National Rural Health Association

September 27, 2022

Dr. LaShawn McIver
Director
Office of Minority Health
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. McIver,

The National Rural Health Association (NRHA) is writing to urge the Centers for Medicare and Medicaid Services (CMS) to take an agency-wide approach to considering obesity as a health equity issue when promoting treatment and prevention in its programs.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Obesity is a highly prevalent and serious chronic disease affecting more than 100 million Americans. Rural populations experience obesity at higher rates than urban populations and this disparity appears to be growing. It is estimated that almost 39% of men and 47% of women living in rural areas have obesity compared to 32% and 38% of men and women in large metropolitan areas.[1] The obesity epidemic accounts for 47.1% of the total cost of chronic diseases nationwide.[2] As one of the greatest contributing risk factors for other chronic diseases in the country, obesity is a significant health equity issue facing rural America.

Given the higher rates of obesity in rural areas, rural areas are more often affected by associated risk factors and worse health outcomes, furthering health disparities. For example, obesity increases the risk for severe COVID-19 and 78% of COVID-19 patients admitted to an intensive care unit had an underlying disease, many being obesity-related.[3] Obesity is a risk factor for other adverse health outcomes such as heart disease, stroke, diabetes, certain types of cancer, sleep apnea, and problems during pregnancy.[4] Rural residents have a greater risk of obesity-related diseases, such as diabetes

[1] Craig M. Hales, et al., *Differences in Obesity Prevalence by Demographic Characteristics and Urbanization Level Among Adults in the United States, 2013-2016*, 319 JAMA 2419, 2422-55 (June 2018) https://jamanetwork.com/journals/jama/fullarticle/2685156.
[2] Hugh Waters & Marlon Graf, *America's Obesity Crisis: The Health and Economic Costs of Excess Weight*, MILKEN INSTITUTE, 16 (Oct. 2018) https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB_2.pdf.
[3] Lyudmyla Kompaniyets, et al., *Body Mass Index and Risk for COVID-19–Related Hospitalization, Intensive Care Unit Admission, Invasive Mechanical Ventilation, and Death — United States, March–December 2020*, 70 MORBIDITY AND MORTALITY WEEKLY REPORT 355 (Mar. 2021) https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7010e4-H.pdf.
[4] Demetrius Abshire & Cassity Gutierrez, *Rural Obesity*, NATIONAL RURAL HEALTH ASSOCIATION, 1 (Oct. 2020) https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2020-NRHA-Policy-Document-Rural-Obesity.pdf.

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and heart disease, than their urban counterparts.[5] Treating obesity is a solution to mitigating some rural-urban disparities in chronic diseases and other adverse health outcomes.

Further, NRHA is concerned about the stigma associated with obesity. Society still views and considers obesity as a lifestyle issue rather than a treatable chronic disease as recognized by the American Medical Association since 2013.[6] Obesity is treatable through a combination of intensive behavioral therapy, bariatric surgery, pharmacotherapy, improved access to healthy and nutritious food choices, and safe, accessible opportunities for physical activity.

NRHA urges CMS to take a thoughtful, coordinated approach to obesity as both a treatable chronic disease and a health equity issue, particularly at the crossroads of rural obesity. NRHA suggests two actions that CMS could take to address health disparities associated with obesity.

First, NRHA believes that Medicare coverage of all obesity treatment is critical including anti-obesity medications (AOMs). Unlike CMS, the Veterans Health Administration, Tri-Care, and Medicaid in 17 states cover AOMs. Beginning in 2023, the Federal Employee Health Benefit Plans will cover AOMs as well. Many commercial plans also cover AOMs, leaving Medicare as the sole payer that does not provide coverage.

CMS must update its regulatory guidance to allow Part D coverage of AOMs. AOMs are Food and Drug Administration (FDA) approved as safe and effective through clinical trials. NRHA believes that because of our evolving understanding of obesity as a chronic disease, CMS' interpretation of the statute excluding drugs for "anorexia, weight loss, or weight gain" is too narrow.[7] Modern AOMs are not weight loss drugs. FDA guidance requires that AOM manufacturers ensure that AOMs are effective in demonstrating clinical improvements in obesity other than weight.[8]

Medicare covers other obesity treatments, like bariatric surgery and intensive behavioral therapy (IBT). However, IBT coverage is limited to services with a physician, nurse practitioner, physician assistant, or clinical nurse specialist only in a primary care setting.[9] IBT services with a specialist, like a nutritionist or dietitian, are not covered by Medicare, so when a beneficiary is referred to a specialist they must pay out of pocket. Lack of access to the full suite of obesity treatments under Medicare is a health equity issue for rural beneficiaries.

Second, CMS should consider covering produce prescriptions in Medicare plans and support for updated health coding infrastructure to allow providers to integrate food as medicine into clinical care. Addressing social determinants of health, like lack of access to healthy food options, is also critical for preventing and treating rural obesity.

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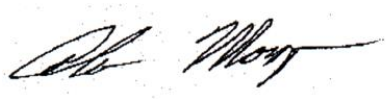
[5] *Id.*
[6] Theodore K. Kyle, et al., *Regarding Obesity as a Disease: Evolving Policies and Their Implications*, 45 ENDOCRINOLOGY AND METABOLISM CLINICS OF AMERICA 511 (Sept. 2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4988332/pdf/nihms797211.pdf.
[7] 42 U.S.C. § 1396r-8(d)(2)(A) (2018).
[8] FOOD AND DRUG ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Guidance for Industry Developing Products for Weight Management*, 1 (Feb. 2007) https://www.fda.gov/media/71252/download.
[9] Dorothea Vafiadis, *Obesity Treatment and Medicare: A Guide to Understanding Coverage*, NATIONAL COUNCIL ON AGING (July 17, 2021) https://www.ncoa.org/article/obesity-treatment-and-medicare-a-guide-to-understanding-coverage.

Produce prescription programs are a medical treatment or preventive service for patients who are eligible due to diet-related health risks or conditions or face other documented challenges in accessing nutritious foods. Produce prescription coverage would create incentives for beneficiaries to purchase fresh fruits and vegetables, thus promoting a nutritious diet. Using food as medicine or as a preventive measure would create long-term health care savings for both CMS health plans and health systems generally. This is critical as the total cost of chronic diseases due to obesity and overweight was $1.72 trillion in 2016 alone.[10]

CMS' focus on obesity moving forward should be through a health equity lens, particularly for rural beneficiaries. Support for obesity requires allowing Medicare beneficiaries access to the full suite of obesity treatments. We thank CMS for all of its hard work and focus on rural beneficiaries and look forward to its continued support of NRHA's members through equitable and accessible programs.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[10] Waters & Graf, *supra* note 2.