TBM

PRACTICE AND PUBLIC HEALTH POLICIES

Society for Health Psychology (APA Division 38) and Society of Behavioral Medicine joint position statement on the Medicare Diabetes Prevention Program

Stephanie L. Fitzpatrick, PhD,[1] Dawn K. Wilson, PhD,[2] Sherry L. Pagoto, PhD[3] on behalf of the American Psychological Association Society for Health Psychology and the Society of Behavioral Medicine

[1]Kaiser Permanente Center for Health Research, 3800 N. Interstate Ave., Portland, OR 97227, USA

[2]University of South Carolina, Columbia, SC, USA

[3]University of Massachusetts Medical School, Worcester, MA, USA

Correspondence to: S Fitzpatrick
Stephanie.L.Fitzpatrick@kpchr.org

Cite this as: *TBM* 2017;7:385–387
doi: 10.1007/s13142-017-0468-2

© Society of Behavioral Medicine 2017

Abstract

Beginning in January 2018, the Centers for Medicare and Medicaid Services (CMS) plans to cover the Diabetes Prevention Program (DPP), also referred to as Medicare DPP. The American Psychological Association Society for Health Psychology (SfHP) and the Society for Behavioral Medicine (SBM) reviewed the proposed plan. SfHP and SBM are in support of the CMS decision to cover DPP for Medicare beneficiaries but have a significant concern that aspects of the proposal will limit the public health impact. Concerns include the emphasis on weight outcomes to determine continued coverage and the lack of details regarding requirements for coaches. SfHP and SBM are in strong support of modifications to the proposal that would remove the minimum weight loss stipulation to determine coverage and to specify type and qualifications of "coaches."

Keywords

Diabetes, Policy, Medicare, Weight loss

The American Psychological Association Society for Health Psychology (SfHP; Division 38) and the Society of Behavioral Medicine (SBM) are in support of the Centers for Medicare and Medicaid Services proposal to cover the Diabetes Prevention Program (DPP) [1]. However, both organizations have concerns about some areas of the proposal that could be strengthened. Recommendations for strengthening this proposal are outlined in detail below.

Between February 2013 and June 2015, the Centers for Medicare and Medicaid Services (CMS) funded YMCA of the USA to test whether DPP could be successfully delivered by nonphysician, community-based organizations to Medicare beneficiaries diagnosed with prediabetes [2]. Findings from this study demonstrated that participants who attended four or more core sessions had clinically significant weight loss (i.e., 5% loss of their initial weight), and there was an estimated savings of $2650 for each Medicare beneficiary enrolled in the pilot over a 15-month period [2].

Implications

Practice: Healthcare providers and clinicians should consider limitations of public health impact if weight outcomes associated with DPP determine continued coverage. Furthermore, clinicians that are well trained in weight management treatments should not require CDC certification.

Policy: Legislators and policy makers should ensure that adequate reimbursement is provided to underserved populations that may not show immediate benefits from weight loss treatments related to the DDP program implementation.

Research: The Society for Health Psychology and the Society for Behavioral Medicine encourage the implementation and translation of the DPP intervention in practice settings that integrate this evidence-based intervention approach that has been demonstrated effective.

Electronic supplementary material
The online version of this article (doi:10.1007/s13142-017-0468-2) contains supplementary material, which is available to authorized users.

Based on these findings, Medicare plans to cover DPP delivered in clinical and nonclinical settings, including remotely (by Web or phone). The Medicare DPP proposes a 12-month program that uses the Center for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum, which was designed to be delivered in community and healthcare settings in a group format by trained community health workers or health professionals [3]. The CDC National DPP consists of 16 core sessions delivered over 16–26 weeks and the option of monthly core maintenance sessions over 6 months if the Medicare beneficiary achieves and maintains a minimum 5% weight loss of their initial weight [1, 3].

During the first 6 months (weeks 1–26), each of the 16 core sessions should be at least 1 h long and must address one of these topics from the CDC National DPP curriculum:

1. Welcome to the National Diabetes Prevention Program
2. Self-monitoring weight and food intake
3. Eating less
4. Healthy eating
5. Introduction to physical activity (move those muscles)
6. Overcoming barriers to physical activity (being active–a way of life)
7. Balancing calorie intake and output
8. Environmental cues to eating and physical activity
9. Problem solving
10. Strategies for healthy eating out
11. Reversing negative thoughts
12. Dealing with slips in lifestyle change
13. Mixing up your physical activity: aerobic fitness
14. Social cues
15. Managing stress
16. Staying motivated, program wrap up

The last 6 months of the 12-month intervention must include at least one core maintenance session per month (minimum of six sessions) that addresses a different topic each session:

1. Welcome to the second phase of the program
2. Healthy eating: taking it one meal at a time
3. Making active choices
4. Balance your thoughts for long-term maintenance
5. Healthy eating with variety and balance
6. Handling holidays, vacations, and special events
7. More volume, fewer calories (adding water, vegetables, and fiber)
8. Dietary fats
9. Stress and time management
10. Healthy cooking: tips for food preparation and recipe modification
11. Physical activity barriers
12. Preventing relapse
13. Heart health
14. Life with type 2 diabetes
15. Looking back and looking forward

To be eligible for coverage of DPP, Medicare beneficiaries would need to be (1) enrolled in Medicare Part B; (2) have a body mass index (BMI) ≥25 (BMI ≥23 if self-identified as Asian) on the date of the first core session; and (3) within 12 months prior to attending the first core session have an A1C between 5.7 and 6.4%, or a fasting plasma glucose of 110–125 mg/dL, or a 2-h post OGTT glucose of 140–199 mg/dL. Eligible beneficiaries would be able to enroll in the Medicare DPP only once, but those who complete the 12-month program and achieve and maintain at least a 5% weight loss would be eligible for additional monthly maintenance sessions for as long as he or she maintains the 5% weight loss.

Only organizations (clinic or community-based) with a CDC-certified DPP program will be eligible to apply for enrollment in Medicare as a supplier beginning January 1, 2017. CMS expects to fully implement Medicare DPP by January 1, 2018. Medicare DPP coaches will be required to obtain a national provider identifier; however, there were no further details about the background requirements for the coaches in the proposed plan. Reimbursement is based on session attendance and weight loss at the time claims are submitted (see Supplementary Table 1 for an overview of the program structure).

The DPP was a landmark study that demonstrated that intensive lifestyle interventions were effective in preventing type 2 diabetes and producing clinically significant weight loss over and above metformin and placebo [4]. Recognition of DPP, an evidence-based program, by a payer is an important step that will hopefully open the door for large-scale implementation of other evidence-based behavioral interventions in healthcare and community-based settings. However, there are several limitations in CMS's proposal to cover DPP that may have implications for its reach and impact.

SfHP and SBM have concerns that requiring a 5% weight loss over the first 6 months in order to continue coverage for DPP may adversely impact high-risk groups (e.g., racial/ethnic minorities, low-income patients) given limited empirical evidence that a 5% weight loss can be achieved in these populations within a 6-month time period. This proposed stipulation on coverage could further widen the gap in health disparities as high-risk patients will have less access to treatment [5]. SfHP and SBM recommend that failure to lose 5% weight loss after the first 6 months of the Medicare DPP should not prompt Medicare to discontinue coverage but encourage providers to collaborate with patients to identify additional treatment options (e.g., meal replacements, individual treatment with a behavioral psychologist and/or with a dietitian, and/or weight loss medication) that should also be covered by Medicare as an extension of Medicare DPP, as described in an evidence-based guide to help providers build and coordinate a multidisciplinary team to help patients manage their weight [6]. In summary, this guide highlights the use of the five As counseling framework (Assess, Advise, Agree, Assist, and Arrange) [7, 8] to help providers: (1) address patients' psychosocial issues, medical, and psychiatric comorbidities associated with obesity treatment failure; (2) deliver intensive counseling that involves goal setting, self-monitoring, and problem solving; and (3) provide supervision, support, and accountability when patients are referred to a specialist (e.g., behavioral psychologist or dietitian) or clinic or community-based program.

In addition to CMS requiring a minimum 5% weight loss in the first 6 months to cover core maintenance sessions, beneficiaries need to maintain this 5% weight loss in order to have continued coverage of monthly maintenance sessions after the first year. Several randomized clinical trials, including DPP, have demonstrated that 1–2 years after a patient achieves clinically significant weight loss of 5% or more, they experience weight regain. Some of this regain can be attributed to "metabolic adaptation" or "adaptive thermogenesis," a biological process in which resting energy expenditure falls in response to reduced caloric intake and weight loss. This makes further weight loss more difficult and in many cases leads to weight regain. Weight regain can also be due to receding behavior changes often resulting from behavioral and environmental challenges and barriers. Regardless, maintenance sessions are essential to offset both of these processes as recidivism rates are likely to be higher in the absence of guidance on how to combat these processes. Further justification for not curtailing benefits for people who regain some weight is evidence for health benefits of lifestyle intervention even when weight is regained. Ten years after the DPP [9], the lifestyle intervention group continued to show an advantage in reducing diabetes incidence despite weight returning to levels of the medication and placebo groups. The SfHP and SBM strongly recommend that this weight maintenance threshold be removed and beneficiaries continue to have access to the maintenance sessions.

The proposal lacks detail about who is considered a qualified "coach" to deliver Medicare DPP besides requiring a national provider identifier and that the organization should be certified by the CDC to provide DPP services. DPP was developed by clinical health psychologists, and it is unclear if Medicare DPP will be expanded to reimburse licensed clinical psychologists who already provide evidence-based weight management treatment in individual- or group-based formats. We believe that it is not appropriate to require health professionals who specialize in weight management (e.g., clinical psychologist and registered dietitians) to be certified by the CDC, when their training, license, years of experience practicing in this space, and continuing education credits should deem them appropriate for delivering the DPP or supervising other health professionals or lay health educators to deliver the program. Otherwise, the requirement to be CDC certified creates a hurdle for licensed clinical psychologists and dietitians who are highly experienced specialists in weight management treatment.

In summary, SfHP and SBM are in support of payers reimbursing DPP to be delivered in clinical and nonclinical settings. Although CMS's proposed plan leads the effort in the large-scale implementation of DPP, we are concerned about the limited public health impact it may have given the emphasis on weight outcomes to determine continued coverage and the lack of clarity about the role of clinicians who specialize in weight management and diabetes prevention. SfHP and SBM are in strong support of modifying the Medicare DPP proposal to remove the minimum weight loss stipulation to determine coverage and to specify type and qualifications of "coaches."

Acknowledgements: This paper has been submitted to the Centers for Medicare and Medicaid Services in response to their request for comments on the Medicare DPP proposal but has not been previously published in a peer-reviewed journal, and this manuscript has not been submitted elsewhere simultaneously.

Compliance with ethical standards

Conflict of interest: The authors declare that they have no conflict of interest.

Funding: There was no funding for this work.

1. Centers for Medicare & Medicaid Services. Federal Register, Vol. 81, No. 136, (2016). Proposal rules. Pages 46413–46418., 11/09/2016, from https://www.federalregister.gov/documents/2016/07/15/2016-16097/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.
2. Hinnant, L., Razi, S., Lewis, R., Sun, A., Alva, M., Hoerger, T. J., et al. (2015). Evaluation of the health care innovation awards: community resource planning, prevention, and monitoring, annual report 2015. Awardee-level findings: YMCA of the USA. 11/09/2016, from https://innovation.cms.gov/Files/reports/hcia-ymcadpp-evalrpt.pdf.
3. Centers for Disease Control and Prevention. (2016). National Diabetes Prevention Program. 11/09/2016, from http://www.cdc.gov/diabetes/prevention/lifestyle-program/index.html.
4. Knowler, W. C., Barrett-Connor, E., Fowler, S. E., Hamman, R. F., Lachin, J. M., Walker, E. A., et al. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med, 346*(6), 393–403. doi:10.1056/NEJMoa012512.
5. Bennett, G. G., Steinberg, D. M., & Pagoto, S. L. (2015). Will obesity treatment reimbursement benefit those at highest risk? *Am J Med, 128*(7), 670–671. doi:10.1016/j.amjmed.2015.01.026.
6. Fitzpatrick, S. L., Wischenka, D., Appelhans, B. M., Pbert, L., Wang, M., Wilson, D. K., et al. (2016). An evidence-based guide for obesity treatment in primary care. *Am J Med, 129*(1), 115.
7. Alexander, S. C., Cox, M. E., Boling Turer, C. L., Lyna, P., Ostbye, T., Tulsky, J. A., et al. (2011). Do the five A's work when physicians counsel about weight loss? *Fam Med, 43*(3), 179–184.
8. Vallis, M., Piccinini-Vallis, H., Sharma, A. M., & Freedhoff, Y. (2013). Clinical review: modified 5 as: minimal intervention for obesity counseling in primary care. *Canadian family physician Medecin de famille canadien, 59*(1), 27–31.
9. Knowler, W. C., Fowler, S. E., Hamman, R. F., Christophi, C. A., Hoffman, H. J., Brenneman, A. T., et al. (2009). 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet, 374*(9702), 1677–1686. doi:10.1016/s0140-6736(09)61457-4.