

Medicare Diabetes Prevention Program: Where Are the Suppliers?

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CMS enacted Medicare coverage of the Medicare Diabetes Prevention Program (MDPP) in April 2018,¹ offering an unprecedented opportunity to reach the estimated 48.3% of older adults with prediabetes.² The MDPP is a structured group class promoting lifestyle change for weight loss¹; it closely follows the evidence-based National Diabetes Prevention Program (NDPP) that has been disseminated by the CDC since 2012.³ Success of the MDPP is critical to diabetes prevention efforts and will likely influence Medicaid and private-payer coverage, as well as determination of other preventive benefits. Initial success may largely depend on having adequate suppliers to ensure beneficiary access. Becoming a designated MDPP supplier is fairly straightforward: MDPP suppliers must participate in the CDC's Diabetes Prevention Recognition Program⁴ to ensure fidelity and pay the standard Medicare Enrollment Application Fee with their application to CMS. To facilitate availability, trained laypersons can provide MDPP services, and suppliers may include community-based organizations and other nontraditional settings.¹

Numerous MDPP suppliers are needed nationwide to serve the estimated 29.5 million Medicare beneficiaries with prediabetes. Inadequate provider payment has been identified as a potential deterrent to increasing the number of suppliers.⁵⁻⁷ Using the MDPP's pay-for-performance reimbursement schedule, which is based on attendance and weight loss outcomes,⁸ estimates show that less than a quarter of service delivery costs may be reimbursed by CMS.^{5,6} Performance-based payments may especially deter suppliers serving racial/ethnic minority populations, who have low attendance and weight loss in the NDPP⁹ yet disparately high diabetes prevalence.² Little is known about early uptake of the MDPP in practice. In this study, we evaluate MDPP access after the first 15 months of the benefit's coverage.

METHODS

We conducted a descriptive analysis of MDPP access using data extracted from the CMS registry of MDPP suppliers as of July 2019,¹⁰ more than a year after CMS enacted the covered benefit.¹

ABSTRACT

OBJECTIVES: The Medicare Diabetes Prevention Program (MDPP) launched in April 2018, offering an unprecedented opportunity to reach the estimated 48.3% of older adults with prediabetes. Success of the innovative policy is likely to depend on adequate supplier availability. We examined supplier data from CMS to assess beneficiaries' potential access to MDPP services.

STUDY DESIGN: We conducted a descriptive analysis of MDPP suppliers using data extracted from the CMS registry of suppliers as of July 2019 and data about beneficiary populations.

METHODS: Identifying the location, type, and number of MDPP suppliers and their respective sites, including within states, US territories, and the District of Columbia (hereafter, *states*), we mapped geographic coverage of MDPP access.

RESULTS: There are 126 unique supplier organizations that offer the MDPP across 601 sites, equating to only 1 site per 100,000 Medicare beneficiaries. Seventy-five percent of states have no MDPP sites, fewer than 1 site per 100,000 beneficiaries, and/or availability limited to a single municipality. Although only 10.3% of MDPP suppliers are community-based organizations, they represent more than half (55.7%) of sites where beneficiaries can access the program.

CONCLUSIONS: Findings show inadequate MDPP access, with relatively few suppliers and locations where beneficiaries can receive services. Insufficient reimbursement relative to costs for suppliers may largely account for limited availability. Strategies to facilitate access are urgently needed, which may include partnering with large organizations for greater per capita reach and rural organizations for broader geographic coverage, along with setting fiscally sustainable rates based on refined program implementation and cost analysis.

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We examined the number of MDPP suppliers and their respective site locations. Because a single supplier can offer the MDPP at multiple sites, site availability was a primary indicator of access. We measured access by the number of MDPP sites per 100,000 Medicare beneficiaries (nearly half of whom may be MDPP eligible based on having prediabetes²) within states, US territories, and the District of Columbia (hereafter, *states*). To assess the most critical gaps in MDPP access, we identified states as having (1) no MDPP sites, (2) fewer than 1 MDPP site per 100,000 beneficiaries, or (3) MDPP site(s) limited to a single municipal area. To assess potential reach to racial/ethnic minority populations, we determined the frequency of these critical MDPP shortages in states with the largest populations of Hispanic, African American, and Native American/Alaska Native beneficiaries. Based on frequency measures and site locations, we mapped geographic coverage of MDPP access. We also examined supplier type (eg, health care system, community-based organization) and their number of respective sites to better understand early patterns in MDPP supply. Finally, we calculated the percentage of organizations as of July 2019 that offer the in-person NDPP and are listed in the CDC's recognition program,¹¹ a prerequisite to MDPP designation.¹

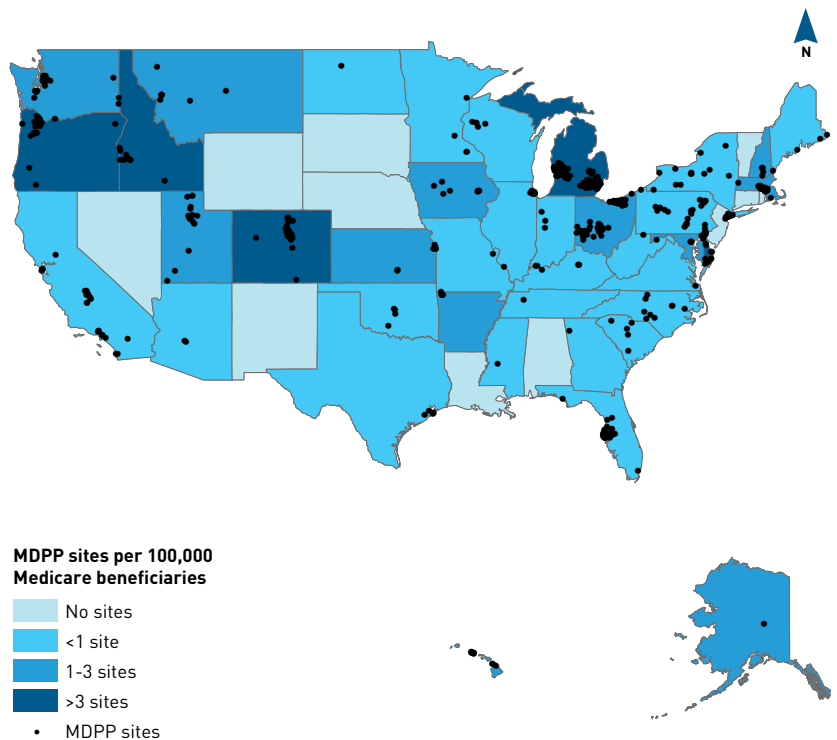
RESULTS

There are 126 unique supplier organizations that offer the MDPP across 601 sites. With an estimated 61 million Medicare beneficiaries in 2019,¹² this equates to 1 site per 100,000 Medicare beneficiaries nationwide. The **Figure**^{10,13} shows geographic and population-based availability of the MDPP. Thirty-nine states (69.6% of the United States) have at least 1 MDPP site, and more than half (22) of these have fewer than 1 site per 100,000 Medicare beneficiaries. There are no sites in 11 states (Alabama, Connecticut, Louisiana, Nebraska, Nevada, New Jersey, New Mexico, Rhode Island, South Dakota, Vermont, Wyoming) and no sites in DC or US territories. Only 5 states (Colorado, Delaware, Idaho, Michigan, Washington) have more than 3 sites per 100,000 Medicare beneficiaries, together averaging 5.5 sites per 100,000 beneficiaries. Geographic coverage is limited such that many beneficiaries appear to lack MDPP access even if their states have sites available. Specifically, sites in 11 states (Alaska, Arizona, Arkansas, Georgia, North Dakota,

TAKEAWAY POINTS

- ▶ Despite the Medicare Diabetes Prevention Program (MDPP) now being a covered benefit, there is inadequate supplier availability to reach the estimated 29.5 million Medicare beneficiaries with prediabetes.
- ▶ Severe shortages of MDPP providers in US states/territories with the largest populations of racial/ethnic minority beneficiaries merit particular attention to address health disparities.
- ▶ Insufficient reimbursement relative to costs for suppliers may largely account for limited availability. Setting fiscally sustainable rates amid further cost analysis may be needed to attract more suppliers.
- ▶ Innovation to allow community-based organizations to serve as MDPP suppliers appears to be beneficial.

FIGURE. Nationwide Availability of MDPP Sites as of July 2019^{10,13,a}



MDPP, Medicare Diabetes Prevention Program.

^aAuthors' analysis of MDPP data obtained from CMS¹⁰ and presented based on the number of Medicare beneficiaries in 2018 as reported by the Kaiser Family Foundation.¹³ US territories have no MDPP sites and are not depicted here.

Missouri, Mississippi, Tennessee, Texas, Virginia, Wisconsin) are all located within a single municipality. For example, Texas, the second largest state and with the third most Medicare beneficiaries,¹³ has only 4 sites clustered in a single municipal area. In total, 75% of the United States has no MDPP sites, fewer than 1 site per 100,000 beneficiaries, and/or availability limited to a single municipality. Regarding gaps in potential to reach racial/ethnic minority populations, 90% of the 10 states with the largest population of Hispanic,

TRENDS FROM THE FIELD

TABLE. Number and Frequency of MDPP Suppliers and Sites by Organization Type^{10,a}

Organization type	Suppliers		Sites	
	n	%	n	%
Health care clinic/hospital/system	83	65.9	171	28.5
Community-based organization	13	10.3	335	55.7
Public health department/county	12	9.5	36	6.0
Health plan	3	2.4	31	5.2
Private wellness company	7	5.6	14	2.3
University	6	4.8	11	1.8
Pharmacy	2	1.6	3	0.5
Total	126	-	601	-

MDPP, Medicare Diabetes Prevention Program.

^aAuthors' analysis of MDPP data obtained from CMS.¹⁰

African American, or Native American beneficiaries¹³ have severe MDPP shortages.

The [Table¹⁰](#) shows the number and frequency of MDPP suppliers and their respective sites by type of supplier. Notably, although only 10.3% of MDPP suppliers are community-based organizations, they represent more than half (55.7%) of sites where beneficiaries can access the program. Nationwide, the Young Men's Christian Association (YMCA) is the largest supplier with 147 MDPP sites, including 53 of 58 Ohio sites and 34 of 40 Florida sites. The YMCA's participation in the original CMS demonstration project¹⁴ may have facilitated its participation in the MDPP. Michigan has the most MDPP sites in the United States, nearly all of which (141 of 145) are operated by the National Kidney Foundation of Michigan. Otherwise, only 10% of organizations that offer an in-person NDPP and are currently listed in the CDC's recognition program¹¹ appear to have become MDPP suppliers.

DISCUSSION

Findings show inadequate MDPP access, with relatively few suppliers and locations where beneficiaries can receive services. Geographic coverage is especially limited, which is a major access barrier given that the benefit has been for in-person classes only.¹ For example, California, the most populous state and the state with the most (6.2 million) Medicare beneficiaries,³ has only 25 MDPP sites across 6 municipalities. Yet even if all 601 sites currently in the United States were well distributed across California and each had an annual capacity to enroll 500 participants, only 10% of California's beneficiaries with prediabetes would have MDPP access within a year. Moreover, there are notable access gaps in states/territories with the largest populations of Hispanic, African American, or Native American beneficiaries, suggesting that the MDPP will encounter barriers to better addressing existing health disparities. Nonetheless, encouraging community-based organizations to become Medicare suppliers appears to be a relatively successful component of the MDPP policy, contributing to a majority of site availability.

Insufficient performance-based reimbursement to MDPP suppliers may explain this limited availability. Per CMS policy, a maximum of \$689 was paid per participant in 2019, including up to \$485 for first-year services and \$204 for second-year services.⁸ One safety net health system estimated an average of \$108 in reimbursement relative to \$553 in year 1 delivery costs per participant,⁵ whereas another estimated \$139 in reimbursement for \$800 in year 1 costs using 2018 rates, which provided up to \$470 for first-year services¹ (second-year reimbursement/cost estimates are unknown).⁶ Using national trends in NDPP outcomes, the average performance-based payment is estimated to be slightly higher at \$190 for first-year services.⁵ Although costs may vary by factors such as setting, staffing, and population served, MDPP payments are likely inadequate for the vast majority of MDPP suppliers. Moreover, performance-based rates as currently structured may exacerbate health disparities by dissuading suppliers from entering markets with especially high-risk populations who are less likely to achieve performance payment milestones.^{5,6} Many small rural organizations are also needed to increase geographic reach, yet rural areas may incur disproportionately higher per-participant costs, further deterring access in rural areas.

Limitations

This study is limited to analysis of publicly available data on MDPP suppliers/sites and does not examine uptake among beneficiaries, which is needed to fully assess the impact of the MDPP.

This study also does not evaluate enrollment capacity of MDPP suppliers, which may be an important factor regarding access. Up to 50 participants per NDPP class has been considered reasonable,¹⁵ with larger classes having potential to maximize reach. Furthermore, supplier and site availability may frequently change, and more time may be needed to fully evaluate initial success of the MDPP based on these measures of geographic coverage. Overall, the NDPP appears to have grown substantially since it was first launched in 2012, and more time may similarly be necessary to improve availability of the MDPP. At the same time, while the MDPP remains under the umbrella of the CMS Innovation Center, suppliers may be hesitant to establish MDPP services because coverage may be discontinued. What constitutes optimal availability of suppliers/sites is also unknown, as it is uncertain what percentage of Medicare beneficiaries would want to participate in the MDPP among those eligible for the program, who are required to have overweight/obesity in addition to prediabetes (and no end-stage renal disease or history of type 1 or 2 diabetes).¹ Current evidence suggests there is substantial potential demand given the high prevalence of prediabetes in Medicare beneficiaries² and previous findings that nearly half of patients with diabetes risks enrolled in the NDPP upon referral by their health care providers.¹⁶

CONCLUSIONS

The new Medicare-covered diabetes prevention benefit is groundbreaking and much needed, yet millions of beneficiaries with

prediabetes appear to lack access. Strategies to facilitate access may include partnering with large organizations for greater per capita reach and rural organizations for broader geographic coverage, along with setting fiscally sustainable rates based on refined cost analyses. Current estimates of future health care cost savings suggest that the MDPP is a high-value service,^{17,18} and a combination of increased payment rates and risk-adjusted payment models appears to be needed to attract adequate MDPP suppliers to provide access to all Medicare beneficiaries. Extending coverage to virtually delivered programs, which have shown comparable weight loss outcomes to in-person programs, may also be necessary.¹⁹ To prevent diabetes nationwide, we need to support early momentum for this critically important Medicare program while planning ahead to ensure benefit access, long-term sustainability, and a robust model for expanded Medicaid and private-payer coverage. ■

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