HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #3

Ensure that Medicare Beneficiaries have Access to the Successful Diabetes Prevention Program

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Executive Summary

The Medicare Part A Trust Fund is projected to become insolvent by 2028. The Medicare Supplementary Medical Insurance Trust Fund, which includes Part B and Part D, has been and is projected to continue to experience spending growth in excess of Gross Domestic Product growth. One option for addressing excessive spending under both the HI and SMI Trust Funds, in part, is suggested by the successful Medicare Diabetes Prevention Program (MDPP) model. Yet despite the substantial Medicare savings that the MDPP achieved, it has not been effectively implemented in the Medicare program and thus the vast majority of eligible beneficiaries are not participating in the program. Congress could require the Medicare program to make three policy changes—paying clinicians for referrals to the MDPP, allowing a virtual option, and increasing program payments—that would capitalize on the success of the program and allow more beneficiaries to benefit from it. Depending on the extent to which clinicians, organizations, and beneficiaries respond to these new policies, the changes could reduce Medicare program spending by $1.4 billion to $18.7 billion over 10 years and improve the quality of care for beneficiaries.

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Issue

The Medicare Trustees expect that Medicare's Hospital Insurance (HI) Trust Fund, which covers Part A, will become insolvent by 2028, due to income from dedicated payroll taxes not keeping pace with expenditure growth.[1] While the impending insolvency of the Medicare Part A Trust Fund receives more attention, the Supplementary Medical Insurance (SMI) Trust Fund that covers Part B and Part D is also experiencing high expenditure growth. The SMI Trust Fund will not become insolvent as by design income increases to meet expenditures. Yet this automatic increase in income through increases in general revenue taxes, federal borrowing, and premiums is a growing strain on taxpayers and Medicare beneficiaries.

One option for addressing excessive spending under both the HI and SMI Trust Funds, in part, is to expand participation in the Medicare Diabetes Prevention Program (MDPP). This demonstration is one of only four models that have met statutory requirements that allow Centers for Medicare & Medicaid Services (CMS) Innovation Center models to be expanded or implemented nationwide into the Medicare program if they reduce program spending, improve the quality of care, or both.[2] The MDPP was found to be successful and expanded to the

[1] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)

[2] Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation, Social Security Administration

Medicare program, beginning April 1, 2018.[3] In fact, the MDPP is perhaps the most successful of all Innovation Center models tested to date. Independent evaluators found that the MDPP demonstration generated savings to Medicare of $278 per participating beneficiary per quarter or almost 14% of average Medicare Part A and B spending on those beneficiaries.[4]

The MDPP is part of the National Diabetes Prevention Program (DPP), which began in 1996 as a National Institutes of Health trial.[5] The program is a structured lifestyle change program that consists of a CDC-approved curriculum led by a trained lifestyle coach during group sessions that meet about once a week for 6 months, then once or twice a month for the next 6 months.[6,7] Lifestyle coaches must be formally trained in the CDC-approved curriculum by a CDC-approved entity for a minimum of 12 hours.[8] Entities that offer the DPP began mostly with community-based organizations, such as the Young Men's Christian Association (YMCA), and have grown to include diverse public and private organizations, including hospitals and health systems.[9,10,11]

The primary goal of the DPP is for participants to achieve at least 5% weight loss through changes in diet, exercise, and lifestyle. The CDC reports that successful participants who are over age 60 can cut their risk of developing type 2 diabetes by 71%.[12] A follow-up study of the original DPP trial found that participants remained a third less likely to develop diabetes a decade after completing the program.[13] Program participants who did develop diabetes delayed the onset of the disease by about 4 years.[14]

Frustratingly, the success of the MDPP demonstration was not followed with broad, effective implementation of the Expanded MDDP model for the Medicare program. As a result, there are too few providers and the estimated 29.5 million Medicare beneficiaries with prediabetes have limited access to MDPP.[15] While the number of MDPP providers have grown from 126 organizations at a total of 601 sites in July 2019 (more than a year after the Expanded MDPP began) to 307 organization with a total of 1,035 sites as of March 31, 2022, this growth has been

[3] 2020 Report to Congress, Center for Medicare and Medicaid Innovation (August 2021)
[4] Ibid.
[5] National Diabetes Prevention Program: Key National DPP Milestones, CDC
[6] Medicare Diabetes Prevention Program (MDPP) Expanded Model, CMS
[7] National Diabetes Prevention Program: Lifestyle Change Program Details, CDC
[8] Centers for Disease Control and Prevention Diabetes Prevention Recognition Program: Standards and Operating Procedures, CDC (May 2021)
[9] Ronald Ackermann, Emily A Finch, Edward Brizendine, Honghong Zhou, David G Marrero. (2008) Translating the Diabetes Prevention Program into the community: The DEPLOY Pilot Study. *American Journal of Preventive Medicine*, 35(4):357-63.
[10] Medicare Diabetes Prevention Program, CMS (March 2022)
[11] Diabetes Prevention Recognition Program Application: Registry of All Recognized Organizations, CDC
[12] National Diabetes Prevention Program: About the National DPP, CDC
[13] Diabetes Prevention Program Research Group. (2009) 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet*, 374(9702):1677-86. Erratum in: *Lancet*. (2009) 374(9707):2054.
[14] Ibid.
[15] Natalie D. Ritchie, Katherine Ann Sauder, R. Mark Gritz. (2020) Medicare Diabetes Prevention Program: Where Are the Suppliers? The American Journal of Managed Care, 26(6):e198-e201.

slow and is not adequately serving Medicare beneficiaries.[16,17] Only a fraction of providers that participate in the National DPP are also enrolled in the MDPP. In the 2022 final rule, CMS acknowledged that only 27% of eligible DPP providers participate in the MDPP.[18]

CMS has taken several steps to expand Medicare beneficiaries' access to the MDPP by implementing rules designed to increase the number of providers and to offer more flexible options for beneficiaries to use the program. In response to the COVID-19 public health emergency, the agency waived enrollment fees for providers and allowed telehealth services, additional make-up sessions, and resumption of interrupted treatment programs.[19,20] As of 2021, CMS extended these flexibilities for any future public health emergencies (subject to limitations) and added an option for MDPP providers to accept self-reported participant weight measurements via photographs of their digital scales.[21,22] As of 2022, CMS waived the Medicare enrollment fee for new MDPP suppliers and shortened the MDPP program from 2 years to 1 year (Table 1).[23] CMS assumes these changes will result in an additional 500 beneficiaries per year participating in the MDPP and, because the MDPP saves money, expects they will thus decrease Medicare spending by $600,000 from 2022 through 2031.[24,25]

The incremental improvements that CMS implemented are not sufficient for adequately harnessing the promise of the MDPP for improving the lives of eligible Medicare beneficiaries who choose to participate. The 1,250 participants that CMS estimates will participate each year following the most recent program changes reflect just one one-hundredth of a percent (0.01%) of the Medicare beneficiaries eligible for the program. Given the number of MDPP providers that participate in the program, this works out to be fewer than 2 Medicare beneficiaries joining at each MDPP provider site. In the 2022 final rule, the agency stated, "While we acknowledge that additional changes will likely be needed in the future to improve access to MDPP, we anticipate that the programmatic adjustments finalized in this rule are likely to result in more

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[16] Ibid.
[17] Medicare Diabetes Prevention Program, CMS (March 2022)
[18] Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. Final rule. CMS-1751-F (November 2021)
[19] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, CMS (updated June 2022)
[20] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Interim final rule with comment period. CMS-1744-IFC. (April 2020)
[21] Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Final rule. CMS-1734-F (December 2020)
[22] MDPP beneficiaries are allowed to either participate in MDPP services virtually during and after a PHE (with no option to later resume MDPP services once in-person services are available due to the once per lifetime limitation) or suspend virtual MDPP services and later resume the set of in-person MDPP services once these are available.
[23] Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. Final rule. CMS-1751-F (November 2021)
[24] Ibid.
[25] CMS does not consider waiving the Medicare enrollment fee as a direct cost in this estimate.

MDPP suppliers, increased beneficiary access to MDPP services, and an ongoing reduction of the incidence of diabetes in eligible Medicare beneficiaries…."[26]

Table 1. Medicare Diabetes Prevention Program Payment Structure

Program activity	Payment prior to 2022	Payment beginning 2022
Core sessions (Months 1–6)		
Attend 1 core session or bridge payment	$26	$35
Attend 4 core sessions	$52	$105
Attend 9 core sessions	$95	$175
Core maintenance sessions (Months 7–12)		
Attend 2 core maintenance sessions in months 7–9		
No 5% weight loss	$15	$70
With 5% weight loss	or $63	or $93
Attend 2 core maintenance sessions in months 10–12		
No 5% weight loss	$15	$70
With 5% weight loss	or $63	or $93
Weight loss achieved		
5% weight loss	$169	$169
9% weight loss	plus $26	plus $35
Ongoing maintenance sessions if weight loss achieved (Months 13–24)		
Attend 2 ongoing maintenance sessions in months 13–15	$52	NA
Attend 2 ongoing maintenance sessions in months 16–18	$52	NA
Attend 2 ongoing maintenance sessions in months 19–21	$53	NA
Attend 2 ongoing maintenance sessions in months 22–24	$53	NA
Maximum payment without 5% weight loss	**$203**	**$455**
Total maximum payment with 9% weight loss	**$704**	**$705**

Note: NA (not applicable). Medicare reimburses MDPP providers a one-time payment, when applicable, called a "bridge payment" if a beneficiary transitions to a new provider after first starting the program with another provider.

Source: HMA analysis of data from Centers for Medicare & Medicaid Services.

Proposed Policy

CMS plans to continue to evaluate the MDPP Expanded Model through September 30, 2024. Annual evaluation reports will provide important insights about the effects of adjustments made to the program. During this time, given the success of the MDPP in preventing or delaying diabetes, improving beneficiaries' quality of life, and reducing Medicare program savings, CMS should quickly act to expand options for increasing both organizations' and beneficiaries'

[26] Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. Final rule. CMS-1751-F (November 2021)

participation in the program. We suggest three potential policies to increase awareness of and participation in MDPP. Each could be considered individually but implementing the policies together would allow them to interact to have the greatest chance of success.

- **Pay for referrals**: CMS could create a new evaluation and management add-on code that would reimburse clinicians $25 for each visit during which they counsel an eligible Medicare beneficiary about pre-diabetes and refer them to an MDPP program. This add-on payment would reimburse clinicians for the time they take to discuss pre-diabetes and the benefits of the MDPP with eligible Medicare beneficiaries and how the program could be integrated into their overall plan of care, as well as non-face-to-face time the clinician and their team spend researching and keeping up-to-date on available MDDP providers and program developments. Evaluations of the Expanded MDPP model have found that clinicians are the largest of source of referrals to MDPP providers, accounting for 44% of all new participants.[27] Billing of this code could be capped to once-per-year for each eligible Medicare beneficiary.
- **Allow all-virtual sessions**: CMS estimates that 57% of eligible Medicare beneficiaries currently reside more than 25 miles from an in-person MDPP provider.[28] In 2020, CMS implemented a temporary flexibility in response to the COVID-19 public health emergency that allowed MDPP providers to provide services by telehealth and will allow this flexibility for future emergencies.[29,30,31] It is unclear the extent to which telehealth may affect the success of the MDPP as results from the second year evaluation of the MDPP Expanded model, which covers 2020, have yet to be released. However, it seems unrealistic to expect that Medicare beneficiaries will enroll in and maintain ongoing participation in a program like MDPP that requires them to travel more than 50 miles roundtrip on a regular basis for a year. While provider enrollment in MDPP is growing, CMS could allow eligible Medicare beneficiaries that reside more than 25 miles from an available in-person MDPP provider to enroll in all-virtual programs and allow MDPP providers to provide these telehealth-based versions of the program to affected beneficiaries. Providing an option to access the MDPP virtually would contribute to CMS's priority of supporting equity by providing flexible access to beneficiaries who live in under-served areas.
- **Increase session payments**: Comments from current MDPP providers and potential providers solicited through rulemaking indicate they face significant cost pressure to

[27] Thomas J. Hoerger, Sara Jacobs, Melissa Romaine, et al. Evaluation of the Medicare Diabetes Prevention Program: First Annual Report (March 2021)
[28] Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. Final rule. CMS-1751-F (November 2021)
[29] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, CMS (updated June 2022)
[30] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Interim final rule with comment period. CMS-1744-IFC. (April 2020)
[31] Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Final rule. CMS-1734-F (December 2020)

provide the approved curriculum for MDPP payment rates.[32,33] In response, CMS shifted payments beginning in 2022 to accommodate a 1-year program rather than a 2-year program and to increase the minimum payment made when participants complete the program but fail to achieve the full weight-loss goal. As a result, providers are paid more per session during the first year. An additional payment increases could attract more providers to the MDPP, thus expanding access for Medicare beneficiaries. CMS set payments for 2022 that range from $455 for completion of the program without achieving weight loss goals to $705 for completion with achievement of the greatest weight loss goal (9% of body weight). Congress could direct CMS to increase payments by 10% in 2025.

Proposed Policy

Medicare could create a mechanism to reimburse clinicians who counsel and refer eligible Medicare beneficiaries to an approved Medicare Diabetes Prevention Program (MDPP) provider. Medicare could also allow participation in a virtual MDPP for beneficiaries who live more than 25 miles from an existing in-person program. Medicare could increase payment rates for the MDPP.

Because the MDPP is a relatively new Medicare benefit with few providers and participants, there is limited data to draw upon to project the effects of these three policies on Medicare program spending. Considering this limitation, we project two scenarios—one where the effects of the proposed policies are more modest and a second where the effects are more robust. The actual effects will depend on the extent to which clinicians opt to provide counseling on pre-diabetes and referrals to MDPP providers, qualified organizations enroll as MDPP providers, and eligible beneficiaries participate in the program (Table 2). All three proposed policies are designed to be somewhat conservative. More ambitious versions of these policies—increasing referral payments to clinicians, allowing all eligible Medicare beneficiaries to choose a virtual MDPP option, and increasing program payments greater than 10%, as well as additional policies beyond those proposed here could yield greater effects.

[32] Ibid.

[33] Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. Final rule. CMS-1751-F (November 2021)

Table 2. Effects of Three Proposed MDPP Policies Will Depend on How Clinicians, Beneficiaries, and Providers Respond

	Modest response scenario	Robust response scenario
Pay for referrals	10% of eligible beneficiaries will be referred each year 3% of people referred will participate in the program	25% of eligible beneficiaries will be referred each year 10% of people referred will participate in the program
Allow all-virtual	1% of eligible beneficiaries who reside more than 25 miles from an in-person provider will participate in an all-virtual program	5% of eligible beneficiaries who reside more than 25 miles from an in-person provider will participate in an all-virtual program
Increase session payments	385 new MDPP providers will be added over 10 years	675 new MDPP providers will be added over 10 years

Potential Savings

Implementing the three Medicare Diabetes Prevention Program (MDPP) policies of paying for referrals, allowing all-virtual programs, and increasing payments beginning in 2025, depending on the extent to which these increase participation, could yield savings to the Medicare program over 10 years of:

$1.4 billion under modest assumptions, or

$18.7 billion under more robust assumptions.

More importantly than the financial savings for the Medicare program, implementing the three proposed MDPP policies would significantly improve the quality of life for many of the beneficiaries who use these services. In addition to preventing or delaying the onset of type 2 diabetes, evaluations have found that beneficiaries who participate in the MDPP are less likely to be hospitalized or have an emergency department visit and may face a lower risk for co-morbid conditions such as hypertension and hypercholesterolemia.[34,35]

[34] Lucia Rojas Smith, Peter Amico, Tom Hoerger, et al. Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring: Third Annual Report (March 2017)

[35] Thomas J. Hoerger, Sara Jacobs, Melissa Romaine, et al. Evaluation of the Medicare Diabetes Prevention Program: First Annual Report (March 2021)

Potential Quality of Care Improvements

Implementing the three Medicare Diabetes Prevention Program (MDPP) policies of paying for referrals, allowing all-virtual programs, and increasing payments beginning in 2025, depending on the extent to which these increase participation, increase the total number of Medicare beneficiaries participating in the MDPP to:

More than 60,000 MDPP participants each year under modest assumptions, or
More than 600,000 MDPP participants each year under robust assumptions.

Increased participation would lead to fewer Medicare beneficiaries developing type 2 diabetes over a 10-year period:

123,000 fewer people would develop diabetes under modest assumptions, or
1.2 million fewer people would develop diabetes under robust assumptions.

Implementing the three proposed MDPP policies may also help the MDPP to better reach disadvantaged Medicare beneficiaries. In the first annual report of the MDPP expanded model, evaluators found that more than 75% of participants are white and not Hispanic or Latino.[36] Policies to increase awareness of and participation in the MDPP could help to expand the program to better serve people in other racial and ethnic groups, who face a greater risk of developing type 2 diabetes.[37] Including an option for accessing the MDPP through telehealth will improve equity for beneficiaries who live in rural and other under-served areas.

Methodology and Assumptions

First, I determined the estimated population eligible for the MDPP by beginning with the total Medicare fee-for-service (FFS) population and then removing the 27% of Medicare FFS beneficiaries who are diagnosed with diabetes. I then estimated that 58% of this remaining population have a BMI above 25 (one of the eligibility criteria for the MDPP), based on data from the literature.

Next, I constructed the estimated Medicare spending for individuals with diabetes. I started with the overall average FFS spending per enrollee per year, using data from the 2022 Medicare Trustees Report. I then used the coefficients from the CMS Hierarchical Condition Category (HCC) and Prescription Drug Hierarchical Condition Category (RxHCC) models for enrollees with diabetes. These coefficients represent the marginal cost of diabetes for the average individual. I applied a 90% weight to HCC 019 / RxHCC 031 (diabetes without complication) and a 10% weight to HCC018 / RxHCC 030 (diabetes with complications). On average, I

[36] Thomas J. Hoerger, Sara Jacobs, Melissa Romaine, et al. Evaluation of the Medicare Diabetes Prevention Program: First Annual Report (March 2021)
[37] National Diabetes Prevention Program: About Prediabetes & Type 2 Diabetes, CDC

estimate diabetes will increase Medicare FFS spending by approximately $2,000 to $3,200 per person per year and Part D spending by approximately $120-$175 per person per year over the 10-year period from 2025 to 2034.

Then, I determined the baseline forecast for the current MDPP program, including the modifications that CMS implemented in 2022. CMS estimates approximately 1,250 FFS enrollees will participate in 2022. I trended these numbers forward using the historical growth patterns that we derived from the recent independent evaluations of the MDPP.

As noted above, I evaluated the effects of each of the three policy proposals given two possible scenarios—a modest and a robust response. The combined effects increase total participation in the MDPP and reduce the number of FFS beneficiaries who develop type 2 diabetes over the 10-year period from 2025 to 2034. I applied my annual per person per year estimated cost of diabetes care to these individuals to determine the total savings associated with the prevention of diabetes.