

PERSPECTIVE

Challenges with the Medicare Obesity Benefit: Practical Concerns & Proposed Solutions

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Obesity and the growing population of older adults are significant public health concerns in the United States. In 2011, the Centers for Medicare and Medicaid Services introduced a Medicare benefit for obesity counselling using Intensive Behavioral Therapy that would reimburse structured visits over a 12-month period. Although we applaud this new benefit that addresses the obesity epidemic in older adults, three major shortcomings limit its utility and potential effectiveness: 1) weight loss interventions differ in older and younger adults, yet the benefit relies predominantly on data from interventions studied in younger populations; 2) body mass index is not an accurate measure for identifying obesity; and 3) tying reimbursement to clinician visits may hamper the integration of this benefit into practice. To overcome these shortcomings, we propose: 1) obesity treatment should focus on improving quality of life and physical function and on mitigating muscle and bone loss rather than focusing solely on weight loss; 2) waist circumference or waist-hip ratio should be considered as additional anthropometric measures in ascertaining obesity; and 3) allied health professionals should be reimbursed for providing this benefit. Incorporating these suggestions will improve its usability in clinical practice and increase the chances that this well-meaning benefit will improve patient outcomes.

KEY WORDS: Medicare; Obesity; Weight Loss.

ABBREVIATIONS

BMI	Body mass index
CMS	Centers for Medicare and Medicaid
USPSTF	United States Preventive Services Task Force
WC	Waist circumference
WHR	Waist-hip ratio

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INTRODUCTION

Managing the growing public health concern of obesity has been fraught with challenges, particularly in primary care.¹

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The prevalence of obesity, defined by a body mass index (BMI) ≥ 30 kg/m², exceeds 35 % across all ages, including older adults.² Obesity leads to adverse social, health and metabolic outcomes, including increased risk of chronic disease.³ Obesity also is associated with premature mortality and lower life expectancy.⁴

Although individuals with obesity may die prematurely, those surviving into older adulthood are at high risk for impaired mobility and impairment in activities of daily living. Older adults with a BMI ≥ 30 kg/m² are more likely to develop functional impairments compared to those with normal weight.⁵ Similar associations are observed in studies of waist circumference (WC) or waist-hip ratio (WHR) and function.⁵ Although epidemiological studies focus mainly on mortality and not function as a primary outcome, older adults tend to value functional preservation and quality of life.⁶ Moreover, older obese adults may not have increased mortality rates at certain BMI levels. Known as the ‘obesity paradox,’ this is a phenomenon where modestly obese older adults have greater longevity.⁷

MEDICARE OBESITY BENEFIT

On 29 November 2011, the Centers for Medicare and Medicaid Services (CMS) approved coverage for Intensive Behavioral Therapy (IBT) for Obesity (CAG-00423 N), based on the United States Preventive Services Task Force (USPSTF) recommendation^{8,9} for screening for obesity in adults:

“The evidence is adequate to conclude that IBT for obesity, defined as a BMI ≥ 30 kg/m² is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B and is recommended with a grade of A/B by the USPSTF.”

This regulation coverage determination was hailed as a major victory for primary care, as practitioners would effectively be reimbursed for obesity counseling. Initial intake under this benefit requires screening an eligible beneficiary

for obesity using BMI and performing a dietary assessment. The benefit covers weekly visits during the first month and bi-weekly visits during months two to six. Each session can be billed separately. At six months, beneficiaries who have lost 3 kg of their initial documented weight can continue with monthly visits through months seven to 12, with reimbursement for each session. Those not meeting this goal require reassessment of their readiness to change. To be covered, treatment must consist of counseling and IBT that promotes sustained weight loss through high intensity diet and exercise interventions. Similar to motivational interviewing for smoking cessation, the 5As are recommended as a framework (Table 1).¹⁰ To encourage routine counselling in busy practices, each visit is expected to last 15 min and is billed separately using code G0477 with up to 22 sessions covered per calendar year. This intensive approach reflects findings from randomized trials including the Diabetes Prevention Program¹¹ and Look-Ahead,¹² which showed the importance of regular and frequent visits to successfully change behavior associated with significant weight loss.

Services must be rendered by “a qualified primary care physician or other primary care practitioner,” defined as a clinician specializing in family medicine, internal medicine, geriatric medicine or pediatric medicine, or a nurse practitioner, clinical nurse specialist, or physician assistant. The service must occur in a primary care setting defined as a “practice providing integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Examples include: an independent clinic, an outpatient hospital, a physician’s office or a state or local public health clinic. Exceptions include ambulatory surgical centers, emergency departments, hospices, independent diagnostic testing facilities, inpatient hospital and rehabilitation

settings, and skilled nursing facilities. No other specific thresholds or standards are provided in the CMS memo.

SHORTCOMINGS OF THE REGULATION COVERAGE DETERMINATION

We strongly support coverage for the treatment of obesity in older adults. As with any coverage determination, a one-month period of public comment was available, with 27 comments submitted. We recognize the constraints of the legislative and policy process in addressing the concerns raised forth in this commentary period. Additional evidence, if introduced and incorporated during the comment phase, may have had an impact on the content and structure of the determination. Below, we identify three major components of the policy that currently limit clinically appropriate and effective care for older adults with obesity.

Management Differences in Older vs. Younger Adults

The determination cited 13 main studies supporting obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss in adults. Each intervention included in the determination: 1) had an evidence grade of A/B by the USPSTF; 2) was reasonable and necessary for the prevention or early detection of illness or disability; and 3) was appropriate for Medicare beneficiaries.

Nearly half of the studies cited in the determination examined populations predominantly < 65 years of age.^{13–18} Only three studies were pertinent to older adults: a weight-loss systematic review;¹⁹ the ADAPT study;²⁰ and a study by Villareal,²¹ all aimed at encouraging functional improvement following weight loss. Studies conducted in primary care settings using IBT were limited,²² as were those using function as the sole outcome measure.^{23,24} Finally, the determination referenced guidelines intended for the general population, including initiatives led by the National Institute for Health and Clinical Excellence, Joint National Committee-7, and USPSTF.

Extrapolating obesity interventions studied in the general population to older adults may be misleading and result in adverse outcomes. Studies demonstrate that intentional weight loss in older adults may be associated with frailty, disability, and premature mortality.^{25,26} This is partly due to the effect of weight-loss induced declines in bone density and in muscle mass and quality (sarcopenia).²¹ An estimated 25 % of total weight lost in older adults undergoing weight-loss interventions constitutes fat-free (muscle) mass.²⁷ While it is difficult to define muscle loss,²⁸ mitigating the impact of weight loss-induced muscle decline can prevent unintended consequences.²⁹ Because of these potential adverse outcomes, clinicians may be reluctant to recommend weight loss in elders.³⁰

Table 1.. The 5 As Approach Adopted by the USPSTF and CMS in Obesity Counseling^{8,9}

Assess	Ask about and assess behavioral health risk (s) and factors affecting choice of behavior change goals and methods
Advise	Give clear, specific, and personalized behavior change advice including information about personal health harms and benefits
Agree	Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change behavior
Assist	Using behavior change techniques (self-help or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social and environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate
Arrange	Schedule follow-up appointments (in person or by telephone) to provide ongoing assistance and support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

CMS Centers for Medicaid & Medicare Services; USPSTF United States Preventative Services Task Force

Table 2.. Relative Risks by Age Group and BMI Level from the Combined NHANES I, II and III Data set⁴

	Relative risk (95 % confidence interval) by age category		
BMI level	25–59y	60–69 y	≥ 70y
< 18.5	1.38 (0.82–2.32)	2.30 (1.70–3.13)	1.69 (1.38–2.07)
18.5 –< 25	1.00	1.00	1.00
25<30	0.83 (0.65–1.06)	0.95 (0.80–1.13)	0.91 (0.83–1.01)
30 –< 35	1.20 (0.84–1.72)	1.13 (0.89–1.42)	1.03 (0.91–1.17)
≥ 35	1.83 (1.27–2.62)	1.63 (1.16–2.30)	1.17 (0.94–1.47)

BMI body mass index (measured as weight in kilograms divided by the square of height in meters); NHANES National Health and Nutrition Examination Survey (Reproduced by Permission from the American Medical Association)

Losing trivial amounts of weight yet engaging in wellness and physical activities results in improved cardiovascular fitness, gait speed, short performance physical battery, and six-minute walk tests,^{31–33} all measures that are likely more important to patient long-term health and quality of life²⁴ than weight loss. This suggests that a wellness rather than a ‘weight-loss’ strategy may be more beneficial for a senior’s health.

Because greater than 90 % of Medicare beneficiaries are over 65 years,³⁴ the evidence used and interpreted by CMS would be stronger if it focused specifically on elders. While similarities exist in obesity interventions in older adults versus younger adults, clinicians administering the CMS benefit should be fully aware of the nuances in managing obesity in older adults, including the importance of function and quality of life, the potential dangers of weight loss, and the possible health benefits of fitness without weight loss.

Measurement and Outcomes: Are They the Same?

Body composition changes with age independent of weight loss, leading to challenges in assessing adiposity (fat). BMI is

the clinical standard for measuring adiposity that is easy to use and predicts disability and mortality.^{4,5} BMI lacks specificity for assessing adiposity in older adults, as the BMI ratio accounts for both fat-free mass and fat mass.³⁵ A subset of elders may have high body fat but normal BMI and not be eligible for the CMS benefit, yet may be at high risk for adverse cardio-metabolic outcomes, mortality³⁶ and disability.³⁷

The relationship between BMI and mortality differs in younger and older populations, as observed in Flegal’s analysis of three waves of NHANES data (Table 2).⁴ While younger adults who are overweight (BMI:25–29.9 kg/m²) or have class I obesity (BMI:30–34.9 kg/m²) have higher mortality than those with normal BMI, elder-specific studies demonstrate that overweight individuals may be at lowest all-cause mortality risk, and those with class I obesity may or may not have slightly higher mortality risk.³⁸ This information should be incorporated into practice, as providers often recommend lifestyle changes and weight loss to individuals with BMI≥25 kg/m².³⁹

Basing treatment recommendations on BMI may increase mortality in older adults both by falsely assuming that low BMI is associated with improved health and that higher BMI is associated with adverse health effects. Other clinically valid anthropometric measures, including WC and WHR, are more strongly associated with mortality and disability in older adults,⁴⁰ can be measured as easily in practice as BMI, do not require sophisticated equipment, and provide additional risk stratification among those with a BMI<30 kg/m². Not measuring WC or WHR is a missed opportunity to identify individuals at risk for obesity-related health outcomes.

Practice Management Challenges

Clinical and financial constraints further limit implementation of this benefit. Clinics often cannot provide effective IBT because of high patient volumes and time constraints. The goal was to

Table 3.. Obesity Coverage Requirements—Pre-Medicare and Post-Medicare Obesity Benefit

	Previous	Current	Proposed Changes	Interim Changes without Practice Change
Office visit duration	Regular office visit	15-min intensive behavioral therapy	Ability to increase visit times	Provide visit under regular E + M time-based code
Frequency of visits	Chronic care management—no definite time frame	Weekly × 1 month Bi-weekly months 2–6 If fulfilling criteria, monthly 7–12	No change	None needed—similar to Diabetes Prevention Program, Look-Ahead trials
Personnel	MD, AP	MD, AP, CNS	Any provider providing behavioral change	Delegate visit to Clinical Nurse Specialist
Anthropometric measure	—	BMI	BMI≥30 kg/m ² Males: WC≥102; WHR > 0.95 Females: WC≥88; WHR >0.85	Office staff to measure waist circumference or waist-hip ratio in addition to BMI
Behavioral strategy	Various—provider specific	5 As Intensive Behavioral Therapy focusing on weight loss	5 As focusing on diet+exercise	Can discuss components required for benefit+ incorporate counseling on exercise
Outcome measure	—	3 kg weight loss	Muscle & bone-sparing weight loss, improvement in quality of life or physical function	Incorporate longitudinal monitoring of self-reported questionnaires into practice
Charge/code	99210–99215	G0447	G0447 with increased reimbursement	Either G0447 or E + M Code

AP Associate Provider; BMI Body Mass Index; CNS Clinical Nurse Specialist; E+M Evaluation and Management Code; MD physician; WC waist circumference; WHR waist-hip ratio

overcome these hurdles by requiring providers to spend only 15 min of face-to-face counseling for reimbursement. While we embrace the provision of multiple sessions, the duration may be too short to effect positive behavior change. In IBT trials,^{11,12} sessions lasted 20 to 30 min. Patient access to this benefit is limited because of the undersupply of primary care clinicians and the need to balance workloads, making it difficult to schedule multiple, frequent visits with the same provider.

Whether the current reimbursement (Healthcare Common Procedure Coding System code G0447) is sufficient to maintain a financially viable practice is unclear. G-codes track demonstration projects, newer technologies and services not classified by existing codes. G0447 must be billed with ICD-10 codes for BMI ≥ 30 kg/m² (Z68.30-Z68.39; Z68.41-68.45), and Medicare coinsurance and Part B deductibles are waived. The Relative Value System Update Committee comprises largely of specialty representation developing codes, and cognitive services often consist of reduced ‘value.’ The American Diabetes Association (and no Internal Medicine societies) provided comments in the review process. The current benefit does not cover services provided by exercise physiologists, psychologists, dietitians, and health coaches, who are integral to the interdisciplinary care of obese patients. These allied-health positions can only bill ‘incident-to’ clinician services. We believe that these multiple barriers to implementation will dissuade clinicians from providing the benefit as it stands.

Other reimbursement strategies exist in primary care. The Annual Wellness Visit requires BMI measurement and execution of a treatment plan focusing on prevention, offering a higher level of reimbursement. Comorbidities related to obesity can be billed as counseling and management using traditional E/M codes. Moreover, Medicare Advantage (Part C) allows private insurance companies to provide the same traditional part A+B benefits, but they differ in rules, quality of service, coverage, restrictions and cost. Some insurance companies offer wellness benefits, including obesity counselling, access to individualized clinical programs, educational materials, and case management beyond the G0447 benefit.

RECOMMENDED MODIFICATIONS

We propose that quality of life and physical function, in addition to weight loss, need to be included as primary outcomes of obesity interventions in older obese adults (Table 3). Self-reported scales can assess quality of life and simple objective measures of physical function can easily be obtained by support staff. Other adiposity measures to identify patients with central obesity may be needed. Combined aerobic and resistance exercise is important to prevent sarcopenia and bone loss. Changing the preferential reimbursement from physicians to other health professions (psychologists, dietitians, health coaches) will allow more effective delivery of this benefit and improve quality of care and financial viability. A practice can charge

for the service, thereby encouraging those developing reimbursement codes to increase the practice expense component of the RVU. While bundled payments may be considered, logistical challenges in monitoring compliance may impact reimbursement should a patient not follow through with treatment.

CONCLUSIONS

CMS has taken the right steps in identifying obesity as a major health priority. A comprehensive focus on wellness, function, and quality of life in older adults, steering away from traditional outcomes including BMI and weight loss would increase the benefit’s effectiveness. Emphasizing preservation of muscle is critical for improving the success and safety of weight-loss interventions tailored to elders. All professionals providing obesity counseling need to be reimbursed to create and sustain the collaborative team approach necessary to safely and effectively treat obesity.

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