NACDD NATIONAL DIABETES PREVENTION PROGRAM (NATIONAL DPP) PROJECT

UMBRELLA HUB DEMONSTRATION

COMPREHENSIVE COST STUDY FOR NATIONAL DPP UMBRELLA HUB ARRANGEMENTS

JULY 2024

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

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NACDD National Diabetes Prevention Program (National DPP) Umbrella Hub Demonstration (UHD) Project:

Comprehensive Cost Study for National DPP Umbrella Hub Arrangements (UHAs) July 2024

Executive Summary

The objective of National Diabetes Prevention Program (National DPP) Umbrella Hub Arrangements (UHAs) is to connect community-based organizations (CBOs), non-profit organizations, academic institutions, and networks of community health centers with healthcare payment systems to secure sustainable reimbursement for the National DPP. Each UHA is managed by an umbrella hub organization (UHO), the leading entity in this arrangement. The following report synthesizes both quantitative and qualitative data from six Umbrella Hub Demonstration (UHD) projects.

To understand costs associated with developing and implementing a UHA to submit claims and receive reimbursements from the Centers for Medicare and Medicaid Services (CMS) on behalf of CBOs, also known as "subsidiary organizations" or "subsidiaries", delivering the Medicare Diabetes Prevention Program (MDPP), NACDD conducted a cost study. The cost study was done in two phases: Phase I, herein referred to as UHD Cost Study Phase I, using 12 consecutive months of data from each UHO for the period of August 2020-July 2021 to examine costs associated with developing and operationalizing a UHA, and Phase II, conducted over various months between November 2023 – March 2024 to better understand costs associated with maintaining a UHA. However, nuances exist with Cost Study Phase II since UHOs were billing Medicaid, Medicare, and Commercial vendors. Additionally, Phase II, was conducted over various months to better understand costs associated with maintaining a UHA, inclusive of expanding efforts to submit claims and receive reimbursements from Medicare Advantage Organizations (MAOs), Medicaid Managed Care Organizations (MCOs), and commercial plans.

The UHD Cost Study Phase I focused on three Umbrella Hub Organizations (UHOs) participating in the UHD Project during this time frame: Health Promotion Council of Southeastern Pennsylvania (HPC); Hawai'i Primary Care Association (HPCA); and Marshall University (MU). The overall goal of the UHD Cost Study Phase I was to obtain estimates of actual costs and cost categories for future organizations to consider when **developing and operationalizing** a UHA for MDPP delivery. It was found that the largest number of labor hours across the three UHOs in the study were directed to the development of the UHA, executing the MDPP supplier application, and planning and communicating with their billing partner (Welld Health).

The findings from UHD Cost Study Phase I concluded that the average labor costs for developing and operationalizing for UHD organizations was $30,000. Additional fees included:

- Legal Fees to support contracting efforts: $12,000
- Insurance to assess liabilities: $3,000
- Financial/budgetary consulting: $2,700
- Billing and Claims: not quantifiable given independent contracting with Welld

In 2023, the UHD Cost Study Phase II commenced to further contribute to the body of information that was documented and shared through the UHD Cost Study Phase I. Data were collected over a three-month period between September 2023 and March 2024, using both a cost study template and one-hour virtual interviews with UHD teams. The UHD Phase II Cost Study Template is included in Appendix A. The interview script is included in Appendix B.

In Phase II, the **ongoing costs of maintaining** a UHA were assessed. The findings from Phase II aim to inform organizations considering the establishment of a UHA, and to provide insights into the costs associated with two developmental stages: the implementation phase for new UHOs and the sustainability phase for those operating for over three years.

Key Findings of UHD Cost Study Phase I:

1. **Cost Categories**:
    - **Salary and fringe benefits of staff:** The largest costs were associated with salary and fringe benefits of staff that included the roles of director, program manager/coordinator, data evaluator, finance officer, and subject matter experts (SMEs) (e.g., diabetes SME, technology, payor outreach, and UHA development).

- **Contractual services:** Contractual services and other approved grant expenses also represented significant costs. Examples of contractual services include SME labor, subcontracts to subsidiaries, technology costs, data security costs, and legal costs.
- **Development and maintenance:** Development costs were high, particularly in labor and planning, while maintenance costs were more stable. Other development costs included legal costs and LLC development, *In the case of Phase I of the UHD Project, various personnel and their time allotted to the development of the UHA were decreased as the UHO entered the maintenance phase of the project*. See Table 4. Staff Breakdown by Title, 2024 compared to 2020 on page 17.

2. **Strengths**:
   - **Supportive leadership:** This demonstrates an ongoing commitment and interest in the development and sustainability of a UHA. Having supportive leadership allows for continued support when fiscal and business challenges arise, such as those around delayed billing revenue.
   - **Organizational expertise (SME):** Subject matter expertise that builds upon years of experience and leadership in the community and public health space because it supports organizational confidence in the UHA process. Also, having a National DPP Master Trainer on staff is a great benefit because it cuts down on costs associated with training Lifestyle Coaches and supports program sustainability.
   - **Partnerships:** Especially those that are built upon commitment, dedication, and collaboration between the organizations and whose valuable contributions can be leveraged without cost, or at a discounted cost, to advance the UHA.
   - **Strategic planning**: This involves the development of a self-sustaining business model with a focus and commitment on advancing diabetes prevention work, which acts as a roadmap for the fiscal health of the UHA.

3. **Challenges**:
   - **Delayed revenue from submitted claims:** Billing complexities and the need to increase technology capabilities of the UHO to successfully submit claims can sometimes led to delayed payment or payment denials for the claims.
   - **Annual staff training needs:** As required by the parent organization (some UHOs are part of a larger organization or corporation) in addition to learnings related to other business models, technology, and federal and state agency processes linked to reimbursement.
   - **Blended and braided sources:** The ability to blend and braid integration of various funding **sources**, such as grants and public financing through CMS.
   - **Non-grant expenses**: Expenses in this category included the development and maintenance of data systems and operational costs that include technology and data system costs.

Phase II Participating Demonstration UHOs:

Six Demonstration UHOs participated, representing diverse regions and organizational structures, including:

- Hawai'i Primary Care Association (HPCA)
- Health Promotion Council (HPC)
- Marshall University
- Association of Asian Pacific Community Health Organizations (AAPCHO)
- American Pharmacists Association Foundation (APhA Foundation)
- YMCA of Metropolitan Milwaukee (Y-MKE)

Recommendations/Suggestions:

1. **Strategic Financial Planning**:
   - **Develop comprehensive budgets that project costs accurately** and secure funding in advance for both development and sustainability phases. See helpful resources in the National Diabetes Prevention Program (National DPP) Business Tools, such as the Revenue Projection Generator, and other cost tools on the National DPP Coverage Toolkit, such as the Budget Projection Template.

- **Strengthen Leadership and Strategic Planning**:
- Develop robust **value propositions** to build strong leadership teams and engage in thorough strategic planning to guide operations and ensure long-term success. Leverage existing Coverage Toolkit resources such as the UHA Value Proposition Workshop.

2. **Streamline Billing Processes**:

    - Adopt advanced **billing** software, partner with experienced vendors, or provide additional training for billing staff to simplify billing processes. Attempt to leverage existing billing infrastructure of subsidiary organizations when available, noting that there are different iterations of UHAs based upon the competencies of their partnering subsidiaries.

3. **Diversify Funding Sources**:

    - **Explore various funding avenues**, including payers (MAO, MCO, and Commercial), grants, partnerships, and multiple funding streams, to ensure financial stability. Leverage existing opportunities through a blended and/or braided funding approach.

4. **Address Non-Grant Expenses**:

    - Properly **budget for non-grant related expenses**, such as travel, events, and staff training, to prevent financial shortfalls.

5. **Enhance Data Management**:

    - Improve data management practices by investing in robust data systems and staff training time to utilize billing and reporting platforms. An example is the data management system built, tested, and maintained by one of the UHOs. Although they use a billing vendor and incur fees, there is still a need for **capacity-building at the UHO level to use the billing vendor's services.**

6. **Training and Development**:

    - Invest in continuous, mandatory **organizational training**, as well as technology, HIPAA, CMS policies, and other necessary trainings to address staff learning needs and program execution challenges.

State Health Departments (SHDs) can play a critical role in supporting UHA models. These roles may include stewardship and convening of organizational partners, such as subsidiaries and payers, startup funding, facilitation of training and technical assistance (T/TA) to CDC 2320 funding recipients of the NOFO for "A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes." NACDD and Mobilizing Access through Capacity Building & Health Equity (MATCH) cultivate shared learnings and communication of ROI/ROV to policy makers through suite of UHA pages on the National DPP Coverage Toolkit and through CDC AMP.

7. **Community Care Hubs:**

In addition to these recommendations, sustainability may be scaled by integrating into social care networks and increasing the number of evidence-based programs available through hub models, such as Community Care Hubs (CCHs). A CCH is a community-focused entity that organizes and supports a network of CBOs providing evidence-based chronic disease prevention and management programs and services to address non-medical drivers of health.. To learn more about emerging CCH models, please visit the Coverage Toolkit CCH resources and Spotlights.

By implementing these recommendations, UHOs can improve their financial health, operational efficiency, overall effectiveness, and sustainability pathways to deliver the National DPP.

NACDD National DPP UHD Project: Comprehensive Cost Study (Phase II) for National DPP UHAs
July 2024

The Importance of UHOs in the Arrangements

UHOs play a crucial role in public health by acting as centralized entities that manage and support the implementation of the National DPP and **focusing on costs is essential for several reasons**:

1. **Financial Sustainability**: Understanding and managing costs are crucial for the financial sustainability of UHOs and the programs they support. Accurate cost projections help secure necessary funding and avoid financial shortfalls.
2. **Resource Allocation**: Detailed cost analysis allows UHOs to allocate resources more efficiently. This ensures that funds are directed towards the most impactful areas, maximizing the effectiveness of the lifestyle change program.
3. **Budget Planning**: Effective budgeting requires a thorough understanding of both initial and ongoing maintenance costs. This enables UHOs to plan for future expenses and secure funding in a timely manner.
4. **Identify Cost Drivers**: By analyzing costs, UHOs can identify major cost drivers and areas where efficiencies may be applied. This supports reductions in unnecessary expenses and optimizing operational processes.
5. **Transparency and Accountability**: Detailed cost analysis provides transparency and accountability to stakeholders, including funders, policymakers, and consumers. It demonstrates prudent financial management and builds trust in the organization's operations.
6. **Informed Decision-Making**: Cost data supports informed decision making by highlighting financial implications of various strategies and initiatives. This helps UHOs develop and continually improve strategic and mission-aligned UHA business models.

Scope

The six UHOs studied represent various regions of the United States. These regions range from mid-Atlantic rural regions Appalachia, East North Central Division of the Midwest, and the U.S. Pacific Islands region including the state of Hawai'i, as well as the U.S.-Affiliated Pacific Islands (USAPI): the Commonwealth of the Northern Marianas Islands (CNMI) and the Republic of Palau (RP).

Phase 1 UHD organizations:

1. **Hawai'i Primary care Association (HPCA)** : HPCA is a statewide network of 15 community health centers (CHCs), (or commonly known as Federally Qualified Health Centers (FQHCs), that provide technical assistance and advocacy support to improve the health of communities with systematic health disparities. HPCA subsidiary CHCs provide the National DPP in many ways, including training Lifestyle Coaches, direct T/TA, billing/claims and reporting functionalities, educational materials, continuous quality improvement (CQI) projects, payer engagement, including the Hawai'i (HI) State Medicaid Agency (i.e., State of Hawai'i Department of Human Services).

2. **Health Promotion Council (HPC):** HPC is a Pennsylvania-based non-profit organization whose mission is to promote health and prevent and manage chronic disease among populations with demonstrated HRSN through community-based outreach, education, and advocacy. HPC fulfills this mission in four primary ways: direct services and programming; T/TA; capacity building; and policy and systems change. In partnership with the Pennsylvania Department of Health, HPC has been building capacity of the National DPP in Pennsylvania since 2014. In 2021, HPC expanded to a cross-state hub whereby they are working in the state of Delaware where they have two subsidiaries and are partnering with an organization that serves persons living with visual disabilities.

3. **Marshall University**: Marshall University is based in West Virginia and offers a variety of evidence-based programs across eight states in Appalachia: OH, WV, VA, KY, TN, NC, MS, AL. Through the Appalachian Diabetes Control and Translation project Marshall University prevents and controls diabetes by developing and providing direct assistance/TA to Coalitions delivering the lifestyle change program in hard-to-reach rural counties throughout the Appalachian region.

Phase II UHD Organizations:

4. **The Association of Asian Pacific Community Health Organizations (AAPCHO):** AAPCHO was formed to create a national voice to advocate for the unique health needs of Asian American and Native Hawai'ian/Pacific Islander communities and their community health providers. This includes collaborating with community members and trusted SMEs to adapt the lifestyle change program curriculum and training to incorporate beliefs and approaches specific to the Native Hawai'ian and Pacific Islander communities they serve.

5. **American Pharmacists Association (APhA) Foundation**: The APhA Foundation is an affiliate of the American Pharmacist Association and serves as a source of research demonstrating how pharmacists can improve health care. The mission of the APhA Foundation is to improve health by inspiring philanthropy, research, and innovation that advances pharmacists' patient care services, including care for and prevention of chronic conditions such as diabetes prevention through the lifestyle change program.

6. **YMCA of Metropolitan Milwaukee**: The YMCA of Metropolitan Milwaukee (Y-MKE) has a long-standing history of serving the greater Milwaukee area since 1858. Y-MKE offers a variety of in-person and virtual evidence-based programs like the lifestyle change program to support residents along the health and well-being journey. The YMCA of Metropolitan Milwaukee is committed to ensuring that all members of the community have the opportunity to learn, grow, and thrive and has reached various populations throughout Metropolitan Milwaukee..

Limitations

Each UHA is unique. Therefore, the steps and associated costs are nuanced because of variation in the type of organization, length of time operating as a UHA, priority populations being served, subsidiary recruitment, and infrastructure. The following table outlines the unique attributes of each UHO.

Table 1: Summary of UHD attributes (*UHO names will be removed prior to public release, if applicable*)

Name	Type of organization	# years as UHO	UHA start date	Priority Populations	UHA payer contracts	CCH start date (*as applicable*)	Coverage notes
HPC Number of subs - 9	CBO	3.5	2020	Medicare & Medicaid beneficiaries and persons living with a disability	CMS FFS, PA and DE Medicaid MCOs and Medicare Advantage (MA) Plans	May 2024 through ACL funding	PA and DE require their Medicaid MCOs to offer the National DPP to Medicaid beneficiaries
HPCA Number of subs – 5	Primary Care Association serving FQHCs	3.5	2020	Native Hawaiians, Pacific Islanders, Filipinos	CMS FFS, Medicare Advantage (MA) Plans	No	HI continues to consider the submission of a Medicaid SPA for National DPP
Marshall University Number of subs - 5	Academic institution	3.5	2020	Appalachia	CMS FFS	No	CMS
AAPCHO Number of subs - 2	National Association	1 month	2023	USAPI and Marshallese (Arkansas)	CDC granted payer exception	No	
APhA Foundation	National Association	2	2023	Hispanic, those 65 and older	CMS FFS	No	

Number of subs – 2 (reaching 25 states collectively)							
Y-MKE Number of subs - 6	CBO	2	2023	Hispanic, African American and those 65 and older	CMS FFS, Medicare Advantage Plans (MA), WI-based employers	No	

More information about these organizations can be found on the Coverage Toolkit's UHA Spotlights page.

Limitations of the UHD Phase II cost study include factors related to the unique attributes of each UHD organization such as the variation in the types of UHD organizations (e.g., academic, national association, CBOs). A further limitation is related to the length of time these organizations have been operating as a UHO. The parameters of data collection represent an additional limitation. Therefore, costs associated with other months not reported may be significantly higher or lower than those reported. Moreover, the data provided are estimates of expenses and not exact numbers.

Methodology

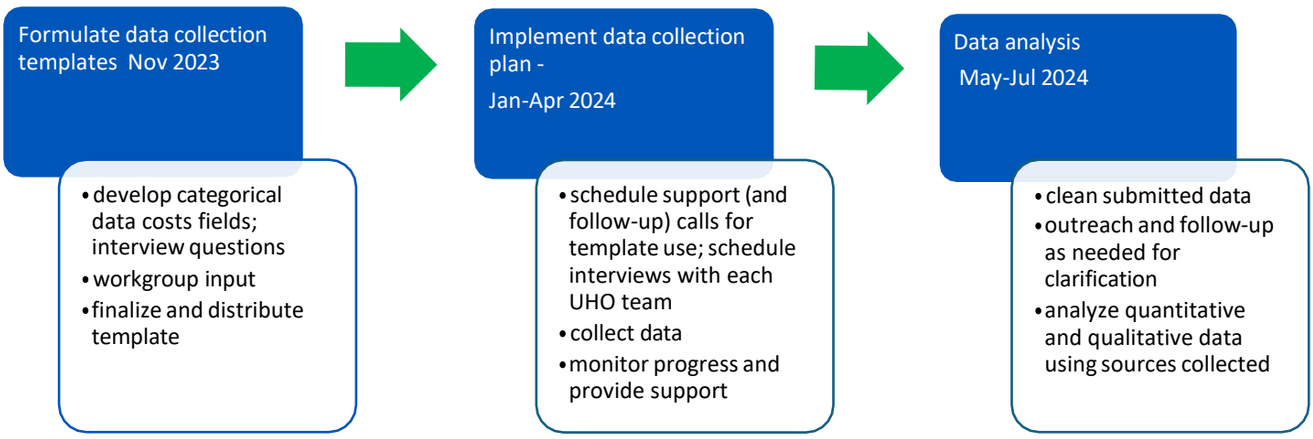
The data collection included the following sources and methods:

Table 2. Methodology Sources and Methods

Data	Source
• Quantitative data - e.g., monthly costs for a series of categories including personnel and fringe, travel, supplies, contractual costs, in-direct, and marketing). • Monthly costs for these categories include costs associated with approved grant budget as well as costs that occurred outside of the approved grant (e.g., in-kind, costs above the approved budget category).	• UHO cost study template and guidance provided to each UHO for data collection. See Appendix A.
• Qualitative data - e.g., one-hour virtual interviews using a consistent list of questions for each UHO.	• Interview recording • Zoom AI summary • Closed captioning • Notes taken by NACDD consultants during the interview. See Appendix B for cost study interview questions script.
• Descriptive data – e.g., UHA background	Coverage Toolkit materials: • UHD Learnings (2022) • Phase I UHD Cost Study 2020 - 2021 • UHA Roadmap • UHA Resource Guide

The illustration below shows how qualitative and quantitative data were gathered and analyzed.

Figure 1. Data collection and analysis model



The cost study template (Appendix A) included expenditure categories such as approved grant budget, personnel services, travel, contractual, indirect, and others.

It is important to note that data were collected for the categories listed regardless of whether the expense occurred within a UHO's approved grant budget or outside of it (known as non-grant expenditures).

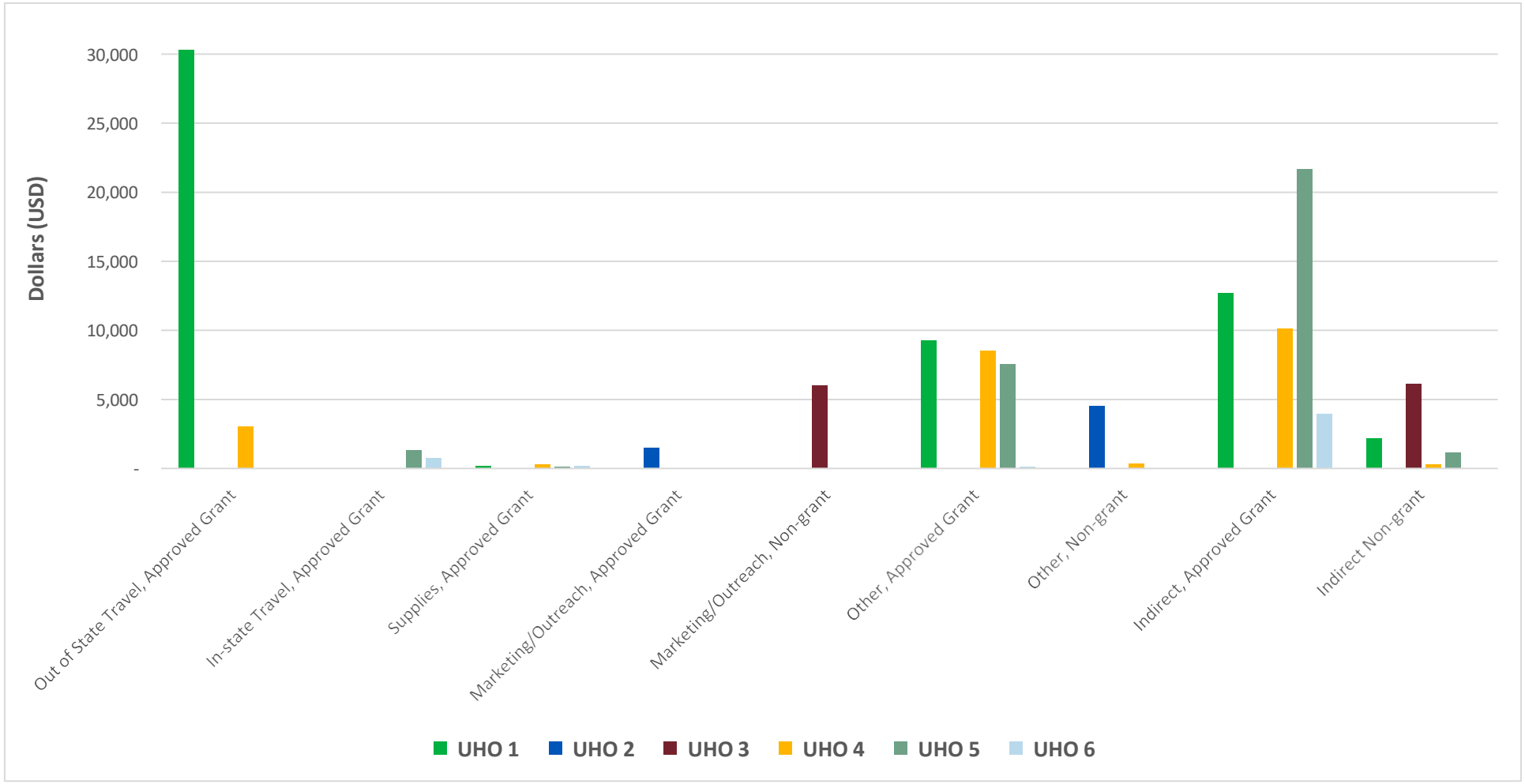
Qualitative data collection (Appendix B) was conducted through one-on-one interviews with the NACDD UHO Demo Team Consultants asking a specific series of questions and categorizing the data collected from the interviews. In the quantitative data discussion below, please note that the bulleted information represents raw data collected from the UHO interviews and is categorized for review and analysis.

Figure 2 below provides a three-month cost average of UHO by the non-salary/fringe cost category. Out-of-state travel was the highest cost in this category and represented travel between islands in the Pacific Region for one UHO that was holding a meeting with its subsidiaries.

Analysis and Discussion

Quantitative Analysis

Figure 2. Three-month Cost Average of UHO by Cost Category, Non-salary/Fringe



When there are extreme outliers in the data, the arithmetic *mean* (or average) can be significantly skewed, leading to a misleading representation of the central tendency. In such cases as this one, the strategy that was used to mitigate the influence of outliers was to include the *median* value of each cost category (Figure 3, Figure 4, Figure 5). Median values are less affected by outliers and provide a better measure of middle values.

Figure 3. Three-month UHO Average Cost by Cost Category

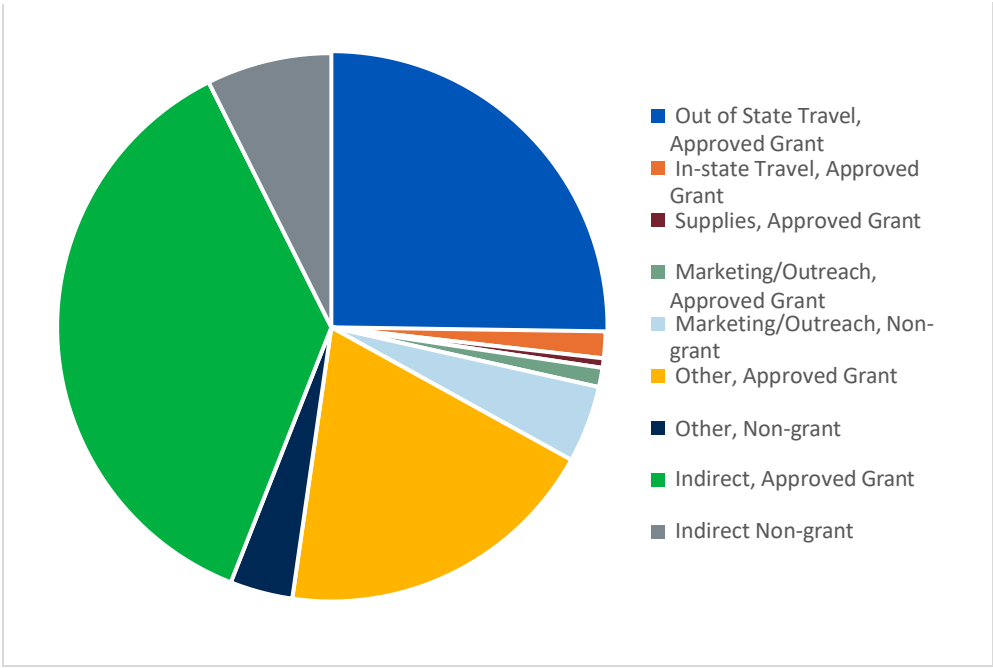


Figure 4. Three-month UHO Median Cost by Cost Category

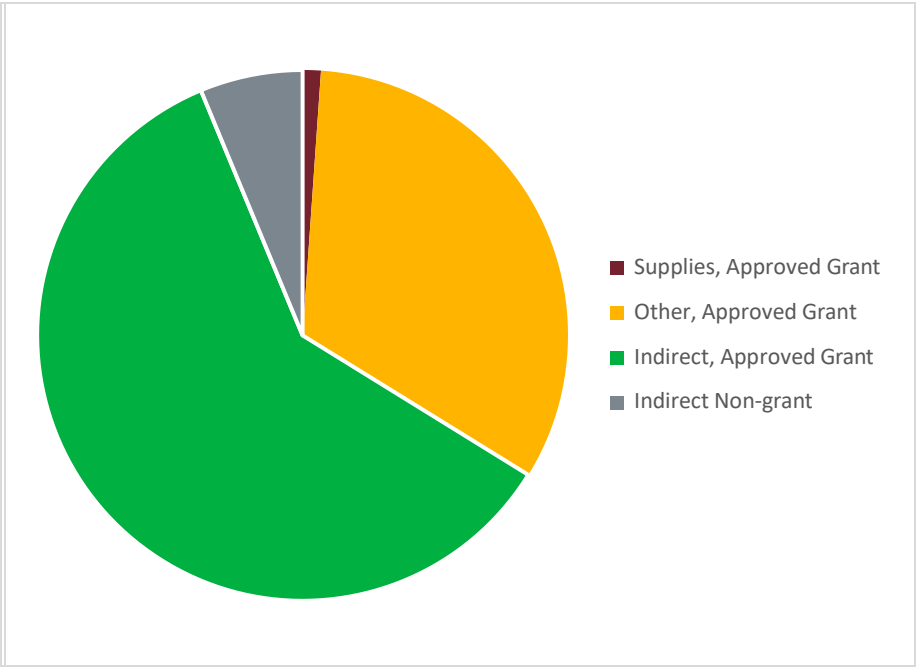
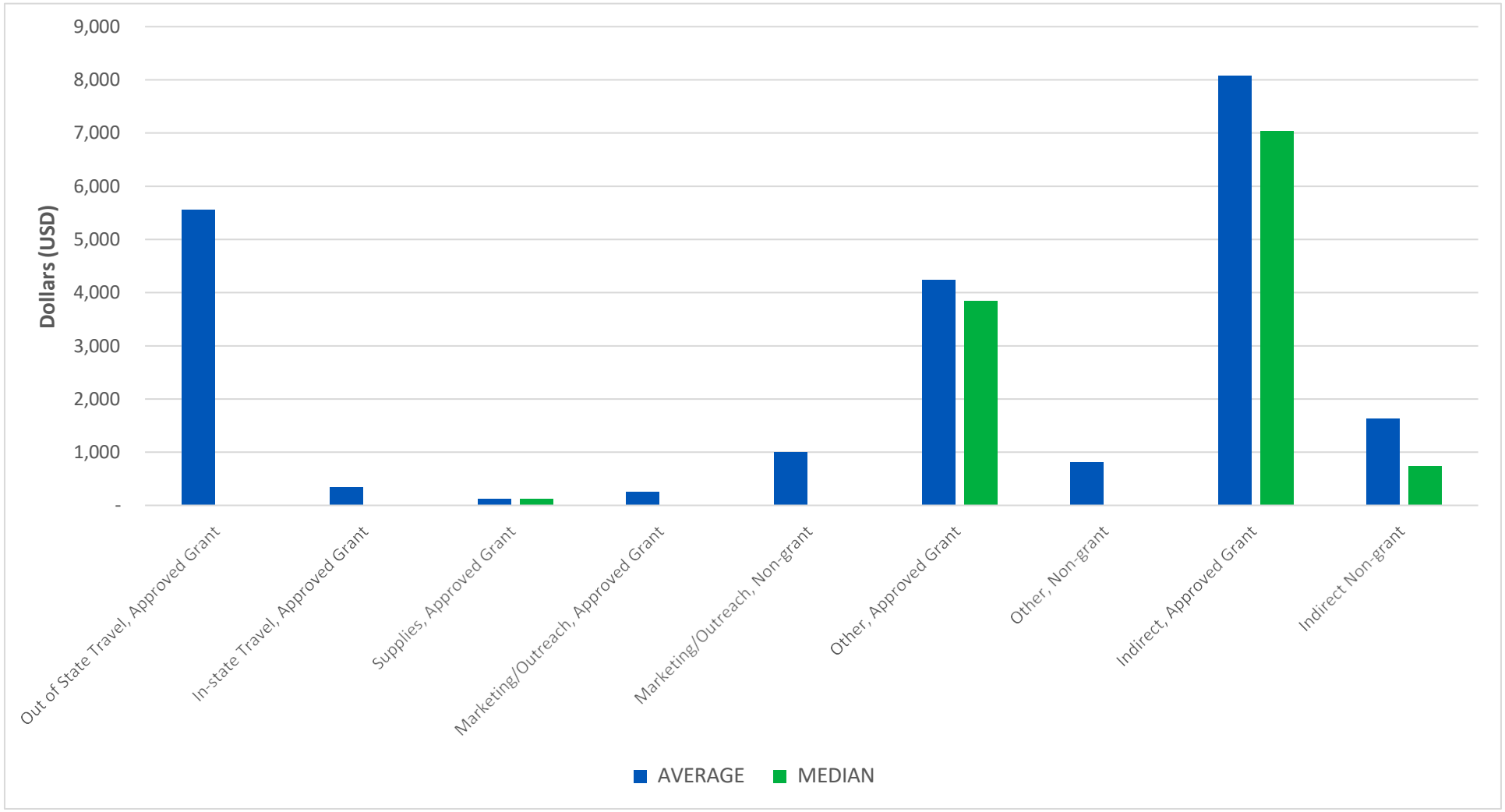
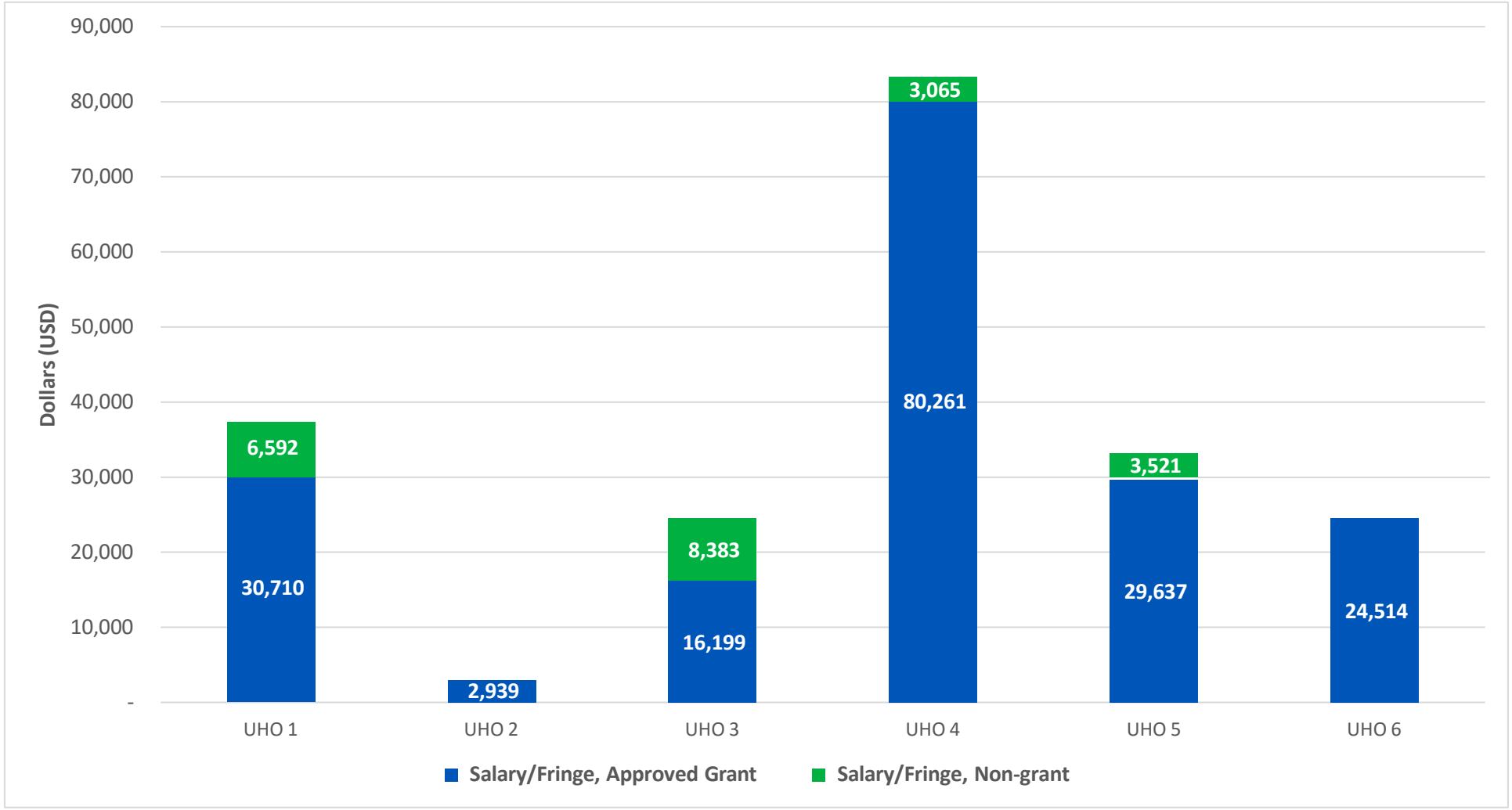


Figure 5. Three-month UHO Average and Median Cost by Cost Category



Salary/fringe was the highest approved budget cost for the UHOs with one UHD organization being significantly higher than the rest (Figure 6). However, at least three UHOs, not including the UHO with the highest salary/fringe approved costs, had contractual subject matter experts (SMEs) who were knowledgeable in their field of diabetes care, technology, payor outreach, and network development.

Figure 6: Salary and Fringe Benefits, Approved Grant and Non-grant



The staff breakdown by title mirrored similarities in staffing titles and roles compared to the 2020-2021 cost data summary (Table 4). **The average monthly cost for labor in this report summary is $30,710** (three-month average). The Phase I UHD Cost Study summary cited an annual average labor cost of **$30,000/ year**. Assumptions for this difference may be due to the combined effects of seasonal variations, COVID-19 pandemic workforce shortages, budget cycles, cost of living adjustments, and fringe benefit payouts.

For example, the data from Phase I UHD Cost Study were mostly start-up costs with minimal UHA implementation functions, especially for one UHO that came on later in the project resulting in much lower staff hours compared to the others. The initial cost study was intended to serve as a high-level estimate and did not include any UHD-specific costs like required grantee meetings, tracking, work on invoices/progress reports, or administrative-related requirements that were part of their contracted scope of work. Additionally, it was heavily influenced by the Public Health Emergency as fewer staff were available to work on the project, staff hours were not necessarily full-time, and many staff positions remained vacant.

Short-term averages tend to be more volatile and can reflect temporary spikes in expenses, while annual averages provide a smoother and stable view of costs. Understanding these factors can help in making informed decisions and planning for both short-term and long-term financial management.

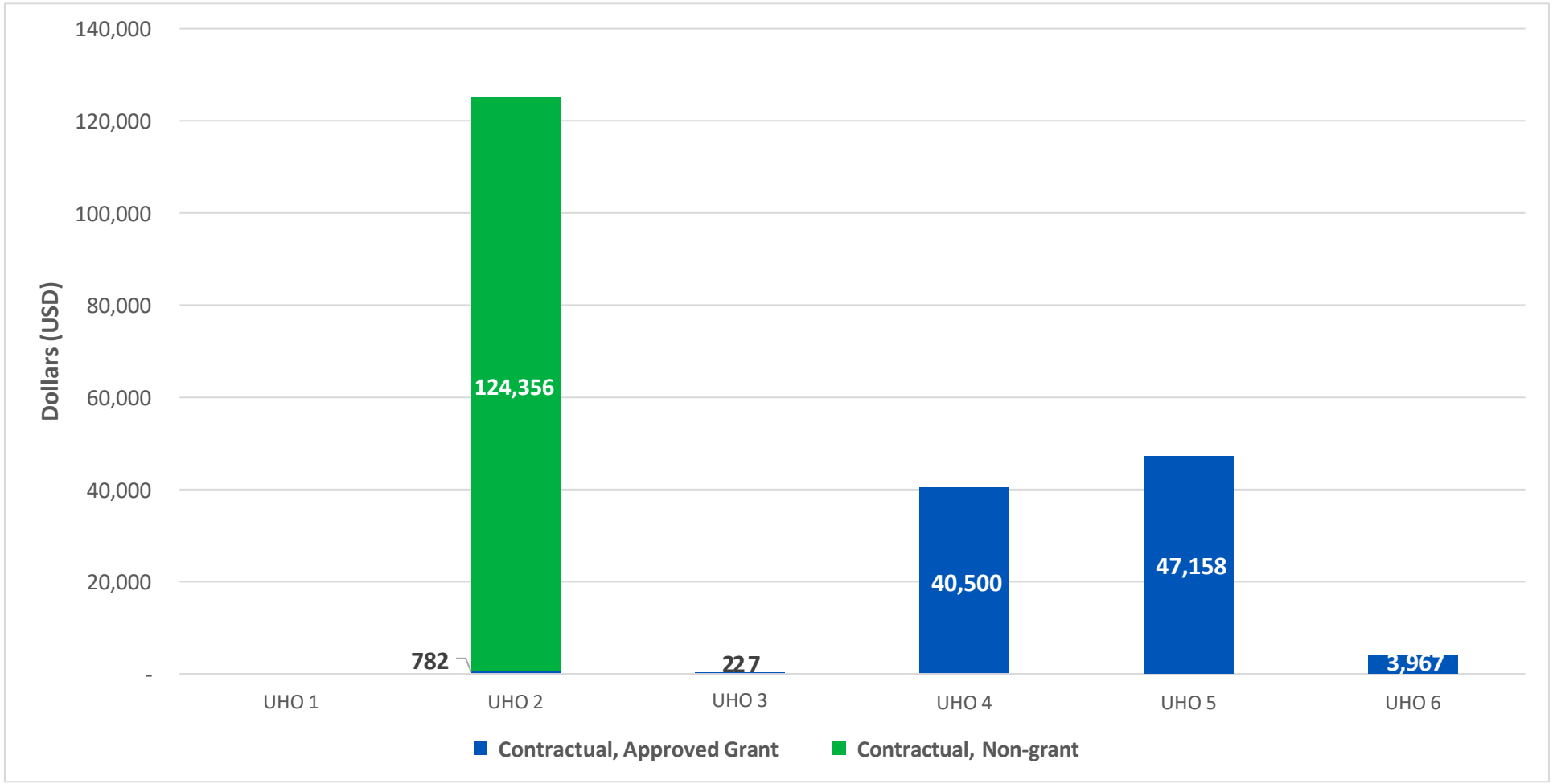
Table 4. Staff Breakdown by Title, 2024 compared to 2020

UHO Name	Personnel Titles (2024)	Personnel Titles (2020)
Phase I: HPC (non-profit organization)	Senior Director of Operations Program Manager Program Manager - programmatic Operations Manager Program Coordinator Outreach and Recruit Manager	Administrative Assistant Coordinator Assistant Director Director Senior Director
Phase I: HPCA (network of community health centers)	Chief Strategy Officer Health Equity Director Program Specialist Population Health Programs Manager SME – payor outreach (contractual) SME – network development (contractual)	Program Manager – population & health systems improvement Program Manager – health equity and research Chief Strategy Officer Chief Financial Officer Chief Operating Officer Chief Executive Officer Accounting Manager Contracts Manager Director of Programs
Phase I: Marshall University (academic institution)	Principal Investigator Project Lead Rural Health Coordinator	Project Director Project Coordinator Rural Health Coordinator

UHO Name	Personnel Titles (2024)	Personnel Titles (2020)
	Grants Manager Financial Analyst	Research Assistant Grants Program Manager Web Developer/IT Specialist
Phase II: AAPCHO (national organization)	Deputy Director Program Manager Data Evaluator SME (contractual)	N/A
Phase II: APhA Foundation (non-profit national organization)	Executive Director Program Manager Evaluator SME – diabetes (contractual) SME – technology (contractual)	N/A
Phase II: YMCA (non-profit organization)	Executive Director Senior Director Program Coordinator Instructor Program Manager – Ops & Finance	N/A

Contractual expenses, for some UHOs, included SMEs that worked on various tasks both short- and long-term throughout the data collection period to assist with the organization's progress primarily towards the maintenance of the UHO and in some cases also the establishment of one (Figure 7). This setup was regardless of whether the organization was in Phase I or Phase II of the UHA work. Other approved grant contractual expenses included subcontracts to subsidiaries for their work, technology costs, data security costs, and legal costs.

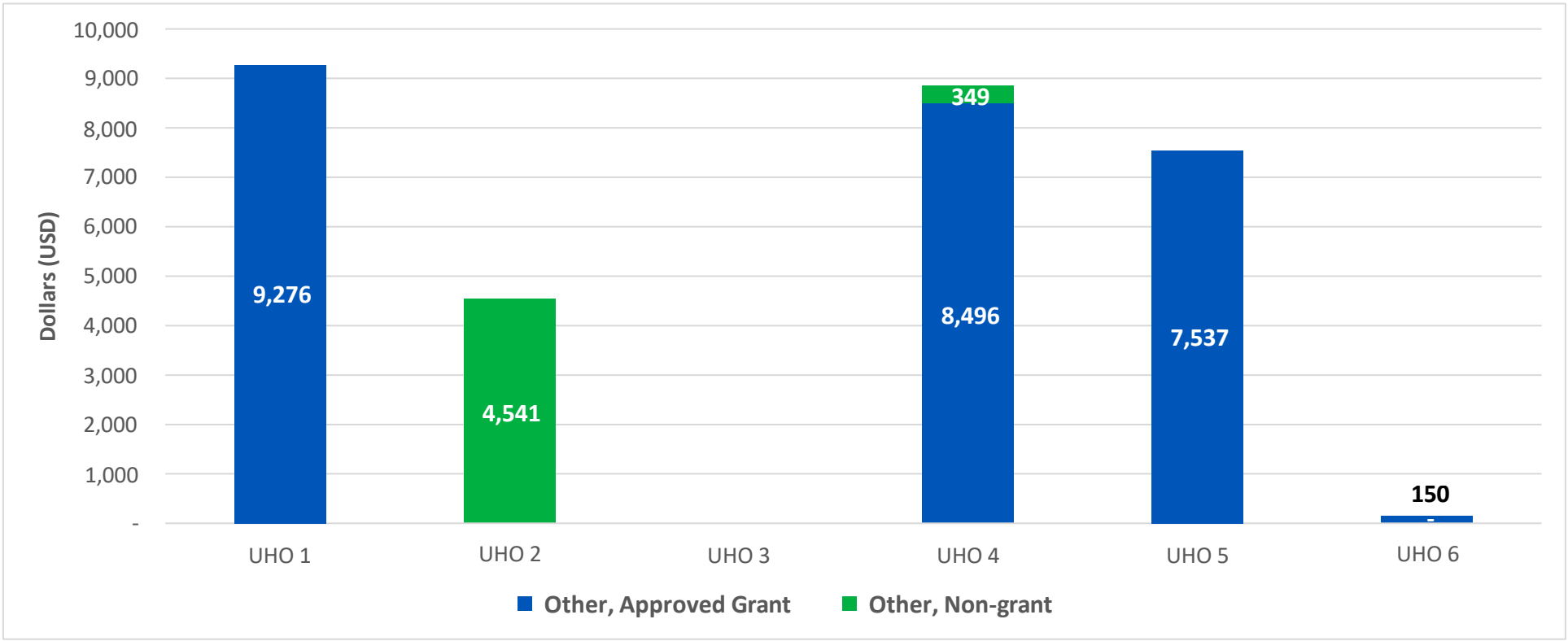
Figure 7. Contractual Expenses, Approved Grant and Non-grant



It is noted that a major non-grant approved cost was the development and maintenance of the data collection and management system developed in-house by one of the UHOs. It included technology services like data integration framework system maintenance, updates, and development of claims submission integration along with system testing to support the development team. Many of these costs are expected to continue in the long term to optimize and maintain the system.

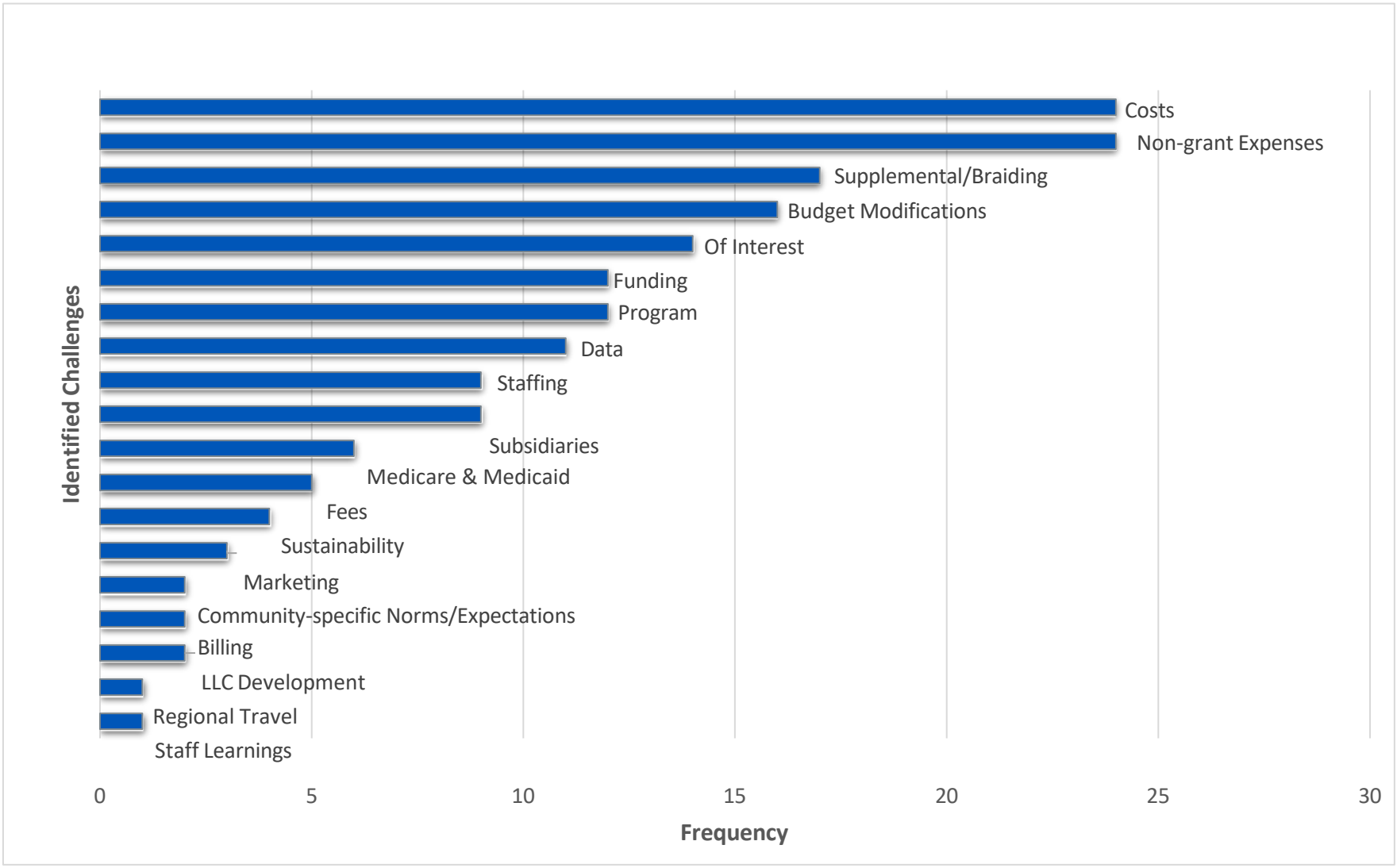
Other grant expenses (both approved and non-grant approved) consisted of expenses such as meeting costs with subsidiaries and partners; operational costs like supplies, telephone, virtual meetings, computer usage, and training; and costs associated with system testing to support development team, server hosting and maintenance, and maintenance and updates (Figure 8).

Figure 8. Other Expenses, Approved Grant and Non-grant



Qualitative Data

Figure 9. Identified Challenges



Challenges identified during the qualitative interviews were aggregated into categories and include examples provided during the interviews (Table 5).

Table 5: Categories and Examples of Challenges

Category	Examples (Raw Data)
Costs	Increased costs related to: • More focused understanding of the unique operations in each jurisdiction • In-person gatherings for understanding workflows and day-to-day processes of their subsidiaries • Consideration of cultural aspects when hosting meetings, particularly in Hawai'i and USAPI. • Cyber insurance costs (currently costs about $8,000 annually) and integration costs could be additional fees • Market adjustments to WELLD fees • $2,500 to join a benefit network that processes billing/ claims (Wisconsin) • Materials • Incentives for participants are not covered
Non-grant Expenses	• Regional travel included targeted visits to better understand unique operations in each jurisdiction • Unique gifts to accompany site and partner visits • Consultant services that went above and beyond the approved grant funding, including network development, research, site recruitment, and technical assistance, particularly at a national scale • Development of own platform for claims processing due to initial contractors' inability to meet their needs and subsequent collaboration with WELLD Health to ensure claims could be submitted, requiring significant work from IT teams to integrate systems • Unanticipated costs such as marketing expenses, server costs, and system testing were identified as one-off expenses; server hosting (long term expense) • Organization-required staff training • Staff attendance at various meetings to understand and describe different processes. These meetings were related to their referral hub, also included relationship building activities with partners, learning about new technologies, participant recruitment, and connecting with payer partners • Integration costs with healthcare entities, increased cyber insurance costs, and the cost of joining the benefit network • Travel costs for Lifestyle Coaches • Program supplies, participant guides, and technology expenses • Working with many different states each with an annual licensing fee for WELLD
Supplemental/Braiding	• (UHO) offer broader resources and training as a supplement • Local-level subsidiaries also innovate with supplemental benefits, like short-term Visa support and access to food pantries

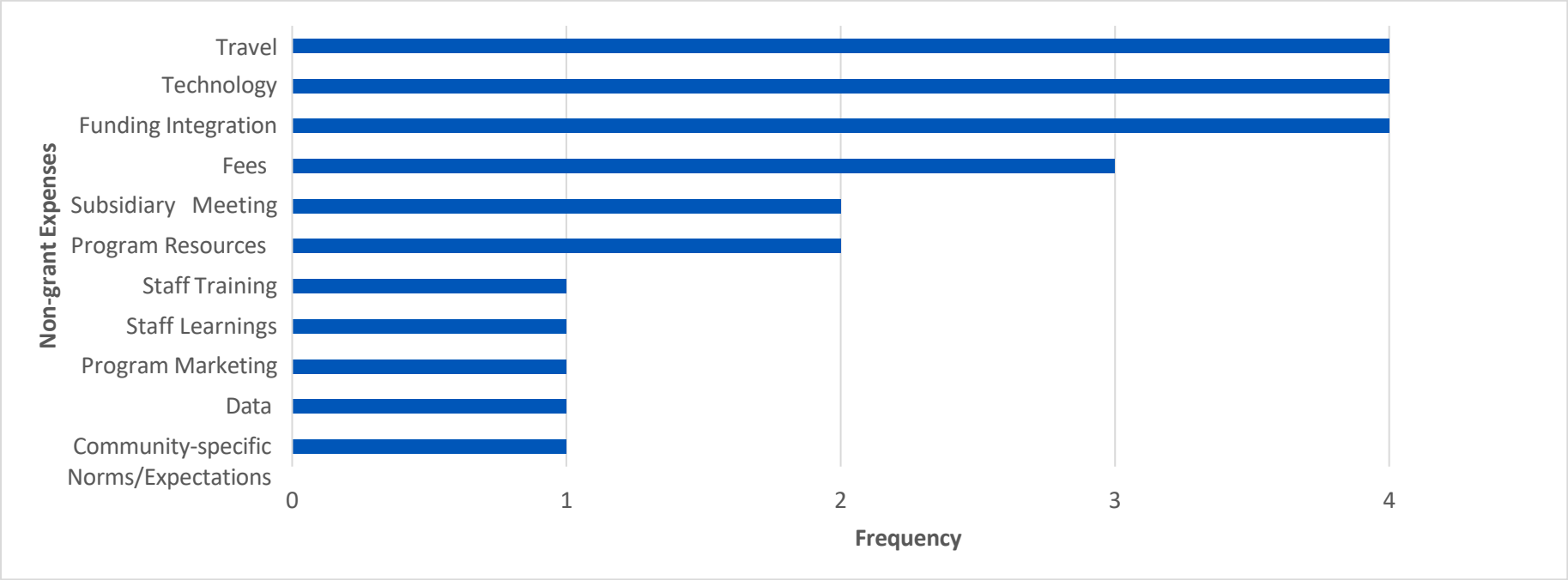
Category	Examples (Raw Data)
	• Community-wide activities like walking groups and Zoom book classes were also mentioned as non-exclusive supplements - initiatives are often funded through grants, including those from the government and private organizations • Conversations internally about potential supplements or blended services for the National DPP • Offering certificate and training programs for DSMES (Diabetes Self-Management and Education Supports) • Previously offered Walk With Ease (WWE) but not currently • Other programs and services offered, including medical nutrition therapy, DSMES, and HRSN screening • The WWE program, previously piloted, is being supported through community living funding, also a Spanish offering • Asynchronous online delivery for the HALT program as a supplement to lifestyle change retention • Subsidiaries are offering physical activity, nutrition programs and the National DPP is built into those other programs
Budget Modifications	• Included the development of their own platform for claims processing due to initial contractors' inability to meet their needs and subsequent collaboration with WELLD Health to ensure claims could be submitted, requiring significant work from both IT teams to integrate their systems. These costs fell under the technology services component • Staffing changes • Additional staff training • Potential increase in legal services • Lifestyle Coach training requires outside trainer
Of Interest (this category includes topics which stood out in the interviews and did not fit easily into any other categories)	• Interest from other Pacific organizations in starting similar programs with their populations • Work with CDC's 1705 Cooperative Agreement, 2017-2023 focused on scaling the National DPP in underserved areas led to development of some hub attributes • Provide informal TA to other organizations considering UHA models • Post- COVID challenges identified: switching from virtual to in-person, challenge of providing free pharmacy screenings, need to rebuild workforce
Funding	• Challenge of securing funding post UHD project • Current lack of funding and community engagement • Additional resources to support more subsidiaries and continue data system development • Importance of braided funding from various sources, such as SHD public health block grants, to support the UHA • Need for future budgets to prioritize staffing and recruitment, and suggested that the funding for these areas should come from a claims and reimbursement model as well as recruitment and outreach efforts

Category	Examples (Raw Data)
	• Proposed CCH project could potentially provide additional funding • Providing startup funds for affiliates and bridging programming gaps due to delayed grant funding, with a strategic approach to infrastructure support and engagement with payers • Additional funding would be necessary for at least the next couple of years to build infrastructure and sustain payment streams • Mix of funding streams from payers to support the program and emphasize the importance of non-medical drivers of health, more participants, subsidiaries, payer contracts, and additional funding to continue the work
Program	• Limited funding for Lifestyle Coach training, and the desire for the organization to train its own coaches • Getting individuals to sign up for the program despite their readiness for change • Initially offered distance learning opportunities, which proved successful and continues to be an ongoing challenge • Lack of eligible Medicare patients in certain communities was challenging particularly in Hawai'i where in many cases Medicare beneficiaries may already have progressed to type 2 diabetes, further shrinking the potential pool of patients • Difficulties in recruiting participants that fall outside the health centers' typical demographic • Only covers UHO and planning, not the implementation and delivery like materials and incentives for participants, needs to be something they (subs) are working on in the background • Including network development, research, site recruitment, and technical assistance, particularly at a national scale • Travel costs for Lifestyle Coaches • Program supplies • Incentive money to subsidiaries
Data	• Need for robust data systems and the potential need for increased investment in resources or staffing in the Pacific region for better operational support • Had to pull back on some data support for organizations not under their umbrella due to a lack of resources • Need more support for data systems infrastructure and requested additional resources for their small team • Potential future costs if they partner with WELLD • Need for in-person gatherings for understanding the workflows and day-to-day processes of their subsidiaries, which has significantly improved their data systems • Development of their own platform for claims processing • Collaboration with WELLD Health to ensure claims could be submitted, requiring significant work from both IT teams

Category	Examples (Raw Data)
	• Consultant services that went above and beyond the approved grant funding, including network development, research, site recruitment, and technical assistance, particularly at a national scale • Use of part-time consultants and the importance of ongoing maintenance for their technology systems including sustainability and maintenance needs of their systems assuring their long-term capability with periodic upkeep • Marketing expenses, server costs, and system testing were identified as one-off expenses • Learning about new technologies; WELLD fees, integration costs with healthcare entities, increased cyber insurance costs, and the cost of joining the benefit network
Staffing	• Significant time commitment and resources currently being used on their project, emphasizing the contributions of key team members and the importance of need for more contracts with payers and additional staff to manage the billing and claims processing with in-kind resources • Workforce constraints including high turnover • Training and onboarding new Lifestyle Coaches, and anticipating the need for more staff in the insurance and billing spaces as they grow • Need for future budgets to prioritize staffing and recruitment and suggested that the funding for these areas should come from a claims and reimbursement model as well as recruitment and outreach efforts
Subsidiaries	• Challenges or concerns about keeping subsidiaries informed about UHA policies, particularly those concerning data retention policies • Concern about subsidiary attrition and the potential loss of their subsidiary base, which could hamper the UHA • Importance of maintaining relationships with subsidiaries and the critical role of their staff • Proposed providing startup funds for affiliates and bridging programming gaps due to delayed grant funding • Relationship building activities with partners
Medicare & Medicaid	• Challenges encountered with different Medicare Administrative Contractor (MAC) and expressed frustrations with the redundancy in the MDPP crosswalk data submission • Issues related to agreements with MACs, recognition by CMS as a provider, limited funding for Lifestyle Coach training, and the desire for the organization to train its own coaches were also discussed • The challenge of securing funding post UHD project • Challenges of recruiting Medicare patients for their programs • Need for funding and reimbursement models for Medicaid patients • Lack of eligible Medicare patients in certain communities was challenging particularly in Hawai'i
Fees	• Potential increase in legal fees • Increased WELDD fees • Integration costs with healthcare entities

Category	Examples (Raw Data)
	• Increased cyber insurance costs • Cost of joining the benefit network
Sustainability	• Challenges of low reimbursement rates and the difficulty in building a sustainable model • Reliance mainly on grant funding and need to increase insurance reimbursements • More participants, subsidiaries, payer contracts, and additional funding to continue the work • Explore addition of other chronic disease self-management programs for diversified revenue • Post-grant funding emphasis with a focus on Medicare and Medicaid payments • Integrating other programs into the National DPP, such as self-measurement blood pressure monitoring and local farmers' markets • Additional services offered by their YMCA, such as a full year membership, a virtual membership platform, and a suite of evidence-based health interventions • Future plans for a community care hub, addressing social needs and offering additional services for sustainability • Potential expansion of chronic disease self-management programs, including diabetes and pain management
Marketing	• Investing in market research and a marketing firm to enhance the organization's identity and decision-making • Re-evaluated their marketing strategy to reach their target audience more effectively • Marketing campaign on a Spanish TV network, suggesting a potential for a larger campaign to boost program enrollment, with assistance from their marketing team
Community-specific Norms and Expectations	• Importance of considering these type of items when hosting meetings, particularly in the Pacific region
Billing	• Challenges faced by community pharmacies in providing new services due to the administrative burden and lack of experience in billing for services • Need for more contracts with payers and additional staff to manage the billing and claims process
LLC Development	• Focusing on the development of the LLC and having more dedicated staff might have prevented some of the current challenges
Regional Travel	• Challenges or concerns importance of regional travel and the related costs for their work • Logistical challenges that can arise, such as coordinating travel and handling unexpected logistical issues • Potential benefits of more focused visits to better understand the unique operations in each jurisdiction
Staff Learnings	• Attendance at various meetings to understand and describe different processes: included relationship building activities with partners, learning about new technologies, participant recruitment, and connecting with payer partners

Figure 10. Categories of Non-grant Expenses



The table below provides specific examples of each of the cost categories that make up non-grant expenses.

Table 6. Categories and Examples of Non-grant Expenses

Categories	Examples
Travel	• Regional travel both interstate and intrastate (Pacific) and jurisdictions/territories
Technology	• Including network development, research, site recruitment, server hosting, and technical assistance, particularly when scaling nationally • Ongoing maintenance for technology system and unanticipated costs such as marketing expenses, server costs, and system testing were identified as one-off expenses by one of the organizations
Funding Integration	• Need for better integration of non-grant related expenditures
Fees	• Initial and increased fees for technology, benefits network, cyber insurance, network security, integration costs, etc.
Subsidiary Meeting	• Costs associated with in-person meeting with subsidiaries
Program Resources	• Such as program materials for participant like handouts, calorie counters, incentives, copies, etc.
Staff Training	• As required by the organization and separate from program training
Staff Learnings	• Including attendance at various meetings to understand and describe different processes • Attendance at partnership building activities, learning about new technologies, participant recruitment, and connecting with payer partners
Program Marketing	• Investing in market research and a marketing firm to enhance the organization's identity and decision-making • Re-evaluated their marketing strategy to reach their target audience more effectively • Implemented a marketing campaign on a Spanish TV network, suggesting a potential for a larger campaign
Data	• Need for robust data systems and the potential need for increased investment in resources or staffing • Need more support for their data systems infrastructure and requested additional resources for their small team • Potential future costs if they partner with WELLD • WELLD collaboration • Need for in-person gatherings for understanding the workflows and day-to-day processes of their subsidiaries, which has significantly improved their data systems • Development of their own platform for claims processing • Integration costs with healthcare entities, increased cyber insurance costs, and the cost of joining the benefit network
Community-specific Norms and Expectations	• Consideration of these type of items when hosting meetings, particularly in the Pacific region

Figure 11. Identified Strengths

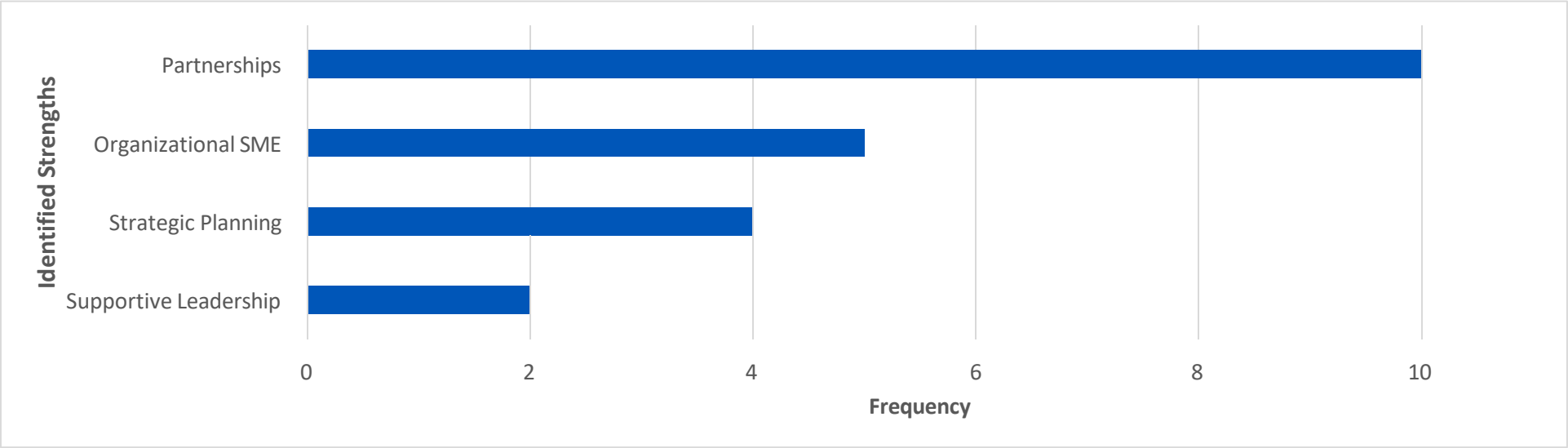


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Table 7. Categories and Examples of Identified Strengths

Category	Examples
Partnerships	• Strategy of partnering with community pharmacies to expand their reach; strong ongoing relationship with their primary partner, Kroger, to potentially offer in-person and distance learning through Kroger's pharmacy residency programs • Dedicated staff, commitment to the National DPP, and the valuable contributions of subsidiary partners and the standardized processes across subsidiaries and the successful efforts in growing and serving more beneficiaries • Positive impact of community clinical linkages and resources on the success of the National DPP • Partnership built with Marshall Health • Strong partnership with Marshall Health's Director of Patient Accounting who works with all the payers • The organization's relationship with Medicare • The MCOs in West Virginia will be a strength moving forward • Collaborative work with the diabetes Healthy Living Coalitions across 8 states and 60 communities
Organizational SME	• Pharmacy association's efforts in offering certificate and training programs for diabetes self-management and prevention, screenings identified many people already having diabetes or being at risk, emphasizing the need for awareness of available programs that could help • Building upon more than 20 years of work across 8 states and 60 communities with Healthy Living Coalitions and the subject matter expertise of the organization's chronic disease team • Having a Master Trainer on staff at the UHO
Strategic planning	• Developing a self-sustaining business model for their organization, with a focus on using Medicare beneficiaries as the foundation – this strategy is expected to advance the organization's position in the payment space and facilitate progress • The provider practice organization with whom the academic organization built their business model with • Organization's commitment to advancing diabetes prevention work
Supportive Leadership	• Ongoing commitment to develop a national network, highlighting the support received from senior leadership at Health Mart Atlas and Kroger • A supportive board, expertise in National DPP delivery, internal support structure, collaboration with WELLD Health, and partnerships with state entities

Some ways to address the challenges identified and discussed throughout each of the qualitative interviews with the UHOs. They include:

- The importance of maintaining relationships with subsidiaries and the critical role of the staff in their work. This can be accomplished through in-person gatherings to understand the workflows and day-to-day processes of their subsidiaries. The importance of in-person gatherings and meetings was stressed as critical to partnership development regardless of geographical location.
- The need for additional funding to support the momentum of their projects was emphasized including additional resources to support more subsidiaries and continue data system development.
- One organization suggested using the (UHO Demonstration) grant funds to implement additional programs or services for participants. They proposed providing startup funds for affiliates and bridging programming gaps due to delayed grant funding. Another organization talked about mixing funding streams from insurers to support the program and emphasized the importance of providing social services that address HRSN. Others talked about the importance of braiding funding from various sources, such as block grants, to support the umbrella hub and its subsidiaries. Another UHD Organization was hopeful that the proposed CCH project would become a reality and could potentially provide additional funding to the UHA work. This UHO subsequently received the Administration on Community Living award.
- Beyond the general need for additional funding, organizations provided specific ideas on how to achieve sustainability for their UHA:
    - Developing a self-sustaining business model for their organization, with a focus on using Medicare beneficiaries as the foundation;
    - Outlining their organization's plans to expand health centers and affiliates with external entities using dedicated funds stating that this strategy is expected to advance the organization's position in the payment space and facilitate quicker progress, despite the current roadblocks;
    - Providing startup funds for affiliates and bridging programming gaps due to delayed grant funding, with a strategic approach to infrastructure support and engagement with payers;
    - Investing in market research and a marketing firm to enhance the organization's identity and decision-making capability; and,
    - Talking in general terms about the need for a strategic approach to infrastructure support and engagement with payers, considering both micro and macro levels of the CCH grants and that future budgets will need to prioritize staffing and recruitment, and suggested that the funding for these areas should come from a claims and reimbursement model as well as recruitment and outreach efforts.

Conclusion

The Phase II UHD Cost Study provides an insightful analysis of the expenses associated *primarily* with the maintenance of Umbrella Hub Arrangements (UHAs). The findings indicate that the primary costs are associated with salary and fringe benefits, contractual services, and other approved grant expenses. There is a significant variance in costs across different UHOs, reflecting the diversity of participating organizations and scale of operations.

The study underscores the importance of understanding the financial requirements of both newly established and long-term UHOs. It reveals that initial development costs are substantial, particularly in labor and planning, whereas sustainability phase costs are more stable but still significant. The data highlights the necessity of a strategic approach to budgeting and financial planning for organizations considering or currently implementing a UHA.

Challenges such as complex billing processes, staff training, and the integration of payer funding sources are prevalent. These challenges must be addressed to ensure the efficient functioning of UHAs. The study also points out strengths like supportive leadership and organizational expertise that contribute to overall successful UHA operations.

Recommendations/Suggestions

1. **Strategic Financial Planning**:
    - Develop comprehensive budgets that project costs accurately and secure funding in advance for both development and sustainability phases. See helpful resources in the National Diabetes Prevention Program (National DPP) Business Tools, such as the Revenue Projection Generator, and the cost tools on the Coverage Toolkit, such as the Budget Projection Template.
2. **Training and Development**:
    - Invest in continuous required organizational training as well as technology, HIPAA, CMS policies, and other necessary types of trainings to address staff learning needs and program execution challenges.
3. **Streamline Billing Processes**:
    - Adopt advanced billing software, partner with experienced vendors, or provide additional training for billing staff to simplify billing processes. Attempt to leverage existing billing infrastructure of subsidiary organizations when available, noting that there are different iterations of UHAs based upon the competencies of their partnering subsidiaries.
4. **Diversify Funding Sources**
    - Explore various funding avenues, including multiple payers, grants, partnerships, and multiple funding streams, to ensure financial stability. Leverage existing opportunities through a blended and/or braided funding approach.
5. **Strengthen Leadership and Strategic Planning**:
    - Develop robust value propositions to build strong leadership teams and engage in thorough strategic planning to guide operations and ensure long-term success. Leverage existing Coverage Toolkit resources such as value proposition materials.
6. **Address Non-Grant Expenses**:
    - Properly budget for non-grant related expenses, such as travel, cultural events, and staff training, to prevent financial shortfalls.
7. **Enhance Data Management**:
    - Improve data management practices by investing in robust data systems for better tracking of costs and outcomes.

State Health Departments (SHDs) can play a critical role in supporting UHA models. These roles may include stewardship and convening of organizational partners, such as subsidiaries and payers, startup funding, facilitation of training and technical assistance (T/TA) to CDC 2320 funding recipients of the NOFO for "A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes." NACDD and MATCH cultivate shared learnings and communication of ROI/ROV to policy makers through suite of UHA pages on the National DPP Coverage Toolkit and through CDC AMP.

By implementing these recommendations, UHOs can improve their financial health, operational efficiency, overall effectiveness, and sustainability pathways in delivering to deliver the National DPP. In addition to these recommendations, sustainability may be improved by increasing the number of evidence-based programs and social services the UHA may expand to deliver, such as transitioning to Community Care Hubs (CCHs) and continuing to examine associated costs for implementing and sustaining these hub models.

Organization Name:
Reporting Period Coverage: MM/DD/YY – MM/DD/YY
NACDD Agreement #:
NACDD Accounting Code:

Report of Expenditures

Expenditure Category	Approved Grant Budget	Non-grant Related Expenditures, if applicable. *Do not include in Budget Balance	Comments	Current Expenses MM/DD/YY – MM/DD/YY	Cumulative Expenses MM/DD/YY – MM/DD/YY	Budget Balance *Do not include non-grant related expenditures
Personnel Services:						
Total Salary and Wages						
List out by title						
Fringe						
List out by title						
In-State Grant-related Travel:						
Mileage						
Hotel						
Meals / Per Diem						
Transportation						
Parking						
Out-of-State Grant-related Travel:						
Airfare						
Hotel						
Meals / Per Diem						
Transportation						
Parking						
Supplies:						
Add here						
Add here						
Contractual Services:						
Technology platform						
Add here						
Add here						
Marketing / Outreach:						
Advertising						
Brochures						
Add here						
Add here						
Other Costs:						
Add here						
Add here						
Indirect Costs (X %):						
Total Costs:						

Appendix B. Cost Study Interview Questions

1. What are the strengths of the UHA?
2. What do you need to continue this work after the demonstration is over?
3. What are the greatest challenges or concerns associated with offering the program long-term? How do you plan to address these challenges or concerns?
    a. Is there anything you would need to discontinue in order to sustain?
4. Are there other types of services, programs that are available as a "supplement" to the National DPP?
5. What types of budget modifications were needed during the course of the grant?
6. How would you revise the approved grant budget next time, if at all?
7. What are some of the affiliate costs/expenditures that were not supported in the approved budget?
8. Please provide some detail behind the non-related grant expenses that occurred during the month(s).
    a. As applicable, are all costs unique or are some repetitive month-to-month?
    b. As applicable, how permanent are the funds that support these expenses?

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