Medicaid and National Diabetes Prevention Program (DPP) Demonstration Technical Guidance

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MARYLAND Department of Health

Medicaid and National Diabetes Prevention Program (DPP) Demonstration Technical Guidance

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EXECUTIVE SUMMARY – UPDATED 11.26.2018

Maryland was one of two states that received funding from the Centers for Disease Control and Prevention (CDC) through a cooperative agreement with the National Association of Chronic Disease Directors (NACDD) for a two-year project to demonstrate ways of offering the National Diabetes Prevention Program (National DPP) to the Medicaid population through Managed Care Organizations (MCOs).[1] Maryland Medicaid, in collaboration with the Center for Chronic Disease Prevention and Control (CCDPC), implemented a delivery model for the National DPP to Medicaid beneficiaries with four MCOs (Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners). The demonstration goal was to achieve sustainable coverage of the National DPP for Medicaid beneficiaries under current Medicaid authorities. Key deliverables included establishing a billing and payment model, and enrolling at least 600 Medicaid beneficiaries into participating National DPP programs by January 31, 2018.

According to Maryland Medicaid claims data (2013 -2015), more than 58,000 beneficiaries are at risk for developing type 2 diabetes. Unless aggressive mitigation strategies are put in place, these beneficiaries are more than likely to join the 19% of current Medicaid beneficiaries, age 25-64 year old, who suffer with type 2 diabetes. Maryland Medicaid believes connecting these high-risk beneficiaries to evidence-based lifestyle change programs will impact overall health, as well as reduce their risk for developing diabetes. Maryland Medicaid was uniquely positioned to immediately and successfully implement systems-level changes, and to design and implement a delivery model for diabetes prevention in managed care organizations (MCOs).

Maryland has a mature Medicaid Managed Care program with significant experience and established relationships between the State agency and participating MCOs. HealthChoice is Maryland's statewide mandatory Medicaid managed care program and was implemented in 1997 under authority of Section 1115 of the Social Security Act. At the end of calendar year (CY) 2017, nearly 85.1% of the State's Medicaid and Maryland Children's Health Program (MCHP) 1.18 million Medicaid beneficiaries were enrolled in the HealthChoice Program. Participants in HealthChoice currently can choose from one of nine (9) managed care organizations (MCOs) and a primary care provider (PCP) from their MCOs' network to oversee their medical care.

Maryland Medicaid and the CCDPC have the advantage of being co-located within the Maryland Department of Health (MDH), and report to the Secretary of Health. Maryland Medicaid engaged four (4) of the eight (8) HealthChoice MCOs through a non-competitive grant process to participate in this project and to adopt a new delivery model for the National DPP.[2]

The CCDPC provides a statewide focus on building and scaling the National DPP. The CCDPC leads a statewide drive to build diabetes prevention in all Maryland communities. The CCDPC currently provides guidance, technical assistance, and networking opportunities for CDC-recognized lifestyle change organizations. The CCDPC built and maintains a referral and data collection website, behealthymaryland.org. The CCDPC provides no-cost lifestyle coach training sessions and maintains four Maryland-based master trainers. The CCDPC is a recipient of three federal grants, which provide staffing to this demonstration project and support the work described above to scale diabetes prevention capacity in the state. The CCDPC staff liaisons provide diabetes prevention expertise to the demonstration project and collaborate with Medicaid to provide technical assistance to the MCOs as they

[1] While the Demonstration was funded for 2 years, it continued to operate under a no cost extension through January 31, 2019, to allow Medicaid beneficiaries enrolled during the Demonstration to complete the 1-year National DPP curriculum.

[2] Aetna Better Health joined Maryland Medicaid's HealthChoice program in 2017, year 2 of the Demonstration.

established relationships with National DPP suppliers.

Start-up efforts included developing the claims reimbursement model which includes a pay-for-performance component, and assisting the MCOs in connecting with and establishing formal contractual agreements with virtual and community-based CDC-recognized lifestyle change programs. Through Year 1 and continuing into Year 2, Maryland Medicaid and the CCDPC assisted the MCOs in navigating relationships with the CDC-recognized lifestyle change programs.

ELIGIBILITY, RETENTION & RECRUITMENT

Chapter 1 : MCO Data Mining Using ICD-10 Codes to Identify Eligible Beneficiaries – FINAL 01.17.2017

Overview

During this demonstration,[3] participating Managed Care Organizations (MCOs) will follow the Centers for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP) criteria to determine eligible beneficiaries for participation in the National Diabetes Prevention Program (National DPP). At the start of the demonstration, Maryland Medicaid provided an initial claims analysis to MCOs, who have since updated and refined this data in preparation for actual enrollment. Throughout the demonstration, MCOs will use claims and/or lab analyses to identify potentially eligible beneficiaries who meet the standard criteria related to elevated blood glucose and weight. This document outlines the logic and specific ICD-10 codes that MCOs can use to identify potentially eligible beneficiaries for referral to their subcontracted DPP suppliers.

INCLUDE:

1. 18 years or older;

AND

2. Overweight or obese (have a BMI of ≥ 25kg/m^2 (≥ 23kg/m^2, if Asian)

AND EITHER

3. Elevated blood glucose level

OR

4. History of gestational diabetes

NOT

5. Diagnosed with type I or type II diabetes (exclude anyone with any of the E10.x, E11.x, or E13.x ICD-10 diabetes codes);

NOR

6. Currently pregnant[4]

Another way to depict this logic is shown in the table below. If 1 + 2 + 3 then Eligible for DPP:

1	+2	+3	= ELIGIBLE FOR DPP
ARE:	AT LEAST ONE (may be both)	ARE NOT:	
✔ ≥ 18 years old ✔ Overweight or Obese	✔ Elevated Blood Glucose ✔ History Gestational Diabetes	≠ Type 1 or Type 2 diabetes ≠ Currently Pregnant[2]	MCOS may refer to demonstration DPPs

For data mining, MCOs may use select ICD-10 codes for overweight and obesity, abnormal or elevated glucose, gestational diabetes, and BMI to identify potentially eligible beneficiaries for this demonstration (see Appendix A, Table A.1 – A.3).

[3] Funded by the Centers for Disease Control and Prevention (CDC) through a cooperative agreement with the National Association of Chronic Disease Directors (NACDD), June 2016 – January 2019.

[4] Participant should be at least eight weeks post-partum with post-partum blood work completed.

Chapter 2 : Comparison of Previous versus Current MCO Data Mining Logic to Identify Eligible Beneficiaries – FINAL 03.08.2017

Overview

During this demonstration,[3] participating Managed Care Organizations (MCOs) will follow the Centers for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP) criteria to determine eligible beneficiaries for participation in the National Diabetes Prevention Program (National DPP). At the start of the demonstration, Maryland Medicaid provided an initial claims analysis to MCOs, who have since updated and refined this data in preparation for actual enrollment. Please see below for a comparison between the two logics for data retrieval.

PREVIOUS LOGIC	UPDATED LOGIC
Limited age to 18 and over	Limited age to 18 and over
Includes overweight/obese **AND/OR** Abnormal glucose (only R73.09, no other elevated glucose codes) **OR** Ever diagnosed with gestational diabetes (does not limit to history of gestational diabetes)	Includes overweight/obese or BMI ($\geq$ 24kg/m^2 or $\geq$ 22kg/m^2, if Asian) **AND** Elevated Glucose level **OR** Includes overweight/obese or BMI ($\geq$ 24kg/m^2 or $\geq$ 22kg/m^2, if Asian) **AND** History of gestational diabetes
Excludes ever diagnosed with diabetes	Excludes ever diagnosed with diabetes
Does not exclude currently pregnant	Excludes currently pregnant
ICD-9 and 10 codes	ICD-10 codes only

Table 2.1. *Comparison of Overweight and Obesity ICD-10 Codes Used in Logic*

ICD-10 Code	Description	Previous versus Updated (Use of Codes)
E66.01	Morbid (severe) obesity due to excess calories	Both
E66.09	Other obesity due to excess calories	Both
E66.1	Drug-induced obesity	Both
E66.2	Morbid (severe) obesity with alveolar hypoventilation	Both
E66.3	Overweight	Updated
E66.8	Other obesity	Both
E66.9	Obesity, unspecified	Both
O99.21	Obesity complicating pregnancy, childbirth and the puerperium	Both
O99.210	Obesity complicating pregnancy, unspecified trimester	Both
O99.211	Obesity complicating pregnancy, first trimester	Updated
O99.212	Obesity complicating pregnancy, second trimester	Both
O99.213	Obesity complicating pregnancy, third trimester	Both
O99.214	Obesity complicating childbirth	Both
O99.215	Obesity complicating the puerperium	Both

Table 2.2. Comparison of Elevated/Abnormal Glucose Level and Gestational Diabetes ICD-10 Codes Used in Logic

ICD-10 Code	Description – Elevated Blood Glucose Level	Previous versus Updated (Use of Codes)
R73.01	Impaired fasting glucose	Updated
R73.02	Impaired glucose tolerance - Oral	Updated
R73.03	Prediabetes	Updated
R73.09	Other abnormal glucose	Both
	History of Gestational Diabetes	
Z86.32	Personal history of Gestational Diabetes	Updated
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled	Both
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled	Both
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control	Both
O24.420	Gestational diabetes mellitus in childbirth, diet controlled	Both
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled	Both

ICD-10 Code	Description – Elevated Blood Glucose Level	Previous versus Updated (Use of Codes)
O24.429	Gestational diabetes mellitus in childbirth, unspecified control	Both
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled	Both
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled	Both
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control	Both

Table 2.3. *Obesity, Abnormal Glucose Level, and Gestational Diabetes ICD-9 Codes used in Previous Logic*

ICD-9 Code	Description – Elevated Blood Glucose Level
720.29	Other abnormal glucose
	Gestational Diabetes
648.83	Abnormal glucose tolerance of mother, antepartum condition or complication
648.81	Abnormal glucose tolerance of mother, delivered, with or without mention of antepartum condition
648.84	Abnormal glucose tolerance of mother, postpartum condition or complication
	Obesity
278	Overweight, obesity and other hyperalimentation
278.00	Obesity, unspecified
649.1	Obesity complicating pregnancy, childbirth, or the puerperium

Chapter 3 : Shared Learning for Integrating the National DPP into Hospitals and Health Systems – FINAL 02.14.2018 [UPDATED 09.16.2018]

Background and Purpose

The National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program proven to delay or prevent the onset of type 2 diabetes among people at high risk by 58 percent (71 percent for individuals over 60 years old).[5][6] Implementing this structured lifestyle change program can improve health outcomes, reduce healthcare costs, result in fewer hospital admissions, and in Maryland align with the goals of the All-Payer Model. A recent study conducted by the YMCA of the USA on Medicare participants enrolled in the National DPP found that during the first three years of the intervention period there was an overall savings of $5,048,449 for the 3,319 participants. Additionally, the total decreases in inpatient admissions and emergency department (ED) visits were significant, with nine fewer inpatient stays and nine fewer ED visits per 1,000 participants per quarter.[7]

This document provides shared learnings for integrating the National DPP into hospitals and health systems, which are organized into the following key categories:

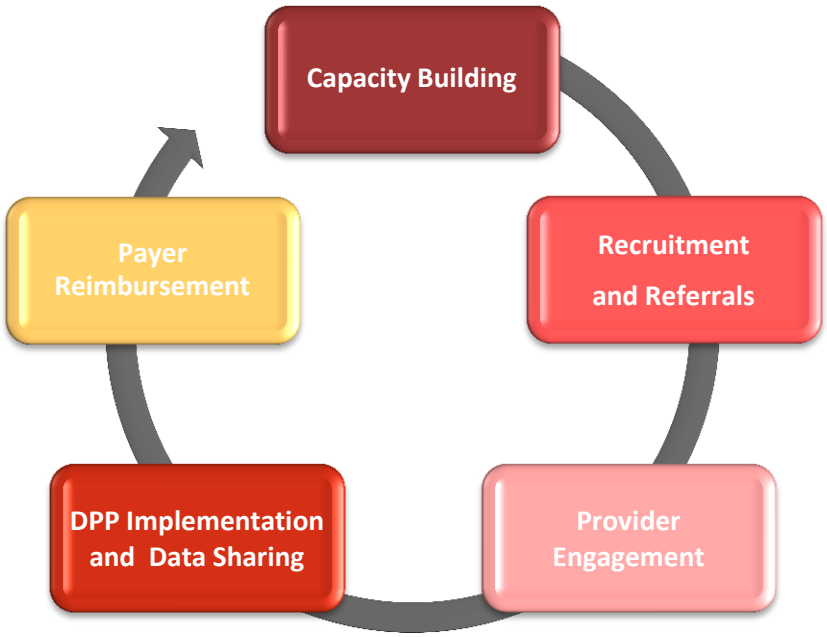

Figure 3.1. Key Categories for Integrating National DPP into Hospitals and Health Systems

[5] American Medical Association and Centers for Disease Control and Prevention. (2015). Preventing Type 2 Diabetes: A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program. Retrieved from https://www.cdc.gov/diabetes/prevention/pdf/stat_toolkit.pdf

[6] US Preventive Services Task Force. (2014). Final Recommendation Statement. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd

[7] Iva, Maria Liliana. (2017). Impact of the YMCA of the USA Diabetes Prevention Program on Medicare spending and utilization. Health Affairs 36. 10.1377/hlthaff.2016.1307.

Capacity Building

Hospitals and health systems, through their patient registries, have the ability to offer or facilitate connection with preventive services to patients, who are developing life threatening, and often expensive, chronic illness, including prediabetes. This positions them well to contribute to state and/or local capacity-building efforts to scale and sustain the National DPP.

Hospitals and health systems can help to build the National DPP infrastructure and increase patient engagement by taking any of the following actions:

- **Become a Centers for Disease Control and Prevention (CDC)-Recognized Organization or Medicare DPP (MDPP)[8] Supplier** and offer classes taught by hospital-employed Lifestyle Coaches at the hospital / affiliated sites.[9]
    - Hospitals often already offer Diabetes Self-Management Education (DSME) classes and may cross-train registered Nurses, Dietitians, Nutritionists, health educators, or lay health workers to be DPP lifestyle coaches and offer the program.
    - Information on how to become a DPP Supplier;[10]
- **Contract with a CDC-Recognized Lifestyle Change Program or MDPP Supplier** and host classes taught by the DPP Supplier's Lifestyle Coaches at the hospital / affiliated sites.9
    - List of CDC Recognized DPP Suppliers in your area[11]
- **Act as a referral hub** in the hospital's community and refer patients to available CDC-Recognized Lifestyle Change Programs.

Recruitment and Referrals

Hospitals and health systems have access to patient information through electronic health records which facilitates taking a targeted approach for DPP recruitment**.** The hospital or health system's DPP implementation leaders can work with their IT and/or data analytics departments to create a report of patients with prediabetes or at risk for type 2 diabetes that appear to meet eligibility criteria for the DPP. This may be done using an algorithm (see Chapter 1) that mirrors the necessary health criteria for DPP participation. All patients can and should be included in the prediabetes eligibility report; data can be sorted and manipulated to align with hospital and health system recruitment priorities (i.e. payer reimbursement, target populations etc.)

Using the prediabetes eligibility report, the following strategies may be deployed depending on the hospital or health system's communication culture:

- **Targeted mailers** to pre-identified patients directing them to either call, go online, or visit a DPP location for an informational session, to register for a DPP (depending on the model). Including the patient's health care provider's name with their contact information often results in more enrollments. The mailers provide an initial contact with the potentially eligible patients but have

[8] Medicare Diabetes Prevention Program Expanded Model (MDPP-EM) suppliers were reimbursed for payment starting April 1, 2018. To be an MDPP supplier, organizations must have achieved at least preliminary or full recognition from the CDC.

[9] Payment for regulated space may depend on payer.

[10] Centers for Disease Control and Prevention. (2017). Implement a Lifestyle Change Program (for Professionals). Retrieved from: https://www.cdc.gov/diabetes/prevention/lifestyle-program/index.html

[11] Centers for Disease Control and Prevention. (n.d.). Find a Class Location Near You. Retrieved from: https://nccd.cdc.gov/DDT_DPRP/Programs.aspx

been most successful when followed up with a call (live or automated).

- **Personal calls** to patients. Similar to the targeted mailers, mentioning the patient's health care provider's name during personal calls has often resulted in more enrollments.
- **Automated calls to patients**, connecting them instantly to a member service representative. Calls are staggered to prevent overburdening of the member services representatives receiving the calls and to limit the number of call-backs needed.
- **Text messages** to patients with a link to the prediabetes risk assessment, informational session invitation, or the online registration portal (if a virtual model is selected). This strategy has been most effective among organizations that communicate via text regularly.
- **Health communications:** Hospitals and health systems can use their social media accounts and other electronic messaging systems to send educational messages that inform the public about prediabetes and promote the availability of DPPs.
- **Employee wellness:** Hospitals and health systems that are self-insured or offer employee wellness programs may offer the DPP for free to employees who meet eligibility criteria.

Provider Engagement

Hospitals and health systems can engage their provider networks to emphasize and/or prioritize a preventive approach to healthcare through screening, testing, and referring patients to the DPP. Providers may be incentivized to refer by taking a prediabetes course with available CME credits, meeting quality metric measures, or billing for services.

The following efforts can be made to involve providers:

- **Engage** your provider networks around diabetes prevention, the risk in their patient panel or population, and potential referral pathways to eligible CDC-Recognized Lifestyle Change Programs, or other choices of intervention for their at-risk population.
    - Outreach efforts have included targeting primary care providers, and also specialists such as Endocrinologists, Dentists, and Ob-Gyns; some organizations have engaged other types of clinical and non-clinical health workers such as Community Health Workers, Case Managers, Dieticians, Nutritionists, and Naturopaths.
    - Other integrated healthcare systems have engaged providers by forming or leveraging existing advisory boards that review evidence-based programs, such as DPP, to make recommendations for provider referrals and process, as well as establish quality metrics or integration with existing chronic disease programs.

The following are examples of strategies used to engage providers:

- **Educate** providers and their office staff about prediabetes as an emerging health risk and emphasize the importance of referring eligible patients to CDC-Recognized Lifestyle Change Programs as soon as possible.
    - **Notify** your network providers about the availability of the American Medical Association's (AMA) CME credits for prediabetes, and consider requiring them to obtain these CME credits.[12]
    - **Inform** your network providers about the AMA's Prevent Diabetes STAT Toolkit, which

[12] American Medical Association (AMA). (2018). Prediabetes PI CME Stage A: Learning from current practice performance assessment. Retrieved from: https://cme.ama-assn.org/Activity/2741078/Detail.aspx

assists providers with integrating diabetes prevention in their practices.[13]

- **Share** the National Diabetes Prevention Program Coverage Toolkit as a resource for further information.[14]

- **Provide** a list of pre-identified patients to your providers via secure email or a provider portal to facilitate the referral process (algorithm found in Chapter 1).
- **Work** with providers and their office staff to establish workflow processes for identification of coverage and eligibility prior to visit and for making referrals (please refer to the AMA Prevent Diabetes STAT Toolkit).
- **Outreach** directly to provider offices via in-person meetings or electronically and offer providers and office staff information and tools that educate patients and facilitate referrals. If time and infrastructure permits a staff member could meet with the patient following a visit to describe the program, answer questions, and make a referral. Some have found motivational interviewing to be an effective tool when making referrals. Alternatively, a provider can share DPP information and make a referral via the patient portal, if available, post-visit.[15] Some tools and resources include:
    - In-clinic presentations to providers, staff, and patients;
    - Prescription pad for lifestyle change programs;
    - One-page handout or postcard describing the CDC-Recognized Lifestyle Change Program, location(s), and how to register;
    - A locally developed community resource guide that supplements or supports the CDC-Recognized Lifestyle Change Program's success (e.g., smoking cessation, nutrition counseling, physical activity, etc.), and includes information on cost;
    - CDC-Recognized Lifestyle Change Programs can offer providers and/or office staff a poster-sized diabetes risk test, in English and Spanish, and encourage them to hang it in the waiting room with the following questions: *Are you at risk for diabetes (based on your test score)? Are you 18 and over? Ask your doctor if you qualify for the National DPP program.*
- **Offer** multiple pathways for referral based on your patient needs.
    - One integrated delivery system developed both a Prediabetes 101 online module and an in-person class offering in order to give their providers and patients choices for follow-up that are most appropriate for each individual.

DPP Implementation and Data Sharing

Hospitals and health systems may have data sharing infrastructure in place to support and enhance the implementation of a CDC-Recognized Lifestyle Change Program. Data sharing between a CDC-Recognized Lifestyle Change Program and a provider can help to improve the overall health of patients and in bridging medical care and public health initiatives.

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[13] American Medical Association (AMA) & Centers for Disease Control and Prevention (CDC). (n.d.). Prevent Diabetes STAT Toolkit. Retrieved from: https://preventdiabetesstat.org/toolkit.html

[14] National Association of Chronic Disease Directors (NACDD). (2018). National Diabetes Prevention Program Coverage Toolkit. Retrieved from: https://coveragetoolkit.org/

[15] Smith, T. (2017). Physicians praise online diabetes prevention program: "Finally." Retrieved on 01/26/2018 from: https://wire.ama-assn.org/delivering-care/physicians-praise-online-diabetes-prevention-program-finally

Data can be utilized to support DPP implementation in the following ways:

- The verification of eligibility for a CDC-Recognized Lifestyle Change Program by a lifestyle coach for the hospital or health system's patients through electronic health records (EHRs).
- Participant outcome data may be shared via the EHR throughout the year (e.g. monthly or quarterly) to providers to inform them about their patient's health status since participating in the DPP.
    - This feedback may prompt the provider to give positive feedback and reinforce the importance of the CDC-Recognized Lifestyle Change Program with the patient, which in return may help lifestyle coaches retain their participants.
    - One integrated delivery network developed a workflow that has the lifestyle coach providing feedback to the provider initially, to indicate initial enrollment and retention status, at six (6) months and again at 12-months to report health indicators that could be impacted by a CDC-Recognized Lifestyle Change Program.

Payer Reimbursement

Currently, approximately 65 commercial health plans nationwide provide partial or full coverage for the CDC-Recognized Lifestyle Change Program, and Medicare reimbursement began on April 1, 2018.[16] Maryland Medicaid has committed to evaluate the diabetes prevention program through its demonstration[3] (through January 31, 2019), and a pathway to sustained coverage is being explored, through a §1115 waiver amendment application to CMS.

- Before offering a CDC-Recognized Lifestyle Change Program to patients, coverage for the CDC-Recognized Lifestyle Change Program should be verified by your billing department.
- Medicare implemented a pay-for-performance model that reimburses for a CDC-Recognized Lifestyle Change Program's services at benchmarks that have been shown to improve retention and health outcomes.[17]
- Currently, CDC-Recognized Lifestyle Change Programs, the National DPP, can use a variety of billing methods to obtain reimbursement:
    - Invoice an employer or insurer who has a contract to pay for services rendered;
    - Self-pay by participant; or
    - Submit claims to insurers or designated benefit administrators using existing Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.[18]

[16] National Association of Chronic Disease Directors (NACDD). (2017). National Diabetes Prevention Program (National DPP) coverage toolkit. Retrieved from: http://www.chronicdisease.org/page/DiabetesToolkit/National-Diabetes-Prevention-Program-Coverage-Toolkit.htm

[17] Centers for Medicare and Medicaid Services (CMS). (2017). Fact sheet: Final policies for the Medicare Diabetes Prevention Program Expanded Model in the calendar year 2018 physician fee schedule final rule. Retrieved from: https://innovation.cms.gov/Files/fact-sheet/mdpp-cy2018fr-fs.pdf

[18] American Medical Association (AMA). (2016) New 2016 National Diabetes Prevention Program CPT Code: Background, description, and frequently asked questions. Retrieved from: https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/cpt-code-brief.pdf

BILLING & CODING

Chapter 4 : Current Procedural Terminology (CPT) Codes, Modifiers and Fee Schedule for DPP Services - FINAL 10.28.2016

Objective

To create a standardized coding structure for MCOs participating in the FY17-19 Medicaid DPP demonstration

Strategies

1. Use the Lifestyle Change CPT Tracking code 0403T[19] for DPP sessions tracking for this demonstration
2. Add modifiers[20] to:
    a. Distinguish between virtual and community based DPP suppliers
    b. Distinguish between enrollment visit, follow-up visits, and performance-based weight loss
3. Payment structure may vary depending on delivery model and/or MCO-DPP agreement, with the average total cost being the same for both virtual and community based DPP suppliers
4. Based on 365 day year
5. Enable tracking of claims through encounter data
6. Set a cap of reimbursement for demonstration purposes in line with providers' needs = $750
7. Write into contracts with DPP suppliers that every year (or quarterly) for the course of the demonstration - the average cost will be evaluated. The cap can be kept high as long as the average cost per participant does not exceed $500. If the average cost exceeds $500, the $750 cap will be reduced or the amount of reimbursement for weight loss during maintenance will be reduced to ensure an average cost of $500 per participant.
8. This $500 limit is set to ensure financial feasibility within the parameters of the grant.

[19] Effective January 1, 2016.

[20] MCOs confirmed feasibility of using two modifiers. They exist in system and are available for use.

Table 4.1. *CPT Codes and Modifiers for DPP services from a Community Based Program (effective July 1, 2016 to January 31, 2019)*[23]

Code	Modifier	Description	Proposed Fee	Limits/Logic
0403T		Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day =enrollment in community based program (class 1)	$90	• Can be used 1 time in 365 days • Cannot be used if 0403T-TG has been used[21]
0403T	TF	TF - Intermediate level of care =weekly core classes, up to 15 (classes 2-16)	$5/class Max of 15 classes (or $75)	• Can be used up to 15 times • Can be used 1 time per week
0403T	TM	TM - Individualized education program = monthly classes (6 maintenance) (classes 17-22)	$6/class Max of 6 classes (or $36)	• Can be used 6 times • Billing cannot start until Start date + 16 weeks
0403T	TS, TF	TS - Follow-up service TF – Intermediate level of care (community) =% weight loss/month (performance based reimbursement, during 16 week core)	$9 x units Max of $250 in 365 days	• Can only be used once per month • TS must be used with a second modifier[22] • 1 unit=1% of weight loss
0403T	TS, TM	TS, - Follow-up service TM – Individualized education program =% weight loss/month (performance based reimbursement, post core)	$9 x units Max of $300 in 365 days	• Can only be used once per month • TS must be used with a second modifier[6] • 1 unit=1% of weight loss
		Maximum possible in 365 days	$751	

[21] This is intended to be an indication of enrollment in a virtual program.

[22] Use TS or TM for community program.

Table 4.2. *CPT Codes and Modifiers for DPP services from a Virtual Program (effective July 1, 2016 to January 31, 2019)*[23]

Code	Modifier	Description	Proposed Fee Virtual	Limits/Logic
0403T	TG	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day TG - Complex/high tech level of care =enrollment in virtual program	$200	• Can be used 1 time in 365 days • Cannot be used if 0403T (no modifier) has been used[24]
0403T	TS, GT	TS - Follow-up service GT – via interactive audio and video communications system =% weight loss/month (performance based reimbursement)	$9 x units Annual max of $550	• Can only be used once per month • TS must be used with a second modifier[25] • 1 unit=1% of weight loss
		Maximum possible in 365 days	$750	

[23] For both virtual and community-based DPP supplier, the designation *'99'* (*Other place of service not otherwise specified*) may be used for *place of service*.

[24] This is intended to be an indication of enrollment in community-based program.

[25] Use GT for virtual program.

Chapter 5 : Eligibility, Billing, and Coding Procedures for Participating National Diabetes Prevention Program (DPP) Suppliers, Effective July 1, 2016 to January 31, 2019 – FINAL 01.19.2017 [UPDATED 09.16.2018]

Overview

During this demonstration,[3] participating National Diabetes Prevention Program (DPP) suppliers who are contracted with participating Managed Care Organizations (MCOs) to provide services to Medicaid beneficiaries will follow the eligibility, billing and coding procedures outlined in this document. These procedures address Diabetes Prevention Recognition Program (DPRP) criteria pathways to eligibility, assignment of ICD-10 codes, ICD-10 code definitions, and instructions for use during billing with CPT codes.

National DPP Eligibility Criteria and Referral Pathways

For this demonstration, DPP suppliers will receive beneficiaries through the following referral pathways:

1. Direct referrals from MCOs,
2. Direct referrals from medical providers, and
3. Indirect referrals through MCO marketing and outreach.

For MCO referrals, MCOs will follow the Centers for Disease Control and Prevention's (CDC) DPRP criteria to determine eligibility for participation in the National DPP. As described further in the companion document "MCO Data Mining Using ICD-10 Codes to Identify Eligible Beneficiaries," MCOs are using claims and/or lab analyses to identify potentially eligible beneficiaries who meet the standard DPRP criteria.

Medical providers may follow the CDC's DPRP criteria to determine eligibility for participation in the National DPP. The medical provider will use recorded medical history and /or lab results to identify potentially eligible beneficiaries who meet the standard criteria.

For beneficiaries that would like to enroll based on marketing and/or outreach, eligibility should be determined on or before the first class.[26] For the beneficiaries for whom the use of the CDC prediabetes screening test[27] or the ADA type 2 diabetes risk test[28] is indicated (those who meet required BMI standard, but do not have a recorded blood test), the DPP suppliers will conduct the risk test, and score accordingly.

DPP suppliers must be able to demonstrate that all participants have met CDC's DPRP eligibility criteria via the assignment of applicable ICD-10 diagnosis codes. Performance improvement will be demonstrated using CPT procedure codes and modifiers combined with units of weight loss. This document provides the steps DPP suppliers can use to ensure consistent and correct billing procedures for National DPP participants in this demonstration. All claims require at least two (2) ICD-10 diagnosis codes for the initial class and at least one (1) code for each subsequent class to be used during billing to demonstrate a participant's eligibility for the program and, accordingly, the DPP supplier's ability to be reimbursed by the MCOs.

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[26] Since participating in an evaluation is conditional to enrollment in the National DPP for this demonstration, informed consent must be achieved prior to participation in the demonstration. For virtual supplier referrals, informed consent will be achieved by the MCOs prior to enrollment. For community-based supplier referrals, informed consent will be achieved prior to or at the start of the first class. Maryland Department of Health. Institutional Review Board Approval – Protocol#16-62. Received by Debra Porterfield, PhD. March 28, 2017

[27] For a copy of the CDC prediabetes screening test, please visit: https: //www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf.

[28] To view the ADA type 2 diabetes risk test, please visit: http: //main.diabetes.org/dorg/PDFs/risk-test-paper-version.pdf.

Diabetes Prevention Recognition Program (DPRP) Eligibility Criteria[29]

MUST BE

1. 18 years of age or older

AND

2. Have a BMI of ≥ 24 kg/m^2 (≥ 22 kg/m^2, if Asian), as demonstrated by:
    a. A BMI specific ICD-10 code (See Appendix A, Table A.3)

AND

3. Have a history of elevated blood glucose level as demonstrated by:
    a. A recent blood test (in the past 12 months) **OR**
    b. An ICD-10 code **OR**
    c. Self-reported history of elevated blood glucose level (see Appendix A, Table A.2)

OR

4. Have a history of gestational diabetes, as demonstrated by:
    a. An ICD-10 code (See Appendix A, Table A.0.2) **OR**
    b. Self-reported history of gestational diabetes

OR

5. Have an elevated risk result on a prediabetes screening test, as demonstrated by:
    a. ≥ 9 on CDC prediabetes risk test **OR**
    b. ≥ 5 on ADA type 2 diabetes risk test

NOT

6. Currently pregnant (should be at least eight weeks postpartum with follow-up blood work completed)

NOR

7. Diagnosed with type 1 or type 2 diabetes

When Filing a Claim, or Completing a CMS 1500 Claim Form[30]:

DPP suppliers must be able use or assign applicable ICD-10 diagnosis codes with CPT procedure codes. These ICD-10 codes will allow the DPP suppliers to bill the MCOs for services rendered. The following section describes the assignment of ICD-10 codes with CPT codes for community-based and virtual DPP suppliers.

Community Based Suppliers' Initial Visit:

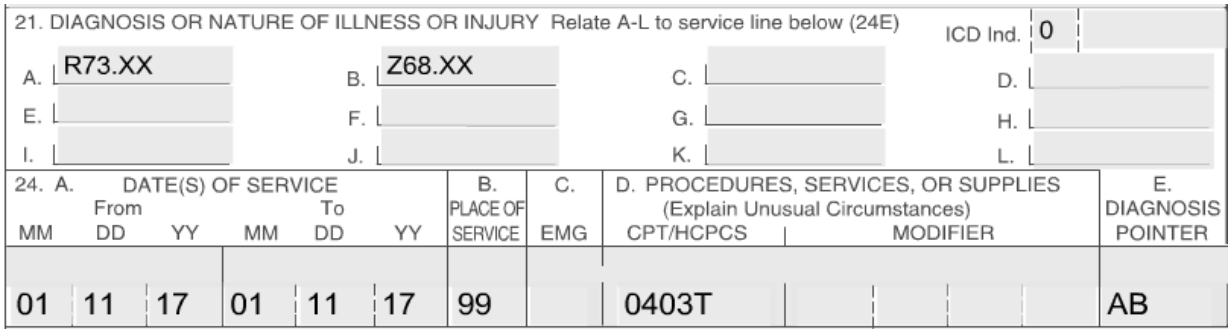
1. Use the CPT code (0403T) for initial visit, and
2. at least two (2) ICD-10 codes,[31]
    a. an elevated blood glucose level/ history of gestational diabetes ICD-10 code (primary diagnosis), **AND**
    b. a BMI ICD-10 code (secondary diagnosis code).

[29] The eligibility criteria is based on the previous CDC DPRP standards and may be updated to reflect the BMI (have a BMI of ≥ 25kg/m^2 (≥ 23kg/m^2, if Asian) of the CDC's 2018 DPRP standards.

[30] For the Maryland Medicaid CMS-1500 paper billing instructions, please visit: https://mmcp.MDH.maryland.gov/docs/MDH_cms_1500_billing_instructions_092315.pdf.

[31] The ICD-10 diagnosis code indicates the reason the service (as indicated by the CPT code) was performed.

Figure 5.1. Sample for Community Based Suppliers Completing CMS 1500 Claim Form for Initial Visit[32,33]



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

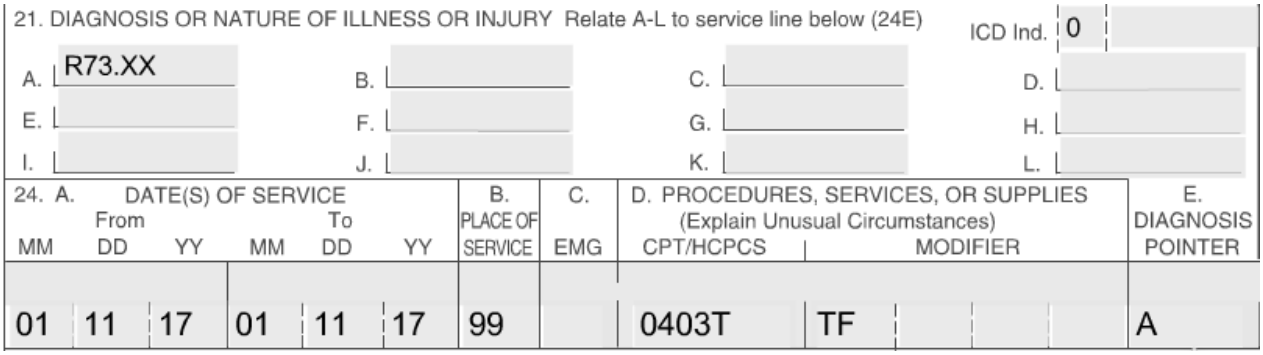
A. R73.XX		B. Z68.XX		C.		D.					
E.		F.		G.		H.					
I.		J.		K.		L.					

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
01	11	17	01	11	17	99		0403T		AB

Community Based Providers' Subsequent Visits:

1. Use the CPT code (0403T – XX; see Table 5.1) for attended and/or performance based claims, and
2. at least one (1) ICD-10 code,
    a. an elevated blood glucose level/ history of gestational diabetes ICD-10 code (use the ICD-10 code listed as primary diagnosis for initial visit.

Figure 5.2. Sample for Community Based Suppliers Completing CMS 1500 Claim Form for Classes Attended



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

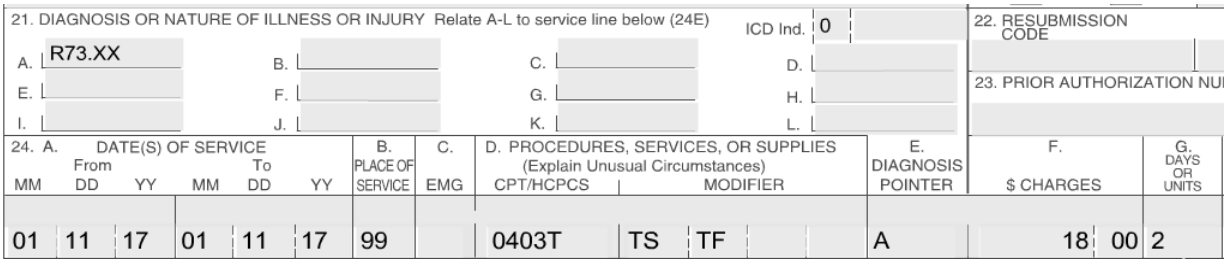
A. R73.XX		B.		C.		D.					
E.		F.		G.		H.					
I.		J.		K.		L.					

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
01	11	17	01	11	17	99		0403T	TF	A

[32] In Section 21, ICD Ind. refers to the ICD version. For example, if a provider were using ICD-9 diagnosis codes, a provider would replace the '0' with '9'.

[33] For *place of service* in section 24 B, it is recommended that both virtual and community based suppliers use the *'99'* designation (*Other place of service not otherwise specified*).

Figure 5.3. Sample for Community Based Suppliers Completing CMS 1500 Claim Form for Performance Based Reimbursement[34]



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. R73.XX B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NU

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
01	11	17	01	11	17	99		0403T	TS	TF		A	18 00	2

Table 5.1. *Performance and visit based CPT codes for Community Based Suppliers*

TYPE	CPT CODE
Classes Attended/Visit-Based - Core[35]	0403T-TF
Classes Attended/Visit-Based- Post Core[36]	0403T-TM
Performance Based- Core	0403T-TS, TF
Performance Based- Post Core	0403T-TS, TM

Virtual Suppliers' Initial Visit:

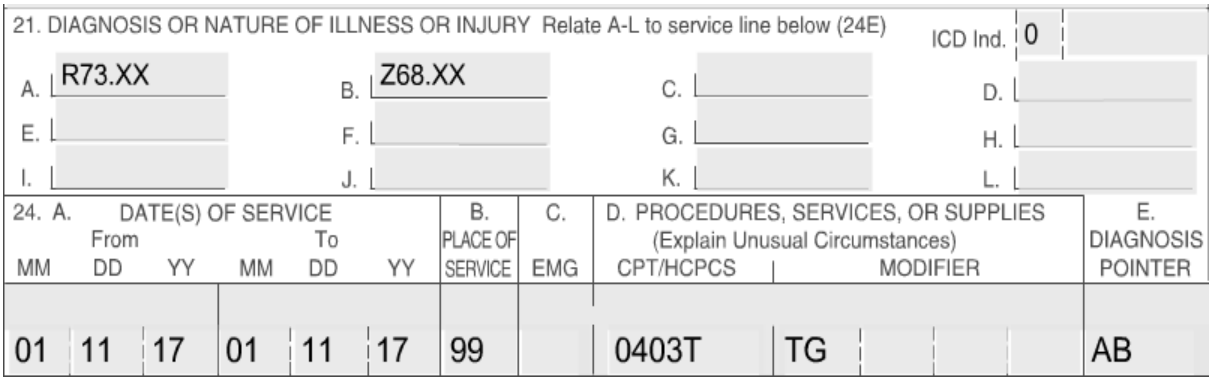
1. Use CPT code (0403T - TG) for initial visit, and
2. at least two (2) ICD-10 codes,[15]
   a. an elevated blood glucose level/ history of gestational diabetes ICD-10 code (primary diagnosis), **AND**
   b. a BMI ICD-10 code (secondary diagnosis code).

[34] The "Maryland MCO National DPP Demonstration-Codes for DDP Services" outlines the CPT coding structure, at $9 per unit, where 1 unit = 1% weight loss for the performance-based CPT codes. Figure 3 and 5 shows the example of 2 units, to indicate a 2% weight loss. 2 units x $9 = $18.00 for charges.

[35] Up to 15 core classes, as defined in the "Maryland MCO National DPP Demonstration-Codes for DDP Services" document.

[36] Up to 6 post-core classes, as defined in the "Maryland MCO National DPP Demonstration-Codes for DDP Services" document.

Figure 5.4. Sample for Virtual Suppliers Completing CMS 1500 Claim Form for Initial Visit



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

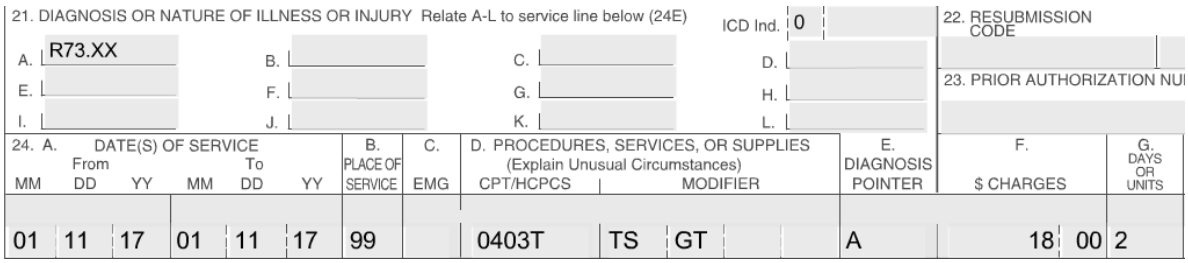
A. R73.XX B. Z68.XX C. D.
E. F. G. H.
I. J. K. L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
01	11	17	01	11	17	99		0403T	TG	AB

Virtual Suppliers' Subsequent Visits:

1. Use the CPT code (0403T – XX; see Table 5.2) for attended and/or performance based claims, and
2. at least one (1) ICD-10 code,
   a. an elevated blood glucose level/ history of gestational diabetes ICD-10 code (use the ICD-10 code listed as primary diagnosis for initial visit).

Figure 5.5. Sample for Virtual Suppliers Completing CMS 1500 Claim Form for Performance Based Reimbursement[18]



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0 — 22. RESUBMISSION CODE — 23. PRIOR AUTHORIZATION NU

A. R73.XX B. C. D.
E. F. G. H.
I. J. K. L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
01	11	17	01	11	17	99		0403T	TS GT	A	18 00	2

Table 5.2. *Performance and visit based CPT codes for Virtual Suppliers*

TYPE	CPT CODE
Classes Attended/Visit-Based	Not Applicable[37]
Performance Based	0403T-TS, GT

[37] No classes after initial visit

Assigning ICD-10 Codes

As there are three referral pathways for a beneficiary, the ICD-10 codes DPP suppliers may assign a beneficiary will depend on the ICD-10 codes provided during the referral process. For billing, DPP suppliers must use at least two (2) ICD-10 codes, one for elevated blood glucose level **and** one for BMI.

Since DPP suppliers need to confirm an eligible BMI before a beneficiary may enroll in the program, this information may be obtained at Class 0 or at the start of Class 1. Once BMI has been obtained DPP suppliers should use or assign the corresponding ICD-10 code (Z68.XX) for BMI (see Appendix A, Table A.3).

As part of the referral process, DPP suppliers may or may not receive ICD-10 codes for the beneficiaries. ICD-10 E and O codes are actual diagnoses of diseases or conditions, which can only be determined by a licensed medical provider since they have to perform assessments, tests, evaluations, or other diagnostic work to rule out some other condition. If there are no ICD-10 codes included in a beneficiaries' referral, DPP suppliers may use certain R, and Z codes, which refer to symptoms, signs, or states of being (see Scenario 1 and 2 below for further details).

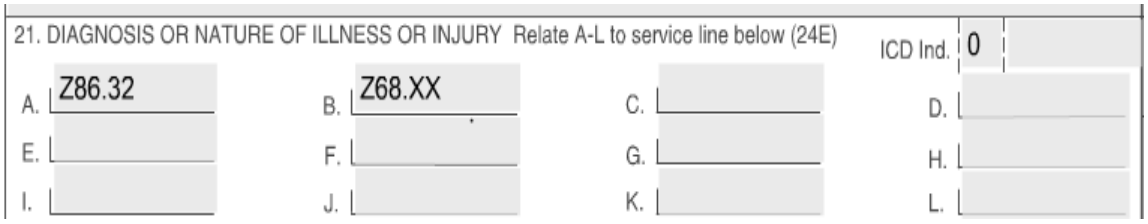
The following scenarios will cover the appropriate ICD-10 codes that DPP suppliers may use if ICD-10 codes are included in the referral or if no codes are included and a prediabetes risk test is conducted to establish eligibility.

Scenario 1 – Referral Includes Medical Provider Assigned ICD-10 Codes:

If a referral is made using one of the 024.xx codes for gestational diabetes mellitus in pregnancy:

1. Confirm participant is not currently pregnant (should be at least eight weeks postpartum with follow-up blood work completed)
2. Assign the appropriate ICD-10 code for personal history of gestational diabetes (Z86.32)[38]

Figure 5.6. Sample for Completing CMS 1500 Claim Form for Initial Visit – History of Gestational Diabetes

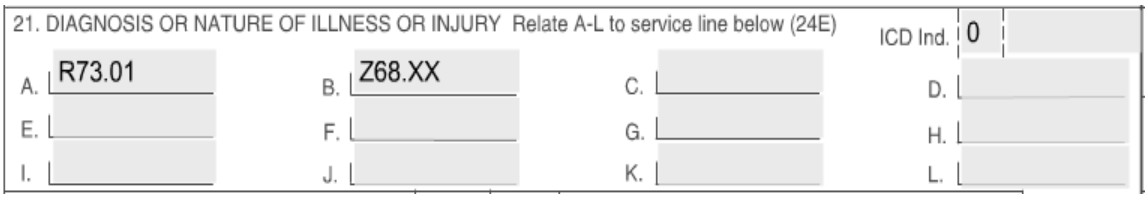


If a referral is made using R73.XX codes for impaired glucose/ prediabetes:

1. Use the medical provider assigned ICD-10 code (R73.XX)

[38] For claims auditing, use the History of Gestational Diabetes code (Z86.32) to indicate beneficiary is not currently pregnant, if referral includes 024.xx codes for gestational diabetes mellitus in pregnancy.

Figure 5.7. Sample for Completing CMS 1500 Claim Form for Initial Visit – Impaired Glucose/Prediabetes



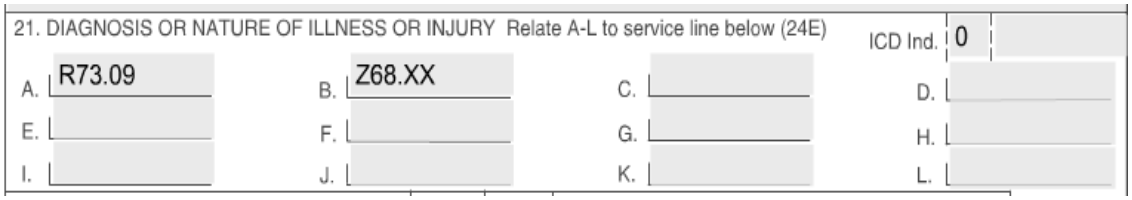
Scenario 2 – Referral Does NOT Include Medical Provider Assigned ICD-10 Codes:

If the referral does **not** include a medical provider assigned ICD-10 code, the DPP must attempt to contact the medical provider or MCO to obtain ICD-10 code.

If there is no ICD-10 code for elevated blood glucose or gestational diabetes:

2. The DPP must administer the CDC prediabetes screening test or the ADA type 2 diabetes risk test
3. Assess risk tests for qualifying scores, ≥ 9 for the CDC prediabetes screening test or ≥ 5 for the ADA type 2 diabetes risk test
4. DPP suppliers may use R73.09 for billing

Figure 5.8. Sample for Completing CMS 1500 Claim Form for Initial Visit – CDC Prediabetes Risk Test or ADA Type 2 Diabetes Risk Test



Question: We were wondering about Maryland's process for fraud review on claims? And will the claims from this demo project be a part of that process? Our compliance officer asked about this today. Working directly with Medicaid plans is new for Omada, so just want to be aware of process and plan.

Response: In Maryland, our Office of Inspector General (OIG) is charged with ensuring Program Integrity. For this demonstration, Maryland's process for fraud review on claims will be to follow established program integrity requirements for MCOs, any provisions present in sub-contracts, grant agreement requirements, and additional State oversight and monitoring, including the following:

1. Each MCO will employ its established program integrity requirements under its contract with the State in accordance with **42 CFR 438.608**.
2. MCOs will operate in accordance with Grant Agreement specifications, including: Section 7. Financial Records: The Grantee Organization agrees to maintain complete records of revenues and expenses for the project, together with appropriate supporting documentation. Upon request, the Grantee Organization will make these records available for inspection by the Department or its agents at reasonable times. The Department, at its expense, may audit or have audited the records of the Grantee Organization insofar as they relate to the disposition of the funds awarded by the Department, and the Grantee Organization shall provide all necessary assistance in connection therewith. Records must be kept for at least five years after completion of the grant. In addition to those records referred to above, records to be kept and maintained for this period include all invoices, bills of sale, receipts, payroll records, and employee time sheets.
3. MDH will review and monitor MCO quarterly invoices of Demonstration costs to make certain Grantee expenditures are within budget and categorically permissible.
4. MCOs will hold sub-contracted entities to the provisions agreed to in the sub-contract, including any DPP Provider-specific Additional Provisions.

Chapter 7 : Managing Changes in Medicaid, MCO and DPP Eligibility and Enrollment during the Medicaid National DPP Demonstration - FINAL 03.08.2017

Overview

During this demonstration,[3] participating Managed Care Organizations (MCOs) who are contracted with participating National Diabetes Prevention Program (DPP) suppliers to provide services to Medicaid beneficiaries will follow the Medicaid enrollment and eligibility procedures outlined in this document. Specifically, these procedures address changes in Medicaid eligibility and enrollment and continuation of DPP services, as well as the associated reimbursement methodology.

<table>
<tr><th>Scenario[39]</th><th>Can continue to DPP classes in Demonstration</th><th>Claims Process/DPP Reimbursement</th><th>Notification of Change in Medicaid Eligibility[40]</th></tr>
<tr><td>No Longer a Medicaid Beneficiary[41]</td><td>1. No, would no longer be in demonstration[42]
2. May continue with DPP if there is an alternate payment option available[43]</td><td>1. Claim denial and no payment
2. No longer a covered benefit</td><td rowspan="4">MCO to verify Medicaid eligibility with claim denial</td></tr>
<tr><td>Changes from HealthChoice (MCO) to Fee-for-Service (FFS)</td><td rowspan="2"></td><td rowspan="2">1. Claim denial and no payment
2. This may be outside the scope of the MCOs claim processing and reconciliation capabilities</td></tr>
<tr><td>Changes from Demonstration MCO to non-Demonstration MCO</td></tr>
<tr><td>Changes between MCOs in demonstration</td><td>Yes</td><td>Claim denial and notification from billing/claims department for alternate payment to DPP supplier from original MCO’s budget</td></tr>
</table>

[39] Any beneficiary enrolled in a DPP by MCO will count towards the MCO’s enrollment goal of 100, as long as the beneficiary has completed at least 1 class before the change in their enrollment and/or eligibility.

[40] Medicaid beneficiaries must renew their eligibility every 12 months, which ends on the last day of the 12th month. For example, if a beneficiary gains coverage on February 15th, 2016, their coverage would end on February 28th, 2017. For more information on Medicaid renewals please visit: https://mmcp.MDH.maryland.gov/Documents/HBX-Redet%20FAQs_FINAL_DISTRIBUTION_1.21.15.pdf.

[41] This refers to any beneficiary that may lose coverage due to changes in income eligibility or health insurance provider, such as commercial or Medicare.

[42] Please see Appendix E for disclosure and protocol for notification and distribution.

[43] Beneficiary data should be excluded from the evaluation data shared with RTI. DPP suppliers should follow CDC guidelines for reporting data to CDC.

Figure 7.1. Changes in Medicaid and MCO Eligibility and Enrollment

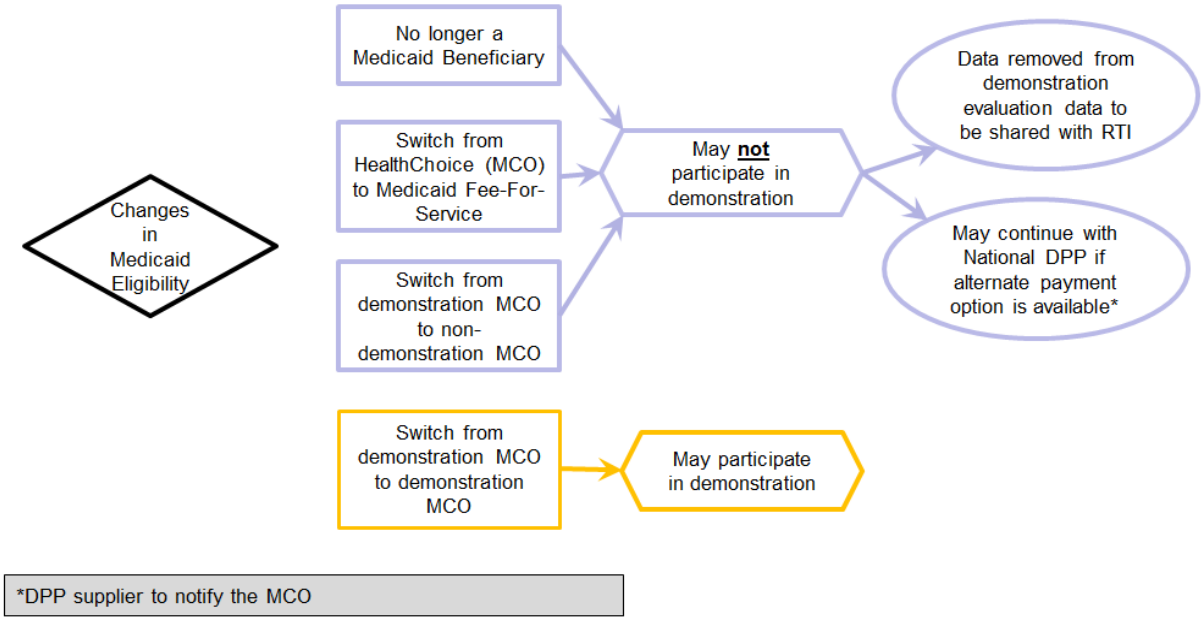
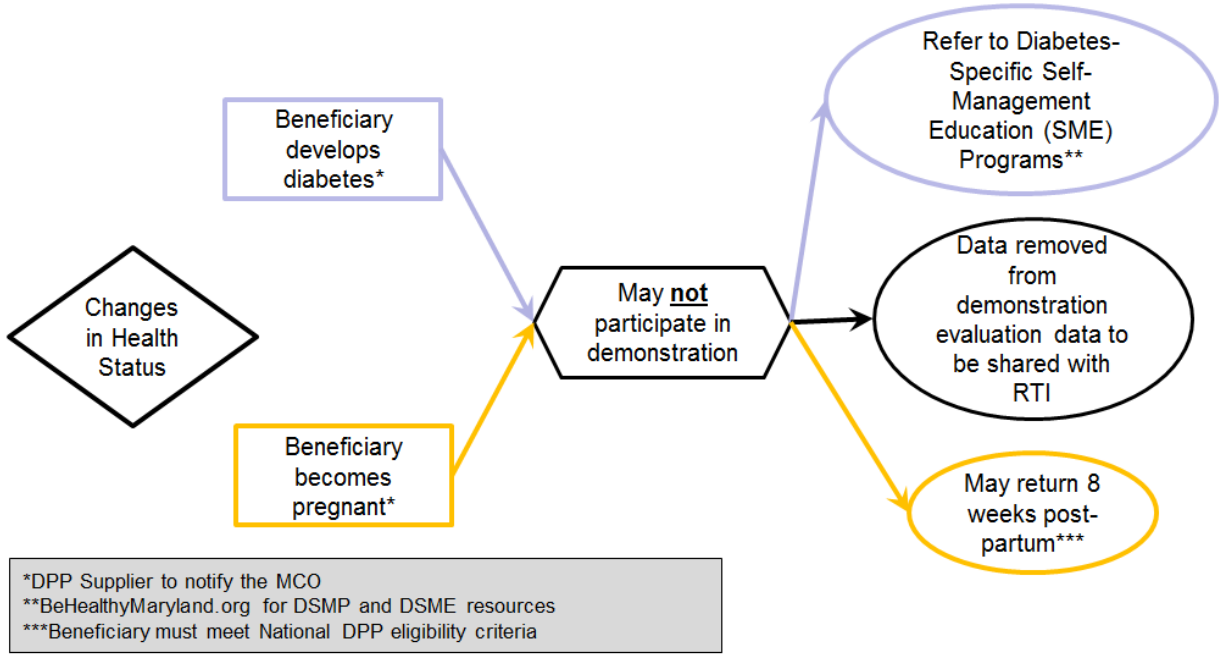


Figure 7.2. Changes in National DPP Eligibility - Health Status



Chapter 8 : MCO Claims Receipt Protocol – FINAL 03.02.2017

Overview

This document is a resource to guide Managed Care Organizations in the receipt of claims and determination of whether claims are acceptable as submitted by participating National Diabetes Prevention Program (DPP) suppliers for the Medicaid National Diabetes Prevention Program demonstration.

DPP suppliers will follow the eligibility, billing and coding procedures outlined in the companion document, "Eligibility, Billing, and Coding Procedures for Participating National Diabetes Prevention Program (DPP) Suppliers- 1.19.2017 (see Chapter 5)."

Requirements of an Acceptable Claim

All claims submitted to MCOs by participating DPP suppliers who provide services to Medicaid beneficiaries under this demonstration, and request reimbursement for services rendered must:

1. Meet usual billing requirements[44] for all providers under contract with the MCO;
2. Adhere to the required 0403T performance-based Coding and Billing Structure (see companion document[45]);
3. Have appropriate/correct ICD-10 diagnosis codes associated with the CPT code[46] in use for (see companion document[47]):
    a. Initial encounter claim (0403T; 0403T-TG)
        i. One elevated blood glucose level or history of gestational diabetes ICD-10 code (see Appendix A, Table A.2)
        ii. One BMI ICD-10 code (see Appendix A, Table A.3)
    b. Subsequent visit codes (0403T-TF; 0403T-TM)
        i. One elevated blood glucose level or history of gestational diabetes ICD-10 code (see Appendix A, Table A.2)
    c. Performance based codes (0403T-TS, TF; 0403T-TS, TM)
        i. One elevated blood glucose level or history of gestational diabetes ICD-10 code (see Appendix A, Table A.2)

Denial Process

MCOs should use the same process and procedures used with other providers to determine acceptability of a claim from participating DPP suppliers and communicate reason for denial and process for re-submission of claim as clearly as possible.

Changes in Medicaid Eligibility and Claims Processing

Due to changes in Medicaid eligibility and enrollment, MCOs should verify eligibility and enrollment when a claim is denied.

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[44] For the Maryland Medicaid CMS-1500 paper billing instructions, please visit: https://mmcp.MDH.maryland.gov/docs/MDH_cms_1500_billing_instructions_092315.pdf.

[45] "Maryland MCO National DPP Demonstration – Codes for DPP Services - 10/28/16"

[46] The ICD-10 diagnosis code indicates the reason the service (as indicated by the CPT code) was performed.

[47] "Eligibility, Billing, and Coding Procedures for Participating National Diabetes Prevention Program (DPP) Suppliers- 1.19.2017"

If a beneficiary loses Medicaid coverage:

They are no longer a Medicaid beneficiary and are not eligible for Medicaid services. As such, they would no longer be a part of the demonstration and claims may be denied. The beneficiary may continue with the DPP supplier, if the DPP supplier is able to provide an alternate payment option to the individual. In this case, the DPP supplier must ensure that data collected on these individuals are removed from the demonstration's evaluation data sets.

If a beneficiary changes from HealthChoice (MCOs) to Fee-for-Service (FFS) or if a beneficiary Changes from Demonstration MCO to non-Demonstration MCO:

This is outside the scope of the MCOs claim processing and reconciliation capabilities.

As such, the beneficiary would no longer be a part of the demonstration and claims may be denied. The beneficiary may continue with the DPP supplier, if the DPP supplier is able to provide an alternate payment option to the beneficiary. In this case, the DPP supplier must ensure that data collected on these individuals are removed from the demonstration's evaluation data sets.

If a beneficiary Changes between MCOs in demonstration:

They are still a Medicaid beneficiary and are eligible for Medicaid services. As such, they would remain in the demonstration. If the claims are denied, the MCO should receive notification from their billing or claims department for alternate payment and should provide the DPP supplier's payment from the original MCO's budget.

If a beneficiary is no longer eligible for DPP services in demonstration:

If a beneficiary becomes pregnant and/or develops type 2 diabetes, they are no longer eligible to receive DPP services through this demonstration. DPP suppliers should notify the MCOs of change in health status and program eligibility status. Additionally, DPP suppliers should refer the beneficiary to their MCOs and provide resources, if appropriate, for Diabetes Specific Self-Management Education programs. DPP suppliers may indicate to beneficiaries who become pregnant that they may resume DPP classes postpartum, if they have not developed diabetes.

As such, the beneficiary would no longer be a part of the demonstration and claims may be denied. The beneficiary may continue with the DPP supplier, if the DPP supplier is able to provide an alternate payment option to the beneficiary (See Also Appendix E).

EVALUATION

Chapter 9 : Evaluation Analysis using ICD-10 Codes - Protocol Proposed to the National Association of Chronic Disease Directors' (NACDD) Evaluator – FINAL 03.10.2017

Overview

The National Association of Chronic Disease Directors (NACDD) contracted with RTI International to evaluate the Medicaid and National Diabetes Prevention Program demonstration. As part of the evaluation, RTI wanted to request data to evaluate the ICD-10 codes used for this demonstration. RTI would review the percent of ICD-10 codes via the proportion of the demonstration population who are at risk for developing diabetes and participating in the Medicaid National Diabetes (DPP) Demonstration. RTI consulted with Maryland Medicaid to determine the specifications needed for this request. Below is the specifications recommended to RTI by Maryland Medicaid.

INCLUDE

1. have ever had a diagnosis code for elevated blood glucose level

OR

2. history of gestational diabetes

AND EITHER

3. who have ever had a diagnosis code for "overweight and obesity

OR

4. have a BMI of $\geq 25 kg/m^2$ ($\geq 23 kg/m^2$, if Asian)

NOT

5. Diagnosed with type 1 or type 2 diabetes (exclude anyone with any of the E10.x, E11.x, or E13.x ICD-10 diabetes codes);

NOR

6. Currently pregnant[48]

To account for the length of the demonstration, the data needs to include CY 2017, 2018 and 2019. The data should be restricted to the NPI numbers of the participating DPP suppliers. This data may be divided by categories such as DPP supplier and/ or managed care organization.

Sample Data Request

3. Participants with ICD-10 codes for **elevated glucose** and **BMI≥ 25kg/m^2 (≥ 23kg/m^2, if Asian)** for between CY17 to CY19 – **EXCLUDING** anyone with a code for "**ever diagnosed with diabetes**", with code for "**pregnant**" and **NPI numbers for non-participating DPP suppliers**, de-duplicated by Medicaid number, by: 1) Age group, 2) Race, 3) Sex , 6) By MCO, 7) By DPP supplier

[48] Participant should be at least eight weeks post-partum with post-partum blood work completed.

Table 9.1. *Sample Data Table for Medicaid National DPP Beneficiaries with an ICD-10 code for elevated blood glucose and BMI≥ 24kg/m2 (≥ 22kg/m2, if Asian),, excluding any participant with a diagnosis code "ever diagnosed with diabetes" and with a code for "pregnant" (CY17 - CY19)*

Categories	Number of participants	Percentage of Medicaid National DPP Beneficiaries
Age Group		
18-24		
25-40		
41-64		
Total		
Race		
Asian		
Black		
White		
Hispanic		
Other		
Total		
Sex		
Female		
Male		
Total		
By MCO		
MCO1		
MCO2		
MCO3		
MCO4		
Total		
By DPP Supplier		
DPP1		
DPP2		
DPP3		
DPP4		
DPP5		
DPP6		
DPP7		
DPP8		
Total		

COMMUNICATION PLAN

Chapter 10 : Maryland Medicaid National Diabetes Prevention Program Demonstration Communication Plan- FINAL 03.16.2017 [UPDATED 12.06.2018]

Purpose of Communication Plan

The overall objective of Maryland Medicaid's National Diabetes Prevention Program (DPP) Demonstration Communication Plan (CP) is to engage internal and external stakeholders, including partners, in supporting the achievement of successful outcomes of the Medicaid National DPP demonstration to demonstrate how state Medicaid agencies, in collaboration with state health departments, can implements a delivery model for the National DPP through Medicaid managed care. The Communication Plan (CP) defines the project's structure and methods of information collection, screening, formatting, and distribution and outline understanding among the project's core team and partners regarding the actions and processes necessary to facilitate the critical links among people, ideas, and information that are necessary for project success.

The intended audience of Maryland's Medicaid National DPP Demonstration CP is the project manager, project team, project sponsor and any senior leaders whose support is needed to carry out communication plans.

Stakeholder Identification and Analysis

The Medicaid National Diabetes Prevention Program (DPP) Demonstration has multiple internal and external stakeholders, who are directly and/or indirectly working on the demonstration. Additionally, there are stakeholders who are interested in the process and outcomes of the Medicaid National DPP Demonstration. To assist in understanding the type of stakeholders and their roles with the demonstration, we conducted a stakeholder analysis (See Appendix G). We assessed the interests, influence, needs, and expectations, and those stakeholders who were classified as high in all four categories were designated internal stakeholders. All other stakeholders were deemed to be external.

Figure 10.1. Medicaid National DPP Demonstration's Internal and External Stakeholders [Updated 09.14.2018]

Maryland Medicaid and National Diabetes Prevention Program (DPP) Demonstration Stakeholders

Internal Stakeholders

Maryland Department of Health
- Maryland Medicaid
  - Planning Administration
- Center for Chronic Disease Prevention and Control (CCDPC)

Health Choice Managed Care Organizations
- Amerigroup Community Care
- Jai Medical Systems
- MedStar Family Choice
- Priority Partners

Maryland DPP Suppliers
- Brancati Center for the Advancement of Community Care
  - Chase Brexton Health Systems
  - Baltimore Medical Systems at St. Agnes
  - Owensville Primary Care
  - John Hopkins Healthcare at Glen Burnie
  - Charm City Clinics
  - Knox Presbyterian
  - Zion Baptist
  - Memorial Baptist
- MedStar Good Samaritan/Union Memorial Hospitals
- MedStar Harbor Hospital
- Omada
- Retrofit
- Soul So Good/Collins Wellness Center
- Y of Central Maryland
- Y of Metropolitan Washington

National Association of Chronic Disease Directors (NACDD)

Research Triangle Institute (RTI) International

Leavitt Partners, LLC

Centers for Disease Control and Prevention (CDC)

External Stakeholders

Maryland Department of Health
- Maryland Medicaid
  - Office of Health Services (OHS)
  - Office of Systems, Operations and Pharmacy (OSOP)
  - Other Medicaid Offices and Administrations
- Public Health Administrations
  - Office of Population Health
  - Other Public Health Offices and Centers
- Leadership
- Key Advisory and Leadership Committees
- University of Maryland Baltimore County – The Hilltop Institute

Health Choice Managed Care Organizations
- Aetna Better Health
- Kaiser Permanente
- Maryland Physicians Care (MPC)
- University of Maryland Health Partners
- UnitedHealthcare

Medicaid Beneficiaries

Statewide Maryland DPP Suppliers

Local Health Departments

Centers for Medicare and Medicaid Services

Commercial Health Insurance Plans

Other State Medicaid Agencies

Other State Public Health Agencies

Chronic Disease Self-Management Programs

Health and Wellness Organizations
- The Center for Older Adult Wellness (COAW)

National Agencies and Organizations
- American Diabetes Association
- National Association of Medicaid Directors
- Centers for Health Care Strategies

Figure 10.2. Medicaid National DPP Demonstration Maryland Department of Health (MDH) Stakeholders

Maryland Medicaid and National DPP Demonstration

Directly Involved

Medicaid
(Health Care Financing)
- Office of Planning

Public Health Services
- Office of Health Promotion and Prevention
  - Center for Chronic Disease Control and Prevention

Indirectly Involved

Leadership
- Secretary of Health
- Deputy Secretary of Health Care Financing
- Medicaid Director
- Chief Operating Officer
- Deputy Secretary of Public Health Services
- Chief Medical Officer for Health Care Financing

Key Advisory and Leadership Committees
- Maryland Medicaid Advisory Committee (MMAC)
- Managed Care Organization Liaison Committee
- Managed Care Organizations Medical Directors
- Quality Assurance Liaison Committee

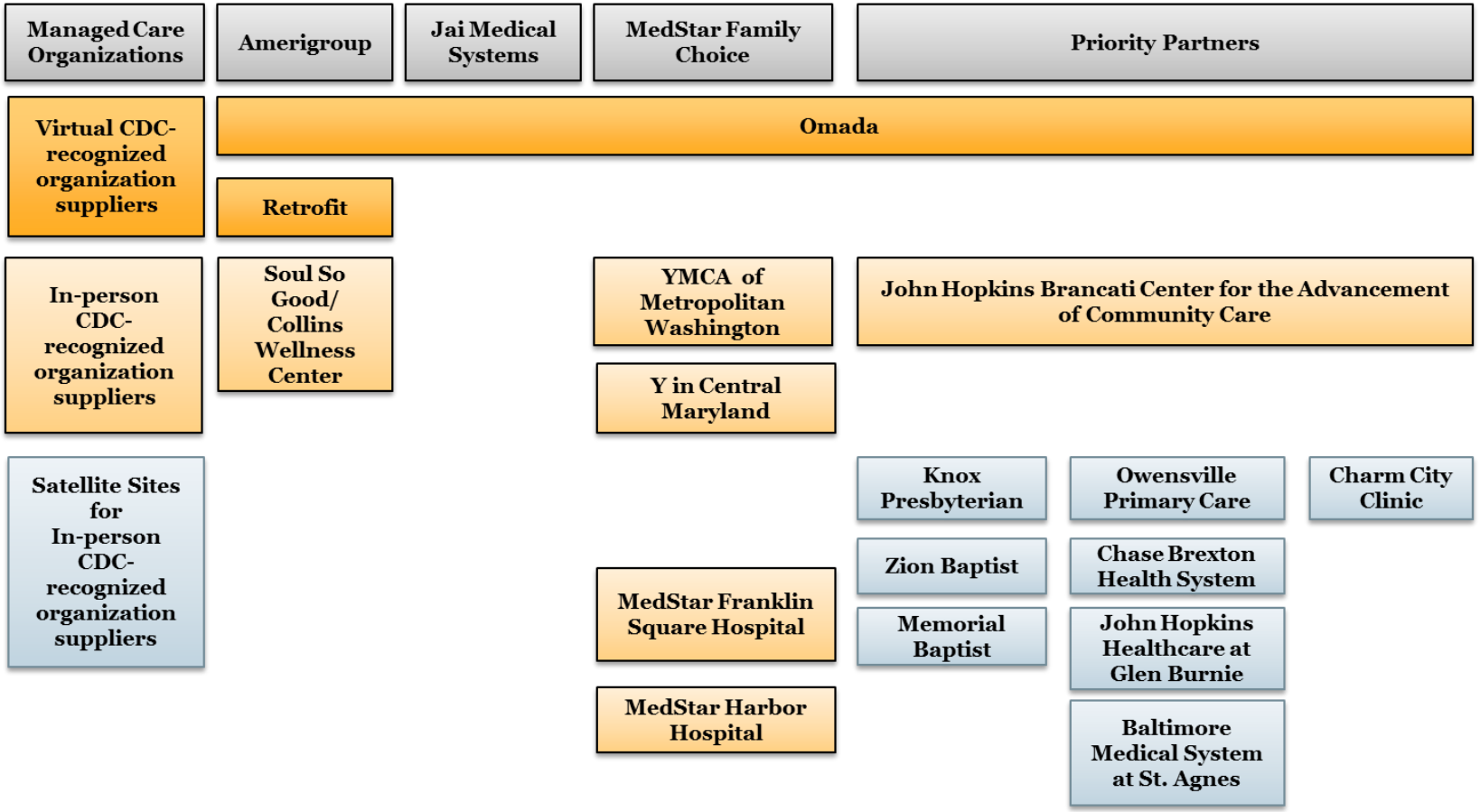
Medicaid
(Health Care Financing)
- Office of Finance
- Office of Health Services (OHS)
- Office of Systems, Operations and Pharmacy (OSOP)
- University of Maryland Baltimore County (UMBC) – The Hilltop Institute

Enterprise Shared Services
- Office of Policy, Regulation, and Communications
- Office of Procurement and Support Services
- Office of Finance

Public Health Services
- Office of Population Health Improvement
- Office for Maryland Primary Care Program

Office of Minority Health and Health Disparities (MHHD)

Figure 10.3. Medicaid National DPP Demonstration's Partners



Communication Vehicles

Communication Matrix:

Vehicle	Target	Description Purpose	Frequency	Owner	Distribution Vehicle	Internal/ External	Comments
Project Meetings	Partners	To provide an opportunity for NACDD and MDH, as well as MCOs and DPP Suppliers, to discuss work plan deliverables, status of implementation, challenges and successes	Annually Quarterly Monthly Weekly As Needed	Medicaid CCDPC NACDD RTI	In Person Webinars Conference Calls	Internal	Please see Section 10.1
Project Reporting	Partners	To provide MCOs and MDH an opportunity to update NACDD on their progress in relation to the work plan	Quarterly	Medicaid CCDPC NACDD MCOs	Email	Internal	Please see Section 10.2
Project Payment Schedule	Partners	To submit invoice to MDH or NACDD for payment of grant funds	Quarterly	Medicaid CCDPC NACDD MCOs	Email	Internal	Please see Section 10.3

Section 10.1 Project Meetings:

Meeting	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Participants
MCO Meetings and Calls	To provide an opportunity for MCOs and MDH to discuss work plan deliverables, status of implementation, challenges and successes	Monthly	Medicaid	Internal	Schedule: Please see Tables 10.2 and 10.4 Participants: Medicaid CCDPC MCOs NACDD Leavitt Partners RTI May include observers, such as CDC
Demonstration DPP Meetings[49]	To provide an opportunity for DPPs and MDH to discuss work plan deliverables, status of implementation, challenges and successes	Monthly	CCDPC	Internal	Schedule: Please see Tables 10.3 and 10.4 Participants: Medicaid CCDPC DPPs
MDH Core	To provide an opportunity for	Weekly/Biweekly	CCDPC	Internal	Participants:

[49] In year two (2) of the demonstration, the MCO and DPP monthly meetings were combined, and the Core team meeting were changed to biweekly.

Meeting	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Participants
Team Meetings[49]	Medicaid and CCDPC to discuss work plan deliverables, challenges and successes, model implementation and/or changes				Sian Goldson, Sandy Kick, Kristi Pier, Sue Vaeth
Evaluation Meetings	To assist MCOs and DPP suppliers with implementing the evaluation protocol as well as discuss progress, challenges, and adjustments.	Quarterly As needed	RTI NACDD	Internal	Schedule: Please see Table 10.5 Participants: Medicaid CCDPC MCOs DPPs NACDD CDC Leavitt Partners RTI May include observers, such as CMS
NACDD Meetings	To provide an opportunity for Medicaid, CCDPC, MCOs and DPPS to discuss work plan deliverables, challenges and successes, model implementation and/or changes	Annually As Needed	NACDD	Internal	Schedule: Please see Table 10.6 Participants: Medicaid CCDPC MCOs DPPs NACDD CDC Leavitt Partners
NACDD Calls	To provide an opportunity for Medicaid and CCDPC to discuss work plan deliverables, challenges and successes, model implementation and/or changes	Monthly	NACDD	Internal External	Schedule: Please see Tables 10.7 and 10.8 Participants: Medicaid CCDPC NACDD CDC Oregon (monthly)

Table 10.1. *Monthly MCO Webinar/Calls with MDH* [50]

Date and Time	Place
09.29.2016, 1:00 – 2:00 pm	MDH, Room 418 and call in
10.27.2016, 1:00 – 2:00 pm	MDH, Room 418 and call in
11.17.2016, 1:00 – 2:00 pm	MDH, Room 418 and call in
12.22.2016, 1:00 – 2:00 pm	MDH, Room 418 and call in
01.26.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
02.23.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
03.16.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
04.20.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
05.18.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
06.15.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
07.20.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
08.17.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
09.21.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
11.16.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
12.21.2017, 1:00 – 2:00 pm	MDH, Room 418 and call in
01.18.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
02.15.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in

Table 10.2. *Monthly Demonstration DPP Meetings with MDH* [50]

Date and Time	Place
11.09.2016, 2:00 - 3:00 pm	MDH Room 418 and call in
12.14.2016, 2:00 - 3:00 pm	MDH, Room 200 and call in
01.10.2017, 8:30 am - 1:00 pm	MDH, Room L1
02.08.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
03.08.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
04.12.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
05.10.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
06.14.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
07.12.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
11.08.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
12.13.2017, 2:00 - 3:00 pm	MDH, Room 200 and call in
01.10.2018, 2:00 - 3:00 pm	MDH, Room 200 and call in
02.14.2018, 2:00 - 3:00 pm	MDH, Room 200 and call in

Table 10.3. *Monthly MCO-DPP Webinar/Calls with MDH* [50]

Date and Time	Place
03.15.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
04.19.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
05.17.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
06.21.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
07.19.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
08.16.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
09.20.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
10.18.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
12.20.2018, 1:00 – 2:00 pm	MDH, Room 418 and call in
01.17.2019, 1:00 – 2:00 pm	MDH, Room 418 and call in

[50] After February 2018, MCO and DPP monthly meetings were combined. For more information see Table 10.4.

Table 10.4. *Joint MCO-DPP In- Person Meetings*

Meeting	Date and Time	Place
Enrollment, Recruitment and Retention Strategies	10.11.2017, 8:30 am – 12:00pm	MDH, L3 and call in
Maryland Medicaid National DPP Demonstration Partner Debrief	11.15.2018, 9:00 am – 12:00pm	Hotel Indigo, Baltimore MD

Table 10.5. *Evaluation Meetings with NACDD, RTI and Leavitt Partners*

Meeting	Date and Time	Place
Evaluation Planning Visit	09 .08.2016, 9:00 am – 4:00 pm	DOT in Hanover, MD
	09.09.2016, 9:00 am – 4:00 pm	MDH, L3
Participant Pre-program Survey Feedback Call	10.14.2016, 1:00 - 2:30 pm	Call in Meeting
Cost Survey Demonstration	12.13.2016, 2:00 - 3:00 pm	Call in Webinar
Program Survey Demonstration	10.17.2017, 2:00 - 3:00 pm	Call in Webinar
Evaluation Phone Interviews	03.06.2017, 60-90 minutes per person	Call in Meetings
	03.07.2017, 60-90 minutes per person	
	03.08.2017, 60-90 minutes per person	

Table 10.6. *NACDD Annual Meetings and State/Site Visits*

Meeting	Date and Time	Place
NACDD National DPP Demonstration Kick-off Meeting	06.28.2016, 9:00 am – 4:00 pm	Atlanta, GA
	06.29.2016, 8:30 am – 12:00 pm	
State Visit with NACDD, CDC, Leavitt Partners	01.10.2017, 8:00 am – 4:00 pm	MDH, L1
NACDD Annual Meeting	06.28.2017, 9:00 am 4:00 pm	Atlanta, GA
	06.29.2017, 9:00 am – 3:30 pm	
State Visit with NACDD, CDC, Leavitt Partners	12.13.2017, 9:00 am – 4:30 pm	Baltimore, MD
NACDD Capstone Meeting	01.10.2019, 9:00 am – 4:00pm	Atlanta, GA

Table 10.7. *Monthly Cross State Meeting with NACDD, Maryland, & Oregon*

Date and Time	Place
10.21.2016, 2:00 - 3:00 pm	Conference Call
11.18.2016, 2:00 - 3:00 pm	Conference Call
12.16.2016, 2:00 - 3:00 pm	Conference Call
01.20.2017, 2:00 - 3:00 pm	Conference Call
02.17.2017, 2:00 - 3:00 pm	Conference Call
03.17.2017, 2:00 - 3:00 pm	Conference Call
04.21.2017, 2:00 - 3:00 pm	Conference Call
05.19.2017, 2:00 - 3:00 pm	Conference Call
06.16.2017, 2:00 - 3:00 pm	Conference Call
10.20.2017, 2:00 - 3:00 pm	Conference Call
12.15.2017, 2:00 - 3:00 pm	Conference Call
01.19.2018, 2:00 - 3:00 pm	Conference Call
02.16.2018, 2:00 - 3:00 pm	Conference Call
03.16.2018, 2:00 - 3:00 pm	Conference Call
04.20.2018, 2:00 - 3:00 pm	Conference Call
05.18.2018, 2:00 - 3:00 pm	Conference Call
06.15.2018, 2:00 - 3:00 pm	Conference Call

Date and Time	Place
09.17.2018, 3:00 – 4:00 pm	Conference Call
12.14.2018, 2:00 – 3:00 pm	Conference Call

Table 10.8. *Monthly Check-Ins with NACDD & Maryland*

Date and Time	Place
08.05.2016, 9:00- 10:00 am	Conference Call
09.02.2016, 9:00- 10:00 am	Conference Call
10.07.2016, 9:00- 10:00 am	Conference Call
11.04.2016, 9:00- 10:00 am	Conference Call
12.02.2016, 9:00- 10:00 am	Conference Call
01.06.2017, 9:00- 10:00 am	Conference Call
02.03.2017, 9:00- 10:00 am	Conference Call
03.03.2017, 9:00- 10:00 am	Conference Call
04.07.2017, 9:00- 10:00 am	Conference Call
05.05.2017, 9:00- 10:00 am	Conference Call
06.02.2017, 9:00- 10:30 am	Conference Call
07.07.2017, 9:00- 10:30 am	Conference Call
08.04.2017, 9:00- 10:30 am	Conference Call
09.01.2017, 9:00- 10:30 am	Conference Call
10.16.2017, 10:30 – 11:30 am	Conference Call
11.03.2017, 9:00- 10:30 am	Conference Call
12.01.2017, 9:00- 10:30 am	Conference Call
01.05.2018, 9:00- 10:30 am	Conference Call
02.02.2018, 9:00- 10:30 am	Conference Call
03.02.2018, 9:00- 10:30 am	Conference Call
04.06.2018, 9:00- 10:30 am	Conference Call
05.04.2018, 9:00- 10:30 am	Conference Call
06.01.2018, 9:00- 10:30 am	Conference Call
07.01.2018, 9:00- 10:30 am	Conference Call
08.03.2018, 9:00- 10:30 am	Conference Call
09.07.2018, 9:00- 10:30 am	Conference Call
10.05.2018, 9:00- 10:30 am	Conference Call
11.02.2018, 9:00- 10:30 am	Conference Call
12.07.2018, 9:00- 10:30 am	Conference Call
01.04.2019, 9:00- 10:30 am	Conference Call

Section 10.2 Project Reporting:

Meeting	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
MCO Reports	To provide MCOs an opportunity to update MDH on their progress in relation to the work plan	Quarterly	MCOs	Internal	Schedule: Please see Table 10.10 Participants: Medicaid CCDPC NACDD MCOs
MDH Reports	To provide MDH an opportunity to update the NACDD on their progress in relation to	Quarterly	Medicaid	Internal	Schedule: Please see Table

Meeting	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
	the work plan				10.10 Participants: NACDD CDC Medicaid

Table 10.9. *Quarterly Reporting Schedule for MCOs and MDH*

Billing/Reporting Period	Latest Date to Submit Quarterly Report to MDH	Date Received from MCO	Latest Date to Submit Quarterly Report to NACDD	Date Submitted
07.01.2016 - 09.30.2016	09.30.2016	09.30.2016	10.31.2016	09.30.2016
10.01.2016 - 12.31.2016	12.31.2016	12.30.2016	01.30.2017	01.06.2017
01.01.2017 – 03.30.2017	04.30.2017	04.05.2017	04.30.2017	04.07.2017
04.01.2017 – 06.30.2017	06.15.2017	06.15.2017	07.31.2017	06.26.2017
07.01.2017 - 09.30.2017	10.06.2017	10.06.2017	10.31.2017	10.13.2017
10.01.2017 - 12.31.2017	12.31.2017	01.31.2018	01.31.2018	01.31.2018
01.01.2018 – 03.30.2018	04.30.2018	04.20.2018	04.30.2018	04.27.2018
04.01.2018 – 06.30.2018	06.30.2018	07.31.2018	07.31.2018	07.24.2018
07.01.2018 – 09.30.2018	09.30.2018	N/A	10.31.2018	10.31.2018
10.01.2018 - 01.31.2019	01.31.2018	N/A	02.28.2019	

Section 10.3 Project Payment Schedule:

Meeting	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
MDH Billing & Payment	To submit invoice to NACDD for payment of grant funds.	Quarterly	Medicaid	Internal	Schedule: Please see Table 10.11 Participants: NACDD CDC Medicaid
MCO Billing & Payment	To submit invoice to Medicaid for payment of grant funds.	Quarterly	MCOs	Internal	Schedule: Please see Table 10.12 Participants: Medicaid MCOs

Table 10.10. *Payment Schedule for MDH*

Billing/Reporting Period	Latest Date to Submit Invoice to NACDD	Amount	Date Submitted	Date Paid
07.01.2016 - 09.30.2016	10.30.2016	$346,258.54	09.14.2016	10.27.2016
10.01.2016 - 12.31.2016	01.31.2017	$187,500.00	01.03.2017	02.13.2017
01.01.2017 – 03.30.2017	04.30.2017	$187,500.36	04.07.2017	05.25.2017
04.01.2017 – 06.30.2017	07.30.2017	$28, 741.10	07.05.2017	07.25.2017

Billing/Reporting Period	Latest Date to Submit Invoice to NACDD	Amount	Date Submitted	Date Paid
07.01.2017 - 09.30.2017	10.30.2017	$150,000.00	10.31.2017	11.28.2017
10.01.2017 - 12.31.2017	01.31.2018	$150,000.00	01.31.2018	03.30.2018
01.01.2018 – 03.30.2018	04.30.2018	$150,000.00	04.30.2018	06.11.2018
04.01.2018 – 06.30.2018	07.31.2018	$75,000.00	07.24.2018	08.24.2018
07.01.2018 - 09.30.2018	10.30.2018	$37,000.00	10.03.2018	11.07.2018
10.01.2018 - 01.31.2019	02.28.2019	$37,000.00	TBD	TBD

Table 10.11. *Payment Schedule for MCOs*

Billing/Reporting Period	Latest Date to Submit Invoice to MDH	Amount	Date Submitted	Date Paid
07.01.2016 - 09.30.2016	10.30.2016	$346,258.54	09.01.2016	10.12.2016
10.01.2016 - 12.31.2016	01.31.2017	$158,758.52	12.07.2016	12.23.2016
01.01.2017 – 03.30.2017	04.30.2017	$158,758.52	04.05.2017	05.16.2017
04.01.2017 – 06.30.2017	07.30.2017	N/A	N/A	N/A
07.01.2017 - 09.30.2017	08.04.2017	$125,000.00	08.04.2017	09.05.2017
10.01.2017 - 12.31.2017	10.01.2017	$125,000.00	10.06.2017	11.07.2017
01.01.2018 – 03.30.2018	01.31.2018	$125,000.00	01.31.2018	03.08.2018
04.01.2018 – 06.30.2018	04.30.2018	$125,000.00	04.20.2018	05.09.2018
07.01.2018 – 01.31.2019	07.12.2018	$36,122.56	07.12.2018	TBD
11.16.2018 – 01.31.2019	12.10.2018	$80,518.12	12.21.2018	TBD

Technical Assistance Communication Vehicles:

Meeting	Vehicle	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
Learning Collaborative	Webinars Conference Calls	To provide MCOs, DPP suppliers and MDH an opportunity to learn from other models and research related to the National DPP, such as reimbursement, incentives, outcomes, etc.,	Quarterly As needed	NACDD	Internal	Schedule: Please see Table 10.13 Participants: Medicaid CCDPC MCOs DPPs Leavitt Partners NACDD
Technical Assistance	Webinars Conference Calls	To provide MCOs, DPP suppliers and MDH an opportunity to learn from other models and research to facilitate the implementation of the National DPP demonstration	Quarterly As needed	Medicaid CCDPC NACDD	Internal	Schedule: Please see Table 10.14 Participants: Medicaid CCDPC MCOs DPPs Leavitt Partners NACDD
DPP	Webinars	To provide DPP suppliers	Weekly	CCDPC		Schedule:

Meeting	Vehicle	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
Trainings	Conference Calls	and MDH an opportunity to learn from other models and research to facilitate the implementation of the National DPP demonstration	Quarterly As Needed			Please see Table 10.15 Participants: Medicaid CCDPC DPPs
6|18 Technical Assistance	Webinars Conferences Calls	To provide 6|18 grantees, state Medicaid and Public agencies, an opportunity to learn from other models and research to facilitate sustained coverage of the National DPP		NACDD Leavitt Partners CHCS		Schedule: Please see Table 10.16

Table 10.12. *Virtual Learning Collaborative (VLC)*

Meeting	Date and Time	Place
September Virtual Learning Collaborative	09.22.2016, 3:00 - 4:00 pm	Call in Webinar
December Virtual Learning Collaborative	12.08.2016, 12:30 - 2:30 pm	Call in Webinar
March Virtual Learning Collaborative	03.23.2017, 12:30 - 2:30 pm	Call in Webinar
May Virtual Learning Collaborative	05.25.2017, 12:30 - 2:30 pm	Call in Webinar
July Virtual Learning Collaborative	07.27.2017, 12:30 – 2:30 pm	Call in Webinar
October Virtual Learning Collaborative	10.26.2017, 12:30 – 2:30 pm	Call in Webinar
January Virtual Learning Collaborative	01.25.2018, 12:30 - 2:30 pm	Call in Webinar
April Virtual Learning Collaborative	04.26.2018, 12:30 – 2:30 pm	Call in Webinar

Table 10.13. *Technical Assistance*

Meeting	Date and Time	Place
Technical Assistance - Incentives talk with RTI	10.06.2016, 2016, 12:00 - 1:00 pm	Call in Meeting
Technical Assistance - DPRP Call	10.19.2016, 11:00 am - 12:00 pm	Call in Webinar

Table 10.14. *DPP Training Schedule*

Meeting	Date and Time	Place
Prevent T2 Curriculum	02.14.2017,12:00 - 1:30 pm	Call in Meeting
Workshop Wizard Tutorials	02.09.2017,11:00 am - 12:00 pm	Call in Webinar
	02.17.2017,11:00 am - 12:00 pm	
	02.23.2017, 11:00 am - 12:00 pm	
Healthcare Referral Webinar Series	02.22.2017, 1:00 pm - 2:30 pm	Call in Webinar
	03.29.2017, 1:00 pm - 2:30 pm	
	04.26.2017, 1:00 pm - 2:30 pm	
Diabetes Training and Technical Assistance Center (DTTAC) Webinars	03.28.2017, 12:00 pm - 1:30 pm	Call in Webinar
	04.25.2017,12:00 pm - 1:30 pm	
Diabetes Prevention Program Lifestyle Coach Training	09.06.2017	
	09.07.2017	

Table 10.15. *6|18 Technical Assistance*

Meeting	Date and Time	Place
6|18 Initiative Kick-Off Meeting	06.19.2017, 8:00 am – 4:30 pm	Atlanta, Georgia
	06.20.2017, 8:00 am – 4:30 pm	
6|18 Core Team Meeting	07.24.2017, 3:00 – 4:00 pm	MDH
	08.04.2017, 1:00 – 2:30 pm	
	08.10.2017, 1:00 – 2:00 pm	
	08.21.2017, 11:00 – 11:30 am	
	08.24.2017, 11:00 am – 12:00 pm	
	08.31.2017, 4:00 - 4:30 pm	
	09.29.2017, 2:00 – 3:00 pm	
	10.31.2017, 1:30 – 2:30 pm	
6|18 Diabetes Prevention TA Monthly Call	08.08.2017, 1:00 – 2:00 pm	Conference Call
	09.01.2017, 10:00 – 10:30 am	
	10.16.2017, 11:30 am – 12:00 pm	
	11.03.2017, 10:00 – 10:30 am	
	12.01.2017, 10:00 – 10:30 am	
	01.05.2018, 10:00 – 10:30 am	
	02.02.2018, 10:00 – 10:30 am	
	03.02.2018, 10:00 – 10:30 am	
	040.6.2018, 10:00 – 10:30 am	
	05.04.2018, 10:00 – 10:30 am	
	06.01.2018, 10:00 – 10:30 am	
6|18 DPP and Provider Engagement Prioritization TA	08.24.2017, 12:30 – 1:30 pm	Conference Call
6|18 Webinar Series	09.13.2017, 3:00- 4:00 pm	
	10.17.2017, 12:00 -1:00 pm	
	11.21.2017, 12:00 -1:00 pm	
	11.28.2017, 12:00 -1:00 pm	
	12.19.2017, 12:00 -1:00 pm	
	01.16.2018, 12:00 -1:00 pm	
	02.20.2018, 12:00 -1:00 pm	
	03.20.2018, 12:00 -1:00 pm	
6|18 Monthly Office Hours TA	09.14.2017, 2:00 – 3:00 pm	Conference Call
	10.12.2017, 2:00 - 3:00 pm	
	11.09.2017, 2:00 – 3:00 pm	
	12.14.2017, 2:00 – 3:00 pm	
	01.11.2018, 2:00 – 3:00 pm	
	02.08.2018, 2:00 – 3:00 pm	
	03.08.2018, 2:00 – 3:00 pm	
	04.12.2018, 2:00 – 3:00 pm	
	05.10.2018, 2:00 – 3:00 pm	
	06.14.2018, 2:00 – 3:00 pm	
Advancing Medicaid and Public Health Implementation of CDC's 6|18 Initiative	10.09.2018, 11:30 am - 4:00pm	Atlanta, GA
	10.10.2018, 8:00 am – 1:00 pm	

Other Communication Vehicles:

Vehicle	Description Purpose	Frequency	Owner	Internal/ External	Comments/ Distribution List
MDH Website	To provide public facing information on demonstration	Update as needed for the duration of the demonstration	Medicaid CCDPC	External	Potential Audience: Statewide DPP Suppliers
MDH Social Media channels/ Press Releases	To support MCO efforts, and assist with outreach and awareness building	TBD	MDH - Office of Communications Medicaid	External	Potential Audience: Statewide DPP Suppliers
Success Stories	To provide information on the accomplishments of the demonstration	TBD	Medicaid CCDPC NACDD Leavitt RTI	External	Potential Audience: Statewide DPP Suppliers Other State Medicaid Programs Other
Journal Articles	To provide information on the planning, implementation and evaluation of the demonstration	TBD	Medicaid CCDPC NACDD Leavitt RTI	External	Potential Audience: Statewide DPP Suppliers
Presentations	To provide high level information on the demonstration	Updated as meetings are scheduled	Medicaid CCDPC NACDD Leavitt	External	Schedule: Please see Tables 10.17 and 10.18 Potential Audience: National Conferences MDH Leadership MDH - Key Advisor or Operational Leadership Committees

Table 10.16. *Other Communications with External Stakeholders*

Meeting	Date and Time	Format
Maryland Medicaid Advisory Council (MMAC) Meeting	February 27, 2017 1:00 pm – 3:00 pm	Presentation
American Health Insurance Plans (AHIP)	March 22, 2017 8:30 am – 1:30 pm	Panel Discussion
National Academy for State Health Policy (NASHP)	October 25, 2017	Abstract Roundtable/Panel Discussion
American Public Health Association (APHA)	November 2017	Abstract [Not accepted]

Table 10.17. *Communication with Stakeholders on Sustainability and Provider Engagement*

Meeting	Date and Time	Format
Statewide Diabetes Prevention Program Networking Meeting	September 19, 2017 8:30 am – 4:00 pm	Presentation
Maryland Medicaid Managed Care Organization (MCO) Liaison Meeting	November 2, 2017	Presentation
Maryland Hospital Association	November 7, 2017	Presentation/Discussion
Chesapeake Regional Information System for our Patients (CRISP)	November 14, 2017	Presentation/Discussion
Maryland Medicaid Quality Assurance Liaison Committee (QALC) Meeting	December 5, 2017	Presentation
Centers for Medicare and Medicaid Services (CMS) Quality Conference	February 13, 2018	Presentation/Discussion
Maryland Medicaid Advisory Council (MMAC) Meeting	February 26, 2018	Presentation/ Discussion
Diabetes Prevention State Engagement Meeting- A Collective Impact Approach (Tennessee)	March 21, 2018	Presentation/Discussion
Academy Health Open Mic	March 15, 2018	Presentation/Discussion
6|18 Webinar: Learnings from the National DPP Medicaid Demonstration Project	May 1, 2018	Presentation/Discussion
Kentucky State Engagement Meeting	May 14, 2018	Presentation/Discussion
§1115 Waiver Post Award Forum & Waiver Amendment Public Hearing	May 24, 2018	Presentation/Discussion
§1115 HealthChoice Waiver Amendment Public Hearing	June 6, 2018	Presentation/Discussion

SUSTAINABILITY

Chapter 11 : Demonstration Reimbursement Model Compared to the Medicare DPP Expanded Model Reimbursement – FINAL 11.26.2018

Overview

While examining sustainability, Maryland Medicaid conducted a comparison of the DPP demonstration reimbursement model and the Centers for Medicare and Medicaid Services' (CMS) reimbursement model. This analysis was to assist in identifying areas for improvement and develop recommendations for a sustainable reimbursement model for Medicaid.

Core Session Reimbursement

Tables 11.1 and 11.2 outline the differences in reimbursement for core session attendance. These comparisons do not include pay-for-performance (P4P). P4P will be discussed in a later section of this chapter.

Table 11.1. *Medicare's Reimbursement Model versus Maryland National DPP Model for Core Sessions' Initial Visit*

INITIAL VISIT						
PAYER	**MEDICARE[51]**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9873 - 1st core session attended	$25	0403T[52]	$90	0403T	$200
Modifier	None		None		TG- Complex/high tech level of care =enrollment in virtual program	
Limits	Once per beneficiary's lifetime		Can be used 1 time in 365 days and **not** be used if 0403T-TG has been used		Can be used 1 time in 365 days and **not** be used if 0403T (no modifier) has been used	

[51] This payment structure is for In-person DPP suppliers. They do not cover virtual DPP suppliers.

[52] Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day.

Table 11.2. *Medicare's Reimbursement Model versus Maryland National DPP Model for Core Sessions' Attendance*

SUBSEQUENT VISITS						
PAYER	**MEDICARE**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9874 - 4 total core sessions attended	$50	0403T	$5 per class	N/A	
	G9875 - 9 total core sessions attended	$90				
	G9891[53] - MDPP session reported as a line-item on a claim for a payable MDPP services	$0				
Modifier	None		TF - Intermediate level of care			
Limits	Once per beneficiary's lifetime		Can be used up to 15 times and 1 time per week			

Post- Core Session Reimbursement

Table 11.3 outlines the differences in reimbursement for post-core session attendance. This comparison does not include pay-for-performance (P4P). P4P will be discussed in a later section of this chapter.

Table 11.3. *Medicare's Reimbursement Model versus Maryland National DPP Model for Post-Core Sessions' Attendance*

PAYER	**MEDICARE**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9875- 2 core maintenance sessions attended in months 7-9 (weight- loss goal not achieved or maintained)	$15	0403T	$6 per class	N/A	
	G9876 - 2 core maintenance sessions attended in months 10-12 (weight loss goal not achieved or maintained)	$15				
	G9891[5353] - MDPP session reported as a line-item on a claim for a payable MDPP services	$0				
Modifier	None		TM - Individualized education program			
Limits	Once per beneficiary's lifetime		• can be used 6 times • Billing cannot start until Start date + 16 weeks			

[53] MDPP session reported as a line-item on a claim for a payable MDPP services HCPCS G-code for a session furnished by the billing supplier that counts toward achievement of the attendance performance goal for the payable MDPP services HCPCS G-code. This CPT code is used to track attendance.

Pay-for-Performance (P4P) Reimbursement

Tables 11.4 through 11.6 describe CMS' pay-for-performance reimbursement, as well as the demonstration's model.

Table 11.4 shows the reimbursement for weight loss; while Tables 11.5 and 11.6 shows Medicare's weight loss and attendance reimbursement for core and post-core sessions. CMS will pay for 2 years of DPP; however, continued enrollment in Year 2 is dependent on the maintenance of a 5% weight loss. Table 11.6 shows CMS' reimbursement for Year 2.

Table 11.4. *Medicare's Reimbursement Model versus Maryland National DPP Model for Pay-for-Performance for Weight Loss*

WEIGHT LOSS						
PAYER	**MEDICARE**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9880 - 5 percent weight loss from baseline achieved	$160	0403T	$9 per unit	0403T	$9 per unit
	G9881 - 9 percent weight loss from baseline achieved	$25				
Modifier	None		TS - Follow-up service TF – Intermediate level of care (core) TM – Individualized education program (post-core)		TS, - Follow-up service GT – via interactive audio and video communications system	
Limits	Once per beneficiary's lifetime		Can only be used once per month TS used with TF to indicate core class and has an annual max of $250 TS used with TM to indicate post-core class and has an annual max of $350 1 unit – 1% of weight loss		Can only be used once per month TS must be used with GT 1 unit = 1% of weight loss Annual Max of $550	

Table 11.5. *Medicare's Reimbursement Model versus Maryland National DPP Model for Pay-for-Performance for Weight Loss and Core Session Attendance*

ATTENDANCE WITH WEIGHT LOSS						
PAYER	**MEDICARE**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9878 - 2 core maintenance sessions attended in months 7-9 and weight loss goal achieved or maintained	$60	N/A		N/A	
	G9879 - 2 core maintenance sessions attended in months 10-12 and weight loss goal achieved or maintained	$60				
	G9891[53] - MDPP session reported as a line-item on a claim for a payable MDPP services	$0				
Modifier	None					
Limits	Once per beneficiary's lifetime					

Table 11.6. *Medicare's Reimbursement Model versus Maryland National DPP Model for Pay-for-Performance for Weight Loss and Year 2 Attendance*

YEAR 2 - ATTENDANCE WITH WEIGHT LOSS						
PAYER	**MEDICARE**		**DPP DEMO**			
	IN PERSON DPP		**IN PERSON DPP**		**VIRTUAL DPP**	
	CPT CODE & DESCRIPTION	**PAYMENT**	**CPT CODE**	**PAYMENT**	**CPT CODE**	**PAYMENT**
	G9882 - 3 ongoing maintenance sessions attended in months 13-15 and weight loss goal maintained	$50	N/A		N/A	
	G9883 - 3 ongoing maintenance sessions attended in months 16-18 and weight loss goal maintained	$50				
	G9884 - 3 ongoing maintenance sessions attended in months 19-21 and weight loss goal maintained	$50				
	G9885 - 3 ongoing maintenance sessions attended in months 22-24 and weight loss goal maintained	$50				
	G9891[53] - MDPP session reported as a line-item on a claim for a payable MDPP services	$0				
Modifier	None					
Limits	Once per beneficiary's lifetime					

Switching DPP Supplier Reimbursement

While the Medicaid National DPP demonstration does not allow beneficiaries to switch DPP suppliers, CMS' rule for the Medicare DPP (MDPP) does allow beneficiaries to change DPP supplier. Table 10.8 provides information on this payment, also known as a bridge payment.

Table 11.7. *Medicare's Reimbursement Model versus Maryland National DPP Model for Bridge Payments if there is a change in DPP supplier*

OTHER						
PAYER	**MEDICARE**		**DPP DEMO**			
	In person DPP		**In Person DPP**		**Virtual DPP**	
	CPT Code & Description	**Payment**	**CPT Code**	**Payment**	**CPT Code**	**Payment**
	G9890- Bridge payment – first session furnished by MDPP supplier to an MDPP beneficiary who has previously received MDPP services from a different MDPP supplier	$25	N/A		N/A	
Modifier	None					
Limits	None					

Reimbursement Amounts

Table 11.8 provides an overview of the payments per person that a DPP supplier may receive with and without weight loss

Table 11.8. *Medicare's Reimbursement Model versus Maryland National DPP Model for Reimbursement Amounts*

TOTAL PAYMENTS			
PAYER	**MEDICARE**	**DPP DEMO**	
	IN PERSON DPP	**IN PERSON DPP**	**VIRTUAL DPP**
1-Year (no weight loss)	$195	$201	$200
1-year[54] (with weight 5% loss)	$355	$255[55]	$245
1-year[56] (with 9% weight loss)	$470	$282[55]	$281
2-year[56] (with weight 5% loss)	$525	Option not Available	Option not Available
2- year[56] (with 9% weight loss)	$670	Option not Available	Option not Available

[54] Assumes 5% weight loss occurred at or near the end of year 1.

[55] During the 1-year curriculum, a DPP supplier may be reimbursed up 60% weight loss. In core, a DPP supplier may be reimbursed up to 27% weight loss. In post-core, a DPP supplier may be reimbursed up to 33% weight loss.

[56] Assumes 5% weight loss occurred in the first 6 months of year 1.

Challenges with Demonstration Reimbursement Model

During the demonstration, the following challenges were identified:

Accounting for Attendance - Virtual Engagement and Make-Up Sessions

There was no CPT code associated with attendance/engagement for the virtual DPP. The virtual DPP supplier was only submitting claims for the initial session and weight loss. This prevented the MCOs from tracking retention via claims.

There was no modifier associated with make-up sessions. Given the limitations the MCOs programmed in their claims system based on the above-mentioned model, this created a billing challenge for DPP suppliers who were submitting claims for the same service on the same date of service. This registers as a duplicate claim leading to claims denials and requiring the MCOs to employ a manual process to process these claims.

Manual Overrides for Duplicate Claims

The demonstration model uses the same CPT code with different modifiers to identify weight loss and attendance. As a result any beneficiary that shows weight loss at a session would result in the DPP supplier submitting a claim with a duplicated CPT code. This registers as a duplicate claim leading to claims denials and requiring the MCOs to employ a manual process to process these claims.

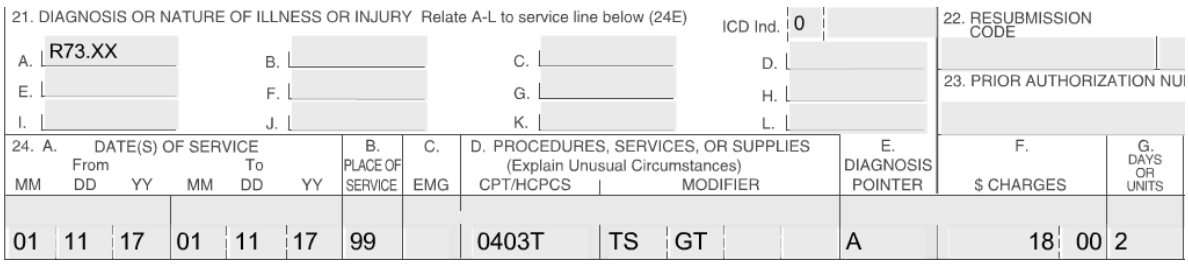
Deviating from CPT Code Definition – Number of Units

The demonstration model uses the CPT code, 0403T, with multiple units of service to indicate % weight loss. For example, a claim for a beneficiary with a 2% weight loss would show 2 units for the CPT code 0403T (see Figure 11.1). Given that 0403T is defined as "*Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day*," where "*per day*" indicates a single unit maximum. This unit maximum is enforced by health plans based on the Patient Protection and Affordable Care Act (ACA) guidelines on Medically Unlikely Edits (MUE) limits.

At our request, NACDD spoke with CMS, CDC, and Leavitt Partners to ascertain if a waiver was needed and if so how to obtain one. In response, CMS, CDC and Leavitt Partners indicated that given this is a demonstration, a waiver is not needed; it is at the discretion of the State to approve the use of the 0403T code outside of its definition.

As such, for the purpose of reimbursement during this demonstration, to pay for DPP services rendered to this demonstration's participants, MDH approved the use of multiple units when the 0403T code is used in conjunction with modifiers TS, TM, or TS, TF to indicate percent (%) weight loss.

Figure 11.1. Example of Claim showing 2% weight loss.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. R73.XX | B. | C. | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NU

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
01	11	17	01	11	17	99		0403T	TS	GT		A	18 00	2

Paying for the same Unit of Weight Loss

The demonstration reimbursement methodology was designed to pay for weight loss. To track weight loss over time, this model reimburses for units of weight losses (1 unit = 1% weight loss). The DPP suppliers measure weight loss back to baseline; as a result DPP suppliers were being reimbursed for the same unit of weight loss multiple times, and were being reimbursed for weight fluctuations (see Figure 11.2).

Figure 11.2. Paying for Same Unit of Weight Loss and Weight Fluctuations

Jane Doe 5'7" Baseline Weight: 250lbs	**DPP Billing**	**DPP Payment**
DPP Month 3 Loses 12.5lbs (237.5lbs)	DPP Month 3 DPP bills for 5 units of weight loss (5%) from baseline weight	
DPP Months 3-6 Maintains weight loss (237.5lbs)	DPP Months 3-6 DPP bills for the same 5 units of weight loss (5%) from baseline weight each month	Paid for same unit of weight loss
DPP Month 7 Gains 8lbs (245.5lbs)	DPP Month 7 DPP bills for the 2 units of weight loss (2%) from baseline weight	Paid for weight fluctuations
DPP Months 8-9 Maintains new weight (245.5lbs)	DPP Months 8-9 DPP bills for the same 2 units of weight loss (2%) from baseline weight each month	Paid for same unit of weight loss
DPP Month 10 Loses 9lbs (236.5lbs)	DPP Month 10 DPP bills for the 5 units of weight loss (5%) from baseline weight	Paid for weight fluctuations
DPP Months 11-12 Maintains weight loss (236.5lbs)	DPP Months 11-12 DPP bills for the same 5 units of weight loss (5%) from baseline weight each month	Paid for same unit of weight loss

Recommendations for a Sustainable Reimbursement Model

A sustainable model would need to do the following:

1. Use different CPT or HCPCS codes to differentiate attendance and weight loss;
2. Use a set % weight loss (align with evidence-based weight loss target) or use a CPT or HCPCS code that allows multiple units of service;
3. Use evidence-based attendance and weight loss targets (based on the CDC's DPRP criteria) to develop pay-for-performance model,
4. Use modifiers to distinguish make-up sessions, and virtual and in-person suppliers; and
5. Use the same payment model, with attendance and weight loss, for both virtual and in-person.

Chapter 12 : National Provider Identifier Taxonomy, General Health Plan Credentialing Overview and Medicaid Eligibility and Enrollment Requirements for DPP Lifestyle Coaches – FINAL 01.12.2018 [UPDATED 10.17.2018]

Overview

Successful implementation, scaling, and sustainability of the National Diabetes Prevention Program (DPP) in Maryland require an adequate network of DPP Lifestyle Coaches to provide the services. In order to provide DPP services to the potentially DPP eligible proportion of the 83% of Maryland's Medicaid population enrolled in the HealthChoice program[57] and submit claims for reimbursement,[58] DPP Lifestyle Coaches, as suppliers, must take the same steps that any provider must take to enroll with Maryland Medicaid in addition to the HealthChoice Managed Care Organization(s) (MCO). Once enrolled with Maryland Medicaid, MCOs verify the training, qualifications and practice history of a provider or supplier, through a process called credentialing. At issue is the fact that several key components or designations required by the enrollment and credentialing processes are not currently available or yet identified for DPP Lifestyle Coaches, and must be addressed in order to enable DPP Suppliers to participate in MCO supplier networks. This paper highlights the issues in detail, defines the terms, and provides options to address these.

Difference between National Provider Identifier (NPI), Provider Enrollment, and Credentialing

National Provider Identifier:

A National Provider Identifier (NPI) is a unique 10-digit identification number for covered health care providers and suppliers, and is needed to submit claims. A NPI is used during the credentialing process to check for provider/supplier specific sanctions, such as fraud, in the National Practitioner Data Bank (NPDB).

To obtain a NPI number, providers and suppliers must apply and self-select a NPI taxonomy code that best describes the provider, supplier or organization's type, classification, and area of specialization or underlying expertise. NPI does not replace any credentialing or validation process that providers and suppliers may need to be complete for payers. The definitions for some of the NPI taxonomy codes do reference specialty or certifying boards as a source, but this reference does not imply that providers or suppliers have met the requirements of that board or certifying body if they self-select that NPI taxonomy code to identify themselves.[59]

The NPI taxonomy code identifies any specialty or sub-specialty that a provider or supplier has, and inconsistencies between services provided and NPI taxonomy may result in a claim rejection.[60]

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[57] The Hilltop Institute, "Evaluation of the HealthChoice Program CY 2011 to CY2015" (Baltimore, MD: University of Maryland Baltimore County, May 3, 2017), https://mmcp.health.maryland.gov/Documents/2017%20HealthChoice%20Evaluation%20 (CY%202011-CY%202015).pdf.

[58] Outside of the Medicaid and National DPP Demonstration

[59] National Uniform Claim Committee, "Does Choosing a Taxonomy Code Mean I Met the Licensure/Certification Requirements for That Provider?," 2017, http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/more-information-mainmenu-55/97-does-choosing-a-taxonomy-code-mean-i-met-the-licensure-certification-requirements-for-that-provider.

[60] Theuns, "NPI: More than Just a Number," AAPC Knowledge Center, 2016, https://www.aapc.com/blog/35428-npi-more-than-just-a-number/.

Provider Enrollment:

Provider enrollment refers to the process of requesting participation in a health insurance network as a participating provider or supplier. The provider enrollment process involves requesting participation or contracting with a health plan or insurance company, Medicare, or Medicaid, and completing the enrollment application, including credentialing.

Credentialing:

Credentialing is a process used by health plans, such as commercial and public payers, to verify the training, qualifications, professional liability insurance and practice history of an individual provider or supplier, or a facility and to protect beneficiaries from being taken advantage of. Additionally, it protects beneficiaries from facilities, providers, or suppliers that have had sanctions levied against their licenses or certifications.[61]

Facility Credentialing:

As part of their credentialing process, health plans may verify a facility's ownership, certification/accreditation, proof of professional liability and worker's compensation insurances, Medicare/Medicaid sanctions, and federal exclusions or fraud, as well as the facility's quality management and patient safety programs, policies and structures, where facility is required to demonstrate their administrative structure and supporting policies.[62] The quality management and patient safety programs, policies and structures should include credentialing.

Delegated Credentialing:

Delegated credentialing occurs when a MCO gives a DPP organization the authority to credential its own lifestyle coaches. The DPP organization is then responsible for evaluating lifestyle coaches' qualifications and making credentialing decisions on behalf of the MCO.

Interaction between NPI, Provider Enrollment, and Credentialing

To become an enrolled provider or supplier with Medicaid and the HealthChoice MCOs, DPP supplier organizations need to:

1. Obtain a National Provider Identifier (NPI) Taxonomy,
2. Enroll in Maryland Medicaid through a screening process (as of January 2018), and
3. Enroll with one or more managed care organization via that MCO's Provider Enrollment and Credentialing Process.

[61] National Committee of Quality Assurance (NCQA), "Credentialing: A Core Consumer Protection" (National Committee of Quality Assurance, 2014), https://www.ncqa.org/Portals/0/Newsroom/2014/CredentialingFactSheetFinal.pdf.

[62] Blue Cross Blue Shield of Idaho, "MA PAP 240 - Credentialing/Recredentialing Standards for Facilities," 20145, https://providers.bcidaho.com/policies-and-procedures/map/map240.page.

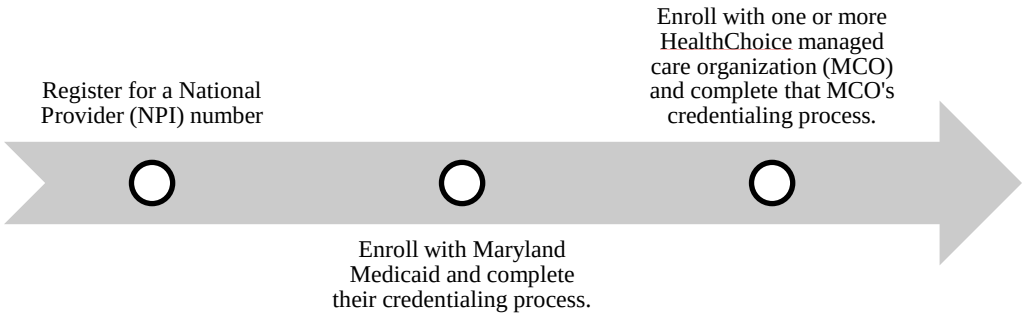

Figure 12.1. Step Process to Become Credentialed adapted from Amvik Solutions (2017). Insurance Credentialing and Enrollment. Retrieved from: https://www.webaba.com/insurance-credentialing-enrollment/

Medicare Diabetes Prevention Program (MDPP) Credentialing Model

In the Medicare Diabetes Prevention Program Expanded Model (MDPP-EM) final rule, DPP organizations, not individual lifestyle coaches, may enroll in Medicare as an MDPP supplier if they have achieved CMS interim preliminary recognition, CDC preliminary recognition (if established), or CDC full recognition. The DPP supplier organization would enroll as Medicare supplier and would provide a roster of its lifestyle coaches to CMS. CMS expects the DPP supplier organization to conduct eligibility checks based on their established standards for coaches who furnish services on behalf of MDPP suppliers.

CMS will screen newly enrolling MDPP supplier organizations as a high categorical risk and DPP supplier organizations would have to undergo high risk screening such as site visits. For those individuals who maintain a 5% or greater direct or indirect ownership interest in the DPP supplier organization, they will have to undergo high risk screening, including background checks and fingerprinting. CMS also requires that MDPP suppliers revalidate every three years after their initial enrollment.

Finally, CMS requires that a DPP supplier not have any prohibitions or sanctions from Medicaid or any other federal program in order to enroll as an MDPP supplier.

Proposed Process in Maryland and HealthChoice MCOs

Maryland Medicaid proposes to mirror the enrollment and credentialing process described in the MDPP-EM final rule. To that end, in order to serve Maryland Medicaid managed care beneficiaries, DPP supplier organizations would have to be CDC DPRP recognized,[63] full, preliminary or pending, and do the following:

1. Obtain a NPI number for the DPP supplier organization,

2. Enroll at the facility level with Maryland Medicaid as a Supplier,

    a. Attest to CDC DPRP recognition and submit proof of recognition with expiration date

[63] Please review the CDC's DPRP Standards for more information on DPRP Recognition. Centers for Disease Control and Prevention (CDC). (2018) Centers for Disease Control and Prevention Diabetes Prevention Recognition Program (DPRP): Standards and Operating Procedures. Retrieved from: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf.

b. Attest to employed lifestyle coaches qualifications to deliver the National DPP curriculum in alignment with the CDC's DPRP criteria, as well as maintain proof of said qualifications

3. Apply to one or more individual MCOs to become a network supplier, and

4. Go through that MCO's credentialing process at the facility level.

If the DPP supplier organization has already been credentialed with a MCO to serve individuals through a different business line, such as Medicare Advantage, they would not need to be re-credentialed for Medicaid. They would be added to the MCO's network for Medicaid.

HealthChoice MCOs have their own internal credentialing policies, which are structured to meet credentialing standards required under the National Committee of Quality Assurance (NCQA), State regulations, and the Delmarva Foundation, Medicaid's external quality review organization (EQRO). The MCOs would consider this type of provider enrollment and credentialing as a facility contract or enrollment. The MCOs would credential the DPP supplier organization, and would not credential or review a roster of individual lifestyle coaches. With this approach, the review and assessment of an individual lifestyle coach's selected NPI taxonomy code and/or licensure is not part of the MCO credentialing process. However, MCOs may require DPP supplier organizations to maintain documentation of lifestyle coaches' qualifications, as required by the CDC DPRP standards.

The DPP supplier organization would be responsible for ensuring each lifestyle coach has a NPI, and for verifying acceptability of NPI, training, qualifications[64], and practice history of the individual lifestyle coaches. As a result, the MCOs would require that the DPP supplier organization to provide documentation of their quality management and patient safety process, which should include a credentialing process. Documentation may include copies of the DPP supplier organization's quality management and patient safety written policies and procedures, which should include written credentialing policies and/or procedures.

Impact on DPP Suppliers

If an MDPP supplier reports an ineligible coach, CMS, Medicaid or a MCO may take administrative action to deny or revoke the MDPP supplier's enrollment in their network (please note the DPP supplier, not the lifestyle coach, will lose eligibility to enroll with CMS and subsequently Medicaid).

CMS proposes that a supplier could respond to the enrollment denial or revocation by submitting a corrective action plan that would include the removal of the lifestyle coach from its roster.

DPP supplier organizations may encounter denials or delayed payments because they employed lifestyle coaches that were not adequately credentialed.

DPP supplier organization would need to allocate money and resources to maintain an internal credentialing body or contract with a credentialing firm, such as the Council for Affordable Quality Healthcare (CAQH).

[64] The requirement for DPRP recognition assumes that lifestyle coaches will be using a CDC-approved curriculum, where the curriculum is approved to be used by DPP suppliers and meets CDC's requirements for DPRP recognition.

Chapter 13 : A Proposed Sustainability Secondary Outcomes Evaluation to Determine Return on Investment for Managed Care Organizations and Maryland Medicaid (Summary) – FINAL 10.04.2017

Background

Through a grant from the National Association of Chronic Disease Directors (NACCD), the Maryland Department of Health (MDH) in collaboration with four Medicaid Managed Care Organizations (MCOs), Maryland is piloting the provision of National Diabetes Prevention Program (DPP) to eligible Medicaid beneficiaries. MCO's began enrolling participants in DPP programs in January 2017 with the goal of enrolling a total of beneficiaries 600 beneficiaries in the National DPP in a two year time span. The grant period ends June 2018.

Study Aims

Although prior studies have evaluated the benefits of DPP participation among Medicare beneficiaries in regard to both health outcomes and cost savings,[65] there are limited studies regarding DPP participation among Medicaid beneficiaries. Given that there are substantial differences between these populations that may affect the magnitude of both the health benefits and the cost savings associated with DPP participation, Medicaid is undertaking an evaluation to determine the affect(s) of DPP participation:[66] (a) utilization of emergency medicine services; (b) all-cause hospital admission; (c) medications; (d) total cost of care (per member per month); and (e) incidence of diabetes.

Study Methods

Propensity score matching will be used to identify a sample of Medicaid beneficiaries from the four participating MCO's, who met criteria for prediabetes, yet did not enroll in a DPP program during the pilot. This sample will be compared to beneficiaries who participated in the National DPP demonstration pilot for various outcomes including health outcomes and associated costs. Outcomes of interest will be evaluated for the 24 months prior to DPP enrollment, during DPP participation, and for the first phase of this study, in the 12 months after DPP participation. Medicaid plans to evaluate these outcomes in several subsequent phases correlated with 24, 36, 48, and 60-months after DPP participation.

Health outcomes and costs will also be compared between groups of DPP participants utilizing the following groups which are aligned with the study providing the basis for CMS' actuary certification for the Diabetes Prevention Recognition Program (DPRP).[67]

Table 13.1. *Potential Categories for Analysis*

CATEGORIES	
Number of Sessions Attended	1-3 sessions
	4-8 sessions
	>9 sessions

[65] Alva, M, Hoerger, T, Jeyaraman, R, Amico, P and Rojas-smith, L. (2017). Impact of the YMCA of the USA Diabetes Prevention Program on Medicare Spending and Utilization. Health Affairs 36(3):417-424. doi: 10.1377/hlthaff.2016.1307.; Centers for Medicare and Medicaid Services (CMS). (2016). Certification of Medicare Diabetes Prevention Program. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf.

[66] This evaluation will examine changes in all-cause health service utilization and overall health costs, as well service utilization and health costs for select comorbidities (referred to in this document as the "suite of diseases" – see Chapter 14) that may also improve with participation in DPP, to determine the potential impact of the DPP.

[67] CMS. (2016). Certification of Medicare Diabetes Prevention Program.

CATEGORIES	
Percent of Weight Loss	0% weight loss
	1-4% weight loss
	>5 % -7% weight loss

Role of Partnering MCOs in the ROI Study

Via a secure finder file, MCOs will provide the Hilltop Institute team with information on their Medicaid beneficiaries who participated in the DPP pilot. The data transfer will be through an encrypted secure File Transfer Protocol (FTP) process. The data transfer will begin in June 2019 (tentative).

IRB Approval for ROI Study

Maryland Medicaid has received IRB approval (Protocol#17-71) for this study. The IRB has deemed this study exempt research (See Appendix I).

Chapter 14 : Secondary Outcomes Evaluation's Suite of Diseases: Prediabetes' Comorbidities and the National Diabetes Prevention Program – FINAL 07.17.2018

Background

Through a grant from the National Association of Chronic Disease Directors (NACCD), the Maryland Department of Health (MDH) in collaboration with four of nine HealthChoice participating Medicaid Managed Care Organizations (MCOs) are piloting Medicaid reimbursement for the National Diabetes Prevention Program (DPP) to eligible Medicaid beneficiaries.

In similar contexts, prior studies have evaluated the benefits of DPP participation among Medicare beneficiaries and other populations, such as private payers and self-pay, in regards to both health outcomes and cost savings. Traditionally, the effects of DPP have been evaluated by looking solely at diabetes related outcomes and costs.[68] However, this approach excludes the potential impact that lifestyle change programs, such as DPP, may have on other health conditions and their associated costs. Maryland believes it is important to examine co-morbid health conditions that studies suggest may be impacted by DPP participation, including increased exercise and weight loss, among Medicaid beneficiaries enrolled in HealthChoice.

Comorbidities and the Evaluation

Medicaid is undertaking an evaluation to determine the effect(s) of DPP participation on: (a) utilization of emergency medicine services; (b) all-cause hospital admission; (c) medications; (d) total cost of care (per member per month); and (e) incidence of diabetes (conversion from pre-diabetes to diabetes). This evaluation will examine changes in all-cause health service utilization and overall health costs to determine the potential impact of the DPP.[69] The evaluation will also examine the service utilization and health costs for select comorbidities (referred to in this document as the "suite of diseases") that may also improve with participation in DPP.

Prediabetes and Comorbidities

Studies have found that there are weight-related comorbidities, such as prediabetes, type 2 diabetes and cardiovascular disease (CVD).[70] Risks associated with these conditions are generally proportional to BMI. Studies show that for each 5kg/m^2 increase in BMI, there is an approximately 27% increase in risk of CVD and an 18% increase in risk of stroke.[71]

Recommendations from the Endocrine Society (ES), the American Heart Association (AHA), the American College of Cardiology (ACC), the Obesity Society (TOS), the American Association of Clinical Endocrinologists (AACE), and the American College of Endocrinology (ACE), recommend losing 5–10% of baseline weight to reduce health risks. Lifestyle modification programs such as DPP can assist in weight loss, improved lipid, and glycemic control, and reduced risk of type 2 diabetes.[71] This

[68] Alva, M, Hoerger, T, Jeyaraman, R, Amico, P, and Rojas-smith, L. (2017). Impact of the YMCA of the USA Diabetes Prevention Program on Medicare Spending and Utilization. Health Affairs 36(3):417-424. doi: 10.1377/hlthaff.2016.1307.; Centers for Medicare and Medicaid Services (CMS). (2016). Certification of Medicare Diabetes Prevention Program. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf.

[69] For more details, see Proposed Sustainability Secondary Outcomes Evaluation to Determine Return on Investment for Managed Care Organizations and Maryland Medicaid Summary.

[70] Due to focus on comorbidities related to weight and the prevention of type 2 diabetes, the risk associated with prediabetes and type 2 diabetes were excluded.

[71] Fujioka, K. (2015). Current and emerging medications for overweight or obesity in people with comorbidities. *Diabetes, Obesity and Metabolism, 17*(11), 1021-1032.

suggests that weight-related co-morbidities, such as CVD, may be impacted by DPP participation.

Metabolic Syndrome

The National Heart Lung and Blood Institute (NHBLI) and the AHA have identified metabolic syndrome as a cluster of several risk factors. Metabolic syndrome risk factors related to CVD that have been shown to be sensitive to weight loss and increased physical activity include:

1) Abdominal obesity or increased BMI ($\geq$ 25 kg/m^2);
2) Atherogenic dyslipidemia or raised/elevated triglycerides and reduced/low HDL;
3) Raised/high/elevated blood pressure or hypertension;
4) Insulin resistance and/or glucose intolerance or elevated glucose;
5) Pro-inflammatory states (elevated hsCRP and SAA, or elevated inflammatory cytokines [TNF-α, IL-6] or decreased adiponectin levels); and
6) Pro-thrombotic states (increased antifibrinolytic factors [PAI-1] or increased fibrinogen).[72]

Asthma

According to the American Lung Association (ALA), people with a BMI of 30 or more have a much higher risk of having asthma than those with a lower BMI. Additionally, obese patients tend to have poorly controlled asthma; increased hospitalizations; and have worse responses to the effects of asthma control regimens in comparison to non-obese patients. Studies have also shown that weight loss among persons who are both obese and suffer from asthma contributed to improved asthma control.[73]

Suite of Diseases

Taken together, this host of evidence suggests that these co-morbidities may be sensitive to lifestyle change programs and should be included as outcomes of interest in the evaluation of the impacts of DPP programming. Comorbidities that may not be captured in claims data or are a subset of DPP eligibility will be excluded. Therefore, Maryland's suite of diseases for the purpose of the DPP evaluation will include the following: 1) Metabolic Syndrome Risk Factors: Raised/high/elevated blood pressure or hypertension, and 2) Asthma.[74]

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[72] Beilby, J. (2004). Definition of Metabolic Syndrome: Report of the National Heart, Lung, and Blood Institute/American Heart Association Conference on Scientific Issues Related to Definition. *The Clinical Biochemist Reviews*, *25*(3), 195–198.; Grundy, S. M., Brewer, H. B., Cleeman, J. I., Smith, S. C., & Lenfant, C. (2004). Definition of metabolic syndrome: report of the National Heart, Lung, and Blood Institute/American Heart Association conference on scientific issues related to definition. *Circulation*, *109*(3), 433-438.; Paoletti, R., Bolego, C., Poli, A., & Cignarella, A. (2006). Metabolic Syndrome, Inflammation, and Atherosclerosis. *Vascular Health and Risk Management*, *2*(2), 145–152.; **Abbreviations:** a) BMI, body mass index; b) HDL, high density lipoproteins; c) hsCRP, high sensitivity C-reactive protein; d) IL-6, interleukin 6; e) PAI-1, plasminogen activator inhibitor 1; f) SAA, serum amyloid A; g) TNF-α, tumor necrosis factor-α.

[73] Dixon, A.E. (2016). American Lung Association: The Link between Asthma and Weight. Retrieved from: http://www.lung.org/about-us/blog/2016/07/the-link-between-asthma-weight.html.; Dixon, A. E., & Poynter, M. E. (2016). Mechanisms of Asthma in Obesity. Pleiotropic Aspects of Obesity Produce Distinct Asthma Phenotypes. American Journal of Respiratory Cell and Molecular Biology, 54(5), 601–608. http://doi.org/10.1165/rcmb.2016-0017PS

[74] The suite of diseases only includes a subset of the risk factors for metabolic syndrome. Several risk factors will be excluded from the evaluation, as they are associated with eligibility for DPP participation. Excluded risk factors include 1) abdominal obesity or increased BMI and 2) insulin resistance and/or glucose intolerance or elevated glucose with a diagnosis of diabetes type 1 or type 2. Other risk factors for metabolic syndrome were excluded due to the limitations of the claims data and/or based on the recommendations of the clinical physician, who were consulted on feasibility of extracting information from claims and on clinical appropriateness in relation to potential impact of DPP. Excluded risk factors include 1)

Table 1 lists the conditions and their associated ICD-10 codes that Maryland may select and apply to capture the suite of potentially co-occurring diseases and may be included in the secondary outcomes evaluation.[75]

Table 14.1. *List of ICD-10 for Suite of Potentially Co-occurring Diseases*

CONDITION	ICD-10 CODES
Raised/High/Elevated Blood Pressure or Hypertension	
Elevated blood-pressure reading, without diagnosis of hypertension	R03.0
Essential (primary) hypertension	I10
Hypertensive heart disease with heart failure	I11.0
Hypertensive heart disease without heart failure	I11.9
Asthma	
Mild intermittent asthma	J45.20-J45.22
Mild persistent asthma	J45.30-J45.32
Moderate persistent asthma	J45.40-J45.42
Severe persistent asthma	J45.50-J45.52
Unspecified asthma with (acute) exacerbation	J45.901
Unspecified asthma with status asthmaticus	J45.902
Unspecified asthma, uncomplicated	J45.909
Other asthma	J45.998

Future Studies

We have received recommendations to include disabilities in the evaluation study. However, the expected incidence of such disabilities in a relatively small sample of 600+ beneficiaries not selected based on their disability status may be low. Additionally, it may not be feasible to retrospectively identify at a consistently high level of validity and reliability those relatively few beneficiaries presenting with one or more disabilities based on the 24-month look-back period.

Again, we did not either include or exclude anyone based on disability. If DPP coverage is expanded beyond the demonstration in Maryland Medicaid and it becomes feasible to obtain a larger sample, the co-occurrence of disabilities may be assessed (pending CMS approval of §1115 HealthChoice waiver amendment).

Finally, there are many health conditions, such as dental, mental health and substance use disorder, as well as different types of disabilities, which might affect participation in DPP. Future studies may want to focus on specific types of disabilities or health conditions that may influence capacity to: 1) attend classes (e.g., a chronic illness that is frequently debilitating and requires inpatient care on a regular basis); 2) to understand/integrate health information; 3) obtain, prepare and ingest appropriate foods (mobility

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Atherogenic dyslipidemia or raised/elevated triglycerides and reduced/low HDL, 2) Pro-inflammatory states (elevated hsCRP and SAA, or elevated inflammatory cytokines [TNF-α, IL-6] or decreased adiponectin levels), and/or 3) Pro-thrombotic states (increased antifibrinolytic factors [PAI-1] or increased fibrinogen)

[75] This list is subject to change based on data availability and feasibility as determined by the University of Maryland Baltimore County (UMBC) – The Hilltop Institute.

restrictions, and tube feeding); and/or 4) to exercise.

Future studies may want to focus on the impact of DPP on the following: 1) specific type of disabilities, 2) dental disease, 3) depression and anxiety, 4) acute coronary events, 5) gastric bypass procedures (specifically tracking procedures), and/ or 6) steatohepatitis (fatty liver).[76]

Future studies may examine the effects of concomitantly prescribed medications that might prevent, slow or facilitate weight loss, or potentiate relapse marked by regaining weight. Medication classes, such as psychoactives, steroids/birth, or seizure control drugs; antihistamines; and beta-blockers, may prevent weight loss or lead to weight gain.[77]

[76] Based on the recommendations of clinical physicians, who were consulted on clinical appropriateness in relation to potential impact of DPP, the following were included for future studies: 1) dental disease, 2) depression and anxiety, 3) acute coronary events, 4) gastric bypass procedures (specifically tracking procedures), and/ or 5) steatohepatitis (fatty liver).

[77] American Academy of Child and Adolescent Psychiatry. (2016). Weight Gain from Medication: Prevention and Management. Retrieved from: https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Preventing-and-Managing-Medication-Related-Weight-094.aspx. ; Shrivastava, A., & Johnston, M. E. (2010). Weight-Gain in Psychiatric Treatment: Risks, Implications, and Strategies for Prevention and Management. Mens Sana Monographs, 8(1), 53–68. http://doi.org/10.4103/0973-1229.58819.

Chapter 15 : Potential Use of ICD-10 Codes for Social Determinants of Health (SDOH) in the National DPP - FINAL 12.04.2017

Overview

During the Medicaid and National DPP demonstration, the HealthChoice Managed Care Organizations (MCOs) and the DPP suppliers identified a need to document the social determinants of health (SDOH) and factors that may impede a beneficiary's success in DPP. This documentation would assist both MCOs and DPP suppliers with identifying needed program supports for the population they serve.

The following are a series of ICD-10 codes that studies have indicated may capture the social determinants of health.[78]

Table 15.1. *ICD-10 Codes for Social Determinants of Health*

SDOH	ICD-10 CODE	ICD-10 DESCRIPTION
Education	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in School
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Resources	Z59.0	Homelessness
	Z59.1	Inadequate housing
	Z59.2	Discord with neighbors, lodgers and landlord
	Z59.3	Problems related to living in residential institution
	Z59.4	Lack of adequate food and safe drinking water
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.8	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Employment	Z56.0	Unemployment, unspecified
	Z56.2	Threat of job loss
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Social Support	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty
	Z60.4	Social exclusion and rejection
	Z60.5	Target of (perceived) adverse discrimination and persecution

[78] National Association of Community Health Centers (NACHC). (2016). Chapter 9: Act on your data. Retrieved from: http://www.nachc.org/wp-content/uploads/2016/09/Chapter_9-Act_On_Your_Data_Aug2016.pdf.; United HealthCare. (2017). 2017 Social Determinants of Health. Retrieved from: https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/MI-Provider-Information/MI-ICD-10-Codes-for-Social-Determinants-of-Health.pdf.; 3M Health Information Systems. (2016). ICD-10 adds more details on the social determinants of health. Retrieved from: https://www.3mhisinsideangle.com/blog-post/icd-10-adds-more-detail-on-the-social-determinants-of-health/.; Health Information Technology, Evaluation and Quality Center (HITEQ). (2017). ICD-10 z-codes for social determinants of health. Retrieved from: file http://hiteqcenter.org/DesktopModules/EasyDNNNews/DocumentDownload.ashx?portalid=0&moduleid=849&articleid=1377&documentid=206

SDOH	ICD-10 CODE	ICD-10 DESCRIPTION
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
	Z73.4	Inadequate social skills, not elsewhere classified
	Z73.5	Social role conflict, not elsewhere classified
Occupational & Environmental Hazards	Z77.010	Contact with and (suspected) exposure to arsenic
	Z77.011	Contact with and (suspected) exposure to lead
	Z77.090	Contact with and (suspected) exposure to asbestos
	Z77.120	Contact with and (suspected) exposure to mold (toxic)
	Z57.0	Occupational exposure to noise
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
Legal Needs	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
Stress	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other physical and mental strain related to work
	Z56.3	Stressful work schedule
	Z63.71	Stress on family due to return of family member from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance and death of family member
	Z63.5	Disruption of family by separation and divorce
	Z63.6	Dependent relative needing care at home

Factors that Affect Program Success

The following are series of ICD-10 codes that may correspond with factors that affect diet and weight loss or gain.

Table 15.2. *ICD-10 Codes for Barriers to Program Success*

FACTORS	ICD-10 CODE	ICD-10 DESCRIPTION
Physical Activity & Diet	Z72.3	Lack of physical exercise
	Z91.81	History of falling
	Z72.4	Inappropriate diet and eating habits
	Z91.11	Patient's noncompliance with dietary regimen

FACTORS	ICD-10 CODE	ICD-10 DESCRIPTION
Sleep Patterns	Z72.820	Sleep deprivation
	Z72.821	Inadequate sleep hygiene
	Z73.810	Behavioral insomnia of childhood sleep-onset association type
	Z73.811	Behavioral insomnia of childhood limit setting type
	Z73.819	Behavioral insomnia of childhood unspecified type
Limited Mobility	Z73.6	Limitation of activities due to disability
Stress	Z73.2	Lack of relaxation and leisure
	Z73.3	Stress, not elsewhere classified
Attendance & Compliance Needs	Z91.82	Wandering in diseases classified elsewhere
	Z91.83	Wandering in diseases classified elsewhere
	Z74.1	Need for assistance with personal care
	Z74.2	Need for assistance at home and no other household member able to render care
	Z74.3	Need for continuous supervision
Food Allergies	Z91.010	Allergy to peanuts
	Z91.011	Allergy to milk products
	Z91.012	Allergy to eggs
	Z91.013	Allergy to seafood
	Z91.018	Allergy to other foods
	Z91.02	Food additives allergy status

Recommendations for Incorporating SDOH Codes into National DPP

The SDOH codes and the codes for factors impacting program success may be incorporated in to DPP in the following ways:

Program Supports

For DPP suppliers that may provide program supports or may be partnered with a health plan to offer program supports, such as transportation or child care vouchers, these ICD-10 codes offer an opportunity to document the need for program supports. This would allow DPP suppliers to use claims data to assess the need for program supports and to adapt support offered as needed.

Referrals for Community Resources

A participants success in DPP may be hindered by, economic and housing challenges. The SDOH ICD-10 codes, would allow DPP suppliers and/or health plans to document the need for additional community resources. For DPP suppliers that may have partnerships with other community organizations that may offer support to address these needs, they may use the ICD-10 codes to track referrals to these community resources.

Assessing and Addressing Barriers to Success

A DPP supplier may offer additional support for participants that are not progressing in the program. The ICD-10 codes for factors impacting program success would allow DPP suppliers to track additional support offered. They may use this information to assess the types of continuing education and training that they may need to provide to their lifestyle coaches.

Chapter 16 : State Medicaid System Changes for National DPP Coverage - Considerations for Implementation – FINAL 08.31.2018

Overview

During Maryland's Medicaid and National DPP demonstration, options for sustainability were discussed. These discussions highlighted that the state Medicaid agency would need to implement system changes to support the Medicaid coverage of DPP services. The following outline represents key policy considerations and decisions that a State Medicaid agency might make in order to implement the National DPP in that state.

Budget, Coverage and Federal Authority

- Consider any legislative mandates
- Determine state budget available/approved for DPP
    - New programs may require a budget initiative
    - State agencies will need to estimate number of potentially eligible individuals
    - Evidence of DPP effectiveness in Medicaid managed care organizations may be required to secure budget approvals
- Availability of funds may determine scale (FFS, MCO or both)
- Budget and scale of DPP drive decision of which federal authority to apply for:
    - If budget is available for entire MA population, then SPA
    - If limited budget available, or limited scale of offering, then 1115 waiver amendment

Provider Enrollment and Credentialing

- Determine method of enrollment and credentialing for DPP suppliers enrolled in the MCO's provider network[79]
    - Determine if enrollment will occur at the facility or individual level (For more information on provider enrollment and credentialing, please see Chapter 12.)
- Designate an existing or create a new provider type
- Determine criteria for supplier participation (i.e. DPRP recognition, etc.)
- Assess DPP supplier network to ensure capacity to serve the expected enrollment in its service area (This may be done in partnership with the State's Public Health Department.)[80]

[79] As per 42 CFR 438.608: "Provider screening and enrollment requirements. The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries."

[80] As per 42 CFR 438.207:" The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at § 438.68 and § 438.206(c) (1)."

Billing & Coding

- Determine if State is aligning with Medicare Expanded Model DPP codes and billing structure
- Determine CPT or HCPCs codes or modifiers, if any, to be used
- Determine fee structure, aligned with CPT or HCPCS codes, for visits only, a pay-for-performance model or a combination, include any modifications needed to distinguish between in-person and virtual suppliers, if desired
- Determine what codes or modifiers, if any, need to be added to the Medicaid Management Information System (MMIS)

Evaluation and CMS reporting

- Determine the best method for evaluating DPP services and beneficiary outcomes
- Determine data sources and administrative burden
- Determine what existing reports need to be adjusted to include new service type and the information (provider type, eligible population, payment structure) that may be needed
- Determine if any additional system requests are needed as part of this reporting requirement

APPENDICES

Appendix A: ICD-10 Diagnoses Codes and Descriptions

Table A.1. *Overweight and Obesity ICD-10 Codes*

ICD-10 Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
O99.21	Obesity complicating pregnancy, childbirth and the puerperium
O99.210	Obesity complicating pregnancy, unspecified trimester
O99.211	Obesity complicating pregnancy, first trimester
O99.212	Obesity complicating pregnancy, second trimester
O99.213	Obesity complicating pregnancy, third trimester
O99.214	Obesity complicating childbirth
O99.215	Obesity complicating the puerperium

Table A.2. *Elevated Blood Glucose Level and Gestational Diabetes ICD-10 Codes*

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
R73.01	Impaired fasting glucose	Z86.32[81]	Personal history of gestational diabetes
R73.02	Impaired glucose tolerance - Oral	O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
R73.03	Prediabetes	O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
R73.09[82]	Other abnormal glucose	O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
		O24.420	Gestational diabetes mellitus in childbirth, diet controlled
		O24.424	Gestational diabetes mellitus in childbirth,

[81] DPP suppliers should include Z86.32 as primary code for all individuals indicating history of gestational diabetes after confirming not currently pregnant.

[82] For beneficiaries that do not have an ICD-10 diagnosis of elevated blood glucose/ gestational diabetes to confirm prediabetes, a DPP supplier may assign R73.09. In these cases, a risk test is given, and the DPP supplier assigns the R73.09 code (primary), along with BMI (secondary; see Scenario 2, in Chapter 4: Eligibility, Billing, and Coding Procedures for Participating National Diabetes Prevention Program (DPP) Suppliers).

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
			insulin controlled
		O24.429	Gestational diabetes mellitus in childbirth, unspecified control
		O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
		O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
		O24.439	Gestational diabetes mellitus in the puerperium, unspecified control

Table A.3. *BMI ICD-10 Codes for BMI 22.0 and greater*[83]

ICD-10 Code	Description – Body Mass Index	ICD-10 Code	Description – Body Mass Index
Z68.22	Body mass index (BMI) 22.0-22.9, adult	Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.23	Body mass index (BMI) 23.0-23.9, adult	Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.24	Body mass index (BMI) 24.0-24.9, adult	Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.25	Body mass index (BMI) 25.0-25.9, adult	Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.26	Body mass index (BMI) 26.0-26.9, adult	Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.27	Body mass index (BMI) 27.0-27.9, adult	Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.28	Body mass index (BMI) 28.0-28.9, adult	Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.29	Body mass index (BMI) 29.0-29.9, adult	Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.30	Body mass index (BMI) 30.0-30.9, adult	Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult	Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult	Z68.45	Body mass index (BMI) ≥ 70, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult		

[83] For data mining, use ICD-10 codes for BMI of 25 or greater.

Appendix B: Centers for Disease Control and Prevention (CDC) Prediabetes Screening/Risk Test used by National DPP suppliers

Table B.1. *CDC Prediabetes Screening Test and ICD-10 code R73.09 (Other Abnormal Glucose)*

Questions	Yes	No	ICD-10 Code
1) Are you a woman who has had a baby weighing more than 9 pounds at birth?	1	0	
2) Do you have a sister or a brother with diabetes?	1	0	
3) Do you have a parent with diabetes?	1	0	
4) Find your height on the chart below. Do you weigh as much as or more than the weight listed for your height?	5	0	
5) Are you younger than 65 years of age and get little or no exercise in a typical day?	5	0	
6) Are you between 45 and 64 years of age?	5	0	
7) Are you 65 years of age or older?	9	0	
Add up your score. If your total score is ≥9 points, this means your risk is high for having prediabetes now and you qualify for the CDC National DPP	**Total Score**		**R73.09**

Table B.2. *ADA Type 2 Diabetes Risk Test and ICD-10 code R73.09 (Other Abnormal Glucose)*

Questions	Responses	Score	ICD-10 Code
1) How old are you?	Less than 40 years	0	
	40-49 years	1	
	50-59 years	2	
	60 years or older	3	
2) Are you a man or a woman?	Woman	2	
	Man	1	
3) If you are a woman, have you ever been diagnosed with gestational diabetes?	Yes	1	
	No	0	
4) Do you have a mother, father, sister, or brother with diabetes?	Yes	1	
	No	0	
5) Have you ever been diagnosed with high blood pressure?	Yes	1	
	No	0	
6) Are you physically active?	Yes	1	
	No	0	

Questions	Responses	Score	ICD-10 Code
7) What is your weight category?	Please see chart below		
<u>Add up your score.</u> If your total score is ≥5 points, this means your risk is high for having prediabetes now and you qualify for the CDC National DPP	**Total Score**		**R73.09**

Table B.3. *ADA Type 2 Diabetes Risk Test Weight Chart*

HEIGHT	WEIGHT		
4’ 10”	119-142	143-190	191+
4’11”	124-147	148-197	198+
5’ 0”	128-152	153-203	204+
5’ 1”	132-157	158-210	211+
5’ 2”	136-163	164-217	218+
5’ 3”	141-168	169-224	225+
5’ 4”	145-173	174-231	232+
5’ 5”	150-179	180-239	240+
5’ 6”	155-185	186-246	247+
5’ 7”	159-190	191-254	255+
5’ 8”	164-196	197-261	262+
5’ 9”	169-202	203-269	270+
5’ 10”	174-208	209-277	278+
5’ 11”	179-214	215-285	286+
6’ 0”	184-220	221-293	294+
6’ 1”	189-226	227-301	302+
6’ 2”	194-232	233-310	311+
6’ 3”	200-239	240-318	319+
6’ 4”	205-249	246-327	328+
Score	**1 point**	**2 points**	**3 points**

Appendix C: Rationale for Using CPT Code - 0403T and Selected Modifiers in the Demonstration – FINAL 01.19.2017

Healthcare Common Procedure Coding System (HCPCS)

According to the Centers for Medicare and Medicaid Services (CMS), health insurers process approximately 5 billion claims for payment. To facilitate efficient and effective claims processing, a standardized coding systems is vital. The Healthcare Common Procedure Coding System (HCPCS) is the standard code set used for this purpose.[84] The HCPCS has two (2) levels.

HCPCS Level I contains five (5) digit numeric Current Procedural Terminology (CPT) codes that are copyrighted and maintained by the American Medical Association (AMA). CPT is a standardized coding system that is used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. Physicians and healthcare professions use this medical code set to bill health insurance programs and payers, such as Medicaid, Medicare and private insurance, for services and procedures. Even though the Secretary of Health and Human Services has adopted this coding system, the AMA determines the addition, deletion, or revision of CPT codes, and updates and publishes the CPT codes annually. However, the CPT code set "does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians." [38]

The CPT code set has three (3) categories: Category I refers to a procedure or service (Codes 00100 – 99499); Category II are optional and are used for execution measurement, such as a glucose blood test results (HbA1c test); and, Category III refers to provisional codes that allow data collection and assessment of new and developing technology, procedures, and services.[85]

On January 1, 2016, the CPT code 0403T[86] became effective. This code is a Category III code and according to the AMA, "more accurately identifies the non-clinical service performed by the CDC-recognized National DPP providers."[87]

Based on feedback from Managed Care Organizations (MCOs) participating in the National DPP demonstration, the CPT code selected needed to be an active code in order to work in their claims systems. As a result of this research and feedback, the 0403T code was selected to develop Maryland's reimbursement model.

Evaluation and Management Codes:

Typically, evaluation and management codes (E/M codes) refer to the billing process where physician-patient encounters are translated into five digit CPT codes. There are different E/M codes for different types of encounters such as office or hospital visits, as well as different levels of care.

> "For example, the 99214 code may be used to charge for an office visit with an established patient; however, there are five levels of care for this type of encounter. The 99214 code is often called a "level 4" office visit because the code ends in a "4"

[84] Centers for Medicare, "HCPCS - General Information. HCPCS Background Information," *Centers for Medicare and Medicaid Services*, August 25, 2016, https: //www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html.

[85] American Academy of Professional Coders (AAPC), "CPT - Current Procedural Terminology Codes," 2016, https: //www.aapc.com/resources/medical-coding/cpt.aspx.

[86] Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day

[87] American Medical Association, "New 2016 National Diabetes Prevention Program CPT Code: Background, description and frequently asked questions," 2016. https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/cpt-code-brief.pdf.

and because it is the fourth "level of care" for that type of visit (with the 99215 being the fifth and highest level of care)."[88]

The 0403T code is not an evaluation and management code, and would not designate different types of encounters or levels of care. In order to develop this level of detail, HCPCS Procedure Modifiers were incorporated into the reimbursement model.

HCPCS Procedure Modifier Codes

HCPCS Procedure Modifier Codes are either alphanumeric or two letters developed by the AMA and/or CMS that may be appended to CPT or HCPCS Level II codes to facilitate physician and healthcare professionals reporting special circumstances or clarifying and/or modifying the description of a procedure.[40]

Modifier codes provide additional information about a service or item identified by the HCPCS code. These modifiers are used when the HCPCS code description may need to be modified to describe the specific circumstances for an item or service.[89]

"To help…collect and analyze data on the value/timing of the stages of services provided," AMA recommended the following modifiers: [42]

- TF: Intermediate level of care,
- TG: Complex, high-tech level of care,
- TS: Follow-up service, and
- TT: Individualized service provided to more than one patient in same setting.

Further research identified the following codes:

- TM: Individualized Education Program (IEP), and
- GT: via interactive audio and video telecommunication systems.

Maryland decided to adopt the modifiers, TF, TG, TM, TS, and GT, in the development of its performance-based reimbursement model for the demonstration (please see Chapter 3 for National DPP Demonstration Fee Schedule for Maryland).

A commonly used modifier in telehealth is the GT modifier. The GT modifier is used to modify the HCPCS codes and indicate that the patient-physician interaction occurred "via interactive audio and video telecommunication systems."[90] Since, the Maryland model has community based and virtual DPP suppliers, this modifier was adopted to distinguish between the types of DPP supplier.

[88] E/M University, "Definitions E/M Coding, EM Evaluation, and Management Coding, E & M Documentation, 99214, 99213," accessed September 8, 2016, http://emuniversity.com/Definitions.html.

[89] Centers for Medicare and Medicaid, "Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures."

[90] American Academy of Professional Coders (AAPC), "CPT - Current Procedural Terminology Codes."

Appendix A: Rationale for Assigning ICD-10 Diagnosis Codes in the Demonstration – FINAL 01.19.2017

DPP Designation as a Supplier and Assignment of ICD-10 Codes by Medicare:

"Medicare Diabetes Prevention Program (MDPP) will enable organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers. MDPP suppliers are obligated to comply with all statutes and regulations that establish generally applicable requirements for Medicare suppliers."[91]

"MDPP suppliers are obligated to comply with all statutes and regulations that establish generally applicable requirements for Medicare suppliers. These regulations include, but are not limited to, time limits for filing claims (§ 424.44), requirements to report and return overpayments (§ 401.305), and procedures for suspending, offsetting or recouping Medicare payments in certain situations (§ 405.371)."[92]

"CMS understands that physicians may not always provide suppliers of DMEPOS[93] with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the claim. These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals, documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional."[94]

Since DPPs are suppliers, we have applied the same coding allowance that CMS gives to suppliers of DMEPOS. The codes DPPs will assign will come from this coding resource (based on 2017 ICD-10-CM/PCS) as well as medical records from MCOs and medical providers.

Supplier Assignment of ICD-10 Codes:

E and O codes are actual diagnoses codes of diseases or conditions, which can only be determined by a licensed medical provider since they have to perform assessments, tests, evaluations, or other diagnostic work to rule out some other condition. Otherwise, the only things that can technically be ascertained are symptoms, signs, or states of being (ICD-10 codes - R through Z).

For example, a DPP supplier can calculate BMI, which requires a relatively accurate measurement of height and weight, converting to metric units, and applying it in a standard formula. Thus, the ICD-10 codes for the different ranges of BMI are under the Signs and Symptoms. However, for diabetes and/or impaired glucose; there are other tests and evaluations performed and their results are evaluated by a licensed medical provider in order to diagnose a beneficiary with diabetes or prediabetes.

If a DPP supplier is also a licensed medical professional whose scope of practice includes the ability to order tests, diagnose conditions, and write a prescription for said condition, then they may use ICD-10 codes, such as the E and O codes without a prior visit from licensed medical provider who can diagnose.

A DPP supplier may only use E and O codes if there is a prior assessment by a licensed medical professional who has performed those tests, and diagnosed the beneficiary with prediabetes or at risk for

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[91] For more information on the Medicare Diabetes Prevention Program (MDPP) Expanded Model, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-02-2.html.

[92] For more information on the Medicare Diabetes Prevention Program (MDPP) Expanded Model Final Rule, please visit:

https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.

[93] Durable Medical Equipment, Prosthetics/Orthotics and Supplies

[94] For more information on the Medicare Claims Processing Manual: Chapter 23 Fee Schedule Administration and Coding Requirements please visit: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf.

type 2 diabetes, and then referred them to the DPP.

Medicaid and National DPP Demonstration Assignment of ICD-10 Codes:

During the Quarter 3 Maryland Medicaid National DPP State Visit,[95] DPP suppliers and MCOs reviewed and discussed appropriate ICD-10 codes for initial enrollment and all following claims. Following the facilitated discussion with Leavitt Partners and input from the MCOs, and DPP suppliers, MDH determined to do the following for the demonstration:

1. Assign at least two (2) ICD-10 codes on initial enrollment claim, a primary code for elevated blood glucose/history of gestational diabetes, and a secondary code for BMI.
2. Assign at least one (1) ICD-10 code for all following claims, elevated blood glucose/history of gestational diabetes (the primary code used on the initial enrollment claim).

The use of appropriate ICD-10 diagnosis codes is necessary for long-term sustainability. Claims may be used to drive quality and process improvements, justify the business case for National DPP reimbursement and to meet integrity/compliance needs in case of audit. Additionally, some MCOs indicated it would be possible to use claims to assess DPP suppliers' performance via the CPT plus modifier structure in conjunction with units (1 unit = 1%) of weight loss.

[95] Maryland Medicaid National DPP Quarter 3 Site Visit on January 10, 2017 in Baltimore, MD.

Appendix B: Changes in DPP Supplier and Eligibility, Medicaid Eligibility and Enrollment, and Health Status – FINAL 03.08.2017

Changes in DPP Supplier Type:

At this time, we recommend that a beneficiary not be permitted to switch from a virtual provider to a community based provider and vice versa. This will be for the duration of Year 1 and will be assessed for Year 2 of the demonstration

Changes in Beneficiary Health Status and DPRP Eligibility:

In the event that a beneficiary becomes pregnant and/or develops type 2 diabetes, they are no longer eligible to receive DPP services through this demonstration. DPP suppliers should notify the MCOs of change in health status and program eligibility status. Additionally, DPP suppliers should refer the beneficiary to their MCOs and provide resources, if appropriate, for Diabetes Specific Self-Management Education programs. DPP suppliers may indicate to beneficiaries who become pregnant that they may resume DPP classes postpartum, if they have not developed diabetes.

For this demonstration, if a DPP supplier chooses to fund individuals who leave the demonstration by switching to a non-demonstration MCO, the DPP supplier must ensure that these individuals' data is removed from the demonstration's evaluation data[28] and that no demonstration funding is used for services rendered after they have left the demonstration.

For this demonstration, if a DPP supplier chooses to fund individuals who leave the demonstration by switching from HealthChoice (MCOs) to Medicaid Fee-for-Service, the DPP supplier must ensure that these individuals' data is removed from the demonstration's evaluation data[28] and that no demonstration funding is used for services rendered after they have left the demonstration.

Disclosure for Changes in Eligibility and Health Status:

Maryland Medicaid and the Center for Chronic Disease Prevention and Control drafted a disclosure related to changes in eligibility and health status. This disclosure has been incorporated into the informed consent, and was submitted as a protocol modification to the MDH IRB for review. This protocol modification for the revised informed consent with disclosure has been approved, and MCOs have been provided with an English and Spanish version of the disclosure and the revised informed consent.

For those beneficiaries already enrolled, MCOs will provide the disclosure on MDH letterhead as a separate communication either by email or hard copy. MCOs should monitor the distribution of this disclosure, via date and method of distribution and name of recipient. The disclosure does not require a signature from the beneficiary, the DPP or the MCO. This should not affect enrollment or participation in classes.

For those beneficiaries that wish to enroll MCOs will provide the revised informed consent, which requires a signature. MCOs need to either modify their online enrollment webpage to include the updated version of the informed consent and/or begin providing the revised informed consent in hard copy form to eligible beneficiaries.

This does not affect the MCOs' and DPP's current eligibility verification process. Please see below for the English and Spanish version of the disclosure.

Disclosure: If you become pregnant or are diagnosed with diabetes during this program, you may no longer be eligible to participate in this program; please talk with your diabetes prevention program lifestyle coach about your options. If you change Maryland HealthChoice MCO plans or no longer

qualify for Medicaid coverage during this program, you may no longer be eligible to participate in the diabetes prevention program through this demonstration program. If you have made such a change, and are unsure of your eligibility to continue, please talk with your diabetes prevention program lifestyle coach.

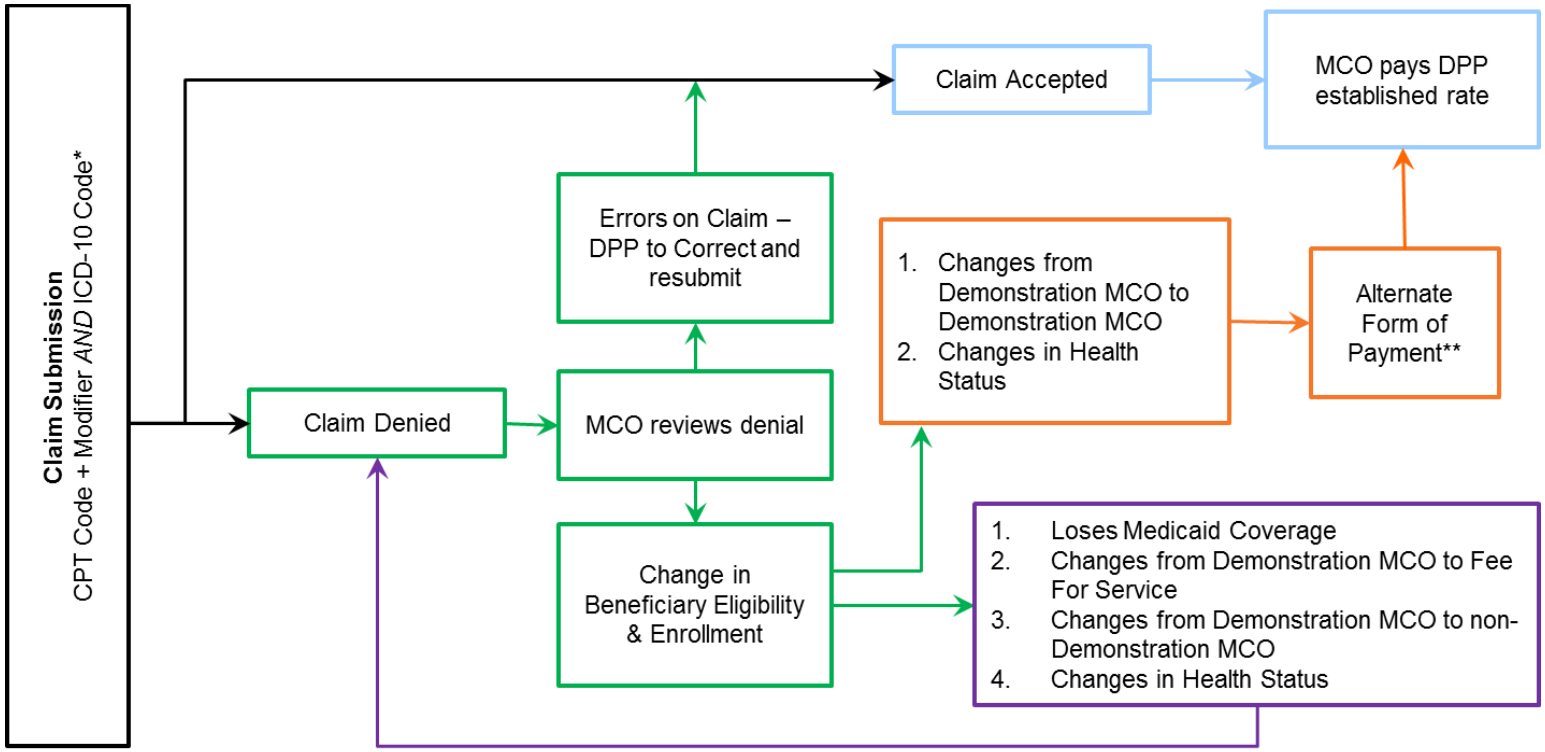
Exoneración de responsabilidad: Si usted cambia de planes Maryland HealthChoice MCO o ya no califica para cobertura de Medicaid durante este programa, es posible que usted ya no sea elegible para participar en el programa de prevención de la diabetes a través de este programa de demostración. Si usted ha hecho tal cambio, y no está seguro (a) de su elegibilidad para continuar, por favor hable con su entrenador de estilo de vida del programa de prevención de diabetes. Si se embaraza o es diagnosticada con diabetes durante este programa, es posible que usted ya no sea elegible para participar en el programa; favor de hablar con su entrenador de estilo de vida del programa de prevención de diabetes para discutir sus opciones.

Appendix F: Claims Preparation, Submission, and Receipt Protocol for Demonstration

	Referral Diagnosis	Diagnosis ICD-10 Code	Place of Service	CPT Code	Modifier	Diagnosis Pointer	Charge	Units
Session 1	Elevated Blood Glucose **AND** Body Mass Index*	A. R73.01+ B. Z68.25-Z68.45	99	0403T		A.B	$90	1
	History of Gestational Diabetes **AND** BMI	A. Z86.32 B. Z68.25-Z68.45						
Core	Elevated Blood Glucose Level	A. R73.01			TF	A	$5	1
	History of Gestational Diabetes	A. Z86.32						
Post Core	Elevated Blood Glucose Level	A. R73.01			TM	A	$6	1
	History of Gestational Diabetes	A. Z86.32						
Core Weight Loss	Elevated Blood Glucose Level	A. R73.01			TF,TS	A	$27	3^
	History of Gestational Diabetes	A. Z86.32						
Core Weight Loss	Elevated Blood Glucose Level	A. R73.01			TM,TS			
	History of Gestational Diabetes	A. Z86.32						

Claims Submission Process

*BMI as assessed by the DPP
+ Please see Appendix A for list of ICD-10 codes related to elevated or abnormal blood glucose levels
^Assumes a 3% weight loss



*Please see Chapter 4 for CPT code, modifiers and ICD-10 codes
**May vary by MCO and/or DPP supplier

Appendix G: Stakeholder Identification and Analysis

STAKEHOLDER	INTERESTS	INFLUENCE	NEEDS	EXPECTATIONS
MDH - Maryland Medicaid 1. Office of Planning 2. Office of Health Services	High - Participating in Demonstration	High - Participating in Demonstration	High - To design and implement reimbursement model and provide support to participating MCOs and DPP suppliers	High - Demonstration of health and social benefit to the beneficiary, as well as return on investment for Medicaid and MCOs, and ability to replicate and sustain health insurance reimbursement model
MDH – Center for Chronic Disease Prevention and Control (CCDPC)	High - Participating in Demonstration	High - Participating in Demonstration	High - To design and implement reimbursement model and provide support to participating DPP suppliers and MCOs	High - Demonstration of health and social benefit to the beneficiary, as well as the ability to replicate and sustain health insurance reimbursement model
Participating HealthChoice Managed Care Organizations: 1. Amerigroup 2. Jai Medical Systems 3. MedStar Family Choice 4. Priority Partners	High - Participating in Demonstration	High - Participating in Demonstration	High - To implement reimbursement model and provide feedback, as well as support participating DPP suppliers and beneficiaries	High - Demonstration of health and social benefit to the beneficiary, as well as return on investment for Medicaid and MCOs, and ability to replicate and sustain health insurance reimbursement model
Participating DPP Suppliers: 1. Brancati Center for the Advancement of Community Care • Charm City Clinic • Knox Presbyterian • Zion Baptist • Chase Brexton Health Systems • Baltimore Medical Systems at St. Agnes • Owensville Primary Care • John Hopkins Healthcare at Glen Burnie 2. MedStar Good Samaritan Hospital	High - Participating in Demonstration	High - Participating in Demonstration	High - To implement reimbursement model and provide feedback, as well as support participating MCOs and beneficiaries	High - Demonstration of health and social benefit to the beneficiary, as well as the ability to replicate and sustain health insurance reimbursement model

STAKEHOLDER	INTERESTS	INFLUENCE	NEEDS	EXPECTATIONS
3. MedStar Franklin Square Hospital 4. MedStar Harbor Hospital 5. OMADA 6. Retrofit 7. Soul So Good/Collins Wellness Center 8. Y of Central Maryland 9. YMCA of Metropolitan Washington				
National Association of Chronic Disease Directors (NACDD)	High - Provided funding for the demonstration	High - Provided funding for the demonstration	High - To provide support to demonstrations states, as well as oversight per contract	High - Demonstration of the ability to replicate and sustain a health insurance reimbursement model for DPP suppliers
Centers for Disease Control and Prevention (CDC)	High - Provided federal fund to NACDD for the demonstration	High - Provided federal fund to NACDD for the demonstration	High - Sustainable health insurance reimbursement model for National DPP suppliers	High - Demonstration of the ability to replicate and sustain a health insurance reimbursement model for DPP suppliers
Research Triangle Institute (RTI) International	High - Evaluator for the demonstration	High - Evaluator for the demonstration	High - Program implementation to align with data needs	High- Data for evaluation
Leavitt Partners, LLC	High - Provided technical assistance for the demonstration	High - Provided technical assistance for the demonstration	High - Required strength, weaknesses, opportunities and threats	High - Provide assistance in addressing weaknesses and threats, as well as use information provided to develop a toolkit for replication guidance
MDH – Leadership: 1. Secretary of Health 2. Deputy Secretary for Health Care Financing/ Medicaid Director 3. Chief Medical Officer for Health Care Financing 4. Deputy Secretary for Public Health Services	High - Provided support for the submission, design and implementation of the program	High - Offered guidance on the implementation and design of the program	Medium - High level information on demonstration's progress	Medium- Demonstration of health and social benefit to the beneficiary, as well as return on investment for Medicaid and MCOs.
MDH - Key Advisory or Operational Leadership Committees 1. Maryland	Medium - Participating MCOs' leaders will have greater interest on project	Medium - Suggest improvements for program implementation	Medium - High level information on demonstration's progress	Medium- Demonstration of health and social benefit to the beneficiary, as well as

STAKEHOLDER	INTERESTS	INFLUENCE	NEEDS	EXPECTATIONS
Medicaid Advisory Committee (MMAC) 2. Managed Care Organizations (MCO) Liaisons 3. Managed Care Organizations (MCO) Medical Directors 4. Quality Assurance Liaison Committee (QALC)				return on investment for Medicaid and MCOs.
Statewide Maryland DPP Suppliers	Medium - Interested in the progress and outcomes	Medium - Additional suppliers of DPP	Medium - To understand health insurance reimbursement, claims submission and processing, health insurance types and how to change business model	Medium - Replicate model and switch from a grant based business model to a reimbursement model
Eligible MCO beneficiaries	Medium - Interested in health service covered by the demonstration	Medium – Determines the need for health service covered by the demonstration	Medium - To understand the health service covered by the demonstration	Medium - To have an improved health outcome
Centers for Medicare and Medicaid (CMS)	Medium- Interested in the program design, implementation, progress, and outcomes	Medium - has the ability to determine the health benefits and associated reimbursement for Medicaid	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model, as well as understand return on investment for health insurance providers
Provider Groups and Associations	Medium - Interested in the progress and health outcomes	Low- Medium - Some providers participating in the demonstration may be members of these groups and/or associations	Medium - To understand varying health insurance reimbursements, referral workflows, impact on quality reporting and programs, and how to embed in business model	Medium - - To use DPP suppliers as a health resource for patients and to learn about and use resources, such as continuing medical education (CMEs) and referral workflows for practice transformation, and impact on quality reporting and billing.
Other State Medicaid Programs	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model, as well as understand return on investment for health insurance providers
Other State Public Health Programs	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and	Medium - Replicate model, as well as understand return on investment for health

STAKEHOLDER	INTERESTS	INFLUENCE	NEEDS	EXPECTATIONS
			evaluation of the demonstration	insurance providers
Local Health Departments	Medium	Low - Not participating in the demonstration	Medium - To increase awareness of the demonstration	Medium - To use DPP suppliers as a health resource for the community
Health & Wellness Community Based Organizations	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model and switch from a grant based business model to a reimbursement model
Chronic Disease Management Programs	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model and switch from a grant based business model to a reimbursement model
The Center for Older Adult Wellness	Medium - Interested in program data reporting needs	Low - Not participating in the demonstration	Medium - Increase awareness of demonstration and associated reporting needs	Medium - To support DPP suppliers using Workshop Wizard to report their health outcome data to CDC
Non-participating HealthChoice Managed Care Organizations	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model, as well as understand as well as return on investment for health insurance providers
Commercial Health Insurance	Medium - Interested in the progress and outcomes	Low - Not participating in the demonstration	Medium - To understand information on the planning, implementation and evaluation of the demonstration	Medium - Replicate model, as well as understand as well as return on investment for health insurance providers
MDH - Maryland Medicaid: 1. Office of Systems, Operations & Pharmacy (OSOP) 2. HealthChoice and Acute Care Administration 3. Office of Health Services 4. Office of Finance 5. University of Maryland Baltimore County (UMBC) - Hilltop Institute	Medium - Provided focused technical assistance	Medium - Offered guidance that may impact design and implementation	Low - Has no needs or expectations for the demonstration	Low - Has no needs or expectations for the demonstration
MDH - Public Health Services	Medium - Provided focused technical	Low - Not participating in the	Low - Has no needs or expectations for the	Low - Has no needs or expectations for the

STAKEHOLDER	INTERESTS	INFLUENCE	NEEDS	EXPECTATIONS
1. Center for Tobacco Prevention and Control	assistance	demonstration	demonstration	demonstration

Appendix H: List of Federal Regulations - Credentialing and Contracting

Network Provider, Subcontractor and Provider

1. **42 CFR 438.2 - Definitions**:
   "Network provider means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement."

   "Subcontractor means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP."

   "Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services."

Federal Regulations for Fraud Protections

2. **Section 1921 of the Social Security Act: "**Section 1921 was enacted to provide protection from unfit health care practitioners to beneficiaries participating in Medicare and State health care programs and to improve the anti-fraud provisions of these programs. Information collected and disclosed by the NPDB under Section 1921 includes State licensure and certification actions against health care practitioners, entities, providers, and suppliers; negative actions or findings by peer review organizations and private accreditation organizations; and certain final adverse actions taken by certain State agencies, including State law enforcement agencies, State Medicaid fraud control units, and State agencies administering or supervising the administration of State health care programs. These final adverse actions include exclusions from a State health care program, health care-related criminal convictions and civil judgments in State court, and other adjudicated actions or decisions specified in regulations."

3. **Section 1128E of the Social Security Act**: "The original purpose of Section 1128E was to establish a national data collection program, formerly known as the HIPDB, to combat health care fraud and abuse. Section 1128E information is now collected and disclosed by the NPDB and includes certain final adverse actions taken by Federal agencies and health plans against health care practitioners, providers, and suppliers. These actions consist of Federal licensure and certification actions, exclusions from participation in a Federal health care program, health care-related criminal convictions and civil judgments, and other adjudicated actions or decisions specified in regulations."

Statutes Related to Provider Enrollment and Credentialing[96]

4. 42 CFR § 438.214 - MCO, PIHP and PAHP Standards: Provider Selection
5. 42 CFR § 438.230 - Subcontractual relationships and delegation
6. 42 CFR § 438.3 – Standard Contract Requirements
7. 42 CFR § 438.608 – Program Integrity Requirements under Contract
8. 42 CFR § 455.400 – 470 - Program Integrity: Medicaid - Provider Screening and Enrollment

[96] 42 CFR §430-456. Medical Assistance. Retrieved from: https://www.law.cornell.edu/cfr/text/42/chapter-IV/subchapter-C

Appendix I: Medicaid and National DPP Demonstration Secondary Outcomes Evaluation IRB Determination 17-71

MARYLAND
Department of Health
Institutional Review Board · 201 W. Preston St. · Baltimore, MD 21201
Carol Johnston, APRN, PMH, BC, Chair

February 9, 2018

Sian Goldson-Desabaye, DrPH, MPH
Planning Administration, Ofc. of Health Care Financing
MDH
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201

REF: Protocol **#17-71**

Dear Dr. Goldson-Desabaye:

Your proposal entitled, "Medicaid and National Diabetes Prevention Program (DPP) Demonstration Secondary Outcomes Evaluation: Medicaid's Return on Investment with DPP" was received by the Institutional Review Board (IRB) and processed by expedited review. It has been determined that your proposal qualifies as exempt research in accordance with 45 CFR 46.101(b)(5). No further IRB review is necessary unless you modify the proposal.

Thank you for your responsiveness to this Board and continued success in future endeavors. If you have any questions, please feel free to contact Gay Hutchen, IRB Administrator at 410-767-8448.

Sincerely,

Carol Johnston, APRN, PMH, BC
Chairperson
Institutional Review Board

cc: IRB Members
Medicaid

health.maryland.gov • Toll Free: 1-877-463-3464 • TTY: 1-800-735-2258
health.maryland.gov/oig/irb • Institutional Review Board : 410-767-8949 • Fax: 410-333-7194

Appendix J: Medicare Diabetes Prevention Program (MDPP) Proposed Rule - Maryland Department of Health Comments - FINAL 09.05.2017

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

September 1, 2017

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8016
Baltimore, Maryland 21244-8013

BY ELECTRONIC DELIVERY

RE: Maryland Department of Health Response to the Centers for Medicare and Medicaid Services Medicare Diabetes Prevention Program Expanded Model Proposed Rule (CMS-1676-P)

Dear Secretary Price and Administrator Verma:

The Maryland Department of Health (the Department) is pleased to submit comments and recommendations regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program - Section K: Medicare Diabetes Prevention Program Expanded Model," published in the Federal Register on July 21, 2017 (82 Fed. Reg. 33950).

These comments were jointly developed by three entities within the Department with complementary roles in diabetes prevention: the Medicaid Planning Administration, the Office of Population Health Improvement and the Center for Chronic Disease Prevention and Control.

The Planning Administration is housed within the Office of Health Care Financing, which administers Maryland's Medicaid program. In addition to leading Maryland's Medicaid and National Diabetes Prevention Program (DPP) demonstration project, which is referenced later in these comments, the Planning Administration represents Medicaid's perspective in the implementation of Maryland's innovative All-Payer Model.

The Office of the Deputy Secretary for Public Health Services oversees both the Center for Chronic Disease Prevention and Control (part of the Prevention and Health Promotion

Administration) and the Office of Population Health Improvement. The Center for Chronic Disease Prevention and Control (the Center) provides a comprehensive focus on building and scaling the National DPP by leading a statewide effort to integrate diabetes prevention in all Maryland communities. Toward this end, the Center delivers guidance, technical assistance and networking opportunities for Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) organizations, as well as lending diabetes prevention expertise to the Medicaid demonstration project. The Office of Population Health Improvement seeks to improve the health of Marylanders through the integration of a high-performing public health system with value-based health care to improve the health of communities and achieve the Triple Aim: improving the patient experience of care; improving population health and reducing the cost of health care.[1]

The Department can offer a number of lessons learned, stemming from its experience with the National DPP. The Department views the resulting Medicare rule as setting the precedent for other payers as well; therefore, facilitating the statewide scale-up of the National DPP will require alignment of DPP administration across payers to the extent possible. The Medicare DPP should build on these lessons learned to improve access to DPP suppliers, reduce administrative burden and increase the participation of referring providers.

Diabetes Prevention Program Network in Maryland

The Center has prioritized diabetes prevention as an area of focus since 2009 and has devoted resources to building capacity for the National DPP since its introduction in 2012. There are currently 60 DPRPs in 22 Maryland jurisdictions; 1,526 participants have enrolled in Maryland's DPPs since 2012. The Center is enhancing statewide DPP infrastructure through a network of DPP suppliers, increasing the number of health systems with established referral systems and raising awareness through prevention campaigns and targeted messaging. The Center established an interactive referral website for bidirectional communication with DPP suppliers and health care providers, which also provides a data collection tool for the DPRPs to track and report mandatory CDC data.[2]

Leveraging Maryland's network of DPP suppliers and collaborative success, the National Association of Chronic Disease Directors, through a cooperative agreement with the CDC, awarded funding to the Department in July 2016 for a two-year demonstration. The project aims to test approaches to offering sustained coverage of the National DPP to Maryland Medicaid enrollees served by managed care organizations (MCOs). With this funding, Maryland Medicaid engaged four MCOs and nine DPP suppliers to provide the National DPP lifestyle-change

[1] Berwick, D., Nolan, T., and Whittington, J. (2008). The triple aim: Care, health and cost. *Health Affairs* 27(3): 759-769.

[2] Maryland Department of Health (n.d.). Welcome to BeHealthyMaryland.org. Retrieved from www.behealthymaryland.org.

program to Medicaid enrollees at risk for type 2 diabetes. The DPP suppliers include both virtual and community-based CDC DPRP lifestyle-change programs.

As of July 2017, 338 Medicaid beneficiaries have enrolled in Maryland's Medicaid DPP demonstration. During the second year, the project will focus on sustainability for both the Department and the MCOs. Many of the following comments and recommendations for the Medicare DPP proposed final rule have been derived from lessons learned through this demonstration project.

Comments and Recommendations

The Department is supportive and enthusiastic about the launch of the proposed benefit to cover the DPP for Medicare beneficiaries at high risk of diabetes. The alignment of the benefit's implementation in April 2018 with the CDC's recently-proposed DPRP standards will allow DPP suppliers to prepare for enrollment as Medicare suppliers, as well as to complete the Medicare Advantage health plan credentialing process. However, the Department would like to call attention to aspects of the proposed rule that may adversely impact Medicare beneficiaries, create administrative burdens for both referring providers and Medicare DPP suppliers and impair the transition of the Medicare DPP to an all-payer, statewide approach. The Department's comments surrounding sustainability, quality, access and cost are categorized into the following areas: 1) Network Adequacy; 2) Credentialing and Re-credentialing; 3) Administrative Burden; and 4) Beneficiary Enrollment and Retention. A more detailed description of comments and recommendations for each of these categories is outlined below.

Network Adequacy

A robust DPP supplier network is imperative to ensure program success and facilitate beneficiary freedom of choice. Both the single mode of delivery (in-person, community-based) and the reimbursement model proposed in this rule could act as barriers to achieving network adequacy and thereby adversely affect beneficiary freedom of choice in Maryland.

Potential Shortage of In-Person and Exclusion of Virtual DPP Suppliers

- ***Allow alternative modes of delivery to be implemented—such as virtual DPP suppliers and hybrid virtual and community-based models—to participate on the implementation effective date for the Medicare DPP (April 1, 2018).***

Maryland has approximately 932,023 Medicare beneficiaries, including 134,199 who are dually-eligible for Medicare and Medicaid.[3] Of these Medicare beneficiaries, potentially 48.3 percent

[3] Centers for Medicare and Medicaid Services (June 2017). 2015 Medicare Enrollment Section. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2015/2015_Enrollment.html.

are at risk for type 2 diabetes and would be potentially eligible for the Medicare DPP.[4] While there are 60 DPRPs in Maryland, only three are currently fully-recognized CDC DPRP lifestyle-change organizations. An anticipated 26 DPP suppliers could potentially meet preliminary recognition status in Maryland, per the fidelity standards in place by the CDC DPRP. DPP supplier requirements need to also take into account the limitations in access due to lack of transportation, shortage of in-person offerings, health concerns, disability, transient lifestyles and geographic limitation (*i.e.,* rural versus urban areas).

The proposed rule excludes virtual DPP suppliers and only allows for only the in-person, community-based delivery model. Exclusion of virtual DPP suppliers from the Medicare DPP would limit Maryland's ability to achieve sufficient DPP network capacity to serve all eligible Medicare beneficiaries. Notwithstanding increasing demand, the Medicare population is transient, making difficult the provision of services in a single location. For example, in 2015, 6,629,205 Medicare beneficiaries were hospitalized nationwide, with 1,844,725 admitted to a skilled nursing facility.[5] Additionally, approximately four percent of Medicare beneficiaries change their place of residence seasonally ("snowbirds"), and 49 percent of this population utilizes health care services in both their winter and summer locations.[6] Finally, Medicare beneficiaries may have transportation limitations due to health concerns or disability or may travel for extended periods of time in retirement.

Offering only a single mode of delivery, in the form of in-person, community-based Medicare DPPs, will not be sufficient to support the health needs of Medicare beneficiaries. This also affects the one-time benefit limitation (see "Beneficiary Enrollment and Retention," below). Offering a virtual DPP option addresses freedom of choice, consumer demand and the flexibility necessary for Medicare beneficiaries to continue their Medicare DPP course in different locations.

Key findings thus far in the Maryland Medicaid DPP demonstration project show that Medicaid MCOs, in serving individuals with social risk factors, have seen participants choose and successfully enroll in virtual DPP models—of the 338 enrolled, approximately 276 selected a virtual DPP supplier. While final evaluation results will not be available until June 2018, preliminary evidence strongly indicates the virtual DPP model is successful in weight loss and engagement. Eighty-five percent of participants completed nine or more core sessions by week 16, and 40 percent experienced the targeted weight loss goal of five percent or more. Among

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[4] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2017.

[5] Centers for Medicare and Medicaid Services (June 2017). 2015 Medicare Utilization Section. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2015/2015_Utilization.html.

[6] Jeffrey, M., Meier, S., Abraham, J., Wolfson, J., and Kane, R. (2016). Healthcare Service Use of Elderly Seasonal Migrators [abstract]. Philadelphia, PA: American Society of Health Economists Conference.

participants who completed four or more core sessions by week 16, 36 percent experienced a weight loss of five percent or more.

The Department understands the potential challenges to program integrity within the virtual model, including the difficulty in verifying reported weight loss of a Medicare beneficiary. One option could include requiring beneficiaries in virtual DPPs to weigh in at an in-person location or via live video conference to ensure program integrity and protect DPP suppliers and Medicare from potential fraud. However, these challenges are not insurmountable, and the Department would like to reaffirm its view that Medicare reimbursement,be available for virtual DPP suppliers along the same timeline as for in-person and community-based DPP suppliers.

Align Payment Structure with Federal Actuarial Findings and Regional Differences

- ***Rebalance the proposed reimbursement structure to increase payments in the first year to reflect the cost to matriculate beneficiaries through the DPP curriculum, as per the analyses conducted by the CDC and the CMS Office of the Actuary.***
- ***Consider varying the payment structure for DPP suppliers in differing markets in which DPP suppliers operate, given the potential effect region may have on operating costs.***

The proposed payment structure should support the administrative and operational costs of the Medicare DPP suppliers based on the governance structure stipulated by the CDC's DPRP standards to ensure fidelity to the model and network adequacy, as well as assure success for both beneficiaries and DPP suppliers.

Under the proposed rule, the payment structure reimburses on a range of $125 to $410, based on a beneficiary's attendance and weight for the one-year DPP in-person program. However, both the CDC and the CMS Office of the Actuary determined actual costs to be higher. According to the CDC, the full curriculum—to matriculate one beneficiary through the one-year DPP curriculum—in a community-based setting costs approximately $500, excluding start-up costs.[7] The corresponding figure indicated by the CMS Office of the Actuary was $450.[8] The significant disparity between the proposed reimbursement methodology and actual needed investment would impact measured outcomes, success for the beneficiary and fidelity to the program, in addition to reducing the cost effectiveness and efficiency of the program.

Additionally, the proposed rule does not account for regional differences in cost. Any business, including a DPP supplier, relies on varying market analyses based on region—such as urban

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[7] Centers for Disease Control and Prevention (2017). National Diabetes Prevention Program: Manage Costs. Retrieved from https://www.cdc.gov/diabetes/prevention/employers-insurers/manage_costs.html.

[8] Centers for Medicare and Medicaid Services, Office of the Actuary (2016). Certification of Medicare Diabetes Prevention Program. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf.

versus rural—and on factors such as environment, legislation and competition. These business processes result in differing administrative and operational costs based on region and organizational structure that, if not addressed through the Medicare DPP payment structure, will impact Medicare DPP sustainability and network adequacy.

Finally, the significant infrastructure required by the Medicare DPP rule, as proposed, and the associated administrative costs to sustain a one- to three-year DPP course will create a burden to most community-based DPP suppliers. Cost may act as a barrier for potential, small or new DPP suppliers to participate in the Medicare DPP. As a result, the proposed payment structure may be inadequate to support DPP suppliers and may be biased towards more resourced organizations and DPP suppliers. This further restricts an already limited in-person DPP supplier network and reduces the opportunity for DPP competition.

Establishing National Credentialing Standards for Lifestyle Coaches

- ***Establish a national standard for credentialing and re-credentialing of lifestyle coaches.***

The proposed credentialing process needs to align with the provider enrollment and credentialing process for private insurers that offer Medicare Advantage plans, as well as with the Medicare final rule on provider and supplier enrollment, which requires screenings such as licensure checks and checks across state lines.[9] The proposed rule does not address how DPP suppliers will verify the validity of the lifestyle coaches' certifications, or how to account for the verification of certification for lifestyle coaches across state lines or differences between services and certification requirements due to individual state provisions or regulations. The Medicare DPP will serve as a model for other payers and should thereby account for any state-level guidance that has been or may be developed for non-Medicare payers. Other payers typically evaluate qualifications of providers and suppliers, including certifications received. The proposed rule does not identify a central body to verify the validity of the lifestyle coaches' certifications or to protect against fraud.

Instead, the proposed rule assigns credentialing responsibility to Medicare DPP suppliers, including oversight and guaranteeing the quality and sufficiency of individual lifestyle coaches; otherwise, suppliers could face sanctions up to the possibility of losing CMS-approved Medicare DPP supplier status. Proper oversight of lifestyle coaches through a credentialing process is essential to ensuring high quality, consistent delivery and fidelity of the Medicare DPP to Medicare beneficiaries, as well as to meeting program integrity standards and requirements.

A centralized credentialing and re-credentialing process is essential for sustainability of DPP efforts in Maryland. Maryland's experience with the Medicaid DPP demonstration yielded a

9 "Medicare, Medicaid, and Children's Health Insurance Programs (CHIP); Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" dated February 2, 2011 (76 Fed. Reg. 5862).

request from participating MCOs for a national credentialing standard as essential to meeting Maryland state standards; this would also apply to other payers and other states. Additionally, a standardized credentialing process for lifestyle coaches protects Medicare and beneficiaries from fraud, ensures subsequent updates to CDC's DPRP standards are adequately addressed through training and ensures all lifestyle coaches meet the same minimum standard. CMS might consider utilizing CDC or a CDC designee, such as the National Committee for Quality Assurance or the National Commission for Health Education Credentialing, to conduct and managed the lifestyle coach credentialing process.

A national standard would indicate all essential requirements are met by the lifestyle coaches in DPP supplier organizations. Potential requirements could include: 1) training is received using an approved DPP curriculum from an approved DPP master trainer; 2) coaches complete a required number of training classes and hours; 3) training occurs within designated timeframe before re-credentialing—such as annually—to remain in good standing; and 4) for re-credentialing, continuing education credits are offered and have been obtained. A national credentialing and re-credentialing standard should include a tracking database that can act as a reliable source for all payers, providing access to verify lifestyle coach credentials, ensuring quality of care for Medicare beneficiaries and protecting Medicare from potential fraud.

Administrative Burden

The proposed rule increases the administrative burden of the Medicare DPP suppliers by requiring multiple data submissions and the use of disparate tracking systems.

Potential Mis-alignment of Multiple Data Submissions

- ***Align the data collection method and submission process to both agencies to minimize the burden on the DPP supplier.***

The proposed rule requires suppliers to submit DPRP-required data not only to CDC but also, through a crosswalk tool, to CMS. Multiple data submissions requiring different data points and submission systems constitute an administrative burden to all DPP suppliers, particular potential, small or new suppliers.

Use of Multiple Tracking Systems

- ***Conduct the following processes at the federal level, ideally in one system: 1) documenting whether an individual has previously participated in a DPP course, and 2) integrating checks on prior DPP services and end stage renal disease.***

In the proposed rule, CMS noted, "We are considering ways to streamline the sharing of information between suppliers, such as through the development of a model tracker that logs the contact information of a beneficiary's previous supplier and/or coach, and the beneficiary's attendance and weight loss." The Department recommends that CMS develop such a tracker to assist Medicare DPP suppliers' determinations regarding whether a beneficiary has taken a DPP

class before. CMS may also consider leveraging state and local HIEs, where they exist, to reduce this administrative burden.

CMS requires DPP suppliers to check two different systems: 1) the HIPAA Eligibility Transaction System, to verify if a beneficiary has end stage renal disease (ESRD); and 2) a standardized tracking system. The latter has been proposed by CMS; however, the Department is not aware if it has yet been developed and applied to beneficiaries who have already received the DPP benefit. For potential, small and new DPP suppliers that typically have limited staff, the proposed administrative processes may be burdensome.

The Medicare DPP proposed rule asks for comment on ways Medicare DPP suppliers could verify if potential Medicare DPP beneficiaries have already received Medicare DPP services. Statewide health information exchanges (HIEs), such as Maryland's Chesapeake Regional Information System for our Patients (CRISP), may be able to determine the feasibility of developing and implementing health IT-driven solutions for this purpose. As an illustration, as a condition of Medicare DPP eligibility, DPP suppliers could search Medicare beneficiary information in a state or local HIE to check for previous DPP engagement; CRISP's master patient index capability would allow this information to be seen across health systems. Claims for Medicare DPP reimbursement could be held until cross-verified in the HIE. Additionally, the proposed evaluation compliance crosswalk (424.205(e), p. 683) to be maintained in an Excel or CSV file could be potentially onerous for Medicare DPP suppliers. This process should be automated as soon as possible to reduce burden and the potential for errors; health IT functionalities could support this automation.

Documenting and Tracking Beneficiary Engagement Incentives

- ***Remove the requirements for documenting and tracking beneficiary engagement incentives, as the technology retrieval requirements are onerous and non-productive on many levels.***
- ***Integrate the documentation of beneficiary engagement incentives into the claims submission process.***
- ***Develop one service code or modifier that describes incentives provided or a limited number of codes to capture the different types of beneficiary engagement incentives category.***

Overall, the Department appreciates CMS provisions around beneficiary engagement incentives for Medicare DPP; however, CMS should consider the administrative burden posed by the documentation and tracking requirements.

CMS proposes that DPP suppliers track and document technology given as beneficiary engagement incentives. The technology retrieval requirements and returned equipment have limited value to the ongoing work and effort of DPP suppliers. In addition to contacting

individuals who may have discontinued their participation in the program, DPP suppliers would have to develop processes for maintenance, documentation and tracking of inventory, which most likely would require a separate, perhaps manual, system from their existing DPP documentation systems. Moreover, technology quickly becomes obsolete, especially since the rule requires any technology to be the minimum necessary to advance clinical goals. The technology may be returned damaged and no longer usable for re-deployment. The technology retrieval requirements have the unintended consequence of a level of effort investment with marginal returns.

Additionally, the documentation requirements have all the same variables of a claims submission; this could be achieved by adding a 'non-covered' (or otherwise) HCPCS service code(s) or code modifier(s) to the billing coding structure detailed in the proposed rule. Such a code or code modifier would reflect that a beneficiary engagement incentive had been provided during one of the Medicare DPP service periods. This would: 1) reduce the administrative burden to the DPP supplier; 2) promote the use of automation in health care administration; 3) promote program integrity safeguards through the Medicare claims system; 4) mitigate the risk of incentives as an inducement for DPP supplier selection; and 5) support the comprehensive evaluation of the use of incentives in Medicare DPP.

Separately, in the Medicaid DPP demonstration, some MCOs and DPP suppliers have experienced success using retail gift cards with this socially at-risk population; participants use the retail gift cards at their discretion to buy healthy food, scales, pedometers, work-out shoes and clothes. Use of such incentives may also reduce the burden to DPP suppliers, as not all direct service suppliers have the capacity to buy equipment in sufficient quantities or to buy different types of items that anticipate each beneficiary's need. In lieu of gift cards, DPP suppliers could offer gym memberships as part of their programs, to support beneficiaries in achieving weight loss goals—32 percent of participants in the Medicaid DPP demonstration indicated a gym membership would support their meeting DPP goals.[10] Other examples include telecommunications technology (cell phones, minutes or cell phone apps), program supports (scales or pedometers) and barrier reductions (on-site child care or transportation).

Beneficiary Enrollment and Retention

- ***Consider a waiver for the once-per-lifetime benefit in certain cases, such as hospitalization or long-term rehabilitation.***

As previously indicated, Medicare beneficiaries are likely to be hospitalized or required short- or long-term rehabilitation stays in skilled nursing facilities. The proposed rule dictates that Medicare DPP is an once-in-a-lifetime benefit; however, it does not account for health issues that may interrupt or prohibit attendance for an extended period of time. This consideration would

[10] Jacobs, S, Elkins, W, and Porterfield, D. (2017). Medicaid National Diabetes Prevention Program Demonstration: Pre-Program Participant Survey Brief. Research Triangle, NC; RTI International.

maximize the provision of the full Medicare DPP benefit and support the continuity of care to Medicare beneficiaries.

Conclusion

The Department commends CMS on its commitment to expanding this critical intervention to improve health outcomes within the Medicare population. The Department looks forward to observing the successful implementation of the Medicare DPP, as it will pave the way toward achieving all-payer alignment of DPP provision in Maryland. Based on Maryland's experience with its Medicaid and National DPP demonstration, flexibility in payment structure and reduced DPP supplier administrative burden are essential markers of success and sustainability. The Department encourages CMS to strongly consider these comments and recommendations as it finalizes the Medicare DPP rule. Please do not hesitate to contact us if further information or clarification is required.

Sincerely,

Tricia Roddy
Director
Planning Administration
Health Care Financing

Donna Gugel
Director
Prevention and Health Promotion Administration
Public Health Services

Appendix K: National Diabetes Prevention Program (DPP) Pilot – An Excerpt from the §1115 HealthChoice Waiver Amendment - FINAL 07.02.2018

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

June 29, 2018

Mr. Tim Hill
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Hill,

The Secretary of Health is requesting an amendment to Maryland's §1115 HealthChoice demonstration to: 1) cover National Diabetes Prevention Program (National DPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age; 4) expand the cap of the Assisted Community Integration Services; and 5) remove the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program Pilot

A waiver will allow the Department to enable HealthChoice managed care organizations (MCOs) to offer National DPP, an evidence-based, Centers for Disease Control and Prevention (CDC)-established program, on a limited basis to eligible participants. This will allow the Department to evaluate the delivery of National DPP via the HealthChoice MCOs and ensure the desired outcomes are achieved.

Adult Dental Pilot Program

A waiver will allow the Department to offer limited dental services, with an overall spend cap per person, to those eligible for both Medicaid and Medicare services ("dual-eligible" participants), 21 through 64 years of age. The Department's objective in seeking this amendment is to determine whether offering an adult dental benefit will improve health outcomes for this vulnerable population.

Expansion of Substance Use Disorder Residential Services

The Department is requesting expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis by seeking to extend coverage for ASAM level 4.0 (Medically Managed Intensive Inpatient services).

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Expansion of Assistance in Community Integration Services (ACIS) Pilot Cap

During the current HealthChoice §1115 Waiver Amendment public comment period, the Department received a request to increase the approved cap. Local government agencies provide general funds for the ACIS. Baltimore City has requested the opportunity to provide additional local funds to expand the program. Based on the supporting data and justification, the Department is requesting an additional 300 participant places for the ACIS Pilot, increasing the total annual cap to 600 participants.

Family Planning Program

The Department seeks to remove the family planning program per Chapters 464 and 465 of the Acts of 2018 (HB0994/SB0774) passed by the Maryland General Assembly, where the Department must apply for a State Plan Amendment (SPA) to expand the eligibility and access to the Family Planning Program.

The Department looks forward to working with CMS to develop a program that will provide high quality, cost-effective care for Medicaid enrollees. Thank you for considering our proposal. If you have any questions, please contact Tricia Roddy, Director of the Planning Administration, at 410-767-5809 or tricia.roddy@maryland.gov.

Sincerely,

Dennis R. Schrader
Chief Operating Officer & Medicaid Director
Maryland Department of Health

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Maryland HealthChoice Program
§1115 Waiver Amendment

Submitted by
Maryland Department of Health

July 2, 2018

Maryland Section 1115 Waiver Amendment Submission

Introduction and Objectives

The Maryland Department of Health (the Department) is pleased to submit this §1115 waiver amendment application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in July 1997 under authority of a waiver through §1115 of the Social Security Act. The initial waiver was approved for five years. In January 2002, the Department completed the first comprehensive evaluation of HealthChoice as part of the first §1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during State Fiscal Year (SFY) 1997, the final year without managed care. The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, 2013, and 2016.

This amendment would authorize the Department to: 1) cover National Diabetes Prevention Program (National DPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age; and 4) expand the annual cap of the Assisted Community Integration Services. The Department further seeks the removal of the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program Pilot

Introduction

The National DPP Pilot would enable HealthChoice managed care organizations (MCOs) to provide the National DPP, an evidence-based, Centers for Disease Control and Prevention (CDC)-established program, on a limited basis to eligible participants beginning in February 2019. Maryland seeks to leverage its extensive knowledge and experience in developing a delivery system for the National DPP within HealthChoice MCOs, gained through work on a two-year demonstration funded through the National Association of Chronic Disease Directors (NACDD) via a cooperative agreement with the CDC, as described below.

Before implementing on a larger scale, the Department is requesting to continue operating the National DPP as a pilot. This will allow the Department to evaluate the current demonstration and ensure the desired outcomes are achieved.

Background and Evidence

Recognizing the critical need to prevent diabetes in the Medicaid population and the growing importance of all-payer alignment and improving population health, Maryland successfully applied in 2016 for funding through NACDD to demonstrate ways of offering the National DPP to the Medicaid population through MCOs. The Department, in collaboration with the CDC, implemented a delivery model for the National DPP to 639 Medicaid participants with four of Maryland's nine HealthChoice MCOs (Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners). With the two-year

demonstration concluding June 30, 2018 and demonstration services ending on January 31, 2019, The Department seeks to continue to provide service coverage to HealthChoice participants through this §1115 waiver amendment. Final Departmental approval will follow review of the demonstration's evaluation, to be published by RTI International on September 30, 2018.

The CDC found that health care costs are 2.3 times higher for those with diabetes compared to those without diabetes. Maryland Medicaid claims (2016) show that 9.5 percent of the HealthChoice population 18 to 64 years of age have type 2 diabetes. The Hilltop Institute at the University of Maryland, Baltimore County (The Hilltop Institute), which serves as Maryland Medicaid's data and claims warehouse, found that the average health care spending for participants with diabetes is approximately $24,387 per participant per year.[1] Thus, the health care cost of the adult HealthChoice population with diabetes is approximately $1.6 billion annually. A peer-reviewed study indicated that if untreated, 5 to 10 percent of those with prediabetes will convert to type 2 diabetes annually.[2] The conversion from prediabetes to diabetes is estimated to cost the Department between $10 and $20 million annually. The Department estimates that providing National DPP to eligible participants would cost $500 per member per year.

National DPP

The National DPP is a structured year-long program intended for adults 18 years of age and older who have prediabetes or are at high risk for developing type 2 diabetes. It includes lifestyle health coaching through weekly and monthly classes that teach skills needed to lose weight, become more physically active, and manage stress. People with prediabetes who take part in this evidence-based, CDC-established structured lifestyle change program can cut their risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years.[3] This is the result of the program helping people lose 5 percent to 7 percent of their body weight through healthier eating and 150 minutes of physical activity per week.

The National DPP includes an initial six-month phase where at least sixteen (16) weekly sessions, including make-up sessions, are offered over a period lasting at least 16 weeks and no more than 26 weeks. The second six-month phase must consist of at least one session each month and six (6) sessions total. Each session must be at least one hour long.

National DPP Eligible Population

To qualify for the DPP Pilot, adults (18-64) must be enrolled in HealthChoice MCOs and meet CDC Diabetes Prevention Recognition Program's (DPRP) criteria for eligibility which are as follows:

INCLUDE: 18 years or older; **AND**

1) Overweight or obese (have a BMI of $\geq$ 25 kg/m^2 ($\geq$ 23 kg/m^2, if Asian)

[1] The Hilltop Institute. (2016). Briefing report: An examination of service utilization and expenditures among adults with diabetes enrolled in Maryland's Medicaid Managed Care program. Baltimore, MD: The Hilltop Institute, University of Maryland Baltimore County.

[2] Tuso, P. (2014). Prediabetes and Lifestyle Modification: Time to Prevent a Preventable Disease. *The Permanente Journal*, *18*(3), 88–93. http://doi.org/10.7812/TPP/14-002.

[3] The Diabetes Prevention Program Research Group. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 346 (6): 393-403.

AND EITHER 2) Elevated blood glucose level **OR** 3) History of gestational diabetes mellitus (GDM);[4]

AND NEITHER 4) Diagnosed with type 1 or type 2 diabetes; **NOR** 5) Currently pregnant.[5]

National DPP Suppliers—Lifestyle Coaches

Lifestyle coaches, who have been trained on the current version of the CDC-approved National DPP curriculum, or Prevent T2 curriculum, will implement this curriculum. This curriculum is designed to offer effective lifestyle change methods for preventing or delaying onset of type 2 diabetes and provide support and guidance to participants in the program.

Lifestyle coaches will have the ability to deliver the program (or specific components within the program) in a way that increases the capacity of participants to make and sustain positive lifestyle changes. This includes understanding and being sensitive to issues and challenges for participants trying to make and sustain significant lifestyle changes.

National DPP Modes of Delivery

Organizations may offer the program through different delivery modes as defined by CDC's DPRP Standards. The Department proposes allowing two of the four CDC-recognized delivery modes: in-person and online.

1. **In-person.** Year-long lifestyle change program delivered 100 percent in-person for all participants by trained Lifestyle coaches; participants are physically present in a classroom or classroom-like setting. Lifestyle coaches may supplement in-person sessions with handouts, emails, or texts, although none of these may be the sole method of participant communication. Organizations that conduct make-up sessions over the phone, online, or via some other virtual modality are still considered to be delivering the program in-person
2. **Online.** Year-long lifestyle change program delivered 100 percent online for all participants; participants log into course sessions via a computer, laptop, tablet, or smartphone. Participants also must interact with Lifestyle coaches at various times and by various communication methods including online classes, emails, phone calls, or texts.

Reimbursement Methodology

For the CDC-funded demonstration, the Department worked with four MCOs to develop a reimbursement methodology. Subsequently, Medicare is now covering DPP services through Medicare Diabetes Prevention Program (MDPP) Expanded Model. The Department is working with stakeholders to develop a reimbursement methodology based on the CDC's average cost for National DPP and MDPP Expanded Model, which aligns payment with the CDC's evidence-based weight loss and attendance milestones.[6]

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[4] This refers to a 1)Fasting glucose of 100 to 125 mg/dl ; 2) Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl; 3) A1c of 5.7 to 6.4; or 4) Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy.

[5] Centers for Disease Control and Prevention (CDC). (2018) Centers for Disease Control and Prevention Diabetes Prevention Recognition Program: Standard Operating Procedures. Retrieved from: https: //www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf.

[6] 82 Fed. Reg. 52976. (2017). Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program. Retrieved from: https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions; Centers for Disease Control and Prevention (CDC). (2016). National Diabetes Prevention Program: Implement a Lifestyle Change Program. Questions and Support: Frequent

The reimbursement model may include the use of modifiers in conjunction with Healthcare Common Procedure Coding System (HCPCS) codes to distinguish between the in-person and online delivery modes, and to facilitate evaluation of the program by delivery mode. A key difference between the Department's pilot program and Medicare is the coverage of online providers. The Department believes this is a critical piece in designing an effective program for Medicaid recipients.

The Department plans on offering grants to MCOs in order to operate the program. The MCOs who have participated in the CDC-pilot will be prioritized in the award process. The Department will work with the MCOs to receive National DPP utilization information.

Evaluation Design

The National DPP has been shown to reduce the risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years, as well as producing cost savings.[7] The Department anticipates a reduction in incidence of diabetes and other related health care costs. Maryland's annual HealthChoice evaluation will be modified to include an evaluation to determine the effect(s) of National DPP participation on: (a) utilization of emergency medicine services; (b) all-cause hospital admission; (c) medications; (d) total cost of care (per member per month); and (e) incidence of diabetes.

Outcomes of interest will be evaluated for the 24 months prior to National DPP enrollment, during National DPP participation, and for the first phase of this study, in the 12 months after National DPP participation. Health outcomes and costs will also be compared between groups of National DPP participants utilizing attendance and percent of weight loss.

Budget Neutrality

The Department and the Department of Budget Management (DBM) have allocated an initial budget of $700,000 Total Funds annually to provide National DPP services to eligible Medicaid participants in the HealthChoice program. This would limit the number that could be served annually to 1,400 participants. Based on DBM approval, this may be increased up to $1.4 million Total Funds annually, which could serve up to 2,800 participants.

Questions about Offering a Program. What can organizations do if they feel that the cost of participating in a CDC-recognized lifestyle change program is too burdensome for participants? Retrieved from: https://www.cdc.gov/diabetes/prevention/lifestyle-program/questions_support.html.

[7] The Diabetes Prevention Program Research Group. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 346 (6): 393-403; Centers for Medicare and Medicaid Services (CMS). (2016). Certification of the Medicare Diabetes Prevention Program (Memo). Baltimore, MD: Office of the Actuary, Centers for Medicare and Medicaid Services. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf

Table 1. Anticipated Participants Served with Funding Allocation of $700K - $1.4M

	State FY2019	State FY2020
Total National DPP Allocation	$700,000	$1,400,000
Per Member Per Month	$41.67	$41.67
Estimated Number of Participants Served	1,400	2,800