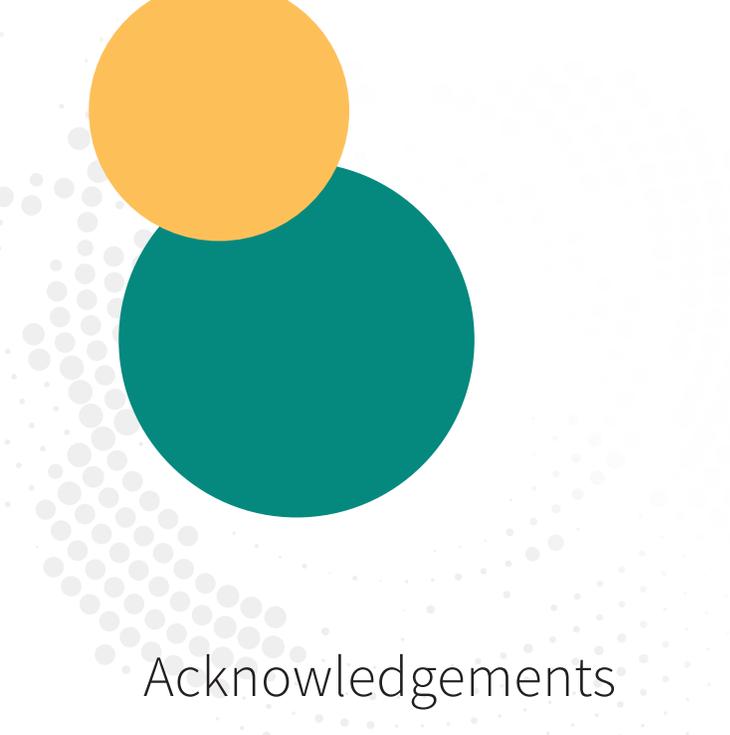


Envisioning Value-based Provider Payment for Obesity Treatment and Support

A NEHI Report

March 2023



Acknowledgements

NEHI research for Envisioning Value-based Provider Payment for Obesity Treatment and Support was conducted with support from Eli Lilly & Company, Form Health, and the Obesity Medicine Association.

Authors

» **Tom Hubbard**

Senior Vice President of Policy Research, NEHI (Network for Excellence in Health Innovation)

Additional Contributors

» **Joe Nadglowski**

Obesity Action Coalition

» **Evan Richardson, Dr. Florencia Halperin, Teresa Mueller**

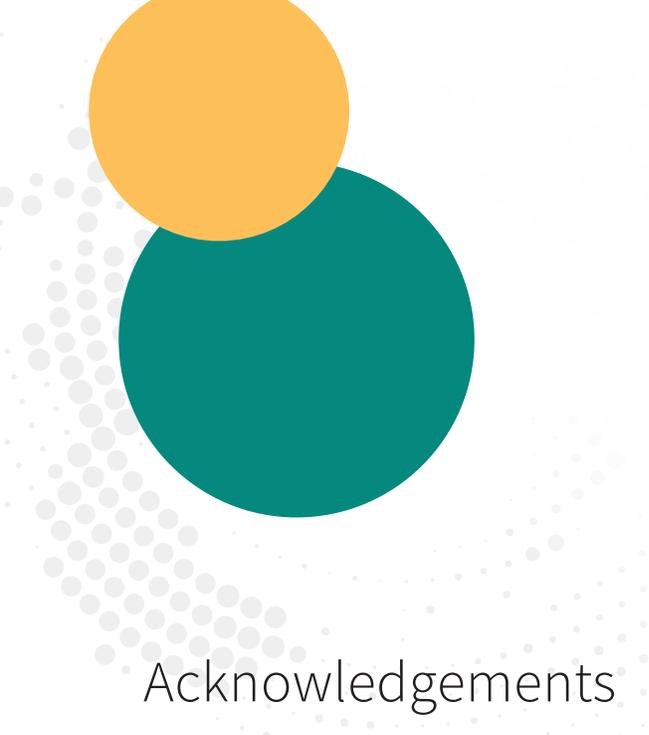
Form Health

» **Dr. Angela Fitch, Teresa Fraker**

The Obesity Medicine Association

» **Gregory Daniel, Tracy Sims**

Eli Lilly & Company



Acknowledgements

Layout and Design

» **Lilly Middleton**

Marketing and Communications Specialist, NEHI

About NEHI

NEHI is a national nonprofit, nonpartisan organization composed of stakeholders from across all key sectors of health and health care. Its mission is to advance innovations that improve health, enhance the quality of health care, and achieve greater value for the money spent.

NEHI brings together expert stakeholder perspectives with relevant research to devise policies that speed the adoption of innovations.

Takeaway Points

- **Ten years after the American Medical Association declared obesity a chronic disease, unmet patient medical needs associated with obesity are growing. Yet obesity treatment and support are not a focus of the ongoing movement towards value-based care.**
- **Two trends now challenge longstanding resistance to treating obesity as a chronic disease:**
 - **A growing scientific understanding of obesity and human metabolism** refutes the stigma of obesity as the patient’s fault. From a biological standpoint, obesity is a matter of “chemistry, not character.”
 - **New options for obesity treatment and support**, including modern approaches to intensive behavioral therapy, next-generation anti-obesity medications (AOMs) and new models of care (such as virtual or hybrid in-person/virtual care) that can be adapted to individual patient needs and characteristics.
- **Demand for obesity treatment is robust and growing, but still meeting only a fraction of patient needs.** The potential cost of treating patients with obesity at a greater scale suggests that now is the time to explore the feasibility of value-based payment for obesity treatment and support.
- **Mapping the journey of patients with obesity through their encounters with the healthcare system can serve as a foundation for designing and testing value-based payment models** for obesity treatment and support. The journey can be envisioned in four stages, each with implications for the design of payment models:
 - Stage I: Patient Engagement and Diagnosis
 - Stage II: Treat or Refer- Clinician Follow-up After Diagnosis
 - Stage III: Treat to Target– Treatment to Reach Individualized Patient Goals
 - Stage IV: Chronic Care
- **Widely accepted concepts of value-based payment can be mapped to the patient clinical journey through obesity treatment and care, and guide the development of new payment models.**
 - An example of widely accepted concepts is the framework of alternative payment models (APMs) developed by the Health Care Payment & Learning

Action Network (HCP-LAN), a framework that categorizes payment models by increasing the level of accountability and risk-sharing. Alternative payment models have played an important role in elevating the treatment of chronic conditions (such as hypertension and type 2 diabetes) by clinicians and enabling the delivery of care through payment incentives. APMs can play a similar role in catalyzing high-quality care for obesity.

- **Design and testing of value-based payment models for obesity treatment and support can follow the incremental path already seen in U.S. provider payment reform;** an incremental pathway to models of outcomes-based payment and provider-payer risk sharing, for example.
- **Looking ahead: patient-payer-provider-policy maker collaboration is needed** to establish standards of care, and validated process and outcome measures that will support delivery of value-based obesity treatment and support. Obesity-related measures must be prioritized by standards organizations, (the National Committee on Quality Assurance (NCQA), the National Quality Forum (NQF), and others). Clinician-friendly capabilities to document, monitor and report on validated measures need to be developed in parallel: user-friendly adaptations in electronic health records, for example. This will require an investment of time and money that may only be incentivized by the promise of a pathway to value-based reimbursement.

Contents

Executive Summary.....8

Envisioning Value-based Provider Payment for Obesity Treatment and Support:

- Key Considerations.....14
- Stage I: Patient Engagement and Diagnosis.....16
- Stage II: Treat or Refer- Clinician Follow-up After Diagnosis.....18
- Stage III: Treat to Target – Treatment to Reach Individualized Patient Goals.....18
- Stage IV: Chronic Care.....21

Adapting Widely accepted Concepts of Value-based Payment to New Models of Provider Payment for Obesity Treatment and Support.....23

Standard Models of Value-based Payment.....23

Adapting Standard Models of Value-based Payment to Patient-Centered.....23

Obesity Treatment and Support.....25

Conclusion.....28

Obesity Treatment: A Challenge and Opportunity for Self-insured Employers.....30

Figure A: The Patient Clinical Journey Through Obesity Treatment and Support.....36

Appendix A: Health Care Payment & Learning Action Network, Alternative Payment Model Framework.....37

Endnotes.....38

Envisioning Value-based Provider Payment for Obesity Treatment and Support:

Executive Summary

Obesity treatment and support: growing unmet patient need, better tools, and an opportunity for value-based payment

While progress is incremental, U.S. health care payers continue to promote a transition in health care provider payment that shifts payment away from volume-based fee-for-service reimbursement and towards alternative payment models that reward health care value. Health care value is defined variably as measurable improvements in patient health outcomes, patients' experience of care, quality of care, and in measures of efficiency such as reductions in health care resource utilization.

Ten years ago, the American Medical Association called for recognition of obesity as a chronic disease, and for greater support of obesity prevention and treatment.ⁱ If current trends persist half of all U.S. adults will have obesity by 2030.ⁱⁱ Yet active treatment of obesity is not a focus of care for most patients with obesity today, nor has it been a focus of payment models that might catalyze delivery of evidence-based obesity care. Health risks and chronic conditions that are highly associated with obesity are major targets of value-based, alternative payment models, including hypertension, hypercholesterolemia, and type 2 diabetes. But obesity itself is not.

The reluctance of health care payers to address obesity at greater scale reflects longstanding attitudes in the public and the health care system. Many people continue to view obesity as a personal failing for which people with obesity themselves should be responsible. The stigma of obesity deters patients from seeking help and deters some providers from offering it, while obesity treatment and weight management have long been considered minimally effective for most patients.ⁱⁱⁱ

Two trends challenge longstanding resistance to treating obesity as a chronic disease

First, the scientific understanding of human metabolism and obesity has accelerated considerably. Scientists view obesity as deeply rooted in patients' genetics, environ-

mental exposures, and social determinants of health. Obesity is recognized as a serious chronic disease; a matter of “chemistry, not character,” requiring active treatment and chronic management.^{iv}

Second, the toolbox of treatment and management options is increasing and promising more effective and durable patient outcomes. Multiple new anti-obesity medications (“AOMs”) have been approved by the FDA and more seem likely to be approved soon. Non-pharmaceutical treatment options, including innovations in Intensive Behavioral Therapy, are also increasing. Obesity treatment can now be delivered through specialty obesity medicine (and some primary care models) on an in-person, all-virtual or hybrid basis.^v Some progressive employer-purchasers and health insurers are offering patients access to multiple obesity care providers so that patients can choose services that best fit their needs, (obesity management coupled with behavioral health services, for example.)

The growing prevalence of obesity is generating an extremely high level of unmet patient need and increasing patient demand for treatment and care. Now is the time to explore how high-value treatment and support can be delivered at scale

Patient demand for anti-obesity medications is already robust, and payer coverage of AOMs and virtual care is improving. Coverage of AOMs will take a step forward in 2023 with mandatory coverage of AOMs by insurers who cover over nine million federal employees and dependents in the Federal Employees Health Benefits (FEHB) program.^{vi}

Coverage gaps persist, however: Medicare Part D does not cover any AOMs, a gap that can only be rectified by an act of Congress. It is an open question whether patient demand alone will drive an upsurge in obesity treatment and supportive care that will be commensurate with the public health risks posed by the increasing prevalence of obesity, and at a scale that will measurably reduce the cost burden of obesity-related conditions.

Since U.S. health care payers are committed to pursuing value-based provider payment, it makes sense for all stakeholders (patients, payers, providers, and manufacturers) to consider the feasibility of designing value-based provider payment models for obesity treatment and support that aim to improve patient outcomes efficiently and with the best positive impact on total costs of care.

Moreover, advance planning now could take advantage of marketplace competition, given the growth of virtual care services now available, and the expected approval of multiple anti-obesity medications in the months ahead. The limited availability and relatively high cost of AOMs today is frequently cited by providers as a barrier to greater uptake of obesity treatment.^{vii} Payer support for value-based provider payment could spur parallel development of value-based arrangements for AOMs and expedite efforts to overcome barriers to obesity treatment and support for patients.

The patient clinical journey is the foundation for designing value-based provider payment for obesity treatment and support

There is no widely accepted policy roadmap to payment models for obesity treatment. The place to start is with a vision of the patient clinical journey. This paper outlines a rudimentary patient clinical journey map that is focused on patients with obesity and their engagement with the health care system, (see Figure A, below.) We invite stakeholders to comment on its usefulness as a guide to identifying key considerations for the design of value-based payment models for obesity treatment and support. The patient clinical journey map breaks down to four stages, each one of which could be a target for development and testing of obesity payment models:

- Stage I: Patient Engagement and Diagnosis
 - Key considerations in this stage would be payer coverage and reimbursement for formal diagnoses of obesity, and for provider-patient counseling. Effective counseling will be important to patients' understanding of obesity as a health condition, to overcome the burden of obesity stigma, and encourage patients' adherence to evidence-based care.
- Stage II: Treat or Refer -Clinician Follow-up After Diagnosis
 - Appropriate clinical action must be taken once a patient is diagnosed with obesity, prompting a decision by the diagnosing clinician to either treat the patient herself/himself, or refer the patient to a specialist. Key considerations in this stage could include provider incentives to ensure that action is taken.
- Stage III: Treat to Target - Treatment to Reach Individualized Patient Goals
 - Key considerations in this stage could include incentives for providers to determine patient-specific goals for weight loss and weight management, and appropriate treatment to reach these goals.

- Stage IV: Chronic Care
 - Key considerations in this stage will be support and incentives to manage and monitor patients so they maintain their specific health goals over time, and routine reassessment of patient goals to adjust treatment and overall care.

Widely accepted concepts of value-based payment can be mapped to the patient clinical journey

New models of value-based payment for obesity treatment and support should be consistent with well-accepted principles of provider payment reform. The Health Care Payment Learning & Action Network (HCP-LAN), an industry consortium that includes the country's largest health insurers, has enunciated a framework of alternative payment models (APMs) that can be applied to the task of designing payment models for obesity treatment and support.^{viii} The HCP-LAN framework identifies fee-for-service reimbursement as Category I, followed by three categories of value-based payment, as follows:

- Category 1: Fee-for-Service reimbursement with no link to quality and value (the dominant payment model in the U.S.)
- Category 2: Fee-for-Service with provider bonuses or other incentives on a pay-for-reporting or pay-for-performance basis.
- Category 3: Alternative payment built on fee-for-service architecture, with shared savings or shared financial risks between payers and providers.
- Category 4: Population-based payment, including condition-specific payment models, or comprehensive (all patients covered) models.

Design and testing of value-based payment models for obesity treatment and support can follow the incremental path already established in U.S. provider payment reform

Value-based provider payment in the U.S. is evolving towards greater risk-sharing between payers and providers, but the path to risk-sharing has been gradual and incremental. The payment categories in the HCP-LAN payment framework move from a model that rewards providers who report on or achieve specific health care quality goals, to more complex models in which providers may be rewarded for achieving measurable improvement in patient health, to models in which providers and payers share in savings achieved when quality and outcome goals are achieved. Alternative, value-based payment models include models that reimburse providers for specific episodes of care as well as models that reward providers for the total care provided to

patients with a specific condition (a disease-specific model), or all care provided to all patients.

Collaboration among patient groups, payers and providers could define payment models for obesity treatment and support that emulate this overall, incremental approach. Four potential options for design, testing and potential implementation can be defined as models of payment for:

- Provider delivery of a defined obesity standard of care
- Provider delivery of a standard of care for obesity treatment episodes
- Outcomes-based payment for episodes of treatment
- Outcomes-based payment for population-level health outcomes

Looking Ahead: Priorities for Stakeholder Collaboration

Cross-sector collaboration is needed in two areas to launch pathways to value-based payment for obesity treatment and support.

First, collaboration is needed to set standards and metrics of patient-specific, high-quality treatment and support that can be incorporated into obesity payment models.

The movement for value-based provider payment in the U.S. is grounded in the older movement for health care quality improvement. The quality movement has enshrined evidence-based goals for routine health care practice that are embedded in the Health-care Effectiveness Data and Information Set (HEDIS) measures, Medicare’s Star ratings, provider accreditation programs that are often now required by payers (such as patient-centered medical home standards for primary care), and other quality measurement programs.

Value-based reimbursement for obesity treatment will require development of both key process and outcome measures, and the development of adequate reporting capability among clinicians.^{ix} A prime example is “treat to target” goals: there is little existing capability among most health care providers to routinely determine patient-specific goals, or validated measures of “treating to target” that will allow documentation and billing for reimbursement. Collaboration among stakeholder groups, including measure development organizations (such as the National Committee for Quality Assurance, the Pharmacy Quality Alliance, and the National Quality Forum) is needed to expedite mea-

sure development. Likewise, focused efforts are needed to improve clinicians' reporting capabilities, such as capability within electronic health records to diagnose and document obesity routinely.^x

Second, collaboration is needed for well-designed and controlled pilot projects or other experimentation that will test the viability of new payment models for obesity treatment and support.

Highly integrated health care systems with strong capabilities to define and track patient outcomes, and an openness to experimentation might be ideal candidates; the Veterans Health Administration (VHA), for example. Larger, self-insured employers might also be well positioned to experiment (or support insurer experiments), given the flexibility they enjoy in designing employee health benefits, employee assistance programs, and other benefits. Employers with relatively stable workforces are also in an ideal position to evaluate the multi-year impacts of obesity treatment and support, and to reap the benefits if value-based obesity treatment succeeds in reducing employee health risks, improving their health outcomes, and reducing obesity-related health utilization.

Envisioning Value-based Provider Payment for Obesity Treatment and Support:

Key Considerations

Health care payment reform continues to evolve in the U.S., but the central theme remains transition away from volume-based fee-for-service medicine towards payment models that support and reward providers that deliver evidence-based care and improved patient outcomes. Financial incentives are tied to achievement of validated metrics of health care quality, patient outcomes, or both.

Innovative payment models continue to take many forms, ranging from models that award bonuses when specific, condition-specific goals are met by providers (e.g. Medicare MIPS payments), to goals met within delivery of an episode of care (an episode of surgery, for example), to risk-shared models in which health care providers share in financial savings or losses incurred in care delivery, provided that care meets benchmark standards of quality.

Health conditions that are often co-morbid with obesity, such as hypertension, hypercholesterolemia, and (to a limited extent) type 2 diabetes have been key targets of payment reforms for many years. Obesity itself has not been a target for payment reform despite the strong correlation of obesity with these conditions and other downstream diseases such as heart disease, kidney disease, and some cancers. Evidence from metabolic and bariatric surgery has been notable: surgery has reversed type 2 diabetes or reduced or eliminated insulin use among many patients, yet only about 1 percent of patients with obesity undergo surgery.^{xi} (Access to surgery is also a source of racial-ethnic disparities: non-white patients and patients with low incomes are less likely than white and higher-income patients to receive surgery).^{xii} Obesity is still perceived as an issue of personal behavior, to be addressed through better eating habits and increased physical activity.

Now, given the development of new modes of Intensive Behavioral Therapy and other care options (in-person, hybrid and virtual-only), and the likely availability of multiple new anti-obesity medications in the near future, it is not too early to look ahead to how provider payment models can be designed and implemented to advance improved

treatment for people with obesity, and deliver high-value results to both patients and payers.

Even before the COVID pandemic, expert clinical guidance on the treatment of diabetes had shifted increasingly toward recommendations for earlier and more aggressive treatment of obesity, including the use of medications to stop or slow the progression of metabolic syndrome in patients before progression into type 2 diabetes or other serious conditions.^{xiii} This shift is based on several continuing trends:

Increasing unmet need:

The U.S. adult population continues a trajectory on which 50% will have obesity by the year 2030.^{xiv} Moreover, while the full impact of COVID-19 on U.S. public health is not yet fully apparent, COVID has exacerbated both the prevalence of unhealthy weight and the health risks suffered by persons with obesity.

Better scientific understanding of human metabolism and obesity:

Research continues to show that obesity is a chronic disease that most patients cannot overcome without active, ongoing medical intervention. The overwhelming majority of patients who successfully lose weight regain the weight because human metabolic systems have evolved to resist weight loss.^{xv} The notion that obesity is a function of “chemistry, not character” is crucial to overcoming the still-widespread stigma associated with obesity, a stigma that is known to inhibit patients from seeking help and further discourages clinicians from offering help.^{xvi}

Under-adoption of evidence-based interventions coupled with unmet demand for obesity treatment and support:

While demand for treatment and obesity care management is increasing, uptake of evidence-based treatment remains low compared to the very high prevalence of obesity. Demand for obesity medicine delivered at obesity medicine centers far outstrips current capacity. The low volume of obesity treatment and care delivered by primary care practices is responsible in part for this bottleneck, as patients may have no recourse but to seek specialty care. The emergence of virtual obesity care delivered either on an all-virtual or hybrid (site-based coupled with virtual care) basis is expanding access to obesity care. Nevertheless, primary care practices will need to play a major role in obesity care, both on a standalone basis and in consultation with specialty obesity care.

Implementation of well-designed alternative payment models can be a catalyst for enabling delivery of obesity treatment and care by primary care practitioners.^{xvii}

Increasing options for treatment and for delivery of treatment:

New models of obesity care delivery are now available to address the care bottleneck. Examples include models of office-based obesity care (e.g., the STOP Obesity Alliance^{xviii} and AMGA Obesity Care Model Collaborative^{xix} models). As already noted, virtual care platforms are stretching the reach of obesity medicine specialists while offering multiple protocols for obesity treatment and support, (i.e., choices beyond “one size fits all” treatment and support).^{xx} Finally, a new generation of safe, effective anti-obesity medications (AOMs) are entering the health care market, and dozens more are now in development.^{xxi}

There is no doubt that devising successful payment models for treating and managing obesity at scale will be difficult given the high prevalence of obesity, as well as the relative novelty and lack of long-term experience with obesity treatment and support innovations such as the new AOMs and virtual care platforms.

We suggest that the place to begin is with a vision of the patient clinical journey through obesity treatment and care from a first stage in which a patient seeks or is offered treatment, through treatment and into chronic care. The patient clinical journey can be segmented into four stages that, for now, seem most relevant to the design of payment models that can be tested, validated, and eventually implemented. These four stages are outlined in Figure A.

Among the points of note:

Stage I: Patient Engagement and Diagnosis

We envision this as a stage in which the result is a formal diagnosis of obesity that triggers appropriate evidence-based care initiation or referral to specialty care as needed. This result can be supported by increasing use of patient-centric, evidence-based, treatment guidelines and achieved in one of several ways: by the patient seeking out the clinician, or by the clinician leveraging techniques to understand the of patients’ needs and health aspirations. Use of non-biased and non- stigmatizing motivational interviewing or other techniques, for example, or through clinical opportunity triggered by a routine patient-clinician encounter, (a BMI measurement taken during an annual

physical, for example). Non-traditional providers, such as health coaches and community health workers, could also play a role in establishing effective and culturally competent engagement with patients with obesity. This could be another opportunity for demonstration of alternative payment models for obesity treatment and care, particularly payment models that support population health management.

Obesity care payment policy should incorporate metrics and reimbursement for a systematic assessment and diagnosis of obesity and associated health risks, no matter how the process begins. While patients are weighed routinely during clinician encounters and Body Mass Index is calculated routinely, diagnosis of obesity is limited, particularly as a primary diagnosis for follow-up treatment.^{xxii} Formal diagnosis and documentation of obesity for the purpose of follow-up treatment or weight management is very limited. A BMI calculation alone is not equivalent to an assessment of the health risks associated with a patient's obesity, or a sufficient basis for a clinician to recommend appropriate follow-up that might not only center on weight loss and weight management, but on treatment for associated risks such as type 2 diabetes and hypertension. (See discussion of the Edmonton Obesity Staging System, below.)

Physician-patient engagement and formal diagnosis of the patient's obesity and health risks can also play a key role in addressing obesity stigma, provided it is conducted sensitively and appropriately. Reimbursement of routine assessment of obesity will send an important signal to both clinicians and patients that obesity will be regarded as a serious medical condition that merits medical attention and support.

Key metrics of Stage I would include measures of diagnosis and documentation of obesity (for example, metrics of diagnoses completed and documented, as recently recommended by leaders of the American Medical Group Association Obesity Care Model Collaborative).^{xxiii} Measures of patient engagement and patient activation might also be developed for potential inclusion for support under new obesity payment models. Successful completion of diagnosis and its documentation are prerequisites to moving the patient to the next stage of the patient clinical journey, (Stage II, below). Recent analysis of clinicians' use of diagnostic coding and documentation of obesity diagnosis suggests that documentation alone can catalyze follow-up action by clinicians,^{xxiv} but that barriers to documentation, billing and reimbursement of obesity diagnosis remain a significant barrier to follow-up care.^{xxv}

Stage II: Treat or Refer – Clinician Follow-up After Diagnosis

Once a patient is diagnosed with obesity, payment policy and reimbursement must ensure that meaningful clinical action is taken. Clinically meaningful action will take one of several directions, depending on the patient’s diagnosis: for example, to treatment by the diagnosing clinician, or referral to a specialist, (board-certified obesity medicine specialists, for example), or to metabolic and bariatric surgery. If the referral is to services within the diagnosing clinician’s organization, then a straightforward metric (such as the number of patients treated compared to the number of patients diagnosed) could be utilized in payment policy.

However, in today’s health care market patients may be referred to services outside their diagnosing physician’s or primary care physician’s organization. Patients may refer themselves to services; for example, employees who have an option through their employer-sponsored benefits to access their choice of multiple virtual care options. In this case, metrics of patient follow-up and engagement with treatment across all available options may be most pertinent to the payer and to payment policy.

Risk Stratification and Patient Identification

Many payers will set priorities for managing patient access to obesity treatment and support to assess clinical outcomes and costs of care for patients at higher levels of health risk before extending the same benefits to patients at lower risk. At present new treatments (such as the new AOMs) and modes of care (such as specialty obesity medicine) are often only available at relatively high cost to patients and payers, or otherwise represent an expansion of services covered by payers. Thus, risk stratification of patients may well determine the services payers are willing to cover and the options for care that the diagnosing clinician can recommend to patients with obesity.

For example, until recently, patient access to metabolic and bariatric surgery has been restricted to patients assessed at higher levels of Body Mass Index, particularly patients with co-morbid conditions. New clinical practice guidelines significantly are now expanding eligibility criteria for surgery, although still linked in part to patient Body Mass Index.^{xxvi} The Edmonton Obesity Staging System (EOSS) is an example of a well-validated tool that has proven superior to simple BMI calculations in predicting risks of obesity-related complications, including mortality, among patients with obesity.^{xxvii}

Stage III: Treat to Target - Treatment to Reach Individualized Patient Goals

Research has shown that modest amounts of weight loss can result in a clinically meaningful reduction of health risks for persons with obesity. This insight is critical to rebutting the stigmatizing notion that the solution to obesity is to force the patient's weight down to a "normal" Body Mass Index level. A five percent reduction in body weight is sometimes cited as a standard of effective weight loss. However, obesity medicine and endocrinology clinical guidance increasingly emphasizes that patients' weight goals should be highly individualized to patients' overall health status, co-morbid conditions, lifestyle, access to healthy food, and level of physical activity. Clinicians are advised to "treat to target," not to a BMI goal.^{xxviii}

Medication use is a case in point. Patients with obesity may also be in treatment for co-morbid conditions for which standard drug therapies induce weight gain as a side effect, (for example, beta blockers for hypertension, insulin for treatment of type 2 diabetes, and some classes of psychiatric medications used to treat depression, anxiety, and serious mental illness.) Personalized goals are necessary to balance what may otherwise be conflicting treatment needs.

In Figure A we envision both goal setting at the initiation of treatment ("Set Individualized Patient Health Goals") and a downstream point that marks success or failure of treatment, ("Achieve Individualized Patient Health Goals").

Both points ("Set Goals" and "Achieve Goals") could serve as start-and-end points for a defined episode of care, and thus define episode-based payment innovations. As patients' health status and needs change over time, patient weight goals will need to be assessed and adjusted over time, suggesting that payment policy may need to accommodate multiple or recurring episodes of treatment over time.

Embedding patient-specific goals for achieving a healthier weight into payment models for obesity treatment will be one of the most challenging tasks in scaling obesity treatment and support. Whereas tracking Body Mass Index at the individual and the population level is routine in medical practice and routinely reported, procedures and systems to track and report individual patients' weight compared to personal health goals are not implemented routinely today. The patient and a clinician will determine the patient's personalized weight goals. The qualifications of the clinician will be a factor in the clinician's reimbursement, and hence a factor in the design of payment models for obesity care. Figure A envisions three clinician categories:

Primary Care:

Interventions may include intensive behavioral therapy (IBT) and medication prescribing and medication management. With the recent proliferation of telehealth and virtual care services, primary care for obesity treatment can be delivered in an office setting, in a hybrid (office and telehealth) or entirely virtual setting.

Specialty Care:

Patients may be referred to obesity medicine specialists or other medical specialists, such as endocrinologists. Obesity medicine practice is based specifically on application of evidence-based practice guidelines to treat patients' obesity to reach individualized patient goals, including goals for nutrition and physical activity support, and medication management. Conventional obesity medicine services are found most often in specialty clinics (such as clinics within major hospitals) or within dedicated physician practices. Telehealth capabilities have won payer acceptance and grown during the COVID-19 pandemic and expanded the ability of site-based specialists to offer virtual care visits to complement site-based visits. Meanwhile, the emergence of virtual obesity medicine has untethered obesity treatment from physical clinics altogether.

Metabolic and bariatric surgery:

Metabolic and bariatric surgery is the most intensive intervention to address obesity and is indicated for patients seen as at highest risk or with the best opportunity to avoid progression into serious or disabling disease. Obviously, there are no virtual options for metabolic and bariatric surgery; surgeries are performed in a hospital or outpatient clinic, and reimbursement is site-based. It is worth noting that these patients still proceed through a period of pre-operative and post-operative obesity care and, ideally, transition to a period of chronic obesity management, (i.e., care under the supervision of non-surgeons.)

Continuity of Care: Transitions of Care, Care Handoffs and Care Coordination

Successful scale-up of obesity treatment and support will clearly require success with the continuity of patient care, from at least two standpoints.

First, patients referred into specialty care will still maintain- or should maintain - a relationship with their primary care provider. Coordination between specialist care and

primary care should be integral to obesity treatment care processes.

Second, the need for effective transitions of care and care hand-offs will grow for those patients who progress from primary care to specialty care or pass back and forth from both types of care over time. Care coordination will become a higher priority as patients pass through different modes of delivery, such as in-person, hybrid, or all-virtual care. As noted above, patients who undergo bariatric surgery already transition from a pre-operative period of care, into surgery and then into a period of post-operative management that may include continuing care for nutrition, physical activity, and the use of AOMs or other medications that facilitate weight loss, (e.g., non-insulin diabetes medications).

The inevitability of care transitions suggests that basic standards for care transitions or care handoffs should be developed, including standards that ensure that patient treatment records follow the patient through the patient clinical journey, from one stage of obesity treatment to another.

Stage IV: Chronic Care

We envision the final stage of the patient obesity treatment journey as chronic care. In chronic care, the patient and clinicians will work to maintain outcomes that meet the patient's individualized health goals.

Chronic care practice is often defined as delivery of a standard of care over the prolonged, even lifelong periods of time in which chronic illness persists such as for hypertension, hypercholesterolemia, and diabetes. Treatment options, such as medication choices, may change over time but services themselves remain relatively stable and change infrequently. Value-based, provider payment models for chronic care aim to provide predictable payment for a guideline-based standard of care and, in effect, to promote investment in care delivery that achieves more efficient care and economies of scale. The challenge for payment innovation in obesity care will be delivering economies of scale for treatment of a condition that is both highly prevalent but at present is not treated among most patients, and episodically treated, among others.

The recent proliferation of virtual-only chronic care and uptake of telehealth among site-based clinicians is now laying groundwork for more accessible obesity treatment and support, and greater competition among providers and in use of treatments and

resulting economies of scale.^{xxix}

At the same time, clinicians point to the relatively high costs of AOMs as a barrier to payer coverage of AOMs, and a barrier to uptake among patients who may be responsible for cost sharing. The cost of AOMs may be mitigated as multiple, new AOMs reach approval and enter the market in the months ahead. Moreover, payer adoption of value-based payment models for obesity care could also be a significant force for moderating AOM and other treatment costs. New obesity payment models that support obesity treatment and support at greater scale would create a stronger rationale for value-based arrangements between payers and manufacturers for purchase of AOMs. Ideally, greater economies of scale would be achieved as a result.

Design of payment models for chronic obesity care could follow on principles already used in the design of payment models for chronic care and population health management, including base payments (such as per patient-per-month fees) that reimburse providers for providing a basic standard of care to patients with obesity.

Financial incentives might also be added to reward performance that achieves health care process or patient outcome milestones achieved across the entire population of patients attributed to the clinician's practice. Incentives would be tied to milestones of patient care as reported against quality and outcome measures. Quality and outcome metrics most relevant to obesity treatment and support might include measures of routine reassessment of weight and personal health goals; uptake of patient engagement and motivation tools; adherence to recommended treatments (adherence to prescribed medications, for example); and population-level metrics that measure maintenance of patient health goals. As noted earlier, development and validation of critical obesity treatment quality and process measures should be expedited to support design of payment incentives and payment models, along with further development of performance and quality reporting capabilities among clinicians.

Adapting Widely accepted Concepts of Value-based Payment to New Models of Provider Payment for Obesity Treatment and Support

Payment innovation for obesity treatment and support is uncharted territory for health care providers and payers. Innovation will depend in many ways on which obesity care objectives are both essential and feasibly achievable. There is a wide array of potential objectives for models of provider payment for obesity treatment and support that could potentially be adapted from alternative payment models already in use throughout the health care system.

Standard Models of Value-based Payment

Reimbursement in the U.S. for health care providers, drugs, and other medical goods and services remains grounded in fee-for-service (FFS) payments. Billing and accounting systems are designed to reimburse for specific, one-time services. At present patient advocates and obesity care providers are focusing advocacy mostly on winning fee-for-service coverage and reimbursement of anti-obesity medications and obesity specialty care.

Value-based payment models link reimbursement to milestones of care including defined patient outcomes, proof that a standard of care is delivered to the patient (as defined by specific quality metrics), or both.

The Health Care Payment Learning and Action Network (HCP-LAN) is a consortium of health care payers, provider systems and others that have met since 2015 to promote the growth of value-based, alternative payment models (APMs).^{xxx} A major priority for HCP-LAN is standardization of APM model concepts and terminology. In 2017 HCP-LAN released a framework for classifying major types of APMs and major sub-types, (see Appendix A, below), which remains a major reference for payment strategists throughout the country.^{xxxi}

The HCP-LAN framework identifies four payment model categories in which Category

1 represents traditional, fee-for-service payment and Categories 2-4 represent alternative payment models (APMs). Category 2 is designed around incentivizing providers by offering bonus payments based on investments in supportive data collection and analysis, or for meeting quality benchmarks. (Investments in adapting electronic health records to facilitate obesity diagnosis, monitoring and reporting might be one such set of investments.) Category 3 puts provider payments at risk, either upside-only risk (providers share in savings from efficient care), or two-sided-risk (providers share in savings or losses). Category 4 APMs are entirely population-based; providers are paid a fixed amount (such as a defined per-patient/per-month, PMPM payment) for every patient attributed to the provider.

Payment under every APM (Categories 2-3-4) is regulated in the sense that providers must demonstrate that the care they deliver meets specific performance or quality benchmarks as defined in quality metrics the providers must report to the payer.

The HCP-LAN framework is useful for envisioning payment strategies for obesity treatment and support, not least because it is a reference point for multiple payers, including large national insurers such as United Health Group, Elevance/Anthem, Cigna, CVS/Aetna, and Humana. Two attributes of the framework also suggest points that are important for envisioning obesity treatment and support payment models:

Metrics:

- Patient outcome and care quality metrics play the role of regulating providers and the services they delivery by ensuring that care is delivered according to guideline-based standards. Clinical practice guidelines and expert consensus on obesity treatment and care have shifted markedly in recent years towards more active treatment of obesity at earlier stages of progression (i.e. before patients develop obesity-related complications and co-morbid diseases.) Guidelines support more assertive treatment, not only with non-medication interventions (such as Intensive Behavioral Therapy) and anti-obesity medications, but surgery as well.^{xxxii}
- Development and validation of obesity-related metrics will be essential for the development of alternative payment models for obesity treatment and support and should spark close collaboration among stakeholder groups, including measure development organizations such as the NCQA, PQA and the National Quality Forum.^{xxxiii} Validation of population-level metrics will also be an opportunity to incorporate measures that track and promote active interventions to close racial-ethnic

disparities in obesity treatment and care, and promote equitable outcomes.

Step-by-step progress:

- Payment for obesity treatment and support can be designed around a strategy for incremental, step by step progress. For example, Category 2 is a variation on traditional fee-for-service reimbursement (offering quality-based bonuses on top of fee-for-service reimbursement), while Categories 2 and 3 progress to more ambitious risk-sharing between providers and payers.

While the HCP-LAN framework promotes standardization of APM models in the U.S. health care system, the eight APM sub-categories in the framework are also a reminder that approaches can be varied in real world practice; for example, a PMPM-based model can be complemented with specific, quality-based bonuses. Models can be “mixed and matched.”

Adapting Standard Models of Value-based Payment to Patient-Centered Obesity Treatment and Support

The over-arching goal for obesity payment innovations will be support for greater patient access to obesity treatment and support, delivered with efficiency and according to guideline-based standards. The four stages of the patient’s journey through obesity treatment and care outlined above can serve as a template for adapting payment models to obesity care, and suggest at least four options for provider payment that could be considered for development, testing and ultimate implementation, all four consistent with basic precepts of the HCP-LAN framework

Provider payment for delivery of a core standard of care

This option will require definition of a core set of obesity care processes, as well as development and validation of appropriate metrics of performance. Payment would be linked to data reporting, to performance against quality benchmarks, or both.

For example, recently published research found that routine documentation of patient Body Mass Index by clinicians by itself is associated with 5-10% of patient body weight in and of itself, suggesting that pay-for-reporting of documentation and diagnosis could be an early, pragmatic, and clinically meaningful step towards payment support

for obesity treatment and support.^{xxxiv} Payment incentives could be targeted to care of sub-sets of patients identified by risk analysis. This approach would be consistent with Category 2 in the HCP-LAN framework, (“Fee for Service-Link to Quality & Value”).

Provider payment for delivery of a standard-of-care for obesity treatment episodes

In this approach payment models would be devised around delivery of care that meets a standard of care for an episode or time-limited interval of obesity treatment. Defined standards of care already exist for episodes of metabolic and bariatric surgery; similar standards would be identified for episodes of other forms of active obesity treatment, such as care that utilizes medications, intensive behavioral therapy, and other supports. This approach would also be consistent with Category 2 of the HCP-LAN framework. It might be particularly pertinent to payment support for specialty obesity medicine in which the patient is referred into specialty obesity medicine, with the expectation that the patient will return to primary care after a course of specialty treatment.

Outcomes-based provider payment for episodes of treatment

In this approach defined episodes of care would be delivered and measured against achievement of the individualized health goals (“treating to target”) of the patient population treated through these episodes of care. Episode-based models could be designed along the lines of the HCP-LANs’s Category 2 (pay-for-reporting or pay-for-performance), or to Category 3 models, (shared savings, or shared risk), provided that patients’ costs of care could be compared to the expected costs of their care if their obesity had not been treated.

Outcomes-based provider payment for population-level health outcomes

In this approach payment models would be devised around a population-level or global payment for achieving patient outcomes that meet individualized patient health goals, measured across the entire patient population under treatment. This is consistent with the HCP-LAN Category 4, which also outlines two population-based approaches: a payment model for all patients (a patient population) with a specific condition (obesity, in this case), or a payment model covering all patients in a defined population, regardless of their medical conditions. In this later case, delivery of obesity-related standards of care would be part of a larger set of standards to which provider payment would be linked.

Population-based payment would clearly be the most ambitious of the four options suggested here, although it is worth noting that it would also seem compatible for integration with payment models that are now addressing health-related social needs (HRSN) with support for patient access to community-based services that provide access to healthy food choices and physical activity programs.

Conclusion

Demand for obesity treatment and support seems likely to increase in coming months and years if, as expected, the prevalence of obesity continues to rise. The increasing number of obesity treatment options, from new anti-obesity medications to specialty obesity treatment and support delivered in-person or virtually, will heighten demand as well.

However, continued reliance on fee-for-service reimbursement for obesity treatment and support could still lock in current inequities in which the stigmatization of obesity inhibits both patients and clinicians from initiating treatment, and in which limited insurance coverage and patient responsibility for cost-sharing limit access and skew uptake away from patients with lower incomes, limited or no insurance coverage, and away from patients from historically marginalized communities.

Moreover, obesity-related health risks are among the most significant drivers of poor patient health and health care spending in the U.S. health care system --- easily as significant as conditions (such as hypertension, hypercholesterolemia, and cardiovascular conditions) that are at the center of value-based payment innovation today. While obesity presents challenges for value-based payment, the challenge seems unavoidable.

Insurance coverage of anti-obesity medications took a notable step forward in 2023 when mandatory coverage of AOMs will be required in health insurance plans serving over nine million federal employees and dependents under the Federal Employees Health Benefits (FEHB) program. The new FEHB coverage will not as of now be linked to parallel development of value-based payment for providers that might enable obesity treatment and obesity support to be offered to federal employees at greater scale.

The federal government and other large employers are in a particularly good position to experiment with the design and implementation of value-based provider payment for obesity treatment and support. Self-insured employers underwrite benefits for naturally defined patient populations --- their employees. Employers have flexibility in designing employee health benefits, employee assistance programs, and other benefits that allow for experimentation with outcomes-based and quality-based reimbursement. Many large employers are demonstrating this flexibility today by offering employ-

ees access to multiple programs for obesity treatment and support, including multiple platforms of virtual obesity care.

Well designed and controlled experiments may prove particularly important in catalyzing needed development and validation of obesity treatment quality and performance metrics by measure development organizations (such as the NCQA, the Pharmacy Quality Alliance, and the National Quality Forum), and parallel development of needed capabilities among providers to routinely document, monitor and report the results of patient treatment (such as adaptation of electronic health records by EHR vendors and users).

Experimentation should encompass multiple approaches to finding practical ways to address major objectives of obesity treatment and support, from payment models that reward a few essential steps in obesity care (such as routine diagnosis of obesity), to more complex objectives, such as payment incentives for achieving and maintaining individualized patient goals on a population scale.

Experimentation needs to begin now, to expedite a transition away from the current status quo in which a relatively low volume of treatment is delivered compared to the level of unmet need, and delivered at relatively high unit costs, and towards a future in which a greater volume of treatment and support can be delivered at lower unit costs, and open up access to treatment on a scale that is commensurate with the great unmet need for obesity treatment and support.

Obesity Treatment: A Challenge and Opportunity for Self-insured Employers

About half of all Americans with health insurance coverage are insured under employer-sponsored health plans.¹ About 60 percent of all private sector workers are covered by employers who self-insure.² Self-insured employers typically delegate management of employee coverage to commercial health insurers who act as third-party administrators, but the employers assume the risks of employee health care coverage themselves.

Obesity is a driver of employee health risk and health care utilization for self-insured employers, just as it is for other health insurers and for individual enrollees who pay their share of annual health insurance premiums. By some estimates, obesity-related costs of health care, disability, and associated productivity losses among employees with more severe obesity can be as much as twice those of comparable costs among employees without obesity.³

Obesity-related health risks and illness has proven to be a special challenge for industries with a concentration of physically demanding jobs. The most well-known example of this is the U.S. Army. The increasing prevalence of obesity among younger Americans has resulted in a diminishing pool of potential recruits who can meet the exacting physical fitness requirements of the Army.⁴

The increasing proportion of desk-bound jobs in American industry has created obesity risks as well, as documented in multiple studies.⁵

More recently the COVID-19 pandemic has exacerbated both the risks posed by employee obesity and the challenges of managing them.

Now three years old and counting, the pandemic has led to a radical upsurge in stress, anxiety, and depression among employees, as it has among school-age children and other segments of the population. Stress-related eating and alcohol consumption is naturally linked to increases in weight, and early studies have clearly shown an upsurge in unhealthy weight during the COVID pandemic.⁶ Surveys show that many employers have responded by increasing employee access to mental health services and by expanding employee wellness benefits (typically including support for exercise programs,

such as reimbursement for gym memberships).⁷ There is little data as yet to suggest an upsurge in employer support for active obesity treatment.

The COVID pandemic also triggered a massive shift towards work-from-home (“WFH, as it is often shorthanded) for many employees. Surveys indicate that WFH remains popular with many employees and is likely to become a permanent option for millions of U.S. workers. However, work-from-home is also thought to have increased stress levels and associated weight gain over the last three years.⁸ Employees working from home are also less apt to access wellness benefits that may be based at employer work sites (such as onsite clinics, gyms, fitness centers, and subsidized cafeterias). Obviously, employees who work remotely and at great distances will have no access to these facilities.

It is worth noting as well that the efficacy of employer-sponsored wellness programs are the subject of continuing debate among health services researchers. While individual corporate wellness programs have published findings that indicate improved employee health and a return on investment from reduced demand for health care spending, multiple studies have found little overall impact of wellness programs on employee health.⁹ They are still considered a core employee benefit among many employers because they are attractive to employees and hiring prospects, and thus are important to employee hiring and retention. Thanks to COVID-19’s impact on the “great resignation” and widespread labor shortages, employee hiring, and retention goals remain paramount for many employers.

In short, rising obesity poses new demands on employer-sponsors of employee health plans at a point in time when employer commitment to wellness benefits may be increasing but efficacy of wellness programming as a health care strategy remains in doubt. At the same time, the launch of new obesity treatment and support interventions (anti-obesity medications, virtual care programs, etc.) means that employee demand for obesity-related services is likely to increase in the months ahead.

While self-insured employers are facing new challenges from the rise in obesity, they are also in a unique position to demonstrate how new medical interventions could succeed, particularly when complemented by services employers continue to support through wellness benefits, such as physical activity incentives and programs. The convergence of rising obesity and the launch of new obesity treatment and support options may create a unique opportunity for self-insured employers that will not only

benefit them but demonstrate viable strategies for other payers as well.

While self-funding among smaller employers has increased modestly in recent years, large employers are more typical of self-insured employers.¹⁰ Large employers are more likely than other employers to have a core of stable, long-term employees, and thus more likely to see a return on investment from health improvements and decreased health care utilization that may result from successful obesity strategies. Large employers are also more likely to have a substantial number of employees who may have identifiable, obesity-related health risks and co-morbid conditions. This could make identification of those patients most likely to benefit more practical and make it feasible to launch early experiments or demonstration projects that are focused on subsets of high-need individuals.

Thanks to the COVID-19 pandemic employers have also been leaders in expanding access to telehealth and virtual care services. Larger, self-insured employers have used their purchasing power to expand virtual care benefits through third-party administrators among commercial health plans, and with virtual care platforms (such as Amwell, Teladoc, Solera and others) that offer access to in-house and external virtual care vendors or through direct contracting with virtual care providers.¹¹

Finally, industry leaders among self-insured employers have also been at the forefront of payment innovations that could be adapted to demonstrate the long-term durability of results from active obesity treatment and support. Employers have pioneered uptake of value-based, alternative payment models that link payment incentives to measurable process or patient health outcome measures, and to globally budgeted, population-based models of payment similar to Medicare's Accountable Care Organizations. Employers have also been at the forefront of experimentation with value-based insurance design (VBID) health plans that incentivize individual patients to access high-value health care services and discourage uptake of low-value services.

It is yet to be seen whether some large, self-insured employers may find it practical to begin experimentation with active obesity treatment and support on their own initiative. At the very least large employers and employer associations throughout the country should be encouraged to explore potential collaborations with their employees, unions, health care providers, and biopharma manufacturers. The most practical next step for the employer community may be to work with others to identify the key barriers

ers and challenges to staging demonstration projects in obesity treatment and support, and how other organizations might help shoulder the burden of implementing them. One early focus might be on retirees with employer-sponsored health care benefits. The National Alliance of Health Care Purchaser Coalitions recently highlighted the fact that employers with obligations for retiree health care are increasingly turning to Medicare Advantage and Employee Group Waiver Plans (EGWP) for coverage of retirees.¹² Administered by commercial health insurers, Medicare Advantage plans increasingly offer a range of non-medical benefits that are now eligible as Medicare benefits addressing social determinants of health (SDOH) and health-related social needs (HRSNs), including nutrition and other services that are relevant to weight management. The Medicare Advantage program has also sponsored an ongoing national demonstration of VBID benefits.

There is a serious public interest to be served by demonstration of new strategies for obesity treatment and support that will create better health and durable results for persons with obesity, not to mention a positive impact on health care spending, including spending in the Medicare program. Well-designed demonstrations in Medicare Advantage – including demonstrations among the nearly 6 million U.S. retirees with EGWP plans, should be of prime interest to large employers and the Medicare program alike.

References for “Obesity Treatment: A Challenge and Opportunity for Self-insured Employers”

¹ Kaiser State Health Facts, accessed at <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

² Kaiser State Health Facts, accessed at <https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Van Nuys K, Globe D, Ng-Mak D, Cheung H, Sullivan J, Goldman D. The association between employee obesity and employer costs: evidence from a panel of U.S. employers. *Am J Health Promot.* 2014 May-Jun;28(5):277-85. doi: 10.4278/ajhp.120905-QUAN-428. PMID: 24779722.

⁴ Dave Phillips, “With Few Able and Fewer Willing, U.S. Military Can’t Find Recruits,” *New York Times*, July 14, 2022, accessed at <https://www.nytimes.com/2022/07/14/us/us-military-recruiting-enlistment.html#:~:text=With%20Few%20Able%20and%20Fewer%20Willing%2C%20U.S.%20Military%20Can%E2%80%99t%20Find%20Recruits>

⁵ Choi B, Schnall PL, Yang H, Dobson M, Landsbergis P, Israel L, Karasek R, Baker D. Sedentary work, low physical job demand, and obesity in US workers. *Am J Ind Med.* 2010 Nov;53(11):1088-101. doi: 10.1002/ajim.20886. PMID: 20737422.; see also Obesity Medicine Association, “Obesity Management for People with Desk Jobs,” July 1, 2022, accessed at <https://obesitymedicine.org/obesity-management-for-people-with-desk-jobs/>

⁶ Daniels NF, Burrin C, Chan T, Fusco F. A Systematic Review of the Impact of the First Year of COVID-19 on Obesity Risk Factors: A Pandemic Fueling a Pandemic? *Curr Dev Nutr.* 2022 Apr 8;6(4):nzac011. doi: 10.1093/cdn/nzac011. PMID: 35415391; PMCID: PMC8989548.

⁷ PriceWaterhouseCoopers, 2021 Health and Well-being Touchstone Survey, accessed at <https://www.pwc.com/us/en/services/consulting/business-transformation/library/touchstone-survey.html>

⁸ Fukumura YE, Schott JM, Lucas GM, Becerik-Gerber B, Roll SC. Negotiating Time and Space When Working From Home: Experiences During COVID-19. *OTJR (Thorofare N J).* 2021 Oct;41(4):223-231. doi: 10.1177/15394492211033830. Epub 2021 Jul 27. PMID: 34315290.

⁹ Karen Pollit and Matthew Rae, Trends in Workplace Wellness Programs and Evolving Federal Standards, Kaiser Family Foundation, June 9, 2020, accessed at <https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/>

¹⁰ See Kaiser State Health Facts, Share of Private-Sector Enrollees Enrolled in Self-Insured Plans, accessed at <https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?activeTab=graph¤tTimeframe=0&startTimeframe=9&selectedDistributions=firms-with-fewer-than-50-employees&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹¹ Paige Minemyer, “Virtual care is here to stay, but employers think it needs to evolve to reach its full potential, survey

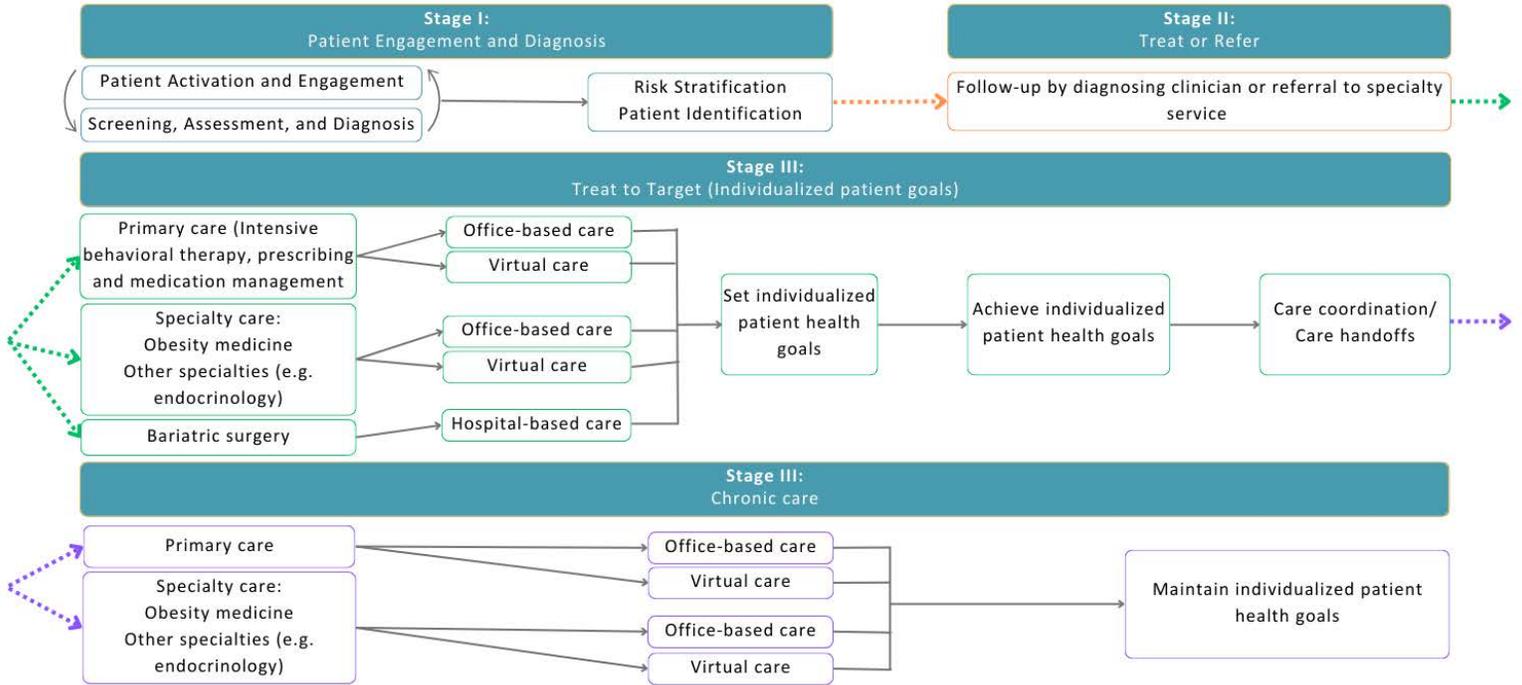
finds,” Fierce Healthcare, Aug 25, 2022, accessed at <https://www.fiercehealthcare.com/payers/virtual-care-here-stay-employers-think-it-needs-evolve-reach-its-full-potential-survey-finds>

¹² See National Alliance of Healthcare Purchaser Coalitions, “Retiree Medical: The Evolving Medicare Advantage Marketplace,” December 14, 2022, accessed at <https://connect.nationalalliancehealth.org/viewdocument/retiree-medical-the-evolving-medi-1>

Figure A- The Patient Clinical Journey Through Obesity Treatment and Support

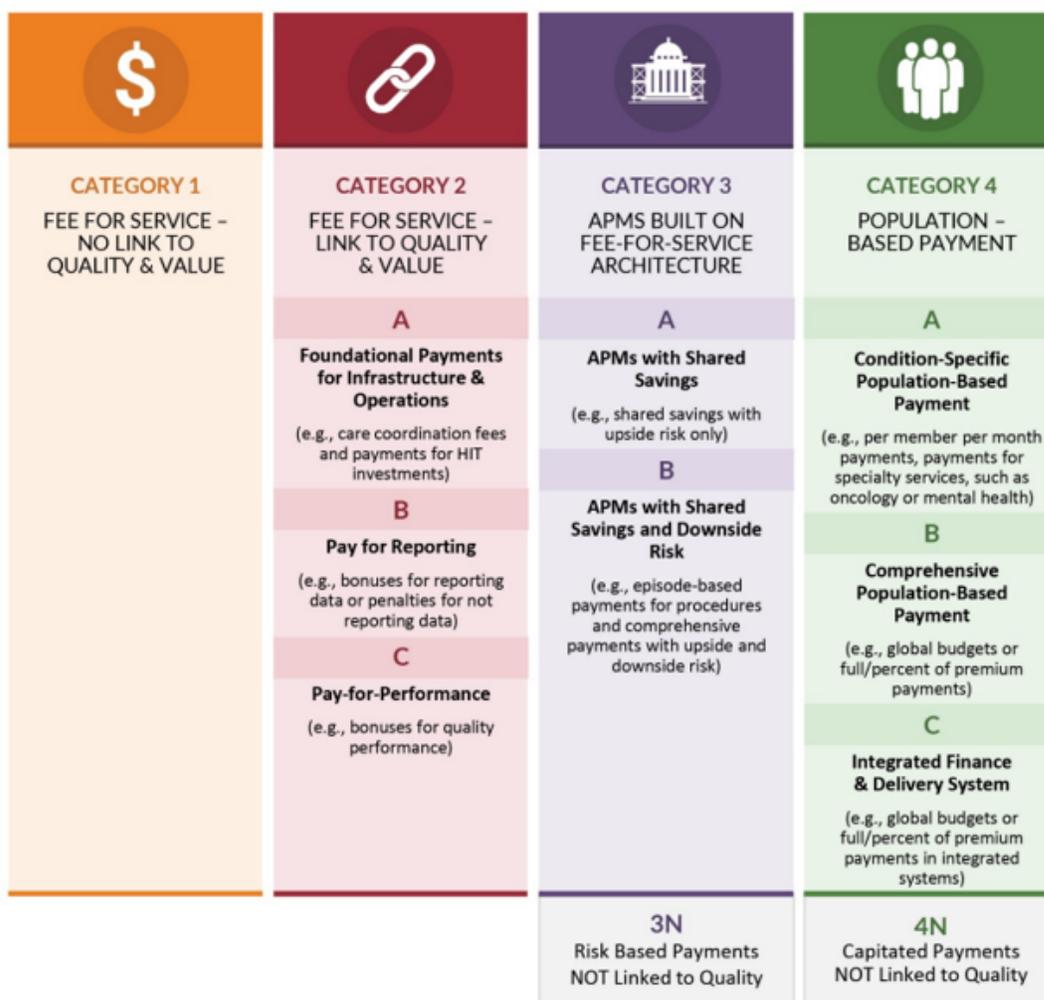


Figure A - The Patient Clinical Journey Through Obesity Treatment and Support



Appendix A

Health Care Payment & Learning Action Network, Alternative Payment Model Framework



Health Care Payment & Learning Action Network, "Alternative Payment Model: APM Framework, Refreshed 2017", Figure 1, 2017, accessed at <https://hcp-lan.org/apm-framework/>

Endnotes

- ⁱ Cite to AMA position statement on obesity as a disease – 2013 <https://policysearch.ama-assn.org/policyfinder/detail/obesity?uri=%2FAMADoc%2FHOD.xml-0-3858.xml>
- ⁱⁱ Ward ZJ, Bleich SN, Cradock AL, Barrett JL, Giles CM, Flax C, Long MW, Gortmaker SL. Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity. *N Engl J Med*. 2019 Dec 19;381(25):2440-2450. doi: 10.1056/NEJMsa1909301. PMID: 31851800
- ⁱⁱⁱ Brown A, Flint SW, Batterham RL. Pervasiveness, impact and implications of weight stigma. *EClinicalMedicine*. 2022 Apr 21;47:101408. doi: 10.1016/j.eclinm.2022.101408. PMID: 35497065; PMCID: PMC9046114.; Müller TD, Blüher M, Tschöp MH, DiMarchi RD. Anti-obesity drug discovery: advances and challenges. *Nat Rev Drug Discov*. 2022 Mar;21(3):201-223. doi: 10.1038/s41573-021-00337-8. Epub 2021 Nov 23. PMID: 34815532; PMCID: PMC8609996.
- ^{iv} Hall KD, Kahan S. Maintenance of Lost Weight and Long-Term Management of Obesity. *Med Clin North Am*. 2018 Jan;102(1):183-197. doi: 10.1016/j.mcna.2017.08.012. PMID: 29156185; PMCID: PMC5764193.
- ^v Saunders KH, Igel LI, Aronne LJ. Telemedicine could be the solution to scaling obesity treatment. *Obesity (Silver Spring)*. 2022 Mar;30(3):573-574. doi: 10.1002/oby.23391. PMID: 35195365.
- ^{vi} Stop Obesity Alliance, “Federal Health Plans Step Up Coverage of Obesity Treatment,” February 29, 2022, accessed at <https://stop.publichealth.gwu.edu/LFD-apr22#:~:text=A%20recent%20updated%20guidance%20sent,should%20help%20in%20our%20efforts>
- ^{vii} Recent media coverage of rising demand for anti-obesity medications and obesity medicine includes: Lisa Jarvis, “New Weight Loss Drugs Work, But Who’s Paying?”, *Financial Advisor*, November 9, 2022 (accessed at <https://www.fa-mag.com/news/new-weight-loss-drugs-work-but-who-s-paying-70534.html>), and Karen Weintraub, “Weight loss treatment is on the verge of transformation. It’s not there yet. Here’s why,” *USA Today*, December 4, 2022, accessed at <https://www.usatoday.com/story/news/health/2022/12/04/weight-loss-treatment-medication-availability/10794568002/?gnt-cfr=1>
- ^{viii} Health Care Payment & Learning Action Network (HCP-LAN), *Alternative Payment Model/APM Framework*, 2017, accessed at <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>
- ^{ix} Zvenyach T, Pickering MK. Health Care Quality: Measuring Obesity in Performance Frameworks. *Obesity (Silver Spring)*. 2017 Aug;25(8):1305-1312. doi: 10.1002/oby.21884. Epub 2017 Jun 24. PMID: 28646541.
- ^x Avalere Health, “Barriers to Obesity Care: Diagnostic Coding, Medical Billing and Reimbursement,” December 2022, accessed at <https://avalere.com/insights/coding-billing-and-reimbursement-barriers-to-obesity-care>
- ^{xi} American Society for Metabolic and Bariatric Surgery, “New Study Finds Most Bariatric Surgeries Performed in Northeast, and Fewest in South Where Obesity Rates are Highest, and Economies are Weakest,” November 15, 2018, accessed at <https://asmbs.org/articles/new-study-finds-most-bariatric-surgeries-performed-in-northeast-and-fewest-in-south-where-obesity-rates-are-highest-and-economies-are-weakest>; McTigue KM, Wellman R, Nauman E, Anau J, Coley RY, Odor A, Tice J, Coleman KJ, Courcoulas A, Pardee RE, Toh S, Janning CD, Williams N, Cook A, Sturtevant JL, Horgan C, Arterburn D; PCORnet Bariatric Study Collaborative. Comparing the 5-Year Diabetes Outcomes of Sleeve Gastrectomy and

Gastric Bypass: The National Patient-Centered Clinical Research Network (PCORNet) Bariatric Study. *JAMA Surg.* 2020 May 1;155(5):e200087. doi: 10.1001/jamasurg.2020.0087. Epub 2020 May 20. PMID: 32129809; PMCID: PMC7057171

^{xii} Hecht LM, Pester B, Braciszewski JM, et al. Socioeconomic and Racial Disparities in Bariatric Surgery. *Obes Surg.* 2020;30(6):2445-2449. doi:10.1007/s11695-020-04394-7

^{xiii} NEHI-Network for Excellence in Health Innovation, “Obesity and Type 2 Diabetes: A NEHI Policy Brief,” November 2019, accessed at <https://www.nehi-us.org/publications/84-obesity-and-type-2-diabetes-a-nehi-policy-brief/view>

^{xiv} Ward, op cit

^{xv} Hall, op cit

^{xvi} Brown, op cit

^{xvii} Saunders KH, Igel LI, Aronne LJ. Telemedicine could be the solution to scaling obesity treatment. *Obesity (Silver Spring)*. 2022 Mar;30(3):573-574. doi: 10.1002/oby.23391. PMID: 35195365.

^{xviii} Dietz WH, Gallagher C. A Proposed Standard of Obesity Care for All Providers and Payers. *Obesity (Silver Spring)*. 2019 Jul;27(7):1059-1062. doi: 10.1002/oby.22507. PMID: 31231954.

^{xix} Casanova D, Kushner RF, Ciemins EL, Smolarz BG, Chambers E, Leaver-Schmidt E, Kennedy J, Garvey WT. Building Successful Models in Primary Care to Improve the Management of Adult Patients with Obesity. *Popul Health Manag.* 2021 Oct;24(5):548-559. doi: 10.1089/pop.2020.0340. Epub 2021 Mar 30. PMID: 33784483

^{xx} Saunders, op cit

^{xxi} Müller TD, Blüher M, Tschöp MH, DiMarchi RD. Anti-obesity drug discovery: advances and challenges. *Nat Rev Drug Discov.* 2022 Mar;21(3):201-223. doi: 10.1038/s41573-021-00337-8. Epub 2021 Nov 23. PMID: 34815532; PMCID: PMC8609996

^{xxii} A recent (2020) study conducted by the American Medical Group Association (AMGA) found documentation of obesity in about 40 percent of 689,000 electronic health records maintained by 15 health care systems throughout the U.S., while a 2022 analysis of nearly 3 million payment claims by Avalere Health found a primary diagnosis of obesity in only about 15 percent or less of claims. See: Ciemins EL, Joshi V, Cuddeback JK, Kushner RF, Horn DB, Garvey WT. Diagnosing Obesity as a First Step to Weight Loss: An Observational Study. *Obesity (Silver Spring)*. 2020 Dec;28(12):2305-2309. doi: 10.1002/oby.22954. Epub 2020 Oct 7. PMID: 33029901; PMCID: PMC7756722; and, Avalere Health, op cit

^{xxiii} Ciemins et al, op cit.

^{xxiv} Ciemins, op cit

^{xxv} Avalere Health, op cit

^{xxvi} “After 30 years -- new guidelines for weight-loss surgery,” *Science Daily*, October 21, 2022, accessed at <https://www.sciencedaily.com/releases/2022/10/221021093735.htm>

^{xxvii} Padwal RS, Pajewski NM, Allison DB, Sharma AM. Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity. *CMAJ.* 2011 Oct 4;183(14):E1059-66. doi: 10.1503/cmaj.110387. Epub 2011 Aug 15. PMID: 21844111; PMCID: PMC31Use 5097.

^{xxviii} Garvey WT. New Horizons. A New Paradigm for Treating to Target with Second-Generation Obesity Medications. *J Clin Endocrinol Metab.* 2022 Mar 24;107(4):e1339-e1347. doi: 10.1210/clinem/dgab848. PMID: 34865050; PMCID: PMC8947217.

^{xxix} Saunders, op cit

^{xxx} Health Care Payment Learning Action Network (HCP-LAN), web site at <https://hcp-lan.org/>

^{xxxi} Health Care Payment Learning Action Network Alternative Payment Model/APM Framework, op cit

^{xxxii} “After 30 years- new guidelines for weight-loss surgery,” Science Daily, op cit

^{xxxiii} Zvenyach, op cit

^{xxxiv} Ciemins EL, Joshi V, Cuddeback JK, Kushner RF, Horn DB, Garvey WT. Diagnosing Obesity as a First Step to Weight Loss: An Observational Study. *Obesity (Silver Spring)*. 2020 Dec;28(12):2305-2309. doi: 10.1002/oby.22954. Epub 2020 Oct 7. PMID: 33029901; PMCID: PMC7756722.