Budget Projection Template Instructions (Commercial Version)

The National Diabetes Prevention Program (National DPP) lifestyle change program is an evidence-based program focused on reducing or delaying the participant's risk for developing type 2 diabetes by helping participants make positive lifestyle changes such as eating healthier, reducing stress, and getting more physical activity. It is a year-long program that is delivered in person, online, through distance learning, or through a combination approach. The program includes at least 16 weekly sessions during the first six months and six monthly sessions during the second 6 months. To learn more about the structure of the program please visit the National DPP Overview page on the National DPP Coverage Toolkit (Coverage Toolkit). When implementing the program, remaining within budget is important to achieving cost savings, and creating a budget projection will help the user understand the costs that will be involved.

This document, the *Budget Projection Template Instructions*, is meant to be used alongside the *Budget Projection Template* to help the user identify the decisions and data needed. It also explains how to interpret the results of the *Budget Projection Template*.

The *Budget Projection Template*, linked in the thumbnail to the right, is a formatted document that can be used to estimate the total cost of providing the National DPP lifestyle change program to eligible members or employees, as well as the average cost per participant. These two estimates from the *Budget Projection Template* can help the user develop their budget when adding the National DPP lifestyle change program as a newly covered benefit. The results may be used to determine an estimated return on investment (ROI), when used in combination with a type 2 diabetes cost avoidance calculation (which is not included in this document). These estimates may also be used to budget for future years and to negotiate and set rates with CDC-recognized organizations.

Budget Projection Template

Alternatively, a budget projection can also be created using the free online tool, the DPP Revenue Projection Tool. This online tool was created using the *Budget Projection Instructions* and the *Budget Projection Template* as a backbone and contains similar information featuring a user-friendly interface.

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Step #1: Choose a Reimbursement Model

The typical formula for estimating the total cost of the program is enrollment multiplied by cost per enrollee. Although straightforward, this formula becomes more complex as different reimbursement models are used.

Estimated total cost of the program = [Cost per member] x [# of Enrollees]

Multiple reimbursement models have been used by payers in the National DPP lifestyle change program. Although the models vary, there are generally three main components that create the reimbursement framework. These components may be used discretely or in combination with one another. See the *Reimbursement Models for Commercial Payers* page of the Coverage Toolkit for more information about each of these reimbursement models, including commercial examples.

- **Fee-for-service component:** Fixed reimbursement amount for each service or session provided
- **Attendance milestone component:** Fixed fees that are reimbursed once attendance has reached pre-determined levels (e.g., 1st session, 4th session, 9th session, 16th session)
- **Performance-based component:** Fixed reimbursement based on outcome achievement, such as weight loss

If the user's organization prefers to reimburse CDC-recognized organizations for each session that is held, the fee-for-service model may be appropriate. If the organization wishes to develop a model that encourages CDC-recognized organizations to focus on attendance and outcomes, the attendance milestone and performance-based combination model may be the best fit.

The *Budget Projection Template* contains two templates, each on a separate tab. **Template A** is used for creating a budget projection using a fee-for-service model, and **Template B** is used for creating a budget projection using an attendance milestone and performance-based combination model. The user selects the reimbursement model that is most appropriate and opens the associated tab.

Please note, the *Budget Projection Template* features a common payment breakdown for each payment model, but a user may customize it to fit their needs.

Template A:
Fee-for-Service Model

Template B:
Attendance Milestone and Performance-Based Combination Model

Step #2: Determine Reimbursement Fees

The next step is to determine the reimbursement amount. Below are example fees that may be used to fill in the *Budget Projection Template*, or organization-specific fees may be used to estimate a more accurate cost projection.

Template A: Examples of Fee-for-Service Fees

In a fee-for-service reimbursement model, CDC-recognized organizations may receive a fixed amount for the initial enrollment, each core session (sessions offered during months one through six of the program and include a maximum of 16 sessions), and for each core maintenance session (sessions are offered during months seven through twelve of the program and include a maximum of six sessions). It may be the same dollar amount regardless of session type, or different fees may be provided for the different types of sessions.

Step #2: Determine Reimbursement Fees

a. Fill out the reimbursement rates in the table below.

Reimbursement Category	Amount	Number of Sessions	Total Cost by Session Type
Each core session		16	$0.00
Each core maintenance session		6	$0.00
Total Cost per Participant (if participant completes all sessions)			$0.00

In Step #2 of Template A in the *Budget Projection Template*, pictured in the image above, the user may fill in fee amounts of their choice. Some examples of fee amounts used in Medicaid are:

	New York Medicaid	Montana Medicaid
Fee per core session	$22.00	$29.10
Fee per core maintenance session	$22.00	$29.10

Additional examples of fee-for-service reimbursement amounts used in other states can be found in the *Reimbursement Models in Practice* section on the *Reimbursement Models for Medicaid Agencies and MCOs* page of the Coverage Toolkit.

Template B: Examples of Attendance Milestone and Performance-Based Fees

Attendance Milestone

In an attendance milestone reimbursement model, CDC-recognized organizations may receive a fixed amount after specified attendance milestones have been met. For example, instead of being paid after each single session provided, reimbursement would be received on four different occasions: after the first session, after the fourth session, after the ninth session, and after the first core maintenance session.

Step #2: Determine Reimbursement Fees

a. Fill out the attendance milestone reimbursement rates in the table below.

Reimbursement Category	Amount
First session	
4 sessions	
9 sessions	
> 16 sessions (core maintenance)*	
Total Cost per Participant (if participant completes all sessions but does not achieve targeted weight loss)	$0.00

In Step #2 of Template B in the *Budget Projection Template*, shown above, the user may fill in fee amounts of their choice. The Kentucky Employees' Health Plan reimburses between $350-$429 per enrollee (see the *Reimbursement Models for Commercial Payers* page for more details), and reimburses at the following milestones:

	% of Total Payment
Fee after the 2nd session	25%
Fee after the 4th session	75%
Fee after the 9th session	0%
Fee after the 16th session	0%

For examples of attendance milestone fee amounts used in Medicaid, visit the *Reimbursement Models for Medicaid Agencies and MCOs* page of the Coverage Toolkit.

Performance-Based Component

In a performance-based reimbursement model, CDC-recognized organizations may receive a pre-determined reimbursement amount if specified outcomes have been met. There are multiple designs to carry this out. Under one example, once an enrollee achieves 5 percent weight loss from baseline weight, the provider will be reimbursed the performance-based amount; however, if weight loss is not achieved, no performance-based reimbursement will be given. Under a different example, the provider may be reimbursed on a sliding scale, and as each additional percentage of weight is lost from the baseline, a level of pre-determined reimbursement amount will be given. It may be difficult to use this component as a discrete model. As such, a combination model is typically favored, such as the Attendance Milestone and Performance-Based Combination Model, which provides payment for attendance along with a performance incentive bonus.

b. Fill out the performance-based component reimbursement rate in the table below.

Weight Loss Outcome	Amount
5% weight loss	

In Step #2 of Template B in the *Budget Projection Template*, shown in the image above, the user may fill in performance-based fee amounts of their choice. The performance-based fee amounts used in the Medicare Diabetes Prevention Program (MDPP) include:

- Medicare Diabetes Prevention Program:
  - $153 when 5 percent body weight loss is achieved from baseline weight
  - $27 when 9 percent body weight loss is achieved from baseline weight
  - $8 for 5 percent weight loss maintenance from baseline weight in months 7-12 (can be billed up to six times)

Note: Although the MDPP includes an additional payment once 9 percent weight loss is achieved, the National DPP lifestyle change program does not include a 9 percent weight loss outcome. As a result, it has not been included in Template B in the *Budget Projection Template*.

Example of Combining Fee-For-Service and Performance Components

Fee-for-services, attendance, and performance-based components can be combined in reimbursement models. The MDPP is one example that combines fee-for-service payments with performance-based payment; the MDPP reimbursement model is shown below. Additional details about the MDPP can be found on the *Medicare* pages of the Coverage Toolkit. Additional examples of states using combinations of fee-for-service, attendance, and performance-based components in a reimbursement model in Medicaid can be found in the *Reimbursement Models in Practice* section on the *Reimbursement Models for Medicaid Agencies and MCOs* page of the Coverage Toolkit.

Medicare DPP Reimbursement Model:

HCPCS G-Code	Description*	Payment
G9871	Behavioral counseling for diabetes prevention, online, group, 60 minutes	18
G9886*	Behavioral counseling for diabetes prevention, in-person, group 60 minutes	$27
G9887*	Behavioral counseling for diabetes prevention, distance learning, group 60 minutes	$27
	Subtotal Maximum Fee-For-Service Payment (22 in-person or distance learning sessions)	$594
G9880	5 percent weight loss (WL) achieved from baseline weight	$153
G9881	9 percent WL achieved from baseline weight	$27
G9888**	Maintenance 5 percent WL from baseline in months 7-12	$8
	Total Maximum Payment	$822

*Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period:
Months 1-6: 1 in-person/distance learning or online session every week (max 16 sessions)

Months 7-12: 1 in-person or distance learning or online session every month (max 6 sessions)
** Months 7-12, once participant achieves 5% WL, supplier may submit Maintenance of 5% WL claim with attendance claim (G9888 + G9886/G9887 or G9871). Medicare will pay for Maintenance 5% WL up to 6 times in months 7-12.

Step #3: Determine Estimated Enrollment

The last step in the *Budget Projection Template* is estimating the number of individuals who will be enrolled and retained throughout the program. This requires an estimation of the 1) number of program-eligible members or employees, 2) number of members or employees who will enroll after recruitment efforts, and 3) rate of retention. If a performance-based component is used, it is also necessary to estimate the percentage of participants achieving the 5 percent weight loss outcome.

Program-Eligible Members/Employees

The number of program-eligible members or employees is an estimation of adult members or employees who meet the eligibility criteria (found on the *Screening and Identification for Commercial Payers* page of the Coverage Toolkit) and is the largest number of enrollees possible for the program. It is entered in Step 3a of the *Budget Projection Template*, pictured below.

Step #3: Determine Estimated Enrollment

a. Enter the number of program-eligible individuals.

Note: if choosing to focus on the highest-risk individuals instead of all potential eligible participants, this should be reflected here.

There are two suggested methods to calculate this number:

- **Claims data extraction**. Through claims data extraction, commercial plans can pull the exact number of covered members who meet the eligibility criteria. This is the most accurate method to estimate the total number of eligible members. Helpful suggestions on how to use this method are found on the *Screening and Identification for Commercial Payers* page of the Coverage Toolkit. Due to patient privacy laws, this method is not available to employers.
- **1/3 of the adult member/employee population**. When claims data is not an option, the user may use a substitute calculation of 1/3 of the covered adult (18+) members or employees. This is the approximate rate of the national adult population who has prediabetes.

The organization may choose to reach out to all National DPP lifestyle change program-eligible members or employees (shown as “high” and “very high” risk in the table below) or to narrow its focus to those at “very high” risk of being diagnosed with type 2 diabetes. The table below indicates the approximate stratification of risk for type 2 diabetes. If the organization chooses to focus on a narrower percentage of the eligible population (i.e., “very high risk”), this should be reflected in the enrollment number.

Risk Level	Percentage of Individuals with Prediabetes	10-Year Type 2 Diabetes Risk	Risk Indicators	Recommended Intervention

Very High	**15%**	>30%	A1c > 5.7% FPG > 110	Structured lifestyle intervention in a community setting
High	**20%**	20% - 30%	FPG > 100 National DPP score 9+	
Moderate	**30%**	10% - 20%	2+ risk factors	Risk counseling
Low	**35%**	0% - 10%	0-1 risk factors	Build healthy communities

Source: Gerstein et al., 2007; Zhang et al., 2010

Enrolled Members/Employees

Although recruitment efforts will be made to enroll the greatest number of program-eligible members or employees as possible, not all will enroll. There are many strategies organizations can use to maximize enrollment. Some strategies include reaching potential participants through multiple avenues, such as mailings, phone calls, emails, text messages, screening or wellness events, or newsletters. Other strategies include creating relationships with primary care physicians to secure support and referrals. For additional tips on participant recruitment and enrollment, see the *Recruitment and Referral* page of the Coverage Toolkit.

b. Enter the percent of eligible individuals who will enroll in the program.

Note: All percents on this form should be entered as decimals.

In Step 3b of the *Budget Projection Template*, shown above, users will enter an estimate of the percent of the eligible individuals identified in Step 3a who will enroll in the program. The number of enrolled members or employers is those individuals who attend at least one session (not including a session zero or discovery session, which is an informational session often used to assess readiness and commitment to the program). When estimating this number, the following estimations may be used:

- **User Choice.** Given the user's understanding of their organization's members or employees, they may be able to estimate the percentage of members or employees who will enroll in a year-long lifestyle change program after recruitment efforts have been made.
- **10 – 15 percent.** Anecdotally, many organizations estimate that about 10 – 15 percent of eligible individuals will enroll in the program. It is often said to enroll 100 people, outreach must be made to 1000 people.
- **15.4 percent, 20.4 percent, or 25.1 percent.** Across three different time periods, the Kentucky Employee Health Plan had 15.4, 20.4, and 25.1 percent of individuals enrolled and actively engaged in the program of those who had agreed to talk with a nurse during outreach.[1]

[1] CDC. Emerging Practices in Diabetes Prevention and Control: Promoting the National Diabetes Prevention Program as a Covered Benefit for State Employees. July 2016. Accessed here: https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-ndpp.pdf

- **82.9 percent**. Minnesota's employee health plan identified just over 5,000 program-eligible individuals through an electronic risk test. Of those eligible, almost 83 percent enrolled. [2]

Rate of Retention

The rate of retention is the percentage of individuals who remain active participants in the program from the first class through the end. Retention will have an impact upon the total cost of the program as well as the benefits gained by participants. For individuals at higher risk of type 2 diabetes diagnosis, steadier participation in the program will result in a higher rate of type 2 diabetes cost avoidance over time. To learn about retention best practices, please see the *Retention* page of the Coverage Toolkit.

d. Fill out the retention rates in the table below, in decreasing order.

Attendance	Percent Retention
1+ sessions	100%
4+ sessions	
9+ sessions	
>16 sessions (core maintenance)	

In Step 3d of the *Budget Projection Template*, pictured in the image above, users will estimate what percentage of enrolled individuals will attend 4+ sessions, 9+ sessions, and >16 sessions. The table below provides example retention rates based on multiple implementations of the National DPP lifestyle change program. The YMCA Retention Rate comes from the YMCA of the USA DPP 2015 Annual Report[3], published in March 2016 and supported by the Centers for Medicare and Medicaid Innovation's Health Care Innovation Awards. For additional data reports from this project, see CMS' Health Care Innovation Awards page.

Session	YMCA Retention Rate – Medicare Beneficiaries	Commercial Payer	Large Health System Employer
Enrollees in session 1	6,874	1,055	893
Attended 4+ sessions	83%	76%	81%
Attended 9+ sessions	63%	52%	79%
Attended >16 sessions	25%	*	*

[2] CDC. Emerging Practices in Diabetes Prevention and Control: Promoting the National Diabetes Prevention Program as a Covered Benefit for State Employees. July 2016. Accessed here: https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-ndpp.pdf

[3]Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring, Annual Report 2015: https://innovation.cms.gov/Files/reports/hcia-ymcadpp-evalrpt.pdf

*Not measured

Weight Loss Achievement

When using a performance-based component in the program reimbursement model, it is important to estimate the percentage of participants achieving the 5 percent weight loss outcome. This percentage is entered in Step 3e on Template B in the *Budget Projection Template*, shown below.

e. Indivduals achieving the weight loss outcome. The default percentage is equal to the retention rate entered for "> 16 sessions" (see step 3d).

Individuals Achieving Weight Loss Outcome	Percent
5% weight loss	0%

As the number of sessions attended increases, the percent of body weight loss generally increases as well. A report analyzing participant results from the first four years of the National DPP lifestyle change program indicated that participants who attended more than 16 sessions achieved a median weight loss of ≥ 5 percent.[4] Therefore, to estimate the percentage of participants who achieve the desired weight loss goal, the following estimation may be used:

- A percent equal to the percent used for participant retention in >16 sessions.

For example, if the estimated percentage of individuals who would attend >16 sessions is 25 percent, then the estimated percentage of participates who would achieve the desired weight loss would also be 25 percent.

[4] Ely, E. K., Gruss, S. M., Luman, E. T., Gregg, E. W., Ali, M. K., Nhim, K., Rolka, D. B., Albright, A. L. "A National Effort to Prevent Type 2 Diabetes: Participant-Level Evaluation of CDC's National Diabetes Prevention Program." Diabetes Care. 2017 Oct. 40(10): 1331-1341. Accessed here: https://coveragetoolkit.org/wp-content/uploads/2018/04/New-CDC-DDT-National-DPP-article.pdf

Budget Projection Results

Once the *Budget Projection Template* has been filled out, the results calculated are the total estimated cost of providing the program and the estimated average cost per participant. The "Output" sections from Template A and Template B are shown in the images below.

Template A:

Output: Total Estimated Cost*

Sessions	Cost
Core sessions 1–3	$0.00
Core sessions 4–8	$0.00
Core sessions 9–16	$0.00
Core maintenance sessions (6)	$0.00
Total Estimated Cost	$0.00
Estimated Average Cost per Participant	$0.00

Template B:

Output: Total Estimated Cost

Sessions	Cost
First session	$0.00
4 core sessions	$0.00
9 core sessions	$0.00
6 core maintenance sessions	$0.00
5% weight loss	$0.00
Total Estimated Cost	$0.00
Estimated Average Cost per Participant	$0.00

The total estimated cost and the estimated average cost per participant can help the user develop their budget when adding the National DPP lifestyle change program as a newly covered benefit or a wellness benefit. This information may be used to determine an estimated return on investment (ROI), when used in combination with a type 2 diabetes cost avoidance calculation (which is not included in this document).

These estimates may also be used to budget for future years and to negotiate and set rates with CDC-recognized organizations.

Please note that some costs have not been included in this estimate, such as administrative costs to get the program up and running, and the cost of program supports used to encourage retention.

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