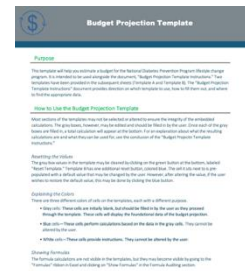
Budget Projection Template Instructions (Medicaid Version)

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

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

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



Budget Projection Template

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Step #1: Choose a Reimbursement Model

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

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

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

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

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

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

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

Template A:
Fee-for-Service Model

Template B:
Attendance Milestone and Performance-Based Combination Model

Step #2: Determine Reimbursement Fees

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

Template A: Examples of Fee-for-Service Fees

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

Step #2: Determine Reimbursement Fees

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

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

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

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

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

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

Attendance Milestone

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

Step #2: Determine Reimbursement Fees

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

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

In Step #2 of Template B in the *Budget Projection Template*, shown above, the user may fill in fee amounts of their choice. Some of the fee amounts used in California and Illinois include:

	California	Illinois
1st session attended	$20	$180
4th session attended	$40	$150
9th session attended	$72	$140
> 16 sessions (core maintenance)	Varies depending on weight loss (see Reimbursement Models for Medicaid Agencies and MCOs page)	Varies depending on weight loss (see Reimbursement Models for Medicaid Agencies and MCOs page)

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

Performance-Based Component

In a performance-based reimbursement model, CDC-recognized organizations may receive a pre-determined reimbursement amount if specified outcomes have been met. There are multiple designs to carry this out. Under one example, once an enrollee achieves 5 percent weight loss from baseline weight, the provider will be reimbursed the performance-based amount; however, if weight loss is not achieved, no performance-based reimbursement will be given. Under a different example, the provider may be

reimbursed on a sliding scale, and as each additional percentage of weight is lost from the baseline, a level of pre-determined reimbursement amount will be given.

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

Weight Loss Outcome	Amount
5% weight loss	

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

- Medicare Diabetes Prevention Program
    - $145 when 5 percent weight loss is achieved from baseline weight
    - $25 when 9 percent weight loss is achieved from baseline weight
    - $8 for 5 percent weight loss maintenance from baseline weight in months 7-12

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

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

Example of Combining Fee-for-Service and Performance Components

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

Medicare DPP Reimbursement Model:

HCPCS G-Code	Description*	Payment
G9886*	Behavioral counseling for diabetes prevention, in-person, group 60 minutes	$25
G9887*	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	$25
	Subtotal Maximum Fee-For-Service Payment (22 Sessions)	**$550**
G9880	5 percent weight loss (WL) achieved from baseline weight	$145
G9881	9 percent WL achieved from baseline weight	$25
G9888**	Maintenance 5 percent WL from baseline in months 7-12	$8
G9890	Bridge Payment	$25
	Total Maximum Payment	**$768**

*Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period:

Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)

Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)

**Suppliers must submit claim for 5 percent WL (G9880) prior to submitting claims for the maintenance 5 percent WL from baseline in months 7-12 (G9888).

Step #3: Determine Estimated Enrollment

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

Program-Eligible Medicaid Beneficiaries

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

Step #3: Determine Estimated Enrollment

a. Enter the number of program-eligible individuals.

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

There are two suggested methods to calculate this number:

- **State Medicaid claims or Electronic Health Records (EHR) data extraction**. Through data extraction, the user can pull the exact number of Medicaid beneficiaries in their state who meet the eligibility criteria. This is the most accurate method to estimate the total number of

eligible beneficiaries. Helpful suggestions on how to use this method are found on the *Screening and Identification for Medicaid Agencies and MCOs* page of the Coverage Toolkit.

- **1/3 of the adult Medicaid population**. When state-specific Medicaid claims data or EHR data is inaccessible, the user may use a substitute calculation of 1/3 of the adult (18+) Medicaid population in their state. This is the approximate rate of the national adult population who has prediabetes. Because the Medicaid population may be more likely to have prediabetes than the non-Medicaid population, this calculation may underestimate the total number of eligible beneficiaries. However, it may still be used as an estimate. Note: This calculation also requires pulling the state's total adult (18+) Medicaid enrollment number.

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

Risk Level	Percentage of Individuals with Prediabetes	10-Year Type 2 Diabetes Risk	Risk Indicators	Recommended Intervention
Very High	**15%**	>30%	A1c > 5.7% FPG > 110	Structured lifestyle intervention in a community setting
High	**20%**	20% - 30%	FPG > 100 National DPP score 9+	
Moderate	**30%**	10% - 20%	2+ risk factors	Risk counseling
Low	**35%**	0% - 10%	0-1 risk factors	Build healthy communities

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

Enrolled Beneficiaries

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

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

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

In Step 3b of the *Budget Projection Template*, shown above, users will enter an estimate of the percent of the eligible individuals identified in Step 3a who will enroll in the program. The number of enrolled beneficiaries is those individuals who attend at least one session (not including a session zero or discovery

session, which is an informational session often used to assess readiness and commitment to the program). When estimating this number, the following estimations may be used:

- **User Choice.** Given the user's understanding of their Medicaid population, they may be able to estimate the percentage of beneficiaries who will enroll in a year-long lifestyle change program after recruitment efforts have been made.
- **10 – 15 percent.** Anecdotally, many organizations estimate that about 10 – 15 percent of eligible individuals will enroll in the program. It is often said to enroll 100 people, outreach must be made to 1000 people.
- **15.6 percent.** Denver Health, Colorado's primary safety net institution, implemented the National DPP lifestyle change program in 2013. It found that 15.6% of recruited eligible beneficiaries enrolled in the program. However, it found that one in two prospective participants signed up if the caller mentioned that the patient's health care provider had asked them to call, versus one in ten from cold calls.[1]
- **15.4 percent, 20.4 percent, or 25.1 percent.** Across three different time periods, the Kentucky Employee Health Plan had 15.4, 20.4, and 25.1 percent of individuals enrolled and actively engaged in the program of those who had agreed to talk with a nurse during outreach.[2]

Rate of Retention

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

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

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

[1] Ritchie, N., Swigert, T. "Establishing an Effective Primary Care Provider Referral Network for the National Diabetes Prevention Program." AADE in Practice. 4: 4, pg. 20-25. Accessed here: http://journals.sagepub.com/doi/abs/10.1177/2325160316647707?journalCode=aipa

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

In Step 3d of the *Budget Projection Template*, pictured in the image above, users will estimate what percentage of enrolled individuals will attend 4+ sessions, 9+ sessions, and >16 sessions. The table below provides example retention rates based on two sources. The first source is the YMCA of the USA DPP 2015 Annual Report[3], published in March 2016 and supported by the Centers for Medicare and Medicaid Innovation's Health Care Innovation Awards. For additional data reports from this project, see CMS' Health Care Innovation Awards page. The second source is the Medicaid Coverage for the National DPP Demonstration Project, supported by CDC's Division of Diabetes Translation, managed by NACDD, and implemented in Maryland and Oregon.

Session	YMCA Retention Rate – Medicare Beneficiaries**	Medicaid Demonstration Project Retention Rate*
Enrollees in session 1	6,874	856
Attended 4+ sessions	83%	71.6%
Attended 9+ sessions	63%	53.7%
Attended >16 sessions	25%	28.6%

*The rates for the Medicaid Coverage for the National DPP Demonstration Project are based on total session attendance over the course of the evaluation period. Some enrollees were enrolled for as little as five months at the data collection deadline so rates are potentially lower than what would be expected during an actual implementation.

** There are unique considerations for Medicare and Medicaid populations that could impact projected retention rates. For example, the eligible Medicaid population is younger and more diverse than the Medicare population, and experiences higher rates of unemployment and partial employment than the general population. To achieve retention rates comparable to the Medicare population, organizations delivering the National DPP lifestyle change program to Medicaid beneficiaries may need to tailor programs to specific cultural communities and address health-related social needs (HRSN) like childcare, transportation, and mobility issues.

Weight Loss Achievement

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

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

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

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

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

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

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

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

Budget Projection Results

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

Template A:

Output: Total Estimated Cost*

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

Template B:

Output: Total Estimated Cost

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

The total estimated cost and the estimated average cost per participant can help the user develop their budget when adding the National DPP lifestyle change program as a newly covered benefit. This information may be used to determine an estimated return on investment (ROI), when used in combination with a type 2 diabetes cost avoidance calculation (which is not included in this document). These estimates may also be used to budget for future years and to negotiate and set rates with CDC-recognized organizations.

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

The **Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program** project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$4.2 million for grant year 6** with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

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