A Framework for a Population-Based Payment Model for Obesity Treatment

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EXECUTIVE SUMMARY

As obesity rates have rapidly increased in the U.S. over the last few decades, so has medical expenditure to treat both obesity and co-occurring clinical conditions. While there is a range of effective treatment options for obesity that demonstrate transformative health effects and may reduce health care spending, persistent barriers to patient access exist. These barriers include stigma against initiating treatment, lack of provider training and bandwidth, and issues around affordability and resulting insurance coverage of treatment options. Population-based integrated care and payment models can support sustained access to treatment for obesity. Integrated models couple value-based payment strategies for medical products with care delivery reforms. Value-based payment strategies can address pricing, coverage, and payment barriers that limit uptake of novel therapies. However, sustained population-level access to these therapies requires additional steps to address common care delivery barriers. These include patient engagement, linkage to care, care coordination, and non-clinical determinants of health, such as geographic proximity to health care services. Novel care delivery models can facilitate more comprehensive and coordinated care that supports sustained access to therapies.

The Duke-Margolis Institute for Health Policy has developed a framework for an integrated population-based care and payment model for obesity to facilitate treatment for Medicare beneficiaries. Framework development was informed by the Duke-Margolis Value for Medical Products Consortium, a multi-stakeholder group composed of payers, providers, manufacturers, and regulatory, legal, and policy experts. It was also informed by conversations with obesity medicine, payer, and care model design specialists. This framework includes alternative approaches for the delivery and payment of obesity treatment in an accountable care environment. This approach allows stakeholders to implement innovative treatments and address access barriers beyond the limitations of fee-for-service (FFS) reimbursement with the goals of:

- Supporting providers with incentives to effectively diagnose, treat, and manage obesity within a multidisciplinary care model;
- Designing and implementing comprehensive, and appropriate obesity treatment;
- Achieving long-term patient engagement which leads to successful treatment and improved health outcomes; and
- Facilitating the development of alternative payment models for novel therapies as appropriate.

Physician who treat obesity have emphasized the need to address the variability of patient needs in a model. Obesity treatment requires coordination across providers to deliver both comprehensive and tailored care. As such, the framework focuses on a treatment agnostic care model that provides the financial flexibility to deliver individualized treatments.

Risk-adjusted, population-based payments support coordinated, multidisciplinary care teams. In turn, accountable provider organizations enter into two-sided risk-arrangements to ensure high-value care, encourage process improvements, and establish accountability for outcomes. This model enables the necessary care infrastructure to achieve high patient volumes and long-term engagement in treatment—facilitating the establishment of alternative payment models for novel therapies that increase access for high-need patients. The core components of the framework are summarized in **Table 1.**

Table 1 | Model Components

	DESCRIPTION
Target Population	• Medicare beneficiaries enrolled in traditional FFS Medicare.
Model Entry	• Patients are eligible for entry upon obesity diagnosis based on Body Mass Index (BMI). • Based on provider assessment of patient readiness and need, including presence/severity of co-occurring clinical conditions.
Model Exit	• Based on provider assessment following patient weight loss. Factors may include change in the presence/severity of obesity and co-occurring clinical conditions, and persistent nonadherence.
Payment Approach	• Participating organizations receive prospective, per-member, per-month (PMPM) payments. • PMPM is risk-adjusted to a composite risk score based on severity of obesity, severity of co-occurring clinical conditions, and drivers of health. • Two-sided risk arrangement between participating organization and payer to incentivize high-value care and improved treatment outcomes.
Accountability	• A larger accountable care model (ACO) takes responsibility for distributing payment and implementing an integrated condition-based payment model with primary care and specialty providers.
Performance Measures	• Use of and adherence to lifestyle and medical interventions. • Change in health status, including BMI, body fat, and/or relevant biomarkers. • Patient-reported outcome measures. • Collected through claims and electronic health record (EHR) data.
Additional Incentives	• Upside payment that rewards providers who move patients through the model and achieve desired health outcomes.

Burden of Disease

Obesity is a chronic disease in which excessive body fat accumulates and increases risk for adverse health outcomes.[1] Obesity is associated with decreased life expectancy, increased morbidity, and an increased risk of multiple co-occurring clinical conditions, including heart, kidney, and fatty liver diseases, sleep disorders, type 2 diabetes, and some cancers.[2] Contributing causes are complex, and may include genetic and medical conditions, built environment and associated drivers of health, and structural factors.[3,4] Obesity rates have rapidly increased. According to the 2021 National Health and Nutrition Examination Survey the prevalence of obesity in the U.S. rose from 30.5 percent to 41.9 percent between 2000 and 2020.[5] Rising obesity rates have led to rising medical expenditure on obesity-related illness. As of 2016, direct health care costs for obesity-related chronic diseases in the U.S. were estimated at $480.7 billion.[6]

Primary treatment options for obesity are both medical and nonmedical, including lifestyle modifications, bariatric surgical procedures, and pharmaceuticals known as anti-obesity medications (AOMs). Older-generation AOMs have had low patient uptake due to inconsistent effectiveness and market withdrawals due to severe adverse effects.[7] However, in recent years, the regulatory approval of new, highly efficacious AOMs has reinvigorated the conversation around coverage, payment, and access to pharmacological options to treat obesity. These new AOMs are predominately glucagon-like peptide-1 (GLP-1) receptor agonists, which work by mimicking hormones related to appetite and feelings of fullness.[7] Originally approved for the treatment of diabetes, studies show new GLP-1s can lead to up to 25 percent of body weight loss and have also been associated with reduced blood pressure and liver fat,[8] reduced risk of cardiovascular events,[9] and protective effects to the kidneys.[10] As a result, use of GLP-1s has greatly increased. Among Medicaid beneficiaries alone, prescriptions of GLP-1s to treat obesity rose from 2,600 prescriptions in 2021 to over 400,000 in 2023.[11]

Shifting perceptions of obesity have created new opportunities to appropriately treat obesity, transform population health, and reduce health care spending. Historically, obesity has been viewed as a condition that results from individual behavior and which aggravates existing diseases.[12] There has been increasing recognition of obesity as its own medical disease. Major clinical guidelines and specialized professional societies have contributed to a standard of care for medical treatment and management across primary and specialty care settings. Clinical guidelines assist providers in decision-making and are regularly updated to include the spectrum of treatment options for obesity. However, amidst persistent patient barriers to accessing care and a rapidly evolving treatment landscape, providers face challenges to effectively and appropriately treat their patient base.

Stigma associated with obesity by both providers and patients likely impacts patient willingness to seek care and provider engagement in treatment. A multi-stakeholder study found that the main reasons providers do not initiate conversations on obesity treatment is because of insufficient time and de-prioritization of obesity treatment. Of the patients sampled in this study, only 55 percent were diagnosed with obesity.[18] Without a proper diagnosis, patients may face more barriers to engaging in weight loss conversations with their provider and starting treatment. Even if patients are diagnosed, they may have difficulty accessing comprehensive and tailored treatment. While a majority of providers in the multi-stakeholder study recommended general lifestyle changes, far fewer provided information on specific diet and exercise programs.[18] For example, 81 percent of providers recommended changes to eating habits, but only 60 percent recommended a meal tracking system and 58 percent a specific diet program. A survey of primary care providers (PCPs) found that providers lack the time, knowledge, and training to effectively and appropriately design and deliver weight loss interventions. This lack includes not only lifestyle, but also surgical and pharmacological interventions.[19]

While bariatric surgery is proven to be safe and effective, only one percent of the eligible population undergoes the procedure.[20] Underutilization is driven by limited knowledge and stigma around surgery by both patients and their referring physicians, a lack of insurance in eligible patients, and high surgery costs even with coverage. Ongoing barriers to accessing GLP-1s exist. Despite their popularity, concerns around the cost of GLP-1s and their use in real-world settings have impacted coverage policies. Health plans and employers hesitate to cover GLP-1s due to their high price and broad population eligibility,[21] concerns around durable weight loss, adverse effects, and the prospect of long-term use. Consequently, coverage for GLP-1s for weight loss remains relatively scarce—a 2024 survey found that only 33 percent of commercial plans covered GLP-1s.[22] The Social Security Act excludes drugs used for anorexia, weight loss, or weight gain from coverage under Medicare Part D,[23] so Medicare beneficiaries cannot access GLP-1s for obesity through their drug plans. A recently proposed rule by the Centers for Medicare & Medicaid Services (CMS) would reinterpret the statute to allow coverage of AOMs to treat obesity.[24] This proposal was ultimately not included in the final rule.[25]

Amidst ongoing barriers to access to and sustained engagement with obesity treatment, digital health technologies present the opportunity to better coordinate and deliver care. Substantial advances in using digital health technologies for obesity are emerging, fueled by growing competition among digital weight management companies. Digital health technologies are broadly defined as information and communication technologies used to manage illness and to promote wellness.[13] These include wearable devices, telehealth, and mobile applications. Multiple digital health programs for obesity that provide physical activity and dietary education and dietary education exist. Some incorporate psychological or mental health elements, and many allow patients to track weight and lifestyle changes, or connect patients to personalized care teams and support peer communities. Taken together, these elements can provide access to lifestyle treatment outside of clinical settings and can empower patients to take an active role in health care decision making. These programs may also directly provide GLP-1s for weight loss, include medication assistance that supports effective use.[14,15] Because of the clinical setting involved, these digital health programs do not typically incorporate surgical treatment supports.

Federal agencies have also focused on the potential for digital health tools to increase access to personalized treatment and advance treatment for chronic disease. The Center for Medicare and Medicaid Innovation (CMMI) strategy for 2025 emphasizes increasing access to preventive care to manage chronic disease, and empowering patients to achieve their health goals through access to personal health data and shared decision-making tools.[16] A recent Centers for Medicare and Medicaid Services (CMS) Request for Information asks specifically about how digital health tools can help patients navigate treatment, how CMS can increase the adoption of digital health tools, and how digital health tools can support successful value-based care arrangements.[17]

Population-Based Care and Payment Models

Traditional FFS reimbursement in Medicare is based on payment per unit of service—such that higher volume of services result in higher reimbursement. Value-based payment arrangements (VBPs) present the opportunity to move away from volume-based reimbursement, towards reimbursement based on units of value like health outcomes. The Health Care Payment Learning & Action Network (LAN) developed a framework for alternative payment models (APMs) for care delivery in which payment for care services progressively moves away from volume, towards payments based on quality and value of care.[26] APMs that are most linked to value engage providers in shared risk and savings based on population outcomes, and/or capitated payments that establish responsibility for total cost of care and quality for a patient population. In recent years, efforts to integrate patients into these types of population-based care arrangements have increased. The recent CMS Innovation Center 2025 Strategy to Make American Healthy Again emphasizes a focus on moving beneficiaries into accountable care arrangements with shared risk.[27] Over half of Medicare beneficiaries are now in Medicare Advantage plans, which utilize payment capitation with plans receiving per-member, per-month payments for patient care.

Similarly, value-based care strategies for care delivery can be also applied to medical products where reimbursement for the product is tied to product performance or outcome measures. Such VBPs can be applied to novel products with large indicated populations to facilitate more timely, broad patient access by promoting treatment success, improved outcomes and high cost.

As described above, payer concerns around budgetary impact, and long-term adherence and impacts for novel products like GLP-1s often result in utilization management techniques that limit widespread access. For instance, payers may be hesitant to provide broad coverage and payment pay for GLP1s given their high cost, large indicated population, and expected long term use. VBPs present the opportunity for manufacturers and payers to negotiate payment rates based on expected or realized outcomes in the patient population, typically capturing outcomes that address payer concerns.

A 2020 Duke-Margolis paper describes a framework for using VBPs to expand access to novel technologies. The paper describes a spectrum of potential arrangements between payers and manufacturers, based on how closely payment is linked to the volume sold.[28] VBPs that are most de-linked from volume establish accountability and link payment to product performance. These types of arrangements involve data collection on agreed upon measures in the relevant patient population. While these arrangements can promote high-value access to novel therapies and address affordability, coverage, and payment barriers for patients, there remain significant barriers to care that limit sustainable uptake for many chronic disease areas. For example, patients may not be eligible for coverage or require prior authorization for treatment; they may live far from sites of care or have limited access to telehealth; or lack access to the personalized treatment plans, multidisciplinary care teams, or care coordination they need to successfully manage their condition.

Establishing sustainable pathways to access to novel therapies should include integrating novel care delivery models with value-based payment strategies. While they will differ across disease areas and patient populations, key components to these models may include:

- Integrating novel therapies into existing clinical care pathways;
- Establishing data infrastructures to support efficient payment and performance arrangements;
- Providing appropriate, high-value wraparound services to novel therapies;
- Aligning with existing models or programs for co-occurring clinical conditions that impact relevant population health outcomes; and
- Integrating novel strategies to better reach patients.

Despite an innovative treatment landscape and increased recognition of the need to treat obesity as a disease, patients and providers face persistent barriers to comprehensive care. Reforms are needed across the care pathway to better engage patients in treatment and promote long-term adherence. Providers also need greater support to effectively design and deliver individualized treatment plans. Enabling greater access to treatment can not only significantly improve weight loss across patient populations, but also improve outcomes for co-occurring clinical conditions and general population health. In addition, implementing treatment reforms can facilitate greater evidence generation to help providers and professional societies understand how to integrate new and evolving treatment options into standard of care. This white paper describes a framework for an integrated population-based care and payment model for obesity that addresses not only payment for medical products, but also targets the barriers that limit treatment.

Framework for a Population-Based Model for Obesity

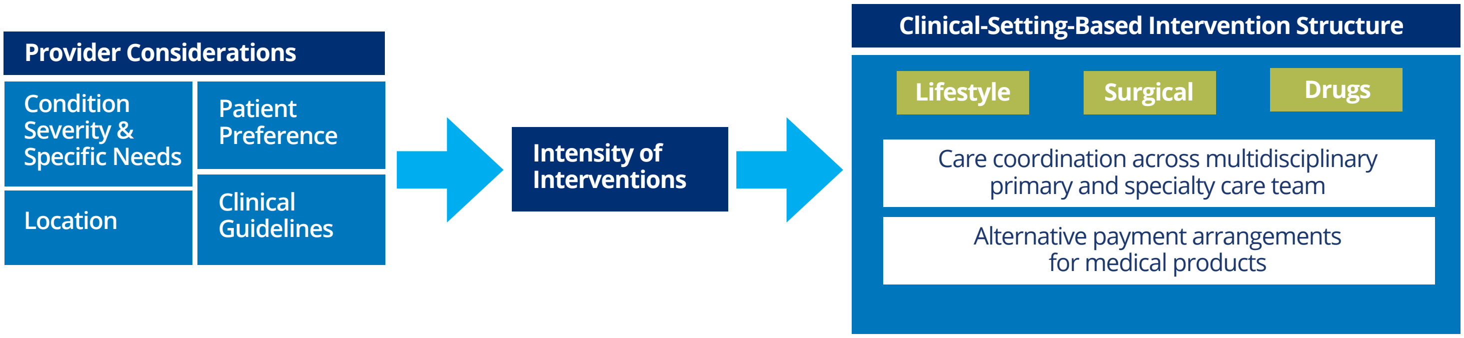
This white paper outlines a care and payment framework for treating patients for weight loss in the clinical setting. The framework describes an approach that is likely suitable for patients who, based on a provider's assessment, are expected to require clinically-based interventions, like patients who will undergo bariatric surgery, or patients with multiple co-occurring clinical conditions who need care coordination between multiple specialists to reach their treatment goals. **Figure 1** illustrates the treatment decision pathway and broad structure of this model.

The framework specifically seeks to address the ongoing challenges to effective obesity treatment for patients in traditional Medicare—which has a robust care accountability infrastructure and existing treatment programs. An integrated model can facilitate comprehensive obesity care that better engages a high volume of patients and significantly improves health outcomes—potentially facilitating alternative payment models for GLP-1s.

This model includes alternative approaches care delivery and payment of medical interventions to:

- Design and implement comprehensive, and appropriate obesity treatment;
- Support providers with incentives to effectively diagnose, treat, and manage obesity within a multidisciplinary care model as needed;
- Achieve long-term patient engagement which leads to successful treatment and improved health outcomes; and
- Facilitate the development of alternative payment models for novel therapies as appropriate.

Figure 1 | Treatment Design Pathway



Includes data collection on optimal use of medical and nonmedical interventions to inform clinical care pathways

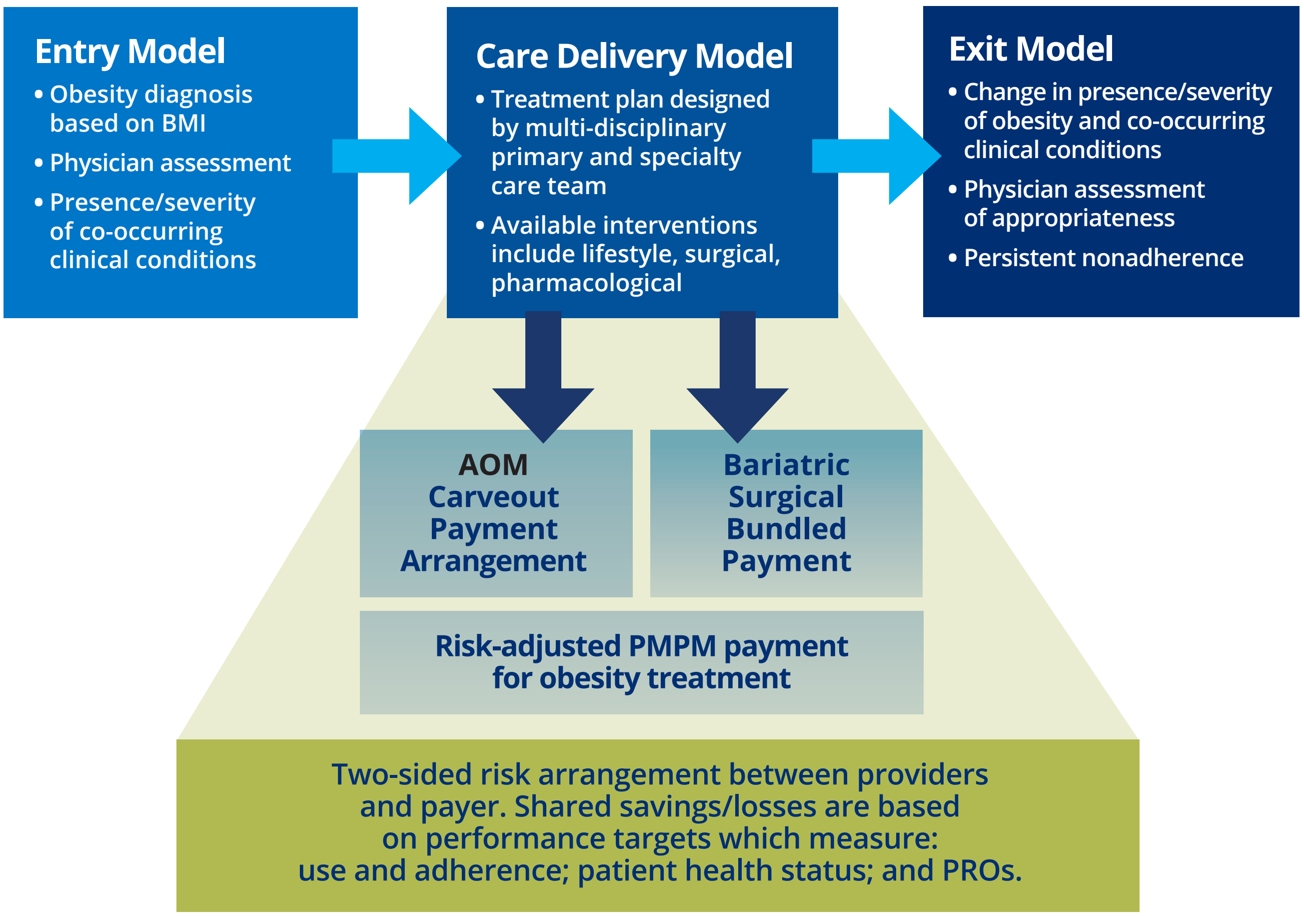
Methods

This framework was informed by an iterative literature review, input from the Duke-Margolis Value for Medical Products Consortium, and 10 informal interviews conducted with subject matter experts. The literature review explored: the epidemiology of obesity; the diagnostic and treatment pathway; and the spectrum of medical products used to treat obesity. This literature review formed the basis for a preliminary framework design which was then refined based on feedback from the Value for Medical Products Consortium, additional research, and informal interviews with expert stakeholders that included physicians who work with patients with obesity, as well as payment and care model design experts.

Overall Model Design

In informal interviews, physicians emphasized the lack of a standard treatment pathway for obesity, and the need to address the variability in patient journeys in a care and payment model. Some patients may require care coordination across providers to deliver comprehensive, individualized treatments for weight loss (differentiated from weight loss maintenance). As such, we propose a treatment agnostic care model that gives providers the flexibility to design tailored treatment plans. This approach also enables delivery of necessary wraparound services to support high-value care in the integrated model, such as nutrition, behavioral health, and physical activity interventions delivered in collaboration with community-based organizations. The model is outlined in **Figure 2**, and the following sections provide detailed descriptions of each model component.

Figure 2 | Overall Design



Care Model Components

Model Entry and Exit

Patients will be eligible for model entry based on several criteria. A diagnosis of obesity as documented in a patient's medical chart will be the "trigger" for entry. Participating providers can rely either on a diagnosis made during their visit with the patient, or on a recent obesity diagnosis from another clinical encounter. According to clinical guidelines, BMI measurements should be the basis for diagnosis.[29] While there is renewed discussion on the appropriateness of BMI as a measure for diagnosis (with a recent Lancet commission urging a new definition that moves beyond BMI)[30], obesity physicians interviewed report it is the most feasible measure to capture given bandwidth constraints. In informal interviews, physicians highlighted the challenges of capturing other potentially more accurate measures, like waist circumference, whereas BMI can be calculated based on routinely and easily collected measurements.

Once a patient is deemed eligible for participation based on an obesity diagnosis, providers will rely on several additional factors to assess whether they should participate. These include:

1. **An assessment of how appropriate it is for the patient to enroll in the model.** This type of assessment may evaluate the patient's readiness to participate, or the enablers/ barriers that impact participation. This allows the provider to identify factors that could hinder participation, and resources the patient may need to keep them engaged in treatment.

2. **The presence and severity of co-occurring clinical conditions in each patient.** Factoring in the impact of co-occurring clinical conditions ensures that patients with high unmet need are not adversely selected for the model. For example, a patient with higher barriers to participation but severe co-occurring clinical conditions should be prioritized for enrollment, with the care team developing solutions to meet their needs as part of the treatment plan.

3. **Guardrails for the even distribution of case complexity.** This can help avoid adverse selection of patients with less complex cases. Providers may utilize an algorithmic or criteria-based selection process similar to that of an analogous, conceptual model for heart failure.[31]

Model exit should be based on provider assessment of how ready the patient is to transition from weight loss to maintenance care. Providers may rely on similar criteria to entry, such as BMI and the ongoing presence or severity of co-occurring clinical conditions in relation to treatment goals. Model exit should also factor in serial nonadherence to the program. While the model design takes non-medical drivers of health into consideration, some patients may not be ready to engage in treatment when selected, or require additional intensive resources that are outside the program's capacity. These are situations where the patient may not be re-enrolled in the model, with the option of renewed participation once they are able to adhere to treatment.

Key Providers

Patients will be aligned to a participating organization through a provider who is in charge of coordinating their treatment. This is likely to be the PCP, as they are the provider patients are most likely to engage with for diagnosis and treatment.[32] Incorporating providers and other health professionals beyond the PCP in the care team is crucial to address bandwidth and scope of practice challenges for obesity treatment. The spectrum of physicians that may participate in care teams will depend on patient needs. These include obesity specialists, bariatric surgeons, internists, gastroenterologists, psychiatrists, and endocrinologists, depending on the complexity and severity of the condition and directly-related co-occurring clinical conditions.[33–36] Other health professionals are equally integral for designing and delivering interventions—like clinical social workers, psychologists, physician's assistants, dietitians, nutritionists, nurse practitioners, and health and well-being coaches.

In order to appropriately deliver interventions, the providers involved in treatment should also rely on non-clinical professionals and organizations. Treatment models for obesity and co-occurring clinical conditions emphasize the benefits of public health services that are based in patient communities. Community health workers (CHWs) can play a key role in engaging patients with limited interactions with the health care system.[33,34,37] Partner community organizations can also deliver resources and services as part of the treatment plan, and integrate patient families into designing or delivering services.[31, 38, 39] Ensuring continuity and coordination between all of these stakeholders will likely require a clinical operations team as utilized by analogous care models to facilitate communication within the care team and with external partners.[40]

Medical Services

According to guidelines, treatment plans should be tailored to individual weight loss and health goals, weight-related conditions, risk, and patient preference across different intervention steps.[29] We propose three types of interventions to be included in this care model based on clinical guidelines:

- Lifestyle interventions that include nutrition, physical activity, and behavioral health components.[29] For example, patients may follow programs for reducedcalorie diets, increased physical activity, and participate in behavioral treatment that can include individual monitoring, sessions with clinicians, or group meetings with peers.[29] Lifestyle interventions are a cornerstone of obesity treatment, and are often the first line of treatment for patients. Stakeholders may utilize digital programs to deliver lifestyle interventions and potentially better reach patients to participate in the integrated model. While still a growing field, certain digital interventions for obesity are proven to be as effective as in-person interventions, and can reduce barriers to comprehensive care for both patients and providers while significantly scaling participation.[41] Providers can rely on digital tools and programs to deliver interventions to patients with less intense care needs which can reduce some burden on the care team. For higher-need patients, digital interventions may be used in coordination with clinical services as required.

- Pharmacological interventions should be used at the discretion of the provider team both in terms of duration and whether they will be used with other interventions. Clinical guidelines recommend that AOMs be used in conjunction with a lifestyle intervention program, whether the patient first engages in lifestyle intervention alone or participates in both from the beginning.[42]
- Surgical interventions which include bariatric surgery, as appropriate. Guidelines recommend evaluation of medical and mental health to assess patient eligibility, and the selection of the surgical procedure based on individual patient risk, preference, and therapy goals.[43,44] Guidelines also recommend the continued use of lifestyle intervention after surgery, with the potential addition of AOMs for patients with significant weight regain.[42] Surgery is recommended for patients with more severe obesity for whom lifestyle intervention and pharmacological intervention are not successful.[29]

Payment Components

Population-Based Payment Approach

While there is the potential to provide more innovative and comprehensive obesity care to patients, the current fee-for-service (FFS) payment system makes it difficult to implement novel care models. APMs facilitate high-value and accountable care that can address the challenges to establishing appropriate care pathways for obesity. APMs for similar chronic conditions demonstrate the potential for population-based payment models to facilitate better treatment. A review of models for the treatment of type 2 diabetes found that models with the most financial accountability from providers (i.e., shared-savings/risk and capitated population-based payments) had the greatest improvements in diabetes quality metrics.[45] This model will utilize per-member, per-month (PMPM) payments that allow for greater provider flexibility to include services not well reimbursed under FFS. These PMPM payments will provide the upfront capital needed to build infrastructure for new care services or data collection systems—supporting long-term implementation of the integrated model's performance and payment arrangements. The participating organization will share in financial savings or losses from implementing these novel treatment plans.

Risk Adjustment

PMPM payments require risk-adjustment to ensure that providers receive appropriate payments to support treatment for heterogeneous patient populations with varying health priorities and treatment needs. Risk-adjustment for patients with obesity will build on CMS' existing risk-adjustment approach.[46] We propose the following components to calculate patient risk score:

- Severity of obesity based in part on BMI. However, given the evolving discussion around the validity of BMI as a measure of obesity, Medicare and providers may go through a systematic process to incorporate additional measures that have been suggested, such as body fat or complications.[30]
- Presence and severity of co-occurring clinical conditions that builds on CMS' use of disease characteristics for risk calculation.[46] These may include type 2 diabetes, cardiovascular disease, hypertension, dyslipidemia, and sleep apnea.[47]
- Use of existing coding infrastructure, like Z-codes that capture factors that influence health status and reasons for clinical visits. These codes specifically capture drivers of health which may influence payment rates.

Performance Measures

Participating organizations will engage in two-sided risk arrangements that ensure high-value care, encourage process improvements, and establish accountability for patient outcomes. The results of key performance measures will dictate the shared savings or losses between the payer and accountable organization. Performance measures should primarily be collected through claims and existing electronic health records (EHR) data to streamline collection and minimize provider burden. We propose performance measures with the following aims:

- **Measures which capture use of, adherence, and persistence to lifestyle and medical interventions.** These may include lifestyle program attendance and completion rates. These measures will reflect how effectively the treatment team engages the patient.
- **Measures which capture patient health status.** These may include changes in BMI, body fat, or relevant biomarkers at different participation milestones. These measures are key metrics to capture the success or failure of the program.
- **Patient-reported outcome measures (PROMs) which capture the patient's perception of their health.** Established measure sets can serve as a starting point for data collection. For example, the Set of Patient-Centered Outcome Measures for Adults living with Obesity captures quality of life, mental health, sleep, cardiometabolic health, waist circumference, and grip strength among other measures.[48]
- **Measures which capture how well the provider moves patients through the model.** These may include the average time patients spend in the model relative to weight loss and to relevant biomarkers. Payment bonuses linked to positive performance can mitigate adverse selection to keep patients in the model when no longer appropriate.

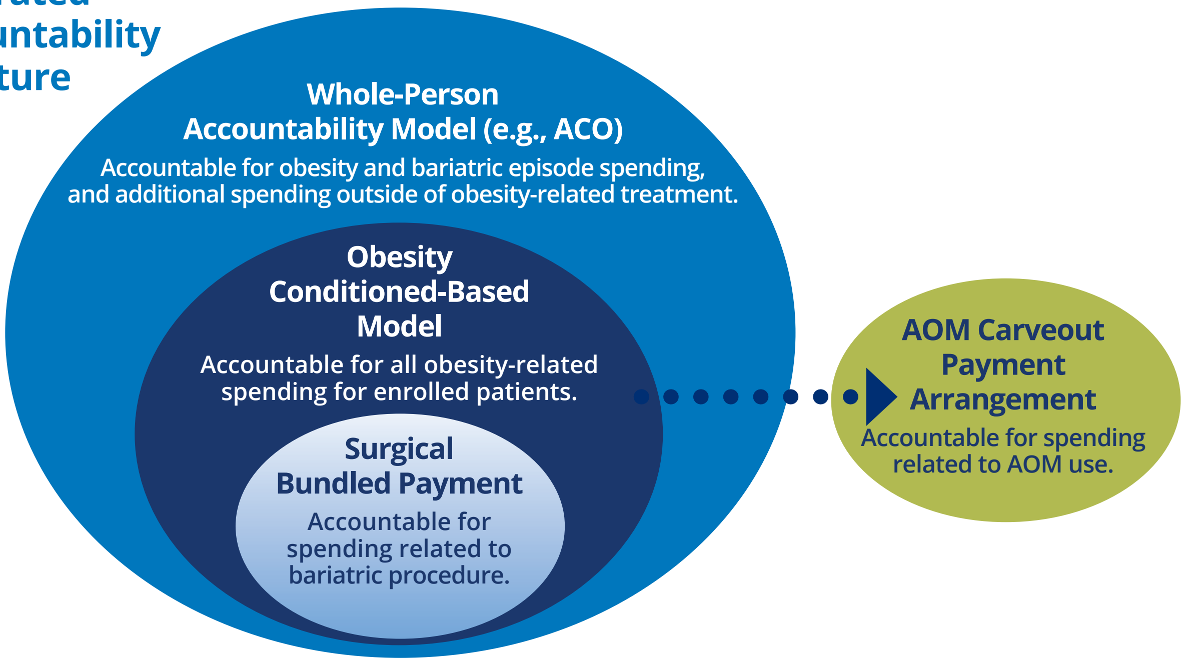
Implementing performance measures will require performance thresholds established by benchmarks. Benchmarks are typically determined based on past performance data, which may be pulled from high-performing obesity management programs or programs for co-occurring clinical conditions that capture relevant measures. Performance in comparison to these benchmarks will dictate shared savings and losses for participating organizations.

Accountability

Participating organizations will receive PMPM payments and be held responsible for treatment outcomes across their patient populations. Taking on accountability requires the infrastructure to distribute payments across the multi-disciplinary care team, and for robust collection of performance measures that dictate shared savings and losses. This model is best suited to a Medicare Accountable Care Organization (ACO) because they have the necessary infrastructure to implement this model. As part of their payment arrangements, ACOs are responsible for building care delivery infrastructures, and collecting quality and performance data.[49] In addition, ACOs tend to be driven by PCPs, with the use of specialists as necessary. This aligns with the likely care delivery approach for obesity treatment—where PCPs play an outsized role due to their availability and close patient relationships, as well as their ability to coordinate care across associated chronic conditions.

While the obesity model will be nested within the ACO, population-based payments for obesity will remain distinct from the rest of the accountability arrangement. This approach can utilize the specialty condition-based payment model (SCMs) approach described in a 2022 Duke-Margolis white paper focused on integrating specialists into ACOs.[50] Medicare payment reforms for specialists have traditionally focused on episode-based payments for defined events,

Figure 3 | Integrated Accountability Structure



rather than payment reform across the care continuum. SCMs separate payment for the selected disease area from the rest of the ACO, allowing the ACO to integrate specialists into long-term arrangements for just their relevant disease areas, and to lower cost of care for these conditions.[50] **Figure 2** illustrates a potential model structure for obesity treatment using an SCM.

In this model, the PMPM payments for obesity remain distinct from payment for the rest of the ACO care through the obesity condition-based model. The ACO will collect and distribute the PMPM payment, and is also responsible for implementing the two-sided risk arrangement in which providers share savings or losses based on performance. Like the SCMs detailed in the Duke-Margolis white paper, the obesity condition-based model will further nest acute episodes—i.e. the bariatric surgical episode. The payment approach for this surgical episode is described in the next section. Of note, surgical team members are solely responsible for spending during the bariatric episode. This layered accountability approach allows for increased provider participation while maintaining distinct responsibilities for different elements of care.

Payment for Bariatric Surgery

As the costs of surgical procedures are both large and a one-time case for most patients (unless revision is needed), payment for surgical procedures will be distinct from the rest of the accountability arrangement. The procedure will remain within the obesity condition-based model, but payment and accountability will be separate from the everyday care that the PMPM supports. This can help create clearer boundaries for what treatment the surgical team versus the everyday care team is responsible for—particularly for perioperative care. For example, patients may be required to complete dietary counseling before surgery[51] and in the post-operative period may need the support of a registered dietitian to modify their diets.[52] Delineating payment for these services between the PMPM payments or the surgical episode bundle can clarify expected periods of responsibility between providers.

This model can build on the existing (CMMI Bundled Payments for Care Improvement Advanced (BPCI-A) model for various clinical episodes, including for bariatric surgery. The model aims to provide high-quality, collaborative patient care while reducing hospital and emergency room use.53 CMS bundles the cost of care for a clinical episode (i.e. bariatric surgery) and compares this target price to FFS spending to determine whether participants will receive additional payments or if they must repay CMS. Payment is also tied to the CMS Administrative and Alternative Quality Measures Sets—which includes several measures that can be used to capture surgical success and safety.[53]

Building Alternative Payment Models for GLP-1s

The new class of GLP-1s offers substantial health benefits for large patient populations, but costs continue to complicate patient access. Given the broad indicated population, coupled with current pricing levels—even as net prices have substantially declined due to rebates and discounts—payers may apply utilization management strategies or other targeted coverage approaches as tools to manage drug and overall health care spending, especially in cases in which long-term health impacts are uncertain. This results in limited access to these novel therapies and limited health benefits. Under current law, Medicare Part D plans are prohibited from covering drugs used for weight loss. While a recent proposal to reinterpret the definition of obesity as a disease to allow AOM coverage was not finalized, the administration indicated that it may consider future policy options for AOMs.[54]

Furthermore, CMS recently selected semaglutide (Ozempic,™ Rybelsus™ and Wegovy™) for the list of selected drugs for the second cycle of the Medicare Drug Price Negotiation Program.[55] An alternative payment arrangement for GLP-1s could build on these efforts by providing access to substantially larger volumes of patients who can benefit from treatment and supporting wraparound services that improve adherence and outcomes. The obesity care and payment model outlined above establishes a care infrastructure and engaged patient base that can be harnessed for a volume-based payment arrangement for GLP-1s.

Specifically, this model would feature a negotiated arrangement between GLP-1 manufacturers and drug plans that reduces the drug's unit price based on a threshold of increased patient volume. In return, plans would commit to significantly expanding access among eligible beneficiaries who would benefit from weight loss—removing traditional coverage restrictions such as prior authorization or step therapy requirements and setting a flat, relatively low maximum copayment for GLP-1s. Implementing such an arrangement would also require shared data collection between stakeholders to capture drug use and patient outcomes which may reflect cost savings for obesity and co-occurring clinical conditions.

Implementation Considerations: Traditional Medicare

The Medicare beneficiary population is well-suited for a payment model which supports more comprehensive, coordinated obesity treatment. An estimated one in five Medicare beneficiaries have been diagnosed with obesity.[56] Additionally, adults aged 65 and older face higher rates of other chronic conditions.[5, 28] This includes co-occurring clinical conditions that may be mitigated by treatment for obesity, like type 2 diabetes, coronary heart disease, and chronic obstructive pulmonary disease (COPD.)[29] The Medicare program has existing value-based payment structures which can be leveraged for a this integrated population-based model. For example, the Shared Savings Program already utilizes risk-sharing strategies, and CMMI has piloted chronic disease payment models through CMMI. Assuming eventual AOM coverage under Part D, CMMI could establish a population-based payment model for obesity which builds on existing Medicare obesity programs.

Several existing benefits that support comprehensive obesity care that may be part of a population-based payment model exist. All Medicare beneficiaries are eligible for Annual Wellness Visits (AWV) which focus on identifying health risks and developing prevention plans. As part of these visits, physicians measure obesity-related measures such as height, weight, BMI, and other measures as they deem appropriate.[57] AWVs also recently incorporated an optional "social determinants of health" risk assessment for patients.[57] While AWVs provide a good entry point for diagnosis and to collect relevant clinical and social measures, low uptake of AWVs hinders their utility in a population-based payment model.[58] ACOs integrating a population-based payment model for obesity could implement reforms to increase AWV attendance. For example, one health system increased their AWVs for eligible patients by 25 percent by: using software that allows health care organizations to view AWV eligibility; integrating AWVs into the EHR; and implementing compensation bonuses for providers who achieved high AWV rates.[58]

Once diagnosed, Medicare beneficiaries are eligible for Intensive Behavioral Therapy (IBT) for obesity. This program includes routine screening of obesity as measured by BMI, dietary assessments, and intensive counseling or therapy which supports diet and exercise interventions.[59] Medicare reimburses PCPs for up to 22 15-minute visits annually—contingent on whether beneficiaries reach weight loss requirements at a six-month follow-up.[60] Despite its utility, there has been minimal uptake of this benefit. This may be due to low reimbursement rates as compared to regular primary care visits, and the frequency of required visits which burdens both patients and providers.[61] CMS can test elements that could support uptake of this program, including expanding the program beyond PCPs (perhaps more heavily relying on digital health interventions), increasing reimbursement, or changing visit requirements to be more flexible to patient needs.

Finally, CMS can build on existing quality measures which incentivize effective obesity treatment, including use of GLP-1s. Programs like the Merit-Based Incentive Payment System (MIPS) rewards providers for improvements in various health outcomes related to obesity that can be improved with widespread coverage and use of AOMs.[62] CMS can take steps to align relevant quality measures between existing care delivery models such as MIPS and outcome-linked payment arrangements, as we propose here, to improve medical care that incorporates these effective drugs. CMS can build on these measures to encourage coordinated, comprehensive care for obesity and track AOM use. Clinical quality measures around these products will incentivize providers to collect data on prescriptions and adherence and provide insights into areas for improvement across health care organizations.

Implementation Considerations: Other Beneficiary Populations

While this framework is focused on implementing a model for Traditional Medicare beneficiaries, this approach could be adjusted for other payer populations—such as Medicare Advantage (MA) and commercial beneficiaries. Over half (54 percent) of Medicare beneficiaries are now enrolled in MA plans.[63] MA plans have the flexibility and discretion to enter into alternative payment arrangements with providers and greater flexibility than FFS Medicare to reimburse for services that are not traditionally covered under FFS. This payment structure enables care delivery reforms that can play a key role in integrated models by supporting comprehensive obesity treatment and facilitating data collection on integrating GLP-1s into existing care pathways.

Following a larger trend, MA plans have increasingly been engaging in downside risk arrangements—the rate of MA population-based payment models increased over

20 percent from 2018 to 2023.[64] Stakeholders can harness existing data infrastructures for these accountability arrangements to develop integrated population-based models that increase access to obesity treatment, improve health outcomes, and provide cost savings across stakeholders. This kind of model can use the care and payment structures outlined above, but will not utilize the larger ACO structure that exists for Traditional Medicare beneficiaries. Instead, MA plans and accountable providers can enter into obesity-specific arrangements with shared savings and losses for performance. An integrated model can harness existing measures under the Star Ratings Program that incentivize weight loss—such as adherence to medications for co-occurring clinical conditions, blood pressure, and physical activity.[62] As a recent Duke-Margolis comment letter highlights,[65] CMS can work with MA plans to increase transparency on adoption of APMs to align on best practices, and promote data-sharing on specialty performance to bring more specialists into APMs for obesity.

Commercial payers also present an opportunity to implement integrated population-based models for obesity. Like in Medicare Advantage, the rate of double-sided risk arrangements, particularly population-based payment models, has increased among commercial payers.[64] There has also been steady growth in the number of commercial ACO contracts, in comparison to slowed growth in Medicare ACOs in recent years.[66] Commercial payers can utilize existing data infrastructure and experience with care reforms to implement population-based models for obesity—potentially through a carved out condition-based model in a larger ACO, or as a standalone condition-based model contracted with relevant providers. In addition to this framework, commercial payers developing integrated models can align with existing approaches to episodic obesity care. For example, Vanderbilt Health has a weight loss program for commercial beneficiaries that bundles all the services needed for surgical weight-loss.[67] Many insurers have also integrated weight-loss programs that could be incorporated into this type of model.[68,69]

CONCLUSION

The rapidly growing rate of obesity in the U.S., coupled with the arrival of transformative but costly GLP-1s, provide the opportunity to rethink standard approaches to care and payment for obesity treatment. Integrated population-based payment models for chronic diseases like obesity can increase access to both medical and nonmedical treatment options and significantly improve population outcomes. Population-based care models provide the opportunity to address fragmented and ineffective care structures which have created barriers to obesity treatment. Simultaneously, stakeholders can implement new payment models to increase access to both established and novel treatment options while containing health care costs. Combined, these efforts can provide appropriate, long-term care to patients that greatly improves their health and reduces their medical spending for obesity and co-occurring clinical conditions. These reforms can also contribute to an updated evidence base that informs care guidelines and the evolving standard of care for obesity treatment.

This integrated care and payment model is a first step in establishing pathways to improve access to transformative therapies like GLP-1s across patient populations. Further reforms will be required to create coverage pathways for these therapies, and to ensure that stakeholders have the infrastructure to support long-term access to GLP-1s—including for data collection capacity, novel clinical care pathways, and flexible manufacturing capabilities to meet demand.

References

[1] Purnell JQ. Definitions, Classification, and Epidemiology of Obesity. In: Feingold KR, Anawalt B, Blackman MR, et al., eds. *Endotext.* MDText.com, Inc.; 2000. Accessed January 24, 2025. http://www.ncbi.nlm.nih.gov/books/NBK279167/

[2] Abdelaal M, le Roux CW, Docherty NG. Morbidity and mortality associated with obesity. *Ann Transl Med.* 2017;5(7):161. doi:10.21037/atm.2017.03.107

[3] Lee A, Cardel M, Donahoo WT. Social and Environmental Factors Influencing Obesity. In: Feingold KR, Anawalt B, Blackman MR, et al., eds. *Endotext.* MDText.com, Inc.; 2000. Accessed January 4, 2024. http://www.ncbi.nlm.nih.gov/books/NBK278977/

[4] Sarwer DB, Polonsky HM. The Psychosocial Burden of Obesity. *Endocrinol Metab Clin North Am.* 2016;45(3):677-688. doi:10.1016/j.ecl.2016.04.016

[5] Adult Obesity Facts. Centers for Disease Control and Prevention. May 17, 2022. Accessed December 4, 2023. https://www.cdc.gov/obesity/data/adult.html

[6] Hugh Waters, Marlon Graf. *America's Obesity Crisis.* Milken Institute; 2018. https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB_2.pdf

[7] Herper EC Matthew. New weight loss drugs are changing the narrative on obesity, with a push from pharma. STAT. March 5, 2023. Accessed September 12, 2023. https://www.statnews.com/2023/03/05/weight-loss-drugs-changing-obesity-narrative/

[8] Wang JY, Wang QW, Yang XY, et al. GLP−1 receptor agonists for the treatment of obesity: Role as a promising approach. *Front Endocrinol.* 2023;14:1085799. doi:10.3389/fendo.2023.1085799

[9] Marx N, Husain M, Lehrke M, Verma S, Sattar N. GLP-1 Receptor Agonists for the Reduction of Atherosclerotic Cardiovascular Risk in Patients With Type 2 Diabetes. *Circulation.* 2022;146(24):1882-1894. doi:10.1161/CIRCULATIONAHA.122.059595

[10] Yu JH, Park SY, Lee DY, Kim NH, Seo JA. GLP-1 receptor agonists in diabetic kidney disease: current evidence and future directions. *Kidney Res Clin Pract.* 2022;41(2):136-149. doi:10.23876/j.krcp.22.001

[11] Williams E, Burns A, Published RR. Medicaid Utilization and Spending on New Drugs Used for Weight Loss. KFF. September 8, 2023. Accessed January 5, 2024. https://www.kff.org/policy-watch/medicaid-coverage-of-and-spending-on-new-drugs-used-for-weight-loss/

[12] Jessica Samuels. From Stigma to Diagnosis: How Medicalizing Obesity Empowers Individuals to Take Charge of their Lives - Petrie-Flom Center. October 15, 2024. Accessed January 23, 2025. https://petrieflom.law.harvard.edu/2024/10/15/from-stigma-to-diagnosis-how-medicalizing-obesity-empowers-individuals-to-take-charge-of-their-lives/

[13] Ronquillo Y, Meyers A, Korvek SJ. Digital Health. In: *StatPearls.* StatPearls Publishing; 2025. Accessed June 6, 2025. http://www.ncbi.nlm.nih.gov/books/NBK470260/

[14] GLP-1 Program For Weight Loss & Health. Accessed May 28, 2025. https://www.omadahealth.com/glp-1-care-track

[15] GLP-1 Medical Weight Loss. Thrive Wellness. Accessed May 28, 2025. https://livethrive.co/weight-loss

[16] CMS Innovation Center 2025 Strategy to Make America Healthy Again. May 13, 2025. Accessed May 27, 2025. https://www.cms.gov/priorities/innovation/about/strategic-direction

[17] CMS Seeks Public Input on Improving Technology to Empower Medicare Beneficiaries | CMS. Accessed May 27, 2025. https://www.cms.gov/newsroom/press-releases/cms-seeks-public-input-improving-technology-empower-medicare-beneficiaries

[18] Perceptions of Barriers to Effective Obesity Care: Results from the National ACTION Study - Kaplan - 2018 - Obesity - Wiley Online Library. Accessed December 6, 2023. https://onlinelibrary-wiley-com.proxy.lib.duke.edu/doi/full/10.1002/oby.22054

[19] Oshman L, Othman A, Furst W, et al. Primary care providers' perceived barriers to obesity treatment and opportunities for improvement: A mixed methods study. *PLOS ONE.* 2023;18(4):e0284474. doi:10.1371/journal.pone.0284474

[20] Gasoyan H, Soans R, Ibrahim JK, Aaronson WE, Sarwer DB. Do insurance-mandated precertification criteria and insurance plan type determine the utilization of bariatric surgery among individuals with private insurance? *Med Care.* 2020;58(11):952-957. doi:10.1097/MLR.0000000000001358

[21] Leo L, Mandowara K. Boom in weight-loss drugs to drive up US employers' medical costs in 2024 - Mercer. *Reuters.* https://www.reuters.com/business/healthcare-pharmaceuticals/boom-weight-loss-drugs-drive-up-us-employers-medical-costs-2024-mercer-2023-11-17/. November 17, 2023. Accessed January 5, 2024.

[22] Trends in Drug Benefit Design Report. Published online Spring 2024. Accessed January 14, 2025. https://link.psgconsults.com/2024-trends-in-benefit-design-report

[23] *United States Code: Social Security Act.* Vol 1296r-8. Accessed March 6, 2024. https://www.ssa.gov/OP_Home/ssact/title19/1927.htm

[24] Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Federal Register. December 10, 2024. Accessed January 17, 2025. https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare

[25] Tong N. Medicare Advantage final rule excludes anti-obesity drug coverage under Medicare, Medicaid. April 4, 2025. Accessed April 14, 2025. https://www.fiercehealthcare.com/payers/medicare-advantage-final-rule-excludes-anti-obesity-drug-coverage-under-medicare-medicaid

[26] Alternative Payment Model (APM) Framework. Published online January 12, 2016.

[27] Strategic Direction. CMS.gov. May 14, 2025. Accessed May 16, 2025. https://www.cms.gov/priorities/innovation/about/strategic-direction

[28] Lopez MH, Daniel GW, Fiore NC, Higgins A, McClellan MB. Paying For Value From Costly Medical Technologies: A Framework For Applying Value-Based Payment Reforms. *Health Aff (Millwood).* 2020;39(6):1018-1025. doi:10.1377/hlthaff.2019.00771

[29] Marc-André Cornier MD. A Review of Current Guidelines for the Treatment of Obesity. 2022;28. Accessed June 15, 2023. https://www.ajmc.com/view/review-of-current-guidelines-for-the-treatment-of-obesity

[30] Rubino F, Cummings DE, Eckel RH, et al. Definition and diagnostic criteria of clinical obesity. *Lancet Diabetes Endocrinol.* Published online January 2025:S2213858724003164. doi:10.1016/S2213-8587(24)00316-4

[31] Joynt Maddox K, Bleser WK, Crook HL, et al. Advancing Value-Based Models for Heart Failure. *Circ Cardiovasc Qual Outcomes.* 2020;13(5):e006483. doi:10.1161/CIRCOUTCOMES.120.006483

[32] Romaire MA. Use of Primary Care and Specialty Providers: Findings from the Medical Expenditure Panel Survey. *J Gen Intern Med.* 2020;35(7):2003-2009. doi:10.1007/s11606-020-05773-7

[33] Our Approach to Treating Obesity. Accessed October 6, 2023. https://nyulangone.org/conditions/obesity

[34] Duke Lifestyle and Weight Management Center. Duke Health. Accessed December 11, 2023. https://www.dukehealth.org/locations/duke-lifestyle-and-weight-management-center

[35] Obesity Management Team. Obesity Medicine Association. Accessed December 11, 2023. https://obesitymedicine.org/blog/obesity-management-team/

[36] Doctors Who Specialize in Obesity. Johns Hopkins Medicine. Accessed October 6, 2023. https://www.hopkinsmedicine.org/health/conditions-and-diseases/obesity/doctors-who-specialize-in-obesity

[37] Foster D, Sanchez-Collins S, Cheskin LJ. Multidisciplinary Team–Based Obesity Treatment in Patients With Diabetes: Current Practices and the State of the Science. *Diabetes Spectr Publ Am Diabetes Assoc.* 2017;30(4):244-249. doi:10.2337/ds17-0045

[38] Casanova D, Kushner RF, Ciemins EL, et al. Building Successful Models in Primary Care to Improve the Management of Adult Patients with Obesity. *Popul Health Manag.* 2021;24(5):548-559. doi:10.1089/pop.2020.0340

[39] Barry SA, Teplitsky L, Wagner DV, Shah A, Rogers BT, Harris MA. Partnering with Insurers in Caring for the Most Vulnerable Youth with Diabetes: NICH as an Integrator. *Curr Diab Rep.* 2017;17(4):26. doi:10.1007/s11892-017-0849-4

[40] Casale PN, Perez C, Hagan EP, Roiland RA, Saunders RS. Aligning Care and Payment for Chronic Cardiovascular Conditions. *J Am Coll Cardiol.* 2021;78(23):2377-2381. doi:10.1016/j.jacc.2021.09.1368

[41] Hinchliffe N, Capehorn MS, Bewick M, Feenie J. The Potential Role of Digital Health in Obesity Care. *Adv Ther.* 2022;39(10):4397-4412. doi:10.1007/s12325-022-02265-4

[42] Garvey WT, Mechanick JI, Brett EM, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Comprehensive Clinical Practice Guidelines For Medical Care of Patients with Obesity. *Endocr Pract.* 2016;22:1-203. doi:10.4158/EP161365.GL

[43] Pearce N. Canadian Adult Obesity Clinical Practice Guidelines. Obesity Canada. 2020. Accessed May 30, 2024. https://obesitycanada.ca/guidelines/

[44] Mechanick JI, Apovian C, Brethauer S, et al. Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures - 2019 update: cosponsored by American Association of Clinical Endocrinologists/American College of Endocrinology, The Obesity Society, American Society for Metabolic & Bariatric Surgery, Obesity Medicine Association, and American Society of Anesthesiologists. *Surg Obes Relat Dis Off J Am Soc Bariatr Surg.* 2020;16(2):175-247. doi:10.1016/j.soard.2019.10.025

[45] Wang S, Weyer G, Duru OK, Gabbay RA, Huang ES. Can Alternative Payment Models And Value-Based Insurance Design Alter The Course Of Diabetes In The United States? *Health Aff (Millwood).* 2022;41(7):980-984. doi:10.1377/hlthaff.2022.00235

[46] Risk Adjustment Methodology. Published online December 2021. https://www.csscoperations.com/internet/csscw3.nsf/RiskAdjustmentMethodologyTranscript.pdf

[47] Lim Y, Boster J. Obesity and Comorbid Conditions. In: StatPearls. StatPearls Publishing; 2024. Accessed November 20, 2024. http://www.ncbi.nlm.nih.gov/books/NBK574535/

[48] Adult Obesity. International Consortium for Health Outcomes Measurement. Accessed January 10, 2025. https://www.ichom.org/patient-centered-outcome-measure/adult-obesity/

[49] Accountable Care Financial Arrangements: Options and Considerations. Published online June 2016.

[50] Mark Japinga, Prakash Jayakumar, Francois de Brantes, Kevin Bozic, Robert Saunders, Mark McClellan. *Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms.* Duke Margolis Center for Health Policy; 2022. https://healthpolicy.duke.edu/publications/strengthening-specialist-participation-comprehensive-care-through-condition-based

[51] Iuzzolino E, Kim Y. Barriers impacting an individuals decision to undergo bariatric surgery: A systematic review. *Obes Res Clin Pract.* 2020;14(4):310-320. doi:10.1016/j.orcp.2020.07.001

[52] Eisenberg D, Shikora SA, Aarts E, et al. 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery. *Surg Obes Relat Dis.* 2022;18(12):1345-1356. doi:10.1016/j.soard.2022.08.013

[53] BPCI Advanced. Centers for Medicare and Medicaid Services. Accessed June 5, 2023. https://innovation.cms.gov/innovation-models/bpci-advanced#episodes

[54] Medicare and Medicaid will not cover weight loss drugs, Trump administration decides - CBS News. April 4, 2025. Accessed May 12, 2025. https://www.cbsnews.com/news/medicare-and-medicaid-will-not-cover-weight-loss-drugs-trump-administration-decides/

[55] Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2027. Published online January 2025.

[56] Medicare Other Chronic and Disabling Conditions. Chronic Conditions Data Warehouse. Accessed January 17, 2025. https://www2.ccwdata.org/medicare-charts/medicare-other-chronic-and-disabling-conditions

[57] Medicare Wellness Visits. Centers for Medicare and Medicaid Services. Accessed January 20, 2025. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

[58] Moore N, Nicholas Koenig MD, Karen Shakiba BS, Jacob Heidbrink MS, Megan Guinn MBA. Increasing Medicare Annual Wellness Visits in Accountable Care Organizations. 2021;9. Accessed January 20, 2025. https://www.ajmc.com/view/increasing-medicare-annual-wellness-visits-in-accountable-care-organizations

[59] Intensive Behavioral Therapy (IBT) for Obesity. https://www.codemap.com/file/MM7641.pdf

[60] Kraschnewski J, Yeh HC, Francis E, et al. Utilization of intensive behavioural treatment for obesity in patients with diabetes. *Clin Obes.* 2021;11(1):e12426. doi:10.1111/cob.12426

[61] Ozoor M, Gritz M, Dolor RJ, Holtrop JS, Luo Z. Primary care provider uptake of intensive behavioral therapy for obesity in Medicare patients, 2013–2019. *PLOS ONE.* 2023;18(3):e0266217. doi:10.1371/journal.pone.0266217

[62] Kirsten Axelsen, Annabelle Fowler, Ashutosh Mishra. *An Analysis of Obesity Diagnosis and Treatment in Medicare and the Associated Policy Landscape.* Charles River Associates; 2023. https://media.crai.com/wp-content/uploads/2023/04/20122406/CRA-Lilly-Obesity-Policy-Federal-Landscape.pdf

[63] Freed M, Biniek JF, Damico A, Published TN. Medicare Advantage in 2024: Enrollment Update and Key Trends. KFF. August 8, 2024. Accessed March 10, 2025. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

[64] 2024 APM Measurement Infographic. Health Care Payment Learning & Action Network. November 14, 2024. Accessed March 11, 2025. https://hcp-lan.org/apm-measurement-effort/2024-apm/2024-infographic/, https://hcp-lan.org/apm-measurement-effort/2024-apm/2024-infographic/, https://hcp-lan.org/apm-measurement-effort/2024-apm/2024-infographic/

[65] Comment Letter on Medicare Program; Request for Information on Medicare Advantage Data (CMS-4207-NC). Accessed March 21, 2025. https://healthpolicy.duke.edu/publications/comment-letter-medicare-program-request-information-medicare-advantage-data-cms-4207

[66] Muhlestein D, Bleser WK, Saunders RS, McClellan MB. All-Payer Spread Of ACOs And Value-Based Payment Models In 2021: The Crossroads And Future Of Value-Based Care. *Health Aff Forefr.* doi:10.1377/forefront.20210609.824799

[67] MyWeightLossHealth. Vanderbilt Health. Accessed March 12, 2025. https://www.vanderbilthealth.com/solutions/myweightlosshealth

[68] The Fundamentals of Effective Weight-Loss Management. The Cigna Group Newsroom. Accessed March 12, 2025. https://newsroom.thecignagroup.com/fundamentals-effective-weight-loss-management

[69] Weight Management Program. https://www.bcbsm.com/amslibs/content/dam/public/employers/documents/weight-management-program-overview.pdf

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Disclosures

Beena Bhuiyan Khan is a former employee of Abbott Laboratories and Boston Scientific Corporation and a shareholder of the respective parent companies.

About the Duke-Margolis Institute for Health Policy

The Robert J. Margolis, MD, Institute for Health Policy at Duke University is directed by Mark McClellan, and brings together expertise from the Washington, DC, policy community, Duke University, and Duke Health to address the most pressing issues in health policy. The mission of Duke-Margolis is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. Duke-Margolis catalyzes Duke University's leading capabilities, including interdisciplinary academic research and capacity for education and engagement, to inform policymaking and implementation for better health and health care. For more information, visit healthpolicy.duke.edu.

Appendix A | Value for Medical Products Consortium 2024 Population-Based Payment Models Workgroup Members

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