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January 14, 2025

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to comment in response to the *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* (*CMS–4208–P*) as published in the *Federal Register* on December 10, 2025.

Representing over 112,000 nutrition professionals, the Academy is the largest organization dedicated to advancing health through food and nutrition. Registered dietitian nutritionists (RDNs) independently provide services like medical nutrition therapy (MNT) [1] under Medicare Part B, playing a vital role in evidence-based patient care.

We offer comments on the following:

- Insulin Cost Sharing
- Part D Coverage of Anti-Obesity Medications
- Promoting Informed Choice—Format Provider Directories for Medicare Plan Finder

[1] Medical Nutrition Therapy (MNT) is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. Academy of Nutrition and Dietetics' Definition of Terms list updated November 2024. Accessed January 3, 2025.

II B. Appropriate Cost-Sharing for Covered Insulin Products under Medicare Part D (§§ 423.100 and 423.120)

The Academy strongly supports CMS' proposal to codify the cost-sharing requirements for covered insulin products under Medicare Part D, as required by the Inflation Reduction Act (IRA), for plan years beginning in 2026 and beyond.

The financial burden of diabetes on the U.S. healthcare system continues to grow. An extensive report[2] released from the American Diabetes Association found that from 2017 to 2022, the direct medical cost of diabetes increased by 7%, while the total national healthcare costs attributed to diabetes surged by $80 billion over the past decade, from $227 billion in 2012 to $307 billion in 2022. For individuals diagnosed with diabetes, medical expenditures are 2.6 times higher than would be expected without the condition, highlighting the financial strain faced by those living with diabetes.

One of the key contributors to these rising costs is the price of insulin. Over the past decade, spending on insulin tripled, growing from $8 billion in 2012 to $22.3 billion in 2022 with a 24% increase from 2017 to 2022. Growing manufacturing costs may be one reason for this increase. A research report,[3] "Comparing Insulin Prices in the U.S. to Other Countries" found that the average gross manufacturer price for a standard unit of insulin in 2018 was more than ten times higher in the US than the price observed in thirty-two other countries.

Notably, individuals over sixty-five face the highest per capita healthcare costs, spending roughly double what any other age group above 18 spends on diabetes-related care[4] further underscoring the need for policies to address the affordability of insulin in the United States.

CMS' proposal to continue to cap insulin cost-sharing at $35 per month or 25 percent of the negotiated price, whichever is lower, is a crucial step in reducing the financial burden for individuals with diabetes, particularly those served by Medicare. By continuing to address the rising costs of insulin, this policy has the potential to make a meaningful impact on the accessibility and affordability of care for the millions of Americans living with diabetes.

Recommendation: Implement as proposed.

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[2] Emily D. Parker, Janice Lin, Troy Mahoney, Nwanneamaka Ume, Grace Yang, Robert A. Gabbay, Nuha A. ElSayed, Raveendhara R. Bannuru; Economic Costs of Diabetes in the U.S. in 2022. Diabetes Care 2 January 2024; 47 (1): 26–43. https://doi.org/10.2337/dci23-0085

[3] Office of the Assistant Secretary for Planning and Evaluation. (2020, September). Comparing insulin prices in the U.S. to other countries. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/196281/Comparing-Insulin-Prices.pdf

[4] Parker, E. D., Lin, J., Mahoney, T., Ume, N., Yang, G., Gabbay, R. A., ElSayed, N. A., & Bannuru, R. R. (2024). Economic costs of diabetes in the U.S. in 2022. Diabetes Care, 47(1), 26–43. https://doi.org/10.2337/dci23-0085

III A. Part D Coverage of Anti-Obesity Medications (AOMs) (§ 423.100) and Application to the Medicaid Program

The Academy of Nutrition and Dietetics supports CMS' proposal to expand Medicare Part D coverage to include anti-obesity medications for individuals with obesity. We agree with CMS that obesity is a chronic disease, as recognized by the American Medical Association (AMA) since 2013,[5] this further underscores the need for comprehensive treatment coverage afforded to other chronic conditions.

The prevalence of obesity poses a significant challenge to public health and the economy. Investing in obesity treatments can improve health outcomes and reduce healthcare costs. Among older adults (aged 60+), 42.8 percent have obesity, a rate similar to younger and middle-aged adults.[6] By 2030, over 20 percent of the U.S. population will be 65 or older,[7] highlighting the importance of addressing obesity in this demographic. Among Medicaid beneficiaries, 38 percent are living with obesity and 70 percent meet diagnostic criteria for overweight or obesity.[8] Without treatment, individuals living with obesity face higher risks of severe health complications, including type 2 diabetes,[9] obesity-related cancers,[10] and renal disease.[11] It has also been established that severe obesity can also increase the risk of falls and related injuries,[12,13] which can contribute to already rising healthcare costs and mortality rates. Economically, untreated obesity imposes significant financial strain on the healthcare system. A 2023 white paper[14] published by USC Schaeffer Center for Health Policy and Economics estimates that expanding Medicare coverage for new obesity treatments could generate approximately $175 billion in

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[5] American Medical Association House of Delegates. (2013). Resolution: 420 (A-13): Recognition of obesity as a disease. Retrieved from https://media.npr.org/documents/2013/jun/ama-resolution-obesity.pdf

[6] Centers for Disease Control and Prevention. (2020). Prevalence of obesity and severe obesity among adults: United States, 2017–2018 (NCHS Data Brief No. 360). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db360.htm

[7] Hoagland, G. W., Parekh, A., & St. John, G. (2022, February 9). Expanding access to obesity treatments for older adults. Bipartisan Policy Center. https://bipartisanpolicy.org/report/expanding-access-to-obesity-treatments-for-older-adults/

[8] Ku, L., Paradise, J., & Thompson, V. (2017, May 17). Data note: Medicaid's role in providing access to preventive care for adults. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/

[9] Cameron NA, Petito LC, McCabe M, Allen NB, O'Brien MJ, Carnethon MR, Khan SS. Quantifying the Sex-Race/Ethnicity-Specific Burden of Obesity on Incident Diabetes Mellitus in the United States, 2001 to 2016: MESA and NHANES. J Am Heart Assoc. 2021 Feb 16;10(4):e018799. doi: 10.1161/JAHA.120.018799.

[10] Centers for Disease Control and Prevention. (2023, November 7). Obesity and cancer. U.S. Department of Health and Human Services. Retrieved January 3, 2025, from https://www.cdc.gov/cancer/risk-factors/obesity.html

[11] Nawaz S, Chinnadurai R, Al-Chalabi S, Evans P, Kalra PA, Syed AA, Sinha S. Obesity and chronic kidney disease: A current review. Obes Sci Pract. 2022 Jul 19;9(2):61-74. doi: 10.1002/osp4.629. PMID: 37034567; PMCID: PMC10073820.

[12] Silvia G R Neri, Juliana S Oliveira, Amabile B Dario, Ricardo M Lima, Anne Tiedemann, Does Obesity Increase the Risk and Severity of Falls in People Aged 60 Years and Older? A Systematic Review and Meta-analysis of Observational Studies, The Journals of Gerontology: Series A, Volume 75, Issue 5, May 2020, Pages 952–960, https://doi.org/10.1093/gerona/glz272

[13] Fjeldstad, C., Fjeldstad, A.S., Acree, L.S. et al. The influence of obesity on falls and quality of life. Dyn Med 7, 4 (2008). https://doi.org/10.1186/1476-5918-7-4

[14] Sexton Ward, A., Tysinger, B., Nguyen, P., Goldman, D., & Lakdawalla, D. (2023, April 18). Benefits of Medicare coverage for weight loss drugs. USC Schaeffer Center for Health Policy & Economics. https://healthpolicy.usc.edu/research/benefits-of-medicare-coverage-for-weight-loss-drugs/

cost offsets within the first decade alone, demonstrating the potential for both improved outcomes and reduced costs.[15]

The Academy acknowledges that the proposed rule addresses both Medicare Part C and Part D and reminds CMS of the importance of aligning obesity treatment with established standards of care. [16,17] Effective treatment requires incorporating lifestyle modifications and ensuring that any anti-obesity intervention aligns with the individual's ability and commitment to recommendations and treatment plans.

To veritably support Medicare beneficiaries who are living with obesity, policies must go beyond pharmaceutical interventions. They should also promote preventive healthcare, ensure increased access to nutritious food and lifestyle interventions[18] and address the environmental factors that perpetuate poor health outcomes. Obesity, a key driver of conditions such as diabetes and cardiovascular disease,[19,20,21] is a complex, multifactorial disease requiring a comprehensive, interprofessional approach. Unfortunately, access to and availability of diet and lifestyle healthcare services remain limited under both Medicare Part B and Part C. **Comprehensively addressing obesity is crucial for improving health outcomes and reducing long-term costs for Medicare and Medicaid**.

CMS' expansion of coverage to include anti-obesity medications, when paired with policies that enhance access to lifestyle modification services and programs, has the potential to drive broader adoption of comprehensive obesity care by private payers, including those participating in Medicare Part C agreements and Medicaid managed care. These programs present valuable opportunities to position medical nutrition therapy (MNT) as a recommended component, either prior to or in conjunction with the use of AOMs. This integrated approach fosters a more comprehensive, evidence-based, and cost-effective approach to obesity care.

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[15] National Center for Health Statistics. (2021). National Health and Nutrition Examination Survey 2017–March 2020 prepandemic data files: Development of files and prevalence estimates for selected health outcomes (National Health Statistics Reports No. 158). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhsr/nhsr158.pdf

[16] Novo Nordisk. (2024, March 8). Wegovy® receives FDA approval for cardiovascular risk reduction in adults with known heart disease and overweight or obesity. https://www.novonordisk-us.com/media/news-archive/news-details.html?id=167031#:~:text=PLAINSBORO%2C%20N.J.%2C%20March%208%2C,heart%20disease%20and%20with%20either

[17] MedStar Health. (2024). Overweight and obesity: Identification, evaluation, and treatment of overweight and obesity in adults: Clinical practice guidelines. MedStar Health.

[18] Boyd K, Medeiros KL, Kramer D, et al. Metabolic health and weight loss outcomes from a combined GLP-1 medication and ILI program at scale. Presentation at Obesity Week, October 14–17, 2023, Abstract Oral 0-69.

[19] Powell-Wiley, T. M., Poirier, P., Burke, L. E., Després, J.-P., Gordon-Larsen, P., Lavie, C. J., Lear, S. A., Ndumele, C. E., Neeland, I. J., Sanders, P., & St-Onge, M.-P. (2021). Obesity and cardiovascular disease: A scientific statement from the American Heart Association. Circulation, 143(21), e984–e1010. https://doi.org/10.1161/CIR.0000000000000973

[20] Oliver I. Brown, Michael Drozd, Hugo McGowan, Marilena Giannoudi, Marcella Conning-Rowland, John Gierula, Sam Straw, Stephen B. Wheatcroft, Katherine Bridge, Lee D. Roberts, Eylem Levelt, Ramzi Ajjan, Kathryn J. Griffin, Marc A. Bailey, Mark T. Kearney, Richard M. Cubbon; Relationship Among Diabetes, Obesity, and Cardiovascular Disease Phenotypes: A UK Biobank Cohort Study. Diabetes Care 1 August 2023; 46 (8): 1531–1540. https://doi.org/10.2337/dc23-0294

[21] Scherer PE, Hill JA. Obesity, Diabetes, and Cardiovascular Diseases: A Compendium. Circ Res. 2016 May 27;118(11):1703-5. doi: 10.1161/CIRCRESAHA.116.308999.

These policies align with CMS' goals of improving health outcomes and reducing overall healthcare costs[22] while supporting a multidisciplinary, evidence-based approach to treating obesity as a chronic disease.[23, 24] By leveraging these managed care structures, payers can support scalable models that prioritize preventive and therapeutic care while enhancing access for vulnerable populations.

There continues to be a growing body of evidence showing that the combination of obesity medications and structured lifestyle interventions can yield significant, long-lasting health improvements. Trials such as SCALE[25] , STEP 1[26] and SURMOUNT[27], which involved medications like semaglutide and tirzepatide, showed participants experienced significant weight loss. These trials, however, also incorporated regular counseling sessions by RDNs or other qualified healthcare professionals, reinforcing the importance of evidence-based nutrition and lifestyle interventions. Additionally, the STEP 3[28] trial, which also combined semaglutide with intensive behavioral therapy and thirty counseling sessions with an RDN, reported an impressive 16 percent mean weight loss.

While AOMs show promise, they are not without risks. Recognizing the barriers that adverse events pose to patient adherence and long-term success is crucial. Common adverse events associated with these medications, such as gastrointestinal discomfort (nausea, diarrhea, vomiting, constipation and abdominal pain), along with more serious complications like acute pancreatitis (particularly in older adults[29]), renal insufficiency, and hypoglycemia, have led to discontinuation rates ranging from 4-30 percent in clinical trials[30] and claims data analysis.[31] RDN intervention can often lead to improved symptom management with adjustments to food choices or meal timing, offering critical support in addressing these adverse

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[22] Centers for Medicare & Medicaid Services. (n.d.). CMS strategic plan. U.S. Department of Health & Human Services. Retrieved January 6, 2025, from https://www.cms.gov/about-cms/what-we-do/cms-strategic-plan

[23] Sharaiha RZ, Shikora S, White KP, Macedo G, Toouli J, Kow L. Summarizing Consensus Guidelines on Obesity Management: A Joint, Multidisciplinary Venture of the International Federation for the Surgery of Obesity & Metabolic Disorders (IFSO) and World Gastroenterology Organisation (WGO). J Clin Gastroenterol. 2023 Nov-Dec 01;57(10):967-976. doi: 10.1097/MCG.0000000000001916. Epub 2023 Sep 27. PMID: 37831466; PMCID: PMC10566600.

[24] Daniel Foster, Shakira Sanchez-Collins, Lawrence J. Cheskin; Multidisciplinary Team–Based Obesity Treatment in Patients With Diabetes: Current Practices and the State of the Science. Diabetes Spectr 1 November 2017; 30 (4): 244–249. https://doi.org/10.2337/ds17-0045

[25] Pi-Sunyer X, Astrup A, Fujioka K, et al. *A Randomized, Controlled Trial of 3.0 mg of Liraglutide in Weight Management.* N Engl J Med. 2015;373(1):11-22. doi:10.1056/NEJMoa1411892

[26] Wilding JPH, Batterham RL, Calanna S, et al. *Once-Weekly Semaglutide in Adults with Overweight or Obesity.* N Engl J Med. 2021;384(11):989-1002. doi:10.1056/NEJMoa2032183

[27] Jastreboff AM, Aronne LJ, Ahmad NN, et al. *Tirzepatide Once Weekly for the Treatment of Obesity.* N Engl J Med. 2022;387(3):205-216. doi:10.1056/NEJMoa2206038

[28] Wadden TA, Bailey TS, Billings LK, et al. *Effect of Subcutaneous Semaglutide vs Placebo as an Adjunct to Intensive Behavioral Therapy on Body Weight in Adults With Overweight or Obesity: The STEP 3 Randomized Clinical Trial.* JAMA. 2021;325(14):1403-1413.

[29] Sodhi M, Rezaeianzadeh R, Kezouh A, Etminan M. Risk of gastrointestinal adverse events associated with glucagon-like peptide-1 receptor agonists for weight loss. JAMA. 2023;330(18):1795–1797.

[30] Jastreboff AM, Aronne LJ, Ahmad NN, Wharton S, Connery L, Alves B, Kiyosue A, Zhang S, Liu B, Bunck MC, Stefanski A; SURMOUNT-1 Investigators. Tirzepatide Once Weekly for the Treatment of Obesity. N Engl J Med. 2022 Jul 21;387(3):205-216. doi: 10.1056/NEJMoa2206038. Epub 2022 Jun 4.

[31] Blue Health Intelligence. (2024, May). Real-world trends in GLP-1 treatment persistence and prescribing for weight management [Issue brief].

events. Additionally, long-standing safety concerns have been raised regarding bone mass loss in older adults who use AOMs[32,33] further supporting the importance of appropriate diet and physical activity recommendations in conjunction with this weight loss strategy.

RDNs play a critical role in helping Medicare beneficiaries make informed food choices, particularly when energy intake is reduced.

Pharmacological treatment of obesity focuses heavily on weight reduction, mainly fat loss; however, significant and rapid weight loss may result in muscle loss, which can negatively impact overall health, especially with rapid and significant weight loss. Preservation of muscle mass is crucial and incorporating services such as MNT and Intensive Behavioral Therapy (IBT), particularly when delivered by RDNs, has been proven to improve the health outcomes of individuals living with obesity.[34] These interventions not only help individuals manage weight, they also address the underlying contributors to obesity, including poor diet quality, lack of physical activity, and environmental factors.

Health extends beyond weight management. Many AOMs reduce food intake due to their hormone-based effects, potentially compromising dietary quality if not carefully managed. For example, studies have shown that medications like liraglutide and semaglutide may reduce energy intake by 300-900 kcal per day which, if left unaddressed, could lead to nutrient deficiencies. A reduction in total energy intake, if not accompanied by guidance on nutrient-dense food choices, may compromise overall health, leaving an already vulnerable population[35] susceptible to greater nutrient inadequacies.

Given the complexity of managing pharmacotherapy side effects and the need for balanced nutrition, a comprehensive nutritional assessment by RDNs, accompanied by an individualized care plan, is essential. RDNs can structure eating patterns to ensure adequate nutrient intake, thereby minimizing poor nutrition outcomes (such as malnutrition and nutrition deficiencies) and optimizing health outcomes (such as weight reduction, improvement in hemoglobin A1c and blood pressure, etc.). This holistic, collaborative approach to obesity treatment aligns with the Academy's belief [36] that combining

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[32] Grosicki, G. J., Dhurandhar, N. V., Unick, J. L., Arent, S. M., Thomas, J. G., Lofton, H., Shepherd, M. C., Kiel, J., Coleman, C., & Jonnalagadda, S. S. (2024). Sculpting success: The importance of diet and physical activity to support skeletal muscle health during weight loss with new generation anti-obesity medications. Current Developments in Nutrition, 8(11), 104486. https://doi.org/10.1016/j.cdnut.2024.104486

[33] Bales CW, Buhr G. Is obesity bad for older persons? A systematic review of the pros and cons of weight reduction in later life. J Am Med Dir Assoc. 2008;9(5):302–312.

[34] W. Timothy Garvey, Andreas L. Birkenfeld, Dror Dicker, Geltrude Mingrone, Sue D. Pedersen, Altynai Satylganova, Dorthe Skovgaard, Danny Sugimoto, Camilla Jensen, Ofri Mosenzon; Efficacy and Safety of Liraglutide 3.0 mg in Individuals With Overweight or Obesity and Type 2 Diabetes Treated With Basal Insulin: The SCALE Insulin Randomized Controlled Trial. Diabetes Care 1 May 2020; 43 (5): 1085–1093. https://doi.org/10.2337/dc19-1745

[35] Ye KX, Sun L, Lim SL, Li J, Kennedy BK, Maier AB, Feng L. Adequacy of Nutrient Intake and Malnutrition Risk in Older Adults: Findings from the Diet and Healthy Aging Cohort Study. Nutrients. 2023 Aug 4;15(15):3446. doi: 10.3390/nu15153446. PMID: 37571385; PMCID: PMC10421189.

[36] Citation: Warshaw, H., Evert, A., Dawkins, C., Gigliotti, L., Schwartz, J., Kushner, R., Susie, C., Subramanian, S., Handu, D., & Rozga, M. (n.d.). The evolving role of registered dietitian nutritionists in obesity management with medications and lifestyle interventions. Academy of Nutrition and Dietetics. Retrieved from https://www.eatrightpro.org/-

pharmacotherapy with evidence-based lifestyle interventions, including MNT, is essential for achieving sustainable, long-term success in the management of obesity.

The Academy is conducting a systematic review that explores the effectiveness of MNT when delivered by an RDN. Preliminary findings indicate that MNT is not only an effective treatment for many health conditions, including weight management but that its success lies within its individualized approach. This approach is grounded in "evidence-based delivery of proven methods in combination with clinical expertise and client values."[37] The review indicates that for adults with overweight or obesity, MNT likely improves weight loss, BMI, systolic blood pressure, and mental quality of life compared to non-MNT interventions. Moreover, MNT, while requiring resources such as RDN time and tools, is relatively low-cost compared to physician-led interventions and has demonstrated cost savings through optimized medication management.

Medical Nutrition and Therapy (MNT) and Intensive Behavioral Therapy (IBT) for Obesity

MNT and IBT for Obesity are valuable services for the treatment of obesity. Both focus on weight reduction; however, they are distinct services and are not interchangeable. The decision to offer MNT or IBT for obesity depends on the individual's health needs, treatment goals, and readiness for change. Both therapies play crucial roles in obesity management, addresses different aspects of the condition and offer complementary approaches to support long-term weight management.

MNT is focused primarily on optimizing diet to support weight loss, improve nutrition, and prevent or manage obesity-related conditions such as diabetes, hypertension, and cardiovascular disease. MNT is delivered by RDNs, who assess a patient's dietary habits and medical history to create personalized nutrition plans. These plans often emphasize calorie restriction, portion control, and nutrient-dense food choices to help patients achieve weight loss while maintaining overall health.

MNT is particularly beneficial for patients whose weight-related health issues stem from poor nutrition or who need structured dietary changes to manage chronic diseases. For instance, an individual with obesity who also has diabetes might require dietary modifications to help regulate blood sugar levels while managing their weight. In such cases, MNT provides the necessary guidance to help the patient make informed food choices and prevent nutrient deficiencies that could arise from drastic weight loss. This is crucial in ensuring that weight loss does not compromise the individual's overall health.

IBT, addresses the psychological and behavioral components of obesity. While it includes a component of nutrition assessment, it differs from MNT. IBT is a structured program designed to help patients make lasting lifestyle changes by focusing on behavior modification. It includes regular counseling sessions that utilize techniques such as goal-setting, self-monitoring, counseling, and motivational interviewing. These methods encourage patients to identify and modify unhealthy behaviors, such as poor eating habits or sedentary lifestyles that contribute to obesity.

/media/files/eatrightpro/aom/academy-om-report.pdf?rev=c9f3a151576d447eabb978292b9a9e55&hash=85188B71FC05F658B4D8018BCDD60901

[37] Effectiveness of MNT: A position paper of Academy of Nutrition and Dietetics (underdevelopment)

IBT is most beneficial for individuals with obesity who do not have additional medical conditions complicating their disease state and who need intensive support in changing their behaviors and adopting a healthier lifestyle. For example, a patient may have a strong desire to lose weight but may struggle with consistently making healthy food choices or staying active. In such cases, IBT helps patients develop strategies to overcome these barriers and stay committed to long-term health goals. The therapy often includes regular follow-up sessions to track progress, provide ongoing support, and adjust the care plan as needed to ensure sustained behavior change.

Choosing Between MNT and IBT

The decision to provide MNT, IBT, or a combination of both depends on the patient's unique circumstances, health goals, and readiness for change. MNT is typically chosen when the focus is on improving dietary habits and managing medical conditions that require nutritional intervention (e.g., a patient with obesity who is also at risk of nutrient deficiencies due to poor eating habits). Whereas IBT is ideal for individuals whose obesity may be influenced by behavioral factors such as emotional eating, lack of motivation, or poor self-regulation. People who face challenges in maintaining consistent healthy behaviors, despite understanding the benefits of weight loss, can benefit from the structured support provided by IBT.[38,39]

In many cases, a combination of both therapies can provide the most comprehensive approach. For instance, a patient who needs to improve their diet may begin with MNT to establish healthier eating habits, while also engaging in IBT to address behavioral triggers that influence eating habits, using strategies like self-monitoring and goal setting. Together, these therapies work synergistically to provide a holistic treatment plan that addresses both the physical and psychological components of obesity.

MNT and IBT are complementary therapies that each offer unique benefits in the treatment of obesity. MNT is ideal for patients who need structured dietary guidance to manage weight and improve nutrition, especially if they have related health conditions. Whereas IBT is designed to address the behavioral and psychological factors that influence weight management, supporting individuals in making lasting lifestyle changes. By assessing the patient's health status, goals, and readiness for change, healthcare providers can determine which therapy, or combination of therapies, is most appropriate for achieving long-term success in obesity management. Together, these interventions provide a comprehensive, patient-centered approach to managing obesity and improving overall health.

The Academy strongly believes that for the inclusion of these medications to be truly effective in improving health outcomes long-term, there must be a requirement for individuals to participate in evidence-based interventions like MNT and/or IBT for obesity. Additionally, it is crucial that these services are covered appropriately under Part B, ensuring that individuals have access to the necessary support and resources to achieve these sustainable health improvements.

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[38] Timkova, V., Minarikova, D., Fabryova, L., Buckova, J., Minarik, P., Katreniakova, Z., & Nagyova, I. (2024). Facilitators and barriers to behavior change in overweight and obesity management using the COM-B model. Frontiers in Psychology, 15, Article 1280071. https://doi.org/10.3389/fpsyg.2024.1280071

[39] Teixeira, P.J., Carraça, E.V., Marques, M.M. et al. Successful behavior change in obesity interventions in adults: a systematic review of self-regulation mediators. BMC Med 13, 84 (2015). https://doi.org/10.1186/s12916-015-0323-6

Lastly, the Academy recognizes the unique challenges faced by individuals living in rural areas. Access to obesity medications and lifestyle interventions, such as MNT and IBT, can be especially difficult in these regions. Rural healthcare settings often experience a shortage of qualified healthcare providers, making it even more necessary to ensure that rural populations have access to comprehensive obesity care. Expanding access, either in person or via telehealth, to these services, particularly for underserved populations, will help bridge the gap in care and improve health outcomes for these communities.

Recommendation:

1. Support AOM inclusion with the requirement of participation in appropriate nutrition therapy as part of the treatment plan for individuals prescribed anti-obesity medications.
2. If expanding coverage for anti-obesity medications under Part D or Medicaid is deemed unfeasible due to cost or legal concerns, the Academy recommends that CMS prioritize broader access to evidence-based nutrition therapy as a practical and effective first step in addressing the obesity epidemic.

P. Format Medicare Advantage (MA) Organizations' Provider Directories for Medicare Plan Finder (§§ 422.111 and 422.2265)

The Academy appreciates CMS' commitment to improving provider directory transparency and supports the proposal to enhance the Medicare Plan Finder (MPF) tool by including searchable provider directory information for all MA organizations. This initiative will undoubtedly help beneficiaries make more informed choices and streamline their ability to compare and select MA plans that best meet their health needs.

As CMS continues to evaluate policies regarding MA provider networks and directories, the Academy reiterates key network adequacy concerns affecting the inclusion and accessibility of RDNs in MA plans. These concerns were previously highlighted in the Academy's 2022 and 2024 comments to CMS (RIN 0938-AV01 and RIN 0938-ZB84). Network adequacy and accurate provider directories are essential for ensuring timely access to care, advancing health equity, and reducing disparities across diverse demographic and geographic populations. A comprehensive provider directory enables patients to access a wide range of specialties and empowers them to choose professionals who best meet their health needs.

The Academy continues to receive feedback from RDNs regarding the inaccuracy of provider directories. Common issues include:

- Directories listing only one provider within a large group practice.
- Outdated or incorrect provider locations, including telehealth availability.
- Providers listed who no longer work with a practice.

Additionally, specialized care, beyond renal or diabetes-focused MNT, can be difficult for beneficiaries to locate due to network limitations and a lack of recognition of RDN specialties. This can leave patients

without access to the care they need, particularly as payers limit network participation to maintain provider-to-patient ratios or control costs.

While the proposed measures, including requiring MA organizations to attest to accurate provider directory data annually, are commendable, we respectfully pose the following recommendations to further enhance beneficiary and provider experiences:

Establish a Mechanism for Reporting Inaccuracies:

- Develop a standardized process for providers and beneficiaries to report incorrect or outdated information in the MPF or plan-provided directories.
- Designate a point of contact or a centralized system at CMS to efficiently review and resolve reported issues regarding MA directory data.

Ensure Accountability for MA Plans:

- Implement specific actions to address repeated instances where MA organizations attest to inaccurate or incomplete provider directories.
- Outline penalties or corrective actions for noncompliance and enforce these measures to ensure MA organizations adhere to directory accuracy requirements.

Enhance Access to Specialized Providers on MPF:

- Incorporate functionality into the MPF to identify provider subspecialties for RDNs, such as those with certifications specializing in eating disorders, oncology, or weight management ensuring access to specialized care for beneficiaries seeking tailored medical nutrition therapy services regarding a specific need or condition.

These enhancements to the MPF will benefit Medicare beneficiaries, but ensuring the accuracy of provider directory data is critical to the success of this initiative. Providing clear mechanisms for reporting discrepancies and holding plans accountable will reinforce the integrity of the tool and help CMS achieve its goals of promoting transparency and informed choice.

Thank you for your consideration of these important issues. Please do not hesitate to contact Alison Steiber by phone at 312-899-1769 or by email at asteiber@eatright.org or Carly Léon at 312-899-1773 or cleon@eatright.org with any questions or requests for additional information.

Sincerely,

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