

Umbrella Hub Arrangements FAQ

Updated June 2022

Introduction

Umbrella Hub Arrangements (UHAs) connect community-based organizations with healthcare payment systems to pursue sustainable reimbursement for the National Diabetes Prevention Program (National DPP) lifestyle change program and the Medicare Diabetes Prevention Program (MDPP).

The FAQ document is intended to support State Health Departments, organizations, and partners considering, supporting, or directly involved in a UHA. The FAQ document is recommended to be used as a reference for common questions and considerations that have been raised during UHA learning events. Questions were edited for clarity and to preserve anonymity. Answers were provided by subject matter experts from CDC's Division of Diabetes Translation, Leavitt Partners, and the National Association of Chronic Disease Directors (NACDD). The questions and answers are arranged by topic area using the outline below. New versions of this FAQ document may be released as questions are gathered from additional events.



[National DPP UHA Guidance and Application](#)

[National DPP Customer Service Center](#)

[Coverage Toolkit UHA page](#)

Use this FAQ to Find Answers in the Following Areas

Structure of a UHA

- [Purpose of a UHA](#)
- [UHA Application](#)
- [Roles and Responsibilities of an Umbrella Hub Organization](#)
- [Roles and Responsibilities of Subsidiaries](#)
- [Program Delivery Mode and Curriculum](#)
- [UHAs with MDPP Suppliers](#)

Sustaining a UHA

- [Business Structure for Billing](#)
- [Medicare Reimbursement](#)
- [Other Payer Reimbursement](#)

Resources for UHAs

Terms and Acronyms

Structure of a UHA

Purpose of a UHA

1. What is the purpose of a UHA?

The main purpose of a UHA is to develop and implement a cost-effective infrastructure to bill payers on behalf of a group of CDC-recognized organizations. While the UHA may provide other services, the primary goal is sustainable reimbursement for the National DPP lifestyle change program.

2. What is the structure of a UHA?

Each UHA is convened by an Umbrella Hub Organization (UHO), which is the lead organization in the arrangement. Community-based organizations participating in a UHA are referred to as subsidiary organizations, or subsidiaries. They are organizations that are CDC-recognized and delivering the National DPP lifestyle change program in their local communities. They can include, but are not limited to, Federally Qualified Health Centers, Area Agencies on Aging, pharmacies, tribes, local health departments, faith-based organizations, extension programs, small social service agencies, and/or other small healthcare providers. UHA is the overarching term that refers to the entire group, inclusive of the UHO, subsidiaries, and the billing platform used to submit claims.

Visit the [Coverage Toolkit UHA page](#), which describes the business structure of a UHA and what it includes.



Structure of a UHA

UHA Application

3. What is the process for applying to establish a UHA?

Learn about and access the application on the [National DPP Customer Service Center's \(CSC\) UHA Guidance and Application webpage](#).

Submit applications or ask questions about UHAs and the application through the [National DPP CSC's Contact Support feature](#). You will need to create or log into your account to access this feature.

Applications will only be accepted from UHOs with at least one subsidiary.

4. Can you provide an overview of the UHA application?

CDC began accepting applications for new UHAs after May 1, 2021. The four main steps to prepare the application include:

- Collection of information about the UHO and subsidiaries
- Completion of parts 1a and 1b of the application by the UHO
- Preparation of documents found on the submission checklist (page 4 of application): statement of intent, a signed Business Associate Agreement (BAA) (required for option 2 arrangements), and a list of CDC funding for the UHO and subsidiary(ies)
- Completion of part 2 of the application by each subsidiary
 - Submission of the following to CDC: parts 1a and b, a copy of part 2 for each subsidiary, and the supporting

documents noted on the submission checklist

Note that UHAs must activate an agreement with at least one payer within two years of submitting their UHA application. Qualifying payer enrollment may include any public or private payer, employer, or health plan.

5. Where should an organization begin to both apply to establish a UHA and enroll as an MDPP supplier?

The first step is applying to establish a UHA through the National DPP CSC. The application must be completed by both the UHO and at least one subsidiary. The subsidiary must include a statement of intent with the application. Approved UHAs may add additional subsidiaries during their data submission month.

Then proceed with the MDPP supplier application process with the Centers for Medicare and Medicaid Services (CMS).

6. Where can organizations talk through their specific status and discuss options for the next steps before applying to become a UHA?

For more information on becoming a UHA, please review all UHA resources on both the [National DPP Coverage Toolkit](#) and the [National DPP CSC](#). After submitting a UHA application to the CSC, a CSC technical assistance agent will contact you to schedule a call to discuss your proposed UHA and answer any questions. For more information on becoming a subsidiary in a UHA, organizations should contact their State Health Department Diabetes Program or a participating [national organization](#).

Structure of a UHA

Roles and Responsibilities of an Umbrella Hub Organization

7. What are the payer benefits of contracting with the UHO?

By contracting with a UHA, payers may:

- Access a “one-stop-shop” where they can contract with one entity to access multiple delivery organizations and streamline reimbursement rates/processes.
- Elevate their organization’s profile and involvement in the effort to prevent type 2 diabetes.
- Achieve cost savings related to providing an intervention at the prediabetes stage.

8. What services do the UHO provide to subsidiary organizations?

The UHO must offer billing services and may provide other services, such as data management or help with referrals. The UHO may allow subsidiaries to choose from a menu of services. While billing services must be offered, the UHO may accept subsidiaries that are not yet ready to bill.

9. Which entity holds the CDC recognition status? What are the allowable variations for CDC-recognition with the UHA?

The UHO holds the CDC recognition status for all subsidiaries in the UHA. The Diabetes Prevention Recognition Program (DPRP) recognition will be based on the aggregation of all subsidiary (delivery organization) data. Non-delivery UHOs are required to have preliminary, full, or full plus CDC recognition based on the aggregated subsidiary data.

10. Can an organization serve as a UHO without directly providing services?

Yes. CDC is now accepting applications for non-delivery UHOs. The non-delivery organization will be assigned CDC recognition on the basis of aggregated DPRP data from subsidiaries. Download and review the revised [National DPP UHA Guidance and Application](#).

11. Can the UHO lose its current recognition status based on performance issues of one or more subsidiaries?

Forming the UHA does not initially put the UHO’s CDC recognition status at risk regardless of the recognition status of the subsidiaries. The UHO will not lose its recognition status during the first two years of operating the UHA.

It will be important for the UHO to monitor and support the subsidiaries in meeting the DPRP Standards since after the initial two years, the UHO’s CDC recognition status could be impacted by poor performance of one or more subsidiaries.

12. Can a professional association apply to be a UHO on behalf of community-based organization entities? Can the participation fee be subsidized by CDC grant funds designated for supporting community-based organizations?

- Yes. A professional association can apply to serve as the UHO of a UHA and enroll community-based organizations. The recognition status of the UHO will be based on the aggregation of DPRP data from the subsidiaries.
- Yes. The association can use CDC funds, as available from CDC-funded recipients, to support start-up costs and operational costs until a payer is billed. Note that the UHA is required to execute a billing arrangement with a payer within two years of approval as the UHA.

13. Does the UHO need to be recognized in all modalities (in-person, virtual, distance learning, combination)?

No. Currently, CDC is only accepting applications for UHAs that deliver the program in-person. The UHO and the subsidiaries must have a DPRP organization (org) code for in-person delivery. They may have org codes for other delivery modes, but only data for participants in in-person programs will be included in the UHA.

14. Does the UHO need to be the covered entity for HIPAA purposes?

Yes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules apply to covered entities and business associates. HIPAA defines a covered entity as: (1) a health plan, (2) a healthcare clearinghouse, (3) a healthcare provider who transmits any health information in electronic form in connection with billing transactions. The UHOs must be covered entities and hold BAAs with the subsidiary(ies) since they transmit protected health information (PHI) or personally identifiable information (PII) as part of the billing process with payers on behalf of the subsidiary(ies).

BAAs are the agreement a covered entity has with another organization that is accessing or sharing PHI or PII. Exceptions are possible but have not yet been raised for consideration.

15. Is there a list of organizations that would like to serve as a UHO?

No. Potential or existing UHOs are encouraged to reach out to National DPP providers in their state or region to gauge interest in forming a UHA.

- Potential UHOs may evaluate their readiness to serve as a UHO by completing the [UHO Capacity Assessment](#) found on the Coverage Toolkit.
- For more information on becoming a UHO, contact CDC through the [National DPP CSC's Contact Support feature](#).
- Organizations should consult with their legal counsel on their specific business arrangement.

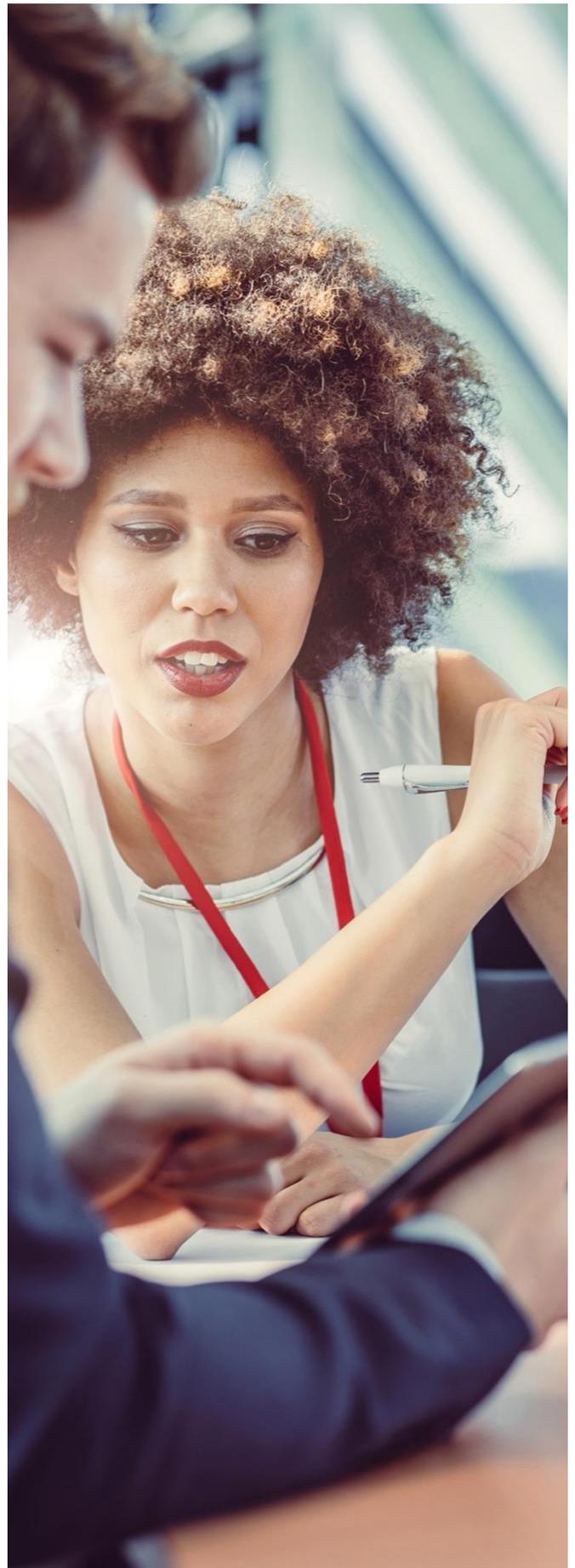
16. What are the benefits to UHA participation that can be used to recruit subsidiaries? As a CDC funded recipient providing support for start-up of UHAs in my state/association, how should we prioritize which National DPP providers will most benefit from the UHA services if there are limited spots?

Subsidiary organizations can benefit from participating in the UHA by receiving administrative support (e.g., claims submission), shared DPRP recognition status, and leveraging economies of scale. When identifying subsidiaries, UHOs are encouraged to consider subsidiary organizations' needs for administrative support and willingness to enter into contractual agreements, including BAAs and data use agreements, before joining the UHA.

17. Is there a limit on the number of subsidiary organizations per UHA?

In general, CDC limits the initial number of subsidiaries to six per UHA for the first year of implementation. This is intended to allow a UHO time to gain experience and ensure the UHO has the internal capacity to manage the subsidiary organizations. Under the [National DPP UHA Guidance](#), CDC may make exceptions to this cap for UHAs established with the support of a CDC-funded recipient (State Health Department or national organization) who is participating in either the UHA Learn. Explore. Activate. Problem-solve. (LEAP) lab or the UHA track of the Medicaid Enrollment Project.

Subsidiary organizations contribute to the UHA's sustainability by sharing the administrative costs of operating the arrangement and by the volume of participants they engage. A UHA with several subsidiaries may be more attractive to payers as they gain access to a network of CDC-recognized organizations by contracting with the UHO. After a year of demonstrated success, including submission of DPRP data on the specified timeline, a UHA may add up to 15 additional subsidiaries per year.



Structure of a UHA

Roles and Responsibilities of Subsidiaries

18. What are the expectations of the subsidiaries?

Expectations of subsidiaries include providing the National DPP, reaching populations of focus, submitting data, training and deploying lifestyle coaches, being open to technical assistance and guidance from the UHO, and contributing financially to the success of the UHA.

In the application process, subsidiaries need a letter of intent, a fully executed BAA specifying agreement with any additional accountability requirements specified by the UHO, and inclusion of the UHO as a contact in the DPRP portal.

Startup costs and ongoing operational costs such as licensing of the billing platform are handled between the UHO and subsidiaries. These will be defined in the BAAs.

19. How are UHOs and subsidiaries connected to form a UHA? What are the main elements of a charter and is there a template available?

Charters and contracts help bind the UHA together. These tools document and legally bind the subsidiaries to the expectations once they are agreed on by both parties.

The charter can capture the UHA's shared mission, objectives, goals, and member, subsidiary, and UHO roles and responsibilities. Although charters are not required legal documents within a UHA, they are recommended to ensure alignment and understanding among and between participants of the UHA.

Contracts can detail the expectations, roles, and responsibilities for each entity in the UHA. For example, a contract can outline financial commitments for the administrative services the UHO provides.

The [Coverage Toolkit UHA webpage](#) offers examples of charters between a UHO and subsidiaries ([sample charter 1](#) and [sample charter 2](#)) and of BAAs between all UHA participants ([BAA sample 1](#) and [BAA sample 2](#)). For an example of how the different contracts and agreements can join a UHA together, see the [Diagram of Contracting in the Umbrella Hub Demonstration](#). These resources are provided by the CDC-funded Umbrella Hub Demonstration project.

20. What are typical percentages for subsidiaries to pay into the UHA?

To work toward sustainability and maintain financial health for both the UHO and the subsidiary organizations, the UHO will likely charge the subsidiary organizations a fee for the administrative services. How much the UHO charges, when to initiate those charges, and how to collect the funds is determined by the UHO and subsidiaries.

21. Is there a list of organizations that would like to serve as a subsidiary in a UHA?

No. For more information on becoming a subsidiary in a UHA, contact your State Health Department.

Potential subsidiaries may evaluate their readiness to serve as a subsidiary by completing the [UHA Questionnaire](#) found on the Coverage Toolkit.

Structure of a UHA

Program Delivery Mode and Curriculum

22. Are the subsidiaries and UHO required to deliver the program in the same delivery mode?

Yes. At this time, UHAs are approved for in-person delivery. The UHO and the subsidiaries must have a DPRP organization (org) code for in-person delivery. They may have org codes for other delivery modes, but only data for participants in the in-person programs will be included in the UHA.

During the public health emergency, an MDPP supplier may deliver the program virtually. However, the UHO and subsidiary still require in-person delivery org codes while delivering virtually during the public health emergency.

23. Do subsidiaries all need to use the same curriculum?

No. Subsidiaries do not all need to use the same curriculum. Refer to the [approved curricula that meet the CDC requirements for recognition](#).



Structure of a UHA

UHAs with MDPP Suppliers

24. If one organization in a UHA is an MDPP supplier, should that organization serve as the UHO to share revenue from Medicare reimbursement with its subsidiaries?

One of the biggest advantages of UHAs for many National DPP providers is the ability to offer the MDPP without needing to go through the application process. For this reason, whichever organization serves as the MDPP supplier for the entire UHA should consider serving as the UHO. Under the UHA, the UHO acts as one MDPP supplier and subsidiaries do not need to separately enroll as suppliers.

At this time, it makes the most sense to have the UHO bill on behalf of the subsidiaries (CMS has accepted this arrangement) rather than try to subcontract the billing role to a subsidiary. Various arrangements might be possible and are subject to what other payers will accept.

25. Can a MDPP supplier establish a data-only UHA with a National DPP organization to achieve full CDC recognition?

No. The UHA must offer billing services and may provide other services, such as data management or help with referrals. A UHO may accept a subsidiary(ies) that are not yet ready to bill; however, the UHA must execute a billing arrangement with at least one payer within two years of approval as a UHA.

26. Can a UHA be used to provide the MDPP in our healthcare system with health facilities located in multiple communities in the region, one of which has full CDC recognition while others have pending recognition?

Yes. A UHA can be used to provide the MDPP for a health system where some locations only have pending recognition.

27. Can one UHA cover two adjacent states for MDPP?

Yes. A single UHA may cover multiple states.

Medicare Administrative Contractors (MACs) process the MDPP claims for programs within their jurisdictions. It will be necessary to determine whether the adjacent states within the UHA are within the same or different MAC jurisdictions. The UHO will be required to apply for and establish an administrative location in each MAC jurisdiction. For more information about the role of the MACs, refer to the [CMS MAC webpage](#).

Other considerations may drive the decision about the number of UHOs to serve multiple states including the administrative and technical capacities of the UHO and the partner and network relationships.

28. What next step must an existing MDPP supplier take to be operational as a UHO and then form a UHA?

See the [UHO Checklist](#) on the Coverage Toolkit website for the steps to become a UHO, including steps to modify an existing MDPP supplier enrollment application to include subsidiaries and submit to CMS.

If an existing MDPP supplier wishes to become a UHO for a UHA, they would modify their existing MDPP supplier enrollment application in the [Provider Enrollment, Chain, and Ownership System](#) (PECOS) to add the subsidiaries as administrative locations/community settings and add the coaches for the subsidiaries to the coach roster.

Then, the MDPP supplier would need to operationalize their billing process (i.e., establish a contract with a billing platform, utilize an existing billing platform, or create a new billing platform; test claims and submission process, and contract with commercial payers).

29. Can an existing MDPP supplier join a UHA?

Yes. Depending on how the UHA arrangement is established, the MDPP supplier may either: a) serve as the UHO, maintain their MDPP supplier account, and bill Medicare on behalf of the UHA; or b) participate as a subsidiary, deactivate their existing MDPP supplier account, and bill through the MDPP supplier account of the UHO.

Other considerations may drive the decision about whether this an appropriate step, depending on the benefits of joining the UHA to the MDPP supplier.

30. Must a UHA subsidiary be an MDPP supplier?

No. Being an MDPP supplier is not a requirement before establishing a UHA.

One of the benefits for a subsidiary in joining a UHA is accessing healthcare payments through the UHO's contracts with payers, such as Medicare and commercial payers (including Medicaid Managed Care Organizations [MCOs] and Medicare Advantage [MA] Plans). See the [UHO Checklist](#) on the Coverage Toolkit website for the steps a UHO would take to become an MDPP supplier.

31. Can an organization with full CDC recognition for a distance-learning program apply to become a UHO to facilitate an in-person program (which is currently on hold due to COVID-19) and enroll as an MDPP supplier?

Yes. The organization will need to take several steps over a period of time.

Refer to the [CDC DPRP Standards and Operating Procedures](#). The [National DPP Customer Service Center](#) offers ongoing updates and a Contact Us feature for additional support on recognition.

An organization with full recognition for its distance learning program may apply for an in-person delivery org code. They will be awarded temporary preliminary recognition for the in-person program until they have sufficient in-person data to be evaluated for recognition on that submission. Temporary preliminary recognition for the in-person program will allow the organization to apply to become an MDPP supplier.

While CMS is allowing virtual delivery during the public health emergency, this only applies to organizations with an in-person org code.

Sustaining a UHA

Business Structure for Billing

32. What are the steps to set up the billing process for National DPP reimbursement?

Refer to the [Umbrella Hub Organization Checklist](#) which lists steps in establishing the contract and/or BAA with subsidiaries, facilitating contracts and/or BAAs between the billing platform and subsidiaries, and testing the claims and submission process.

33. Do most UHOs contract with a third party for billing or build their own system?

A primary purpose of the UHO is to submit claims on behalf of the subsidiaries. UHOs may leverage an in-house platform that all subsidiaries can access or contract with a third-party vendor to submit claims.

Given there are limited UHOs as examples and they are in the early stages of implementing the UHA model, there is a small sample from which to draw trends. Most of these initial UHOs contract with a third-party vendor for billing services and to submit claims.

34. Where can more information be found about the billing platform options for the National DPP and other services, including the cost, process, training, and other support available?

Billing platform vendors for the National DPP include the American Diabetes Association, HabitNu, and Welld Health. For more information, visit:

[American Diabetes Association's DPP Express](#)

[HabitNu's platform for DPP](#)

[Welld Health's platform](#)

35. What are ways to obtain leadership buy-in, especially leadership focused on the bottom line?

- Articulate the UHA's value proposition and how it can help advance the goals of the organization or payer, including health equity.
- Highlight participant success stories to communicate positive outcomes to the organization or payer.
- Refer to the [Modifiable Slide Deck](#) for presenting the business case and value proposition to leadership.

Sustaining a UHA

Medicare Reimbursement

36. What are the steps for billing CMS for the MDPP?

Refer to the [Coverage Toolkit MDPP Implementation Resources](#) for information about billing CMS for the MDPP.

Watch the two-part Billing Workshop hosted by CDC, CMS, and NACDD focused on increasing general knowledge about the MDPP billing and claims processes:

- [MDPP Supplier Learning Series Billing Workshop Part 1](#) – On Sept. 22, 2021, part 1 demonstrated how MDPP enrollment and the [Provider Enrollment, Chain and Ownership System](#) (PECOS) application processes impact billing.
- [MDPP Supplier Learning Series Billing Workshop Part 2](#) – On Nov. 10, 2021, part 2 presented the process for submitting a successful MDPP claim to CMS.

37. What is the current MDPP payment rate?

The CMS calendar year 2022 Medicare Physician Fee Schedule will reimburse for the year-long program at the rate of \$705 for one year if all benchmarks are met.

Note that when billing for Medicare beneficiaries, MDPP suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect any additional amount from an eligible beneficiary. MDPP suppliers may not deviate from the MDPP Fee Schedule with the outcomes-based benchmarks when billing CMS for MDPP services provided to fee-for-service (Original Medicare) beneficiaries.

Regardless of Medicare coverage (e.g., fee-for-service or Medicare Advantage), under no circumstance may an eligible Medicare beneficiary be charged for MDPP services.

38. Is it possible for the UHO to submit claims to a Medicare Administrative Contractor (MAC) on behalf of a subsidiary, but have the payment made directly to the subsidiary?

To date, we are not aware of any cases where CMS or other payers have approved an arrangement like this. [Contact your MAC](#) or other payers with your proposed arrangement for consideration.

39. What is the process for billing a Medicare Advantage plan?

If an MDPP supplier contracts with a MA plan to provide MDPP services to plan enrollees who receive their Medicare coverage via Medicare Part C, the MA plan is not required to utilize the MDPP fee schedule, although they often do follow the same payment structure. The two parties may determine their payment structure. MDPP suppliers would then request reimbursement per their agreement with the MA plan from the MA plan directly for any MA plan enrollees.

For more information and resources, visit the MA Plans and the MDPP section of the Coverage Toolkit's [MDPP Basics webpage](#).

Sustaining a UHA

Other Payer Reimbursement

40. How can a UHA inclusive of all payers be built?

Positioning the UHA to capture healthcare payer reimbursement is an important step towards achieving sustainability. The UHO can position the subsidiaries to access a wide array of payer reimbursement by enrolling as an MDPP supplier and Medicaid provider—in states where the National DPP lifestyle change program is a covered Medicaid benefit—and by contracting with MA plans, MCOs, other commercial payers, and self-insured employers.

To contract with commercial payers (including Medicaid MCOs, MA plans, and other commercial payers), use these resources and considerations:

Coverage Toolkit Resources:

- [The Case for Coverage for Commercial Plans and Employers](#)
- [Coverage in Practice](#)
- [Contracting with CDC-Recognized Organizations](#)
- [Prospective Contract Components Between a Commercial Payer and a CDC-Recognized Organization](#)

First, identify payers in the UHA's region with which the UHO might contract (see [Participating Payers](#) of the Coverage Toolkit for assistance).

Then make a business case to potential payers by articulating the UHA's value proposition and how it can help advance the goals of each payer. Lastly, communicate positive outcomes to the payers by highlighting participant success stories.

Connect with payers by:

1. Reviewing the payer's website to become familiar with the payer
2. Identifying a point of contact within the payer organization
3. Requesting a meeting with the payer to present the UHA and the opportunities it presents for the payer
4. Beginning the contracting process with the payer
5. Finalizing the contract

41. Are private payers also reimbursing for MDPP?

Only CMS reimburses for the MDPP. Private payers and other public payers could reimburse for the National DPP lifestyle change program. For a full list of plans that reimburse for the National DPP or MDPP, see the [Participating Payers](#) webpage of the Coverage Toolkit.

We also suggest looking into MA plans. MA plans are Medicare health plans offered by private companies, and they can contract with Medicare-enrolled MDPP suppliers to provide MDPP services to their enrollees, or the MA plan can enroll in Medicare as an MDPP supplier itself. Refer to the [CMS Fact Sheet on Medicare Advantage Plans](#) as a resource.

42. Does the UHA have to accept all insurance?

No. It is not required for a UHA to work with all insurance carriers. It is up to the UHA to decide which payers they want to bill. Each payer will have different requirements, so the UHA will need to negotiate arrangements separately with each one.

43. How are services provided to a mixed cohort of Medicare and non-Medicare participants?

CMS states that MDPP suppliers may bill Medicare beneficiaries while providing the National DPP lifestyle change program to a mixed cohort of both Medicare and non-Medicare beneficiaries.

The CMS regulations governing the MDPP services only apply to the Medicare beneficiaries. Note that CMS cannot speak to or provide regulations on the payment rates organizations establish for the National DPP to non-Medicare participants.

The MDPP supplier is not bound to the Medicare fee schedule for National DPP services provided to either non-Medicare beneficiaries or Medicare beneficiaries who do not meet the eligibility criteria to receive MDPP services.

All participants, regardless of their Medicare status, would be subject to the requirements of the CDC's National DPP.

44. How are services provided to uninsured participants?

For self-pay clients, including those whose insurance does not cover the National DPP services, suppliers should bill the client directly. The UHA should seek counsel regarding the amount it charges for the delivery of services.

Note that CMS cannot speak to or provide regulations on the payment rates organizations establish for the National DPP to non-Medicare participants.

45. Are there state or federal government grant opportunities to incentivize the startup of potential UHOs or fund a pilot?

Yes. It is recommended that organizations interested in participating as a UHO first reach out to their State Health Department Diabetes Program or participating [national organizations](#).

Resources for UHAs

46. What resources are recommended for preliminary interest in participating in a UHA as a UHO or subsidiary?

The following documents are recommended and may be requested through the [National DPP CSC Contact Support](#) feature for those who want to pursue either becoming a UHO or participating in a UHA (as a subsidiary):

- [UHA Landscape Analysis](#)
- [UHA Questionnaire](#)
- [UHO Capacity Assessment](#)
- [Modifiable Slide Deck](#)
- [National DPP UHA Guidance and Application](#)
- [Considerations for Purchasing Technology Platforms for the National DPP, DSMES, and Pharmacists](#)

47. Is there a step-by-step guide for signing up as a UHO that outlines what type of organization is eligible and requirements?

Yes. The [Umbrella Hub Organization Checklist](#) resource captures the main steps needed to operationalize a UHO. However, it is not meant to be a step-by-step process, as the order may vary for different organizations.

See [National DPP UHA Guidance and Application](#) for the latest guidance and application on becoming a UHA.

48. What are some key UHA resources that can be accessed from the [Coverage Toolkit UHA webpage](#)?

- [Sample BAA for UHO Subsidiary and Billing Platform \(Example 1\)](#)
- [Sample BAA for UHO Subsidiary and Billing Platform \(Example 2\)](#)

- [Sample Charter Between a UHO and Subsidiary \(Example 1\)](#)
- [Sample Charter Between a UHO and Subsidiary \(Example 2\)](#)
- [Diagram of Contracting in the Umbrella Hub Demonstration](#)
- [UHA Basics Webinar](#)
- [UHA One-Pager](#)
- [UHA Terminology Guide](#)
- [Checklist to Help Organizations Establish a UHA](#)

49. Where can the UHA Basics webinar be accessed?

The UHA Basics webinar introduces viewers to UHAs and provides basic information about the who, what, and why of UHAs. Information is provided on the sustainability and the role of State Health Departments in supporting the development of UHAs.

The UHA Basics webinar recording from August 19, 2021, is posted on the [Coverage Toolkit UHA page](#).

50. How can an organization become part of a UHA LEAP Learning Lab cohort?

The UHA Learn. Explore. Activate. Problem-solve. (LEAP) Learning Labs are offered by NACDD to help State Health Departments and 1705 recipients and affiliates understand their role in supporting the development of UHAs that access healthcare payments for sustainability. Participants are expected to work toward establishing at least one organization as a UHO, to bill Medicare and/or other payers (e.g., Medicaid, commercial payers).

State Health Departments and 1705 recipients are notified by NACDD and CDC when new cohorts are forming and can indicate their interest in participating at that time.

Terms and Acronyms

- BAA = Business Associate Agreement
- CDC = Centers for Disease Control and Prevention
- CMS = Centers for Medicare and Medicaid Services
- DDT = Division of Diabetes Translation
- DPRP = Diabetes Prevention Recognition Program
- FAQs = frequently asked questions
- MA = Medicare Advantage
- MAC = Medicare Administrative Contractor
- MCO = Managed Care Organization
- MDPP = Medicare Diabetes Prevention Program
- NACDD = National Association of Chronic Disease Directors
- National DPP = National Diabetes Prevention Program
- National DPP CSC = National Diabetes Prevention Program Customer Service Center
- PECOS = Provider Enrollment, Chain, and Ownership System
- UHA = Umbrella Hub Arrangement
- UHO = Umbrella Hub Organization

This UHA Frequently Asked Questions document contains questions adapted from those asked by participants during UHA learning events, including the UHA Basics webinar held in August 2021 and UHA Office Hours held in November 2021, February 2022, and May 2022. Answers were provided by subject matter experts from CDC's Division of Diabetes Translation, Leavitt Partners, and NACDD.

If you have additional questions or need further clarification, contact us at nacdd.diabetes@chronicdisease.org.

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