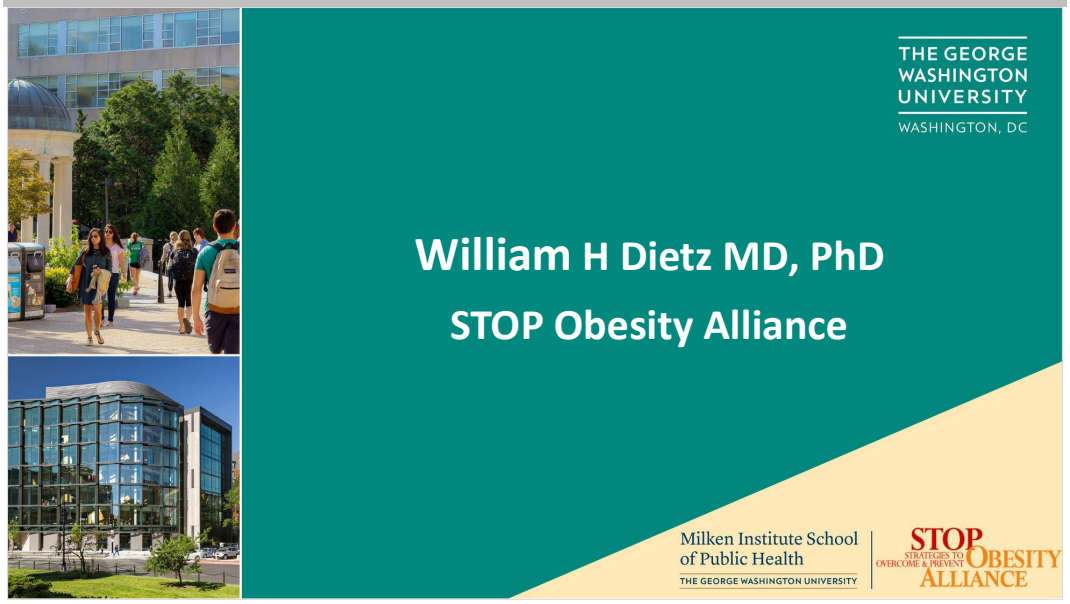
So, to get us started, we're going to pop up a poll to find out what you think about obesity-related measurement and barriers to implementing measures. So we're going to leave this poll open for a little bit so that you have time to go ahead and enter your answers.

[SLIDE 5]



GHUNNEY: So I see people are answering the poll. That's great! So today we're really excited to welcome Dr. William Dietz from the STOP Obesity Alliance, and Dr. Tracy Zvenyach from the Obesity Action Coalition (OAC). We thank you both for being with us today, and I will turn it over to Bill to get us started.

[SLIDE 6]



DIETZ: Good afternoon. I'm Bill Dietz from the STOP Obesity Alliance, and I'm pleased to be on this webinar with a number of my colleagues. My presentation is going to cover the prevalence and complications of obesity, as well as its costs, and then turn to the development of measures and close with the review of the Lancet Commission Report.

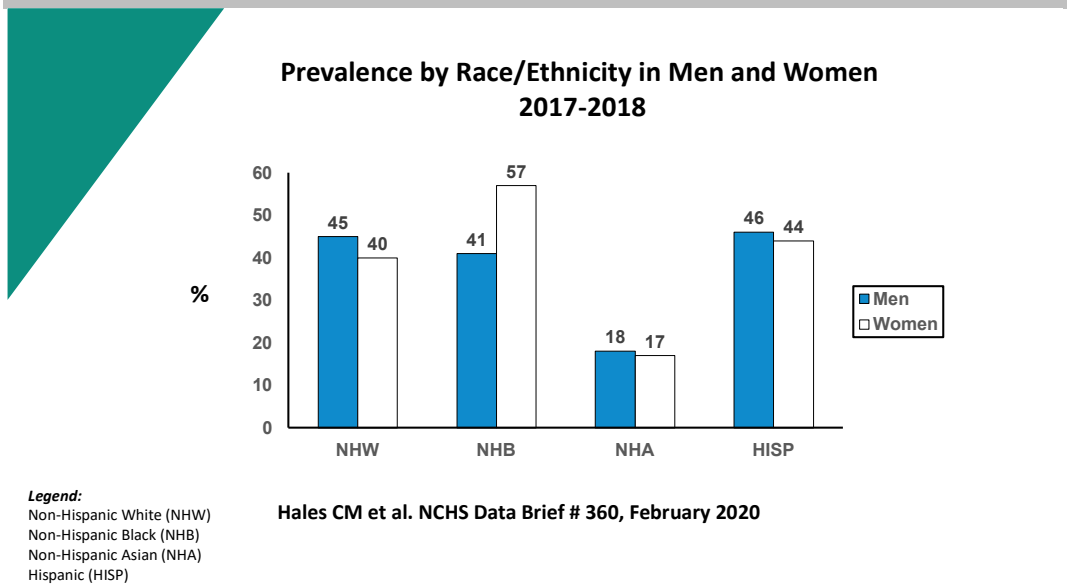
Before I do that, I want to introduce Patty, because I think it's important to hear directly from people who suffer from the disease of obesity. Patty?

[SLIDE 7]

***PATTY**: "I've lived in a large body my entire life. I've had a lifetime of ridicule, bullying, being put down, being discriminated against, being stereotyped as being lazy or lacking in willpower or dirty or sloppy. Diet after diet after diet. All that shame and blame that I got, I turned it inward. I became my own worst bully. I would say things to myself that were so incredibly negative that I'd never say them to any other person ever! Weight bias is woven into the fabric of our society, and it's a thread we need to pull out."*

DIETZ: So I think what Patty says nicely summarizes a theme that should run throughout our considerations of obesity.

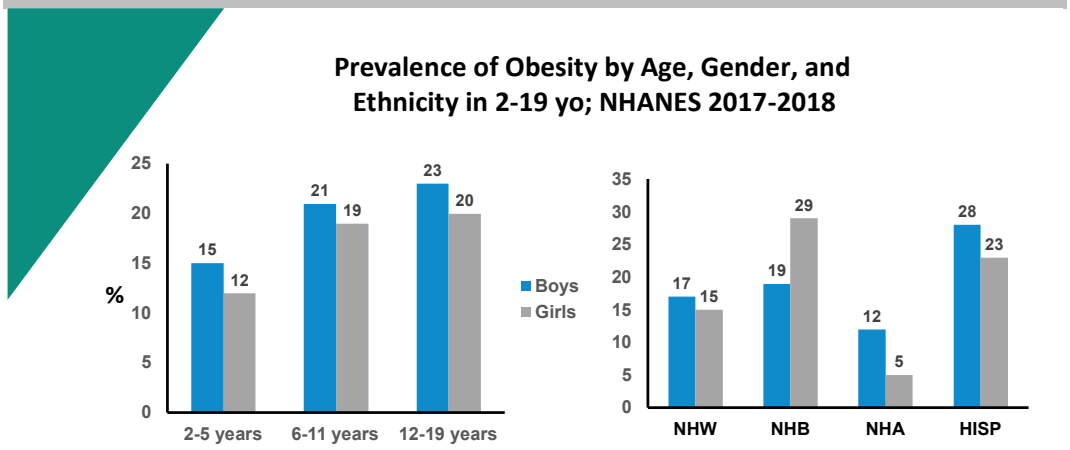
[SLIDE 8]



DIETZ: So I'd like to begin, as I said, with the prevalence of obesity. This slide shows the prevalence of obesity in non-Hispanic Whites, non-Hispanic Blacks, non-Hispanic Asians, and Hispanics. You can see that there's a significant disparity. The highest prevalence is among Black females, and Black female adults. The lowest prevalence, and it's probably an artificially low prevalence, is among non-Hispanic Asians.

The reasons those populations are so low is that they use the same criteria as the adult criteria of BMI. That really underestimates the importance of different patterns of growth that if we correct it — the non-Hispanic Asian population for the true prevalence of obesity — it would be much higher. The cut points for obesity in that population are diagnosis of obesity occurs between 25 and 27 units of BMI, and a prevalence of obesity is above BMI of 27.

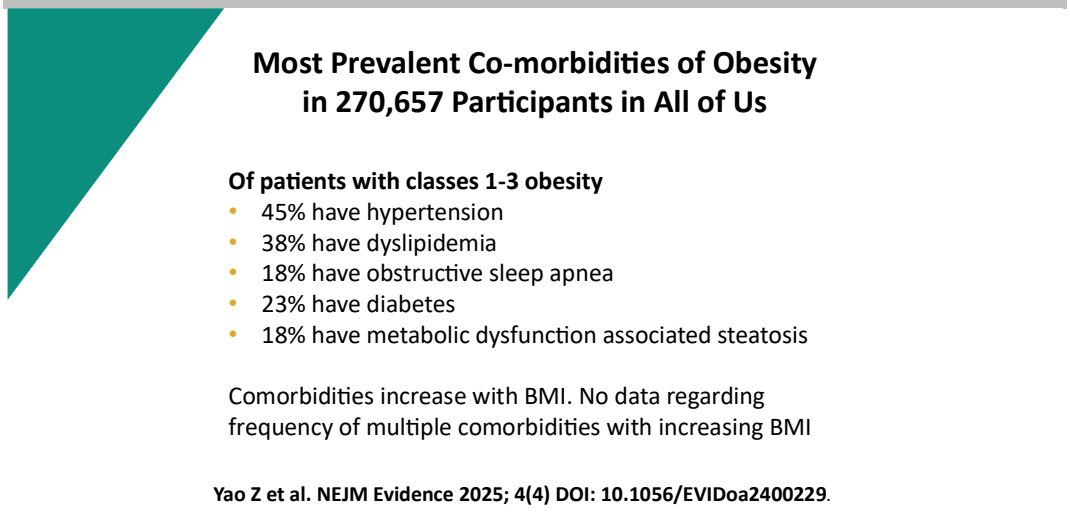
[SLIDE 9]



Fryar CD et al. NCHS Health E-stat December 2020
Note: Prevalence in NHA sample of girls considered unreliable

DIETZ: So the same criteria, or the same findings that we saw in the adult population are really somewhat replicated in the pediatric population. If you look at the right-hand side, you can see that that disparity between non-Hispanic Black girls and Black boys exists. There's still the highest prevalence of obesity among the non-Hispanic Black population. As the left-hand side shows, there's a real difference because boys tend to have a higher prevalence of obesity than girls in the pediatric age group, and that's a very consistent finding.

[SLIDE 10]



DIETZ: The most prevalent comorbidities of obesity in the adult population, these are underestimates because its not a representative population of the United States. Patients with Classes 1-3 of obesity, almost half have hypertension; about 40% have dyslipidemia; 20% have obstructive sleep apnea, 23% have diabetes, and 18% have metabolic dysfunction associated with hepatic steatosis.

These comorbidities increase with BMI. The more severe the level of obesity, the greater the likelihood of comorbidities. And, in general, the studies of adults fail to look at the multiple comorbidities with increasing BMI. So, for example, how many patients with hypertension also have dyslipidemia, sleep apnea, or diabetes?

[SLIDE 11]

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

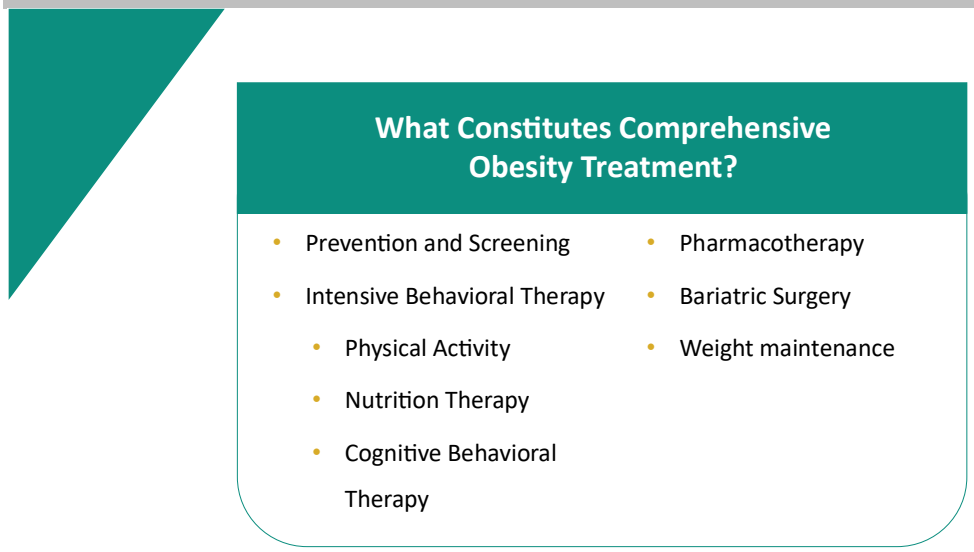
BMI	Cost Savings
30 ESI- 5% decrease	$441
30 Medicare – 5 % decrease	$834
30 ESI - 15% decrease	$1234
30 Medicare -15% decrease	$2351
45 ESI - 5% decrease	$1426
45 Medicare - 5% decrease	$2293
45 ESI – 15% decrease	$3860
45 Medicare – 15% decrease	$6271

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

DIETZ: This next slide shows an interesting phenomenon, and I'm going to walk you through it very slowly because it's complicated. So the first element is "weight loss." So these are people with employer-sponsored insurance or Medicare, and the degree of weight loss is expressed as a percent decrease. So you can see that at each level people on Medicare have a higher cost than people who have employer-sponsored insurance.

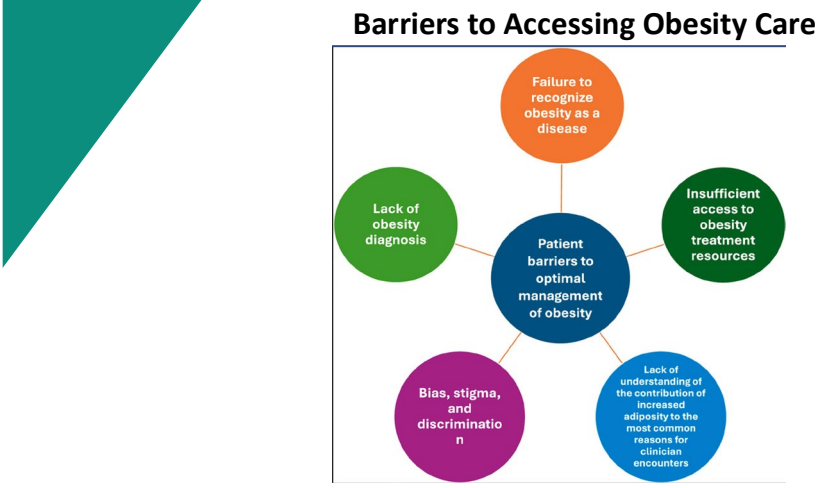
The other observation here is that the higher your BMI, the greater the impact on weight loss on costs. So there's almost a twofold difference for people with a BMI of 45 who have a 15% decrease in their weight. You can see here that that cost savings is about $4,000 compared to the group with Medicare who have a 15% decrease, and they have about a $6,000 difference.

[SLIDE 12]



DIETZ: So what constitutes comprehensive obesity treatment? This is something that the STOP Obesity Alliance has focused extensively on, and it shows the variety of approaches for a comprehensive obesity treatment, beginning with prevention and screening. Intensive behavioral therapy (IBT) is the bottom line for all of this with a focus on physical activity, nutrition, and cognitive behavioral therapy (CBT). And, in the more severe cases, you move to pharmacotherapy, bariatric surgery and weight maintenance.

[SLIDE 13]



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

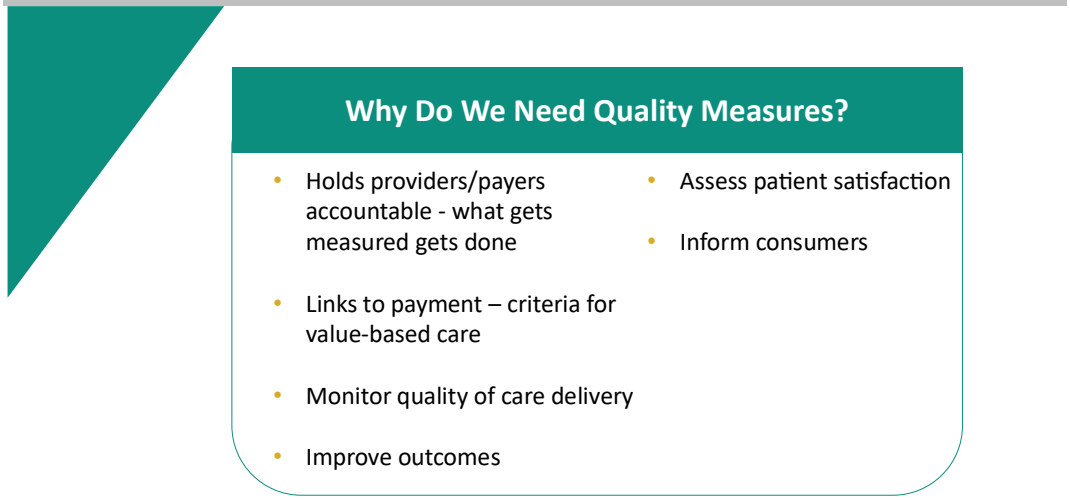
DIETZ: So the obesity care faces a double burden. First, the kind of environments contribute to obesity are hard to address. So, for example, the way our communities are designed limits opportunities for physical activity and people rely on car use. Likewise, large segments of the population lack access to fresh fruits and vegetables, or cannot afford those fruits and vegetables. And beyond that, there are multiple other factors which affect the levels of physical activity and dietary intake.

This slide shows the barriers to addressing obesity care. These include the failure to recognize obesity as a disease, the lack of familiarity with the diagnostic measures, the insufficient access to obesity treatment resources like knowing what to prescribe in terms of GLP-1, how to refer to bariatric surgery, or the lack of understanding of how increased obesity contributes to disease, or the very prominent role of bias, stigma, and

discrimination which leads medical providers to dismiss obesity as a personal failing, and thereby ignores the kind of efforts that people with obesity have made over time.

And, most importantly, I think there's lack of agreement on an obesity diagnosis that is the topic of this webinar. That is the use of BMI or BMI Plus, which we'll come to in a few minutes, but overall I think there's a need to recognize that obesity is a disease and not simply a behavioral problem. All of these factors contribute as barriers to accessing obesity care.

[SLIDE 14]

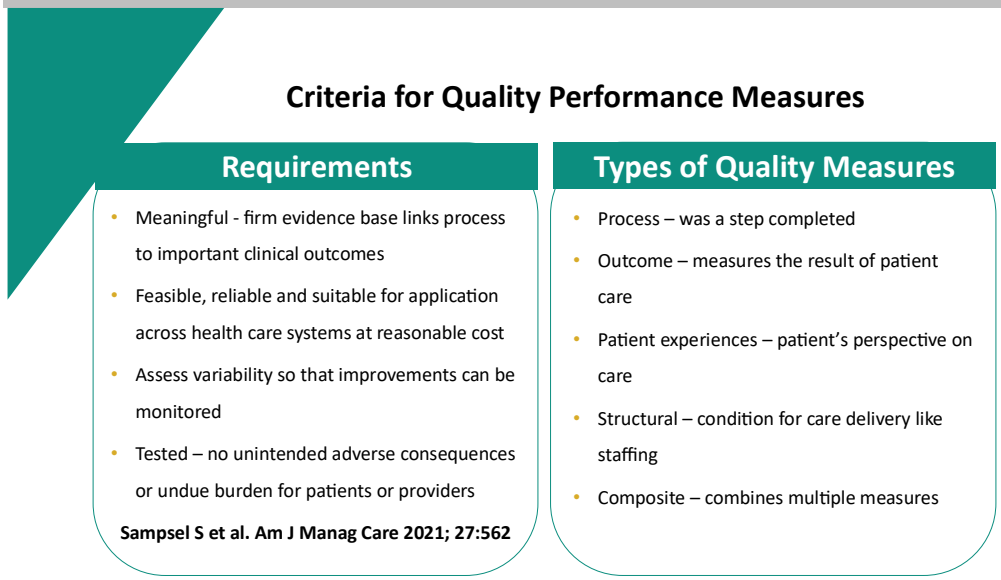


DIETZ: So why do we need quality measures? Well, for a number of reasons. Quality measures hold providers and payers accountable, and importantly, what gets measured gets done. So if people document BMI or the degree of obesity, that right away focuses attention. We know that

when providers share the diagnosis of obesity with patients, patients are more likely to initiate weight loss.

Quality measures linked to payment. They're the criteria for value-based care, changes in BMI. So if you're not measuring BMI, you're not assessing whether the care that you're delivering is making a difference. It monitors the quality of care delivery and it improves outcomes. Also, ultimately measures can be used to assess the patient satisfaction and to inform consumers.

[SLIDE 15]

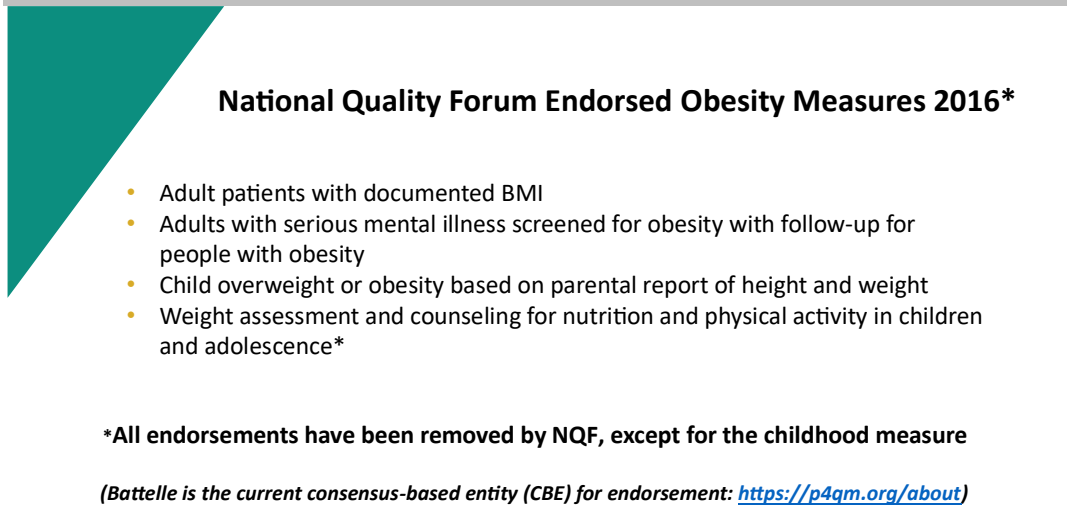


DIETZ: So what constitutes the criterion for a quality performance measure? Well, it must be meaningful. It needs to be feasible and reliable and absolutely possible to apply within healthcare systems. It needs to be able to assess the variability so that improvements can be

monitored, and it needs to be tested so that we're sure that there are no unintended consequences of the diagnosis of obesity.

There are a variety of measures of obesity, which include process measures about whether steps were completed or outcomes or patient experiences, or structural or composite measures, but our focus and the most important thing is that this whole process starts with the diagnosis of obesity and emphasizes the need for a performance measure or quality measure for the assessment and diagnosis of obesity. We cover that in just a few minutes, in the next series of slides.

[SLIDE 16]



DIETZ: So I'd like to turn now to the history of measures of obesity, and these began in 2008 with the National Quality Forum-endorsed obesity measures that were in place up until 2016. These measures included adult patients with documented BMI, adults with serious mental illness screened for obesity with a follow-up, children who were overweight or

obese based on a parental report of height and weight, and weight assessment and counseling for nutrition and physical activity in children and adolescents.

So one of the important observations about these measures that were in place for the National Quality Forum (NQF) in 2016 was that all endorsements of these measures had been removed by the National Quality Forum, except for the childhood obesity measure, and that measure itself is flawed because it doesn't specify what the counseling for nutrition and physical activity in children and adolescents is, or how successful it is.

[SLIDE 17]

Current Obesity Measures

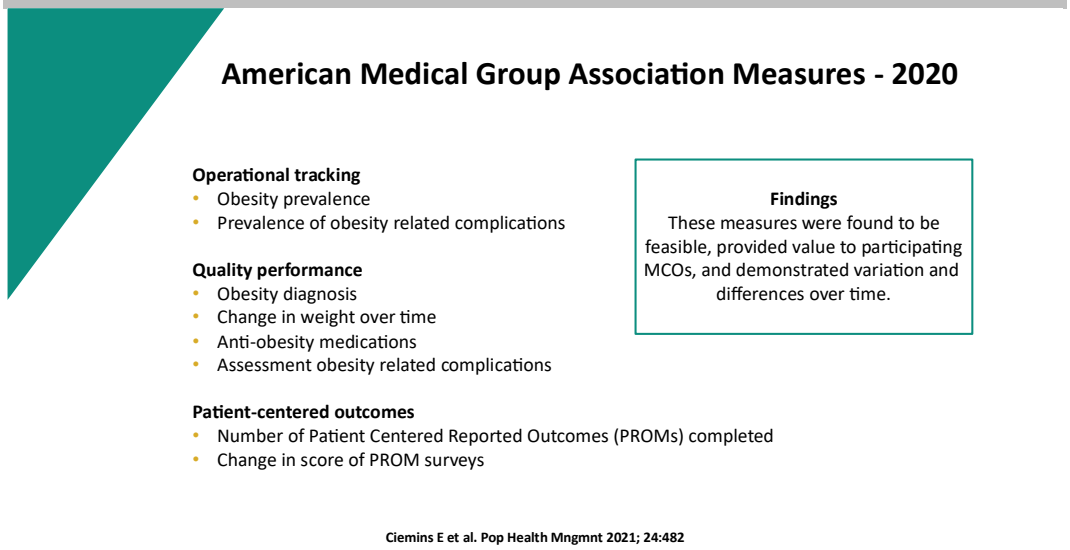
Measure Name	CMS Merit-based Incentive Payment System (MIPS)	NCQA HEDIS Measures	CMS Medicaid Child Core Set (0 adult measures)
Adult measure: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	√		
Pediatric measure: Weight Assessment and Counseling for Nutrition and Physical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

DIETZ: There are some measures that are still in place. These include an adult measure for obesity care and screening based on a body mass index (BMI), which is part of CMS' Merit-based Incentive Payment System (MIPS), and they also have a pediatric measurement for weight

assessment and counseling for nutrition and physical activity for children and adolescents. NCQA still has a HEDIS measure for children, and the CMS Medicaid Child Core Data Set still has a measure, but notice that there is no measure of BMI, or the degree of obesity absent the measures that were previously in place from the National Quality Forum (NQF).

[SLIDE 18]



DIETZ: So there are a number of efforts underway to assess the availability, importance, or validity of other measures of obesity. This is a study that was done by the American Medical Group Association (AMGA) and published in 2021 that looked at operational tracking of the obesity prevalence using BMI, and the prevalence of obesity-related complications. They looked at performance measures such as the frequency of the obesity diagnosis, or the change in weight over time, or the use of anti-obesity medications, or the assessment of obesity-related complications. They looked at a number of outcomes like patient-centered reported outcomes and change in the score of these patient-centered reported outcomes.

These measures were found to be feasible. They provided value to the participating medical care organizations that were part of this study and

demonstrated variation and differences over time; however, these were not implemented before that or after that process.

[SLIDE 19]

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)

DIETZ: AMGA is initiating another effort to understand the quality measures for obesity and quality improvement, and they've enlisted six AMGA members to participate over a nine-month period to increase the number of people with obesity who will receive a formal diagnosis. So you can see here that there's a need for a measure of the diagnosis of obesity. They're also assessing evidence-based comprehensive care and education on long-term sustainable outcomes. Measures include the prevalence of overweight and obesity and an obesity diagnosis, both of which depend on a measure of obesity. They are assessing obesity care such as weight management, prescriptions, bariatric surgery or other interventions.

[SLIDE 20]

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.**

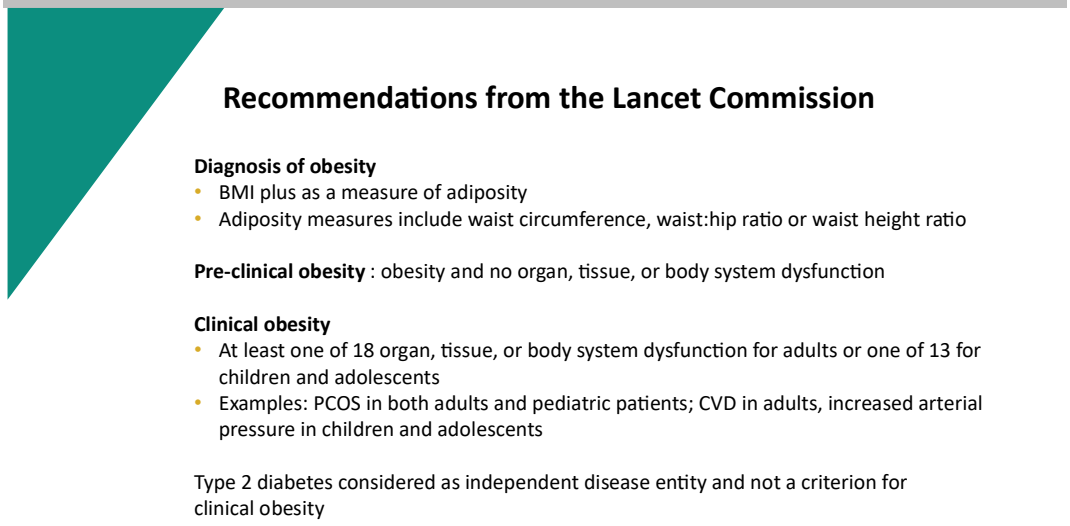
DIETZ: So the frequency of assessments of obesity in children and adolescents have been sparse. There were the earlier measures, which I just covered, but there's currently a program underway using AllianceChicago which is a national network of community health centers (CHCs) to improve personal, community, and public health through innovative interventions. They've developed a suggested measure in children ten years and older in which pediatricians and other primary care providers should evaluate for a variety of lipid abnormalities or abnormal glucose metabolism, or abnormal liver function in children and adolescents with a BMI greater than the 95th percentile.

That 95th percentile is a marker for the prevalence of obesity in children and adolescents, and they also add the importance of screening for lipid

abnormalities in children and adolescents who are overweight. That is a BMI between the 85th and 95th percentile.

So the measure description is in the box on the right. These are patients 10-17 years of age who are eligible and receive guideline-based metabolic screening for diabetes, hyperlipidemia, and liver disease. These are measures for the prevalence of obesity and its associated complications. This has also not gone any further than the work that has been done by the CDC and the Alliance for Chicago data.

[SLIDE 21]



DIETZ: So one of the big steps forward was the convening and report of the Lancet Commission on obesity, which was a meeting of a number of experts on obesity who began to revise the perception of obesity as a diagnosis vs. obesity as a clinical diagnosis. The commission recommended the use of the BMI Plus as a measure of adiposity and that "Plus" of adiposity includes waist circumference, waist-hip ratio, or waist-

to-height ratio. These are measures that potentially reflect the virulence of intra-abdominal obesity in causing the complications of obesity.

They defined preclinical obesity as "obesity that's diagnosed above and no organ tissue or body system dysfunction." The definition of clinical obesity is "termed on the presence not only of the diagnosis of obesity, but the presence of at least one of 18 different organ tissue or body system dysfunctions for adults, or 30 of those measures in children and adolescents."

So, for example, the polycystic ovary syndrome (PCOS) worked for both adults and pediatric patients, cardiovascular disease in adults, and increased arterial pressure in children and adolescents. They excluded Type 2 diabetes as an independent disease entity and not a criterion for the diagnosis of clinical obesity.

[SLIDE 22]

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

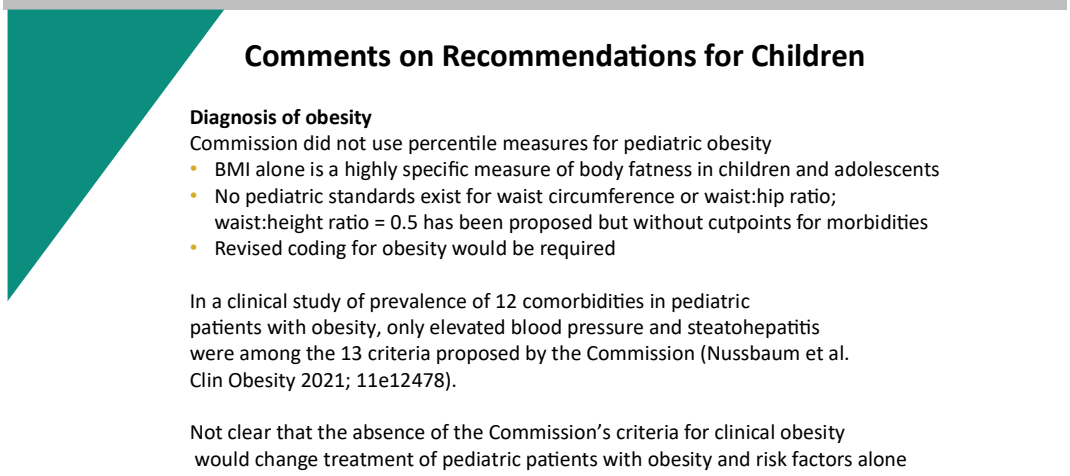
No estimates of prevalence of clinical obesity

- 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

DIETZ: Now, one of the problems and comments on the recommendations is that BMI Plus is a sound measure of obesity. We agree with that; that waist circumference reflects fat distribution as well as adiposity and adult standards for waist circumference exists — a waist circumference greater than 88 centimeters in women or 102 centimeters in men. However, one of the downsides of this is that there is no provider experience with weight measures in the United States, and those measures would require changes in the coding for obesity. Furthermore, there are no estimates of the prevalence of clinical obesity. So, for example, over half of adults with obesity have at least 1 of 18 comorbidities, but only about half of these were among the comorbidities at the Lancet Commission's disease states.

[SLIDE 23]



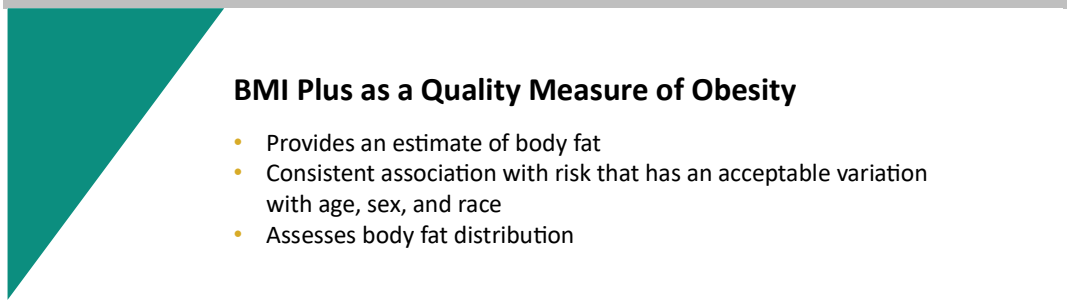
DIETZ: So these measures in children and adolescent are even more problematic. So in the diagnosis of obesity, the commission did not use

the percentile measures for pediatric obesity, which are widely used based on the prevalence of obesity in kids who have a BMI greater than the 95th percentile. We published a paper last year showing that BMI alone is a highly specific measure of body fatness, but no pediatric standards exist for waist circumference or waist-hip ratio. The measure of waist-to-height ratio of 0.5 has been proposed as a measure of morbidity in children and adolescents, but there are no cut points for the morbidities. That is "is the waist-to-height ratio of 0.6 adequate? How many of the comorbidities of obesity does that actually capture, or do we need a higher waist-to-height ratio to do that?"

And then as in the adult problem, revised coding for obesity would be required. In a study we looked at the prevalence of 12 comorbidities in pediatric patients with obesity, and only elevated blood pressure in steatohepatitis also overlapped with the 13 criteria proposed by the commission. So there's really a disconnect of these measures with the actual observations of morbidity in pediatric and adult populations.

Furthermore, it's not at all clear among pediatricians that the absence of the commission's criteria for clinical obesity would change the treatment of pediatric patients with obesity and risk factors alone. Pediatrics is about the prevention of adult disease, and regardless of the presence or absence of some of these complications, obesity treatment should proceed. So, in summary, next slide.

[SLIDE 24]



DIETZ: We still recommend BMI Plus as a quality measure of obesity. This is in accordance with the Lancet criteria. The BMI Plus measure of abdominal fatness provides an estimate of body fat. It has a consistent association of risk with acceptable variation in age, sex, and race, and it assesses body fat distribution.

So, in summary, there's a lot of work that still needs to be done, but the most important piece of work that needs to be done is the definition and utilization of a quality measure for the diagnosis of obesity, and we believe that the BMI Plus a measure of abdominal fat is that quality measure. Thank you for your attention. It's my pleasure now to introduce Tracy Zvenyach, Director of Policy, Strategy & Alliances in the Obesity Action Coalition (OAC). Tracy?

[SLIDE 25]

Tracy Zvenyach, PhD
Director, Policy Strategy & Alliances
July 8, 2025

OAC Obesity Action Coalition 20 YEARS

ZVENYACH: Thank you, Dr. Dietz. Again, my name is Dr. Tracy Zvenyach with the Obesity Action Coalition (OAC). My organization is the patient group. We are dedicated to serving people who live with the disease of obesity. We fulfill our mission through raising awareness, education, and providing support and advocacy. As you can see here, we will be celebrating our 20th anniversary. I would like to invite you, your family and friends, and colleagues to join us at our upcoming national convention on July 24th-26th taking place in the DC area.

[SLIDE 26]

Obesity treatment recommendations in progress

Obesity Medicine Association

THE OBESITY SOCIETY
Professionals Collaborating to Overcome Obesity

ENDOCRINE SOCIETY

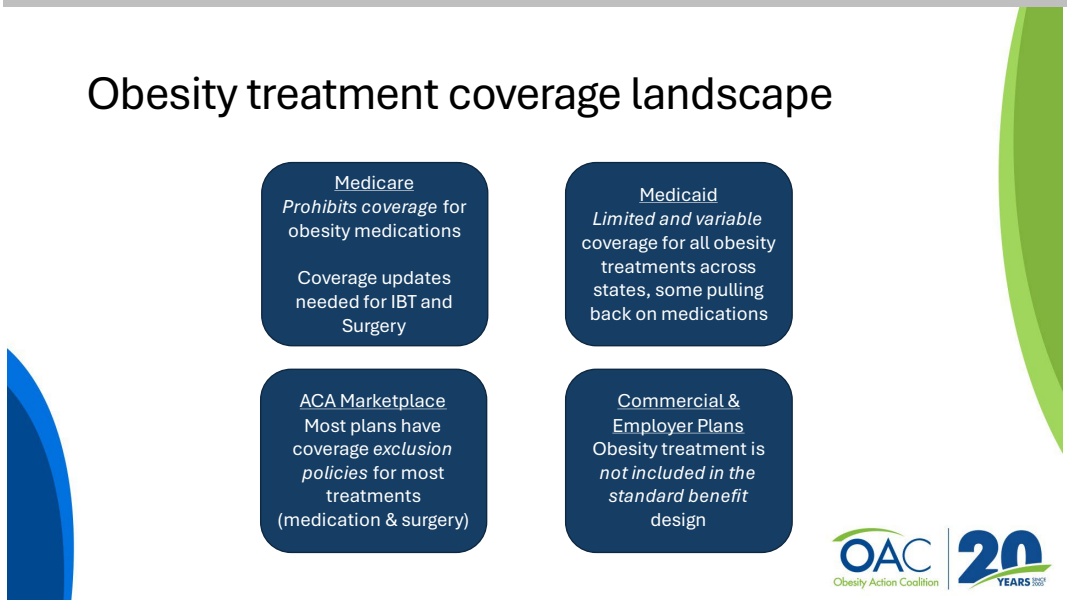
OAC Obesity Action Coalition 20 YEARS

ZVENYACH: Picking up from where Dr. Dietz spoke about the work coming out of the Lancet Commission, there are a few other obesity treatment recommendations in progress. This year we are awaiting the full standards for obesity care from the American Diabetes Association. They have released their methodology chapter, and a chapter on weight bias and stigma, which OAC was a part of the writing group.

Recently, a number of organizations worked together to develop a joint advisory statement on nutritional priorities to support GLP-1 therapy for obesity. In addition, The Obesity Society (TOS) is partnering with the Obesity Medicine Association (OMA) to develop updated practice guidance later this year. The Endocrine Society is working on an update to their obesity pharmacology practice guidance, which is expected to release in the next two years. These new evidence-based

recommendations will provide the most up-to-date scientific data for clinicians and to help measure developers working in this space.

[SLIDE 27]



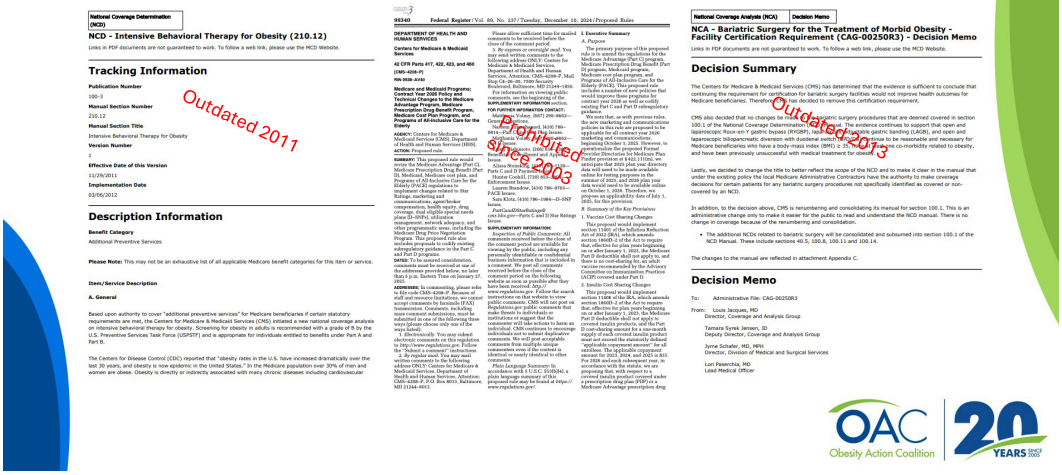
ZVENYACH: Next, we will turn our attention to the obesity treatment coverage landscape and discuss some of the barriers to care that exist across payer types. In Medicare we find outdated coverage policies across intervention type, including for intensive behavioral therapy (IBT) and metabolic and bariatric surgery. For obesity pharmacotherapy there is coverage prohibition due to statute interpretation under Medicare Part D.

Across state Medicaid programs there is limited and variable coverage for obesity treatments with pharmacotherapy being the intervention type with least coverage. Under Affordable Care Act (ACA) plans on the Exchange Marketplace, coverage data shows that most plans have exclusion

policies for obesity care, especially for pharmacotherapy and metabolic and bariatric surgery. We find wide variation in obesity treatment coverage among commercial and employer plans. This is because obesity is not included in the standard benefit design. Next we'll take a closer look at each payer type's coverage policies.

[SLIDE 28]

Medicare: Obesity treatment coverage



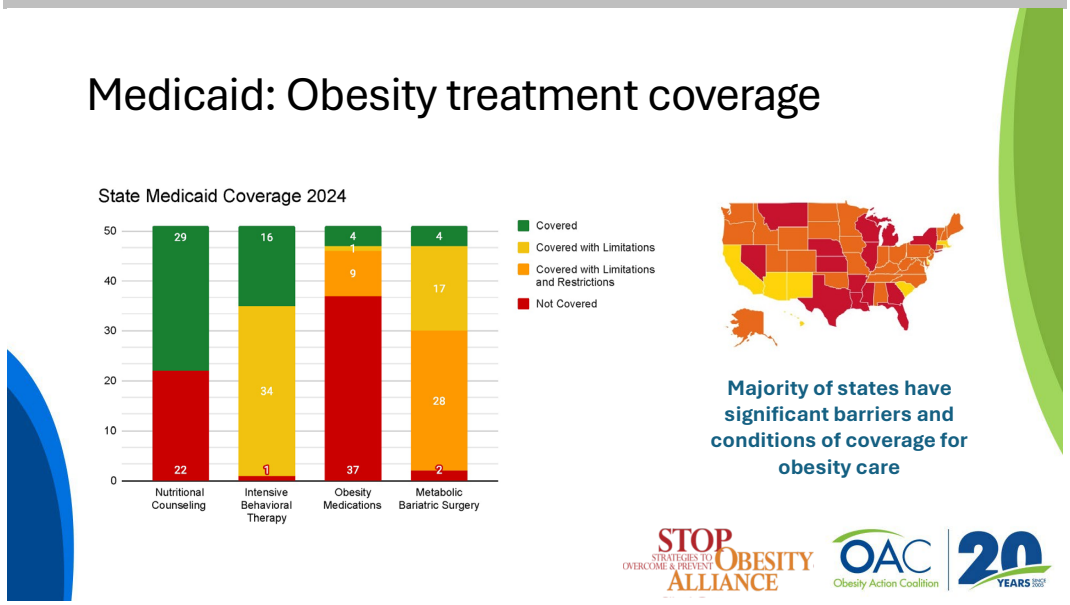
ZVENYACH: Under Medicare obesity treatment coverage policies are significantly outdated. Starting from the left to the right, we have the national coverage determination for intensive behavioral therapy (IBT) for obesity. Under the current benefit IBT for obesity can only be delivered by a primary care provider, and it can only take place in a primary care setting. As we know, there are other qualified provider types such as registered dieticians (RDs), clinical psychologists, and specialty physicians that could be delivering service outside of a primary care setting. This policy also dates back to 2011. There have been two relevant evidence

updates from the U.S. Preventive Services Task Force (USPSTF) that can be incorporated, with another one coming. A formal request for revision has been submitted to CMS for this NCD.

In the middle you can see the Part D rule that prohibits coverage for obesity medications. This interpretation dates back to 2003, a time when we didn't have the level of evidence we have today, including multiple FDA-approved pharmacotherapy options. On the right you can see a bariatric surgery decision memo from 2013. Plus, there is another from 2006. Since this time there are new clinical guidelines that could be incorporated. In addition, there is the opportunity to update language. For example, we don't use the terms "morbid obese," or "obese" anymore, and instead use the new ICD-10 codes released by the CDC last year.

The new codes use the classes of obesity — Class I, II, and III. Other preferred terms would be "severe obesity," and using "people with obesity." These are People First language options. There are Patient First language writing recommendations available as resources as well. Updating Medicare policy as a focus, as you know, it drives and influences other payer coverage policies.

[SLIDE 29]



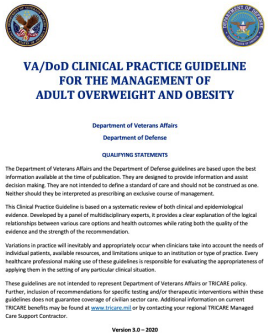
ZVENYACH: For Medicaid last year the OAC and the STOP Obesity Alliance collaborated on a research project where we assessed conditions of coverage for obesity treatments among all state Medicaid programs. We used a dataset for all states' fee-for-service and managed care plan documents. In the left stacked bar chart you'll see the range of coverage that exists by obesity treatment type, including nutritional counseling, intensive behavioral therapy (IBT), FDA-approved obesity medications, and metabolic and bariatric surgery.

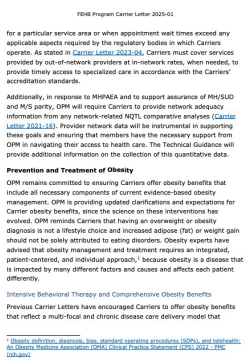
Coverage for nutrition counseling is split. For IBT the majority of states include limitations to coverage, seen in yellow. For medications about a dozen states provide some form of coverage, but most exclude, seen in red. And then while metabolic and bariatric surgery is covered in all but two states, you can see that the majority of states use a variety of

coverage limitations and restrictions. Overall, the majority of states have significant barriers and conditions of coverage for access to obesity care.

[SLIDE 30]

Other Federal Programs: Obesity treatment coverage



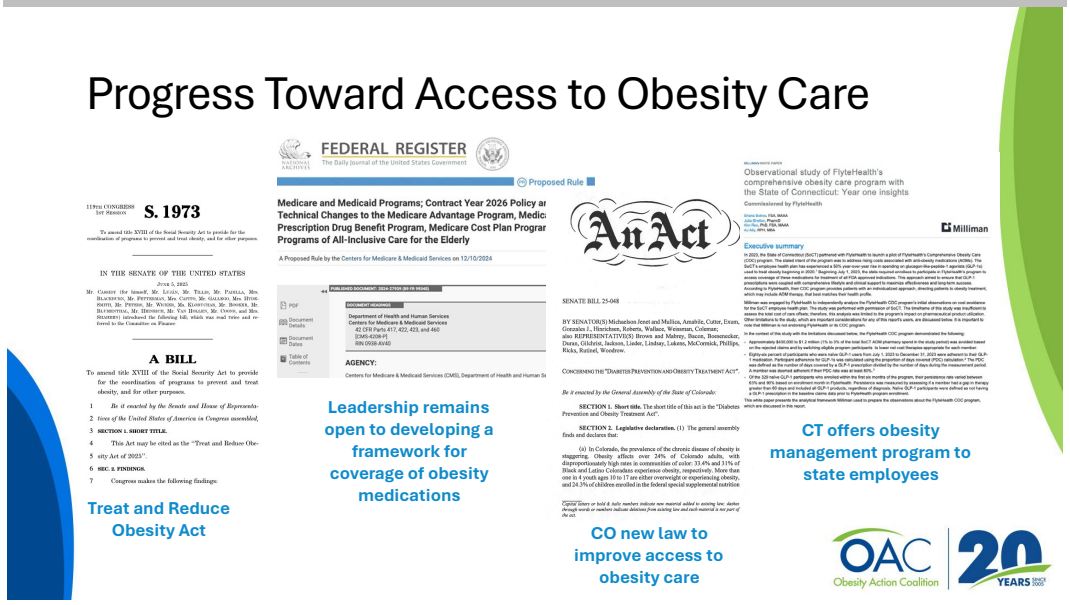


ZVENYACH: There are several other federal government programs that offer evidence-based obesity treatment coverage. There is the Veterans Affairs (VA) MOVE! Program, the VA MOVE! Program, which is a well-studied behavioral intervention-based program. The Department of Defense (DOD) has a clinical practice guideline for the management of adult overweight and obesity, and the Federal Employees Health Benefit (FEHB) Program also provides coverage for comprehensive obesity care.

It is important to recognize that these programs and policies exist; however, there are several documented barriers to utilization and implementation for each program. I won't go into the details here, but a

couple quick examples include difficulty in transitioning to higher levels of intervention and complicated prior authorization processes.

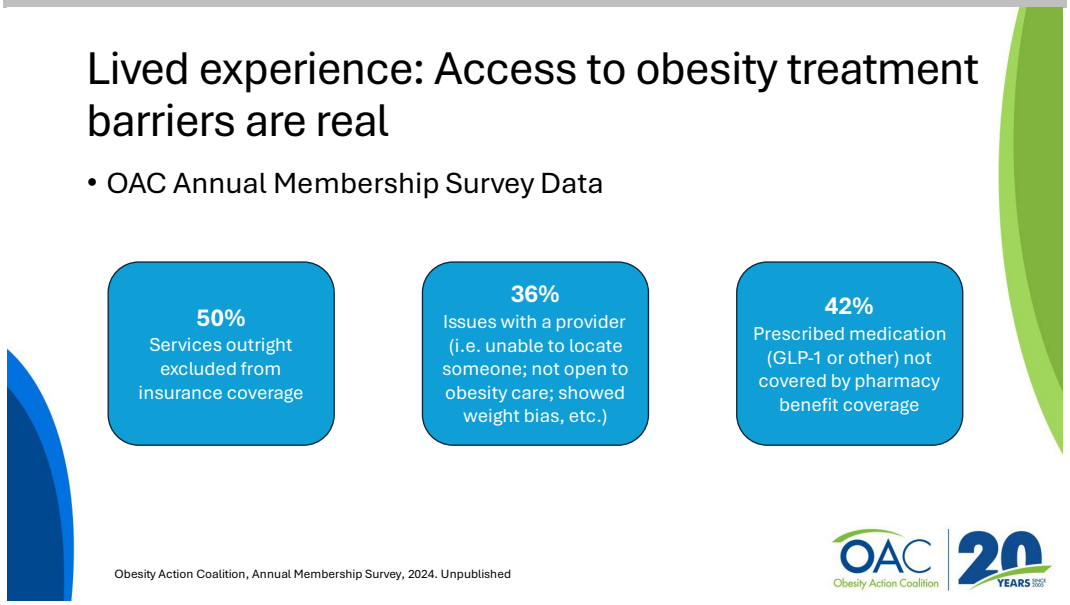
[SLIDE 31]



ZVENYACH: While the evidence finds many policy barriers, progress toward access to obesity care is underway. At the federal level the Treat and Reduce Obesity Act (TROA) was recently reintroduced. This legislation would correct the policy barriers we see under Part B for intensive behavioral therapy (IBT) for obesity, and Part D for coverage for obesity medications. From the regulatory perspective a proposed rule was released last year that would have reinterpreted the Part D prohibition on coverage for obesity medications. While that provision was not finalized, public statements by CMS leadership show they remain open to developing a framework for coverage of obesity medications.

Next, the state of Colorado recently passed legislation that expands access to obesity treatment for large group plans in the state. Finally, the state of Connecticut offers an obesity management program to state employees. A recent analysis by Milliman showed significant improvements in health outcomes and cost offsets for total savings. So again, we are seeing some progress towards access to obesity care.

[SLIDE 32]



ZVENYACH: When we talk to patients living with obesity, we confirm and validate that barriers to obesity care are real. OAC annual membership survey data show that 50% of respondents' health insurance policies fully exclude coverage for any obesity treatment. Over a third of our members have a hard time finding a healthcare provider that can help them manage their chronic disease. And when asked about prescription drug coverage, 42% of patients lacked any coverage at all. This data tells us that real people are struggling to access care for their chronic disease.

[SLIDE 33]

ZVENYACH: We heard from Patty at the beginning of this presentation. Her story clearly demonstrates that weight bias and stigma contribute to the gaps, but also opportunities to improve how obesity care is delivered. It is indisputable that 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 live healthy lives, and Americans want choice and quality in their obesity care. So quality measures for obesity care really do matter. They are an important part of when and how obesity care gets delivered for millions of Americans, for millions of patients. The evidence strongly supports the need for measure development in this space.

[SLIDE 34]

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

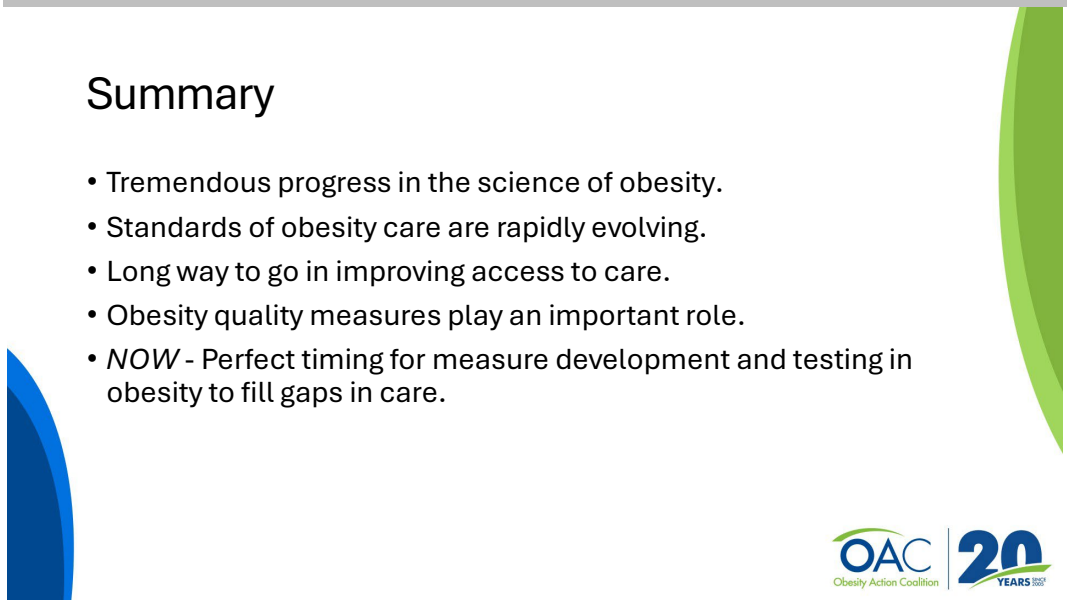
OAC Obesity Action Coalition 20 YEARS

ZVENYACH: I'll conclude by sharing a recent initiative in obesity measure development. OAC had the opportunity to collaborate with the International Consortium for Health Outcomes Measurement (ICHOM) on the development of a measure set for adults living with obesity. As you can see, the measure set included domains for physical health and clinical outcomes, wellbeing, health behaviors, body functioning, adverse outcomes, surgery-specific adverse events, and obstetric and gynecological outcomes.

Within each of these domains there are several components seen on the color wheel. The conditions included pharmacological treatment, non-pharmacological treatment, and surgical treatment in populations of adults age 18 years and above. The publication is expected this year, and

information about the measure set and methodology can be found on the ICHOM website.

[SLIDE 35]



ZVENYACH: In summary, there has been tremendous progress in the science of obesity. Standards of obesity care are rapidly evolving; however, we still have a long way to go in improving access to care. Obesity quality measures play an important role, and now is an opportune time for measure development and testing in obesity to fill gaps in care.

Our organizations, OAC, and the STOP Obesity Alliance at George Washington University (GWU), are excited about the future of quality measures to improve obesity care. We'd be happy to provide subject matter expertise and collaborate on obesity quality measure development. Thank you.

[SLIDE 36]

Q: "Beyond individual behaviors or genetics, what other factors influence obesity?"

DIETZ: So we have to recognize that obesity is a disease, and as Tracy mentioned, it's not a behavior, but the factors associated with obesity come from a variety of outside influences like the environment or socioeconomic status (SES), or cultural and social influences, all of which are directed towards changes in food consumption and physical activity.

So, for example, in the environmental side the availability of healthy foods affect the likelihood of obesity and its susceptibility. Neighborhood walkability is another environmental factor that limits access to recreation and physical activity. On the socioeconomic side, income, education and occupation can all affect access to nutritious food, as well as opportunities

for physical activity. Finally, cultural and social influences are important in terms of cultural norms, family habits, and social networks.

All of these relate directly or indirectly to the effect of obesity care, as we emphasized, but the most important barriers to care are the lack of the obesity diagnosis, or the bias and stigma that accompanies obesity on the part of both families and providers. Finally, insufficient access to obesity treatment resources. So the environmental factors and socioeconomic status (SES) pull the trigger on our—the bullets that—that what pulls the trigger on obesity is the disease itself.

Q: "I thought BMI was discredited. Why do we continue to use it?"

DIETZ: Well, it's not discredited. It needs to be modified as we argued, and it needs to include a measure of fat distribution. So in children and adolescents, as we showed in a paper last year, the BMI is an adequate measure of body fat in contrast to adults, but the key to the diagnosis of obesity is not just BMI, but also as we argued in the presentation, a measure of abdominal fat, which is really the determinant of morbidity and mortality in association with obesity.

Q: "Why can't we use DEXA to assess abdominal obesity?"

DIETZ: Well, DEXA is a good measure of abdominal obesity. The problem is that it does not distinguish between subcutaneous and visceral fat, and visceral fat is the real determinant of morbidity and mortality. Furthermore, DEXA is a complicated measure requiring special equipment and is not available as a routine measure in clinical patients.

Q: "What is the role of a primary care provider in the treatment of obesity?"

DIETZ: Well, we believe that the primary care provider should really be the person most responsible for care. Unfortunately, there's a high degree of bias among primary care providers. About half of providers still see obesity as a "behavioral" problem, not as a "disease-related" problem, but they are really the first-line responders, and should be responsible for sharing decision-making about what kind of alternatives should be pursued. That's rarely the case, because many primary care providers continue to say to a patient with obesity, "All you need to do is move more and eat better." That ignores the fact that most people with obesity have already done that multiple times. They've lost weight and relapsed and regained that weight, but ultimately we think that the primary care provider is the key to adequate therapy.

By primary care providers we don't just mean physicians. Other groups as Tracy emphasized, like dieticians and nurse practitioners and physical assistants—assistants are all appropriate people to care for obesity, but under Medicare's legislation that's prohibited. The only people that can deliver care are the physicians. "Physician assistants" is what I was trying to say, and they are also prohibited from delivering care.

ZVENYACH: I'd add just a couple of points to Dr. Dietz's response there. We recognize that the aspiration would be for any person living with obesity that wants help with their chronic disease could go to their primary care provider and know and trust that they will receive evidence-based,

quality, compassionate care. We just know that it's not quite there yet, and one of the other reasons to that is the lack of education and the lack of requirements and national boards, for example. So we know that there's a gap and a barrier there around provider education, and there is work in this area to address that gap as well.

So while most care is being delivered in a specialty setting today, we see a high increase in the number of physicians who are getting obesity medicine board-certified, an ABOM certification. That area of medical specialty is growing very fast right now, and that is wonderful to see.

One quick clarification from a policy perspective is the current Medicare coverage policy for IBT is our providers in the primary care setting, that does capture NPs and PAs and physicians in the primary care setting, but not the other provider types. So if you are an NP or a PA, not in a primary care setting, you cannot bill for those services. If you are a specialty physician not in a primary care setting, you cannot bill for those services — clinical psychologists, registered dieticians (RDs), as Dr. Dietz said.

Q: "So what are the short-term opportunities for adding an obesity measure, and what are the long-term opportunities? What are some other things that we might suggest?"

DIETZ: I think the shortest opportunity is to pass TROA, because that not only leads to the approval of medication, but also the possibility that care can be delivered by people other than physicians.

ZVENYACH: And then from a quality measure perspective, I think that one of the near-term opportunities is this focus on diagnosis. We know that there is work underway in that space. So that's really exciting to see, but then thinking longer-term it would be the hope to see a measure that represents good care. Perhaps a measure that would go from diagnosis to assessment to treatment to maintenance — a full care model. A measure that represents quality care I think is the aspiration in this space.

Q: "So with the relative cost savings, why isn't obesity recognized as a chronic condition?"

DIETZ: Ah, that's a really good question, and I think part of the answer is bias and stigma. Part of the answer is related to the cost of anti-obesity medications which are a real struggle when we have to recognize that 42% of the adult population has obesity. And if all those people are treated with a GLP-1, for example, it would break the bank. So there's a real hesitancy on the part of health plans to fund obesity treatment that includes medication.

Part of that I think that's a real concern, and an important concern, but one which reflects this kind of "all or nothing" thinking about the treatment of obesity. It's either use of the GLP-1 or not, whereas a much more graded approach would be to think about GLP-1s for who? Who is the best patient, or the most urgent patient for treatment with a GLP-1? Begin there and look at the cost savings associated with that intervention.

ZVENYACH: And I would just add or emphasize the presence of weight bias and stigma from many areas within healthcare, and one of those

areas is health insurance policy language. So a lot of the "exclusionary" language we see is rooted in kind of stigmatized views. Now that goes to knowledge and understanding. We need to catch the policy up with the science essentially. We need to change mindsets to move away from "we're looking for short-term solutions" to a mindset of "we need to manage a chronic disease over a lifetime." So it's part changing mindset. It's part updating policies and really chipping away and continuing to address the weight-based stigma that exists. It's prevalent in our society. It's there, it's around the world, but ways to recognize and continue to work toward better care.

Q: "Can you address BMI reliability as a measure
for populations 60 and over?
Is there an accessible measure
that's better than BMI for this particular age group?"

DIETZ: I think this is a really good question for which there's not an immediate answer. We know that body composition changes with age; although, abdominal circumference continues to be a reasonable measure of risk for fat distribution. How to correct for changes in height that come on with aging — that is people get shorter as they age — would suggest that the BMI needs to be corrected for that, but I'm not aware of any studies which have looked carefully at measures other than BMI. In our view it would be BMI Plus for this age group.

Q: "When I hear quality measure,
I think of a defined quality metric like measuring provider or plan,
or some kind of performance with a numerator and a denominator,

rather than the unit.

So how would you recommend translating BMI Plus into such a metric?"

DIETZ: Well, the diagnosis of obesity has to begin with a quality measure, and as we've argued that quality measure should be BMI Plus. Acting on that measure would be the next step, and that's where there is likely to be disagreement about what that should be, but we know from the earlier AMGA study that when BMI is measured and called to the attention of a patient, the patient is much more likely to act. So the way to measure the effectiveness of this quality measure would be to look at the baseline prevalence of obesity now. And then after some introduction of an intervention, to look at changes in that quality measure as an index of the impact of measurements of BMI. Long-term, as we've said, there need to be a number of other measures of obesity that have to do with the quality of care and not just the diagnosis of obesity.

Q: "How would you propose to include measures of abdominal fat in a telehealth setting, or are there any alternatives?"

DIETZ: Well, I think that waist circumference can be measured in a telehealth program. The criteria for waist circumference need to be specified. Where it's measured, for example, is really important, and it's certain at a very high BMI, a waist circumference probably doesn't add any significant information. Some of the work that has been done at NIH in the past has shown that this waist circumference at the level of the umbilicus in somebody who doesn't have a big pannus — a big deposit of abdominal fat — can be an accurate measure. It's easy enough to convert that measure from inches to centimeters.

Q: "So given that intense behavioral therapy is foundational in obesity treatment guidelines, should it be expected that IBT be provided for all patients receiving pharmacotherapy or bariatric surgery?

How should organizations measure comprehensive care when patients may receive different parts of care?
Behavioral, medical, surgical, across different sites or providers?"

ZVENYACH: Nutrition and lifestyle behavioral interventions are absolutely foundational to obesity care. They're foundational to health and wellness. So specifically, though, when we look at obesity interventions, having intensive behavioral therapy (IBT) is very much adjunct to metabolic and bariatric surgery. It's also adjunct to pharmacotherapy. So yes, it should be covered and accessible to patients, specifically USPSTF. It is a Grade B recommendation for behavioral therapy for adults with obesity. So it technically should be a covered service, too, per the Affordable Care Act (ACA). We see some variability in what those coverage policies look like, but it should be available.

And then I think over the course as we think about obesity as a chronic disease, you know, people will need different treatments at different points in their care journey, right? Sometimes people need multiple treatments at once. So access to care should be available for any person living with this chronic disease, no matter who their payer type is. That's really the aspiration. That's what we're working toward from an advocacy perspective for the patient community is to ensure that people have the care that they need, when they need it, and where they need it.

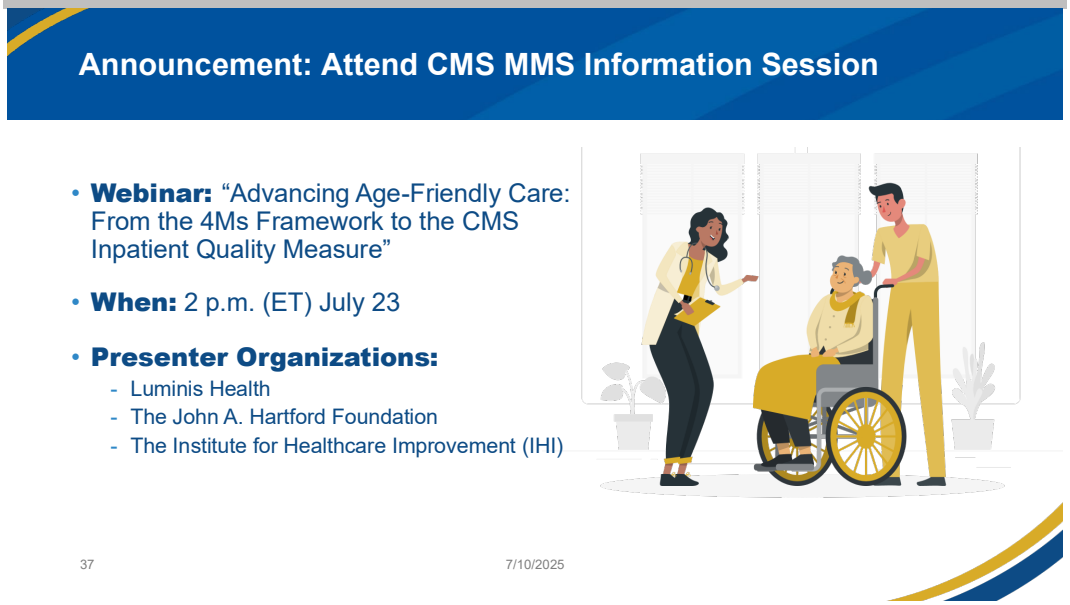
Q: "So given the efforts to wrap obesity into a CKM measure or a broader metabolic health measure, do you believe it's important to have distinct measures specific to obesity?"

DIETZ: So the NCQA has hosted two meetings on this whole topic of cardiovascular, kidney and metabolic (CKM) health, and there's not been a specific recommendation yet about how to wrap obesity into these measures. In fact, at a recent meeting which I attended, it was understood that obesity was at the heart of these cardiovascular, kidney and metabolic (CKM) measures. The problem is that nobody has really suggested exactly what that CKM measure should be, or whether it should be broader than that for health.

So I think at this point it's safe to say that we need to rely on the measures specific to obesity like the BMI Plus and wait for more information about the validity and utility of a CKM measure. I think it's enormously complex and perhaps a better use of that measure would be to determine the severity or urgency of treating obesity with respect to the nature of cardiovascular health, kidney dysfunction, Type 2 diabetes, or diabetes itself.

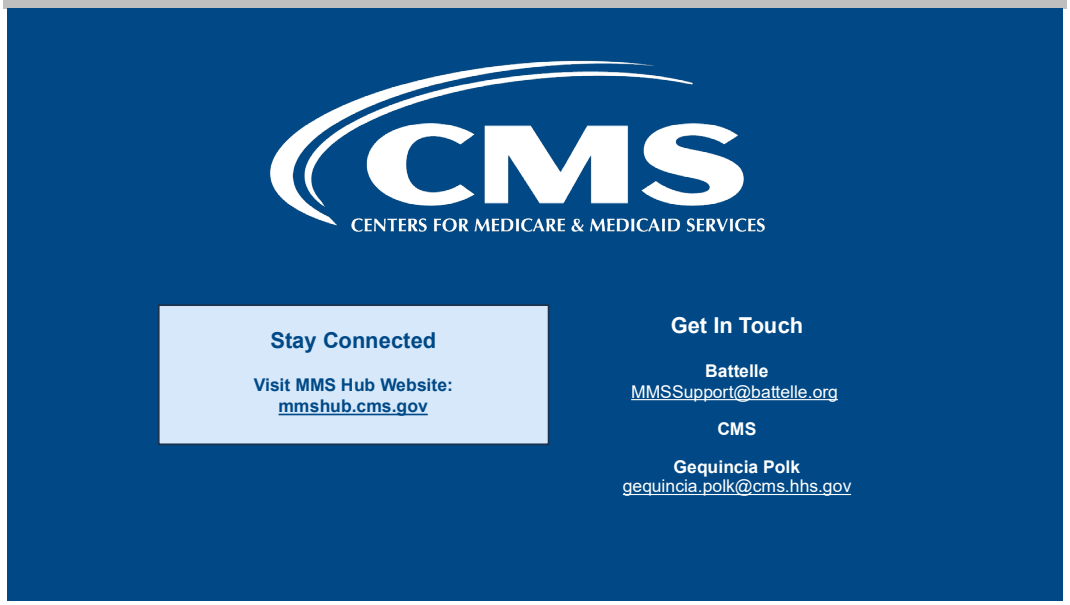
GHUNNEY: Thank you so much, Dr. Dietz and Dr. Zvenyach, for taking the time for this great presentation and for taking your time to answer all these wonderful questions. Thank you to everyone who attended for your questions and for your engagement in today's webinar.

[SLIDE 37]



GHUNNEY: If you're interested in learning more about quality measurement, I invite you to join us on July 23rd for our MMS Information Session which is entitled "Advancing Age-Friendly Care: From the 4Ms Framework to the CMS Inpatient Quality Measure." So this webinar is going to feature presentations from Luminis Health, the John A. Hartford Foundation, and the Institute for Healthcare Improvement (IHI). That link to register is in the chat, and we really hope to see you there.

[SLIDE 38]



GHUNNEY: So, as always, please visit the MMS Hub for upcoming events and opportunities to reach out, to engage in quality measurement, or reach out to us at MMSsupport@battelle.org. Thank you again for attending today's session.

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