Session Title: Medicaid Coverage for the National Diabetes Prevention Program: An Unfinished Symphony

Session Coordinators:
• Jean Gearing, PhD, MPH
• Jennifer Barnhart, MPH, National Association of Chronic Disease Directors

1815/1817 Category A Virtual Showcase
Presentation Date (February 2, 2022)
Medicaid Coverage for the National Diabetes Prevention Program: An Unfinished Symphony

- Introduction & Facilitation: National Association of Chronic Disease Directors
  - Jennifer Barnhart, MPH
- Maryland’s HealthChoice and Public Health Collaboration
  - Kristi Pier, MHS, MCHES
- Medicaid Coverage for the National Diabetes Prevention Program: A New York Story
  - Susan Millstein, MSW, MPH
  - Philip Pittman, MPH, MS
- Medicaid Beneficiary Enrollment Pilot: Creating a Pathway for National Diabetes Prevention Program Sustainability in Rhode Island
  - Benvinda Santos, MPA

- Question and Answer
  - Jean Gearing, CDC
Maryland’s HealthChoice and Public Health Collaboration
Centers for Disease Control and Prevention
Category A Virtual Showcase

Kristi Pier, MHS, MCHES
Director, Center for Chronic Disease Prevention and Control

February 2, 2022
Objectives

• Identify the role of public health in supporting the development and implementation of the HealthChoice DPP
  • HealthChoice DPP is based on the National Diabetes Prevention Program Lifestyle Change Program

• Identify 2-3 aspects that support integrated public health and Medicaid collaborations

• Understand the current structure of the Maryland HealthChoice DPP
The start of a lovely partnership

• Laying the groundwork for Medicaid and public health collaboration
• Seizing opportunities–1305 and CDC/National Association of Chronic Disease Directors (NACDD) Diabetes Prevention Demonstration Project
• Building on expertise
• Identifying roles based on traffic lanes
• Ongoing communication
• Dedicated staff support
Demonstration to Coverage Timeline

- **July 2016**: Medicaid and National DPP Demonstration Begins
- **Jan. 2018**: Demonstration Enrollment Ends, New DPP Provider Type Requested
- **Nov. 2018**: Demonstration Debrief, Coverage 2.0 Begins
- **Jan. 2019**: DPP Provider Type Established, Capstone Meeting, Executive Summary Available, Demonstration Ends
- **Sept. 2019**: HealthChoice DPP Starts
Maryland Medicaid (January 2022)

**Fiscal Impact**
- Approximately $13.5 billion in state and federal funds
- Typically accounts for about 24% of State budget

**Reach**
- Provides benefits for approximately 1.6 million people
  - 1.4 million (87%) are enrolled in HealthChoice
  - 427,356 adults are enrolled as a result of the Affordable Care Act Medicaid expansion
Maryland HealthChoice National DPP

Statewide implementation of the National DPP LCP through HealthChoice Managed Care Organizations (MCOs)

Required changes to Maryland Medicaid regulations

Built into MCO capitation rates

Aligns with CDC Diabetes Prevention Recognition Program (DPRP) eligibility criteria

Closely aligns with the Medicare Diabetes Prevention Program (MDPP) Expanded Model

Includes both in-person and virtual CDC-recognized organizations

Effective Date: September 1, 2019
National DPP Provider Enrollment

- New Provider Type
- Provider Enrollment in ePREP (electronic Provider Revalidation and Enrollment Program)
- Contracting with MCOs
Overview of the Public Health and Medicaid roles to support HealthChoice DPP implementation

CDC-recognized National DPP provider training on how to enroll in Medicaid

- MDH National DPP Website: https://health.maryland.gov/mmcp/Pages/HealthChoice-DPP.aspx
- Technical Assistance offered through the Center for Chronic Disease Prevention and Control
- Facilitated 8 information sessions for new Medicaid-enrolled National DPP providers to meet with MCOs and describe their programs in order to facilitate potential contracting

CDC-recognized National DPP provider supports (e.g., business plan assistance, facilitating meetings between providers and MCOs)

- Monthly meetings with MCOs, Maryland Medicaid, and Maryland Public Health
- Workshop Wizard: Data management and new claims report functionality (837p)

Algorithm development to identify potentially eligible HealthChoice DPP participants

- Developed by the Hilltop Institute at UMBC concurrently with prediabetes flag development by CRISP (Statewide HIE)

Use of Chesapeake Regional Informational Systems for Our Patients (CRISP) -- statewide HIE to alert providers about potentially eligible HealthChoice DPP participants

- Care Alerts (those with prediabetes or at risk for type 2 diabetes)
- Smart Alerts (reports to MCOs of those members receiving Care Alerts)
CRISP/Medicaid Collaborations

Prediabetes Flag
- Aligned prediabetes flag logic with Medicaid’s eligibility algorithm
- Worked with MCOs to develop uniform:
  - Care Alert language
  - Smart Alert reporting structure and secure methods for transferring the reports.

Referrals to HealthChoice DPP
- Part of broader statewide collaborative workgroup discussing how to map referrals, including Workshop Wizard integration, with input from the Medicaid perspective
- Supporting onboarding of MCOs as intermediaries
- Convening Regional Partnerships and MCOs to build relationships around referrals and hand-offs and to share best practices and challenges
Developing a Prediabetes Flag

Scope of Work:

• CRISP developed a prediabetes (or an at-risk for type 2 diabetes) flag based on the following use cases:

  • Clinicians see the flags at the point of care and can take appropriate action to address the condition (e.g. referral to HealthChoice Diabetes Prevention Program (National DPP LCP))

  • Flags will enable population-based reporting on individuals with prediabetes (or at-risk for type 2 diabetes), in support of the Maryland Total Cost of Care Model’s population health goal related to diabetes prevention.
Initial Results

- Care Alerts went live in June 2021
- Initially identified ~75,000 individuals who were likely eligible for HealthChoice DPP
  - Care Alerts created and updated monthly
- 9 MCOs receiving monthly Smart Alert reports
  - Continuously updated
  - About 14,000 new/updated individuals last month
Next steps for HealthChoice DPP in Maryland

Sustainability with focus on:

• Increased number of CDC-recognized National DPP providers engaged and participating Medicaid MCOs
• Increased member enrollment and retention for HealthChoice DPP
• Continued MCO collaboration and capacity-building; public health partnership for CDC-recognized National DPP provider network development
• CRISP: National DPP Referral Tool and Reporting Refinement around prediabetes flag care alerts
Resources/Contact

• HealthChoice DPP Website: [https://mmcp.health.maryland.gov/Pages/HealthChoice-DPP.aspx](https://mmcp.health.maryland.gov/Pages/HealthChoice-DPP.aspx)

• HealthChoice DPP Email: [MDH.MedicaidDPP@maryland.gov](mailto:MDH.MedicaidDPP@maryland.gov)

• Medicaid:
  - Sandy Kick, Senior Manager, [sandra.kick@maryland.gov](mailto:sandra.kick@maryland.gov)
  - Liz Herrick, Policy Analyst, [elizabeth.herrick@maryland.gov](mailto:elizabeth.herrick@maryland.gov)

• Public Health
  - Kristi Pier, Director, Chronic Disease, [kristi.pier@maryland.gov](mailto:kristi.pier@maryland.gov)
Medicaid Coverage for the National Diabetes Prevention Program (National DPP): A New York Story

1815/1817 Virtual Showcase
Introduction
## Agenda

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<tr>
<td>Overview of steps to coverage</td>
</tr>
<tr>
<td>Implementation and beyond</td>
</tr>
</tbody>
</table>
Background
Background

• In New York State (NYS), diabetes rates have almost tripled over the past two decades.

• An estimated 1.4 million adult New Yorkers (10.5%) have been diagnosed with prediabetes.

• You are more likely to report being diagnosed with prediabetes if you are:
  • living with obesity, older, Black, a person living with a disability, living in New York City

• In 2014, NYS Medicaid spent $1.2 billion on diabetes-related expenses for 460,000 beneficiaries with diabetes.
Overview of Steps to Coverage
Timeline

Relationship-building/Making the case


CDC/NACDD Medicaid National DPP Intensive TA grant
July 2019 – July 2021
Implementation and Beyond
Implementation

• Kick-off Webinar

• Establishment of dedicated e-mailbox for National DPP inquiries

• Medicaid Managed Care Plan Quarterly Meeting with Medical Directors

• Statewide Symposia
Implementation

- National DPP LCP Fact Sheet for Medicaid members
- eMedNY (electronic Medicaid of NY) Provider Enrollment Webinar
- Bronx Project
Beyond.....

- Managed Care Organization contracting challenges
- Organization-level administrative and billing capacity challenges
- Network adequacy (enough National DPP providers in a region)
- Enrollment and retention
- COVID-related telehealth expansion
Thank you!

Please contact me with questions

<table>
<thead>
<tr>
<th>Presenter</th>
<th>Contact Information</th>
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</table>
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Diabetes Program Manager  
[Susan.Millstein@health.ny.gov](mailto:Susan.Millstein@health.ny.gov) | **NYS Department of Health**  
**Bureau of Community Chronic Disease Prevention**  
**150 Broadway, Suite 350**  
**Albany, NY 12204**  
**518-408-5142** |
Medicaid Coverage for the National Diabetes Prevention Program (National DPP) & Diabetes Self-Management Education and Support (DSMES) in Illinois

Philip Pittman, MPH, MS
Chronic Disease Epidemiologist
Illinois Department of Public Health

February 2, 2022

Contributors
Cara Barnett, MPH – Illinois Department of Public Health
Wendy Childers, MPH, MA – National Association of Chronic Disease Directors
Janna Simon, MPH – Illinois Public Health Institute
Medicaid Coverage of
The National DPP and DSMES in Illinois

• Coverage began August 1, 2021
• Partners involved in achieving coverage
  – Illinois Public Health Institute (IPHI)
  – Illinois Department of Healthcare and Family Services (DHFS)
  – Illinois Department of Public Health (IDPH)
  – Managed Care Organizations in Illinois (MCO)
  – U.S. Centers for Disease Control and Prevention (CDC)
  – National Association of Chronic Disease Directors (NACDD)
  – County Health Rankings and Roadmaps
  – National Network of Public Health Institutes (NNPHI)
  – Meridian Health
  – Federally Qualified Healthcare Centers (FQHCs)
  – Chicago Department of Public Health (CDPH)
  – Statewide National DPP Partners
How We Arrived at Coverage
2014

- Illinois Public Health Institute (IPHI) received a $5,000 grant from County Rankings and Roadmap to start discussion about Medicaid coverage of the National DPP lifestyle change program (LCP)

- Initial convening with Illinois Departments of Healthcare and Family Services and Public Health, Medicaid Managed Care Organizations (MCOs), and National DPP providers

- Initiated a roadmap to coverage for the state
How We Arrived at Coverage 2015 - 2017

- Further developed the roadmap toward a pilot project and toward coverage with additional grants

- Convenings with partners
  - Conducted research
  - Worked with NACDD on the concept of a hub
How We Arrived at Coverage 2018

• Cooperative agreement funding awarded by CDC
  • Illinois Department of Health (IDPH) - 1815
  • Chicago County Department of Public Health - 1817
    (IPHI acting as bona fide agent)

• Illinois joined the CDC/NACDD 6|18 cohort focusing on Medicaid coverage for the National DPP LCP.
  • IDPH and DHFS collaboratively applied for 6|18
  • Technical assistance and coordination from NACDD
  • Learning opportunities from other states’ experiences
  • IPHI played a central role in coordination
How We Arrived at Coverage
2019 - 2020

- **Fall 2019** - DHFS decided to proceed with initiating Medicaid coverage of the National DPP LCP and DSMES

- IPHI, IDPH, and stakeholders provided recommendations for coverage to DHFS, including amending the State Medicaid Plan

- A pilot project began with an MCO and National DPP providers to test the exchange of data and referrals
How We Arrived at Coverage 2020 - 2021

Pilot with Meridian Health MCO and FQHCs offering the National DPP LCP

Who
• Funded by Meridian Health Plan (MCO) in partnership with the Illinois Public Health Institute (IPHI).
• 4 CDC-recognized FQHCs

Why
• Shape and test proposed National DPP Medicaid benefit design

How
• Documented and identified effective recruitment strategies
• Implemented mock claims and data sharing processes

Outcomes
Pilot revealed key gaps in systems related to data-sharing, referrals, staff awareness/engagement, and checking for Medicaid eligibility
How We Arrived at Coverage 2021

• Medicaid coverage of both the National DPP LCP and DSMES announced in the spring

• Focus shifted to implementation in the summer

• Coverage started August 1, 2021

• Illinois awarded a one-year $100,000 NACDD Medicaid Beneficiary Enrollment Project grant supported by CDC
<table>
<thead>
<tr>
<th>Session/Event</th>
<th>HCPCS Code and Description</th>
<th>Payment</th>
<th>Virtual or Telehealth Modifier</th>
<th>Virtual or Telehealth Make-Up Session Modifier</th>
<th>Limitation</th>
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</thead>
<tbody>
<tr>
<td>Milestone 1</td>
<td>G9873 – 1st core session attended</td>
<td>$180 GT</td>
<td>None</td>
<td>Can be used 1 time in 355 days</td>
<td></td>
</tr>
<tr>
<td>Milestone 2</td>
<td>G9874 – 4 total core sessions attended</td>
<td>$150 GT</td>
<td>VM</td>
<td>Can be used 1 time in 355 days (use GT or VM)</td>
<td></td>
</tr>
<tr>
<td>Milestone 3</td>
<td>G9875 – 9 core sessions attended</td>
<td>$140 GT</td>
<td>VM</td>
<td>Can be used 1 time in 355 days (use GT or VM)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>HCPCS Code and Description</th>
<th>Payment</th>
<th>Telehealth Modifier</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Outpatient DSMES</td>
<td>G0108 – Diabetes outpatient self-management training services, individual per 30 minutes</td>
<td>$55/unit</td>
<td>GT</td>
<td>3 hours (6 units) per 12 months</td>
</tr>
<tr>
<td>Group Outpatient DSMES – 2 or more participants in the group</td>
<td>G0109 – Diabetes outpatient self-management training services, group session (two or more), per 30 minutes</td>
<td>$16/unit</td>
<td>GT</td>
<td>15 hours (30 units) per 12 months</td>
</tr>
</tbody>
</table>

Milestone 4:
- G9876 – 2 sessions in months 7-9, 5% weight loss achieved or maintained OR G9878 – 2 sessions in months 7-9, 5% weight loss achieved or maintained
- $20 (without WL/$50 with WL)
- GT
- VM
- Can be used 1 time in 365 days (use GT or VM)

Milestone 5:
- G9877 (5% weight loss net achieved or maintained) or G9879 (5% weight loss achieved or maintained) – 2 sessions in months 10-12
- $30 (without WL/$50 with WL)
- GT
- VM
- Can be used 1 time in 365 days (use GT or VM)

Performance: 5% weight loss achieved
- G9880 – 5% weight loss from baseline achieved
- $100
- GT
- None
- Can be used 1 time in 365 days

National DPP
Lessons Learned

• Engage all partners early in the process.

• Recognize that different partners may have very little knowledge about other partners’ systems, workflows, and terminologies.

• The value of an outside advocacy organization (IPHI)
  – A neutral, non-governmental honest broker
  – Buy-in among decision-makers

• Continuity of leadership is important.

• Communicate with other states and learn from each other.
Six Month Status Report and Focus for 2022

• Enrollment
  – A handful of providers are up and running.
  – Many more have applied.
  – Very high level of interest in the National DPP Lifestyle Coach training

• 10 National DPP LCP providers selected to receive $10,000 each to support Medicaid enrollment using CDC funds received from NACDD and 1817 grants

• DSMES – hospital providers need technical assistance in understanding the need to build a different provider type

• Umbrella Hub Organization (UHO) planning to meet the needs of community-based partners
THANK YOU

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https://dph.illinois.gov
Medicaid Beneficiary Enrollment Pilot: Creating a Pathway for National Diabetes Prevention Program Sustainability in Rhode Island

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Rhode Island Medicaid Landscape

Population approx. 1.1 million (Census 2020)

<table>
<thead>
<tr>
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<th>2019</th>
<th>2021</th>
</tr>
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<tbody>
<tr>
<td>Number of adults aged (18-64) enrolled in Medicaid</td>
<td>Approximately 133,000</td>
<td>Approximately 331,538</td>
</tr>
<tr>
<td>Estimated number of adults aged (18-64) with prediabetes</td>
<td>44,055</td>
<td>65,000</td>
</tr>
<tr>
<td>Medicaid Cost</td>
<td>$1,982,250</td>
<td>$2,924,668</td>
</tr>
</tbody>
</table>
Title: Medicaid Beneficiary Enrollment Pilot (MBEP)

Timeline: August 1, 2021 – July 31, 2022

MBEP Award: $100,000.00

Pilot Goals:

- Enroll 75-80 Medicaid beneficiaries in the National DPP lifestyle change program that complete at least 1 session (not session zero)
- Make the case for Medicaid coverage for National DPP
Medicaid Beneficiary Enrollment Pilot Partners

Sustainability Planning:

MBEP Planning Partners:
# Medicaid Beneficiary Enrollment Workflow

<table>
<thead>
<tr>
<th>Identify Eligible Beneficiaries</th>
<th>Electronic Health Record (EHR); Prediabetes or at high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach and Recruitment</td>
<td>Letter from provider and texting</td>
</tr>
<tr>
<td>Referrals &amp; Rosters</td>
<td>Batch referrals to RIPIN/ Community Health Network (CHN)</td>
</tr>
<tr>
<td>Patient Navigators/Community Health Workers (CHWs)</td>
<td>Readiness, identify/address social Determinants of health (SDOH)</td>
</tr>
<tr>
<td>National DPP Enrollment</td>
<td>CDC-recognized program delivery organizations</td>
</tr>
<tr>
<td>Retention</td>
<td>Follow-up calls, texting, supports</td>
</tr>
<tr>
<td>Close Loop</td>
<td>Provider updates: 3x</td>
</tr>
</tbody>
</table>
Provider notified of status:
- Unable to reach
- Declined
- Agreed
- Enrolled in Program

Sent to CHN via EHR, fax, email, website, or phone call

Program

Referral Source

Address needs and barriers to find the right program

CHN

Patient

Patient Navigators call Patient
- No answer = Leave Message
- Two Follow-up calls, different times of day
Steps Toward Sustainability

• Continue to receive technical Assistance from National Association of Chronic Disease Directors (NACDD)/Centers for Disease Control and Prevention (CDC)

• Enroll and retain (75-80) Medicaid beneficiaries

• Implement Sustainability Action Plan
  • Maintain and expand partnerships
  • Leverage Community Health Worker reimbursement
  • Develop a reimbursement workflow map
  • Refine outreach, recruitment, and engagement to boost enrollment and retention (e.g., texting, coordinating classes)

• Continue to identify and address SDOH (e.g., digital resources)

• Document process and lessons learned

• Engage the State Medicaid Office
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