Medicaid Coverage of the National Diabetes Prevention Program:

Considerations for Texas

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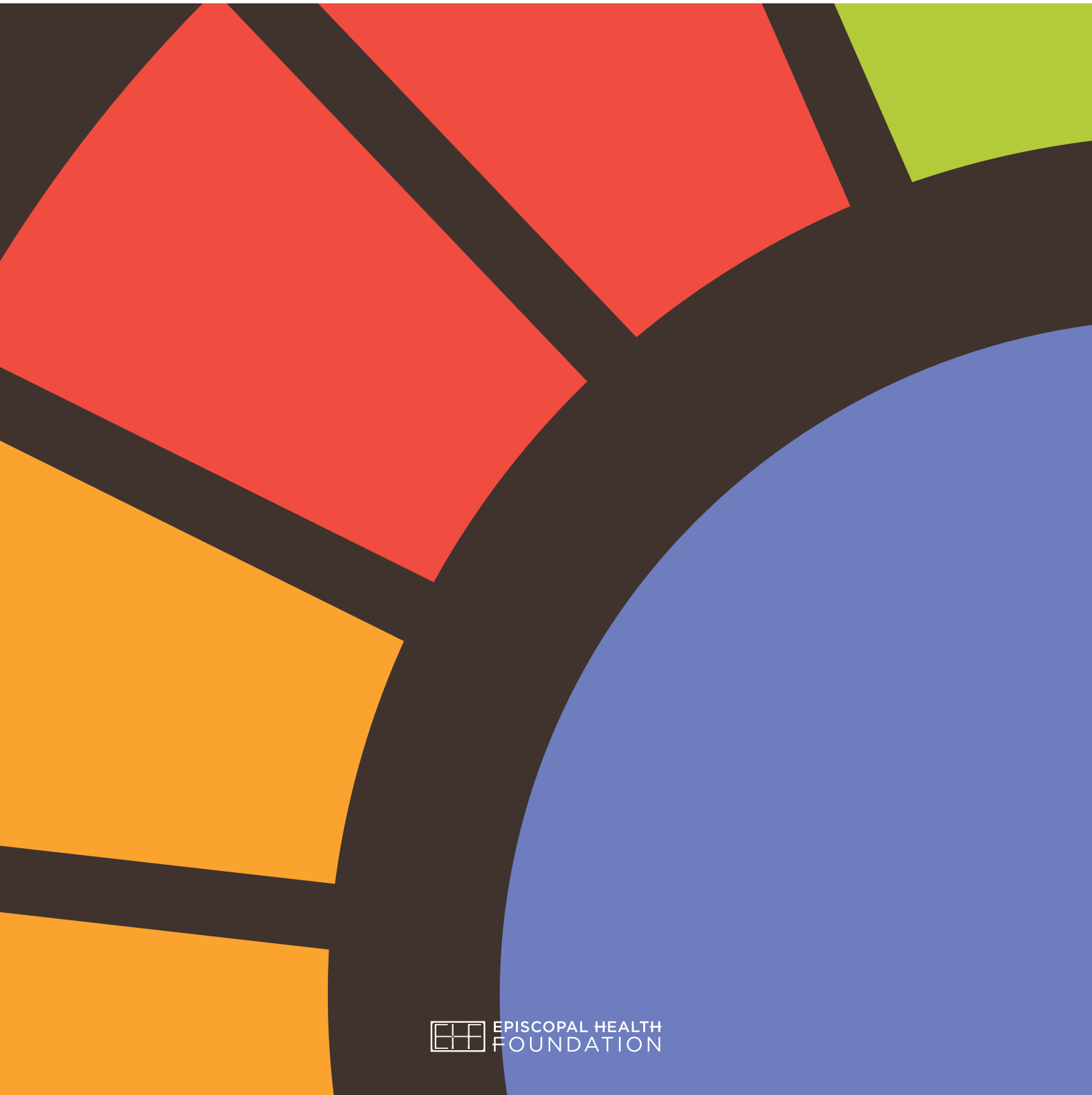

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About this Report

With support from Episcopal Health Foundation, the Center for Health Care Strategies developed this report to summarize evidence and design and implementation options for Medicaid coverage of the National Diabetes Prevention Program.

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Introduction

Prediabetes and diabetes are a public health epidemic in the United States. The Centers for Disease Control and Prevention (CDC) report that approximately 38 million Americans, about 11 percent of the population, have diabetes, with an estimated one in five unaware of their diagnosis. In addition, more than 115 million U.S. adults have prediabetes, and over 80 percent are unaware of their condition.

Diabetes, predominantly type 2, significantly increases the risk of serious complications, including cardiovascular disease, kidney disease, nerve damage, and vision loss. It is also a leading contributor to mortality, with over 339,000 deaths in 2023 listing diabetes as an underlying or contributing cause.

The economic burden is substantial. The American Diabetes Association estimates $412.9 billion in total annual costs, including $306.6 billion in direct medical costs (approximately 74 percent) and $106.3 billion in lost productivity (approximately 26 percent), making diabetes the most expensive chronic condition for the U.S. health care system. Diabetes accounts for one quarter of total annual health care expenditures.

Thirty-four percent of the adult population in Texas — over seven million people — have prediabetes and 13.2 percent have diagnosed diabetes. Adults with low incomes are twice as likely to have diabetes compared to those with higher incomes, which has significant implications for Medicaid. According to the National Institute of Diabetes and Digestive and Kidney Diseases, adults under age 65 with diabetes are nearly twice as likely to have Medicaid coverage. A recent analysis found that diabetes-related health care costs for Texas Medicaid members may reach $8.1 billion annually, representing nearly 21 percent of total Medicaid spending.

Evidence shows that prediabetes can reverse and/or significantly reduce the onset of type 2 diabetes through healthy eating, increased physical activity, and sustained behavior change. The CDC-recognized National Diabetes Prevention Program (National DPP) offers a proven, evidence-based framework to support these changes, reduce long-term disease risk, and lower health care costs.

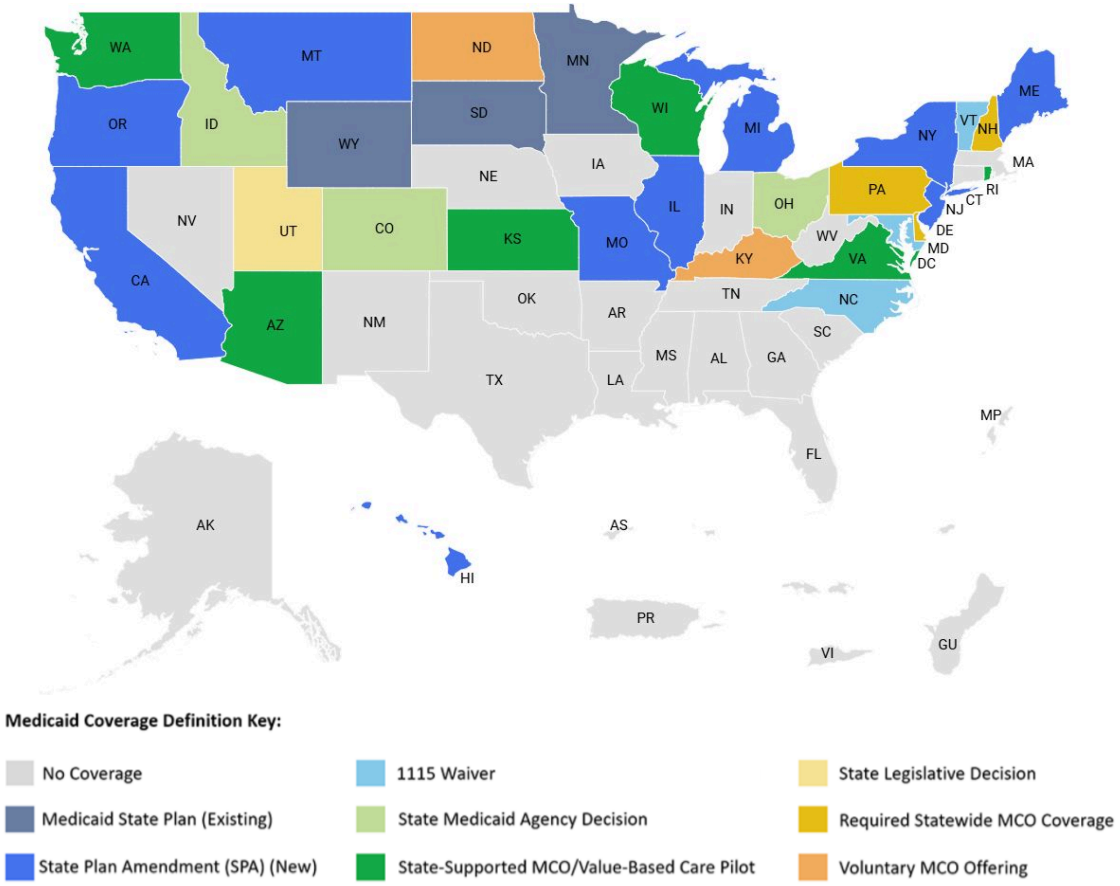
The National Diabetes Prevention Program

The National DPP is a year-long, lifestyle change program that focuses on healthier eating, physical activity, and long-term behavior change support. Through a structured coaching approach, the curriculum includes weight management strategies, physical activity goals (typically 150 minutes/week), stress reduction activities, and problem-solving skills to sustain healthy behaviors. Across the country, over 2,300 sites are recognized by the CDC as National DPP providers and include community-based organizations (CBOs), fitness centers, hospitals, health care provider groups, pharmacies, health plans, and virtual/online program providers. Adults are eligible for National DPP participation if they have prediabetes (A1C between 5.7 percent and 6.4 percent) or otherwise meet clinical or risk-based criteria indicating elevated diabetes risk, as defined by CDC-approved guidelines.

The National DPP is backed by strong clinical evidence that demonstrates its ability to prevent or delay type 2 diabetes in adults with prediabetes. A randomized controlled trial found that participation in the National DPP reduced the risk of developing type 2 diabetes by 58 percent for adults with prediabetes, and benefits continued 21 years after completing the program. Individuals who participated in the program had a 27 percent reduction in diabetes incidence 15 years after participation compared with non-participants.

To address the disease burden and high costs of diabetes care, many states have opted to cover the National DPP through Medicaid. Since 2012, 31 states have implemented Medicaid coverage for the program using a range of mechanisms *(see figure on next page and an interactive map to learn more)*.

National DPP in Medicaid by Coverage Mechanism



A Milliman report summarizing the evidence base for National DPP under Medicare and Medicaid indicated that the program is shown to be effective in achieving weight loss for a subset of participants (on average between three and five percent of their body weight), although some may regain a portion of the weight lost.

A landscape analysis of diabetes prevention programs in Texas highlighted financial and programmatic limitations to National DPP in Texas, including challenges with provider enrollment in the Medicare Diabetes Prevention Program due to low reimbursement rates, contracting with Medicare Advantage plans, and provider and beneficiary awareness of the benefit. The report names actions the state could take to overcome these challenges, including: (1) working with Medicare, Medicaid, and private insurers to increase reimbursement rates through pilots; and (2) creating opportunities for collaboration across Medicaid agencies and public health, and shared learning with National DPP providers.

With support from the Episcopal Health Foundation, the Center for Health Care Strategies (CHCS) conducted an environmental scan to document design features, implementation experiences, and lessons on implementing the National DPP as a Medicaid benefit. Through a literature review and key informant interviews, CHCS examined state coverage pathways, provider types, payment rates, state cost calculations, eligibility requirements, and state implementation lessons. The following report summarizes findings and offers key considerations for implementing the National DPP as a Medicaid-covered benefit.

Coverage Mechanisms and Benefit Design Options

National DPP implementation requires navigating financial, clinical, and administrative aspects of the program. To identify common challenges and practical solutions, CHCS conducted key informant interviews with state Medicaid officials, public health officials, and a representative from the National Association of Chronic Disease Directors. This section includes information about the states interviewed and synthesizes findings on the National DPP Medicaid coverage mechanisms and benefit design options, including key levers for policy change and successful delivery models.

CHCS interviewed three states that currently have established Medicaid coverage for National DPP, and North Carolina which offered Medicaid coverage for National DPP through its 1115 waiver. CHCS also interviewed Wisconsin, which currently lacks coverage for National DPP, to learn about the infrastructure the state has built for the successful implementation of National DPP through public health funding, and Oklahoma, which is exploring ways to achieve coverage. States have used a variety of mechanisms, including Section 1115 demonstration waivers, Medicaid managed care organization (MCO) pilots, and State Plan Amendments (SPAs) to achieve National DPP Medicaid coverage. State interviewed with coverage mechanism include:

- **Illinois** (SPA)
- **Michigan** (SPA)
- **New York** (SPA)
- **North Carolina** (1115 waiver)
- **Oklahoma** (no Medicaid coverage for National DPP)
- **Wisconsin** (no Medicaid coverage for National DPP)

Of note, nearly all states interviewed administer their National DPP Medicaid benefit through both their managed care structure and fee-for-service (FFS). North Carolina is the only state interviewed that had coverage through an 1115 waiver. Oklahoma and Wisconsin have not yet obtained and implemented coverage. The National DPP Coverage Toolkit offers information about contracting with MCOs, including MCO contract language considerations, state examples of addressing non-clinical health needs through MCO contracting, and credentialing considerations.

National DPP Medicaid Coverage Mechanisms

States reported using or exploring two mechanisms for National DPP coverage: (1) 1115 waiver; or (2) SPAs.

1115 Demonstration Waiver

North Carolina used its 1115 waiver from 2022-2025 for National DPP coverage through its Healthy Opportunities Pilots. This waiver included services across four domains reflecting non-medical conditions that affect patient health — nutrition, housing, transportation, and interpersonal violence/toxic stress. To design the nutrition component of its waiver, North Carolina used: (1) national landscape data for National DPP Medicaid coverage, including California National DPP Medicaid coverage data; (2) Geographic Information System mapping; and (3) a Request for Information, mainly informed by CBOs and other National DPP providers. The National DPP was a component of a robust nutrition domain, which also included nutrition case management, home-delivered meals, and other related services.

State Plan Amendment

Several states have used SPAs to implement Medicaid National DPP coverage, some with state legislature support, which provided infrastructure such as funding, timelines for planning and coverage adoption, and task forces. In 2019, **New York** amended its social services law, which allowed the state to incorporate National DPP coverage into Medicaid and enroll CDC-recognized organizations, such as CBOs, into Medicaid and receive Medicaid reimbursement for rendering National DPP services. The state Medicaid agency submitted a SPA in the same year to secure Federal Financial Participation, which was approved in 2020 within three months of submission. The approval happened faster than typical, in part, due to the state collaborating with the regional Centers for Medicare & Medicaid (CMS) team for input before official review of the SPA. The SPA was built on evidence from several years of implementing and growing public health infrastructure through the New York Diabetes Prevention Program, which included collaboration with the state's YMCAs as New York DPP providers, and had similar positive clinical outcomes to National DPP, such as weight loss and a reduction in diabetes risk for participants. The National DPP Coverage Toolkit includes a case study on New York's road to coverage.

Oklahoma passed legislation in 2015 that required a structured, collaborative effort to explore and expand coverage for a state DPP and Diabetes Self-Management Education and Support (DSMES). However, initial efforts focused on DSMES due to the passage of SB972 in 2018 that directed the Oklahoma Health Care Authority to examine the feasibility of an SPA to the Oklahoma Medicaid Program for diabetes self-management training (DSMT). Oklahoma has explored submitting a SPA for National DPP coverage but indicated that competing priorities have delayed implementation. While the state is exploring a SPA as a pathway for coverage, they are also open to other options, including *in lieu of* services (ILOS) for MCO coverage, according to 2023 CMS ILOS guidance, or packaging National DPP with their Food is Medicine efforts in an 1115 waiver. This 2015 legislation did not provide funds for seeking coverage.

MCO Pilots as a Bridge to SPAs

Some states designed SPAs after launching MCO pilots that helped build the case for coverage. In **Michigan**, Medicaid engaged the state's MCOs and the Michigan Association of Health Plans to execute a two-year National DPP state-supported pilot beginning in 2020, which included 18 months of data collection to support SPA development. They selected higher risk participants, established agreements with two National DPP providers, and paid National DPP providers directly using CDC 1815 funding. While CDC funds were used to reimburse for delivery of the program, at least one of the MCOs engaged in this pilot provided in-kind support to help with implementation (e.g., staffing, outreach, member-facing program resources). MCO pilot enrollment included over 60 percent enrollment of people of color, which is consistent with overall Medicaid population demographics nationwide. Sixty-six percent of the total participants completed the pilot program. Over 80 percent of individuals who completed the pilot program reached one of three desired health outcomes (i.e., weight loss, combination of weight loss and physical activity, A1C reduction). The state used pilot data and interviews with National DPP providers and MCOs to assess the value, outcomes, successes, and ways in which the state should or should not model National DPP coverage after Medicare.

Michigan sought National DPP Medicaid coverage under the SPA preventive service option. This offered the state flexibility by allowing: (1) National DPP service coverage without a physician's order, just a physician recommendation; and (2) non-licensed providers to render National DPP services. The National DPP Coverage Toolkit includes a case study on Michigan's road to coverage.

In 2014, the **Illinois** Public Health Institute (IPHI) received a grant from County Rankings and Roadmaps that, combined with other funding, led to the creation of a roadmap to coverage for chronic disease prevention, by a coalition of multiple stakeholders, including Illinois Medicaid and public health. The roadmap focused on Medicaid coverage for National DPP, based on its strong national evidence base. In 2018, the CDC provided funding and support to various members of the coalition that facilitated the journey to coverage for National DPP: a CDC 1815 grant going to the Illinois Department of Public Health and a CDC 1817 grant going to IPHI as the bona fide agent of the Chicago Department of Public Health. Medicaid and public health were selected to receive technical assistance through the CDC's *6|18 Initiative*. In 2020, the state embarked on a one-year MCO mock claims pilot program, which was funded by Meridian Health Plan of Illinois ("Meridian") in partnership with IPHI. The pilot entailed: (1) examining different payment rate structures, such as providing more upfront reimbursement at the outset of the one-year long lifestyle change program; (2) engaging MCOs to learn about implementing Medicaid coverage for National DPP; and (3) determining the process for developing new provider types to enable reimbursement. It tested claims and data sharing processes between four federally qualified health centers (FQHCs) and one MCO with no actual exchange of money. Lessons from the pilot include: (1) the importance of clear and consistent communication between MCO and National DPP providers, especially for billing and claims processes; and (2) the need to cast a wide net for participant recruitment using a referral program to ensure adequate enrollment into each National DPP cohort. The MCO pilot, along with emerging evidence of the cost effectiveness of the National DPP from other states, resulted in Illinois submitting a SPA for coverage, approved in 2022, with retroactive coverage effective August 1, 2021.

States can use a variety of resources to support their road to coverage, including CDC programs and initiatives. While CDC funding was used in Michigan and Illinois to support National DPP implementation (e.g., MCO pilots, technical assistance, infrastructure), it is not intended to pay for National DPP sessions once a state has established Medicaid coverage. National DPP services are offered to eligible Medicaid members as preventive services under the approved Medicaid State Plan in Michigan, Illinois, and other states offering coverage, and National DPP services are paid 100 percent by the Medicaid program.

The Role of Partnerships in Medicaid Coverage

State interviewees emphasized the importance of partnership as a facilitator for coverage implementation, starting with interagency or cross-agency collaboration between Medicaid and public health. Medicaid-public health partnership has increasingly become a vehicle for designing and implementing initiatives aimed at improving health outcomes for Medicaid members. State agencies have moved away from working in silos and are working to identify shared goals and collaborate to maximize health improvement efforts.

Oklahoma Medicaid has collaborated with the Oklahoma State Department of Health's Community Development Services Division since the 2015 legislation recommending National DPP implementation, which includes the use of grant funding and joint attendance at the Legislative Diabetes Caucus. **New York** named the state's Diabetes Task Force, which included Medicaid leadership and public health partners, as a driving force in the Medicaid and public health relationship that helped achieve National DPP Medicaid coverage. Interviewees discussed public health's lead role in (1) National DPP Medicaid coverage promotion; (2) building community partnership; and (3) assisting YMCAs and other CBOs with provider Medicaid enrollment. New York's public health evaluation and surveillance team was also involved in collecting data for the SPA. **North Carolina** shared that Medicaid and public health came together to share their respective expertise to design the Section 1115 waiver to reduce health care costs and improve health outcomes.

Interviewees consistently highlighted the value of partnering with organizations and individuals "on the ground," such as CBOs and Medicaid beneficiaries. They stressed the significance of partnering with CBOs since they have strong community ties and are key Medicaid National DPP providers, making them a primary stakeholder in the design of the National DPP Medicaid benefit. Interviewees indicated partnerships with CBOs, such as food pantries and social service agencies, faith-based organizations, and other community-based National DPP providers and referral organizations played the most integral role in the design and implementation of the National DPP Medicaid benefit. They named the importance of building trust in these partners and having them build trust in Medicaid agencies by engaging in conversations about resources and support needed to: (1) become National DPP Medicaid providers; (2) refer, enroll, and support program participants; and (3) bill effectively. Partnerships with insurance administrations, divisions of social services (responsible for the administration of complementary nutrition support, such as SNAP), Cooperative Extensions, and traditional health care providers (e.g., hospitals and FQHCs) were also mentioned. The National Association of Community Health Workers, for example, may have data helpful with closed-loop referrals for community health workers (CHWs). While **North Carolina** engaged with their State Office of Rural Health and **Illinois** partnered with IPHI. Interviewees also partnered with consulting firms — **Illinois** partnered with Health Management Associates and **North Carolina** with Manatt Health.

Experience from states that implemented MCO pilots suggests that early engagement with MCOs strengthens benefit design and helps mitigate downstream implementation barriers. MCO pilots used four categories of metrics used to assess effectiveness:

1. Program engagement and retention (e.g., retention rate, per-session attendance rate, participant satisfaction);
2. Clinical effectiveness (e.g., weight loss, A1C reduction, increase in physical activity);
3. Financial metrics (e.g., cost per participant, total medical cost reduction [hospitalization, pre/diabetes-related emergency department utilization]); and
4. Process metrics (e.g., ability to enroll National DPP providers into MCO systems and reimburse).

Interviewees shared that they engaged Medicaid members via town hall meetings open to the public and consumer advisory groups, and engaged community advocates as a secondary approach to seeking community input on benefit design.

Medicaid Benefit Design Options

Interviewees shared various National DPP Medicaid benefit design options, including different delivery and reimbursement models, provider enrollment requirements, and technical assistance for providers.

Member Eligibility

All states interviewed indicated that they use CDC eligibility guidelines to identify National DPP Medicaid participants. In particular, **North Carolina** limited its eligibility to certain regions of the state for the 1115 waiver Healthy Opportunities Pilot. The American Medical Association (AMA) prediabetes measures can be useful in identifying National DPP participants. Some interviewees shared that expanding eligibility to include more simplistic methods, such as the CDC risk assessment tool, may reduce barriers to National DPP access and support member enrollment. States with Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) will be better equipped to identify members eligible for both Medicare and Medicaid with the potential adoption of prediabetes quality measures by CMS.

Provider Types and Enrollment Processes

Interviewees specified the following provider types as approved National DPP providers:

- Physicians;
- Nonphysician licensed practitioners (e.g., nurse practitioners, registered nurses, registered dieticians); and
- Unlicensed practitioners under the supervision of CDC-certified National DPP providers or licensed practitioners (e.g., YMCAs, CBOs, food pantries, CHWs)

To allow National DPP service provision by unlicensed practitioners (i.e., prevention-based service providers such as CBOs and CHWs) — who are the primary providers for the National DPP Medicaid benefit — Medicaid agencies created a new category of provider for their billing systems. Interviewees noted that there is substantial rigor conducted by the CDC to recognize National DPP providers through the Diabetes Prevention Program Registry.

Each state interviewed has its own Medicaid enrollment requirements for National DPP providers. The table below outlines each state's requirements.

Medicaid National DPP Provider Enrollment Requirements

State	Enrollment Requirements
Illinois	The IMPACT system, the state's web-based provider system, creates streamlined credentialing. Organizations enroll as providers, rather than individuals. The state relies on each provider organization's CDC Diabetes Prevention Recognition Program code to prove National DPP provider recognition and does not monitor provider standing since the CDC already does.
Michigan	The CDC-recognized National DPP provider is the organizational and billing entity, and the Lifestyle Coach is the session leader and provider that is associated with the billing entity. Each must meet CDC recognition standards, including education and experience requirements and the state's Department of Health & Human Services (MDHHS) provider pre-enrollment requirements (including both having a National Provider Identifier [NPI]) before enrollment in Medicaid. Quality checks are completed by the Diabetes and Kidney Unit within MDHHS.
New York	All National DPP providers must enroll as, or under, a lead organization and must have their own NPI, regardless of licensure or lay worker status. New York's provider type was designed with community providers (non-traditional) in mind. More information is available on New York's provider enrollment and billing.
North Carolina	The state provided flexibility and accepted providers with atypical provider IDs who enrolled under a lead entity with an NPI. While this allowed for broader National DPP provider enrollment, MCOs in North Carolina had to navigate challenges related to lead entities holding the MCO contracts while paying rendering CBO providers with atypical provider IDs directly.

CHWs as National DPP Providers

In **New York**, CHW services are covered by Medicaid. CHWs are encouraged to become National DPP providers if they are employed by an enrolled National DPP provider organization. However, the state requires CHWs to have their own NPI. In **Illinois**, CHWs can provide services while employed by CDC-recognized organizations without having their own NPI. CHWs in **Michigan** can be Medicaid National DPP rendering providers when associated with a Medicaid National DPP billing entity and are able to provide other services for covered benefits to sustain their work.

Delivery Models

Interviewees shared a range of service modalities available for National DPP participants:

- In-person;
- Distance learning (live/synchronous);
- Online (asynchronous); and
- A combination of the above methods.

While **New York** first offered only in-person participation, the COVID-19 pandemic created a shift to offering flexible options (telephonic, and synchronous and asynchronous virtual learning), which have since been made permanent modalities. The National DPP Coverage Toolkit includes more about service delivery models.

When asked about considerations for National DPP service delivery in rural areas, **New York** shared that rural areas benefit from these flexible delivery options allowing more connection to available programs. However, challenges still exist around geographic access. Other access barriers in the state include delivery in different languages and disability accommodation. The state plans to review the soon-to-be-released CDC National DPP curriculum for individuals with intellectual and developmental disabilities and adopt it as needed. In **North Carolina**, most of the Healthy Opportunities Pilot National DPP-eligible regions were rural. While the State Office of Rural Health was more important during design, provider lead organizations were integral during implementation in understanding their population's needs and determining the need for in-person versus virtual service delivery and satellite locations. **Illinois** encouraged National DPP providers operating as regional hubs to expand services to rural areas in collaboration with local CBOs in those areas serving as local National DPP lifestyle coaches through a memorandum of understanding. An Illinois interviewee also shared that having place of service codes available to National DPP providers allows for coverage access and tracking of services rendered in rural places. **Michigan** named broadband access for virtual delivery as a barrier but noted that virtual delivery is not a preferred method for rural members. In some regions, distance prohibits in-person delivery, especially in the winter. While not a member preference, the state continues to see telemedicine use across the state and has the same reimbursement rates for all delivery models, like other states interviewed. Interviewees encouraged other states to use CMS' Rural Health Transformation Program funding to improve National DPP efforts in rural areas.

While **Wisconsin** does not have Medicaid coverage for National DPP, an interviewee shared that the state's National DPP participant retention rate is 70-80 percent, including in rural areas. They also shared that this is likely due to the high engagement of National DPP providers. The interview attributed this high engagement to: (1) the willingness of National DPP providers to talk to and support each other; (2) extensive lifestyle coach training; and (3) strong public health support and practices, including the convening of lifestyle coaches to discuss their needs.

Reimbursement Models

Reimbursement across interviewed states is session-based, with **New York**, **Michigan**, and **Illinois** reporting additional performance-based payments, such as a bonus payment for weight loss. After discussions with a stakeholder engagement group, including several National DPP providers and leaders, **Oklahoma** is likely moving away from a performance-based model to a per-session reimbursement model with perhaps one additional billing code tied to a five percent weight loss. **New York** named billing efficiency as one of the main drivers of provider retention. The state offers one billing code for per-session reimbursement after researching data on utilization and lessening financial burden on providers to determine rate structure. Billing efficiency

ensures providers get paid and remain engaged, especially for non-traditional providers who lack infrastructure for Medicaid billing. Interviewees shared the importance of implementing session-based over completion- or performance-based reimbursement to protect providers from the financial burden of covering the costs of early sessions — a lesson learned in **Michigan** using the Medicare Diabetes Prevention Program benefit provider experience. Actuaries can help states develop more nuanced approaches, which **North Carolina** shared it would have liked to do, and which **Illinois** indicated was part of its benefit design experience. While some states, like **Michigan**, reimburse at 100 percent of the Medicare reimbursement rate, most states have lower reimbursement rates for the National DPP Medicaid coverage benefit. The table below contains the reimbursement rates for the four states interviewed that have implemented coverage.

Reimbursement Rates for States Interviewed

State	Maximum Reimbursement per Member	Reimbursement Breakdown
Illinois	$670	• **Milestone 1**: Attending first core session - (G9873) **$180** per member • **Milestone 2**: Attending 4 core sessions - (G9874) **$150** per member • **Milestone 3**: Attending 9 core sessions - (G9875) **$140** per member • **Milestone 4**: Attending 2 core sessions in months 7-9 ○ Without 5% weight loss: (G9875) **$30** per member ○ With 5% weight loss: (G9879) **$50** per member • **Performance**: Achieve 5% weight loss from baseline (G9880) **$100** per member
Michigan	$782	• **Attendance-Based Payments**: ○ **G9886:** In-person attendance, 60 minutes: **$27** ○ **G9887:** Distance learning attendance, 60 minutes: **$27** ○ **G9871:** Online attendance, 60 minutes: **$18**. ○ **Subtotal maximum attendance-based payment (22 total sessions): $594** • **Performance-Based Payments**: ○ **G9880:** 5% weight loss achieved from baseline: **$153** ○ **G9881:** 9% weight loss achieved from baseline: **$27** ○ **G9888:** 5% weight loss maintained from baseline: **$8**
New York	$559.54	• **0403T** – This is a **$22.22 per-member, per-session reimbursement** for members who attend in-person National DPP lifestyle change program group sessions. This reimbursement is not tied to weight loss benchmarks. • **G9880** – This is a **$70.70 incentive payment** that is awarded to providers for members that have achieved at least 5% weight loss from their baseline. This incentive payment is available only once to the provider over the course of the 22 sessions when the member first achieves the 5% weight loss from baseline. If the member re-enrolls in a new National DPP lifestyle change program cohort at a later time, this incentive payment will be available again to the provider when the member achieves at least a 5% weight loss from the new baseline.
North Carolina	$398.52	• **Phase 1: $289.83** ○ Completion of 4 classes: **$28.77** ○ Completion of 4 additional classes (8 total): **$57.55** ○ Completion of 4 additional classes (12 total): **$71.93** ○ Completion of 4 additional classes (16 total): **$131.58** • **Phase 2: $108.69** ○ Completion of 3 classes: **$32.59** ○ Completion of 3 additional classes (6 total): **$76.10**

While a published fee schedule exists for FFS across states interviewed, MCOs are allowed to negotiate and pay higher rates to network providers to encourage participation in the lifestyle change program. The National DPP Coverage Toolkit includes more information on Medicaid reimbursement models and rate setting, as well as an interactive tool with state-specific Medicaid reimbursement amounts.

Technical Assistance for MCOs and Providers

Interviewees indicated several barriers for implementing the National DPP as a Medicaid benefit, such as provider network deficiencies. MCOs have experienced challenges with negotiating rates with non-traditional National DPP providers, such as CBOs, that lack experience contracting with Medicaid FFS or managed care. Clinical providers do not always know how to refer Medicaid members to National DPP services. Both traditional and non-traditional providers experience administrative burden when becoming National DPP Medicaid providers due to: (1) complex Medicaid enrollment processes; (2) unfamiliar billing practices and systems; (3) documentation and reporting requirements; and (4) limited staffing with the necessary technical expertise. National DPP providers also face MCO-related challenges such as different credentialing applications and processes and unique billing guidance for each MCO. Additional barriers providers face includes professional liability insurance for non-traditional providers being cost prohibitive, which leads them to not enroll with MCOs, and not having one point of contact for all National DPP-related questions and concerns.

Michigan shared that low member enrollment and utilization rates are likely due to National DPP providers not billing for every Medicaid member enrolled in their classes because of billing challenges. Not all MCOs contract with all Medicaid-enrolled National DPP providers, posing an additional challenge. MCOs have had to navigate a learning curve to classify new provider types and better understand the rigor established by the CDC's process for delivery organizations. Likely also impeding higher enrollment rates are non-local National DPP providers enrolling Medicaid members. The state is considering how to make billing easier for providers and how to better inform MCOs of the benefits of the National DPP model of care.

Interviewees shared the need for states to provide intensive technical assistance to National DPP Medicaid providers, especially non-traditional providers, such as CBOs. Technical assistance can also help address the National DPP implementation needs of MCOs through one-on-one technical assistance sessions or MCO convenings. MCOs often need support with: (1) participant outreach, referrals, and recruitment; (2) promotion; (3) billing and claims; (4) monitoring and evaluation; and (5) quality improvement plans. During the Healthy Opportunities Pilot in **North Carolina**, the state offered training to CBOs to support them in becoming National DPP Medicaid providers, including an initial hour-long training on National DPP program design and what CBOs need to know/do to participate in Medicaid. The training was provided by the North Carolina Area Health Education Centers (AHEC) which has infrastructure for training and education for a broad range of providers. The state developed standardized training for all providers, and then CBO-specific training for National DPP. Illinois engages the Medicaid Technical Assistance Center for direct technical assistance to providers, and IPHI now also provides direct technical assistance, such as guidance for enrolling in Medicaid as an organization versus an individual. technical assistance is provided during one-on-one meetings for implementation as needed. The state hosts webinars and large meetings to provide updates for MCOs and providers, and has disseminated four provider notices during different stages of National DPP implementation *(see example)*.

State Evaluation

Interviewees reported low provider and member enrollment rates as a barrier to evaluation.

An interviewee from **Illinois** named state-specific data from the Medicaid Coverage for the National DPP Demonstration Project as valuable to the development of its SPA. The Demonstration Project included **Maryland** and **Oregon** and yielded: (1) a higher average attendance rate than the national average (19 sessions in the first six months and eight in the second six months, compared with 17 and seven sessions, respectively); and (2) a 4.5 percent weight loss outcome, compared to a six percent national average, with a strong association between the total number of National DPP sessions per participant and weight loss.

Interviewees generally encouraged other states to rely on national DPP data to make the case for coverage.

Evidence and Outcomes

Numerous studies demonstrate the short- and long-term effectiveness of the National DPP. A systematic review of literature showed that participants routinely experienced reduced incidence of diabetes, a return to normoglycemia and A1c levels, reductions in weight, and improved comorbidities, such as cardiovascular disease.

The Diabetes Prevention Program (DPP) was an initial study, launched in 1996, to test whether an intensive lifestyle intervention or metformin (an antidiabetic medication) could prevent or delay Type 2 diabetes in adults with prediabetes. The Diabetes Prevention Program Outcomes Study (DPPOS) is a 10-year follow up and ongoing long-term study of the National DPP, launched in 2002. During the DPP study, diabetes incidence among high-risk individuals was reduced by 58 percent among National DPP participants. DPPOS demonstrated lasting impact at 10 years and found that participants in the program had lower blood pressure and lipid medication use, suggesting their cholesterol and blood pressure were able to be managed through lifestyle changes, rather than medication.

Evidence also demonstrates that the National DPP produces cost savings. A two-year prospective study, conducted in a large workplace setting, found that National DPP enrollees had an average reduction of $4,552 in 2-year total direct medical costs, primarily related to reduced hospitalizations, outpatient visits, and emergency room visits. Other studies show that while more expensive than a placebo intervention, the greater costs of the National DPP and medication treatment were offset by reductions in the costs of nonintervention-related medical care.

The return on investment (ROI) for Medicaid coverage of the National DPP generally demonstrates a positive ROI over a longer-term period, with significant cost-effectiveness typically realized over a 10-25-year time frame. While cost savings are realized sooner within the general health care system, National DPP is a viable preventive investment within Medicaid at the 5-year horizon; and cost-effectiveness is clearly demonstrated at 10 years with the reduction of costs for diabetes-related complications. At 25 years, the National DPP is projected to lead to savings of $27 to $548 per participant. The greatest cost-savings impact is associated with Medicaid beneficiaries at highest risk for developing type 2 diabetes. The National DPP Coverage Toolkit includes more details on National DPP ROI, including ROI calculation tools.

The Diabetes Prevention Impact Toolkit, developed by the CDC, projects the health and economic effects of the National DPP on populations of interest, and from the perspectives of states, insurers, and employers. The toolkit allows users to input details on risk groups (e.g., persons with prediabetes, and other persons at risk for type 2 diabetes); estimated program costs; participation rates; body weight data; and medical costs (at year of diagnosis and years after diagnosis). Many states have used the toolkit to determine National DPP costs and anticipated Medicaid savings. Examples of the toolkit's dashboard and results for **Illinois** are included in the tables and chart below/on the next page.

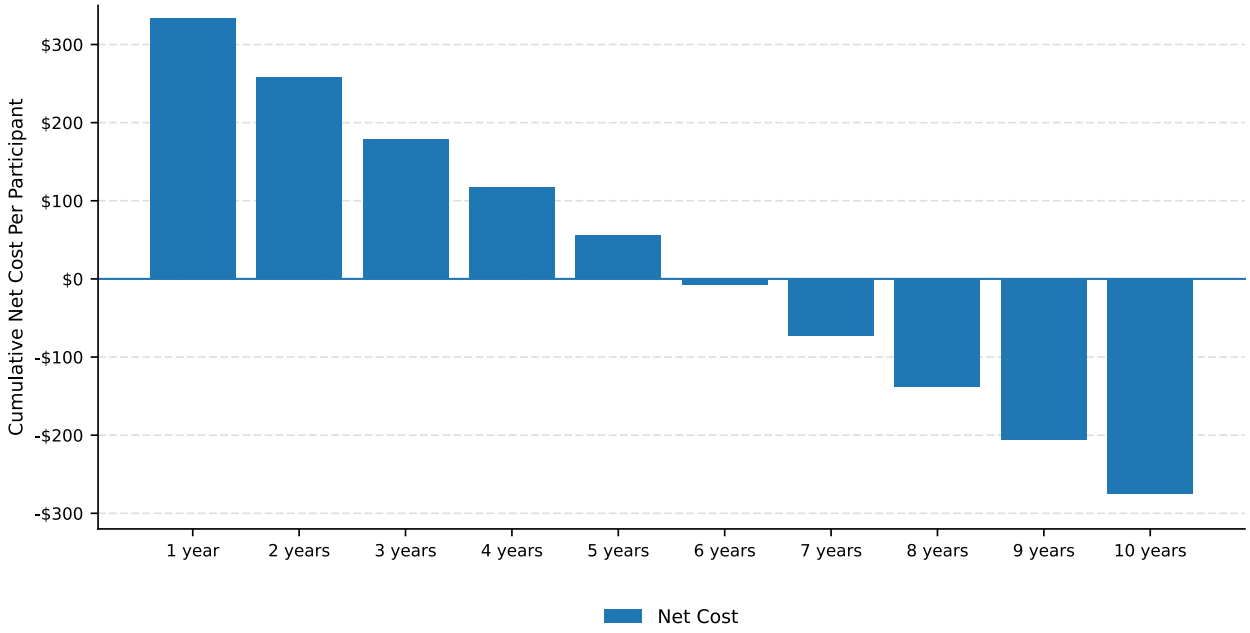
Illinois: Program Costs

Assumption	Default Value	Values Used in Your Analysis
Program cost per person	$417.00	$417.00
Screening cost per person *(only if conducting screening)*	$12.50	N/A
Other costs	$20.00	N/A

Illinois: Medical Costs

Assumption	Default Value	Values Used in Your Analysis
Costs incurred in the year of diagnosis	$6,425	$6,425
Costs incurred per year after diagnosis	$3,900	$3,900
Discount rate	3.0%	3.0%

Illinois: Net Costs (Program Costs Minus Medical Cost Savings) Per Participant



Year	Medical Cost with No Intervention ($)	Medical Cost with Intervention ($)	Medical Cost-savings[1] ($)	Program Cost[2] ($)	Net Cost[3] ($)
1	5,852	5,768	84	417	333
2	11,683	11,524	159	417	258
3	17,476	17,237	239	417	178
4	23,220	22,920	300	417	117
5	29,005	28,644	361	417	56
6	34,729	34,305	424	417	-7
7	40,401	39,912	489	417	-72
8	46,020	45,465	555	417	-138
9	51,576	50,953	623	417	-206
10	57,076	56,385	692	417	-275

Note: All costs are discounted back to year 0. The default discount rate (3%) or user-entered rate is used to discount costs.

[1] The "Medical Cost-savings" column is the cumulative difference between costs in the "Medical Costs with No Intervention" column and the "Medical Costs with Intervention" column.

[2] Program Cost includes the cost of screening if you have chosen to do a screening program. The cost of screenings that do not detect cases of prediabetes are accounted for in the program cost.

[3] The "Net Cost" column is the difference between the "Program Cost" column and the "Medical Cost-savings" column.

Michigan estimated that eight years after program implementation, the Medicaid program would realize cost savings for program participants. Michigan estimated that people diagnosed with diabetes incur an average of $9,600 per year of medical expenditures and, on average, have medical expenditures 2.3 times higher than what they would be in the absence of the disease. Based on the estimated population screened for diabetes in Michigan and an approximate 10 percent enrollment rate, the state anticipated that 3,000 Medicaid members would participate in the program annually. Based on these estimates, an ROI study using Michigan DPP experience in the Medicaid population indicated that the estimated decrease in diabetes for a beneficiary with prediabetes can provide net savings of approximately $363 per participant by year 10, a budget-neutral status by year eight and with a projected overall 1.5 ROI.

Michigan: National DPP Cost Calculations and Anticipated Savings

Input	Estimate
Disease Impact	$9,600
Weight Loss	4.4%
Medical Costs Per Person First Year of Diabetes Diagnosis	$6,669
Future Medical Costs Per Person Diabetes Diagnosis	$4,940
Medical Cost Savings Per Participant in First Year of Program	$84
Net savings per participant at Year 10	$363

New York noted that their program achieves budget savings rather than neutrality through a return-on-investment framework. The state Medicaid agency's Evidence Based Benefit Review Advisory Committee (EBBRAC) — a committee charged with making recommendations regarding Medicaid coverage of services and technology — commissioned an analysis of diabetes prevention programs in Medicaid in collaboration with the New York State Department of Health. The results of the analysis led the EBBRAC to unanimously recommend Medicaid coverage of the National DPP. The report summarized available literature, with high impact of the National DPP on reduced diabetes incidence and return to normoglycemia, and a moderate impact on weight change and A1c levels. The state also looked at the Medicare Diabetes Prevention Program, which found that participation among seniors with prediabetes reduced type 2 diabetes risk by 58 percent for those over 60, and showed an 84–88 percent probability of saving money by reducing hospitalizations and emergency visits.

The National Association of Chronic Disease Directors has supported states with the design and implementation of National DPP as a Medicaid benefit in the form of technical assistance, tools, and training. To support this scan, the National Association of Chronic Disease Directors shared state cost savings language and calculations for additional states, including **Montana** and **Virginia**.

The following excerpt is from a Montana ROI report, the first state to offer National DPP as a Medicaid benefit in 2012:

> *"In 2010 in Montana, the lifestyle program cost $557 per participant and treatment costs were approximately $11,268 per person with diabetes annually. The annual return on investment for preventing one case of type 2 diabetes was close to $10,711 per person. Overall, the program saves over $1.1 million each year in health care costs."*

Supporting Information for Montana's ROI analysis is included in the table on the next page.

Montana: ROI Analysis Supplemental Data

Cost	Source/Calculation
$557/person for Lifestyle program in MT, 2008	*Effectiveness of a Lifestyle Intervention Program among Persons at High Risk for Cardiovascular Disease and Diabetes in a Rural Community*, The Journal of Rural Health, Montana, 2010) Note: in 2013, MT Medicaid still reimburses $500/person for this program
49,700/ MT population with diabetes, 2010	Scientific Statement, Supplemental Data, Diabetes Care, Vol. 36, April, 2013
698/MT enrollees in the DPP, 2010	MT Lifestyle Program, 2010
$560 million Total Cost spent annually on treatment of diabetes in MT, 2010	Scientific Statement, Supplemental Data, Diabetes Care, Vol. 36, April, 2013
58% risk reduction in type 2 diabetes incidence over 3 years follow up	*Long-Term Benefits From Lifestyle Interventions for Type 2 Diabetes Prevention*, Diabetes Care, Vol 34. May, 2011
$11,268 /annual cost per person for diabetes treatment	$560,000,000 (annual total cost spent on diabetes) / (49,700 annual population with diabetes)
$10,710.6 Return on Investment per person annually	$11,268 (annual cost per person for diabetes treatment) - $557 (annual cost of Lifestyle Program)
134.9 people w/o diabetes per year	698 *.58 = 404.8 / 3 years
97.7 people who would develop type 2 diabetes per year	698-404.8=293.2 /3 years
$1,521,180 savings over 1 year	135 (people w/o diabetes) *$11,268 (cost to treat person with diabetes)
$388,786 annual cost of DPP	698 (total enrolled in DPP) *$557 (DPP cost/person)
$1,132,394 return on investment over 1 year	$1,521,180 (savings over 1 year) - $388,786 (annual cost of DPP)

The National Association of Chronic Disease Directors also shared the following tables from a cost and ROI analysis for **Virginia**.

Virginia: Cost of National DPP for Medicaid

Assumptions	Data
Number of Adults in Medicaid	38,0000
Prevalence of Prediabetes, VA	36%
Enrollment into National DPP, VA	12%
Cost of National DPP, full	$650.00
Estimated Cost, VBP	$273.73
Analysis	**Value**
Number prediabetics in Medicaid	136,800
Number of prediabetics in Medicaid enrolled in National DPP	16,416
Cost of National DPP among enrolled, one year, VBP	$4,493,512.12
Cost of National DPP among enrolled, one year, $650	$10,670,400.00

Sensitivity Analysis		# People	Cost; VBP	Cost Full
ENROLLMENT	2%	2,736	$748,918.69	$1,778,400.00
	17%	23,256	$6,365,808.84	$15,116,400.00
COST OF PROGRAM		**COST**		
	450	$7,387,200.00		
	550	$9,028,800.00		

Virginia: Cost Per Case Prevented

Assumptions	Data
Conversion rate: preDM to T2/year	5%
Reduced incidence with National DPP	58%
If no National DPP, # people converted	821
If National DPP, # who would still convert (2.1% incidence instead of 5%)	345
Number of DM cases prevented	476
Cost Savings of preventing these DM Cases	$4,570,690
Cost of providing the program	$4,493,512
Savings, Yr 1 of National DPP provision	$77,178
Cost per case of prevented DM	$9,439
Direct Cost of DM (ADA, 2017)	9,601
Direct Cost savings pp of treating PreDM	$162

Virginia: Cost of Diabetes for Medicaid

Assumptions	Data
Number of prediabetics in VA Medicaid population	136,800
Conversion rate: PreDM to T2D, year	5%
Direct Cost of DM, pp, Trogdon, 2017$	$6,397.00
Direct Cost of DM, pp, ADA, 2017$	$9,601.00
Direct Cost of DM, pp, Medicaid 2013 inflated to 2017$	$4,450.00
Indirect Cost of DM, pp ADA, 2017$	$3,640.00
Analysis	**Value**
Number Prediabetics in VA Medicaid	136,800
# Medicaid PreDM convert to T2D, one yr	6,840
Direct Cost of DM, pp/yr	$43,755,480.00
Indirect Cost of DM, pp/yr	$24,897,600.00
Total Cost of DM, pp/yr, Virginia	$68,653,080.00

Sensitivity Analysis				
DM Costs, Direct	**PP Cost**	**Direct Cost**	**Indirect Cost**	**Total Cost**
2017 ADA	$9,601.00	$65,670,840.00	$24,897,600.00	$90,568,440.00
2013 Medicaid (2017)	$4,450.00	$30,438,000.00	$24,897,600.00	$55,335,600.00

Return on Investment		
Conservative	**Total Savings**	**ROI**
Medicaid (DM) & $650 cost	$19,767,600.00	$2.85
Medicaid Cost (DM) & VBP	$25,944,487.88	$6.77
Total Medicaid + Indirect, VBP	$50,842,087.88	$12.31
Mid-Range	**Total Savings**	**ROI**
Trodgen (DM) & $650 cost	$33,085,080.00	$4.10
Trodgen (DM) & VBP cost	$39,261,967.88	$9.74
Trodgen (DM) + Indirect, VBP	$57,982,680.00	$15.28
Liberal	**Total Savings**	**ROI**
ADA & $650	$55,000,440.00	$6.15
ADA& VBP	$61,177,327.88	$14.61
ADA Direct and indirect, VBP	$86,074,927.88	$20.16

Virginia estimated that in year five there would be a 49 percent reduction in diabetes incidence and a cost savings per National DPP participant of $11,607.78.

While in the early stages of implementation, **Oklahoma** anticipates Medicaid cost savings from the National DPP program and will monitor health indicators, such as reductions in diabetes diagnoses, first-episode hospitalizations, and diabetes-related complications, such as diabetic ketoacidosis.

Key Implementation Considerations

Interviewees were asked to share key takeaways from their design and implementation experiences. Key takeaways include:

- **Partnering with key stakeholders — such as public health, MCOs, and providers — during design is paramount**, especially for anticipating provider technical assistance needs and determining a reimbursement model/rate structure;
- **Examining the national coverage landscape and leveraging lessons from other states** can help build the case for adoption of National DPP coverage as a Medicaid benefit;
- **Establishing billing efficiencies, parity with Medicare rates, and technical assistance** may yield higher provider enrollment and retention rates;
- **Relying on a state's unique context and building leadership buy in** can help pave the road toward National DPP Medicaid coverage;
- **Piloting coverage through MCOs can be a powerful tool** for demonstrating impact and advancing the development of a SPA to achieve coverage;
- **Requiring only organizations to enroll as providers, and not individuals**, may support National DPP provider enrollment; and
- **Investing in prevention often returns savings over a longer time horizon**, necessitating collaboration and realignment with payers whose models are typically anchored in annual benchmarks.

Conclusion

Exploring Medicaid coverage for National DPP in Texas offers an opportunity to reduce the incidence of type 2 diabetes among high-risk individuals, while supporting the state's broader population health and fiscal sustainability goals. Evidence from other states suggests that the program can help participants achieve modest weight loss, reduce diabetes risk, and generate savings over time to the state by avoiding or delaying diabetes-related complications, hospitalizations, and other high-cost services.

Although Medicaid coverage of the National DPP requires upfront investment, tools such as the Diabetes Prevention Impact Toolkit can help Texas and other states estimate program costs, potential savings, and return on investment over both short- and long-term horizons. With careful planning, Texas can build on lessons from other states to design a National DPP Medicaid benefit that supports prevention, strengthens community-based delivery infrastructure, and advances practical strategies to reduce the impact of diabetes in the state.