Evidence for Community-Based Approaches to Weight Loss: A Case for Revising the Centers for Medicaid and Medicare Services Reimbursement Structures

To the Editor: In a recent issue, Katula and colleagues[1] report an RCT that demonstrated the effectiveness of a community-based lifestyle intervention on weight, waist circumference, insulin resistance, and blood glucose up to 2 years. In addition to achieving long-term effects that were on par with the Diabetes Prevention Program lifestyle intervention,[2] the intervention was elegantly designed to be implemented in a manner to facilitate sustainability in a real-world community setting. The intervention was conducted in community parks and recreation centers where kitchens and communal space were utilized for cooking demonstrations, exercise classes, and group meetings. Lifestyle interventions can be resource-intensive, but community settings often have the space and resources for this type of programming. To offset costs, interventionists were community health workers trained by registered dietitians. The intervention was also of sufficient intensity and dose to allow participants ample time to learn and practice the behavioral strategies that studies have demonstrated to be key to weight loss. Their findings add to the growing body of research supporting the effectiveness of lifestyle interventions when implemented at sufficient intensity by highly trained staff in settings accessible to the intended participants.[2] Community approaches are particularly crucial to reducing health disparities in diverse populations.[3]

Unfortunately, current reimbursement structures for lifestyle interventions are incompatible with this research. In 2011, the Centers for Medicaid and Medicare Services (CMS) released a decision to cover behavioral counseling for obesity, but limit coverage to primary care physicians (PCPs) in the primary care setting.[4] In the open-comment period that preceded the decision, several organizations, including the Society of Behavioral Medicine, argued that the proposed coverage was too narrow, citing studies demonstrating effectiveness outside the primary care setting.[2,5] CMS stood firm in keeping coverage limited.

Effectiveness trials like Katula et al.[1] show that evidence-based programs can be effectively implemented in a variety of settings and by a wide range of providers, many of whom are less costly and more accessible than PCPs. That community health workers can be trained to deliver lifestyle interventions is good news in the context of spiraling healthcare costs. PCPs bill at much higher rates, have limited time for counseling, and their training does not typically cover nutrition, physical activity, and behavioral modification. Further, the primary care setting is not ideal from a physical standpoint given that lifestyle interventions often involve group-based counseling and are enhanced with cooking demonstrations and exercise instruction and classes. Community settings where successful effectiveness studies have been performed include YMCAs[2] and psychiatric rehabilitation centers,[6] each of which have the appropriate facilities.

Katula et al.[1] and other community-based intervention studies[3] strongly make the case for a revision of the CMS decision to incorporate coverage by community health workers and healthcare professionals employed in community settings. This is highly consistent with the evidence and a promising approach to reducing obesity health disparities. Unless major revisions are made to extend CMS coverage, the population impact of this work and the CMS decision are likely to be minimal.

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