

Expanding Health Insurance Coverage in California for the National Diabetes Prevention Program

May 2016



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ACKNOWLEDGMENTS

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The authors would like to thank the teams at the North East Valley Health Corporation and the Montana Diabetes Program for their assistance in the development of this report.

This paper was developed by ChangeLab Solutions through a work order with the Los Angeles County Department of Public Health.

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Introduction

This report examines strategies for supporting diabetes prevention program (DPP) interventions, modeled after the Centers for Disease Control and Prevention's *National Diabetes Prevention Program (the National DPP)*. It provides stakeholders in California with information to help them promote the expansion of Medi-Cal coverage for DPP services.

The report is divided into four sections. The first three sections lay out general information about DPP and Medicaid coverage. The first section provides a short overview of the National DPP and the evidence base supporting the program; the second section summarizes the federal policy landscape related to insurance coverage for DPP interventions; and the third section provides an overview of insurance coverage for DPP at the state level. The fourth section focuses on California. The conclusion outlines several steps stakeholders can take to expand Medi-Cal coverage for DPP in California. A case study and model policy language are included in the appendices.



Background on the National Diabetes Prevention Program

Diabetes is a national epidemic. The number of cases increases substantially every year, as does the cost of treatment. There is a critical need to adopt proven programs that stem rising diabetes rates and reduce treatment costs. The National DPP is a year-long program; participants work with a trained lifestyle coach to learn the skills needed to make lasting lifestyle changes. It is based on a clinical research study led by the National Institutes of Health (NIH) and supported by the CDC. Since the NIH and CDC published the research in *The New England Journal of Medicine* in 2002,¹ the CDC and other national institutions have worked to expand participation in the program. Evidence shows that the National DPP enhances care and reduces diabetes risk. By preventing or delaying diabetes onset, the program also reduces health care costs.

DPP is a key strategy for supporting people with diabetes, who face serious health issues and steep treatment costs. Diabetes incidence is rising rapidly, and direct medical costs for those with diabetes are 2.3 times higher than costs for those without diabetes. In 2012, care for people with diabetes accounted for one-fifth of U.S. health care spending.^{2,3} In 2008, there were eight new cases of diabetes for every thousand people; by 2050, there will be 15 for every thousand. Total diabetes prevalence is expected to increase to over 25 percent of the adult population by 2050.⁴

According to the California Department of Public Health, one out of every 12 adults in California has been diagnosed with diabetes – more than 2.3 million people in total.⁵ Hispanics and African-Americans in the state are nearly twice as likely as non-Hispanic whites to have the disease.⁶ A recent study found that nearly half of adults in California have prediabetes, including 33 percent of adults ages 18 to 39, 49 percent of adults ages 40 to 59, and 60 percent of adults ages 55 and older.⁷ In 2012, California incurred more than \$27.5 billion in diabetes-related health care costs.⁸ Yet California spends less per capita on diabetes prevention than any other state.⁹

DPP has proven successful in reducing both short term and long term diabetes risk. One study found that diabetes incidence among the study participants decreased by 58 percent following the lifestyle intervention.^{10,11} Another study found that ten years after the start of the intervention, diabetes incidence among study participants decreased by 34 percent.¹²

DPP and related efforts also have economic benefits. DPP creates cost savings, provides a substantial return on investment, and makes economic sense for payers. Research has established that DPP “provides good value for the money spent”¹³ and has proved that lifestyle interventions result in long-term economic returns. Indeed, studies have found that DPP lowers health care costs, with average savings ranging from \$4,250 to \$6,300 per participant over a ten-year period.¹⁴⁻¹⁶ Increased participation in the program would likely produce even greater returns on investment. It is important to note, however, that most research about DPP’s efficacy has looked at its effect on the general population. Additional, more specific research is needed to assess DPP’s effectiveness within populations covered by Medicaid.

Spreading the National DPP: One Safety-Net Provider's Experience

It will take more than health insurance coverage to expand access to DPP particularly to underserved communities although coverage is a primary concern. To illustrate the challenges faced by safety net providers who want to offer DPP to their patients, consider the experience of Northeast Valley Health Corporation (NEVHC) in Los Angeles County.

NEVHC, a Federally Qualified Health Center (FQHC) located in California's San Fernando and Santa Clarita valleys, is one of the nation's largest community health centers. Its mission is to provide quality, safe, and comprehensive health care to the medically underserved residents of Los Angeles County in a manner that is sensitive to the economic, social, cultural, and linguistic needs of the community. It has 14 sites, which include one mobile clinic, three school-based centers, four dental sites, and one pharmacy. Most of NEVHC's patients are low-income residents covered by Medicaid or Medicare.¹⁷

In 2015, NEVHC served 63,596 patients and provided 250,123 total medical and dental visits. Twenty-three percent of the patients NEVHC serves say they are best served in a language other than English. Ninety-eight percent live below 200 percent of the federal poverty level (FPL); 81 percent are below 100 percent of FPL; and 43.9 percent of the adults are uninsured.¹⁸ NEVHC also is the Women, Infant and Children's (WIC) local agency for the San Fernando and Santa Clarita valleys. WIC centers provide nutrition counseling, breastfeeding support and vouchers for WIC foods for pregnant and lactating women and their children under the age of 5. In 2015, NEVHC's WIC Program provided services to 60,040 clients.

NEVHC's Health Education Department offers patients education and self-management classes that cover a wide range of health conditions, including diabetes, asthma, weight management, and autism. Debra Rosen, Director of the Quality and Health Education Department, is deeply committed to connecting with patients and providing them with different approaches to managing chronic conditions. But she notes that it is an ongoing challenge to get patients to participate in health education programs, given their busy and often complicated lives.

For over four years, NEVHC has received funding from the WISEWOMAN Program, CDC-sponsored cardiovascular disease (CVD) risk reduction program for underinsured and uninsured women ages 40–64 years. The goal of WISEWOMAN is to implement interventions such as DPP to improve diet, increase physical activity and promote hypertension control, thus decreasing clinical CVD risk factors and optimizing participants' health. In March 2015, NEVHC started a DPP group as part of their WISEWOMAN work. The group's target population is patients diagnosed with prediabetes based on an A1C result of between 5.7 and 6.4. (The A1C test is a blood test that measures a person's blood glucose or blood sugar.) The DPP program takes 12 months to complete; participants meet weekly for the first six months, and then once or twice a month for the second six months. Twenty participants enrolled in NEVHC's first DPP group, but only three completed the course.

In September 2015, the Los Angeles County Department of Public Health (LACDPH) funded NEVHC to expand DPP at their sites using a grant from the Centers for Disease Control and Prevention (CDC). As part of its work for LACDPH, the NEVHC team uses

CDC's public education materials and curricula for DPP delivery, and information logs among other resources. To date, NEVHC has organized three DPP groups and enrolled more than 70 patients. About half are on track to complete the year-long program. Patient participation and retention are improving, although it is still difficult to get patients to complete all the required sessions.

While the health education team at NEVHC is committed to offering DPP, they are clear about the challenges. Maria Guerrero, Program Manager, Health Education at NEVHC, notes that it is time-consuming and labor-intensive to meet enrollment targets for DPP classes. Members of NEVHC's health education team post flyers about classes at all NEVHC facilities, highlight the programs on social media and call at-risk patients individually. In addition, doctors refer patients and patients self-refer.

Although NEVHC has advertised DPP groups in English, to date, the sessions have been conducted in Spanish. NEVHC serves a large Latino population, and DPP participants have requested that the groups communicate in Spanish. Currently, NEVHC does not bill any payers for DPP services. They would like to be able to bill for DPP, which would make the program much more sustainable.

Patient retention is the greatest challenge to expanding DPP at NEVHC. Rosen and Guerrero say the two biggest barriers for current and prospective participants are lack of transportation to the sites and the time commitment the program requires. NEVHC is trying to address the challenges associated participant recruitment and retention by offering an online DPP class through Omada Health.¹⁹ NEVHC is part of an evaluative research study on whether an online DPP class can serve Medi-Cal and uninsured patients well. NEVHC plans to enroll one hundred patients in this program.

Despite hurdles in DPP implementation, the NEVHC team is committed to offering the program to their patients. Many members of their patient population are prediabetic, and DPP offers an evidenced-based strategy for delaying or preventing the onset of diabetes.

The following barriers currently serve to limit the uptake and diffusion of DPP, some of which are highlighted in the NEVHC example:

1. Lack of awareness about prediabetes and DPP among the general population
2. Inadequate supply of DPP providers who can offer linguistically and culturally appropriate care to patients
3. Lack of awareness among health care providers about DPP
4. Limited mechanisms for referring patients to a DPP provider and for billing payers for services
5. Lack of awareness among payers about DPP and its economic benefits
6. Need for expansion of insurance coverage for DPP
7. Lack of transportation and other support for low-income patients who wish to participate in DPP

This report focuses on expanding health insurance coverage for DPP through Medi-Cal, California's Medicaid program. The discussion, however, points to many of the other issues listed above, which should be addressed along with expanding insurance coverage.

THE U.S. PREVENTIVE SERVICES TASK FORCE AND THE COMMUNITY PREVENTIVE SERVICES TASK FORCE²³

The U.S. Preventive Services Task Force (USPSTF) and the Community Preventive Services Task Force are expert panels that make evidence-based recommendations about prevention interventions using data from scientific reviews. However, each panel focuses on different settings.

- The USPSTF makes recommendations about clinical prevention for patients. Clinicians and decision makers typically use the recommendations in health care settings. The USPSTF evaluates clinical services such as screening tests and preventive medications.
- The Community Preventive Services Task Force provides recommendations on interventions at the community level. The recommendations are used by a wide range of stakeholders at the local, state, and federal levels. This task force has evaluated community education programs, behavior change programs, organizational and legislative policies, and health systems interventions.

The USPSTF's recommendations directly influence health insurance coverage.

Federal Policy Landscape for DPP Coverage

Several provisions in the Affordable Care Act (ACA) can be used to support DPP coverage and expansion. The ACA identifies ten categories of health care services as Essential Health Benefits (EHB), which, with some exceptions, Medicaid must cover for new enrollees in states expanding their Medicaid programs. One of the Essential Health Benefits is "Preventive and Wellness Services and Chronic Disease Management."²⁰ The required preventive services in this category come from recommendations made by four expert medical and scientific bodies, including the U.S. Preventive Services Task Force (USPSTF), which has provided specific guidance on lifestyle interventions. In 2014, USPSTF recommended that lifestyle management programs like DPP be considered an EHB.²¹ However, within the "Preventive and Wellness Services" category, there is no requirement that plans cover DPP specifically, and most do not.²²

The ACA includes several potential funding sources for DPP coverage:²⁴

- *The Medicaid Incentives for the Prevention of Chronic Disease Grant Program:* The ACA established the Center for Medicare & Medicaid Innovation (CMMI) to test "innovative payment and service delivery models to reduce program expenditures... while preserving or enhancing the quality of care" for those on Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).^{25,26} In 2012, Montana's Medicaid Program and the Montana Department of Public Health and Human Services jointly received a Medicaid Incentive to Prevent Chronic Disease (MIPCD) grant to support DPP implementation. The grant was administered by CMMI, a division of the Centers for Medicare and Medicaid Services (CMS). Additionally, there have been calls for CMMI funding designated for diabetes prevention to increase the availability of DPP.²⁷
- *Prevention and Public Health Fund:* The Prevention and Public Health Fund, established by the ACA, supports both community-based prevention and efforts to prevent chronic disease, including diabetes, at the state, local, and community levels.²⁸ Some of this funding has supported DPP.²⁹
- *The National Diabetes Prevention Program (the National DPP):* The ACA established a grant program that funds local efforts to increase awareness about the CDC's National DPP.^{30,31} Groups have recommended that the National DPP be included as an EHB and adopted by state Medicaid programs and Medicare nationally.³²
- *Employers:* The ACA offers employers flexibility to provide eligible workers with financial incentives to participate in workplace wellness programs. These wellness programs could be linked to DPP.³³

Medicare Coverage for DPP

In March 2016, HHS announced that CMS' independent Office of the Actuary certified that DPP expansion would reduce Medicare spending and improve the quality of patient care without limiting coverage or benefits. These findings of cost-savings and improved quality are necessary in order for an intervention to be considered for Medicare coverage. The Office of the Actuary examined the results of the results of a DPP initiative led by the Y-USA which served eligible Medicare beneficiaries. The Y-USA's program demonstrated measurable cost savings of \$2,650 for each enrollee over a 15-month period. This is the first time that a preventive service model from the Center for Medicare & Medicaid Innovation has become eligible for coverage by the Medicare program.³⁴ HHS plans to release more information about Medicare coverage for DPP in Summer 2016.³⁵

State Policy Landscape for DPP Coverage

Despite evidence that DPP improves health outcomes and reduces health care costs, public and private insurance coverage for DPP is the exception rather than the rule. Since 2010, some private insurers, such as UnitedHealthcare and Anthem Blue Cross, have offered DPP as a covered benefit to their members. More recently, several states have included DPP as an option in health insurance plans for state employees; as of August 2015, those states were Colorado, Kentucky, Louisiana, Maine, Minnesota, New Hampshire, Ohio, and Washington.³⁶ Also states are starting to explore covering DPP through their Medicaid programs (discussed in more detail below), with Montana leading the way, having provided coverage for Medicaid recipients since 2012. Nevertheless, much more is needed to make DPP coverage the norm.

Medicaid

Medicaid is the public health insurance program that provides coverage for low-income Americans. It is administered by states, according to federal requirements, and has not traditionally focused on providing preventive care. To better align Medicaid with the ACA's prevention priorities, CMS recently expanded the definition of "preventive services [for which providers can be reimbursed]" to include services *recommended* by a physician or other licensed practitioner.³⁷ This change is significant for the expansion of DPP. Previously, only services a physician *provided* directly were reimbursable under Medicaid. The modification should make it easier for Medicaid to cover DPP and similar programs, which are run by health educators.³⁸

Under Medicaid, states may choose to cover services that go beyond federally required benefits. Each state prepares a Medicaid reimbursement plan, which is submitted to CMS. Modification of a state plan is known as a state plan amendment (SPA), and CMS must approve the change.³⁹ Only one state, Montana, explicitly covers DPP through its Medicaid program. A few other states have made limited resources available for DPP pilot programs through Medicaid waivers. These programs are described briefly below.



Montana's Medicaid Coverage for DPP

As the only state to date to provide DPP coverage to Medicaid recipients, Montana serves as the model for other states' Medicaid programs exploring DPP coverage. In 2010, the state conducted a health assessment of a sample of adult Medicaid beneficiaries and found that the Medicaid population was at higher risk for diabetes than the general state population.⁴⁰ The Montana Medicaid Program partnered with the Diabetes Program (both housed within the Montana Department of Public Health and Human Services) to apply for a Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Program grant from CMMI. Montana was awarded the grant in September 2011 and established coverage for DPP effective as of February 2012.⁴¹

To establish Medicaid coverage and reimbursement for DPP, the Montana agencies had to make two policy changes. First, the administrative rules that govern Medicaid in Montana had to be amended.⁴² Second, the Montana Medicaid program needed to request a state plan amendment from CMS. In Montana, the group working on DPP coverage drafted state plan amendment language, which was reviewed by the Montana Medicaid Program, the Regional Medicaid Office, and CMS staff.

Once CMS signed off on the plan amendment, the public discussed the issue at a hearing in March 2012 and approved the benefit in April 2012. The Medicaid Program and the Diabetes Program started implementing coverage the following month. (See Appendix 1: The Path to Medicaid Coverage for the Diabetes Prevention Program in Montana.)

Section 1115 Medicaid Waivers

Conversations about expanding Medicaid coverage for DPP frequently reference Section 1115 Medicaid waivers and Delivery System Reform Incentive Payment (DSRIP) programs as possible mechanisms to establish this coverage. Typically Section 1115 waivers and DSRIPs are used for driving widespread change within the health care system – not for focusing on a single intervention like DPP. As part of a package of broader changes within a state's health care system, Section 1115 Medicaid waivers may provide opportunities to expand DPP coverage.

Section 1115 Medicaid waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules.⁴³ Waivers have been used to expand coverage to former ineligible populations, enhance benefits packages, and drive delivery system reforms.⁴⁴ DSRIP programs are part of Section 1115 waiver programs, and provide states with significant funding that can support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were narrowly focused on funding safety net hospitals; however, they are increasingly being used to promote a more sweeping set of payment and delivery system reforms.⁴⁵

Two states, New York and Texas, have included coverage for DPP in their DSRIP initiatives as an optional program that providers may offer to patients.^{46,47} As of December 2015, only one health care provider that received funding under New York's DSRIP had identified DPP as part of its DSRIP plan.⁴⁸ DPP was not included in California's 2015 DSRIP application to CMS, and there is no reference to DPP in California's new Medi-Cal 2020 1115 waiver. In the future, PRIME, the section of California's new 1115 waiver that replaces the DSRIP program from the previous 2010 waiver, could provide an opportunity to support DPP. California's public hospitals or district hospitals could implement DPP as an optional PRIME project, but it is not mentioned or required.

Private Insurance Coverage for DPP

Some private insurers offer DPP as a covered benefit, most notably UnitedHealthcare. In 2010, UnitedHealthcare started providing DPP to its members in certain markets.⁴⁹ Since then, it has expanded its offerings, established a partnership with Y-USA, and set up a division called the Diabetes Prevention and Control Alliance, which markets Y-USA's DPP program to their members and other employers.⁵⁰ When the UnitedHealthcare and YMCA scaled up their DPP lifestyle interventions to create a national program, the insurance company predicted that savings from reduced medical spending for diabetes treatment would outweigh the initial costs of the intervention within three years.⁵¹ The Association of Health Insurance Plans identifies other insurance companies that provide DPP to their members in certain markets.⁵² Kaiser Permanente, for instance, offers DPP to its members.

As part of their efforts to increase access to DPP, many state-level diabetes coalitions have focused on increasing coverage for state employees. The state government is often a state's largest employer. Therefore, state employee benefit plans that cover DPP provide an important benefit to many people, set a precedent for other employers in the state, and ideally create a state-based success story about DPP that encourages other insurers to offer the benefit. As of August 2015, eight states covered DPP for state employees: Colorado, Kentucky, Louisiana, Maine, Minnesota, New Hampshire, Ohio, and Washington.⁵³

Private Insurance Coverage for DPP in California

In California, Kaiser Permanente provides a range of diabetes prevention services to its members, and has made a commitment to support DPP. As discussed above, United Healthcare also provides DPP to members in some markets. In February 2016, Anthem Blue Cross added DPP to the services it offers commercial members in California. CalPERS, the state employee benefit plan, is exploring the possibility of providing DPP to its members. The CalPERS board will consider a proposal to cover DPP in 2016. Nevertheless, many challenges stand in the way of significantly expanding coverage for DPP in the state, including the lack of CDC-certified providers. This barrier may be addressed somewhat through online DPP initiatives, such as Omada Health's program, Prevent.⁵⁴



Medi-Cal and DPP

Medi-Cal is California's Medicaid program. The California Department of Health Care Services (DHCS) administers Medi-Cal across the state. As discussed above, federal law lays out specific requirements for Medicaid coverage, but states have the discretion to decide which specific services to cover within a benefit category. Additionally, Medicaid-managed care plans can decide to cover interventions not covered by the state Medicaid program.⁵⁵

At the simplest level, Medi-Cal has two payment structures: fee-for-service (FFS) and managed care. In a fee-for-service payment structure, providers are paid for every allowable service they provide to patients. Managed care plans are organized to manage cost, utilization, and quality. There are many nuances to how Medi-Cal delivers and pays for services at the county level, but much of that detail is beyond the scope of this report.

Medi-Cal covers more than 13 million people in California, and approximately 80 percent of those individuals are in Medi-Cal Managed Care.⁵⁶ The remaining beneficiaries receive FFS Medi-Cal. DHCS lays out the terms of coverage for FFS Medi-Cal. Medi-Cal Managed Care Plans have the ability, within certain parameters, to choose to offer preventive services, such as DPP, to their members. Therefore, two paths could lead to the expansion of Medi-Cal coverage for DPP. First, proponents of DPP can encourage the Department of Health Care Services to cover DPP under the Medi-Cal program. Additionally, advocates for DPP can work with local Medi-Cal Managed Care Plans to push for DPP coverage.

Fee-for-service Medi-Cal

States have broad discretion to decide which services to cover under the state Medicaid program, and few states have clear standards for determining covered benefits.⁵⁷ A 2015 report commissioned by the California Health Care Foundation identified California as a state without a formal process for coverage determinations, but noted that "California officials reported a willingness to speak to anyone interested in raising a health intervention for coverage consideration."⁵⁸

DHCS will weigh the following factors when considering whether to cover a benefit:

1. How much does the intervention cost?
2. Does the proposed benefit make efficient use of limited Medi-Cal dollars?
3. What is the strength of the evidence supporting the intervention?
4. How much of an impact will the intervention have on the Medi-Cal population?

Before deciding to cover DPP, DHCS will need satisfactory answers to the questions above as well as the question of whether there are enough DPP providers to meet the needs of the Medicaid population. Because California's Medicaid population is so large, the cost of providing DPP may have budget implications that require approval by the state legislature.⁵⁹

Medi-Cal already covers comprehensive preventive services in other contexts. As advocates think about how to work with DHCS to expand DPP coverage, it is worth looking at the coverage of existing preventive programs. The Comprehensive Perinatal Services Program (CPSP) could serve as a model for how to structure a diabetes prevention program.

Appendix 2 lays out the basic steps for adding a benefit to the Medi-Cal program and provides model language to help illustrate the process for stakeholders.

CPSP became a Medi-Cal benefit in 1987. The state legislature enacted CPSP in 1984 in response to the OB Access Project's findings, which suggested that comprehensive public health support for soon-to-be mothers reduced both low-birth-weight rates and health care costs. The program provides a wide range of services to pregnant women on Medi-Cal, from conception through 60 days postpartum. In addition to standard obstetric services, women receive health education, nutrition counselling and psychosocial services. Medi-Cal Managed Health Care Plans are required to provide pregnant women who are eligible for Medi-Cal with "access to CPSP-comparable services."⁶⁰

Medi-Cal Managed Care

As noted above, Medi-Cal Managed Care Plans can choose to cover benefits the state does not require them to cover. Not all Medi-Cal Managed Care Plans are the same. DHCS currently recognizes four managed care models: County Organized Health System; Geographic Managed Care; Two-Plan Model; and Regional and County-Specific.

In determining whether to include DPP within the package of member benefits, individual Medi-Cal Managed Care Plans will consider many of the same factors as DHCS. Plan leaders will want to know the cost of the intervention; the return on investment; the strength of the evidence supporting the intervention; how the intervention works for the Medicaid population specifically; and the health benefits for plan members. Although senior managers play a critical role in determining what benefits to cover, it is very important to get buy-in from the Chief Medical Officer (CMO) of the Managed Care Plan. While a plan might be willing to cover DPP because of the strong evidence base, it will more likely be open to testing a pilot project, at least initially.

Counties with County Health Care Systems

Twelve counties, home to more than 60 percent of the California's Medi-Cal population, run their own health systems.⁶¹ In these counties, the county health care facilities (public hospitals and outpatient clinics) serve many Medi-Cal patients. It is important, therefore, to connect with representatives of the primary care or ambulatory care departments in a county's health care system and ensure they understand the value of DPP.

County facilities are natural allies in developing demonstration projects for DPP, and advocates can work with system leadership to promote DPP throughout the system. In addition, several other counties (Santa Barbara, Solano, Santa Cruz and Placer) have extensive primary care and specialty clinic services.

For a detailed description of the differences between these four models, see *Locally Sourced: The Crucial Role of Counties in the Health of Californians*. www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties

To identify which Medi-Cal Managed Care structure exists in a county as well as which plans provide Medi-Cal in a county, visit DHCS' online directory of managed care plans. www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

Conclusion and Recommendations

While momentum is building to expand coverage for DPP in private insurance plans, coverage through public insurance programs is extremely limited. Local public health departments and diabetes prevention coalitions can potentially partner with safety net providers in the county health care system to expand DPP coverage. They can also work with other community stakeholders and local Medi-Cal Managed Care Plans to help expand this important, evidence-based program.

The following recommendations may serve as action items for diabetes prevention coalitions working on DPP expansion.

County-Level Actions:

- Work with county health care systems to establish DPP demonstration projects to produce county-level data about DPP that will be persuasive to local Medi-Cal health plans.
- Look for opportunities to build relationships with local Medi-Cal health plan leadership and managers, and build support and funding for DPP.
- Provide information to health plans about DPP, and do not assume health plan staff or leaders are familiar with DPP or the role of a local health department in the provision of DPP.
- Consider the challenges and barriers Medi-Cal members might face in a year-long lifestyle management program, and be prepared to think through how to address those barriers with health plan staff.
- Research other demonstration projects the local Medi-Cal health plan has initiated, and see if connections can be made to DPP.

Cross-County Actions:

- Share information across counties about DPP provision and coverage. Currently two counties in California are receiving CDC 1422 funding to expand DPP – Los Angeles and San Diego.

State Level Actions:

- Work with the California Department of Health Care Services to expand coverage for DPP across the state. See Appendix 2: Model Legislative and State Plan Amendment Language on Including DPP in the Medi-Cal Program.

APPENDIX 1

The Path to Medicaid Coverage for the Diabetes Prevention Program in Montana

Along with health professionals across the country, the team at the Montana Department of Public Health and Human Services' Diabetes Program (Diabetes Program) watched in alarm as diabetes rates climbed between 1990 and 2010. The prevalence of diabetes among Montana adults increased from 2.8 percent in 1990 to 8.8 percent in 2014.⁶² In 2011 and 2012, an estimated 38 percent of adults in the state were at high risk for developing type 2 diabetes.⁶³ According to Sarah Brokaw, Manager of the Diabetes Program, diabetes was a problem in Montana – a problem that was only getting worse.

For years, the Diabetes Program team had been collecting data on diabetes rates and prediabetes rates in Montana, as well as information on the outcomes of specific prevention interventions. The team planned to make the case that the state's Medicaid program should cover diabetes prevention program (DPP) services.

The National Diabetes Prevention Program (the National DPP), which the Centers for Disease Control and Prevention (CDC) runs and operates, is an evidence-based lifestyle change program designed to identify prediabetes and prevent the onset of type 2 diabetes. During a year-long program, participants work with a trained lifestyle coach to learn the skills needed to make lasting lifestyle changes. The National DPP is based on a clinical research study led by the National Institutes of Health (NIH) and supported by the CDC.⁶⁴

DPP is a key strategy for supporting people with diabetes, who face serious health issues and steep treatment costs. Diabetes incidence is rising rapidly, and direct medical costs for those with diabetes are 2.3 times higher than costs for those without diabetes. In 2012, care for people with diabetes accounted for one-fifth of U.S. health care spending.^{65,66} Total diabetes prevalence is expected to increase between 25 percent and 28 percent by 2050.⁶⁷ DPP has proven successful in reducing diabetes risk in both the short term and the long term.

The Planning Process

In 2010, the Diabetes Program conducted a health assessment of a sample of adult Medicaid beneficiaries and found that the Medicaid population was at higher risk of diabetes than the general state population.⁶⁸ The Montana Medicaid Program partnered with the Diabetes Program (both housed within the Montana Department of

Public Health and Human Services) to apply for a Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Program grant from the Center for Medicare & Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS). Montana was awarded the grant in September 2011 and established coverage for DPP effective as of February 2012.

To make the case for DPP, the Diabetes Program team used state-specific data to show that DPP led to improved health outcomes. The data also showed that DPP was cost-neutral; in fact, it would likely lead to cost savings, based on the state's funding levels. The team analogized DPP to tobacco prevention and cancer screening, which are well-established, evidence-based prevention initiatives covered by Medicaid.

Policy Changes

To establish Medicaid coverage and reimbursement for DPP, the Montana agencies had to make two policy changes. First, the administrative rules that govern Medicaid in Montana had to be amended.⁶⁹ Second, the Montana Medicaid program needed to request a state plan amendment (SPA) from CMS. The group working on DPP coverage drafted state plan amendment language, which was reviewed by the Montana Medicaid Program, the Regional Medicaid Office, and CMS staff. Reviewers asked the Diabetes Program team the following questions about DPP:⁷⁰

- Is DPP evidence-based?
- Is DPP cost-effective, or at least cost-neutral?
- Adults enrolled in Medicaid cycle on and off Medicaid. How will this be addressed?
- Are the lifestyle coaches licensed health care professionals or non-licensed health care professionals?
- What criteria are used to determine whether an intervention site can be reimbursed for the service?
- How effective is the intervention among low-income populations?
- What are the outcomes among Montana adults who have received this service?

CMS presented the state with five additional questions which were specific to how Medicaid services are funded and delivered in Montana. Once the questions were answered to CMS' satisfaction, the public discussed the issue at a hearing in March 2012 and DPP coverage was approved in April.

Implementation and Outcomes

The team in Montana is committed to building the evidence base and studying program implementation and outcomes. The results of the program evaluation indicate that an adapted DPP can be effective for Medicaid populations. Of 983 adults enrolled in the Diabetes Prevention Program from July 2012 through June 2013, 12 percent were Medicaid beneficiaries. Compared with the non-Medicaid cohort, the Medicaid cohort was 9.4 years younger on average and had a significantly higher baseline body mass index (BMI). The Medicaid cohort attended slightly fewer core sessions and self-monitored fat intake for fewer weeks than did the non-Medicaid cohort. The average weight loss over the 16-week period of core sessions was 3.0 kg and 5.4 kg in the Medicaid and non-Medicaid cohorts, respectively. More non-Medicaid participants achieved the 7 percent weight loss goal (32%) than did Medicaid participants (17%).⁷¹

For Brokaw, the initial results have been promising. DPP can provide substantial health benefits for participants on Medicaid and may also provide positive financial return on investment for Medicaid. Montana's experience suggests that it is feasible to recruit adult Medicaid beneficiaries for DPP and sustain their participation. Data from Montana also shows Medicaid recipients achieve significant weight loss (although lower than that of older non-Medicaid participants).

Despite Montana's success, there have been challenges. DPP providers find the billing processes difficult to master. The Diabetes Program is addressing billing issues by having sites provide technical assistance to each other and by requiring that staff from the Medicaid Program answer providers' specific billing questions about hours, expenses, and frequency. Also, providers report that the process to get CDC recognition is hard; the team is seeking support from the CDC to improve the process.

Brokaw notes that more community education is needed about prediabetes and diabetes prevention to help encourage people enrolled in Medicaid to participate in the program. Patients identify several barriers that make it difficult to complete the program, including lack of transportation to the sites, the number of sessions the program requires, and the physical activity and nutrition tracking requirements, the length of the program, and the complexity of the program.

In Montana, the partnership between the Medicaid Program and the Diabetes Program has paved the way for other states to get Medicaid coverage for DPP. The same team is now working on securing state employee insurance plan coverage for DPP.

APPENDIX 2

Model Legislative and State Plan Amendment Language on Including DPP in the Medi-Cal Program

ChangeLab Solutions is a non-partisan, nonprofit organization that educates and informs the public through objective non-partisan legal analysis, studies and/or research. Appendix 2 lays out the basic steps for adding a benefit to the Medi-Cal program and provides model language to help illustrate the process for stakeholders. There is no intent to reflect a view on any specific legislation.

California could add DPP to its Medicaid state plan as a covered benefit – most likely characterizing DPP as a preventive service. This would require the following steps:

1. The legislature must pass authorizing legislation.
2. The Department of Health Care Services would have to develop and submit a proposal for CMS approval according to the processes set forth in regulation.
3. The state would likely engage in some period of negotiation with CMS.
4. CMS would ultimately approve the proposal, perhaps in modified form; and
5. California would implement the benefit in Medi-Cal by issuing guidance to providers and plans.

The model documents below are intended to provide stakeholders with general guidance about the state plan amendment process. In the event that the state embarks on a state plan amendment to cover DPP, these documents will need to be adapted to reflect current legal, practical and political considerations.

Model Authorizing Legislation to Extend Medi-Cal Coverage to DPP

This model legislative language is intended to serve as an illustration for stakeholders of the type of legislation needed to extend Medi-Cal coverage to DPP.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 14132 of the Welfare and Institutions Code is amended to read:

14132.

The following is the schedule of benefits under this chapter:

...

(ad) diabetes and cardiovascular disease prevention services are covered when medically appropriate and subject to utilization controls, when they are evidence based and likely to assist in preventing Medi-Cal beneficiaries from developing diabetes and cardiovascular disease.

- (1) For purposes of Medi-Cal diabetes and cardiovascular disease prevention services, the following definitions apply:*
 - (A) "After core program" means six consecutive monthly sessions.*
 - (B) "Core program" means 16 consecutive weekly sessions.*
 - (C) "Eligible beneficiary" means Medi-Cal beneficiary at high risk for developing diabetes or cardiovascular disease.*
 - (D) "Eligible provider" means Medi-Cal providers with licensed and trained health care professionals on staff delivering standardized curriculum and reporting data to the Department.*
 - (E) "Evidence-based intervention" means the Centers for Disease Control and Prevention's National Diabetes Prevention Program as adapted by the Department.*
- (2) Diabetes and cardiovascular disease prevention services include the following evidence-based intervention services:*
 - (A) Group nutrition counseling to prevent diabetes and cardiovascular disease; and*
 - (B) Physical activity coaching to prevent diabetes and cardiovascular disease.*
- (3) Services are provided to eligible beneficiaries in 16 core program weekly sessions and six after core program monthly sessions.*

Model State Plan Amendment Language to Extend Medi-Cal Coverage to DPP

After authorizing legislation is passed, the California Department of Health Care Services (DHCS) would need to submit a chart similar to one below to request a state plan amendment from CMS. Public health advocates may question why it is necessary to repeat the information twice as the language in the chart titled “Limitations on Attachment 3.1-A” is restated verbatim in “Limitations on Attachment 3.1-B”. Attachment 3.1-A refers to services for populations which the Medi-Cal program must cover under federal law. Attachment 3.1-B refers to additional groups which the Medi-Cal has chosen to cover.

The state plan amendment language would be submitted with Form CMS 179, “Transmittal and Notice of Approval of State Plan Material.”

Limitations on Attachment 3.1-A Page 18b		
STATE PLAN CHART		
TYPE OF SERVICE	PROGRAM DESCRIPTION	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
13c Preventive Services (Cont.) Services to prevent diabetes and cardiovascular disease	A. Medically necessary services to prevent diabetes and cardiovascular disease provided to people at risk for diabetes and cardiovascular disease: <ol style="list-style-type: none"> 1. Group nutrition counseling to prevent diabetes and cardiovascular disease 2. Physical activity coaching to prevent diabetes and cardiovascular disease B. Providers: <ol style="list-style-type: none"> 1. Licensed dietitians 2. Licensed nurses 3. Licensed physical therapists 4. Certified diabetes educators working under the direct supervision of a physician or other licensed practitioner 5. Exercise physiologists working under the direct supervision of a physician or other licensed practitioner 	Licensed dietitians and licensed nurses will provide services limited to group nutrition counseling and physical activity coaching medically necessary to prevent diabetes and cardiovascular disease. A physician or other licensed practitioner supervising a certified diabetes educator or exercise physiologist will assume professional liability for care of the patient and will furnish services within his or her scope of practice under State law. Services are provided to eligible beneficiaries in 16 core program weekly sessions and six after core program monthly sessions. The beneficiary must receive additional authorization to continue the six after core program monthly sessions, which will only be granted if the beneficiary demonstrates successful completion of the 16 core sessions.

Form CMS 179: Transmittal and Notice of Approval of State Plan Material

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB No. 0938-0193	
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER _____	2. STATE
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i>			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION		7. FEDERAL BUDGET IMPACT	
		a. FFY _____ \$ _____	
		b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i>	
10. SUBJECT OF AMENDMENT			
11. GOVERNOR'S REVIEW <i>(Check One)</i>			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL		16. RETURN TO	
13. TYPED NAME			
14. TITLE			
15. DATE SUBMITTED			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL		20. SIGNATURE OF REGIONAL OFFICIAL	
21. TYPED NAME		22. TITLE	
23. REMARKS			

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