EPISCOPAL HEALTH FOUNDATION

MCO NMDOH Learning Collaborative Webinar: The Cost of Diabetes in Texas and Diabetes Prevention Programs

Shao-Chee Sim, PhD, MPA
Episcopal Health Foundation

Texas is experiencing a diabetes crisis.

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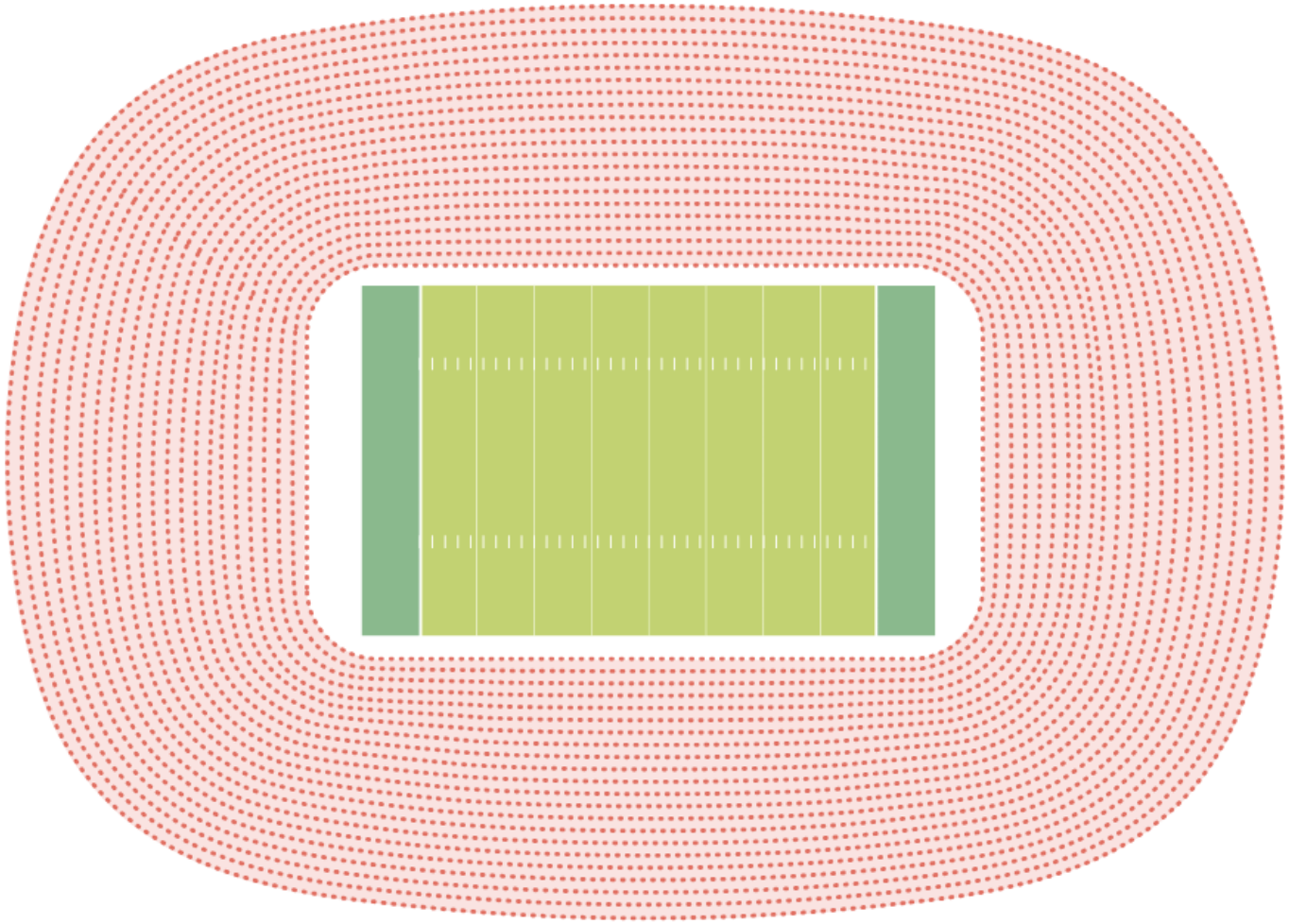
Imagine a football stadium at full capacity, approximately 72,000 people



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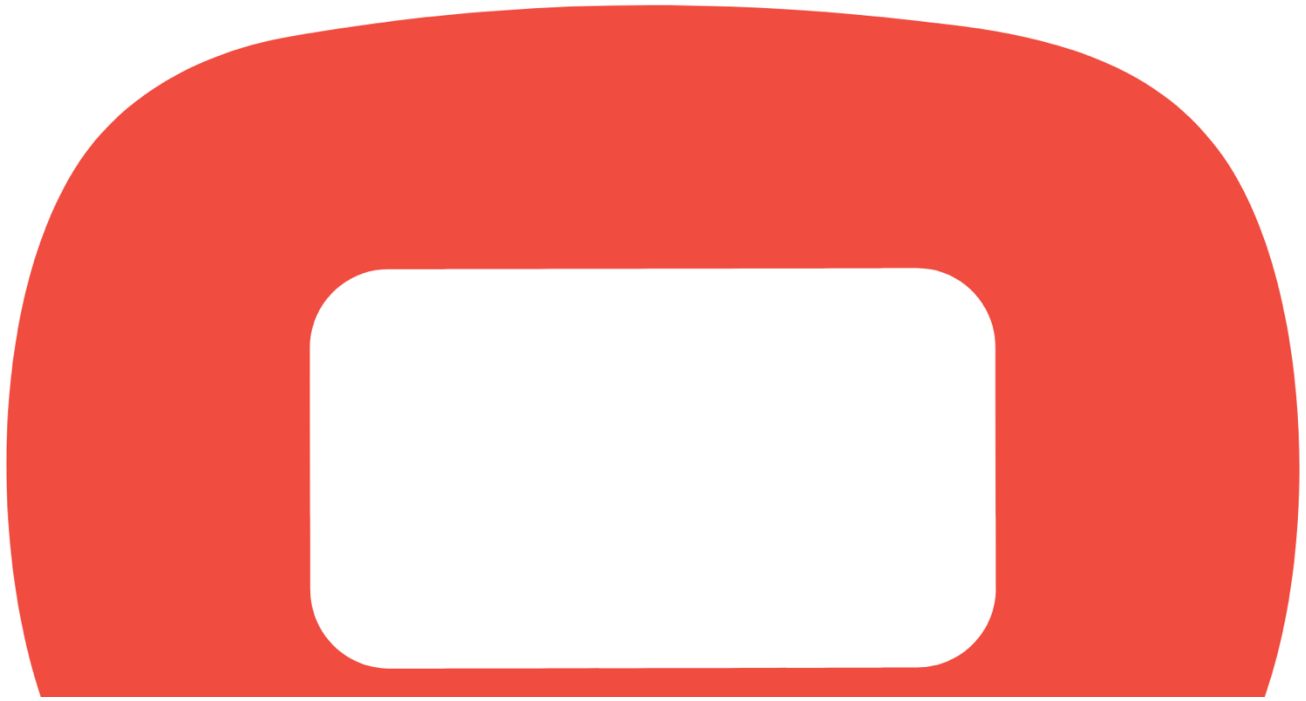

This icon represents 72,000 people who have been diagnosed with **type 2 diabetes**

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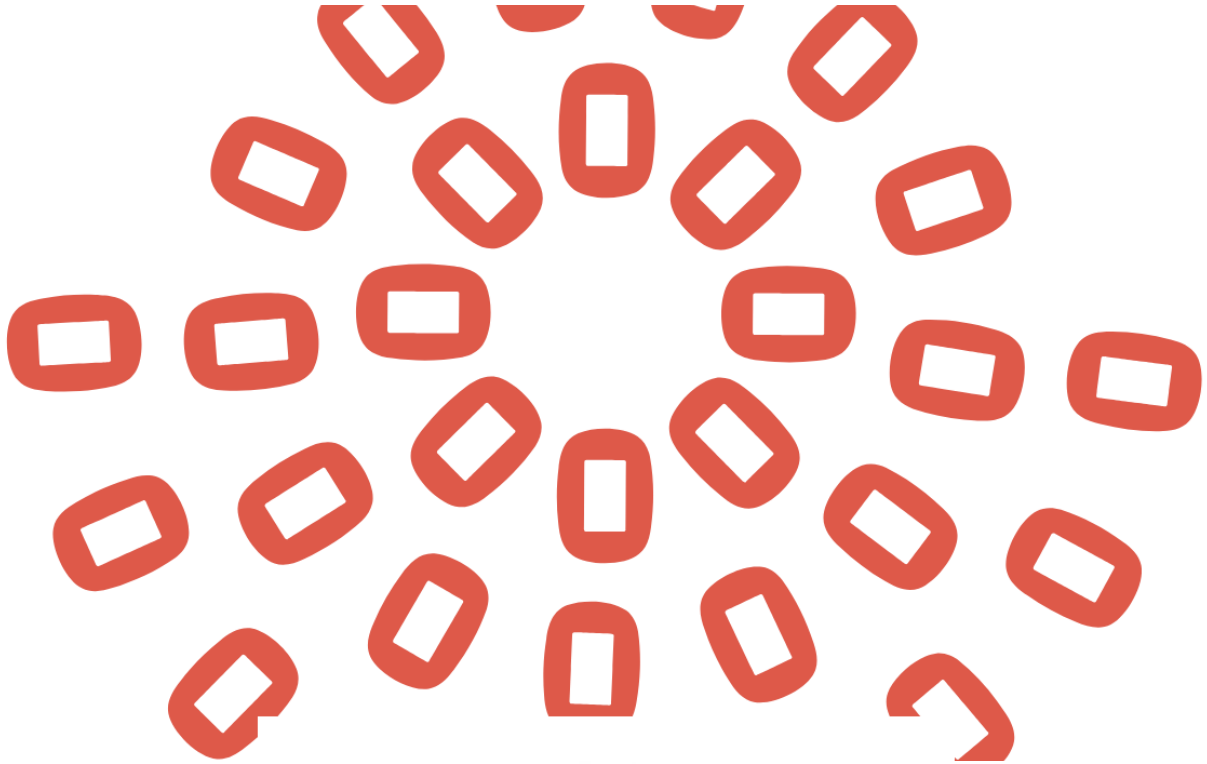
2.7 million Texans have been diagnosed with diabetes



That's **37.5 stadiums** full of people.

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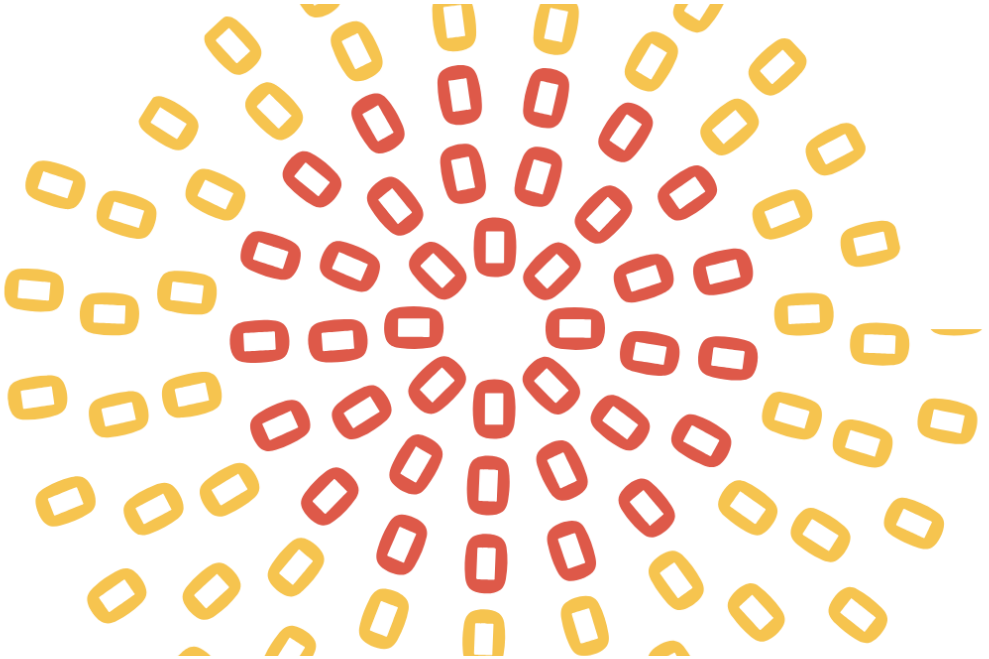
7.1 million Texans have prediabetes



That's an additional **99 stadiums** full of people.

Cost of diabetes and potential prevention strategies in Texas Medicaid

Highlights from Milliman reports commissioned by the Episcopal Health Foundation

Stoddard Davenport & Bridget Darby

October 27, 2025

Milliman

Background

The Episcopal Health Foundation engaged Milliman to produce a report describing the population demographic characteristics, economics, and healthcare experience of the populations in Texas Medicaid with type 2 diabetes and associated risk factors.

Milliman also produced a report summarizing what's known about the cost and clinical effectiveness of the Diabetes Prevention Program (DPP) across Medicare and Medicaid programs in other states.

Background

Type 2 diabetes and prediabetes are highly prevalent.

- In 2021, nearly **38%** of the adult population in US had prediabetes (CDC).
- And over **14.7%** of the adult population had diabetes (CDC).

People with diabetes are at risk for developing:

- Eye disease,
- Nerve damage,
- Kidney disease,
- Cardiovascular disease, and
- Many other diseases or conditions.

Diabetes is also associated with higher healthcare costs.

References provided on slide 20.

What is the Diabetes Prevention Program, and what is known about outcomes?

Milliman

Diabetes Prevention Program

Typical program structure

The DPP is a CDC-credentialed, evidence-based lifestyle and health behavior change program aimed at preventing diabetes by targeting at-risk populations.

Started as a clinical trial, scaled to a national program, including a CMS reimbursed Medicare DPP program. States may also operate Medicaid programs.

Eligible populations: have prediabetes, be overweight and at least 18 years old.

Program is 6 – 12 months.

Can be delivered in-person, telehealth or virtually

Curriculum includes education on improving eating habits, increasing exercise, stress management and improving sleep

Includes a combination of individual or group coaching sessions for 6 months with a lifestyle coach

Coaches can be clinicians, nurses, CHWs or community members

References provided on slide 20.

DPP evidence – health outcomes

Outcome	
Weight Loss	• Achieve modest weight loss (~3-5% of body weight within 12 months) for a subset of participants. • No difference in outcome between treatment modalities. • Program effectiveness is positively associated with number of program sessions attended. Individuals who attend more sessions lose more weight. • Weight is often regained within 12 months after program participation for 50% of participants.
Diabetes Incidence	• An assumed association between weight loss and a reduction in diabetes incidence. • In clinical trial, diabetes incidence was reduced by 58% relative to a control and 50% of participants lost at least 7% of body weight. • New since our literature review – MDPP evaluation found 5.9% of participants progressed to diabetes each year after MDPP participation. For those who achieved 5% weight loss had lower incidence rate than those who did not meet weight loss goal. Study lacked control group and sample size was small.
Blood Glucose	• Not typically measured for program. • Clinical trial found HbA1c restored to normal levels relative to control group. • Recent studies found significant but small reduction in HbA1c (<1% change).
Cardiovascular	• Some evidence from clinical trial follow ups suggest program improves blood pressure and cholesterol. • Further research is needed in this area to determine the effectiveness in current DPP programs.

References provided on slide 20.

DPP evidence – cost effectiveness

Short-term savings:

- National pilot: A study found $1,112 savings per participant per year relative to control
- Digital DPP program: A study found $1,169 gross savings and $598 net savings per participant per year relative to control
- MDPP: Cost savings were not statistically significant.
- Medicaid: Unavailable in literature.
- Savings often related to reductions in inpatient admits and ED visits.

Long-term savings:

- Long term healthcare cost savings have not been directly measured for the DPP.
- Economic models have estimated cost effectiveness from the DPP program on longer time scales.
- Cost-effectiveness is dependent on durability of program health outcomes.

References provided on slide 20.

DPP evidence – program implementation

Participating population skews female and older across all iterations of the program.

Low enrollment has been cited as an issue across all markets

Example: Approx. 9,000 beneficiaries enrolled in the Medicare DPP nationally between 2018-2024, but CMS predicted enrollment between 50,000 – 100,000 annually.

Possible drivers:

- Transportation barriers
- Limited availability of DPP sites in given geography
- Clinician and patient awareness of program
- Patient awareness of diabetes risk factors

References provided on slide 20.

What does diabetes look like in the Texas Medicaid population?

Milliman

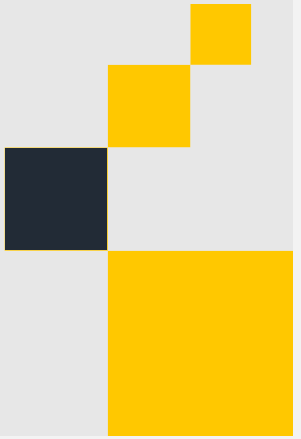
Methods

Data

- Administrative health claims data provided by Houston-area MCOs between 2019-2021
- CMS Transformed Medicaid Statistical Information System (T-MSIS).
  - Contains detailed administrative claims, managed care encounters, and enrollment records for all patients covered by Medicaid and the Children's Health Insurance Program (CHIP).

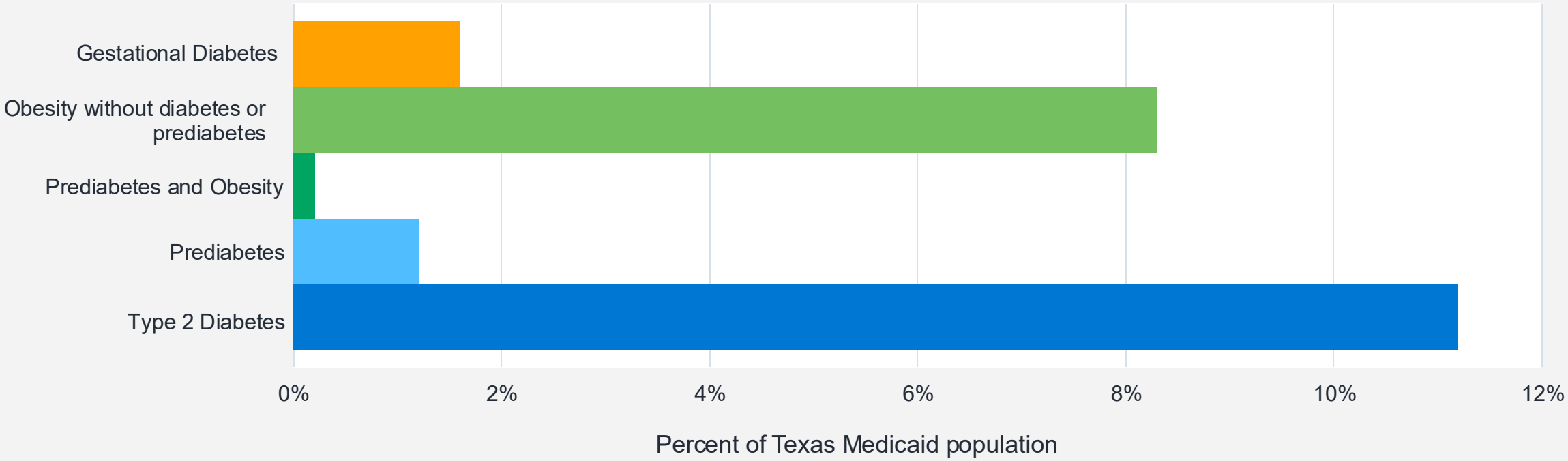
Condition identification

- Used a combination of ICD10-CM diagnostic codes and demographic criteria.
- Selected diabetes risk factors include: prediabetes, obesity (with and without prediabetes), and history of gestational diabetes



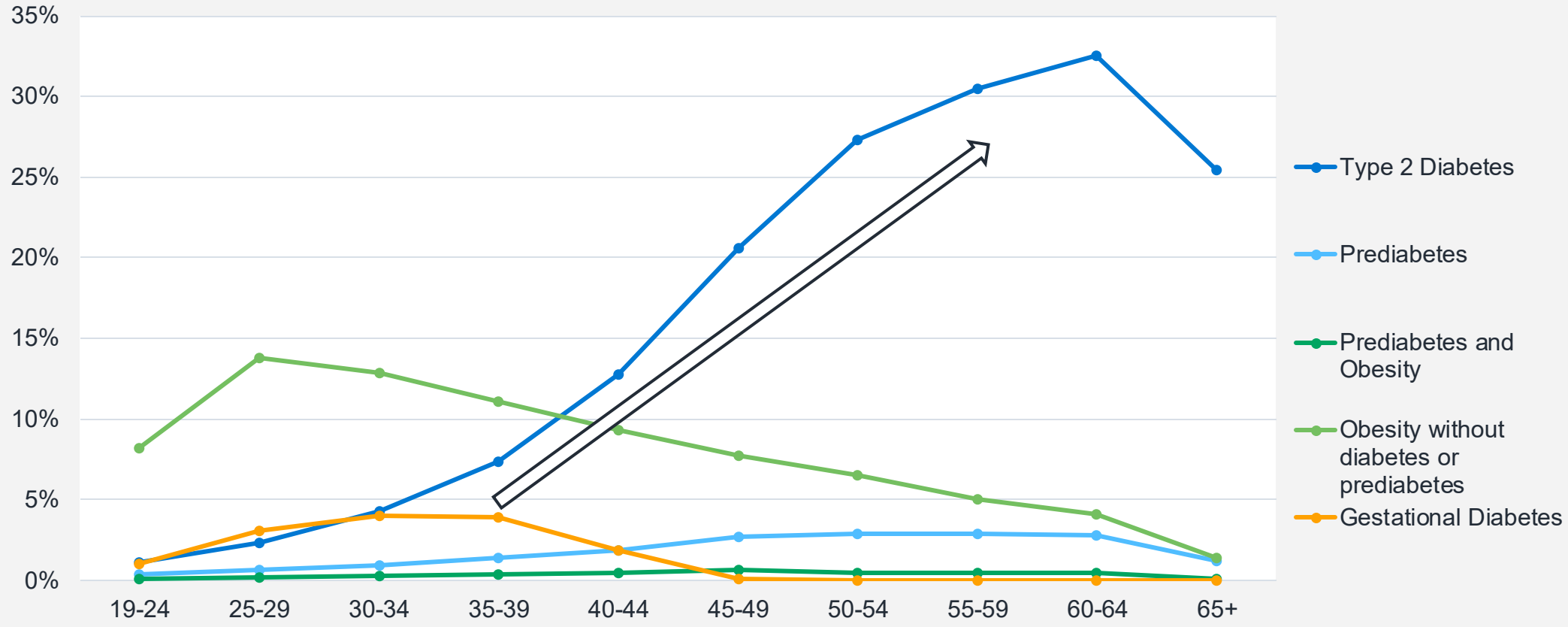
Disease prevalence

Percent of Texas Medicaid population, 2021



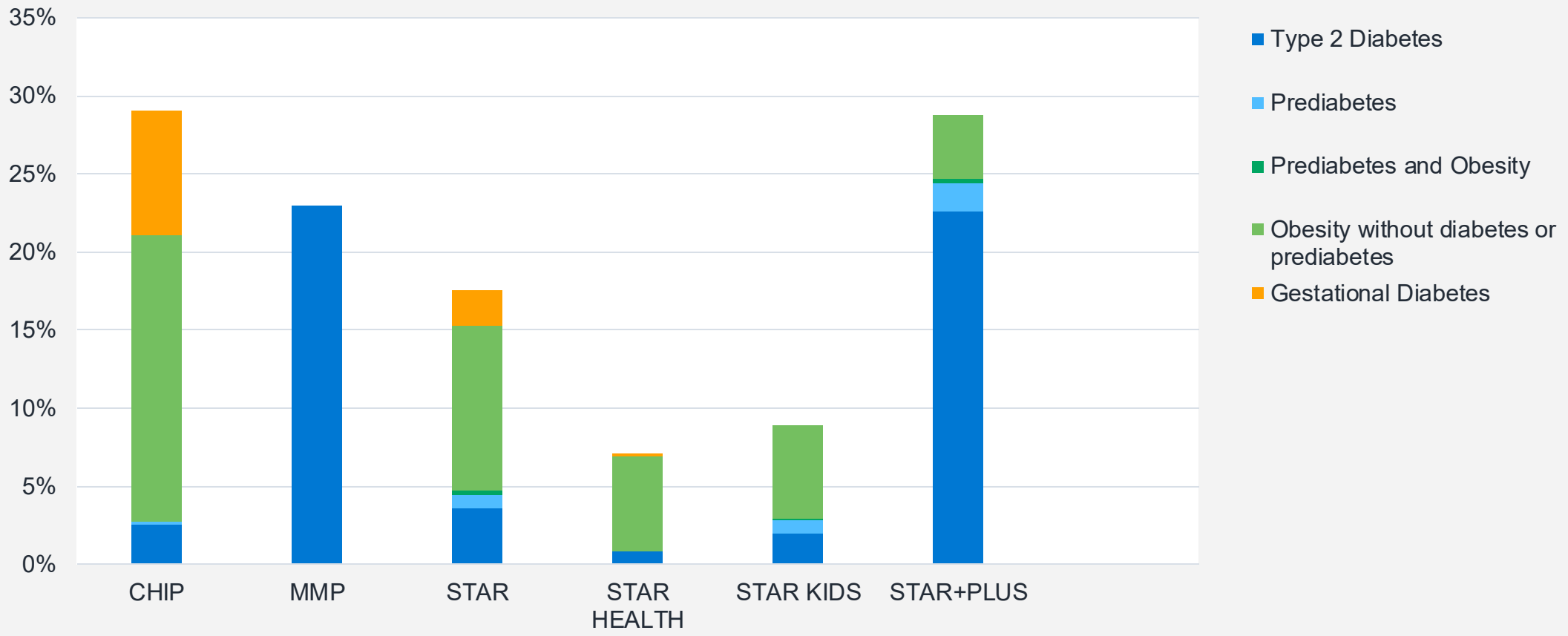
Diabetes prevalence increases with age

Prevalence of diabetes and select risk factors by age, 2021 (adults only)



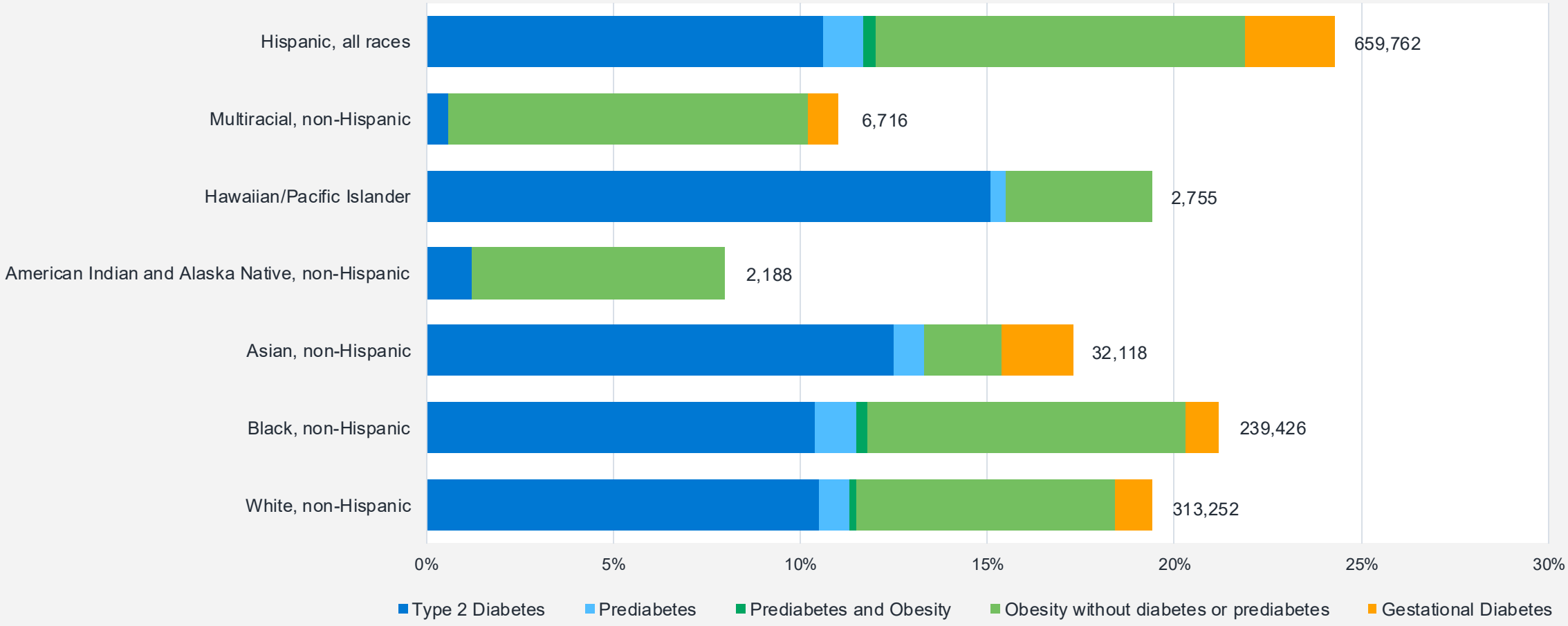
Diabetes is most prevalent in STAR+PLUS and MMP

Prevalence of diabetes and select risk factors by Texas Medicaid program, 2021 (all ages)



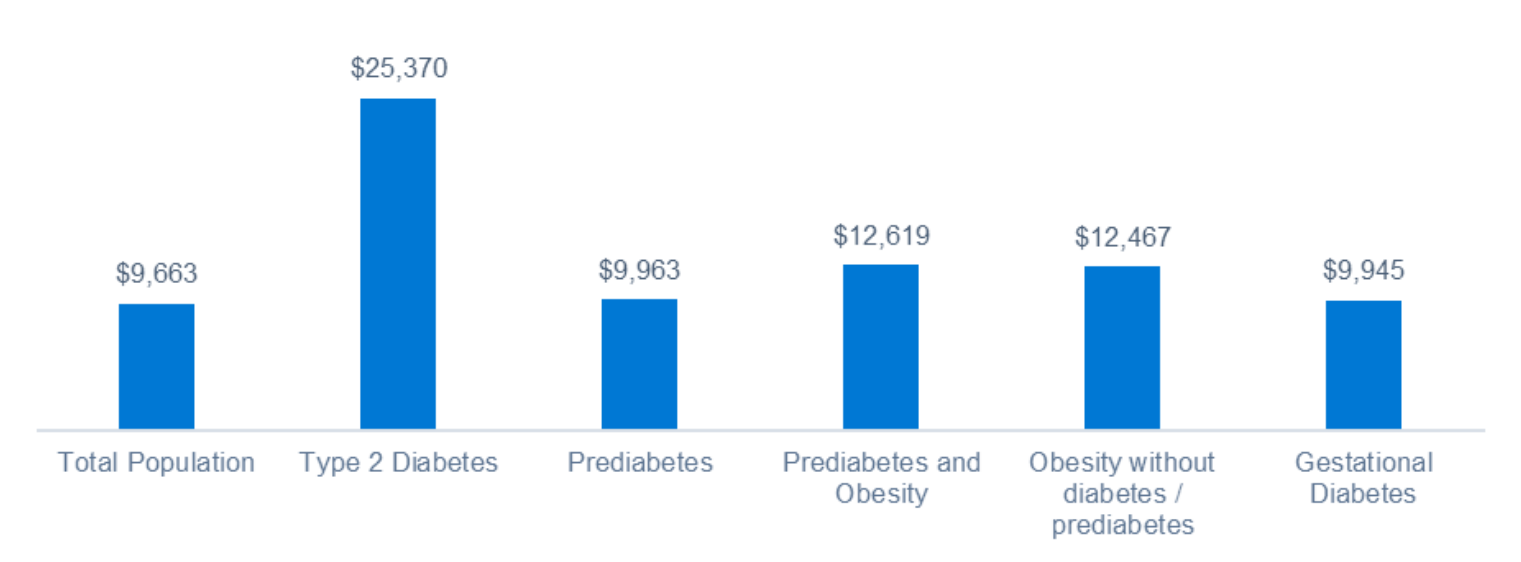
Diabetes is more prevalent for those of Asian descent compared to other races or ethnicities

Prevalence of diabetes and select risk factors by race/ethnicity, 2021 (adults only)



Healthcare costs for individuals with diabetes are high

Average annual costs per adult with diabetes or select risk factors, by condition, 2021



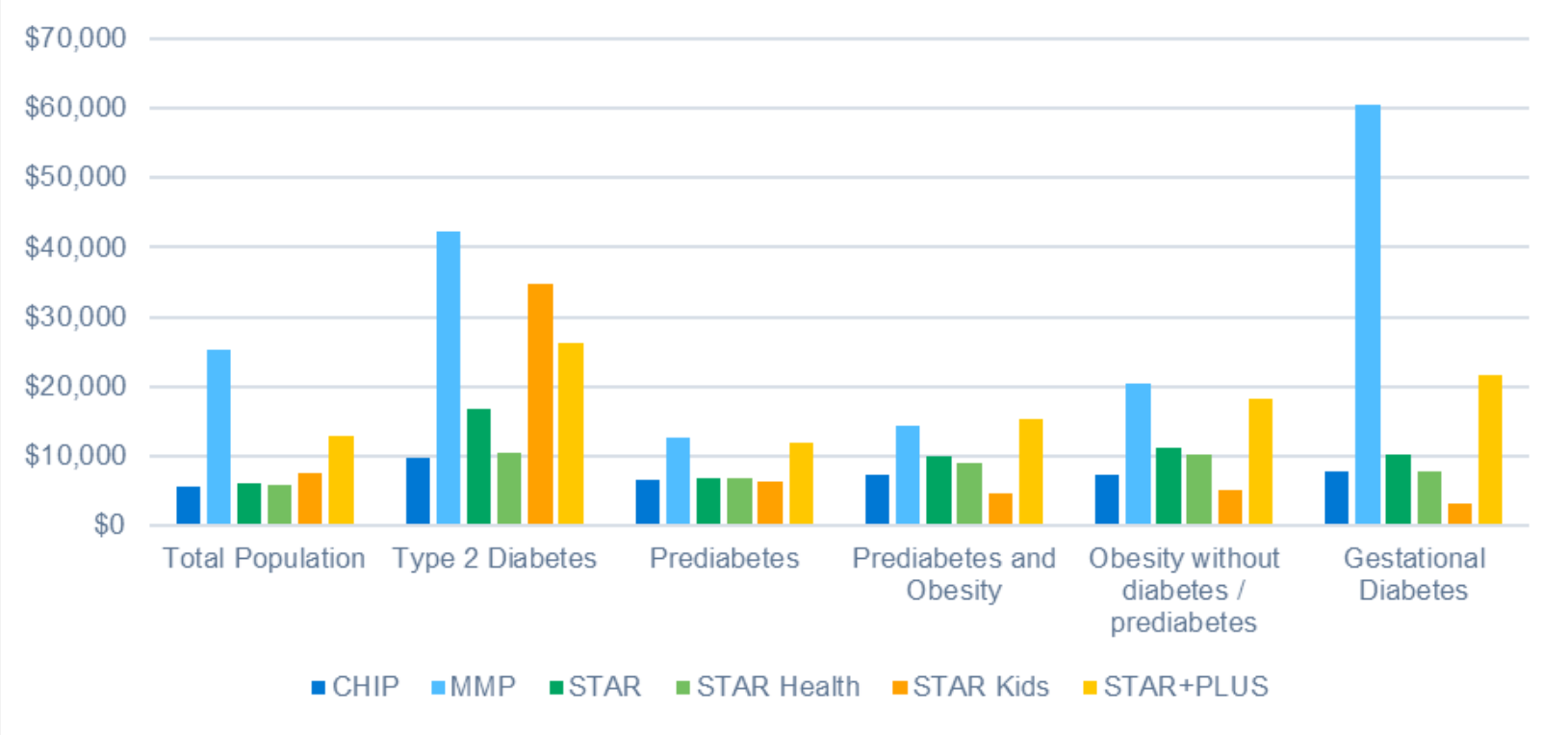
2.63x more than total population per year

2.54x more than population with prediabetes

2.03x more than population with obesity

Healthcare costs are highest for STAR+PLUS and MMP

Average annual cost per person, by condition and medicaid Program, 2021



Higher costs in diabetes population driven by inpatient and outpatient medical services

Distribution of costs by major service category for select conditions, 2021 (adults only)

	Allowed costs per member per month				Costs relative to total population		
	Total population	Prediabetes	Obesity	Type 2 Diabetes	Prediabetes	Obesity	Type 2 Diabetes
Inpatient - Medical	$333.80	$243.51	$662.82	$1,032.10	0.73x	1.99x	3.09x
Inpatient - BH	$4.66	$5.43	$10.67	$10.42	1.17x	2.29x	2.24x
Outpatient - Medical	$114.35	$175.63	$286.46	$320.34	1.54x	2.51x	2.80x
ER visits	$34.53	$39.73	$75.93	$60.05	1.15x	2.20x	1.74x
Outpatient - BH	$0.55	$1.09	$0.91	$0.69	1.99x	1.67x	1.27x
Prof - Medical	$115.61	$148.08	$264.76	$228.55	1.28x	2.29x	1.98x
Prof - BH	$2.88	$6.53	$5.03	$3.16	2.27x	1.75x	1.10x
Other	$196.06	$204.36	$175.33	$454.18	1.04x	0.89x	2.32x
Additional Benefits	$2.78	$5.87	$2.63	$4.71	2.11x	0.94x	1.69x
Total Medical	$805.22	$830.23	$1,484.53	$2,114.20	1.03x	1.84x	2.63x

Estimates of total cost of diabetes to Texas Medicaid

In FY2021, we estimate that total healthcare costs for individuals with diabetes was between **$6.2 billion and $8.1 billion** including both state and federal payments.

This represents about **15.9% to 20.6%** of total Medicaid medical benefits spending in FY2021 or about **22.7% to 29.5%** of spending for adults.

These estimates are likely understated because claims analyses cannot identify all people with diabetes.

Key takeaways

- The health conditions and risk factors studied are prevalent and have substantial impacts on health outcomes and healthcare costs for Texas Medicaid.
- There are known ways to address some of the risk factors and prevent at least some portion of diabetes cases.
- Programs that can effectively reduce the incidence of diabetes may be able to generate healthcare cost savings. Whether savings will be net of intervention costs depends on the effectiveness of the program, and the costs of implementing it.
- The impact of GLP-1s and other anti-obesity medications on diabetes prevention or management and health care costs is an open question for this population.

Citations

Milliman research reports for the Episcopal Health Foundation:

- https://www.episcopalhealth.org/wp-content/uploads/2024/11/Milliman-Diabetes-prevalence-and-costs-in-Texas-Medicaid-2024-11-15.pdf
- https://www.episcopalhealth.org/wp-content/uploads/2025/07/Milliman-Diabetes-Prevention-Literature-Review-Final.pdf

References for overview of the Diabetes Prevention Program (slides 3 and 5)

- https://www.cdc.gov/diabetes/prevention/about.htm
- https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp
- https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program
- https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt
- Hoerger TJ, Jacobs S, Romaire M, et al. Evaluation of the Medicare Diabetes Prevention Program (MDPP): Second Evaluation Report. RTI International. 2022.

References for cost and clinical effectiveness of the DPP (slides 6-8)

- https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt
- Hoerger TJ, Jacobs S, Romaire M, et al. Evaluation of the Medicare Diabetes Prevention Program (MDPP): Second Evaluation Report. RTI International. 2022.
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- Alva ML, et al. Impact of the YMCA of the USA Diabetes Prevention Program on Medicare spending and utilization. Health Aff. 2017;35(3):417-424.
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- Herman, WH. The cost-effectiveness of diabetes prevention: results from the Diabetes Prevention Program and the Diabetes Prevention Program Outcomes Study. Clin Diabetes Endocrinol. 2015; 1(9).
- Ritchie N, Baucom K, Sauder K. Current perspectives on the impact of the National Diabetes Prevention Program: building on successes and overcoming challenges. *Diabetes Metab Syndr Obes*. 2020;13:2949-2957

Milliman

Thank you

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Unpacking Takeaways from a Landscape Scan of Diabetes Prevention Programs in Texas

EHF's MCO Learning Collaborative

Monday, October 27, 2025

By: Ankit Sanghavi, MPH, BDS

Executive Director

Texas Health Institute

About Texas Health Institute

OUR COMMITMENT

Ensuring everyone has the opportunities they need, free from barriers, to pursue their best health.

It centers everything we do and how we do it.

VISION

Healthy People,
Healthy Communities

MISSION

To advance the health of all

OUR PRIORITIES

- Advancing health systems transformation
- Strengthening public health infrastructure
- Promoting healthy communities

Our Strategies

We are **Texas-focused** and **nationally engaged**.
We optimize our role as *the* independent public health institute in the state by:

Leading Through Research and Evaluation

Provide and leverage objective, participatory, and applied research.

Translating Data and Insights Into Impact

Empower communities and stakeholders with trusted and actionable information and tools.

Fostering Collaborative Action

Facilitate dialogue, partnerships and actions for shared priorities

Providing Technical Assistance and Training

Ensure success and sustainability through learning and capacity building.

Project Overview

- Episcopal Health Foundation (EHF) contracted with THI in April 2024 to carry out a landscape scan of Diabetes Prevention Programs (DPP) in Texas.

- Purpose –
  - *To better understand how DPPs are operating in Texas, the program*
  - *Identify successes and challenges in the context of the state, and*
  - *Assess the current financial landscape of DPPs, including long-term sustainability and scalability of the programs.*

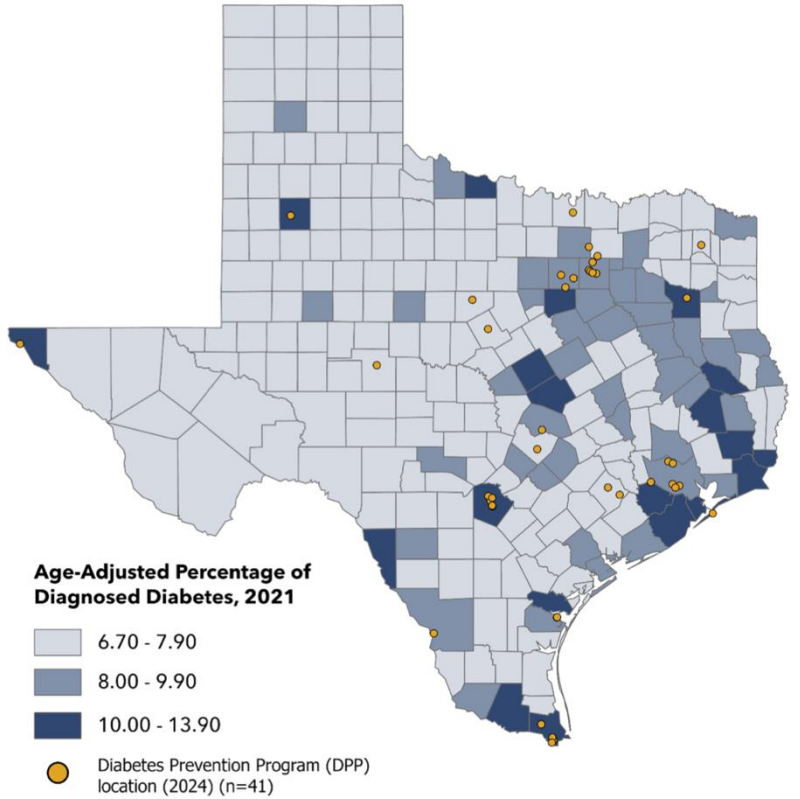
Our Approach

- THI worked with EHF to co-design a research agenda and evaluation framework
- Used the CDC RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework
- From May through August 2024, a three-phase mixed methods approach:
  - *Scoping review of existing data and literature,*
  - *Key informant interviews (10), and*
  - *a survey of DPP staff (n=34).*

ADOPTION AND REACH: THE WHO, WHAT, AND WHERE OF DPPS IN TEXAS

- Nationally, only three percent of adults diagnosed with prediabetes have engaged in the program
- In Texas, of the estimated 7.1 million eligible Texans, only 33,000 Texans are/have participated in DPP
- Nationally, there are 2,100 CDC-recognized DPP providers
- As of March 2024, there were 66 CDC-recognized programs operating in Texas

Figure 1. Diabetes Prevention Program Locations, Diabetes Prevalence, and CDC DPP Recognition Status



- The 66 DPPs operating in Texas are run by 56 organizations across the state.

- Population with
  - *41 organizations delivering in-person programs,*
  - *7 organizations delivering hybrid programs,*
  - *18 Texas-based organizations offering programs categorized as distance learning or online, and*
  - *28 non-Texas online programs that may or may not serve Texans.*

- Approximately 72% of respondent DPPs have fewer than 50 participants registered.

Key Findings

- DPPs primarily recruit and engage participants directly followed by referrals.
  - *Visibility in the community and offerings that are culturally responsive keys to success.*
  - *Challenges exist in engaging men, particularly working aged men of color*
  - *Providers are not as engaged as referral sources as DPP program staff would like.*

- Participants face multiple barriers to engagement which necessitates adaptation and innovation
  - *Several NMDOH and program components were identified as barriers*
  - *Person-centeredness, including through modalities and peer and coach support is key to success*
  - *DPPs enhance the program through community embedded and culturally responsive ways.*

- Significant concerns around long-term sustainability.
  - *Funding models (grants) are not sustainable*
  - *Workforce challenges exist across program types*
  - *There is desire and need for shared learning and collaboration*

Participant Recruitment & Engagement

Community Outreach & Recruitment

Visibility in the community is a key factor for successful recruitment, particularly for traditionally underserved communities.

We started an online workshop just recently with 20 people in it. And so, the recruitment was localized, and it was also through social media. But it was heavily localized. So, a lot through community partnerships and health fairs. And then just going out and talking to the people that have gone through the program, too, to see if they can refer other people to DPP.

– Key Informant

People, if they are just going online and reading stuff, they can't stumble upon our page, and they take the risk assessment test and see if they are eligible for the program. And if I do this-- because it's self-administered, so we had to put a blurb here up there to tell them what to expect about the program.

– Key Informant

And then our recruitment, that's where the community partnerships are very beneficial. So, the CHWs will do recruitment through those partnerships. They'll contact the partnerships.

– Key Informant

Provider Referrals

Providers are not as engaged as referral sources as interviewees would like

We get a lot of people through, so referral from providers in general, self-referral. Health fairs, that's a big thing. We have [eligibility forms] on tablets, and we distribute these in select clinics. And while you're waiting to be seen by the provider, you just fill out the form and see if you're eligible or not. So that made an additional way of recruitment from the select clinic.

– Key Informant

We don't have nearly as many physician referrals as I would like. Mostly insurance agencies, and then our local VA sends over referrals as well... I think that not everyone does email. It's just harder to make phone calls. It's more time-consuming, so that could be a barrier. I was just on a call earlier with Community First Health Plans, and I have a feeling a lot of our responses are going to spam.

-Key Informant

Then there's also this other element around the referral networks for the Diabetes Prevention Program. Today, a lot of those gaps exist. And in Texas, it is primarily because of coverage, right? It's not that a provider doesn't want what's best for their patient. The pathways are just not set up in a friendly way to connect that over. So, I would say the second piece around that is the referral system and having a strong referral network around it.

– Key Informant

Recruiting Spanish Speakers

Several Texas programs focus specifically on the Hispanic community, with the majority of their groups offered as Spanish language groups.

Our community, they speak actually more Spanish than English. It's 90% Hispanic... And well, of course, because they're Hispanic, we have a big number with people with diabetes here in our community... we are working a lot with people with diabetes, with people with prediabetes.

– Key Informant

And during the 28 years I have been working here, I can tell that only on five occasions, I need to use the English curriculum because the majority of our population is from Hispanic origin, and their first language is Spanish. I mean, we have bilingual people. But when you are explaining information, they feel more comfortable with the Spanish language. Now, sometimes if they need to read something, they say, "Do you have it in English?" So, it is a combination. I guess we are Tex-Mex Spanish, 100%.

– Key Informant

Missing Men

Also recognized by key informants was the challenge of recruiting men, particularly working age men of color to participate in the program.

- *I mean, when you look at DPP classes, we have a lot more females enrolled than males. Males do not want to. And we just had an event the other day, last week, actually, where it was 350 males. And out of the 350, only 80 got screened.*

– Key Informant

- *It's like the men typically work longer and harder. So, they're exhausted when they get home. So again, that might be something where I know we looked into another program when I attended the diabetes conference, the ADCES Diabetes Conference. It was for Black men, and they developed this app, and it was interactive. And I thought, "Wow, that would be so wonderful."*

- Key Informant Interview

Enrolling males is challenging. We've been successful enrolling males who are retired but not actively working.

– Key Informant

Recruitment & Engagement in Rural Communities

DPPs in rural areas face unique challenges.

It's hard to get people through the door and to commit initially to essentially 12 months. I mean, they meet weekly and then monthly after that. But it's really hard, especially in rural areas, to get them to commit, it's a lot. Even if our office is centrally located, you still have people driving 30, 40 minutes to get to a class. And that becomes a challenge.

– Key Informant

We don't have great infrastructure for buses. Not everybody, again, is going to go into rural areas with an Uber-type deal. We're not going to do that. We're not going to spend the 20 bucks to get on an Uber to go across the other side of town.

- Key Informant

In [one] county, we have abundance of resources that we can refer people to. But in the rural counties, not so much. So it's limited. There are still there to be found, but it's few and far between. So those are two limitations with rural.

- Key Informant

Barriers & Supports For Engagement

NMDOH were Frequent Barriers to Participation

Transportation, access to healthy foods, work schedules, childcare, and family support were often identified as key barriers impacting engagement.

So, for transportation, we don't have any funding for getting people their own Uber. So that's always been something we haven't done. Back in the day when we were first starting out, we gave rides to people, but that has since then stopped because that's prohibited by [organization].

– Key Informant

If we have participants that have a job in which they have been changing the schedule, okay, well, we have the option. "Does your schedule change? Okay. You can come in the morning, or you can come in the afternoon. And if, next week, you're going to have a different schedule, okay, we have the three options for you." So, they can go to a different class because we have three courses that initiate during the same week and finish during the same week.

– Key Informant

So early on, I would say about a year after we started the program, we realized that the people that were coming to the classes, they faced many challenges. And it's really difficult to work with people and show them how to eat and to manage this chronic disease if they don't have access to food or shelter.

– Key Informant

Family Engagement

Strategies to engage families play a dual role of meeting childcare needs and enhancing program effectiveness.

And I think we've played with the idea of doing some family workshops. And so back when I was still doing them, we did actually do one where we had two CHWs split up, and so one dealt with the adults. And then the other one worked with the children and did some little workshops with them. I think what's been harder is finding curriculum for kids that's age appropriate.

– Key Informant

And so, all this DPP on the CDC website for adults. What about teens? Because they will become adults one day, and they will have that extra weight that they don't know what to do with, and it will be with them for the rest of their lives. So, I think targeting people early on, having family-centered approach.

– Key Informant

We've had a mom go through the program. And as she was going through the program, one day at some point in the program, she was going grocery shopping with her daughter. And she was picking stuff off the grocery shelf. And her daughter, who, I guess, listens to the program, goes, "Mom, I don't think you can eat that according to the program. You're not supposed to be eating that." So now we have not only this daughter keeping her mom in check, but it is so incredibly rewarding to see this daughter is now learning something, right?... Like I said, there's a multi-generational impact that comes from this that is heavily discounted in the way the program operates there.

– Key Informant

Peer Support

The mental and emotional support provided by DPP coaches and peers are often the best and most long-lasting participant supports.

And so we build up those peer-to-peer support groups in a way, so people feel like when they're coming to these workshops, they're not just getting some health-- they're not just getting health education information from the CHW, but they're also getting that support back from their peers.

– Key Informant

Those little bright spots are like people like getting together. They like sharing. I wouldn't call it a support group because when you call-- because we have stigmas. So, when you call something a support group, they think that you're under mental health issues or whatever. So, they like getting together and sharing their experiences. They love to do that. And that's when you begin to see the actual improvement in their health.

– Key Informant

But little by little, when they start developing those abilities, they can get in front of the group and share their knowledge or their experiences. And they feel comfortable sharing with them because we establish an atmosphere in which everybody feels welcome and respected... A human being has to be recognized. It has to be valued. It has to - I don't know - feel that it's welcome and appreciated. By doing that, we are accomplishing, little by little, goals that we establish.

– Key Informant

Person-Centeredness

Supporting participants by providing options to engage in the program through different modalities makes the program more person-centered.

You have people who just do better in a group setting where they actually are face-to-face with the instructors and with the other participants. But then when you think about virtual ones, not everyone has the time to travel to another branch. Some people have to worry about daycare and things like that. So, I noticed that the active older adults, the senior population tend to want the in-person, and it is mid-30s to mid-40s that want those virtual options. Probably a lot of parents have to worry about cooking dinner and all the things. It's easy to just hop online than it is to hurry up and cook dinner and then take a drive to the gym and then worry about what can their kid go to the childcare or having to find someone to watch their child during that time.

– Key Informant

So online has actually worked out really, really well for us. You'll be surprised to hear this, but we have someone who's gone through our program, and she does the cleaning service at a hotel... She's part of the cleaning crew there. And she actually tunes into our program while she is working, right? Talk about meeting them where they are and where they're spending their time, right? So, it cannot be defined by our assumptions of what is right for an individual. It has to come from a place of, "Let's give them this option and let them decide what is best for them," right?

- Key Informant

Cultural-Responsiveness

Several DPPs adapt the CDC curriculum by incorporating culturally appropriate and responsive foods, activities, and examples into sessions.

I had a group of coaches that I trained, and I had at least four or five that were Filipinos or Vietnamese. And when we were talking about the food part I said, "Okay. Today and tomorrow, you go home and calculate everything you eat and calculate calories and whatnot and come back." And they came back, "I don't know. I don't eat this way. We eat in a bowl. We eat in a bowl with everything mixed together, so that doesn't fit, and I didn't know how to do it."... And it was a very interesting conversation because you see it from a different perspective.

– Key Informant

Thinking about the language, it is very important to speak Spanish but from the region that you are, or the participants are. Because remember, we have people from Puerto Rico speaking Spanish. We have people from the Dominican Republic...It's just not only to speak Spanish, to speak their language, but also to have a facilitator that knows the culture, which knows the people that are participating there.

- Key Informant

And so, I think that's also one thing that the CHWs have done really well, is really think about how to make the education components very accessible to the community members. And so I have CHWs right now that like to do little physical activity sessions with the seniors, and then also have some CHWs that will bring their faith into it in the past, or they'll work on making sure that the examples that they use for food are culturally relevant versus just saying, "Oh, let's just eat more vegetables," but not discussing what vegetables is it that we eat in our culture, and let's talk about those vegetables.

– Key Informant

Community Partnerships

DPPs also engage with local communities and partners to bring in additional resources and expand upon existing modules.

There's kind of the curriculum, as it's written. But then what seems to be, really, a best practice is pulling in partners, pulling in extras that go beyond that curriculum to really make it a holistic, person-centered approach.

-Key Informant

So, we are connected with sleep medicine folks, and one of their faculty would come to the class and talk about the importance of sleep. Granted, that it's already in the curriculum. We know that. But when we do that session, we also have this-- there is a questionnaire about sleep disorders. And if you tally the score, you can tell maybe you are at risk for sleep apnea, maybe you have restless leg syndrome, and so forth. And many of our participants, when they would take these questionnaires, they realize that. And we help them arrange to meet with a provider and get a CPAP machine. And once they get a CPAP, their breathing is better, they don't have sleep apnea, and they lose weight. So, it's a continuous-- so we're not dealing with them from, "Okay, here is the curriculum. We give you the curriculum, and we're done." We're trying to have a more holistic approach to ensure that all the aspects are taken care of.

– Key Informant

Another thing I would say, too, as far as coaching, we had or have people in the community come out with the class all the time. So, for example, stress management, the week that we cover stress management, we have counselors come and they share things about stress management. We have pharmacists come and talk about medication. We have people come and do a bone density test, like one of those-- not anything major. So, we had a lot of people that would come in from other organizations and teach the class, and that was always really popular.

– Key Informant

Programmatic Barriers

Several key informants mentioned challenges inherent to the DPP as a barrier to implementation.

Even we wanted to do also in Arabic, you're talking about different languages, the CDC curriculum is not in Arabic. It used to be the old curriculum was translated, but not the new one. So there are challenges in terms of minorities or if you want to address different populations.

– Key Informant

So that's the most challenging part is getting people not only to sign up for the class but to come and then continue coming. Because after a year, if you only end up with two people in the class, they're not getting the full effect because it's a facilitated class. They're not getting the help and support from their peers for the program. It just doesn't have the same effect.

– Key Informant

Okay? So, there is an initiative by the American Diabetes Association to go ahead and get all organizations to be CDC recognized. The problem with that is it's very time-consuming. There are a lot of little meticulous details or requirements that need to be met before you are recognized by the CDC. So, a lot of organizations have said, "You know what? We don't have the funding and we don't have the time."

– Key Informant

Program Impact

Measuring Outcomes

Some key informants mentioned ways they were measuring success beyond the substantial programmatic data provided to the CDC.

One of the things that we developed with our funders is a questionnaire, and that questionnaire has questions about demographics, and eating habits, exercise habits, and socioeconomic status. I want to capture everything. Income, and what else? Food security, for example. We had so many items, and we started collecting that maybe a couple of years ago, not much, for all our participants at baseline, at 6 months, and at 12 months, to see a difference. The amount of data is huge and we haven't gone through it all, but we hope to see a difference with the program on people's lives.

– Key Informant

We do have a form they fill out at the beginning, and it talks about-- I mean, it briefly covers mental health, whether they feel motivated. So, like a brief PHQ-9, depression screening form, but not as formal. And then we do it post-class. And yes, so there is significant improvement between the pre and post among a lot of our [participants], especially the participants who come regularly.

– Key Informant

Life-Changing Impacts

Several key informants told stories and shared insights about the ways the DPP made a difference in the lives of participants.

We've had someone go through and tell us things like she has energy to play with her kids for the first time in years. I mean, just that, in itself, is incredibly rewarding... These patients also come from a background where they've had a family history of diabetes, where they've had an uncle, a parent lost their leg, lose vision. And so those are all those stark fears that are very real for them in their own lives... it is incredibly rewarding for me... to see that these lives that change are multi-generational.

– Key Informant

It is more than just preventing diabetes. It is something that you're sharing with them in order to improve their whole life-- I mean, their quality of life. For example, okay, I mentioned before that we talked a little bit about communication with them. It's going to be communication with your nurse, with your healthcare provider... So, they learn some skills that can be applied in different areas of their life, professional, personal, in regards to health. So that is our main goal, not only to prevent diabetes. And they start developing some abilities, and they feel more confident. They start just advocating for themselves.

– Key Informant

I remember a CHW telling me about this recent DPP workshop that she did in person, where she had a woman that was, I assumed, going through a very long depressive episode. But toward the end of the workshops, she noticed that the woman was much happier. She would come in very nicely dressed, now was doing her hair, paying much more attention to her physical appearance. And then at the end, thank the CHW and talked about how she hadn't left her house in a long time, but decided to leave for these workshops.

– Key Informant

Impacts on Coaches & Staff

Interviewees also shared stories about the positive impacts the program has on coaches and other staff.

And when you are conducting the sessions, since you are conducting the sessions for 10 weeks and then you can continue with the support group, you are establishing a relationship with them, and you are also capturing their successes and their challenges. It is different..." So, I said, "Yes, I want to go back [after taking another job]. I want to go back because I'm missing the patients. I'm missing that relationship with them,"

– Key Informant

We had a lot of success with one specific CHW out in [her community] that I remember. Even she lost weight. Multiple participants lost weight. It was a small group... and she herself had pre-diabetes. And so, she was able to find these people from her community. She built these really deep relationships with them. She would be active. She would be physically active with them. She would weigh herself in front of them. She really put herself out there.

– Key Informant

When I see them smiling, changing their attitude, their behavior and they're very positive, I mean, that is providing me with the purpose, the mission to do it. Even if nobody pays me for the classes, it's like, "Okay. What the patients give to me is [inaudible]." I mean, it's beautiful. It's a very rewarding experience – Key Informant

Funding & Sustainability

DPP Funding

One of the biggest barriers mentioned by key informants was funding.

What I know is that funding is a big issue. We are lucky that we were able to sustain our funds. Most of these programs are dependent on getting funds, and they don't have the means and facilities. Even if they are interested, they will not do it... So, around Texas, I would say the majority of them are dependent on external funding. The reimbursement itself is ridiculously low and shameful. I'll tell you something. Since 2019, we became an MDPP supplier, and we haven't billed CMS even for one patient till now...The fact that you're giving people a reimbursement of-- what is it now? $670, or even if they increase it to 720, what is that? For a year-long program where coaches are working hard with their participants.

– Key Informant

And then when it comes to health plans, right, within health plans in Texas, as you know, DPP is not a required coverage for MCOs or managed care plans to offer today, right? So, it's just not a state that makes it a requirement, which also makes it hard. So, when you're going to these plans, you're having to knock on every single door, help them, again, understand this thing that they should cover, that they likely should cover. It's not a need to have for them. It is a good to have for them. Again, same thing with these health plans. This is a future benefit that you are showing them. They may not even have the state contract for that many years. So what is in it for them, right?

– Key Informant

And we're using diabetes prevention as mainly an outreach kind of program, health education, but we're not focused on Medicare billing just because it's very difficult to get it done.

- Key Informant

Participant Costs

Nearly all our key informants operating programs provide their DPP free of charge to participants and take pride in that fact from an equity perspective.

And I always say, one of the big things with us is everything is free. Everything is 100% free.

-Key Informant

Our Health Department fully funds our program, which allows us to be able to offer it for free. They give us a monthly stipend that's the same amount, and then we get reimbursed per participant that finishes the program.

– Key Informant

We just don't want our participants to have to pay anything out of pocket.

– Key Informant

DPP Workforce

Finding and retaining a DPP workforce, particularly coaches able to relate to underserved communities, was mentioned as another challenge.

So, I think one of the things has also been seeing more diversity in the trainers. So, I think there aren't a lot-- definitely monolingual English speakers outnumber the bilingual speakers and then monolingual Spanish speakers.

– Key Informant

The turnover is very high. I have to tell you, since 2020, I think close to 200 people I trained and certified-- I can look at the number exactly and tell you. But out of these, how many really are practicing or even working with us? Not many. So being a lifestyle coach, that's not a position. You cannot hire someone and call them a lifestyle coach. HR will not recognize that. We tried it. So, they have to be called something else. They have to be called research something, coordinator, whatnot, another word for it. So, the problem is the classification of this job does not exist.

– Key Informant

And as far as other best practices, the coach is an integral part of the program, and that is with retaining your participants and just getting success, having coaches that they connect with that they can see themselves through, I guess, in a way. So, if you're having a program for Black men, you'd want a coach that is relatable, that is a Black man, and same with any other. I think that's really crucial. And it's really difficult to find a coach that can connect with participants and that has that passion that comes through.

- Key Informant

Innovations For Sustainability

Key informants shared several ideas for innovations at the organizational, state, and systems levels.

Actually, I was actually talking to [an alliance], and they do have some funding, but the way that all these organizations come together to support each other. And they do their own fundraising outside of the grant spectrum to maintain their work, golf tournaments and other types of deals and stuff just to keep their initiative alive.

– Key Informant

We have seen some where they would actually go out and do fundraising and have organizations fund it, or they would incorporate themselves within an existing large employer and offer it that way... [or] a donor, where you can get items that maybe grants would not allow for, like the purchase of food to give to participants sometimes.

– Key Informant

It's sort of those things that we incorporated into the day-to-day activities that the CHWs do. And so, we have CHWs that do DPP. We have CHWs that do mental health. We have CHWs that do early childhood brain development kind of workshops. And so, we give the CHWs a lot of freedom in deciding what workshops they're going to be doing out in their communities. And then many of them love DPP. Actually, all of them love DPP. They complain about it, but they love it. And I think it's because it's very process-oriented, but at the same time, outcome-oriented, where you're going to see a change if you stick to the program, like you will lose weight.

– Key Informant

Innovations For Sustainability - Continued

Key informants shared several ideas for innovations at the organizational, state, and systems levels.

Back when I was looking into the funding, I don't remember seeing a lot of private insurers covering it. And then I think expanding it so it's not just Medicare, but it's also Medicaid, maybe incorporating it or making enhancements to it that pregnant women could benefit from it while they're covered under Medicaid, for example, or private insurance. I think if we can find ways for it to receive more funding through government and private insurers, then I think it would expand. And I think it could be a program that becomes readily available to people. But right now, I don't see it moving forward unless there's actually cash being injected into it.

- Key Informant

I think the other part of it is, yeah, the financial sustainability as well... One of the things that we know health plans or health systems even look to attain are improving their HEDIS measures... Coming back to the value proposition piece, if there's a way for us to connect the dots between the outcomes from DPP into those HEDIS measures that, again, show a very quick short like, "Okay, it's not ROI in the way you're used to, but at least it helps you with these quality measures in that it accomplishes A, B, and C."

– Key Informant

And then I'll also say there's a fourth bucket with foundations, right?... There are a bunch of other foundations that are pouring money into this. But then there's also a question of it's not only about sort of the financial-- excuse me, the immediate financial sustainability, but how do you bring the right ecosystem to the table, the right payers, the right help plans, sort of those payer-provider relationships to the table that are willing to take this bet on years out.

– Key Informant

Opportunities

Opportunities for Action

Advancing Capacity, Innovation, Impact of Existing DPP's –

- There is need and value in investing in individual programs; however
- Systemic challenge of statewide sustainability is the bigger need
- State-level initiative to facilitate knowledge sharing, capacity-building and collaboration is needed

Building Pathways for Long-term Sustainability and Scale –

- More research is needed to develop pathways for DPP sustainability.
- EHF may consider convening other funders and payers in Texas to align investments
- Engage communities with lived-experience in research and co-creation

Questions?

research@texashealthinstitute.org

Texas Health Institute

Stay in touch with us

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We believe everyone should have an equitable opportunity to achieve optimal health.

Center for Health Care Strategies
Better care where it's needed most

Environmental Scan: Medicaid Coverage of the Diabetes Prevention Program

Texas MCO NMDOH LC Webinar

October 27, 2025

Funded by Episcopal Health Foundation

CHCS Core Team

Anna Spencer, Senior Program Officer

Stephanie Paneca-Navarro, Program Officer

Shilpa Patel, Director, Population Health

Center for Health Care Strategies

DPP Scan: Project Objective

- To better understand design features, implementation experiences, and lessons learned on making the DPP a Medicaid benefit
- The scan and report would build on existing EHF resources:
  - Preventing Diabetes in Texas
  - Passion, Trust, Person-Centered: A Landscape Scan of Diabetes Prevention Programs in Texas

Planned approach

Literature Review

- Research into existing state models

Interviews

- Up to 15 with key stakeholders
- States and national or state-based experts with implementation experience
- NACDD

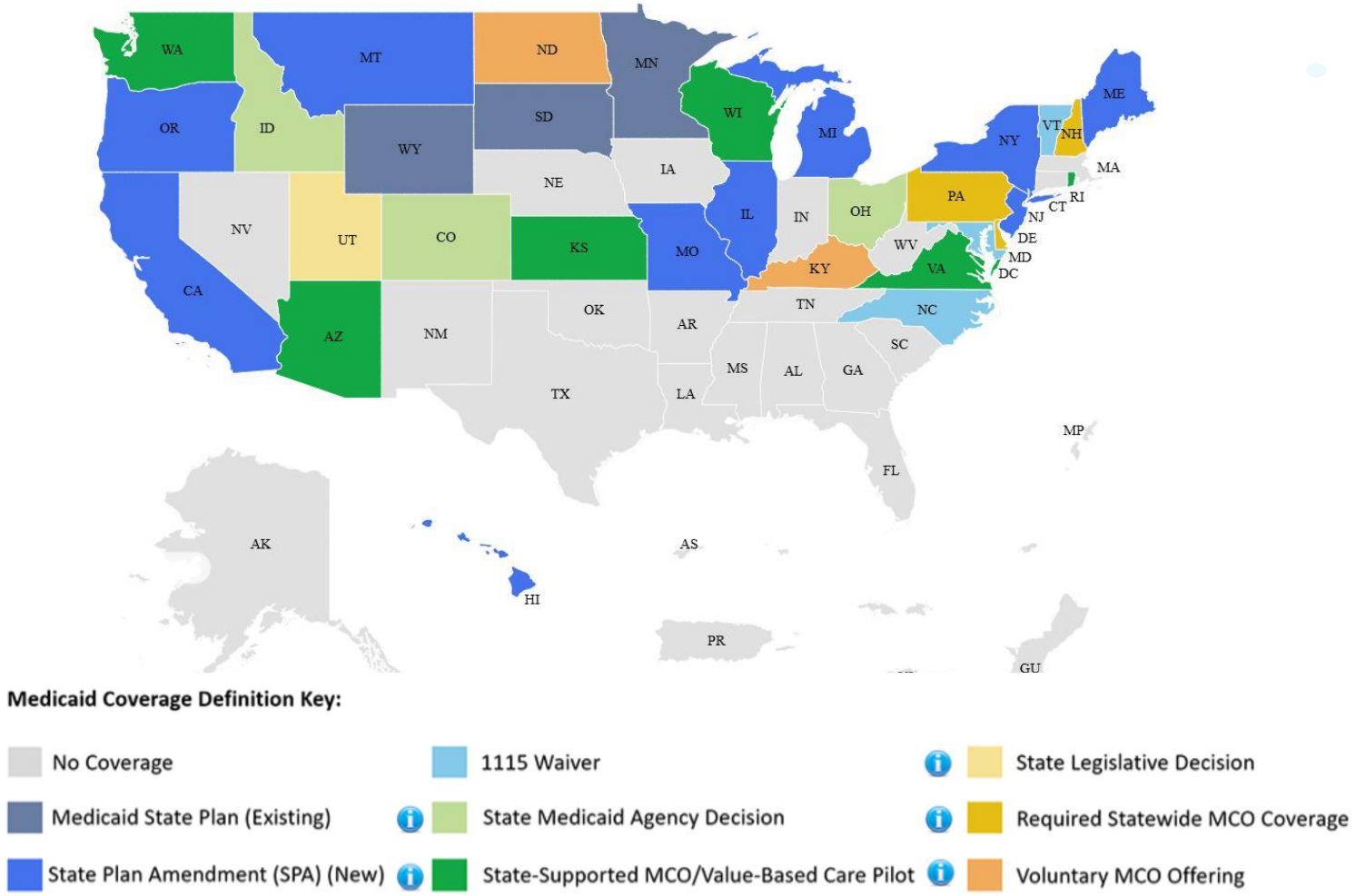
Monthly or bi-weekly meetings

- Updates, discuss key insights uncovered during the research process, provide strategic advice, and get ongoing input and guidance from EHF

External Report

- Develop a 12-15 report examining different approaches and key considerations for design and implementation

DPP State Medicaid Coverage Map



Medicaid Coverage Definition Key:

- No Coverage
- Medicaid State Plan (Existing)
- State Plan Amendment (SPA) (New)
- 1115 Waiver
- State Medicaid Agency Decision
- State-Supported MCO/Value-Based Care Pilot
- State Legislative Decision
- Required Statewide MCO Coverage
- Voluntary MCO Offering

National Association of Chronic Diseases Directors, ***Diabetes Prevention Project Toolkit****, Available at: https://coveragetoolkit.org/medicaid-coverage-landscape/*

Center for Health Care Strategies

Key Areas of Exploration

- Setting and provider types
- Provider outreach or education
- Payment rates
- Carved-in or carved-out of managed care
- Identified operational barriers and solutions to barriers
- Population-specific considerations (urban vs. rural)
- Regulatory details (policy language, bill number/language)
- Design and implementation timelines
- Outcome measures of impact, including fiscal impacts

High-Level Timeline & Deliverables

Milestone	Date
Kick Off Meeting	October 2025
Key informant Interviews	November – January 2026
Report Outline	December 2025
Draft Report	January 2026
Sensemaking Discussion	February 2026
Finalize Report	March 2026
Monthly Check-Ins	Ongoing

Obesity Training-to-Practice Program

TEXAS
The University of Texas at Austin

Leah Whigham, PhD, FTOS

Professor, Department of Nutritional Sciences, The University of Texas at Austin

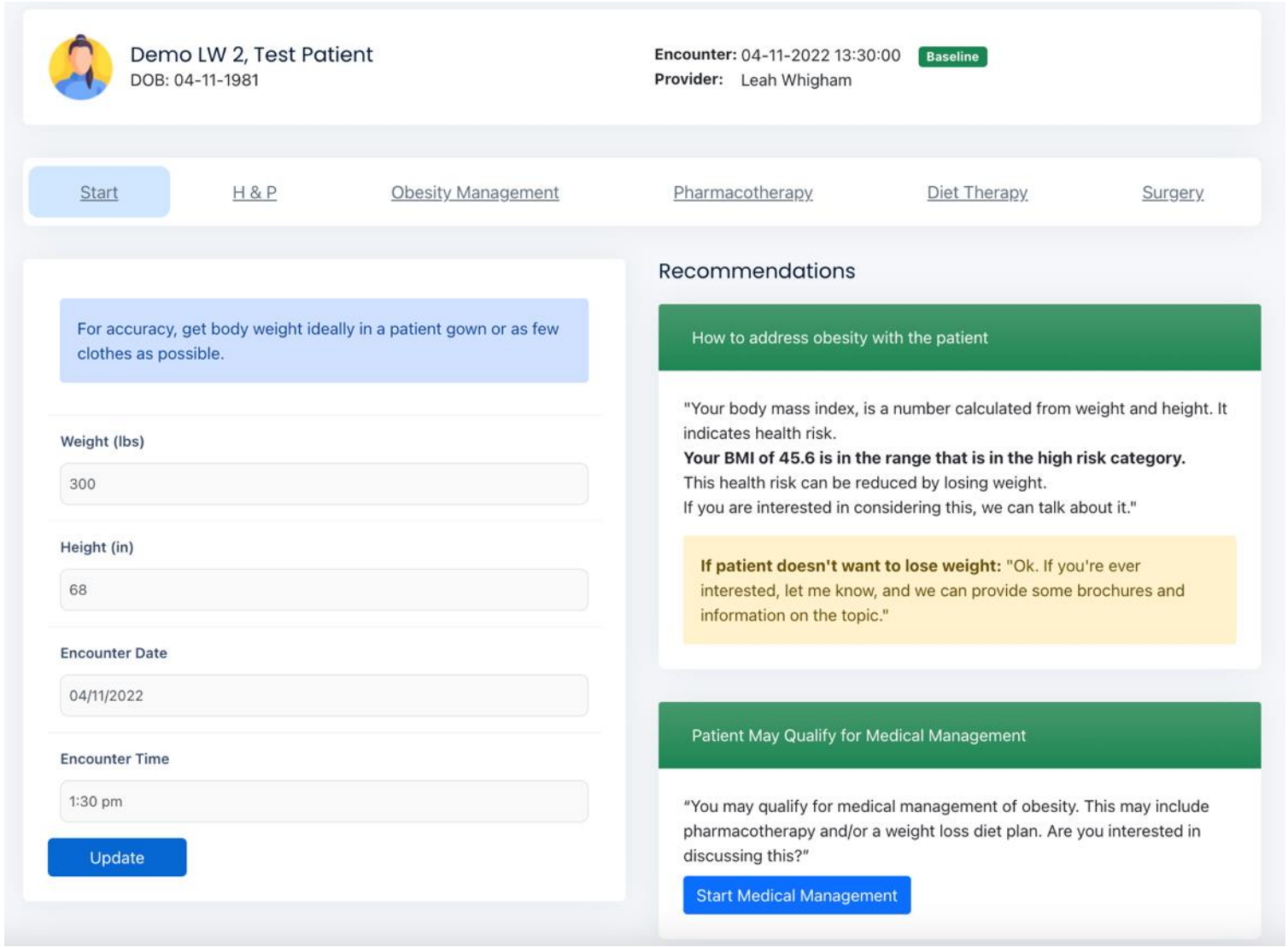
Adjunct Professor, UTHealth Houston

Founding Director, Center for Community Health Impact and El Paso Nutrition & Healthy Weight Clinic

Practical Obesity Management Course

- Etiology of obesity
- Obesity screening and diagnosis
- Treatment options and efficacy
- Practical skills on behavioral counseling for treatment through diet and exercise
- Relevant billing and coding
- Community resources
- Case management with standardized patients

Clinical Decision Support System (CDSS)



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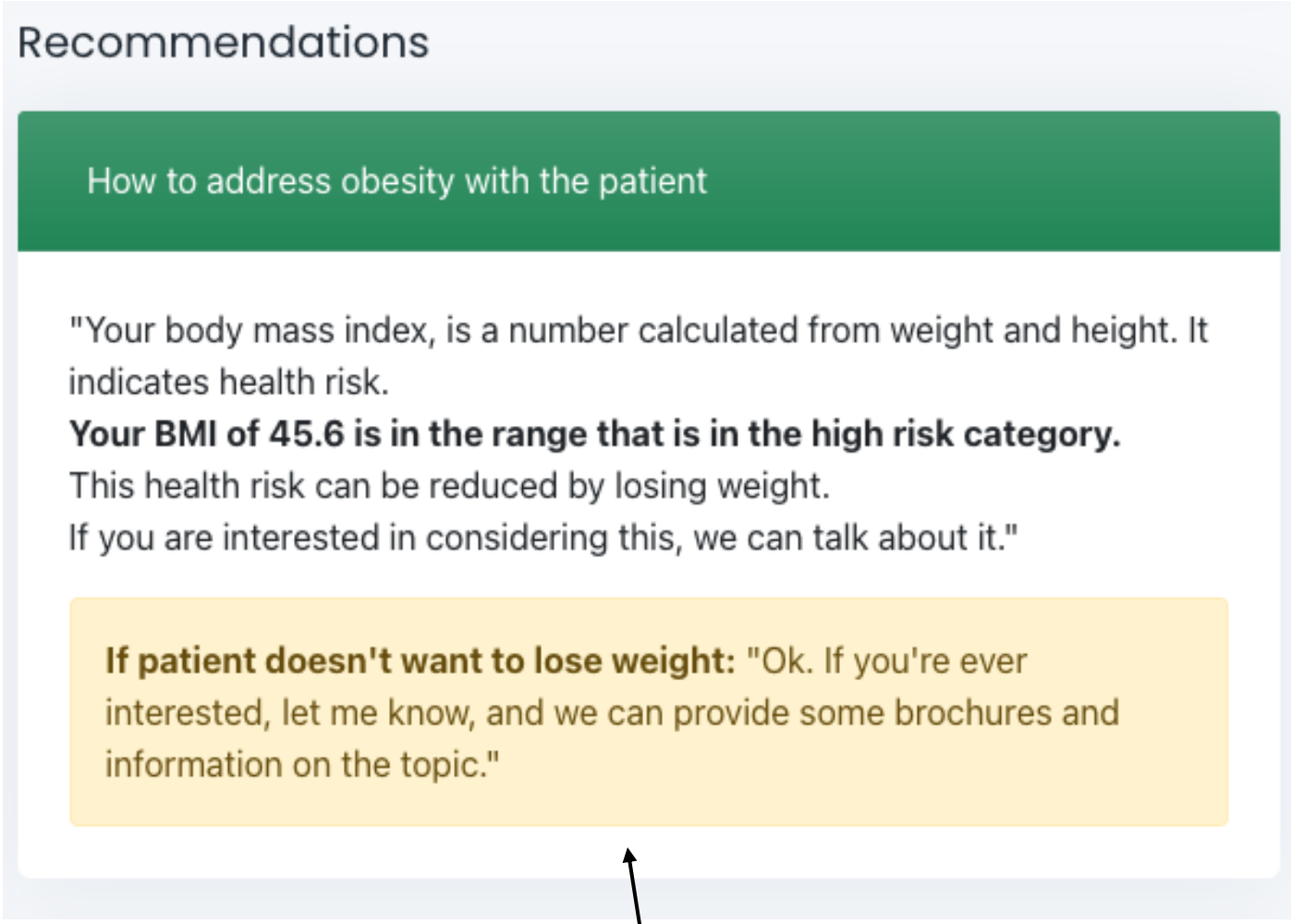
Clinical Decision Support System (CDSS)

- Features include:
  - dialog boxes
  - info boxes
  - physical exam adaptations
  - diagnostics reference



Dialog boxes guide provider on how to have the conversation:

- Ask permission
- No stigma or shame
- Optimal word choice

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Clinical Decision Support System (CDSS)

- Features include:
  - dialog boxes
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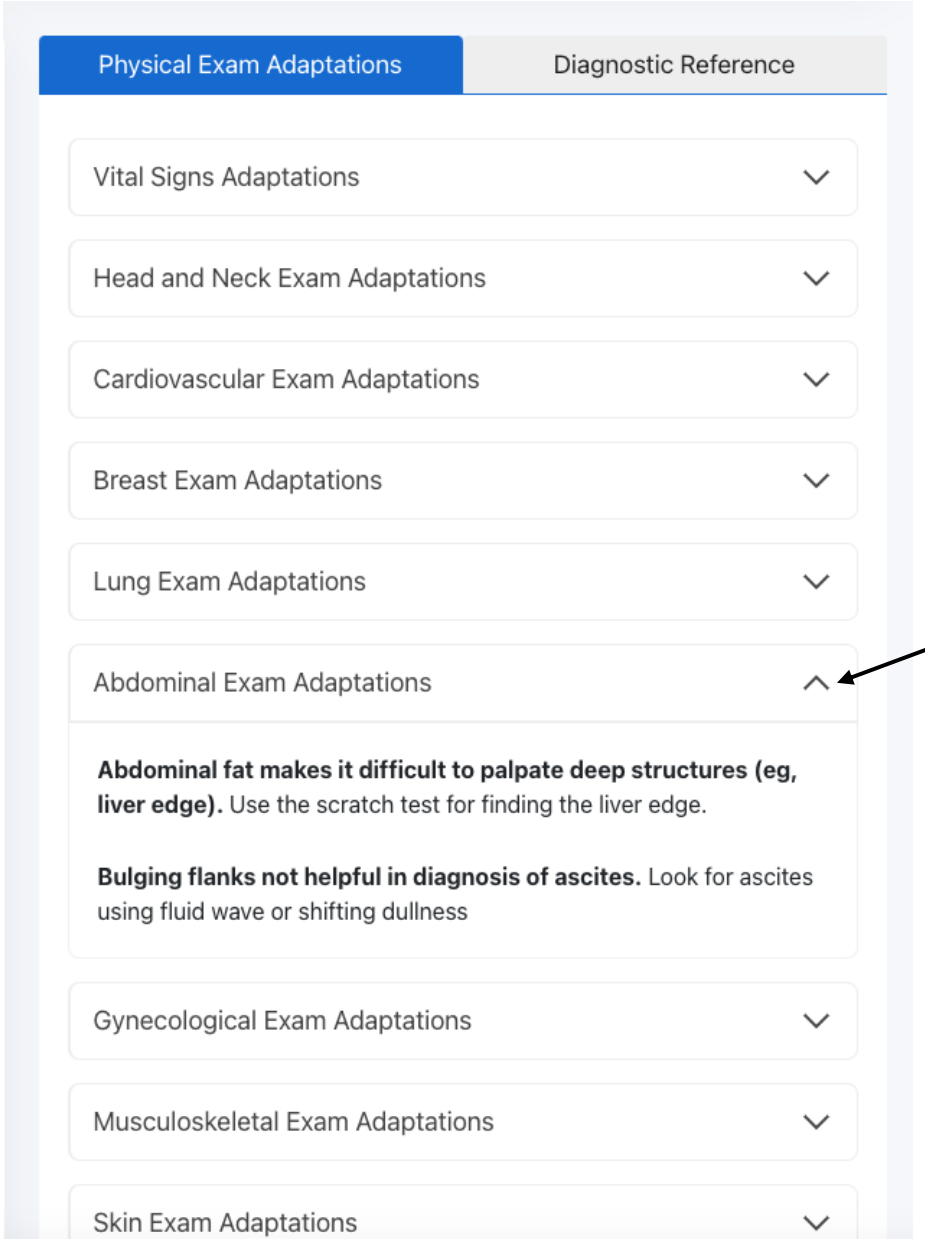
  - physical exam adaptations
  - diagnostics reference



Physical exam adaptations available in drop-down menus

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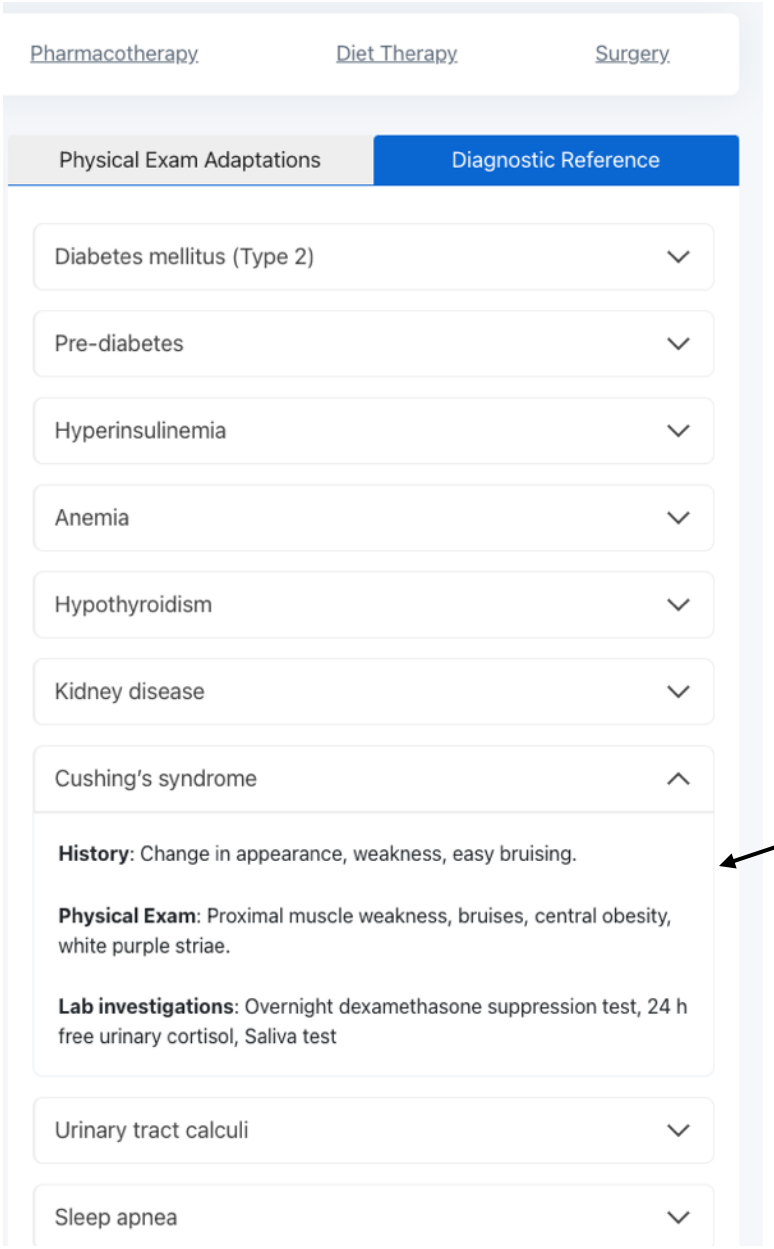
Clinical Decision Support System (CDSS)

- Features include:
  - dialog boxes
  - info boxes
  - physical exam adaptations
  - diagnostics reference



Diagnostic reference guides for history, physical exam, and lab investigations

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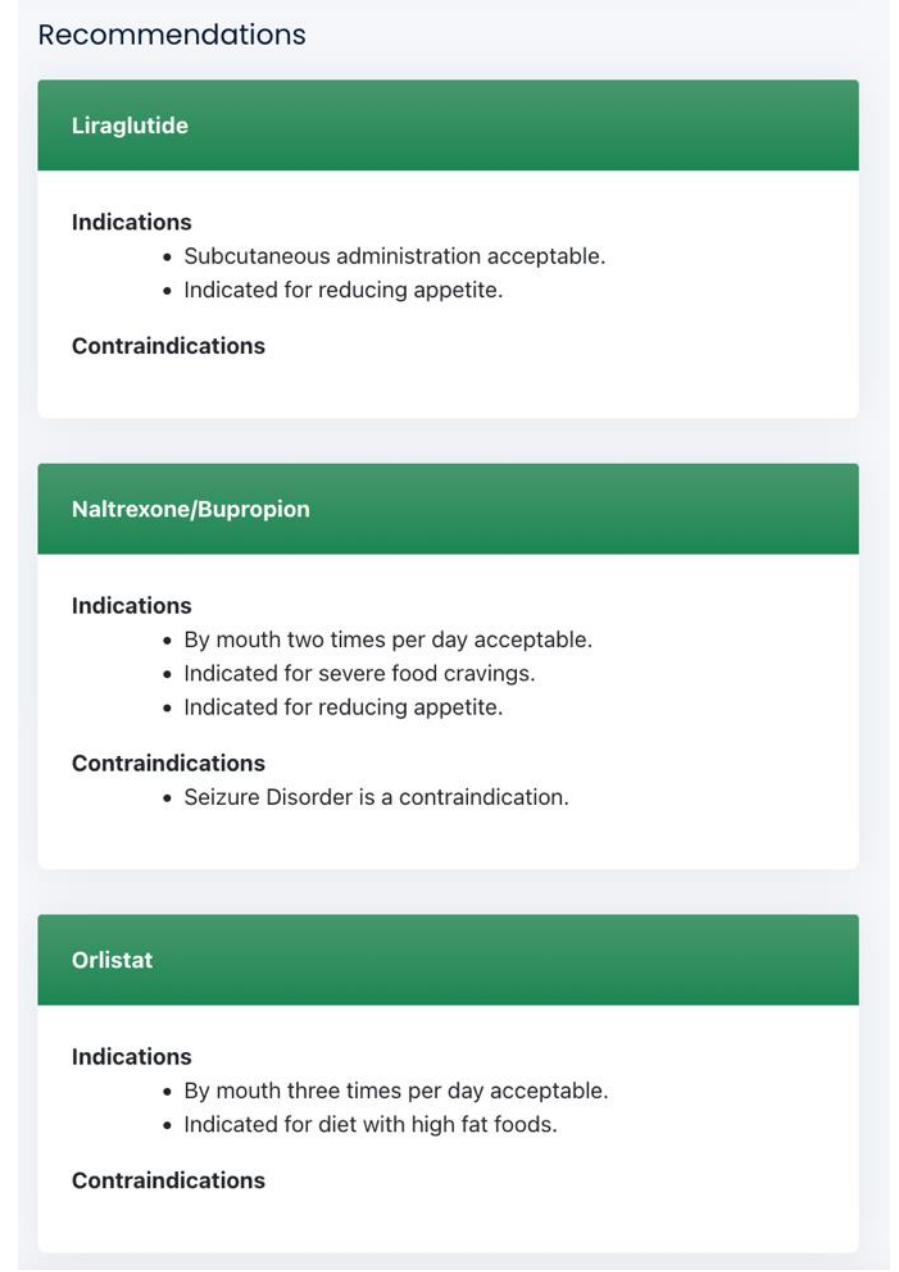
Clinical Decision Support System (CDSS)

Pharmacotherapy recommendations based on:

- conditions
- other medications hypersensitivity
- routes of administration
- type of hunger/satiety challenges



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Dietary Management: gradual changes in lifestyle

Lose Weight

Without Making Big Changes to Your Eating Habits

By following individualized recipes, your body gets the nutrients it needs to reduce body fat and improve health.

Get Started Now

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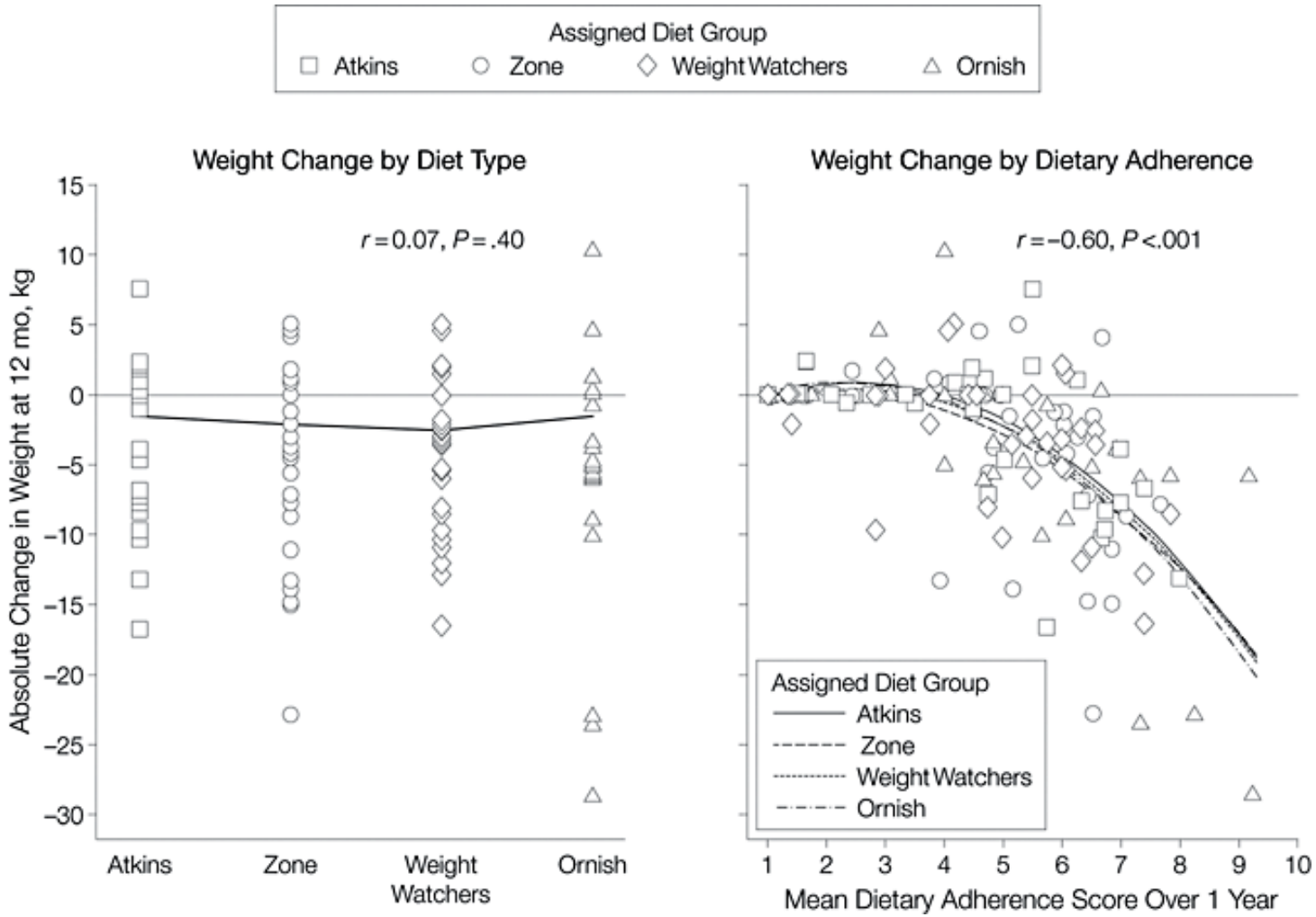
The science behind Small Changes

It’s not the diet type, but compliance, that matters most.



Dansinger ML et al. JAMA 2005; 293:43-53

Our Dietary Approach

Meet people where they are

Tailor the plan to lifestyle and preferences

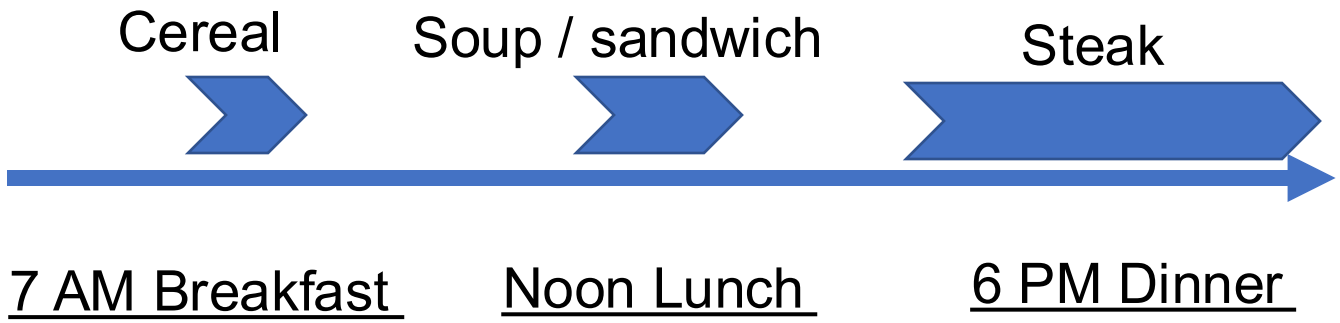
Adjust over time

SMALLCHANGES

The science behind Small Changes

The “protein shield”

Protein helps feel full for a few hours after a meal



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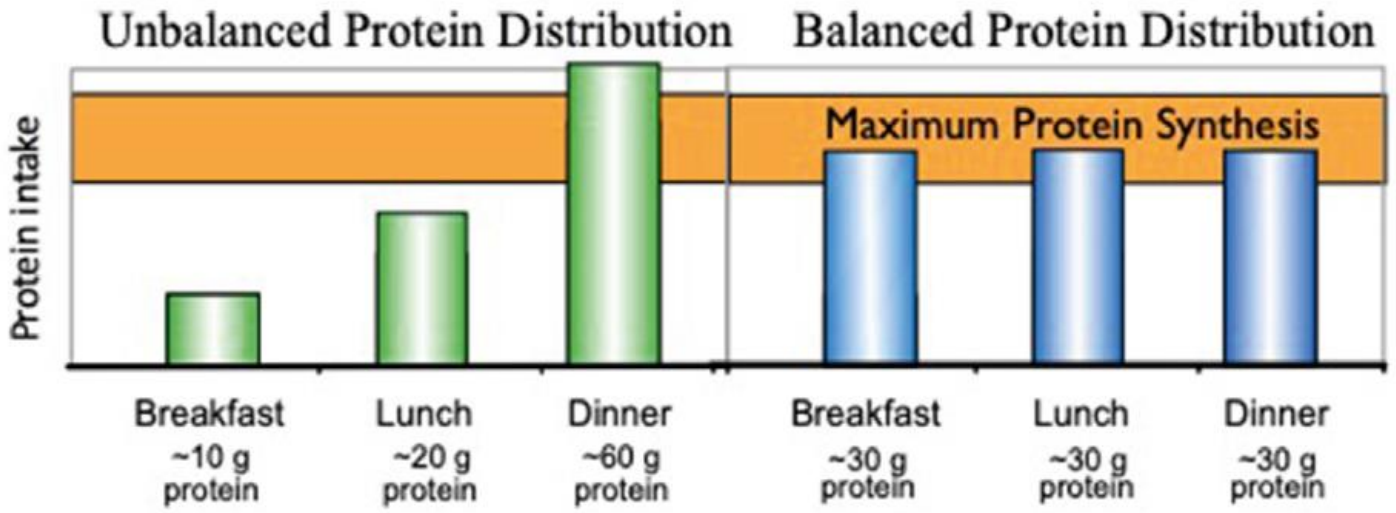
The science behind Small Changes

Protein helps optimize maintenance of muscle mass



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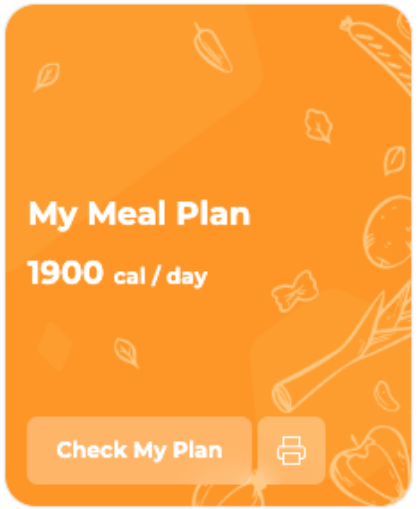
Arentson-Lantz EJ, et al. J Nutr. 2023 Mar;153(3):615-621.

Patient selects their own meal plan. Recipes are personalized.

SMALLCHANGES



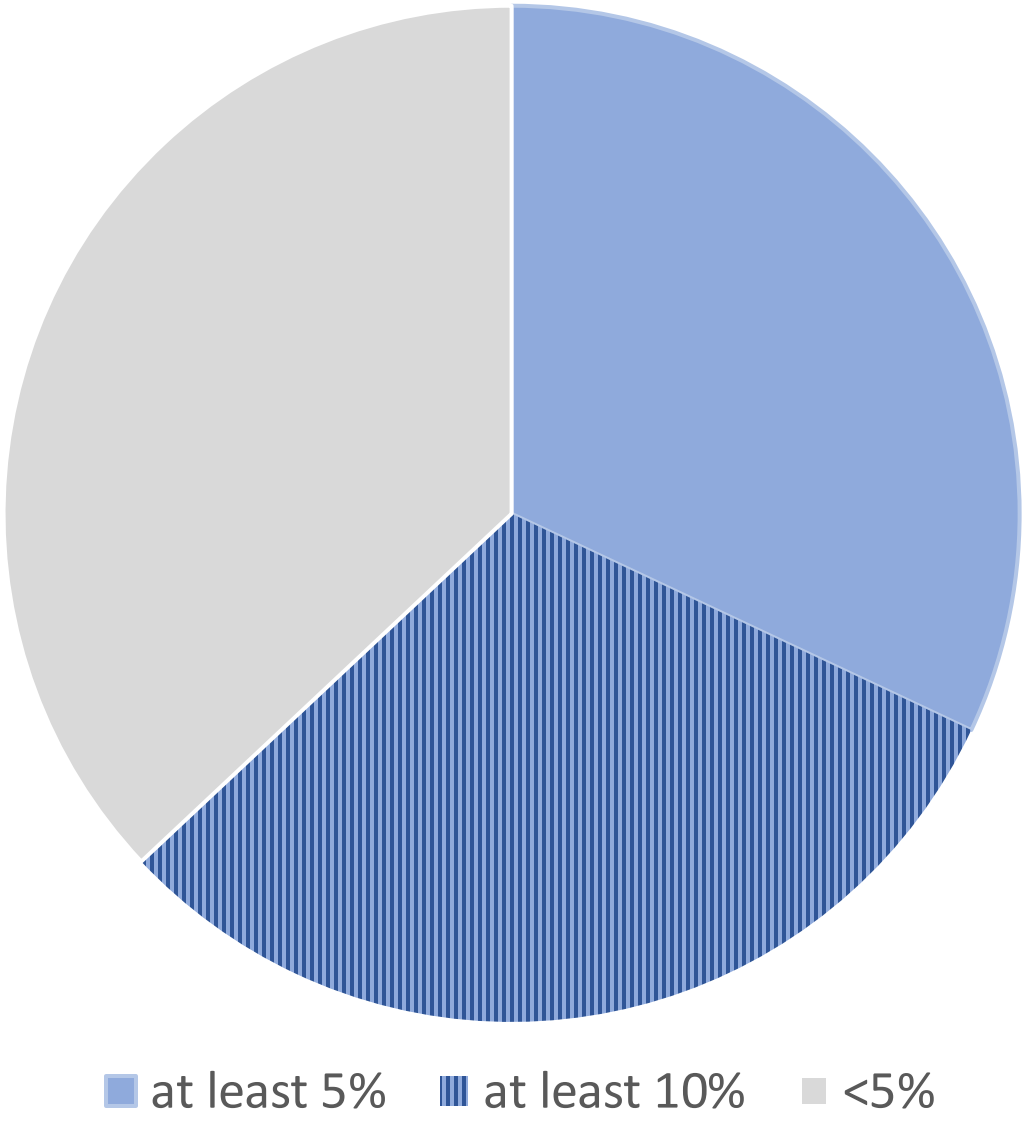
Dinner

Albondigas ›

Bean and Cheese Flautas ›

Dominos Pepperoni Pizza ›

Subway Mozza Meat Wrap ›



Pragmatic Clinical Study Results

- Total mean weight loss was 7.7% (3.2 to -18.7%)
- Weight loss at 12 weeks: 5.0% (0.75 to -14.6%)
- Mean fat% loss: 3.2% points
- Clinically meaningful weight loss: of at least 5%
  - 63% lost at least 5% (all blue segments)
  - 31% lost at least 10% (blue stripes)

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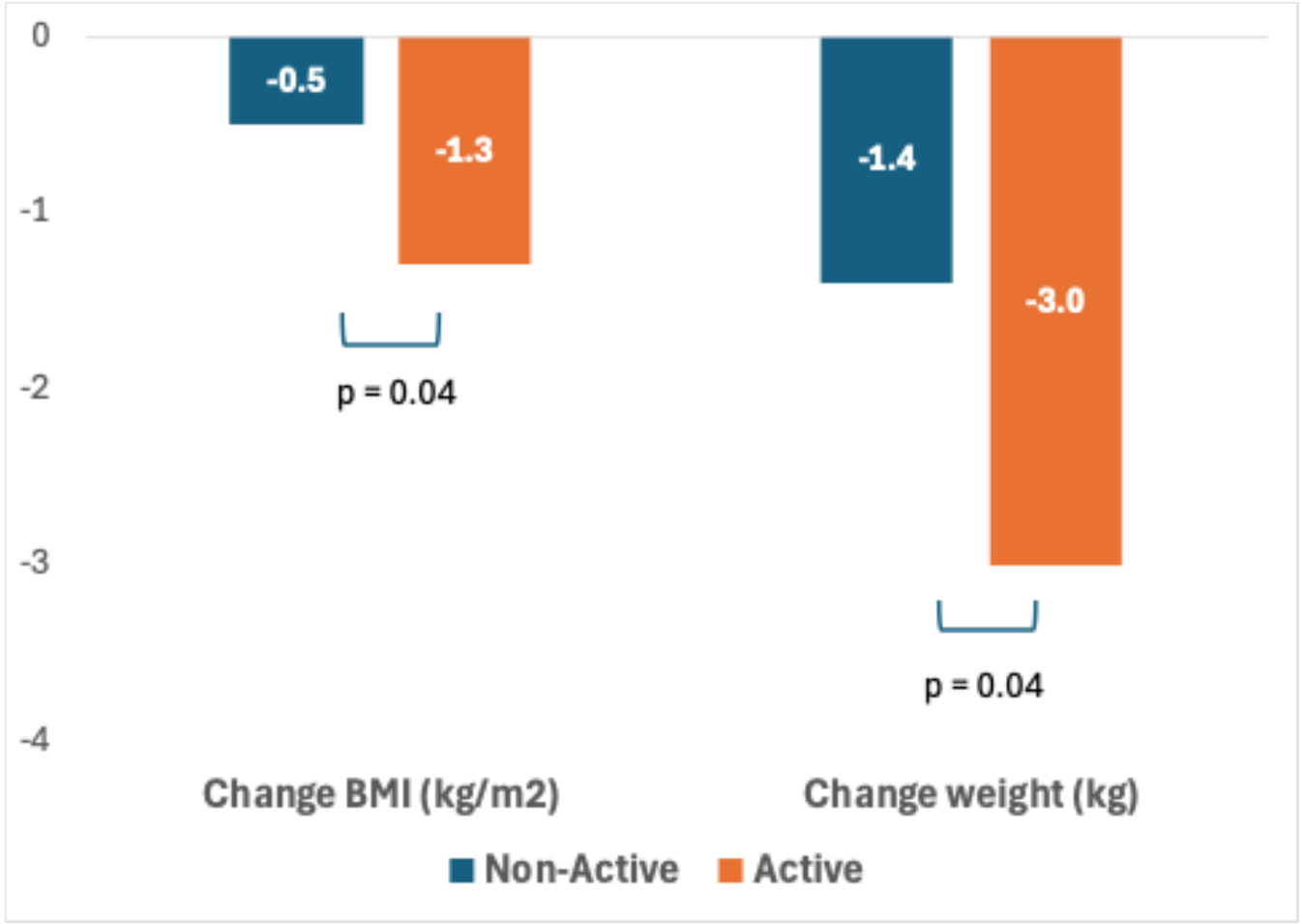
South Texas
Diabetes Prevention Program
Enhanced with Small Changes

Leah Whigham, PhD, FTOS

Coach Demographic

- 3 coaches led 5 different DPP cohorts (2 coaches taught 2 cohorts each)
- All self-report as a Hispanic female
- 1 research assistant; 2 community health workers

Change from Baseline to 6 Months: BMI and Weight



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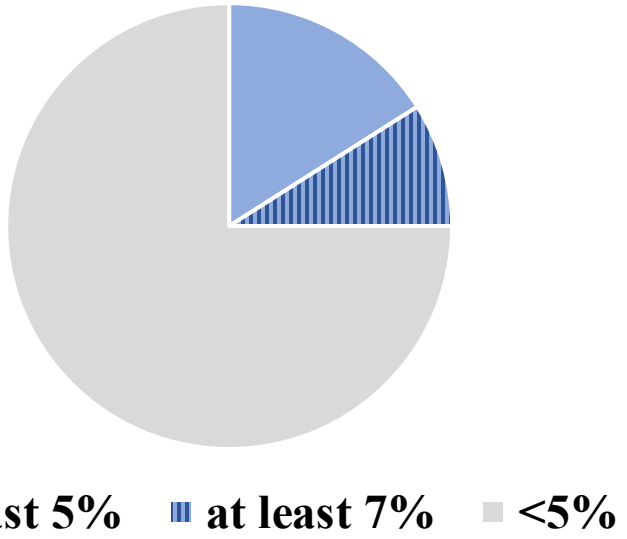
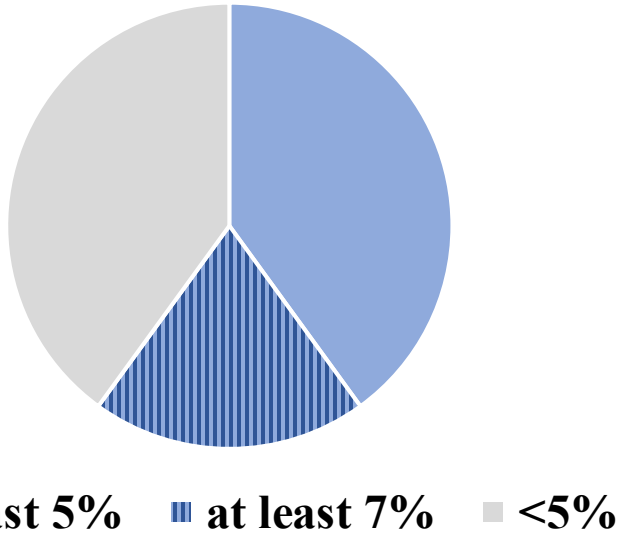
Clinically Significant Weight Loss

Non-Active



Active



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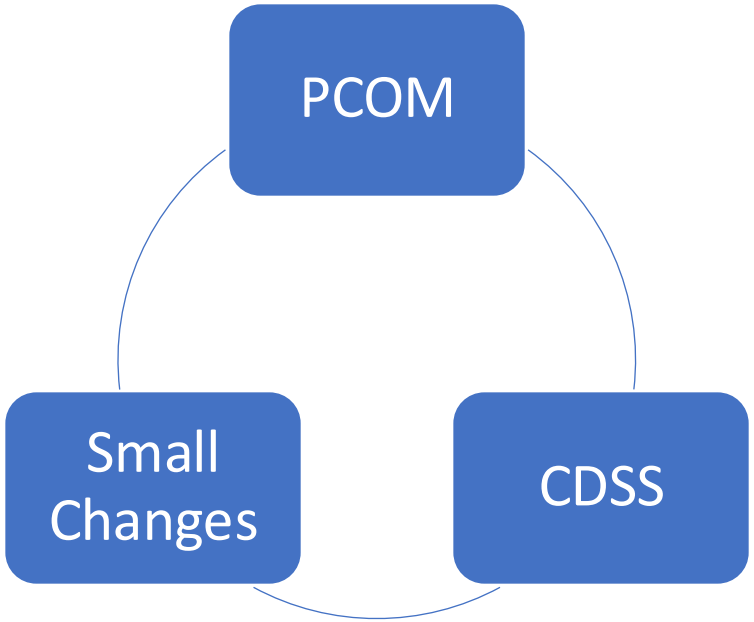
SMALLCHANGES

Primary Care Obesity Management Training-to-Practice Program

- Train PCPs in evidence-based obesity management through the Practical Clinical Obesity Management Course.
- Deploy the PCOM-CDSS in participating primary care clinics to facilitate guideline-concordant care.
- Integrate the Small Changes program for patient self-management, supporting long-term adherence and lifestyle change.
- Provide implementation support to ensure adoption, workflow integration, and ongoing use of the tools.
- Evaluate impact on provider confidence, care delivery patterns, and patient outcomes.

TEXAS ACADEMY OF FAMILY PHYSICIANS



TEXAS
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