



September 6, 2013

Ms. Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1600-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Fee Schedule & Other Revisions to Part B for CY 2014

Dear Ms. Tavenner:

On behalf of the more than 125,000 members of the Obesity Care Continuum (OCC), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014* (Proposed Rule) that was published in the *Federal Register* on July 19, 2013.

### **Complex Chronic Care Management Services**

While the Obesity Care Continuum commends CMS on its proposal to establish payment for non-face-to-face chronic care management services, we are concerned that obesity is not on Medicare's list of complex chronic conditions eligible for this new enhanced payment. Patients with multiple chronic diseases require a high level of ongoing engagement with their health care providers. While historically this engagement primarily took place in face-to-face office visits, the system has evolved, and such care is increasingly being provided via telephone and email. In addition, these complex patients require a substantial amount of care coordination among providers to address myriad health needs. Establishing codes for maintaining a plan of care and providing coordination services (e.g., communicating with other health professionals) will greatly enhance physicians' ability to care for these patients.

As CMS continues to develop the details of this proposal in anticipation of implementation in CY 2015, the OCC recommends that CMS consider the following regarding provider and patient eligibility for these new payments.

#### *Provider Eligibility*

The OCC is supportive of CMS' proposal to determine provider eligibility based on specific quality requirements and not solely on provider specialty designation. Depending on the mix of chronic conditions, demographics, and other factors, chronic care management services may be provided by a range of provider specialties. We also recommend that CMS include a range of options for providers to demonstrate that they meet the standards that CMS establishes. While third-party accreditation should certainly be among the options, we do not believe that third-party accreditation as a specific type of care model (e.g.,

patient-centered medical home) should be the only option for providers to demonstrate eligibility, given the expense and time typically associated with these processes.

### *Patient Eligibility*

The member groups of the Obesity Care Continuum believe that the 15 chronic conditions identified by CMS are a good starting point for determining patient eligibility. However, this list should be expanded to include obesity, a prevalent chronic disease among Medicare beneficiaries with serious deleterious effects. On June 18, 2013, the American Medical Association (AMA) officially recognized obesity as a disease. A statement from AMA board member Patrice Harris, MD, notes the complex nature of the condition and its common comorbidities, “Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans. The AMA is committed to improving health outcomes and is working to reduce the incidence of cardiovascular disease and type 2 diabetes, which are often linked to obesity.”<sup>1</sup>

CMS discusses 15 chronic conditions to be eligible for the proposed complex care management payment. We note that 13 of these 15 conditions (high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, COPD, atrial fibrillation, certain cancers, asthma, and stroke) are commonly associated with obesity and/or are exacerbated by obesity.<sup>2, 3,4,5, 6</sup>

While some obese beneficiaries may have two or more of these 15 conditions in addition to obesity, if CMS does not add obesity to the list of included conditions, beneficiaries who have obesity and one of the other chronic conditions on the list (e.g., heart disease or diabetes) would be excluded from complex care management services coverage. This creates a perverse incentive, since care management could potentially prevent these beneficiaries from developing some of the additional complex chronic conditions commonly associated with obesity.

Furthermore, obesity clearly meets the criteria CMS outlines in the proposed rule as the rationale for selecting the 15 chronic conditions eligible for the complex chronic care management payments. Specifically, obesity (1) is highly prevalent among the Medicare population; (2) is chronic; i.e., typically lasts for more than 12 months; (3) poses increased risk for death, acute exacerbation/decompensation, or functional decline; (4) results in increased use of health care services; and (5) successful care management can improve outcomes/reduce costs, as described in detail below.

**1. The prevalence of obesity in older adults is high.** The prevalence of obesity is estimated to be 37% among men and 34% among women ages 60 years and older.<sup>7</sup> About 35% of people aged 65 and older were obese in 2007-2010.<sup>8</sup> The prevalence of obesity in the U.S. continues to rise, including for individuals ages 65 and over. In fact, by 2050, the number of persons aged 65 and over in the US is expected to more than double, rising from 40.2 million to 88.5 million.<sup>9</sup>

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<sup>1</sup> American Medical Association, June 18, 2013. Press Release: AMA Adopts New Policies on Second Day of Voting at Annual Meeting. Accessed on July 19, 2013 at <http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-18-new-ama-policies-annual-meeting.page>.

<sup>2</sup> NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

<sup>3</sup> Beuther DA, Sutherland ER. Overweight, Obesity, and Incident Asthma: A Meta-analysis of Prospective Epidemiologic Studies. *Am J Respir Crit Care Med.* 2007;175:661–6.

<sup>4</sup> Dolan CM, Fraher KE, Bleecker ER, et al. Design and baseline characteristics of the epidemiology and natural history of asthma: Outcomes and Treatment Regimens (TENOR) study: a large cohort of patients with severe or difficult-to-treat asthma. *Ann Allergy Asthma Immunol.* 2004;92:32–9.

<sup>5</sup> Kopple JD, Feroze U.J. The effect of obesity on chronic kidney disease. *Ren Nutr.* 2011 Jan;21(1):66-71.

<sup>6</sup> Wanhita N, Messerli FH et. al. Atrial Fibrillation and Obesity -- Results of a Meta-Analysis. *Am Heart J.* 2008;155(2):310-315.

<sup>7</sup> NHANES (Flegal) 2010

<sup>8</sup> Tala H.I. Fakhouri, Ph.D., M.P.H.; Cynthia L. Ogden, Ph.D., M.R.P.; Margaret D. Carroll, M.S.P.H.; Brian K. Kit, M.D., M.P.H.; and Katherine M. Flegal, Ph.D. NCHS Data Brief, No. 106, September 2012. Prevalence of Obesity Among Older Adults in the United States, 2007–2010.

<sup>9</sup> Vincent GK, Velkoff VA. The next four decades, the older population in the United States: 2010 to 2050. *Current Population Reports* P25–1138. Washington, DC: U.S. Census Bureau. 2010.

2. **Obesity is a chronic condition, which typically lasts well longer than 12 months.** Obesity is a chronic condition that poses lifelong challenges for many individuals. In addition to the AMA via its recent Board decision, numerous healthcare professional organizations, such as the American Heart Association, American Diabetes Association, and the American Association of Clinical Endocrinologists define obesity as a chronic disease. Obesity is also recognized as a chronic disease in the NHLBI Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, which state, “Obesity is a complex multifactorial chronic disease developing from interactive influences of numerous factors—social, behavioral, physiological, metabolic, cellular, and molecular.”<sup>10</sup> The long-term negative effects of obesity have been well-documented (see number 3, below).
3. **Obesity poses an increased risk for death, acute exacerbation/decompensation, or functional design.** Studies have demonstrated that obesity results in higher morbidity to a range of health conditions – including many on the list of 15 chronic conditions proposed by CMS - hypertension, type 2 diabetes, coronary heart disease (CHD), stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer (endometrial, breast, prostate, and colon), among others.<sup>11</sup> Approximately 75% of people with morbid obesity have at least one co-morbid condition, often type 2 diabetes, hypertension or sleep apnea, which increases the risk of premature death.<sup>12</sup>
4. **Obesity results in increased use of health care services, including hospitalizations.** The medical costs of obesity in the US were estimated to be \$147 billion, and per person health care spending for obese adults is 56 percent higher than for normal weight adults.<sup>13</sup> Obese patients incur 46% increased inpatient costs, 27% more physician visits and outpatient costs, and 80% increased spending on prescription drugs.<sup>14</sup> A recent study of Medicare beneficiaries noted that obese patients were more likely than normal weight patients to have 5 or more office/clinic visits and visits to a personal physician.<sup>15</sup>
5. **Successful care management can improve outcomes/reduce costs.** Most importantly, CMS notes that care management can improve outcomes and/or reduce costs for the identified conditions. The benefits of care management in individuals with obesity have been well documented. As noted in a report by STOP Obesity Alliance Research Team at The George Washington University School of Public Health and Health Services, “In general, care coordination mechanisms can take a variety of forms, many of which may be useful for improving primary care practice around obesity. Providers make decisions in the context of health care systems (e.g., care settings, payment structures and arrangements) and patient access depends on the system structure and ease of navigating health care resources.”<sup>16</sup> Inclusion of obesity in the proposed complex chronic care management payment would build on CMS’ 2011 coverage of face-to-face intensive behavioral therapy (IBT) for obesity, giving providers a mechanism to be reimbursed for the extensive non-face-to-face time they spend managing their patients with obesity and other chronic illnesses.

For these reasons, the member groups of the Obesity Care Continuum urge CMS to add obesity to the list of chronic diseases eligible for the proposed Complex Chronic Care Management Services payments.

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<sup>10</sup> NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

<sup>11</sup> NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

<sup>12</sup> A Must et al. The disease burden associated with overweight and obesity. JAMA. 1999. 282:1523-1529.

<sup>13</sup> EA Finkelstein et al. Annual medical spending attributable to obesity: payer-and service-specific estimates. Health Affairs. 2009, 28(5):w822-31.

<sup>14</sup> IBID.

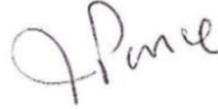
<sup>15</sup> Malinoff RL, Elliott MN, Giordano LA, Grace SC, and Burroughs JN. Obesity Utilization and Health-Related Quality of Life in Medicare Enrollees. J Ambulatory Care Manage, Vol. 36, No. 1, pp. 61–71.

<sup>16</sup> Ferguson CF, Langwith C, Muldoon A, and Leonard J. Improving Obesity Management in Adult Primary Care. White Paper released March 6, 2010.

Sincerely,



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#### **About the Obesity Care Continuum**

*The Obesity Care Continuum was established in 2011 and currently includes the Obesity Action Coalition, The Obesity Society, Academy of Nutrition and Dietetics, the American Society for Metabolic and Bariatric Surgery, and the American Society of Bariatric Physicians. With a combined membership of over 125,000 healthcare professionals and patient advocates, the OCC is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity. The OCC also challenges weight bias and stigma oriented policies – whenever and wherever they occur.*