

# POLICY BRIEF

## The Society of Behavioral Medicine position statement on the CMS decision memo on intensive behavior therapy for obesity

Translational Behavioral Medicine

By Sherry L. Pagoto, PhD, Lori Pbert, PhD, University of Massachusetts Medical School; Karen Emmons, PhD, Harvard School of Public Health; Dana Farber Cancer Institute; on behalf of the Society of Behavioral Medicine Public Policy Leadership Group

The citation is: Centers for Medicare and Medicaid Services. Decision memo for intensive behavioral therapy for obesity. 2011. (Accessed August 22, 2012, at <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253&>)

### POLICY RECOMMENDATION

1. Expanding the Centers for Medicare and Medicaid Services (CMS) policy on behavioral therapy for obesity to providers other than primary care physicians is likely to expand reach.

### RESEARCHS AND PRACTICE RECOMMENDATIONS

1. Research is needed to determine if the nature (intensity, setting, and provider) of behavioral therapy for obesity as covered in the CMS decision is efficacious.
2. The CMS decision to cover behavioral therapy for obesity allows primary care physicians the opportunity to bill for this service. Training should be offered as part of medical education.

### ABSTRACT

In 2011, the Centers for Medicare and Medicaid Services (CMS) issued a decision to cover intensive behavior therapy for obesity in the primary care setting. The Society of Behavioral Medicine (SBM) Public Policy Leadership Group reviewed the CMS decision and has issued a position statement. SBM is in support of the CMS decision to cover intensive behavior therapy for obesity but expresses significant concern that aspects of the decision will severely limit the impact of the decision. Concerns focus on the degree to which this care can be feasibly implemented in its current form given the limitations in providers who are covered and the short length of counseling visits relative to evidence-based protocols. SBM is in strong support of modifications that would include providers who have expertise in weight control (e.g., psychologists and dietitians) and to expand the treatment time to better match protocols with confirmed efficacy.

### KEYWORDS

Obesity, Policy, Behavioral interventions, Weight loss

The Society of Behavioral Medicine (SBM) is in support of the Centers for Medicare and Medicaid Services' (CMS) decision to cover intensive behavior therapy for obesity [1] but expresses significant concern that aspects of the decision will severely limit the impact of the decision. The details of the decision are as follows:

CMS will cover screening and intensive behavioral counseling for obesity by primary care providers in the primary care setting for Medicare beneficiaries with a body mass index of  $\geq 30$  kg/m<sup>2</sup>.

Specifically, Medicare will cover one face-to-face visit every week for the first month (four visits), one face-to-face visit every other week for months 2–6 (twelve visits), and one face-to-face visit every month for months 7–12 (six visits), if the beneficiary has achieved a reduction in weight of at least 3 kg over the course of the first 6 months of intensive therapy. A total of 22 visits of 10–15 min in length over the course of the year can be covered.

The service must be furnished by a “qualified primary care physician or other primary care practitioner and in a primary care setting.” CMS defines “primary care practitioner” as a physician with a primary specialty designation of family medicine, internal medicine, geriatric or pediatric medicine or a nurse practitioner, clinical nurse specialist, or physician assistant in accordance with the Social Security Act. The service must be furnished in the primary care setting.

Lifestyle intervention, which involves multiple visits that include behavioral modification, nutrition counseling, and exercise counseling,

### BOTTOM LINE:

SBM is in support of behavior therapy for obesity being a reimbursable health care service, however is concerned about the degree to which it can be feasibly implemented in its current form given the limitations in providers who are covered and the length of counseling time being significantly shorter than in evidence-based protocols.

has been shown effective via several large randomized clinical trials [2, 3]. A weight loss of 7 % has been shown to reduce risk for type 2 diabetes and cardiovascular disease as well as incur a host of other health benefits [2, 3]. In 2003, the intensive lifestyle intervention received a B rating by the US Preventive Services Task Force [4]. That third party payers have not covered this service has limited implementation in healthcare settings, thus leaving primary care physicians without referral sources. The current CMS decision is a small step toward resolving that conflict, although it has significant limitations that may have serious implications for its potential impact.

When CMS opened comment on the proposal for coverage of behavior therapy for obesity, SBM responded by raising the concern that limiting coverage to primary care physicians may limit access to treatment given that “PCPs have short appointment times, often lack space for group-based programs, lack training in delivering behavior therapy protocols, and are currently in short supply in the USA” [5, 6]. SBM also noted that this could result in insufficient treatment intensity and insufficient impact on minorities who already have access barriers. SBM also raised the concern that behavioral medicine professionals have developed behavior therapy for obesity, often deliver it in the trials that tested its efficacy, and are more cost-effective than primary care physicians. CMS responded to these concerns by emphasizing that “these preventive services should be furnished in a coordinated approach as part of a comprehensive prevention plan within the context of the patient’s total health care. Primary care practitioners are characterized by their coordination of patient’s comprehensive healthcare needs. Primary care practitioners are generalists who are specifically trained to provide primary care services. Other provider specialties may provide patient care in other settings but do not offer care in the context of being the coordinator of the patient’s healthcare needs, not limited by problem origin or diagnosis. Coordination of health services is especially important in the presence of the coexisting health issues of our Medicare beneficiaries. In the primary care office setting, Medicare may cover these services when billed by the primary care physician or practitioner and furnished by auxiliary personnel.” While we agree that preventive services should be furnished in coordination with the primary care physician, models for delivering this care that appropriately reimburse professionals with expertise in behavior therapy for obesity are now needed. Psychologists and other allied health care professionals working in primary care settings must bill for their services and therefore cannot be considered auxiliary personnel but should have the opportunity to furnish this service.

The second feature that may limit the impact of the CMS decision is that the length of visit that is reimbursable is 10–15 min. In the randomized trials that established the efficacy of behavior therapy, visit length was typically 60 min [7, 8]. The content in standard protocols (e.g., LEARN [9], Diabetes Prevention Program Lifestyle Intervention [7]) is too intensive to be delivered in the length and duration of visits that will be covered. Research is still needed to determine whether such an abbreviated intervention is efficacious.

In summary, SBM is in support of behavior therapy for obesity being a reimbursable health care service. While the CMS decision is a step in that direction, we are concerned about the degree to which it can be feasibly implemented in its current form given the limitations in providers who are covered and the length of counseling visits being significantly shorter than in evidence-based protocols. SBM is in strong support of modifications that would include providers who have expertise in weight control (e.g.,

psychologists and dietitians) and to expand the treatment time to better match protocols confirmed to be efficacious.

1. Decision memo for intensive behavioral therapy for obesity. 2011. (Accessed August 22, 2012, at <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=2538>.)
2. Look AHEAD Research Group. Reduction in weight and cardiovascular disease risk factors in individuals with type 2 diabetes: one-year results of the Look Ahead trial. *Diabetes Care*. 2007;30(6):1374-83.
3. DPP Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *The New England Journal of Medicine*. 2002;346(6):393-403.
4. U.S. Preventive Services Task Force. Screening and interventions for overweight and obesity in adults. Rockville, MD: Agency for Healthcare Research and Quality; 2003. Report No.: 00-4084.
5. Schwartz M, Durning S, Linzer M, Hauer K. Changes in medical students' views of internal medicine careers from 1990 to 2007. *Archives of Internal Medicine*. 2011;171(8):744-9.
6. Bodenheimer T. Primary care—will it survive? *The New England Journal of Medicine*. 2006;355(9):861-4.
7. DPP Research Group. The Diabetes Prevention Program (DPP): description of lifestyle intervention. *Diabetes Care*. 2002;25(12):2165-71.
8. Look Ahead Research Group. Look AHEAD (Action for Health And Diabetes): design and methods for a clinical trial of weight loss for the prevention of cardiovascular disease in type 2 diabetes. *Controlled Clinical Trials*. 2003;24:610-28.
9. Brownell K. *The Learn program for weight management*. 10th ed. Eulless: American Health Publishing Company; 2004.