2025 PRMR Roundtable Measure Summary

Measure Title
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Measure Steward
Centers for Medicare & Medicaid Services
Administration and National Health Care Priority
Priority Topic Area: Obesity **Rationale for Consideration:** CMS is considering this measure because it could fulfill the Administration's priorities, including those outlined under the Making America Healthy Again (MAHA) initiative. MAHA reflects a shift toward patient-centered care, emphasizing primary, secondary, and tertiary prevention; patient empowerment; nutrition and physical activity; and improvements in overall well-being and quality of life.

Measure Overview
Measure rationale: BMI continues to be a common and reasonably reliable measurement to identify overweight and obese adults who may be at an increased risk for future morbidity. Although good quality evidence supports obtaining a BMI, it is important to recognize it is not a perfect measurement. For example, BMI and its associated disease and mortality risk appear to vary among ethnic subgroups. Black/African Americans appear to have the lowest mortality risk at a BMI of 26.2-28.5 kg/m2 in Black women and 27.1-30.2 kg/m2 in Black men. In contrast, Asian populations may experience lowest mortality rates starting at a BMI of 23 to 24 kg/m2. The correlation between BMI and diabetes risk also varies by ethnicity (LeBlanc et al., 2011). BMI is not a direct measure of adiposity and as a consequence, it can over or underestimate adiposity. However, overall, BMI is a derived value that correlates well with total body fat and markers of secondary complications, e.g., hypertension and dyslipidemia (Barlow & the Expert Committee, 2007).It is important to enhance beneficiary access to appropriate treatments for obesity, which could result in decreased healthcare Measure Information 2025 Performance Period costs and lower obesity rates. Behavioral weight management treatment has been identified as an effective first-line treatment for obesity with an average initial weight loss of 8-10 percent. This percentage of weight loss is associated with a significant risk reduction for diabetes and CVD (Wadden, Butryn & Wilson, 2007). Evidence also shows that when provided 14 or more high-intensity behavioral intervention sessions of face-to-face individual or group treatment across 6 months, participants lose up to 8 percent of their weight during that time and experience improvements in heart disease risk factors and quality of life (Wadden, Tronieri, & Butryn, 2020). There is also evidence that high-intensity behavioral counseling is effective, whether delivered in-person, by phone, or electronically (Tronieri et al., 2019). Moreover, intensive behavioral therapy for obesity provided by registered dietitian nutritionists for 6-12 months shows significant mean weight loss of up to 10 percent of body weight, maintained over one year's time (Raynor & Champagne, 2016). Despite the evidence that supports weight

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Measure Overview	
management counseling, the rate of use in primary care for patients with obesity decreased by 10 percent from 39.9 percent in 1995-1996 to 29.9 percent in 2007-2008 (Kraschnewski et al., 2013). Weight management counseling during primary care visits further declined from 33 percent to 21 percent between 2008-2009 and 2012-2013. This suggests that obesity management in primary care remains suboptimal (Fitzpatrick & Stevens, 2017). Therefore, screening for BMI and follow-up is critical and will help in reaching the quality goals of population health and cost reduction.	
Measure history: Measure is currently used in a Medicare program and being submitted without substantive changes for a new or different program. Measure is currently being used in the Merit-Based Incentive Payment System and Medicare Shared Savings Program.	
Numerator: Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period. **Exclusions:** N/A	
Denominator: All patients aged 18 and older on the date of the encounter with at least one qualifying encounter during the measurement period. **Exclusions:** Patients who are pregnant at any time during the measurement period. Patients receiving palliative or hospice care at any time during the measurement period. **Exceptions:** Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan for a BMI outside normal parameters (e.g., elderly patients 65 years of age or older for whom weight reduction/weight gain would complicate other underlying health conditions such as illness or physical disability, mental illness, dementia, confusion, or nutritional deficiency such as vitamin/mineral deficiency; patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status). Patients who refuse measurement of height and/or weight. Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan for a BMI outside normal parameters (e.g., elderly patients 65 years of age or older for whom weight reduction/weight gain would complicate other underlying health conditions such as illness or physical disability, mental illness, dementia, confusion, or nutritional deficiency such as vitamin/mineral deficiency; patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status). Patients who refuse measurement of height and/or weight.	
Measure is a composite: No **Measure is a paired measure:** No **Measure is a survey measure:** No **Measures is a digital measure and/or an eCQM:** Yes	**Measure type:** Process
Level of analysis: Clinician Group **Settings where measure was tested:** Not Available	**Data source(s):** Digital-Electronic Health Record (EHR) Data
CBE endorsement status: Not Endorsed	**CBE endorsement history:** Never Submitted

Evidence
Type of evidence to support the measure: Clinical Guidelines or U.S. Preventive Services Task Force (USPSTF) Guidelines
Summary of evidence: The USPSTF recommends that clinicians offer or refer adults with a BMI of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions[1]. Interventions: Effective intensive behavioral interventions were designed to help participants achieve or maintain weight loss of at least 5% through a combination of dietary changes and increased physical activity. Most interventions lasted for 1-2 years, and the majority had at least 12 sessions in the first year. Most behavioral interventions focused on problem solving to identify barriers, self-monitoring of weight, peer support, and relapse prevention. Interventions also provided tools to support weight loss or weight loss maintenance (e.g., pedometers, food scales, exercise videos)[1]. In addition, weight reduction prescriptions in older persons should be accompanied by proper nutritional counseling and regular body weight monitoring[2]. The possibility that a standard approach to weight loss will work differently in diverse patient populations must be considered when setting expectations about treatment outcomes.

Feasibility
eCQM feasibility testing/analysis conducted: Yes, historical eCQM testing was available.
Feasibility: For this eCQM, the developers report that all data elements are in defined fields in electronic sources and align with United States Core Data for Interoperability (USCDI/USCDI+) Quality standard definitions. While recent eCQM testing was not available for consideration at the time of this review, prior eCQM testing conducted in 2016 for this measure's inclusion in CMS programs indicated a high level of feasibility within at least two EHR systems.

Performance in Program

This measure is currently being used in the Merit-Based Incentive Payment System and Medicare Shared Savings Program.

For this measure, the analysis team reviewed the publicly available datasets:

- The 2025 Quality Benchmarks CSV file from https://qpp.cms.gov/benchmarks was used for the 2023 data in this assessment.
- The 2024 Quality Benchmarks CSV file from https://qpp.cms.gov/benchmarks was used for the 2022 data in this assessment.

[1] US Preventive Services Task Force; Curry SJ, Krist AH, Owens DK, Barry MJ, Caughey AB, Davidson KW, Doubeni CA, Epling JW Jr, Grossman DC, Kemper AR, Kubik M, Landefeld CS, Mangione CM, Phipps MG, Silverstein M, Simon MA, Tseng CW, Wong JB. Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(11):1163–1171. doi:10.1001/jama.2018.13022.

[2] Initiative, N. O. E. (1998). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. *National Institutes of Health*, 98-4083.

About Figure 1: Figure 1 is a boxplot that shows the distribution of scores and how they have changed over the past 2 years. Each box consists of lines and dots to help visualize the range and distribution of scores. The dots represent the points where the lowest 5% and highest 5% of scores fall, and the line connecting them shows where 90% of the scores are located. The box itself covers the middle half of the scores, from the 25th to the 75th percentile. Inside the box, a horizontal line marks the median score, which is the middle value, while a "+" sign shows the average score. This type of graph makes it easier to see overall trends in the scores over time and to understand how spread out or consistent the results have been.

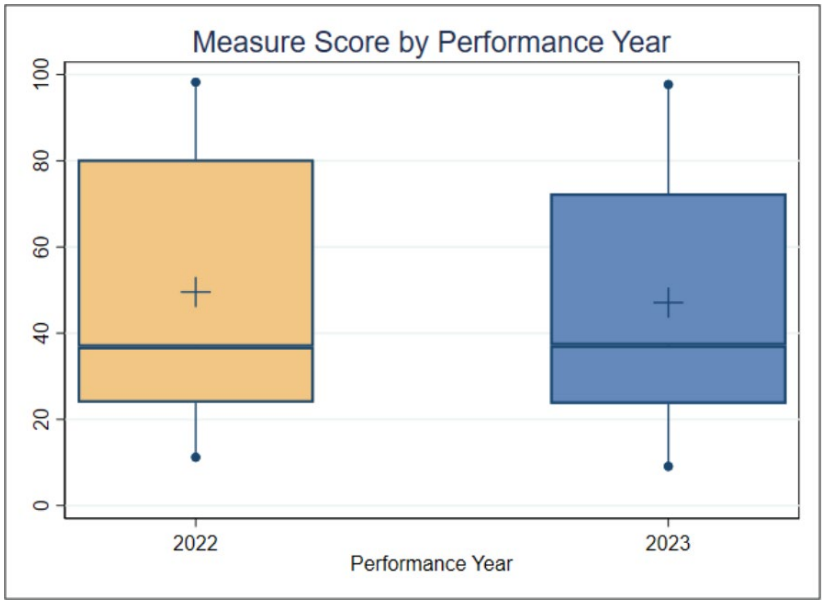

Figure 1. Boxplot of Measure Score by Program and Year

Figure 1 Interpretation: For this measure, a higher score indicates better quality of care. In the boxplot above, there is negligible difference between performance in 2022 and 2023 (36.83 and 37.17, respectively).

About Table 1: Table 1 illustrates the distribution of scores and the number of entities represented within each decile. The number of patients for each entity is not available, so it is not possible to infer whether group size is associated with performance scores.

Table 1. Importance (Decile by Measure Score, 2023)

Lowest Performers → Highest Performers

	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Mean Score	47.1	9.1	19.0	23.6	28.3	34.0	41.4	53.5	72.4	89.4	97.7
Number of Organizations	41,302	4,131	4,130	4,130	4,130	4,130	4,131	4,130	4,130	4,130	4,130

Table 1 Interpretation: The average performance of Decile 8 (72.4%) may be considered a “plausible, achievable” score. If the entities in Deciles 1 through 7 improved to reach that score, the number of patients receiving BMI screening could increase by 50% or more, which could potentially lead to better health outcomes.