



GUIDANCE DOCUMENTS
CATEGORY A

DP18-1815 COOPERATIVE AGREEMENT

*Improving the Health of Americans Through Prevention and
Management of Diabetes and Heart Disease and Stroke*

Table of Contents

Strategy A.1	Diabetes Self-Management Education and Support (DSMES) Access and Participation	1
Strategy A.2	Diabetes Self-Management Education and Support (DSMES) Coverage	4
Strategy A.3	Pharmacists: Medication Management; DSMES	7
Strategy A.4	Prediabetes Screening Testing and Referral	10
Strategy A.5	National DPP Coverage: Employers and Commercial Payers	14
Strategy A.5	National DPP Coverage: Medicaid	18
Strategy A.6	Increasing Participant Enrollment in CDC-Recognized Lifestyle Change Programs	25
Strategy A.7	Community Health Worker Sustainability	38

1815 Cooperative Agreement Guidance Document: Strategy A.1

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES): ACCESS & PARTICIPATION

Strategy A.1

Improve access to and participation in ADA-recognized/AADE-accredited DSMES programs in underserved areas

Intent of strategy:

The intent of this strategy is to increase access to and participation in American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited diabetes self-management education and support (DSMES) services in areas of the state that have limited access to DSMES, which should include areas where priority, high risk populations live and work. Recognized or accredited DSMES services meet national quality standards and are more likely to be sustained long term due to reimbursement by Medicare, many private insurance plans, and some State Medicaid agencies.

A large body of evidence supports the effectiveness of DSMES in improving health outcomes (A1c, systolic blood pressure), lowering medication use, and decreasing hospitalizations and other health care costs for people with diabetes (PWD).¹ However, DSMES utilization rates are low.

State health departments can partner with health systems and community organizations to increase DSMES access, patient referrals, and reimbursement. Activities should be anchored in 3 areas necessary for successful implementation and spread of DSMES: 1) supporting organizations in establishing ADA-recognized or AADE-accredited DSMES services, 2) establishing referral policies and practices in health care systems to efficiently connect PWD to DSMES services, and 3) raising awareness and enhancing the capacity of PWD to participate in DSMES.

Key terms/definitions related to Strategy A.1:

- Diabetes self-management education and support (DSMES): The ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards.^{2,3}
- Diabetes self-management support (DSMS): The support that is required for implementing and sustaining coping skills and behaviors needed to self-manage diabetes on an ongoing basis.²
- Diabetes self-management training (DSMT): The Centers for Medicare & Medicaid Services (CMS) uses the term “training” (DSMT) instead of “education and support” (DSMES) when defining the reimbursable benefit. This term relates specifically to Medicare billing.
- Recognition and accreditation: Recognition and accreditation help ensure that DSMES services offer quality education. CMS has authorized two organizations, the ADA and AADE, to grant recognition or accreditation for DSMES. ADA uses the term recognition, while AADE uses the term accreditation. The two terms essentially involve similar processes to evaluate DSMES services. Both organizations rely on the *2017 National Standards for Diabetes Self-Management Education and Support* ([2017 National DSMES Standards](#)).
- Umbrella DSMES ADA-recognized/AADE-accredited service: A DSMES service where an agency serves as the sponsoring organization to secure ADA-recognition or AADE-accreditation, managing all the certification requirements, while other agencies serve as multi-sites or branch sites to deliver DSMES.

Removing barriers to participation for high burden populations:

- Work with DSMES services to identify alternative locations convenient for both PWD and health care providers (telehealth, pharmacies, churches, libraries, community centers, and worksites, etc.).
- Explore ways to waive co-pays for DSMES.
To learn more about removing barriers to DSMES, refer to [Increasing Referrals and Overcoming Barriers to Participation](#) in the DSMES Toolkit.

Examples of state and community level activities:

1. Provide support to organizations delivering DSMES to assist them in obtaining ADA-recognition/AADE-accreditation (e.g. provide access to recognition/accreditation resources or consultants or other accredited DSMES sites that can offer guidance or mentoring). (Note: Cooperative agreement funds may be used to support the initial application fee for ADA-recognition or AADE-accreditation on a once in a lifetime basis per organization.)
2. Provide support to health care systems (federally qualified health centers [FQHCs]/community health centers [CHCs], local health departments [LHDs], and other safety net organizations serving vulnerable, high risk populations) to establish new ADA-recognized/AADE-accredited DSMES services.
3. Obtain a statewide umbrella license from the ADA or AADE for the state department of health to facilitate expansion of recognized/accredited DSMES services throughout the state.
4. Promote alternative locations for delivery of DSMES that are appealing to both patients and referring providers (e.g., telehealth, pharmacies, churches, community centers, etc.).
5. Integrate DSMES services/referrals into coordinated care (e.g. Patient-Centered Medical Homes).
6. Work with health care organizations/providers on building EHR-generated or other systems to facilitate and track referrals to DSMES and enhance decision support.
7. Work with partners to eliminate barriers to access to increase participation in DSMES services.
8. Engage community health workers to link people with diabetes to DSMES services.
9. Conduct targeted marketing and promotional activities for DSMES to recruit priority populations. (It is important to understand the barriers to DSMES access and utilization in these populations before embarking on marketing efforts.)

Activities not allowed in this strategy:

- Paying for DSMES start-up costs or participant fees/co-pays
- Paying for personnel time to provide DSMES directly to individuals
- Purchasing equipment to support delivery of DSMES via distance learning or telehealth

Performance measures for this strategy:

- Short term
 - A.1. # and proportion of new recognized/accredited DSMES programs
- Intermediate
 - A.8. # of people with diabetes with at least one encounter at an ADA-recognized/AADE-accredited DSMES program
- Long term
 - A.10. Proportion of people with diabetes with an A1C > 9 (goal is to decrease)

Technical assistance and training resources:

1. [DSMES Technical Assistance Guide](#): This tool identifies four key drivers that influence DSMES access and participation: 1) availability of DSMES services, 2) payers and payment mechanisms, 3) referral policies and practices, and 4) willingness of people with diabetes to participate in DSMES services.⁴
2. [DSMES Toolkit](#): The purpose of this toolkit is to increase access to and participation in DSMES services among PWD. The toolkit provides available resources and tools in one place to assist with the development, promotion, implementation, and sustainability of DSMES services.
3. [AADE Diabetes Education Accreditation Program \(DEAP\)](#): As one of the certifying organizations for DSMES, AADE offers an accreditation process based on the [2017 National Standards for Diabetes Self-Management Education and Support](#). ([2017 National Standards for DSMES](#))
4. [ADA Education Recognition Program \(ERP\)](#): As one of the certifying organizations for DSMES, ADA offers a recognition process based on the [2017 National Standards for Diabetes Self-Management Education and Support](#).

5. [2017 National Standards for DSMES](#): This article by the 2017 Standards Revision Task Force introduces the *2017 National Standards for Diabetes Self-Management Education and Support*. The Standards define timely, evidence-based, quality DSMES services that meet or exceed the Medicare diabetes self-management training (DSMT) regulations and assist those providing or wishing to provide DSMES.³
6. [Diabetes State Burden Toolkit](#): Use this tool to report the health, economic, and mortality burden of diabetes in your state.
7. [DSMES Joint Position Statement](#): This statement presents an evidence-based visual depiction of when to identify and refer individuals with type 2 diabetes to DSMES. The algorithm contained in the joint position statement defines four critical time points for delivery and key information on the self-management skills that are necessary at each of these critical periods. The diabetes education algorithm can be used by health care systems, staff, or teams to provide guidance on when and how to refer to and deliver DSMES.² Refer to the [DSMES Algorithm of Care](#) for a full-page version of the algorithm.
8. [2018 Standards of Medical Care in Diabetes](#): This resource provides current clinical practice recommendations, and is intended to provide information for clinicians, patients, researchers, payers, and others on the components of diabetes care, general treatment goals, and tools to evaluate the quality of care. [American Diabetes Association Diabetes Care 2018 Jan; 41(Supplement 1). DSMES can be found in Supplement 4: Lifestyle Management: *Standards of Medical Care in Diabetes—2018*: S38-S50. (<https://doi.org/10.2337/dc18-S004>)]
9. [Approaches to Increase Access to and Participation in DSMES](#): This report describes the work of three states to increase access to and participation in DSMES through targeted outreach, partnership, technical assistance, funding opportunities, and reimbursement initiatives.
10. States with a DSMES umbrella ADA-recognized or AADE-accredited DSMES service include:
 - [DiabetesSmart: Diabetes Education Recognition Program](#): North Carolina was the first state to develop a statewide “umbrella” service where the Division of Public Health serves as the sponsoring agency, managing all the ADA recognition requirements, while local health agencies are “multi-sites”, providing DSMES services for people in their communities.
 - [Kentucky DSMES Program](#): Kentucky implemented an AADE-accredited “umbrella” service where the Department of Public Health holds the accreditation and local health departments deliver DSMES.
 - [Mississippi Diabetes Prevention and Control Program](#): Mississippi followed a similar model in establishing an umbrella ADA-recognized DSMES service where DSMES is offered through local health departments.

APPENDIX A

References:

1. Klein HA, Jackson SM, Street K, Whitacre JC, Klein J. Diabetes self-management education: miles to go. [Nurs Res Pract](#). 2013;58:1012.
2. Powers, MA, Bardsley, J, Cypress, M, et al. Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *Diabetes Care*. Jul 2015; 38(7): 1372-1382. <https://doi.org/10.2337/dc15-0730>
3. 2017 National Standards for Diabetes Self-Management Education and Support. *Diabetes Care*. 2017; 40:1409–1419. Retrieved from <http://care.diabetesjournals.org/content/40/10/1409.full-text.pdf>.
4. Morgan JM, Mensa-Wilmot Y, Bowen S, Murphy M, Bonner T, Rutledge S, et al. Implementing Key Drivers for Diabetes Self-Management Education and Support Programs: Early Outcomes, Activities, Facilitators, and Barriers. *Prev Chronic Dis* 2018;15:170399. DOI: <http://dx.doi.org/10.5888/pcd15.170399>

1815 Cooperative Agreement Guidance Document: Strategy A.2

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES): COVERAGE

Strategy A.2

Expand or strengthen DSMES coverage policy among public or private insurers or employers, with emphasis on one or more of the following: Medicaid and employers

Intent of strategy:

Medicaid:

The intent of this strategy is to increase Medicaid and employer coverage of diabetes self-management education and support (DSMES) services that meet the *2017 National Standards for Diabetes Self-Management Education and Support* and have achieved accreditation by the American Association of Diabetes Educators (AADE) or recognition by the American Diabetes Association (ADA).

While Medicaid* covers disease management programs, including diabetes self-management education in some states, it is important that state health departments work with their state Medicaid agencies to expand or strengthen coverage or establish new coverage where needed. This may begin by working with Medicaid to develop a State Plan Amendment, or to stipulate specific language addressing DSMES in Managed Care Organizations' (MCOs) contracts or requests for proposals. This language should state that DSMES must:

- conform to the *National Standards for Diabetes Self-Management Education and Support*, and
- be either AADE-accredited or ADA-recognized.

Employers and Private Insurers: State health departments are in an ideal position to inform and educate employers and insurers on the benefits of DSMES to improve the health of PWD and reduce health care costs. Employers and insurers are interested in reducing costs and improving employee performance. It is key to link the benefits of DSMES to better control of diabetes and thus prevention of costly complications.

Leveraging Efforts to Secure Coverage: There are strategies addressing health benefit coverage for both DSMES and the National Diabetes Prevention Program under 1815. While each strategy is different, recipients are encouraged to ensure that coverage efforts are considered together and approached synergistically.

*For more information on Medicaid, refer to the guidance document for Strategy A.5.

Key terms/definitions related to Strategy A.2:

- **Diabetes self-management education and support (DSMES):** The ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards.¹⁻²
- **Medicaid:** Jointly funded state and federal program to provide health care to low-income Americans.
- **Medicaid State Plan and State Plan Amendment:** Every state is required to file a Medicaid State Plan with the Centers for Medicare & Medicaid Services (CMS). If the state wants to make a change to its Medicaid program by altering the services covered (within federal guidelines), or the populations covered, it must submit a State Plan Amendment.
- **Medicaid Managed Care:** Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid programs and MCOs that accept a set amount per member per month payment for these services.
- **DSMES Recognition and Accreditation:** Recognition and accreditation help ensure that DSMES services offer quality education. CMS has authorized two organizations, ADA and AADE, to grant recognition or accreditation. AADE uses the term accreditation, while ADA uses the term recognition. The two terms essentially involve similar processes to evaluate DSMES services. Both organizations rely on the *2017*

National Standards for Diabetes Self-Management Education and Support to evaluate DSMES services ([2017 National Standards for DSMES](#)).

Removing barriers to participation for high burden populations:

- Work with Medicaid to secure or expand DSMES coverage for beneficiaries with diabetes.
- To learn more about removing barriers to DSMES, refer to [Increasing Referrals and Overcoming Barriers to Participation](#) in the DSMES Toolkit.

Examples of state and community level activities:

1. Review and understand health insurance coverage laws in your state pertaining to DSMES: <http://lawatlas.org/datasets/diabetes-self-management-education-laws>.
2. Work with state/public employee health plans, private employers, and/or the state Medicaid program to extend coverage for DSMES, or strengthen current DSMES coverage language or policy.
3. Work with state business coalitions on health to engage employers, health plans, and health care professionals to inform them of DSMES benefits and potential cost savings.
4. Establish partnerships with key organizations that also have a stake in expanding access to, participation in, and reimbursement for DSMES.
5. Include coverage for DSMES as a priority in the State Diabetes or Chronic Disease Plan (or in the State Diabetes Action Plan if your state is required to have one).

Activities not allowed in this strategy:

- Recipients cannot engage in lobbying activities to influence legislative decisions related to DSMES coverage.

Performance measures for strategy:

- Short term
 - A.2 # of employees and Medicaid beneficiaries that have DSMES as a covered benefit
- Intermediate
 - A.8. # of people with diabetes with at least one encounter at an ADA-recognized/AADE-accredited DSMES program
- Long term
 - A.10. Proportion of people with diabetes with an A1C > 9 (goal is to decrease)

Technical assistance and training resources:

1. Medicaid: This is a jointly funded state and federal program to provide health care to low-income Americans.
2. [Emerging Practices in Diabetes Prevention and Control—Medicaid Coverage for DSMES](#): This document describes the experiences of three state health departments—Colorado, Mississippi, and New York—that collaborated with their state Medicaid agencies to make Medicaid coverage for DSMES a reality. Although each state faced unique challenges along the way, they shared similar success factors, including: strong relationships between the state health department and Medicaid at both the program/staff and executive levels, compelling use of public health and cost data to make the case for coverage, and ongoing support and contributions from other partners that shared their goals.
3. [2017 National Standards for DSMES](#): This article by the 2017 Standards Revision Task Force introduces the *2017 National Standards for Diabetes Self-Management Education and Support*. The Standards define timely, evidence-based, quality DSMES services that meet or exceed the Medicare diabetes self-management training (DSMT) regulations and assist those providing or wishing to provide DSMES.²
4. [Health Insurance Coverage Laws for Diabetes Self-Management Education and Training](#): This website shows which states have laws requiring private insurance plans and/or Medicaid to cover DSME/T, and provides information on legal requirements for, among other things, when DSME/T coverage is triggered, what specific activities are covered, and the standards that DSME/T must meet.

5. [DSMES Technical Assistance Guide](#): This tool identifies four key drivers that influence DSMES access and participation: 1) availability of DSMES services, 2) payers and payment mechanisms, 3) referral policies and practices, and 4) willingness of people with diabetes to participate in DSMES services.³
6. [DSMES Toolkit](#): The purpose of this toolkit is to increase access to and participation in DSMES services among PWD. The toolkit provides available resources and tools in one place to assist with the development, promotion, implementation, and sustainability of DSMES services.
7. [2017 Economic Cost of Diabetes in U.S.](#): This article by the American Diabetes Association describes the economic burden of diabetes in the U.S. and its impact on the quality of life. (<https://doi.org/10.2337/dci18-0007>)

APPENDIX A

References:

1. Powers, MA, Bardsley, J, Cypress, M, et al. Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *Diabetes Care*. Jul 2015; 38(7): 1372-1382. <https://doi.org/10.2337/dc15-0730>
2. 2017 National Standards for Diabetes Self-Management Education and Support. *Diabetes Care*. 2017; 40:1409–1419. Retrieved from <http://care.diabetesjournals.org/content/40/10/1409.full-text.pdf>.
3. Morgan JM, Mensa-Wilmot Y, Bowen S, Murphy M, Bonner T, Rutledge S, et al. Implementing Key Drivers for Diabetes Self-Management Education and Support Programs: Early Outcomes, Activities, Facilitators, and Barriers. *Prev Chronic Dis* 2018;15:170399. DOI: <http://dx.doi.org/10.5888/pcd15.170399>

1815 Cooperative Agreement Guidance Document: Strategy A.3

PHARMACISTS: MEDICATION MANAGEMENT; DSMES

Strategy A.3

Increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes

Intent of strategy:

This strategy aims to increase the number of 1) pharmacy-based diabetes self-management education and support (DSMES) services that are recognized by the American Diabetes Association (ADA) or accredited by the American Association of Diabetes Educators (AADE) and/or 2) pharmacists using patient care processes that promote medication management for people with diabetes. In both areas, the goal is to serve high burden populations. Pharmacy locations and pharmacists can play a critical role in promoting medication management or DSMES programs for people with diabetes and may serve as a collaborative partner for other clinical care providers.

Key terms/definitions related to Strategy A.3:

Diabetes Self-Management Education and Support (DSMES): The ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards ([2017 DSMES Standards](#)).

Medication Management is used by doctors and pharmacists to ensure that patients are achieving optimal therapeutic outcomes for the prescription medications they may be taking. Medication Management is used to cover a broad range of professional activities, such as:

- Performing patient assessments or a comprehensive review of prescriptions and their possible interaction or side effects.
- Formulating both short and long term medication treatment plans.
- Monitoring the safety and efficacy of any and all prescription medication plans.
- Ensuring directional or instruction-based compliance through patient education.
- Ensuring better documentation and communication between health providers in order to maintain a high standard of care between medical professionals.

Pharmacists' Patient Care Process¹: Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes. The process is focused on 5 steps:

1. **Collect**: The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.
2. **Assess**: The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.
3. **Plan**: The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver, which is evidence-based and cost-effective.
4. **Implement**: The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.
5. **Follow up**: The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

¹. <https://icpp.net/wp-content/uploads/2016/03/PatientCareProcess-with-supporting-organizations.pdf>

Removing barriers to participation for high burden populations:

Pharmacists are well-positioned to provide DSMES and medication management for people with diabetes. In general, pharmacists are highly-trusted, visited by patients more frequently than their primary care providers, and present in communities that may not otherwise have sufficient health care providers and clinical resources. In many situations, pharmacy partners such as large chains, groups of independent pharmacies, and clinic-based pharmacies may be better able to impact high burden or underserved populations because of their expansive reach. Leveraging the support of existing partners in the health care system or state medical organizations to promote collaboration or team-based care efforts with community pharmacies can improve timely access to services and improved health outcomes.

Examples of state and community level activities:

1. Identify pharmacies that already deliver diabetes self-management education but are not currently ADA-recognized/AADE-accredited, and provide technical assistance/resources/training on how to seek accreditation/recognition, and thus, reimbursement for services. (DSMES Toolkit: <https://www.cdc.gov/diabetes/dsmes-toolkit/index.html>)
2. Sponsor the training of pharmacists in DSMES, medication management, or collaborative drug therapy management (CDTM) as it relates to diabetes care; provide state-specific data and resources on diabetes in conjunction with the educational event.
Training links:
 - [Diabetes Accreditation Standards-Practical Applications \(DASPA\)](#)
 - [Delivering Medication Management Services](#)
3. Identify health systems or clinics without pharmacist support (none or inadequate) that treat high burden or underserved populations (FQHCs, CHCs), and connect them with pharmacists who can provide care or services— either through team-based approaches, in cases where collaborative practice agreements are in place, or through DSMES.
4. Assess the laws and related rules in your state that govern Collaborative Practice Agreements (CPAs) between pharmacists and other health care providers. State pharmacy associations may provide support for this ([click here](#) for pharmacy associations by state). In states where CPAs are allowed, you may wish to facilitate the establishment of CPAs between pharmacists and physicians in high burden communities. Supportive activities may include hosting webinars on best practices; disseminating toolkits on how to establish and implement a CPA; and identifying physician-pharmacist teams who can serve as team-based care “champions” and help mentor newer teams. See this [CPA example](#) of work involving the Massachusetts Board of Pharmacy.
5. In states where CPAs are not allowed, or allowed only under restricted terms, determine what restrictions exist that may limit pharmacists’ scope of practice, and promote CDC tools to the applicable audience(s) using the following links:
 - [Payers](#)
 - [Decision Makers](#)
 - [Pharmacists](#)
 - [Health Care Providers/Prescribers](#)
6. Work with Schools of Pharmacy ([click here for locations](#)) and Medicine to promote ways to incorporate team-based care into curricula, experiential training, and residency programs. Foster relationships between health professional schools in cases where none exist.
7. Facilitate the formation of a new work group or coalition (or support an existing one) involving key players/partners in your state with common goals and interests in utilizing pharmacists. Supportive activities

could include: developing a strategic plan that promotes identifying and assisting in the DSMES credentialing of pharmacies located in target populations; assessing current investments related to the goals of 1815; hosting meetings and facilitating communications that support state and local pharmacy organizations in aligning their efforts with 1815 (i.e. State Engagement Meetings). Develop and disseminate state-specific toolkits or training materials (from national pharmacy organizations or other credible sources) that address policies and best practices for working with pharmacists.

Activities not allowed in this strategy:

- Direct Services- Cooperative agreement funds cannot be used to pay a pharmacy or pharmacist to provide patient care services.
- Work with organizations that offer generalized pharmacy services, with no means of targeting people with (or at risk for) diabetes, is not appropriate for this strategy.

Performance measures for this strategy:

- Short term
 - A.3. # of pharmacy locations/pharmacists using patient care processes that promote medication management or DSMES for people with diabetes
- Long term
 - A.10. Proportion of people with diabetes with an A1C > 9 (goal is to decrease)

Technical assistance and training resources:

- Implementing medication management and DSMES in alignment with the Pharmacist Patient Care Process format: <https://jcpc.net/wp-content/uploads/2016/03/PatientCareProcess-with-supporting-organizations.pdf>
- DSMES Toolkit: <https://www.cdc.gov/diabetes/dsmes-toolkit/index.html>
- CPA Toolkit: <https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf>
- Pharmacy's Appointment Based Model: <http://www.aphafoundation.org/appointment-based-model>
- Collaborative Practice Agreements and Pharmacists' Patient Care Services: https://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

1815 Cooperative Agreement Guidance Document: Strategy A.4

PREDIABETES SCREENING, TESTING, & REFERRAL

Strategy A.4

Assist health care organizations in implementing systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention

Intent of strategy:

The goal of this strategy is to increase physicians'/health care professionals' awareness of prediabetes as a serious health condition, and to increase the number of health care organizations implementing systems to screen, test, and refer adults with prediabetes to CDC-recognized organizations offering the National Diabetes Prevention Program (National DPP) lifestyle change program.

Key terms/definitions related to Strategy A.4:

Screening: Screening involves the examination of a group of asymptomatic individuals to identify those with a high probability of having or developing a given disease, typically by means of an inexpensive diagnostic test (National Institutes for Health). Currently, the ADA Type 2 Diabetes Risk Test (<https://doihaveprediabetes.org/take-the-risk-test/#/>) is the recommended screening tool for prediabetes. Individuals who score 5 or higher on the risk test should follow up with their health care providers for a blood glucose test.

Diagnostic testing: The use of a clinical test to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic individuals, or those who screen positive on a risk test (<https://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding>).

Testing for Prediabetes: For those whose risk test score is elevated, conduct a blood test using one of the three tests described in the Diabetes Prevention Recognition Program (DPRP) Standards:

- Fasting glucose of 100 to 125 mg/dl
- Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl
- A1c of 5.7 to 6.4

Referral: A health system referral describes the practice of transferring some aspect of a patient's care from one setting to another. It is a process whereby a patient is recommended to receive a specific service or program delivered by another entity. A health care provider/health care professional referral is not required for participants to enroll in the National DPP lifestyle change program but can be effective in increasing the likelihood of enrollment.

Identifying and Referring Patients with Prediabetes in a Clinical Setting:

In the toolkit entitled [*Preventing Type 2 Diabetes—A Guide to Refer Your Patients with Prediabetes to an Evidence-based Diabetes Prevention Program*](#), the American Medical Association and CDC have developed guidance for health care providers/organizations to identify people with prediabetes, either prospectively or retrospectively, and refer them to a CDC-recognized organization. Refer to the following sections in the toolkit for step-by-step guidance:

- [M.A.P. to Diabetes Prevention for Your Practice](#)
- [Point-of-Care Prediabetes Identification Algorithm](#)
- [Retrospective Prediabetes Identification Algorithm](#)
- [Sample Patient Referral Form](#)

Reminders (Alerts): Reminders are a type of alert triggered by particular parameters (e.g. time and date, high/low threshold, or clinical indication) usually presented as highlighted text or a pop-up that requires action. Reminders serve to cue clinicians that certain events should take place, but have not yet done so. Reminders are regularly used in primary care systems, particularly with respect to the management of patients with chronic conditions that require regularly scheduled repetitive tasks (<http://www.americanehr.com/blog/2013/02/optimizing-the-ehr-alerts-and-reminders/>).

Electronic Health Records (EHR): An EHR is an electronic version of a patient's medical history that is maintained by a health care organization/provider over time. EHRs include key administrative and clinical data relevant to an individual's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting (<https://www.cms.gov/Medicare/EHealth/EHealthRecords/index.html>).

Electronic Medical Record (EMR): A digital version of a patient's chart in the health care provider's (HCP) office. An EMR contains the medical and treatment history of the patient in one practice.

Clinical Decision Support (CDS): Clinical decision support (CDS) provides clinicians, staff, patients, and others with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care. CDS encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools include computerized alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information, among other tools. They require computable biomedical knowledge, person-specific data, and a reasoning or inferencing mechanism that combines knowledge and data to generate and present helpful information to clinicians as care is being delivered. This information must be filtered, organized, and presented in a way that supports the current workflow, allowing the user to make an informed decision quickly and take action. The majority of CDS applications operate as components of comprehensive EHR systems, although stand-alone CDS systems are also used (<https://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds>).

Enabling Services: Enabling services (ES) are non-clinical services that support the delivery of basic health care and facilitate access to comprehensive medical and social services. They include case management, benefit counseling or eligibility assistance, health education and supportive counseling, interpretation, outreach, transportation, and education of patients and the community regarding the availability and appropriate use of health services. Community Health Workers (CHWs) can be engaged to deliver these enabling services and to serve as advocates and health guides for clients with prediabetes. For more information, visit <http://enablingservices.aapcho.org>.

Interoperability: The ability of different health information technology systems to seamlessly communicate and exchange data.

Removing barriers to participation for high burden populations:

- Work with health care organizations to sponsor prediabetes-screening events to identify and follow up with people with prediabetes in high-burden, high need communities.
- Engage CHWs at the health systems level to reach adults with prediabetes to encourage them to take the prediabetes risk test, and to help individuals referred to CDC-recognized lifestyle change programs navigate the enrollment process and overcome barriers they might experience.
- Partner with FQHCs serving high burden populations to establish screening, testing, and referral systems.

Activities not allowed in this strategy:

- Recipients may not use federal funds to cover the costs of blood glucose (diagnostic) testing.
- Recipients may not provide cash incentives to health care providers/organizations to encourage them to screen, test, and refer patients with prediabetes to CDC-recognized organizations.

Examples of state and community level activities:

- Complete an assessment of health systems serving high burden populations to ascertain current prediabetes screening, testing, and referral practices.
- Work with targeted health care organizations to administer the ADA Type 2 Diabetes Risk Test to screen patients for prediabetes (<https://doihaveprediabetes.org/take-the-risk-test/#/>) in waiting rooms, and follow up with high risk patients during the provider visit to complete blood glucose testing and referral if warranted.
- Work with targeted health care organizations to retrospectively screen for and identify clients with prediabetes using EHRs and patient registries; generate health care provider referral letters for high risk patients (<https://preventdiabetesstat.org/toolkit.html>).
- Work with targeted health care organizations to embed prediabetes algorithms in the EHR to assist in identifying and referring patients with prediabetes to CDC-recognized lifestyle change programs.
- Empower individuals in high-burden communities to complete the risk test and follow up with their health care providers.
- Collaborate with other relevant programs, such as the Women, Infants, and Children (WIC) Program; implement protocols to identify and follow up with women previously diagnosed with gestational diabetes to determine their readiness to enroll in a CDC-recognized lifestyle change program.
- Collaborate with the QIN/QIO to support health care providers/organizations in high-burden, high need areas to incorporate prediabetes screening, testing, and referral into the clinic workflow.
- Incorporate the Prevent Diabetes STAT Toolkit into existing health care provider learning collaboratives to assist HCPs in implementing and institutionalizing prediabetes screening, testing, and referral protocols.

WORK PLAN EXAMPLES

- In Q1-Q4, the recipient will work with local medical societies to implement a prediabetes screening, testing, and referral survey for health care systems in targeted counties, and use resulting information to guide the development of MOUs/agreements with these systems to screen, test, and refer people with prediabetes to CDC-recognized lifestyle change programs within their communities.
- In Q1-Q2, the recipient will provide training on the Prevent Diabetes STAT Toolkit for health care providers/staff from targeted health systems, focusing on how to use the tools and resources provided in the Toolkit.
- In Q3-Q4, the recipient will provide technical assistance on implementing these tools/resources, with emphasis on using smart search phrases within the EHR to identify patients with prediabetes, following up with these patients through outreach, initiating referrals, and facilitating enrollment in CDC-recognized lifestyle change programs.

Performance measures for this strategy:

- Short term
 - A.4. # of patients served within healthcare organizations with systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs
- Intermediate
 - A.9. # of participants enrolled in CDC-recognized lifestyle change programs
- Long term
 - A.11. # of CDC-recognized organizations achieving a minimum average weight loss of 5% in their eligible participants

Technical assistance and training resources to support this strategy:

American Association of Clinical Endocrinologists (AACE). Screening and Monitoring of Prediabetes. <http://outpatient.aace.com/prediabetes/screening-and-monitoring-prediabetes>

Diabetes in Control. 2014. Using EHRs to Track Prediabetes Recognition and Treatment. <http://www.diabetesincontrol.com/using-ehrs-to-track-prediabetes-recognition-and-treatment/>

Preventing Type 2 Diabetes: A Guide to Refer Your Patients with Prediabetes to an Evidence-based Diabetes Prevention Program. <https://preventdiabetesstat.org/toolkit.html>

National Institutes for Health. Prediabetes Screening: How and Why. <https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/game-plan-preventing-type-2-diabetes/prediabetes-screening-how-why>

APPENDIX A | Key Terms and Definitions

National Diabetes Prevention Program (National DPP):

A partnership of public and private organizations working together to build the infrastructure for nationwide delivery of an evidence-based lifestyle change program for adults with prediabetes to prevent or delay onset of type 2 diabetes. The National DPP provides a framework for type 2 diabetes prevention efforts in the United States.

National DPP lifestyle change program :

A key component of the National DPP is a structured, evidence-based, yearlong lifestyle change program to prevent or delay onset of type 2 diabetes in adults with prediabetes or at risk of developing type 2 diabetes. The lifestyle change program is group-based, facilitated by a trained lifestyle coach, and uses a CDC-approved curriculum. The curriculum incorporates regular opportunities for direct interaction between the lifestyle coach and participants, builds peer support, and focuses on behavior modification through healthy eating, increasing physical activity, and managing stress. The program can be delivered in-person, online, via distance learning, or through a combination of delivery modes.

Diabetes Prevention Recognition Program (DPRP):

The Division of Diabetes Translation manages the DPRP, which is the quality assurance arm of the National DPP. The DPRP awards CDC-recognition to organizations delivering the lifestyle change program that are able to meet national quality standards and achieve the outcomes proven to prevent or delay onset of type 2 diabetes.

Prediabetes: Prediabetes is a health condition where blood sugar levels are higher than normal, but not high enough for a diagnosis of type 2 diabetes. Prediabetes increases an individual's risk for type 2 diabetes and cardiovascular disease.

References and Additional Resources

Centers for Disease Control and Prevention. The National Diabetes Prevention Program. <https://www.cdc.gov/diabetes/prevention/index.html>

Centers for Disease Control and Prevention. Resources for Health Care Professionals. <https://www.cdc.gov/diabetes/prevention/lifestyle-program/resources/professionals.html>

Centers for Disease Control and Prevention. *Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016. <https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf>

National DPP Customer Service Center
<https://nationaldppcsc.cdc.gov/s/>

1815 Cooperative Agreement Guidance Document: Strategy A.5

NATIONAL DPP COVERAGE: EMPLOYERS & COMMERCIAL PAYERS	Strategy A.5 Collaborate with payers and relevant public and private sector organizations within the state to expand availability of the National DPP lifestyle change program as a covered benefit for employees of public and private sector organizations
<p>Intent of strategy: Covering the National DPP lifestyle change program (LCP) as a benefit through commercial or employer-provided insurance is a key pillar to sustaining the National DPP. More than 50% of Americans obtain health insurance through their employers¹; as such, engaging payers (insurance companies) and employers to cover the program is a critical intervention to both expand knowledge of prediabetes and encourage the uptake of the National DPP LCP for people at high risk for type 2 diabetes.</p> <p>In addition to engaging payers and employers that cover members of the general population, recipients are encouraged to identify employers that employ members of priority populations within the state.</p>	
<p>Key terms/definitions related to Strategy A.5 (Employers & Commercial Payers):</p> <ul style="list-style-type: none">• Covered benefit: A health service included in the premium of a health insurance policy paid by or on behalf of the enrolled individual (also called benefit or covered service). For the purpose of this strategy, this is employer-provided insurance covering the National DPP LCP. A covered benefit is a more sustainable way to offer preventive services than a wellness program.• Wellness benefits/wellness programs: Wellness benefits are benefits offered by an employer or health plan to improve and promote employee health and fitness. The employer or health plan generally offers premium discounts, cash rewards, gym memberships, and other incentives to encourage employees to participate. Wellness benefits are not a part of a health insurance program. For the purpose of this strategy, the employer may offer the National DPP LCP in several ways: 1) by contracting with a CDC-recognized organization to offer the LCP at the worksite, 2) by subsidizing employee participation in community-based CDC-recognized organizations, or 3) by applying for CDC recognition to offer the LCP directly. While employers generally fund wellness programs with discretionary dollars, these programs can help build long-term sustainable support for the LCP by demonstrating successful outcomes.• Fully-insured employer: A fully-insured health plan is the traditional way to structure an employer-sponsored health plan. The employer pays a predetermined premium to the insurance carrier. The premium rates are fixed for a year, based on the number of employees enrolled in the plan each month. The insurance carrier assumes the financial risk for providing all contracted health care benefits.• Self-insured employer: The employer assumes the financial risk for providing health care benefits to its employees. Self-insured employers may still contract with an insurance carrier to handle the administrative aspects of the claims process. (This is also called an Administrative Services Only [ASO] health care plan.)	
<p>Strategic Approach to Coverage</p> <p>Recipients should develop a strategic approach to collaborating with employers and commercial payers to expand health benefit coverage for the National DPP LCP. At a minimum, recipients should identify the potential reach of candidate employers and payers and consider previous or current expressed interest in covering the National DPP LCP, such as previous attendance at a State Engagement Meeting.</p> <p>Recipients should review existing resources (see “Key Resources” below), to inform the approach for engaging employers. Recipients should engage stakeholders who have a knowledge of the payer and employer landscape</p>	

¹ <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/>

within the state and identify champions who can serve as advocates of the program and help make the business case. Recipients are encouraged to leverage relationships with members of the State Diabetes Council/Network/Coalition, review Diabetes Prevention Strategic Plans, and compile a list of state employers. Recipients without a comprehensive understanding of the employer and payer health benefit landscape are encouraged to work with a subject matter expert, such as a representative from a local business council on health. The landscape analysis should include the following information: types of employers, employer size, types of industries within the state, employee demographics (as an indicator of increased likelihood of prediabetes), type of insurance that each employer offers (fully-insured or self-insured), and the name of the national carrier for fully-insured employers.

After reviewing the current landscape and the background resources, recipients should consider the potential readiness of candidate employers and payers. There are three general categories of readiness: 1) pre-decisional (needs information on prediabetes and the National DPP), 2) provisional decision (ready to take first step by implementing a pilot class) and 3) full commitment decision (ready to cover the program as a health benefit.) Activities will vary depending on the state of readiness of each candidate employer or payer.

- 1) **Pre-decisional Group:** Engaging employers will require a long-term plan for discussing the National DPP lifestyle change program and its benefit for their employees' health. The National DPP Coverage Toolkit, Diabetes Prevention Impact Toolkit, and AMA Employer Toolkit (links below) are useful resources for making the business case for coverage.
- 2) **Provisional-decision Group:** Some employers may more likely to offer the National DPP LCP as a wellness benefit initially, usually through a pilot project to determine if employees will take advantage of the offering. This approach is an intermediate step and allows the employers to determine what mode of delivery works best for the employees (for example, offering the program in-person during the lunch hour, immediately after work, or as an online option). The Emerging Practice document on Employer Coverage (link below) provides information about offering pilot programs.
- 3) **Full Commitment Group:** After delivering a pilot class, the recipient should work with the employer to consider offering the program as a covered benefit. Offering the program as a covered benefit through health insurance is the most sustainable option. Whether an employer is implementing a pilot class or offering health benefit coverage, obtaining commitment and engagement from senior management to promote and offer the National DPP LCP is critical to employee uptake and long-term success. This could include having a CEO taking the prediabetes screening risk test with other employees and encouraging supervisors to allow their staff to take the class during the lunch hour. The Emerging Practice document on Employer Coverage also provides information on covering the National DPP LCP. (Note: Additional resources for the full commitment group are currently under development.)

If recipients were working with their state employee benefits office to expand coverage for state/public employees under 1305, they are encouraged to continue those efforts under this cooperative agreement.

Examples of state and community level activities/interventions:

1. Collaborate and/or contract with local business groups on health or business councils on health to identify employers and purchaser coalitions; identify leaders within these groups with whom to discuss the program.
2. Identify payers and employers within the state that are covering the program; determine if they would be willing to serve as champions or advocates to help make the case for covering the National DPP LCP to other employers.
3. Identify employers within the state that may consider covering the National DPP LCP as a covered benefit or as a wellness benefit/offering, and develop a strategic approach for working with them, starting with benefits managers. Specifically, identify employers for whom type 2 diabetes prevention and chronic disease prevention are priorities.

4. Establish a tracking tool to identify employers within the state and manage engagement processes with targeted employers.
5. Create a community of practice/sharing group for organizations that are offering the program as a wellness or covered benefit that may want to hear from others who are offering the program.
6. Follow up with employers and payers that participated in a State Engagement Meeting to plan next steps. For example, determine if they are interested in working on a pilot, either individually or as a group.

Activities not allowed in this strategy:

The recipient may use funds to help an employer design, implement, and evaluate a pilot project, and cover the costs of program delivery for the pilot cohort, but may not use funds to support ongoing employee participation in a National DPP LCP without an employer commitment to provide coverage.

Performance measures for strategy:

- Short term
 - A.5. # of employees; # of employees of private sector organizations who have the National DPP lifestyle change program as a covered benefit
- Intermediate
 - A.9. # of participants enrolled in CDC-recognized lifestyle change programs
- Long term
 - A.11. # of CDC-recognized organizations achieving a minimum average weight loss of 5% in their eligible participants

Technical assistance and training resources (to support strategy):

CDC subject matter experts are available to help recipients determine the best approach to engage with employers and payers. Additionally, the National DPP Customer Service Center (<https://nationaldppcsc.cdc.gov/s/>) is a resource available to recipients as well as payers and employers to help them learn more about the program and how it can benefit people at high risk for type 2 diabetes.

Key resources:

- **National DPP Coverage Toolkit:** www.coveragetoolkit.org; specifically review the section titled “Commercial Payers”.
- **Preventing Type 2 Diabetes: A Guide to Refer Your Patients with Prediabetes to an Evidence-based Diabetes Prevention Program:** <https://preventdiabetesstat.org/employers-and-insurers.html>
- **Diabetes Prevention Impact Toolkit:** <https://nccd.cdc.gov/Toolkit/DiabetesImpact/>
Use this Impact Toolkit to project the health and economic effects of the National DPP lifestyle change program on your population at risk for type 2 diabetes.
- **Diabetes State Burden Toolkit:** <https://nccd.cdc.gov/Toolkit/DiabetesBurden> Use this tool to identify the health, economic, and mortality burden of diabetes in your state. This tool is particularly useful to determine what the projected outlook of health and economic costs will be if nothing is done to prevent type 2 diabetes.
- **Employer and Payer Toolkit:** <https://www.cdc.gov/diabetes/prevention/pdf/ta/Implementation-Guide-Employers-Insurers.pdf> This implementation guide will help you learn how to work with employers and

insurers to recruit, enroll, and engage people with prediabetes who have health insurance coverage in a CDC-recognized lifestyle change program to prevent or delay the onset of type 2 diabetes.

- **CDC Emerging Practice for Employer Coverage of the National DPP for Employees at Risk of Type 2 Diabetes** https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-employer_coverage.pdf

This document tells the stories of five employers offering the National DPP lifestyle change program as a covered health or wellness benefit for their employees and discusses the varied approaches, challenges, and key factors contributing to their success. A table summarizing and comparing the different approaches is provided at the end of the document.

- **CDC Emerging Practice for Diabetes Prevention and Control: Promoting the National Diabetes Prevention Program as a Covered Benefit for State Employees** https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-ndpp.pdf

This document describes the experiences of three states—Kentucky, Minnesota, and Washington—whose health departments have collaborated with state employee benefit agencies, health plans, CDC-recognized organizations, and other partners to make the benefits of the National DPP more available to state/public employees and their families.

1815 Cooperative Agreement Guidance Document: Strategy A.5

NATIONAL DPP COVERAGE: MEDICAID

Strategy A.5

Collaborate with relevant public sector organizations and other stakeholders within the state to expand availability of the National DPP lifestyle change program as a covered benefit for Medicaid beneficiaries

Intent of strategy: Covering the National DPP lifestyle change program (LCP) as a benefit through state Medicaid programs is a component of the Division of Diabetes Translation's all-payer strategy for sustaining the National DPP. While there are various options state Medicaid programs may use to cover the National DPP LCP, all options should require delivery by a CDC-recognized organization as a condition of coverage.

Health Equity: In examining the impact of factors labeled as social determinants of health (SDOH), poverty is the most significant in its relationship to poor health status. Individuals with low incomes are at higher risk of morbidity and mortality from a wide range of health issues, including chronic conditions and risk factors such as obesity, high blood pressure, prediabetes, and diabetes. Medicaid is a joint state and federal program that funds health care for low-income populations. It serves as a major policy tool to support health equity.

Relevant Policy: Understanding how to obtain coverage for the National DPP LCP through a state Medicaid program requires an understanding of the policy requirements for Medicaid under federal law, especially how new services can be covered. Deciding which pathway to pursue will require leadership discussions between the state health department and the state Medicaid program.

Medicaid Background: Authorized by Title XIX of the Social Security Act, [Medicaid](#) was signed into law in 1965 alongside Medicare. All states, the District of Columbia, and U.S. territories have Medicaid programs designed to provide health coverage for low-income populations. Although the federal government establishes certain parameters for all states to follow, each state administers the Medicaid program differently, resulting in variations in Medicaid coverage across the country.

Medicaid is a jointly funded federal and state program that, together with the Children's Health Insurance Program, provides health coverage for over [72.5 million](#) Americans. Medicaid is the single largest source of health coverage in the U.S. The federal government provides states with a significant portion of the funds necessary to support Medicaid. In order to participate in the Medicaid program, federal law requires states to cover certain groups of individuals. Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of [mandatory eligibility groups](#).¹

Every state must file a Medicaid State Plan with the Centers for Medicare & Medicaid Services (CMS) that clearly defines who is eligible to receive services (Medicaid beneficiaries.) In addition, the State Plan defines covered services. While the federal government sets basic requirements for services that every state must cover, it gives states the flexibility to provide additional services. When a state wants to change some aspect of its Medicaid Program, it will usually submit a State Plan Amendment (SPA) to CMS. Once the SPA is approved, it does not expire, but the state can change it through a subsequent SPA.

Under the Affordable Care Act (ACA) of 2010, states have the option to expand their Medicaid programs to include health care services for nearly all adults under age 65 with incomes at or below 133 percent of the Federal Poverty Level (FPL). The majority of states have chosen to expand coverage to adults, and those that have not yet expanded may choose to do so at any time.² Under the Affordable Care Act, states that choose to expand their Medicaid programs to cover adults with incomes at or below 133 percent of the FPL receive a higher proportion of federal matching dollars for health care services for this population.

Under the ACA, states were also allowed to adopt a variety of mechanisms under different programs to deliver health care and related support services to Medicaid beneficiaries to improve access to care, quality of care, and the number of persons receiving appropriate care. These different mechanisms have allowed states to address SDOH, including care coordination between Medicaid beneficiaries, health care systems, and social services; and to complete a comprehensive assessment of factors related to SDOH, such as access to housing; sufficient food; a safe environment; transportation; education; employment; and past and current exposure to trauma, mental illness, and substance abuse. States have developed Medicaid Health Homes with integrated and co-located comprehensive services, including physical health, dentistry, vision health, and behavioral health. These new efforts to better coordinate care and social services may also include improving access to preventive health services and prevention programs focused on lifestyle change.

Reimbursement for Medicaid Services and Medicaid Managed Care: States can reimburse for services provided to Medicaid beneficiaries through a traditional fee-for-service payment system or through managed care. The majority of states now operate through contracts with managed care organizations (MCOs). States can implement a Medicaid managed care delivery system using three basic types of federal authorities: (1) State Plan authority [Section 1932(a)]; Waiver authority [Section 1915 (a) and (b)]; and Waiver authority [Section 1115].

States can use a managed care delivery system by getting a SPA approved by CMS. The [state plan preprint](#) includes information such as the types of entities that will be used and what groups of people will be enrolled.

States can implement a voluntary managed care program under 1915 waivers simply by executing a contract with companies that the state has procured using a competitive procurement process. CMS must approve the state waiver in order to make payments. Thirteen states and Puerto Rico use 1915(a) contracts to administer 24 voluntary managed care programs. The approval period for a state's 1915(b) waiver program is limited to 2 years, while Medicaid state plan authority does not have an expiration date.

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; or using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Section 1115 demonstrations are usually approved for an initial 5-year period and can be extended for up to an additional 3-5 years, depending on the populations served. States commonly request and receive additional 3-year extension approvals. Generally, these are referred to as 1115 waivers.

Regardless of the authority, states must comply with federal regulations that govern managed care delivery systems, and ensure that Medicaid beneficiaries have access to quality health care.

Other options under which Medicaid MCOs can provide the National DPP LCP as a service for Medicaid beneficiaries are to include it as:

- (1) Part of a Performance Improvement Project (PIP) as required by federal regulations of Medicaid MCOs. In this case, providing the National DPP LCP to beneficiaries to produce weight loss and alter attendant clinical indicators would show an improvement in the quality of care provided.
- (2) A health promotion service offered by a Medicaid Health Home under Section 2703 of the ACA, an effort to provide integrated primary, acute, behavioral, and preventive health services and referral to community social support services for Medicaid beneficiaries.

For detailed information on the various Medicaid waiver mechanisms for covering the National DPP LCP, please see the National DPP Coverage Toolkit at <https://coveragetoolkit.org/medicaid-agencies/medicaid-coverage-2/>.

Key terms/definitions related to 1815 Strategy A.5 (Medicaid):

- **Medicaid:** Jointly funded state and federal program to provide health care for low-income Americans.
- **Traditional Medicaid:** Delivers health care services for the populations originally identified as eligible in the Medicaid program: pregnant women; young children; and the disabled, including the frail elderly in long-term care; the severely mentally ill; and the cognitively, physically, and developmentally disabled.
- **Expanded Medicaid (under the ACA):** Under the ACA passed in 2010, states were required to expand Medicaid coverage to all individuals with incomes at or below 133% of poverty; in a later Supreme Court decision, this was made optional for states.
- **Medicaid-eligible:** Individuals who meet their state Medicaid program's eligibility requirements; not everyone who is Medicaid-eligible is enrolled in Medicaid.
- **Medicaid beneficiary:** An individual who has been determined to be eligible to receive Medicaid benefits and has enrolled in the program. This status can change if a person's income changes.
- **Medicaid State Plan and State Plan Amendment (SPA):** Every state is required to file a Medicaid State Plan with CMS. If the state wants to make a change to its state Medicaid program by altering the services covered (within federal guidelines), or the populations covered, it must submit a SPA.
- **Medicaid Managed Care Organizations (MCOs):** Private organizations that contract with health care providers in a state to deliver specific services to Medicaid beneficiaries under the state's State Medicaid Plan. MCOs operate on a capitated basis, meaning they are reimbursed on a per-capita basis per beneficiary. If the costs of providing care to a beneficiary are over the capitation fee, the MCO is responsible for absorbing the overage. If the costs of providing care to a beneficiary are below the capitation fee, the MCO retains the excess as profit. (MCOs are also reimbursed for administrative costs and care management in addition to specific health care costs).
- **1115 Demonstration Waiver:** A process instituted by CMS to allow states to institute reforms that go beyond routine medical care and focus on evidence-based interventions that drive better health outcomes and quality of life improvements.
- **Beneficiaries with complex social needs:** Many Medicaid beneficiaries have unstable housing or are homeless, are un- or under-employed, are victims of domestic or child abuse, have job insecurity, have no means of transportation, have poor or no education, are involved with the criminal justice system, are refugees or immigrants, may not speak English, and/or may have limited or unreliable social networks. These factors can contribute to poor health status and can also make this population harder to reach and harder to retain in lifestyle change programs.
- **Health literacy:** Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. An individual may be literate but unable to comprehend, either verbally or in writing, complicated health care terminology ("jargon"). While most individuals who are not trained health care providers have some degree of health illiteracy, this is an especially difficult issue for individuals who do not speak English and for older or less well educated adults. These difficulties can be further compounded when individuals are illiterate (do not know how to read or write in their spoken language). The Agency for Healthcare Quality Improvement (AHRQ) and the Health Resources and Services Administration (HRSA) have developed resources and training to improve awareness and knowledge among health care providers of the three main factors that affect communication with patients: health literacy, cultural competency, and low English proficiency (LEP).

Following a Strategic Approach to Securing Medicaid Coverage for the National DPP Lifestyle Change Program (LCP)

It takes time to make a change in the state Medicaid program. If a state uses Medicaid MCOs to deliver health care services, these are provided under contracts that go out to bid to MCOs every few years; states are on different schedules. Determining where in the cycle your state is can be very important. States are more likely to consider making changes ~two years before putting contracts out to bid, while they still have time to understand how the new benefit (the National DPP LCP) will be delivered, how it will be reimbursed, who will be eligible, how eligible participants will be recruited, and how other relevant decisions will be made. Concurrent with discussions with Medicaid program staff on this new benefit and what it will entail, discussions will also need to occur with the

Medicaid MCOs and with CDC-recognized organizations. All of these stakeholders, in addition to the state Diabetes Network/Coalition, if there is one, should be part of the process.

To effect a significant change in the State Medicaid Program, a state must either submit a SPA or one of the waivers described above. Developing these application(s) and waiting for approval from CMS can also take time. Do not underestimate the time, energy, and commitment required for this process, as it can take two or more years to get the National DPP LCP fully established as a benefit under the State Medicaid Program.

Three ways that state diabetes program staff have gotten this process underway are through (1) preparing the legislatively mandated Diabetes Action Plan; (2) collaborating with CDC and the National Association of Chronic Disease Directors (NACDD) to hold a State Engagement Meeting which includes a focus on reimbursement strategies (Medicaid, private employers, Medicare); and (3) participating in the CDC 6/18 Initiative, which focuses on obtaining coverage for evidence-based preventive services and programs by Medicaid and private employers/insurers. Other efforts that have contributed to achieving Medicaid coverage for the National DPP LCP include the development of State Health Improvement Plans (SHIPs) and specific Governor's initiatives focused on obesity and diabetes. Finalizing Medicaid coverage may also include revising the Medicaid budget request in the state budget and gaining legislative approval, processes that also take time and are dependent on the legislative cycle.

Steps in the Process

1) Gain Knowledge of Medicaid and the Specifics of Your State Medicaid Program

- Recipients with no prior experience working with the state Medicaid program should first educate themselves about Medicaid in general and the specific parameters of the Medicaid program in the state. Explore all of the CDC and CMS Medicaid-related resources available. Attend sponsored webinars and virtual learning collaborative sessions. There are key questions that should be answered before developing a relationship with the state Medicaid program to pursue coverage for the National DPP LCP. These questions include: (1) Did your state expand its Medicaid program under the ACA, or did it retain "traditional" Medicaid? (2) What is the demographic make-up of your state's Medicaid-eligible population? (3) Does your state use managed care or fee-for-service reimbursement for medical services under Medicaid? (4) Does your state have any of the following – 1115 waiver, 2703 Medicaid Health Home Waiver, or 1915 (b) waiver (s)? (5) What services are included in your State Plan for preventive care or self-management of chronic disease, including care coordination? (6) What are the names of the Medicaid MCOs operating in your state (if applicable)? Most of this information is available on your State Medicaid Program webpage, or on the CMS Medicaid webpage: <https://www.medicaid.gov/index.html>.

2) Build A Relationship with Your State Medicaid Program

- The second step is to build a relationship with your state Medicaid program staff. The Medicaid program may be located in the same organizational unit as the state health department or in a different unit completely. Before reaching out, it is important to review the Medicaid program's organizational chart to determine who has the authority to make decisions about which services are covered under the State Plan, who has authority over MCO contracts (if applicable), and who has authority over medical services (Medical Director). These individuals may be located in the topmost levels of the organization, and an overture to them to begin discussions regarding the National DPP LCP should be initiated by an individual similarly positioned in the organizational hierarchy of public health. Make sure public health leadership thoroughly understands the National DPP LCP, especially the health benefits and the business case. Medicaid is a substantial portion of every state's budget, and discussions around changing the program can have financial or political repercussions.
- After an initial agreement is reached to explore coverage for the National DPP LCP, continued work on the details will probably be delegated to other staff. Examine the Medicaid organizational chart to determine which official is your counterpart and will be most helpful during the process. Initiation of this partnership between public health and Medicaid is legislatively mandated as part of the Diabetes Action Plan process (if applicable in your state). Medicaid staff can be invited to participate in a State Engagement Meeting and resulting workgroups created to develop a state diabetes prevention plan. Participation in the CDC's 6/18

Initiative also requires a joint application and equal commitment from state public health and Medicaid to participate.

3) *Making the Case for Medicaid Coverage of the National DPP LCP*

- Gaining buy-in from Medicaid officials is similar to gaining buy-in from State Employee Health Benefit Plan officials, employers, and commercial insurers. Medicaid is a health care financing program concerned about providing high-value services to Medicaid beneficiaries at the lowest cost. Public health representatives must make the case that covering the program is cost effective and a benefit to the long term health of beneficiaries. State Medicaid staff, working with their stakeholders in this process, must also determine what mechanism will be used to provide coverage for the National DPP LCP under the various Medicaid authorities (SPA, waivers). The National DPP Coverage Toolkit, the Diabetes Prevention Impact Toolkit, documents resulting from the Maryland and Oregon Medicaid Demonstration Project, and other documents resulting from the CDC 6/18 Initiative (listed below) will all be useful.

4) *Operationalizing the Delivery of the National DPP LCP under the State Medicaid Program*

- After the “why should we do this?” question is answered to Medicaid staff’s satisfaction, the next step in the process is to work through a series of “how do we do this?” questions. Depending on whether your state has Medicaid Managed Care or fee-for-service, the major components that must be developed and agreed upon by all concerned parties include the following:
 - (a) Defining the benefit;
 - (b) Determining eligibility criteria and processes to select eligible participants;
 - (c) Deciding how the benefit will be delivered (delivery network, including choice of delivery modalities) and requirements for qualified organizations delivering the program;
 - (d) Deciding how to manage reimbursement for the program and reimbursement schedules/pay for performance arrangements, including coding and billing schedules and procedures;
 - (e) Developing contractual language for Medicaid MCOs to cover the inclusion and operation of the National DPP LCP benefit;
 - (f) Developing contractual language for CDC-recognized organizations that will either be under contract to Medicaid MCOs or will directly bill the State Medicaid Program; this may include determining whether Medicaid needs to establish a new provider type for CDC-recognized organizations to be eligible to participate;
 - (g) Deciding to implement an initial pilot or to go forward with statewide implementation.
- Eligibility criteria for participation in the National DPP LCP should follow the CDC’s Diabetes Prevention Recognition Program (DPRP) guidelines and stress the presence of prediabetes or a history of gestational diabetes in potential participants. The National DPP LCP was developed to prevent type 2 diabetes and is not a weight loss program for those without a demonstrated risk for type 2 diabetes. Whether a choice is made for a pilot or for statewide implementation, one issue that needs to be resolved early on is the delivery network of CDC-recognized organizations that will offer the National DPP LCP to Medicaid beneficiaries. While CMS has limited Medicare coverage to in-person organizations, some state Medicaid programs have approved the inclusion of virtual program delivery. Another approach is for Medicaid MCOs to subcontract with existing CDC-recognized organizations. A third approach is for the Medicaid MCOs themselves to become CDC-recognized organizations and deliver the National DPP LCP directly to their beneficiaries.
- State diabetes program staff should ensure that the delivery network is limited to CDC-recognized organizations. The state may also want to work with the CDC-recognized organizations to encourage them to use a curriculum that has been adapted culturally, linguistically, and for literacy and health literacy levels; and is respectful of cultural norms around food, physical activity, and stress management. States may also consider encouraging CDC-recognized organizations to employ community health workers (CHWs) as lifestyle coaches or to do follow-up and outreach with participants. CHWs can also work effectively with MCO care coordination staff to identify and connect participants to relevant social and additional health care services. Medicaid program staff, MCO staff, and CDC-recognized organization staff should work together with

Medicaid beneficiaries to discuss and plan for obstacles to participation and potential solutions, including assistance in the form of transportation vouchers, childcare, and other support.

- After the major components discussed above have been addressed, the following processes should be developed that spell out how the various stakeholders will perform necessary functions. These stakeholders include Medicaid staff, Medicaid MCO health care and fiscal personnel, state diabetes program staff, and staff at the CDC-recognized organizations. Functions include:
 - Identification and referral of eligible beneficiaries;
 - Modification of EHRs to support prediabetes screening/testing and patient referral;
 - Marketing the program to potential participants and to health care providers;
 - Recruitment and enrollment of eligible beneficiaries;
 - Retaining and supporting beneficiaries in the program, including use of incentives/supports;
 - Maintaining communications with referring health care providers on participants' progress; developing patient and participant registries for long-term follow up;
 - Coding/billing and reimbursement;
 - Integration with Medicaid MCO care coordination personnel, especially those working with community social services and the full array of health services.
- After the Medicaid National DPP delivery network is determined, an approach to identifying and recruiting eligible Medicaid beneficiaries will be needed. This can be done retrospectively through a review of patients' records, or prospectively through provider screening, testing, and referral, potentially combined with community outreach and screening. Efforts should be made to insure that connections are made between the Medicaid MCO (the payer), the health care provider, the CDC-recognized organization, and the eligible participant. Recruitment, enrollment, and retention may be challenging with Medicaid beneficiaries for many reasons, including lack of stable housing or employment, other health conditions, health literacy, immigrant status, etc.
- Prior to launch of the National DPP LCP as a Medicaid covered benefit, additional training should be provided for:
 - (a) Health care providers on how to screen, test, and refer eligible beneficiaries; on the benefits of the National DPP LCP; and on what to expect once beneficiaries enroll;
 - (b) Medicaid MCOs, Medicaid staff, and CDC-recognized organization staff on coding, billing, and reimbursement procedures;
 - (c) MCO Service Coordinators on prediabetes, the benefits of the National DPP LCP, and how to refer and follow up on beneficiary enrollment and progress in the program;
 - (d) CDC-recognized organization staff on working with the Medicaid population and with Medicaid MCO Service Coordinators and fiscal administration staff;
 - (e) CHWs on providing support for community-based CDC-recognized organizations new to providing the National DPP LCP to the Medicaid population.

Activities not allowed in this strategy:

- Recipients cannot engage in any advocacy effort to influence state or federal policy makers on any aspect of Medicaid program regulations or policies, including budget recommendations.

Performance measures for strategy:

- Short term
 - A.5. # of Medicaid beneficiaries who have the National DPP lifestyle change program as a covered benefit
- Intermediate
 - A.9. # of participants enrolled in CDC-recognized lifestyle change programs
- Long term
 - A.11. # of CDC-recognized organizations achieving a minimum average weight loss of 5% in their eligible participants

Technical assistance and training resources:

CDC subject matter experts are available to help recipients determine the best approach to engage with public and private payers. Additionally, the National DPP Customer Service Center (<https://nationaldppcsc.cdc.gov/s/>) is available to recipients as well as payers to help them learn more about the program and how it can benefit people at high risk for type 2 diabetes.

Key resources:

- **National DPP Coverage Toolkit:** www.coveragetoolkit.org; specifically review the section on Medicaid.
- **Diabetes Prevention Impact Toolkit:** <https://nccd.cdc.gov/Toolkit/DiabetesImpact/>
Use this Impact Toolkit to project the health and economic effects of the National DPP lifestyle change program on your population at risk for type 2 diabetes.
- **Diabetes State Burden Toolkit:** <https://nccd.cdc.gov/Toolkit/DiabetesBurden> Use this tool to identify the health, economic, and mortality burden of diabetes in your state. This tool is particularly useful to determine what the projected outlook of health and economic costs will be if nothing is done to prevent type 2 diabetes.
- **Preventing Type 2 Diabetes: A Guide to Refer Your Patients with Prediabetes to an Evidence-based Diabetes Prevention Program:** <https://preventdiabetesstat.org/toolkit.html>
- **CDC 6/18 Initiative: Prevent Type 2 Diabetes:** <https://www.cdc.gov/sixeighteen/diabetes/index.htm>

DP18-1815 (Strategy A.6) & DP18-1817 (Strategy A.2) Cooperative Agreement Guidance Document for Increasing Participant Enrollment in CDC-Recognized Lifestyle Change Programs

WORKING WITH NEW AND EXISTING CDC-RECOGNIZED ORGANIZATIONS TO ENROLL HIGH BURDEN POPULATIONS OF FOCUS

INTENT OF STRATEGY

An estimated 84.1 million adults in the US have prediabetes. To date, 257,820 individuals have enrolled in the National DPP lifestyle change program (for whom the Diabetes Prevention Recognition Program [DPRP] has received data); however, more work is needed to reach the remaining millions of individuals with prediabetes, or those who are at risk for type 2 diabetes, and enroll them in a CDC-recognized lifestyle change program. This strategy is designed to help start new CDC-recognized organizations in areas of the country with few or no CDC-recognized lifestyle change programs, or help enroll high burden populations of focus in existing CDC-recognized lifestyle change programs, and is included in both DP18-1815 and DP18-1817. Cooperative agreement funds may be used to accomplish the goal of this strategy, as long as the funds are administered using a value-based payment system. Value-based payment assures that payments are made to the CDC-recognized organization based on achievement of lifestyle change program-specific outcomes, such as participant attendance and/or weight loss.

Recipients will be expected to serve as payers when using cooperative agreement funds to enroll high burden populations of focus in CDC-recognized lifestyle change programs. CDC approximates the delivery cost of administering the National DPP lifestyle change program to a participant who completes all 22 sessions of the year-long program to be \$500. (This does not include program support costs such as incentives or additional services to address barriers to participation, such as transportation. Specific guidance on participant enrollment cost is provided below.) Activities that drive overall program cost include marketing and recruitment efforts, facility costs, and direct program delivery costs, including staffing. This document describes the value-based payment options available to recipients and provides guidance to support the decision-making process.

APPROACHES TO INCREASE ENROLLMENT IN CDC-RECOGNIZED LIFESTYLE CHANGE PROGRAMS USING VALUE-BASED PAYMENT

To fulfill the goal of this strategy, recipients can use two main approaches:

- Support participant enrollment in existing CDC-recognized lifestyle change programs. Find a CDC-recognized lifestyle change program, and pay the costs to enroll high burden populations of focus.
- Start new CDC-recognized organizations. If there are no available CDC-recognized lifestyle change programs that have the capacity and expertise to serve the high burden population(s) of focus, find new organizations willing to pursue CDC recognition.

Three Steps to Determine the Appropriate Approach

To determine the appropriate approach (or in some cases, approaches), recipients should take the following three steps and answer the minimum questions in Table 1 below.

1. Do a landscape analysis.
2. Review the administrative and financial options available to distribute and oversee accountability for funds.
3. Make strategic decisions about options with the greatest reach and potential for success.

Table 1. Three step decision-making process and questions to determine the appropriate approach for using cooperative agreement funds to increase participant enrollment in CDC-recognized lifestyle change programs.

Step 1: Do a landscape analysis.	<ul style="list-style-type: none"> Where are the high burden populations of focus? Where are there existing CDC-recognized organizations? Where are there gaps? Can the gaps be met with online and distance learning programs? Which partners might be willing to establish new organizations to offer the National DPP lifestyle change program?
Step 2: Review the administrative and financial options available to distribute and be accountable for funds.	<ul style="list-style-type: none"> Are you limited to making annual awards? Are the awards required to be competitive? Are the awards limited to 12 months? Can you pay vouchers when services are rendered? How do you reconcile awards that are made prospectively to ensure that deliverables are met? How will you set and monitor performance measures at either, or both, the participant and organizational level? Would it be more efficient and effective to contract with a third party for the administrative and financial functions?
Step 3: Make strategic decisions about options with the greatest reach and potential for success.	<ul style="list-style-type: none"> How much funding do you have dedicated to strategy A.6 (DP18-1815)/strategy A.2 (DP18-1817)? What is the minimum amount of program delivery funding you need to provide to an organization to ensure the probability of success? How will you adjust the participant enrollment cost (i.e., the funds provided to an organization) based on program delivery (i.e., Add funds for incentives or supports for social determinants of health, or subtract funds for costs that you will cover such as Lifestyle Coach training)? How will you assess the capacity of the organizations you plan to work with? (General guidance: Organizations with preliminary or full recognition have already demonstrated ability to deliver the National DPP lifestyle change program. New organizations, or organizations with pending recognition should complete the Organizational Capacity Assessment for DPRP Applicant Organizations as a condition of receiving funding.) What is the best way to allocate funds to reach and have a positive impact on the largest number of priority populations? (Ask your Project Officer to review your proposal if you are unsure how to proceed.)

WHAT IS VALUE-BASED PAYMENT?

Value-based payment (VBP) is payment tied to outcomes, which typically include session attendance and weight loss. The administration of VBP typically requires a voucher system or a claims processing system (which is observed in MDPP, Medicaid, and private payers). Payments are usually made only after outcomes are met (e.g., the first payment may occur after a participant attends four class sessions). For DP18-1815 and DP18-1817 recipients, the following modified VBP options are available and based on the usual ways that states fund community-based organizations (i.e., through mini-grants or sub-awards):

- Modified Full VBP – Applies to existing CDC-recognized organizations and includes enrollment targets and performance goals.
- Modified interim VBP – Applies to new CDC-recognized organizations and includes annual enrollment targets. No performance goals are required for the initial 24 months. New organizations must meet enrollment targets for the first 12-month period, or they cannot continue to receive funds for an additional 12 months.

DETERMINING PARTICIPANT ENROLLMENT COSTS

Participant enrollment costs include program delivery costs and program support costs.

Program Delivery Costs: CDC approximates the direct delivery cost of administering the National DPP lifestyle change program to a participant who completes all 22 sessions of the year-long program to be \$500. This \$500 cost may include: formal Lifestyle Coach training, Lifestyle Coach salary, space rental, marketing and advertising to recruit and enroll participants, and program materials and supplies.

Program Support Costs: In addition to the \$500 per participant cost of delivering the program, recipients may use funds up to an additional \$500 per participant for program support costs related to:

- Removing barriers to participation;
- Providing program support incentives;
- Addressing social determinants of health; and
- Providing incentives related to direct family needs (*DP18-1817 recipients only*).

These additional program support costs may be aggregated at the organizational level as long as the aggregate total does not exceed the sum of \$500 for each participant enrolled. Additional guidance for each of these types of program support costs is provided below.

Barriers to Participation

- Recipients may use a limited amount of cooperative agreement funding to remove enrollment barriers for high burden populations of focus by supporting resources/services such as transportation vouchers or child/elder care. Recipients should work with their Project Officers to determine appropriate expenditures related to these supports.
- Recipients should ensure that proposed activities are relevant to the high burden populations of focus and consider the delivery modalities that may best support participation. Funds may be used to support the addition of a second delivery modality to an existing CDC-recognized organization (e.g., distance learning) if feasible.

Program Support Incentives

Recipients may use some limited cooperative agreement funds for program support incentives to increase participant retention and completion.

- Program support incentives are directly related to the lifestyle change program curriculum and may include items such as pedometers, measuring cups, “Calorie King” fat/calorie counting books, and stretch bands.
- Program support incentives cannot exceed a monetary value of \$20 per participant for the duration of the yearlong lifestyle change program.
- Lifestyle Coaches and/or Program Coordinators should consider when to offer program support incentives to enhance participant retention and program completion. Data have shown that participants who make it to the 17th class or 7th month of the National DPP lifestyle change program are more likely to achieve the 5% weight loss goal.
- In general, partners should be approached first to see if they are willing to support allowable incentives before using cooperative agreement funds.

Addressing Social Determinants of Health

- Recipients may use limited cooperative agreement funds to address social determinants of health that are relevant to the high burden population(s) of focus. For example:
 - Some populations may require additional outreach and 1-on-1 support from the Lifestyle Coach in between class sessions. This staff time can be added as an additional cost above the base delivery cost of \$500 per participant.
 - Some populations may need assistance with access to healthy foods. Recipients may use limited cooperative agreement funds to provide food or farmers market vouchers, healthy food coupons, or healthy foods for recipe demonstrations during class sessions.

Direct Family Needs Incentives (DP18-1817 Recipients Only)

For DP18-1817 recipients only, CDC-recognized organizations that have an approved higher enrollment fee per participant for addressing costs associated with social determinants of health may provide incentives related to direct family needs, including toilet paper, baby wipes, and school supplies.

- The cost of direct family needs incentives cannot exceed a monetary value of \$20 per participant for the duration of the yearlong lifestyle change program, and may be added in addition to the \$20 allotment for Program Support Incentives, as long as the recipient evaluates the use and effectiveness of these incentives on participant retention and outcomes in the National DPP lifestyle change program.

Recipients opting to support the use of program support or direct family needs incentives under this strategy will be expected to evaluate the effectiveness of the incentives in increasing participant retention. If any of these incentives, items, or services are provided by partners “in-kind,” please inform your Project Officer.

Examples: Participant Enrollment Cost above \$500 per Person

1815 Recipient

Per Participant:

- Program Delivery Cost: \$500
- Program Support Incentives: \$20

- Transportation support – gas cards: up to \$72 per participant (based on \$9 gas card provided after attending 3 sessions [total of 24 sessions])
- Vouchers for healthy foods at local community garden (addressing social determinants of health): up to \$160 per participant (based on \$20 in vouchers provided after attending 3 sessions [total of 24 sessions])
- Lifestyle Coach time for additional outreach and support to program participants in between class sessions (addressing social determinants of health): \$125 (based on rate of \$25 per hour for 5 hours per participant for the duration of the yearlong program)
- **Total: \$877 per participant (\$13,155 contract total for 15 participants)**

1817 Recipient

Per Participant:

- Program Delivery Cost: \$500
- Program Support Incentives: \$20
- Direct Family Needs Incentives: \$20
- Childcare (provided on-site during class): \$90 (based on rate of \$25 per hour for 52 hours for the duration of the yearlong program [2 hours for 26 total class sessions], divided among 15 participants)
- Vouchers for healthy foods at local community garden (addressing social determinants of health): up to \$160 per participant (based on \$20 in vouchers provided after attending 3 sessions [total of 24 sessions])
- Transportation support – gas cards: up to \$72 per participant (based on \$9 gas card provided after attending 3 sessions [total of 24 sessions])
- Lifestyle Coach time for additional outreach and support to program participants in between class sessions (addressing social determinants of health): \$125 (based on rate of \$25 per hour for 5 hours per participant for the duration of the yearlong program)
- **Total: \$987 per participant (\$14,805 contract total for 15 participants)**

Approval for Participant Support Costs

Recipients who are only providing organizations with up to \$500 in funding/participant for program delivery costs do not require any further approval. Recipients who wish to provide up to an additional \$500/participant for program support costs must submit a written request and justification to their Project Officer for prior approval. In addition to a justification explaining the context and need for these support costs, please include itemized information (such as in the examples provided above).

VALUE-BASED PAYMENT OPTIONS AND GUIDELINES FOR USING COOPERATIVE AGREEMENT FUNDS TO INCREASE PARTICIPANT ENROLLMENT IN CDC-RECOGNIZED LIFESTYLE CHANGE PROGRAMS

Based on the results of the 3-step decision-making process, recipients should choose from the options in Table 2 to select and fund organizations.

Table 2. Value-based payment options and guidelines for using cooperative agreement funds to increase participant enrollment in CDC-recognized lifestyle change programs.

	Existing Organizations – Full VBP		New Organizations/New Sites for Existing Organizations – Interim VBP		Contracting
	Option 1	Option 2	Option 3	Option 4	Option 5
Payment Mechanism	Voucher (Real-Time) (No cap, tied to enrollment)	Annual award Example: Mini-grant (no cap, tied to enrollment)	Voucher (Real-Time) Payments for allowable start-up costs up to the \$15,000/year cap*	Annual Award Lump sum payment up to \$15,000/year cap*	Contractor must follow the required VBP guidance
Deliverables	Enrolled participants (Negotiated number)	Enrolled participants (Negotiated number)	Minimum cohort of 15 participants per each 12 month period	Minimum cohort of 15 participants per each 12 month period	Contractor sets enrollment targets with individual sites
Performance Goals (PGs) (Recipient can require data as a condition of funding)	Attendance and weight loss for individual participants	Average attendance and weight loss for the organization	No performance goals during first 24 months	No performance goals during first 24 months	Contractor sets participant or organizational PGs for individual sites
Accountability (If PGs or deliverables are not met, 1815 funding must end.)	Accountability happens in real time since payment is only made when PGs are met	Annual review to ensure that enrollment targets and PGs were met	Annual review to ensure that at least 15 participants were enrolled for each 12 month period Must achieve preliminary recognition by month 24	Annual review to ensure that at least 15 participants were enrolled for each 12 month period Must achieve preliminary recognition by month 24	Either real time VBP or annual review of enrollment targets and PGs required

Abbreviations: VBP = Value-Based Payment; PGs = Performance Goals.

*Please see information below entitled *Start New CDC-Recognized Organizations/New Program Delivery Sites (Options 3 and 4)* for information regarding the \$15,000 per year funding limit.

Additional Details and Guidelines

Support Enrollment in Existing CDC-Recognized Lifestyle Change Programs (Options 1 and 2)

- Use the [DPRP Registry of All Recognized Organizations](#) to identify existing CDC-recognized organizations and their locations.
 - Some CDC-recognized organizations may offer classes in additional locations. Use [Find a Class Location](#) to identify class locations and confirm the accessibility of existing CDC-recognized lifestyle change programs.
- Determine the ability of an organization to enroll eligible participants from the high burden population(s) of focus.
 - Determine whether staff at the organization have specialized expertise to enroll and deliver the lifestyle change program to the high burden populations of focus.
 - Assess the organization's current referral processes and potential to add/improve upon these processes to reach high burden populations of focus.
- Recipients may choose to prioritize CDC-recognized organizations that are or are interested in becoming MDPP suppliers. If recipients choose to work with an MDPP supplier, the supplier cannot be reimbursed twice for the same participant. In other words, the supplier cannot receive reimbursement for a participant from the Centers for Medicare & Medicaid Services (CMS), and also receive reimbursement from the recipient based on its VBP system for the same participant.
 - This also applies to recipients in states that have Medicaid reimbursement for the National DPP lifestyle change program.
- In order to appropriately reimburse or reconcile for milestones met, it is important to negotiate and set terms for data requirements and collection. The intent is not to set up a data collection system that duplicates the DPRP, but recipients will need information to ensure that payments are made correctly according to the VBP plan in use.
 - At a minimum, include data on participants enrolled with cooperative agreement funds as part of the negotiation.
 - Recipients may include other data as part of the negotiation (e.g., weight loss, number of sessions attended).
 - Any information on individual participants must be de-identified.
 - Recipients may choose to use the DPRP evaluation reports that CDC-recognized organizations receive after making their six month data submissions to CDC. In this case, recipients should include this in the terms and set a timeline with the CDC-recognized organization for the recipient's receipt of this report. CDC cannot provide this report directly to the recipient.

Start New CDC-Recognized Organizations/New Program Delivery Sites (Options 3 and 4)

- If the recipient has determined it is most feasible to start a new CDC-recognized organization with the specialized expertise and capacity to reach and serve high burden populations, the recipient should identify organizations that have this specialized expertise and sufficient organizational capacity to successfully deliver the program, as evidenced by the outcome of the [Organizational Capacity Assessment for DPRP Applicant Organizations](#).
 - Potential organizations may include: organizations with experience delivering an evidence-based behavior change program (e.g. AADE-accredited/ADA-recognized DSMES programs, clinics, cooperative extension agencies, community-based organizations, pharmacies).
- Funds provided to organizations that are starting new CDC-recognized organizations or adding new program delivery sites cannot exceed a total of \$15,000 per year. (This is based on a minimum cohort of 15 individuals with participant reimbursement up to \$1,000 per participant.)

Recipients should ensure that the organizations with which they choose to work for this strategy have high capacity to deliver the National DPP lifestyle change program.

- Any new organizations supported by cooperative agreement funds must apply for and receive CDC recognition from the DPRP within 30 days of receiving the cooperative agreement funds.
- Recipients should ensure that organizations develop a plan demonstrating how they will achieve long-term financial sustainability.
- Recipients should ensure that new organizations understand the terms associated with accepting cooperative agreement funds for start-up costs.
- Recipients may only sub-contract with the identified organizations; further sub-contracting by the identified organizations with other in-person organizations to deliver the National DPP lifestyle change program is not allowed. Note: Please contact your Project Officer if an identified organization wishes to sub-contract or partner with an online organization.
- Recipients should know the DPRP Standards and help the new organizations understand the required metrics.
- Although not a specific component of strategy A.6 (DP18-1815)/strategy A.2 (DP18-1817), participant retention should be considered and planned for from the beginning when starting new CDC-recognized organizations.

Contracting out Payment Functions (Option 5)

- If recipients determine that Option 5 – contracting out payment functions to a statewide organization – is most feasible to implement the strategy, then the organization must have a direct relationship with the delivery sites. Examples of such organizations may include, but are not limited to: State Primary Care Association to work with FQHCs, State Cooperative Extension Agency to work with local extension sites, a large pharmacy group to work with community pharmacists, and a state AADE or ADA group to work with DSMES sites. These organizations can operate in two ways:
 1. Become CDC-recognized and act as an umbrella organization, submitting data and distributing payment. The local sites can serve as class locations for the umbrella organization.
 2. Act as an administrative/management support group. In this case, the organization would set enrollment targets, distribute payment, and maintain accountability for the performance goals. The individual CDC-recognized organizations would submit their own data to the DPRP.
- Recipients are encouraged to consider limiting the levels of sub-contracting only to those needed to avoid possible contract and start date delays, as well as added complications to contract and accountability management.

For any option, recipients should:

- Provide technical assistance and support to ensure the lifestyle change program is being delivered with fidelity to the DPRP Standards, and assist the funded organizations in achieving full recognition. Recipients should refer to the resources in the **Technical Assistance and Training Resources** section of this document to ensure successful new CDC-recognized organization start-up and lifestyle change program implementation. Please note: the National DPP Customer Service Center is not a replacement for the direct technical assistance that recipients should provide to the organizations that they support; it should be used to supplement the assistance provided.
- Ensure that the activities being done to implement other cooperative agreement strategies support participant referral to and enrollment in CDC-recognized organizations. Please refer to the guidance documents for those strategies for additional information.

- Consider providing support and assistance to market the program to high burden populations of focus to help increase enrollment. Please refer to the DP18-1817 strategy A.3 guidance document for additional information on implementing tailored communication/messaging to reach high burden populations of focus.

If working with DP17-1705 recipients and/or their affiliate sites:

- Recipients may choose to work with current DP17-1705 recipients and/or their affiliate sites. This is allowed as long as the three-step decision making process is followed and the payment is not duplicated for the participants. In other words, an organization receiving payment for a participant’s enrollment with DP17-1705 funds – either through start-up or another payment mechanism – cannot receive payment for that same participant’s enrollment using DP18-1815 or DP18-1817 funds.
- Please inform your Project Officer if you will be working with current DP17-1705 recipients and/or their affiliate sites.

Key Elements for Successful Implementation of Value-Based Payment

- Enrollment Targets
 - While the focus of this cooperative agreement is on enrolling high burden populations of focus, funds may be used to also enroll the general population. This will help organizations recruit and enroll full cohorts (about 10-20 participants).
- Performance Goals
 - Recipients should negotiate attendance and weight loss goals based on their knowledge of the organization and the context within which they are operating. While CDC is not mandating specific performance goals, here are some examples:
 - Individual participant level – performance goals are a measure of how many participants met the performance goals.
 - Session attendance: measure how many participants attended 1 session, 4 sessions, 9 sessions, 16 sessions, and 22 sessions.
 - Weight loss: measure how many participants lost a certain amount of weight at 6 months and at 12 months.
 - Organizational level – performance goals are a measure of an average of all participants served by the organization for a given 12-month time period.
 - Average number of sessions attended in months 1-6.
 - Average number of sessions attended in months 7-12.
 - Average weight loss at 6 months and 12 months.
- Timelines
 - The 24-month timeline for supporting the start-up of new organizations begins when the organization receives the funds.
 - New organizations must apply for pending CDC recognition within 30 days of receiving the funds and begin offering the lifestyle change program within 6 months.
 - New organizations should achieve preliminary recognition by 24 months. When preliminary recognition is achieved, the organization should be moved to full VBP with performance goals.

Working with Online CDC-Recognized Organizations

Online CDC-recognized organizations often have unique value-based payment considerations.

1. Online organizations usually require a significant frontloaded payment of about \$200. This payment covers the Bluetooth scale and technical assistance in using the application platform.
2. Online organizations usually are paid by weight loss, not session attendance. After the initial payment, they may report weight loss monthly. Payments are tied to the percentage weight loss, which can be as small as one tenth of a percent. The recipient will be responsible for reviewing the weight loss reports.

Recipients contracting with an online provider should contact their Project Officer for assistance. Cooperative agreement funds cannot be used to start a new online CDC-recognized organization.

LIFESTYLE COACH TRAINING

- Lifestyle Coaches must be trained according to the [DPRP Standards](#).
- Cooperative agreement funds may only be used to train Lifestyle Coaches who are directly associated with specific CDC-recognized organizations. Cooperative agreement funds may not be used to train a general pool of Lifestyle Coaches to be employed statewide.
- The number of Lifestyle Coaches that may be trained for a given CDC-recognized organization will vary depending on many factors, including the projected participant enrollment, the number of classes to be offered, and the employment status of the Lifestyle Coach (i.e. full-time, part-time, etc.). A new organization that is proposing to offer only one class to ~10-15 participants may only need to train one Lifestyle Coach (and one Program Coordinator, if a different person will fill that role). Organizations planning to offer multiple classes and reach larger number of participants will need to train additional Lifestyle Coaches.
- Methods for paying for Lifestyle Coach training will also vary depending on how the recipient is funding start-up costs for individual organizations. Recipients may include funds for Lifestyle Coach training in a “package” of start-up costs for individual organizations. Recipients may also contract directly with a CDC training entity to provide training for the Lifestyle Coaches associated with these organizations.
 - In either case, recipients should ensure that the individual organizations are providing justification for their projected enrollment targets, and that the number of Lifestyle Coaches being trained aligns with the projected enrollment targets.
- Lifestyle Coach training plans are subject to Project Officer approval.

WAYS TO ADDRESS HEALTH EQUITY

Tailor program implementation activities for high burden populations of focus:

- Recipients should support tailored participant recruitment and retention activities, such as customization or adaptation of materials, directed at reaching and enrolling high burden populations of focus in CDC-recognized lifestyle change programs.
 - A portion of cooperative agreement funds may be spent on translating the PreventT2 curriculum as part of a more comprehensive approach to addressing DP18-1815 strategy A.6 or DP18-1817 strategy A.2. Post-award, and before pursuing the translation, recipients should follow up with their CDC Project Officer to confirm that other organizations are not working on a similar translation to prevent duplication of effort. It will also be important to determine the potential reach of the translation (e.g. Will the translated version of the curriculum target populations of significant number in your state/jurisdiction?). While strict translations of Prevent T2 do not require

CDC approval, they must be reported to CDC for inclusion on the list of approved curricula. Any translations also involving cultural adaptation of the material will require CDC review/approval. (Please refer to the [DPRP Standards for additional guidelines related to curriculum requirements and changes that require CDC approval.](#))

- When appropriate, recipients should involve Community Health Workers (CHWs) in supporting enrollment and retention of participants in CDC-recognized lifestyle change programs. (CHWs can also serve as Lifestyle Coaches.) CHWs may be used to connect participants to resources in the community that can help them achieve their goals and address any other needs.

EXAMPLE WORK PLAN ACTIVITIES

- By the end of Q2, <recipient> will complete a landscape analysis to determine whether to start new CDC-recognized organizations, or support participant enrollment in existing CDC-recognized lifestyle change programs.
- By the end of Q3, <recipient> will submit the strategy A.6 (DP18-1815)/A.2 (DP18-1817) participant enrollment plan based on the landscape analysis findings and Lifestyle Coach training plan to the Project Officer for review and approval.
- By the end of Q4, <recipient> will provide formal Lifestyle Coach training to 15 coaches according to the CDC DPRP Standards for the new CDC-recognized organizations and those expanding to serve additional underserved areas/high burden populations of focus.
- In Q2-4, <recipient> will provide technical assistance to the funded CDC-recognized organizations for the linguistic/cultural tailoring of the curriculum and/or other program materials to support the enrollment and retention of high burden populations of focus.
- In Q4, <recipient> will work with the funded CDC-recognized organizations to assess existing participant referral mechanisms and identify additional ways to increase referrals to the program.

ACTIVITIES NOT ALLOWED IN THESE STRATEGIES

- Funds may not be used to enroll participants in National DPP lifestyle change programs that are not CDC-recognized. Recipients can verify the recognition status of an organization via the DPRP Registry of All Recognized Organizations: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx.
- Recipients may not provide program support incentives in the form of cash or gift cards. Please refer to the **Program Support Incentives** section for specific guidance.
- Funds may not be used to train Master Trainers. Master Trainers must be associated with a CDC-recognized organization and must have offered the program successfully for at least one year before entering a formal Master Training program with one of the training entities that hold an MOU with CDC. Master Trainer training programs are not intended to prepare independent trainers or national trainers. CDC is in the process of working with training entities to strengthen programs to train Lifestyle Coaches and Master Trainers. Further guidance will be provided post-award if there are changes regarding the use of cooperative agreement funds to support Master Trainer training in years 2-5.
- Funds may not be used to build new data entry systems for the collection and monitoring of participant data. CDC is in the process of developing a web-based data entry system for the DPRP that will include a performance metrics dashboard for use by organizations to monitor their data. In the meantime, we encourage organizations to look carefully at existing systems such as DAPS (American Association of Diabetes Educators), Chronicle (American Diabetes Association), and COMPASS (Quality and Technical Assistance Center of New York). Cooperative agreement funds

may be used to pay the licensing fees to acquire use of these applications. An alternative for organizations that are prohibited from using third party applications is to modify an existing data collection platform such as Workshop Wizard or Redcap. Cooperative agreement funds up to \$10,000 may be used to purchase these applications and modify them for internal use.

- Funds may not be used to purchase telehealth equipment, but may be used in other ways to support expanded use of telehealth as a means to expand access to CDC-recognized lifestyle change programs to reach high burden populations of focus, particularly in underserved areas.

PERFORMANCE MEASURES FOR THIS STRATEGY

- Intermediate
 - A.9. # of participants enrolled in CDC-recognized lifestyle change programs
- Long term
 - A.14. # of CDC-recognized organizations achieving a minimum average weight loss of 5% in their eligible participants

TECHNICAL ASSISTANCE AND TRAINING RESOURCES

- The following key resources contain information to help your organization execute a successful type 2 diabetes prevention program.
 - To gain CDC recognition, your organization must show that it can meet the [DPRP Standards](#) and effectively deliver a proven type 2 diabetes prevention lifestyle change program.
 - The [Organizational Capacity Assessment for Organizations](#) offers guidance to help you decide if your organization has the resources to start and maintain a lifestyle program that meets the requirements for full recognition.
 - The [National DPP Welcome Guide](#) offers helpful tips about the recognition program, national registry, evaluation requirements, and data collection.
 - The [National DPP Welcome Video](#) presents a brief overview of the DPRP and encourages viewers to use and apply the Welcome Guide.
 - [Lifestyle Coach and Program Coordinator Videos](#) are for Lifestyle Coaches and Program Coordinators working with organizations that are planning to apply for CDC recognition or are CDC-recognized.
 - [Implementation Guides for Working with Medicare or Medicaid Beneficiaries and Employers and Insurers](#) help organizations learn how to recruit, enroll, and retain Medicare and Medicaid beneficiaries with prediabetes in the National DPP lifestyle change program, and how to work with employers and insurers to recruit, enroll, and engage people with prediabetes who have health insurance coverage.
- The [National DPP Customer Service Center](#) provides organizations with easy access to information and resources about prediabetes and the National DPP. Organizations can access training materials, toolkits, and videos; ask questions; and receive technical assistance related to all aspects of the program.
 - Keys to Success Tip Sheets provide lessons learned and insights from others implementing the National DPP lifestyle change program. Topics include recruiting and retaining participants, collecting and monitoring data, and achieving CDC recognition:
 - [Keys to Success: Recruiting Participants](#)
 - [Keys to Success: Increasing Participant Retention](#)

- [Keys to Success: Collecting and Monitoring Data](#)
- [Achieving Participant Goals and CDC Full Recognition](#)
- Technical Assistance for Success Tutorials offer CDC-recognized organizations tips on how to implement a National DPP lifestyle change program and how to achieve full CDC recognition through the DPRP.
 - [Technical Assistance for Success Part 1. Organizational Capacity Assessment](#)
 - [Technical Assistance for Success Part 2. Learning the DPRP Standards](#)
 - [Technical Assistance for Success Part 3. Making Required Data Submissions](#)
 - [Technical Assistance for Success Part 4. Improving Outcomes Using Data Results](#)
- The [National DPP Coverage Toolkit](#) provides information about the mechanics of covering the National DPP lifestyle change program.
- The [CMS Webpage for the Medicare DPP Expanded Model](#) contains resources related to implementation, supplier requirements, billing, and more.
- The [Special Diabetes Program for Indians Diabetes Prevention Program Toolkit](#) provides keys to success and lessons learned from 38 Special Diabetes Program for Indians recipients as they implemented an evidence-based lifestyle change program for type 2 diabetes prevention to meet the needs of their communities, incorporating culture and traditions.
- CDC's [Sources for Data on Social Determinants of Health contains tools and databases at various levels – national, state, county, census tract – to help improve understanding of social determinants of health and focus efforts to improve community health.](#)

Updated: 5/30/2019

1815 Cooperative Agreement Guidance Document: Strategy A.7

COMMUNITY HEALTH WORKER (CHW) SUSTAINABILITY

Strategy A.7

Develop a statewide infrastructure to promote long-term sustainability/reimbursement for CHWs as a means to establish or expand their use in a) CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or b) ADA-recognized/AADE-accredited DSMES programs for diabetes management

Intent of strategy:

The intent of this strategy is to develop a statewide infrastructure to promote sustainable financing for Community Health Workers (CHWs). This includes but is not limited to:

- Developing policies and practices that define who CHWs are and what they can do in clinical or community settings;
- Developing standardized curricula and training;
- Establishing CHW certification systems, as appropriate;
- Documenting the kind of supervision required for their work and by whom; and
- Securing reimbursement for CHW services.

It is imperative to include the voice of CHWs in the planning, implementation, and evaluation of this work. Recipients should ensure that CHWs at the state, regional, or local levels are included. Remember this as a mantra for this work: “Nothing about CHWs, without CHWs”.

Key terms/definitions related to Strategy A.7:

Community Health Workers:

CHWs are known by a variety of names (see: https://www.cdc.gov/dhdsp/docs/chw_brief.pdf). As defined by the CHW section of the American Public Health Association, CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as liaisons, links, or intermediaries between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. One of the most important features of CHWs is that these women and men strengthen already existing ties within their communities. (American Public Health Association, 2014: <https://www.apha.org/apha-communities/member-sections/community-health-workers>)

CHW Covered Services:

Services ordered by a licensed provider to be provided by a CHW. These services frequently include providing health education to individuals and groups in conjunction with a health care team. Services can occur face-to-face with recipients (individually or in a group) in an outpatient clinic, hospital, client’s home, or other community setting. The content of the education or training should be based on a standardized curriculum consistent with established or recognized health standards. It is worth noting that a standardized self-management, skill-building curriculum may also be required for related CHW administrative tasks such as documentation, phone outreach, and coordination of community resources or other enabling services in order for the CHWs to be reimbursed. It is also important to ensure that the curriculum can be modified to meet clinical needs, cultural norms, and health literacy levels. Examples of CHW covered services can be found in the policy brief developed by CDC’s Division for Heart Disease and Stroke Prevention, *Addressing Chronic Disease through Community Health Workers*, and in the technical assistance guide, *States*

Implementing CHW Strategies. These and other resources can be found in the following CHW Toolkit: <https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm>.

CHW Payment Mechanisms:

This broadly refers to the means by which CHW services are financially reimbursed. For example, in January 2014, the Centers for Medicare & Medicaid Services (CMS) created a final rule (CMS-2334-F), [Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligible Notices, Fair Hearings and Appeal Process, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment](#), which opened up payment opportunities for preventive services by non-licensed individuals and offers potential for CHW reimbursement under Medicaid.

CHW Certification:

Certification is intended to ensure that CHWs have met key training requirements. The administrative oversight provided and the training and certification processes and requirements for CHWs vary considerably between states. Some have state-regulations determining training and certification requirements for CHWs that must be met in order to practice and receive reimbursement for CHW services.

Sustainability:

The Center for Public Health Systems Science at the Brown School, Washington University in St. Louis, defines sustainability capacity as the ability to maintain programming and its benefits over time. To improve capacity for sustainability, it suggests that organizations strengthen the structures and processes that exist within their programs to ensure that they can strategically leverage resources to weather the changes and challenges that will come their way. Relative to CHWs, sustainability ensures that a CHW program is structured and financed to provide services over time. The Rural Health Information Hub, supported by the Health Resources and Services Administration, suggests that there are three critical issues linked to the sustainability of CHW programs: 1) evaluation, 2) financing, and 3) credentialing. (Community Health Worker Toolkit, Rural Health Information Hub: <https://www.ruralhealthinfo.org/toolkits/community-health-workers>)

Reimbursement/Financing:

Reimbursement usually means receiving money in repayment for money already spent or an expense already incurred. In this context, reimbursement means that CHWs are paid for the services they perform. As you consider reimbursement for CHWs, consider the following:

- Including CHW services in Medicaid administrative cost claims.
- Integrating CHWs into managed care or team-based care models.
- Providing tools for motivating private insurers to engage CHWs.

Enabling Services:

Enabling services (ES) are non-clinical services that support the delivery of basic health services and facilitate access to comprehensive patient care as well as social services. They include case management, benefit counseling or eligibility assistance, health education and supportive counseling, interpretation, outreach, transportation, and education of patients and the community regarding the availability and appropriate use of health services. CHWs can be engaged to deliver these enabling services and to serve as advocates and health guides for clients with prediabetes. (Association of Asian Pacific Community Health Organizations, 2010: <http://enablingservices.aapcho.org>)

Examples of state and community activities:

- Complete an assessment of the CHW landscape in your state/locality to assess where CHWs are located, what they are doing, and if/how they are being reimbursed for their services.
- Use findings from the CHW sustainability assessment to develop an action plan to address CHW sustainability.
- Convene CHWs and CHW allies to formalize a state or regional network to advance CHW work in your state/locality, with emphasis on sustainable financing.
- Work with an existing CHW coalition or task force to build a sustainability framework.

- Develop a statewide CHW training and/or certification program in collaboration with partners.
- Educate health care providers and other stakeholders about the value of CHWs, and how to embed them in team-based care.
- Work to secure inclusion and coverage of CHWs and their services in Medicaid State Plans and State Plan Amendments, 1115 Waivers, Medicaid Health Homes, and other Medicaid funding mechanisms.

Activities not allowed in this strategy:

- Paying CHWs to deliver direct services to clients with diabetes or prediabetes.
- Lobbying for CHW policy changes at the state or national level.

Performance measures for this strategy:

- Short term
 - A.7. # of CHWs covered under state efforts to expand CHW curricula and training delivery vehicles, CHW certification systems, and/or CHW payment mechanisms
- Long term
 - A.10. a) Proportion of people with diabetes with an A1C > 9
 - A.11. b) # of CDC-recognized organizations achieving a minimum average weight loss of 5% in their eligible participants

Technical assistance and training resources to support this strategy:

CMS/Medicaid Resources:

- Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative: Annual Report Year 3. February 2018. Centers for Medicare & Medicaid Services (CMS). Center for Medicare and Medicaid Innovation. <https://downloads.cms.gov/files/cmimi/hcia-metaanalysisthirdannualrpt.pdf> (Note: The 6th paragraph of the Executive Summary mentions the finding that of the six innovation types evaluated, only CHW innovations were found to lower total costs.)
- Medicaid Preventive Services: Regulatory Change (CMS)—webinar slides
- State Medicaid Manual—Chapter 4, Section 4385: Preventive Services (CMS)
- Integrating Community Health Workers into Care Teams. The Commonwealth Fund. 2015. <https://www.commonwealthfund.org/publications/newsletter-article/2015/dec/focus-integrating-community-health-workers-care-teams>
- Medicaid Reimbursement for Community-based Prevention. Trust for America’s Health. 2013. <http://www.astho.org/community-health-workers/medicaid-reimbursement-for-community-based-prevention/>
- Questions and Answers Regarding Medicaid Rule Change Allowing Reimbursement for Preventive Services Delivered by Non-licensed Providers. <http://www.astho.org/Community-Health-Workers/Q-and-A/>
- Diffusion of Community Health Workers Within Medicaid Managed Care: A Strategy to Address Social Determinants of Health. Health Affairs Blog, July 25, 2017. DOI: 10.1377/hblog20170725.061194
- Center for Medicaid and CHIP Services Informational Bulletin. November 27, 2013. Update on Preventive Services Initiatives. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf>.

Examples of CHW Models:

- National Academy of State Health Policies. 2018. State Community Health Workers Model. <https://nashp.org/state-community-health-worker-models/>
- East Central Ministries. <http://www.eastcentralministries.org/our-model.aspx>
- University of New Mexico Health Sciences Center. Pathways to a Healthy Bernalillo County. <https://hsc.unm.edu/community/chwi/pathways/index.html>
- Visión y Compromiso. Key Workforce Priorities for the Community Transformation Model

CHW Certification and Financing:

- CHW Certification and Financing Issue Brief. Association of State and Territorial Health Officials. 2016. <http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/>
- Community Health Worker Return on Investment Study Final Report. Center for Program Evaluation, School of Community Health Sciences, University of Nevada, Reno. 2017. <http://dph.nv.gov/uploadedFiles/dph.nv.gov/content/Programs/CHW/dta/Publications/CHW%20ROI%20Report%209-26-17.pdf>
- Minnesota Department of Human Services. Minnesota Health Care Programs Provider Manual. Community Health Worker section. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357#lr
- Financing of Community Health Workers: Issues and Options for State Health Departments. ASTHO Technical Assistance Presentation. <http://www.astho.org/Community-Health-Workers/CHW-Financing-Presentation-Slides/>

Other CHW Resources

- Community Programs Linked to Clinical Services. Resources for Diabetes and Hypertension. CDC and the National Association of Chronic Disease Directors. https://www.chronicdisease.org/mpage/domain4_chw_ra
- CDC. 2015. Addressing Chronic Disease through Community Health Workers. A Policy and Systems-level Approach. https://www.cdc.gov/dhdsp/docs/chw_brief.pdf
- CDC. 2016. A Community Health Worker Training Resource. https://www.cdc.gov/dhdsp/programs/spha/chw_training/index.htm
- The Community Guide. Community Health Workers. <https://www.thecommunityguide.org/content/community-health-workers>
- The Community Guide. 2016. Diabetes Prevention: Interventions Engaging Community Health Workers. <https://www.thecommunityguide.org/findings/diabetes-prevention-interventions-engaging-community-health-workers>
- Rural Health Information Hub. Community Health Worker Toolkit. <https://www.ruralhealthinfo.org/toolkits/community-health-workers>
- Center for Public Health Systems Science. George Warren Brown School of Social Work. Washington University in St. Louis. 2018. Program Sustainability Assessment Tool (PSAT). <https://sustaintool.org/>