

**CMS All Tribes Call
Medicare Diabetes Prevention Program (MDPP) Webinar
December 14, 2016**

Ms. Ryan: Thank you. Good morning and welcome to today's All Tribes Call on the Medicare Diabetes Prevention Program. I'm Rachel Ryan with the Tribal Affairs Office and the Center for Medicaid and CHIP Services. The purpose of today's All Tribes Call is for CMS staff to provide a brief overview of the Medicare Diabetes Prevention Program Model Expansion. We're interested in hearing more about the Special Diabetes Program for Indians and receiving feedback about the Medicare Diabetes Prevention Program Model. I'm joined today by Shanara Smith and Carly Bird from CMS. Ms. Bird is the team lead for the Medicare Diabetes Prevention Program Model Expansion and she will provide a brief overview of the program. We're also joined by Patricia Schumacher from the Centers for Disease Control and Dr. Ann Bullock, Director of the Division of Diabetes Treatment and Prevention with Indian Health Service. Ms. Schumacher will also provide an overview of the program from CDC's perspective and Dr. Bullock is on the phone to answer any IHS specific questions or concerns. I'll turn it over to you Carly for an overview of the program and then we can open up the call for discussion.

Ms. Bird: Great. Thank you so much. So, hi everyone. Thanks so much for joining today. What I'm going to try to do in about 10 minutes or less, I'm hoping, is to go over the highlights of what was finalized in the last round of rulemaking and what we intend to address in future rulemaking and also try to highlight some of the areas where we know you all have concerns about and had submitted comments during our last rulemaking process. And, what I'm hoping to do in the latter half of the call is hear about the Special Diabetes Program for Indians, learn more about it, and how it intersects with MDPP or how it may intersect and also hear some of your

concerns that may help inform our next round of rulemaking. There's several policy areas that we are intending to address in one more round before the benefit goes live in 2018. So with that, I'm going to start by just describing what was finalized in the last round of rulemaking for the benefit. So, the MDPP benefit was proposed to mirror the National DPP as closely as possible. What we were able to finalize in the last round was that the benefit would be a 12-month core benefit with optional maintenance sessions on an ongoing basis. We did finalize that this would be a preventive service and clarified in the final rule that the benefit would not require any co-pay for eligible beneficiaries. We also finalized that the benefit would require the use of a CDC approved DPP curriculum, not just one type of curriculum, but a CDC approved curriculum, um, either their standard or something that alternatively that has been approved and we also clarified that, um, beneficiaries who are participating in the 12-month core benefit do have access to the entire year of the core benefit, and then, if they meet weight loss, the minimum weight loss in the last three months of the core sessions, that they would be able to go on to ongoing maintenance sessions. We also finalized some aspects of the beneficiary eligibility criteria. Most of the criteria were finalized. So, benies have to be enrolled in Medicare. They have to have a BMI of at least 25 and 23 for those self-identified as Asian. They have to present one of three blood tests and they cannot have a previous history of diabetes, although gestational diabetes is okay. One of the things that we are intending to address in our next round of rulemaking is, "What happens when a beneficiary is diagnosed with diabetes during the program? Do they get kicked out? What happens?" So, we do intend to address that in our next round. We also heard from the tribal organizations, in particular, some concerns around the once for lifetime benefit restriction and we did finalize this as a default policy but we said in our final rule that we intend to address any exceptions to this restriction in future rulemaking as needed. So, that is something where we

would like to hear some of the tribal organizations concerns around that policy. We also intend to propose a limit to the ongoing maintenance session. We did hear a lot from commenters that it was not sustainable for their organizations to have maintenance sessions in perpetuity. So, we do intend to propose a cap and we welcome your comments on that as well. We finalized our referral policy; so, no referral is necessary for coming into the MDPP. We also finalized that CDC recognition will be the basis upon which CMS will determine eligibility for enrollment. We were able to finalize our proposal that *** (*unclear* - 5:35) have full recognition as a requirement to enroll and we were not able to finalize our original proposal around preliminary recognition because of...because we weren't able to propose the specifics around the standard in the proposed rule. So, we intend and we state in the rule to propose that preliminary standard as an interim CMS standard in our next round of rulemaking before the CDC BPRP standards go into effect and we are doing this so that enrollment, uh, because we intend for enrollment to start beginning before 2018 that this CMS finalization of a preliminary standard will allow organizations that meet that standard to enroll before the new CDC standards come into effect. So, happy to answer any questions about that because I know it was a source of confusion for a lot of commenters. We also finalized our proposed screening level of high risk for enrolling MDPP suppliers and this was also an area where I know TTAG and others that submitted letters within that campaign had some concerns. And, we are looking into our program integrity manual, which is also published to the public to try to better understand how this higher screening and fingerprinting applies to different organizations and are hoping that we are able to get enough information to release a sub-regulatory guidance versus, you know, another round of rules, but we do recognize that this is a concern for many and are open to your thoughts on how to communicate that policy. Um, we also finalized... Um, we finalized part of our, um, of flat

supplier enrollment, unfortunately we were not able to finalize all of our policies regarding supplier enrollment. What we did finalize was that suppliers would enroll at the organizational level and then the coaches upon enrollment, the organizations would submit a roster of their coaches NPI's. So, those are the National Provider Identifiers. So, lifestyle coaches as part of MDPP would have to obtain NPI's and then the MDPP organization upon enrollment would have to submit those to CMS. What we weren't able to finalize, unfortunately in this round of rulemaking was, "What then does CMS do with that information and how does it impact enrollment or, um, well, at the beginning of enrollment and throughout the program?" So, we intend to propose more specifics around that in our next round of rulemaking and we welcome your input on that as well. I'm going to skip over to some finalized policies around IT infrastructure and capabilities. I know this is also an area of concern and we are really looking for some ways that we can be more proactive about providing technical assistance to suppliers of different types and know that this is an area that we...that is a concern for the tribal organizations. So with, you know, with our submission of claims policy, you know it as a standard for Medicare to use electronic claim submissions. There are exceptions to that based and, you know, we can talk through your concerns about that and try to provide guidance around the exceptions in either sub-regulatory or future rulemaking. We also finalized that suppliers would have to maintain medical records that contain detailed documentation of the services furnished the beneficiaries. We did not require the use of any HR in this final rule. We know that a lot of organizations in this new type of service are not, you know, yet part of a larger healthcare system and may not have an electronic health record in place and we, um, and are new to medical record keeping. So, that was something that we did require in this round of rulemaking and they're open to your thoughts on that. Um, other kind of infrastructure and IT

capabilities/policies that we finalized in this last round of rulemaking was that MDPP suppliers would have to maintain and handle any PII and PHI in compliance with HIPAA and other privacy laws and CMS standards. So, that's pretty, you know, much in line with how existing providers and CMS operates. And now, I'm going to just quickly review the outstanding, the large kind of areas outstanding policies that we weren't able to finalize in addition to kind of the deferred policies that I highlighted as I was going through each of these different areas. So, supplier enrollment is kind of the biggest, is one of the bigger ones: how the coach roster will affect the MDPP supplier. We are planning to address that in our next round of rulemaking and we also will be proposing our payment structure. We did include it, the table of the reimbursement structure in our last round of rulemaking but we didn't specifically... We didn't explicitly propose it. So, in this case, we will take the comments that we received on that structure and respond to them in our next round of rulemaking and we are happy and welcome to hear the tribal organizations perspective on this current payment that was outlined. We will also be addressing the issue of virtual MDPP services in our next, um, we intend to address it in our next round of rulemaking and I know this was another area where you all may have some thoughts that may help us inform our upcoming policies. So, I will pause there. I know I went through it really fast. I basically followed the MLN webinar that I know is included as a link in the document that was sent out for this call. So, if you're looking for kind of more information, the final rule is there obviously, and this webinar, but at this point I will actually ask Pat Schumacher from CDC to just provide a little bit more from CDC's perspective on the CDC recognition aspect and knowing that CDC has also engaged in discussions with tribal organizations around the concerns there. So Pat, I'm passing the mic to you.

Ms. Schumacher: Okay. Thanks and appreciate the opportunity to be on the call this afternoon. I'm going to just briefly touch on one of CDC's key roles in our work on the National DPP which is the Diabetes Prevention Recognition Program. And, I think as most of you know that's primarily a quality assurance function in running the recognition program and we actually had two webinars earlier this fall for tribes who were interested in learning more about CDC recognition and the process for applying for recognition. We had very good participation on the webinars. I think we had in total over 300 people who joined us for those discussions and, you know, it gave us an opportunity to talk about the National DPP in more detail and the recognition program specifically and it also gave us a chance to talk about some of the benefits of CDC recognition, in particular, why tribal programs would want to participate in a recognition program? So, we touched on four aspects of that, but I'll just share briefly with you this afternoon and the first of those was just the concept of unity, because the recognition program give us an overall umbrella that helps bring all diabetes prevention programs that are operating in communities across the US under one national framework which is a very powerful thing. The second aspect that we talked about was quality and as you all know the program is met to a set of national quality standards which is very important for all of us in terms of demonstrating outcomes across programs. And thirdly, we talked about data which gives us a way to monitor and really speak with one voice on how we're doing in diabetes prevention as a nation, as well as individually by program. And then, finally we focused on sustainability through reimbursement because if we're talking about Medicare here this afternoon, we also have a number of private payers across the country that are reimbursing for the program. All of those payers are basically coming back and requiring CDC recognition for a lot of the reasons we just kind of went through and emphasized. And that reimbursement helps programs cover cost and really sustain

themselves long-term, which is critical. So, we have been asked... In the course of these discussions, we have been asked by tribes that have been delivering the Diabetes Prevention Program under SDPI, why we can't automatically grant full recognition based on the work that they've been doing over the past few years; so kind of like a grandfathering in type approach. So I wanted to address that briefly this afternoon; just because there are a few very practical reasons why we just really can't do that. As I mentioned, the recognition program is a quality assurance program. So, that means it's very, very critical that we collect the same data in the same way from all of the organizations across the recognition program. Right now, we have over 1,100 organizations represented in our program, but we're really expecting that number to increase exponentially moving forward into 2017. So, it just becomes more and more important that we have processes in place that are applied in the same way across all of those organizations. And then secondly, as you all know this is a year-long program. So, in association with that, we have specific time frames that are tied to when an organization submits their data to CDC; in addition to what data they give us, what formatting it is submitted in and so forth. And that's important because in order for us to upload that information through our national database it has to be consistent. It has to be in one format so that we can do that. We analyze the data. We give it back to each program in the form of a report so they can monitor how they're doing against the standard and then we also, most importantly, we aggregate that information. So, we pull that together with all of the data across all of these other programs across the country so that we can monitor and we can report progress nationally. So, the point that I'm trying to make in saying and providing that background is that there's really a delicate balance here and each organization participating in the program has to be treated in the same way both for consistency, as well as quality. If we start making exceptions to those policies we really run the risk of undermining the

purpose of our quality assurance program, um, because there are many other organizations who would either want those exceptions or would want similar exceptions based on the data they collect, how they collect the data, what format they submit the data, the type of program that they're running and so forth. So, just to summarize, I'll just say, you know, it really gets back to maintaining the integrity of the quality assurance program and to do that it's really critical that we have protocols in place and that those protocols hold true across all of the organizations that apply for CDC recognition. And that helps us ensure that the recognition program actually means something and that we aren't comparing apples to oranges when we look at the data that we're collecting across different groups and then finally, as I said, that all organizations are treated fairly and consistently. So I'll stop there. I'm happy to take any questions at the end of the call, but I just wanted to give a little bit of an explanation behind the recognition program.

Thanks.

Ms. Bird: Thank you, Patricia. Um, I think we'll go ahead and open up the call now for discussion. Nick, if you want to give instructions for how folks can ask questions.

Operator: At this time I would like to remind everyone in order to ask questions press star and then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

(Pause.)

Operator: There are no further questions at this time. Please continue.

Ms. Bird: I don't think we have any more overviews to provide unless anyone who...any speakers on the call want to give more any information while we're waiting to see if anyone has questions or any questions that you want to ask of our participants.

Operator: Well, ma'am, we have questions from the line.

Ms. Bird: Great.

Operator: Thank you. The first question comes from the line of Ms. Alberta Rand. Please ask your question.

Ms. Rand: Hi, this is Alberta Rand. I'm from Phoenix Indian Medical Center. We just had a question about the eligibility for the program. What if they are on Metformin? They don't have diabetes, but they are on Metformin.

Ms. Bird: Um, thanks for that question. Our eligibility criteria don't take in to account Metformin. Um, they take into account BMI and falling into a range of one of three blood glucose results. So, those three tests are A1C, *** (*unclear* - 21:20) glucose, and 2 hour blood glucose, also known as the oral glucose tolerance test. So, Metformin won't be a part of the eligibility criteria.

Ms. Rand: So, if they are on Metformin, they are not eligible?

Ms. Bird: Not saying that they're not eligible, but they have to meet the other eligibility criteria in order to enroll in the program, because I know... A lot of pre-diabetics will go onto Metformin. So, if they don't meet the eligibility criteria while on Metformin that they are not eligible for the program.

Ms. Rand: Okay, thank you. We have another question as well.

Ms. Stowan: Hi, my name is Alicia Stowan. I'm also from PIMC. Did I hear you say that referrals were not necessary?

Ms. Bird: Yes.

Ms. Stowan: Okay. So, if we have an EHR program, there's no need for us to have a formal referral for DPP?

Ms. Bird: No.

Ms. Stowan: Thank you.

Ms. Bird: Thank you. I will just add that referrals are not discouraged. Um, one of the primary way that the models have...the DPP models have older people coming into the program was through their primary care physician referring them to the program. So, we highly encourage that linkage to happen, but we didn't want to require it at this time because it felt like it would be prohibitive to certain folks that either got their blood tests within the last year or maybe received their blood test from their community provider or at like an employer's health fair or something that doesn't necessarily link to their PCP's.

Operator: Your next question comes from the line of Ms. Melody Pelot from *** (*unclear* - 23:33.) Please ask your question.

Ms. Pelot: Yes, hi. I want to ask you about the lifestyle coaches that you were referring to about MPI's and providers. What kind of credentials do the lifestyle coaches have to have or they have special training?

Ms. Bird: Thank you for that question. That was definitely something that a lot of people asked in the comments. So, the coaches have to abide by the standards that CDC lays out in their standard operating procedures and Pat, you can probably fill in the details here, but there is a... There are no specific credentialing requirements, but the standards do lay out training requirements.

Ms. Schumacher: Yeah, and the only thing I'll add here is just, we do encourage organizations to have their lifestyle coaches trained as we get more data on the program. As it's run across the country we're finding there's a strong link between an *** (*unclear* - 24:39) relationship between the lifestyle coaches and the participants. So, having people, you know, as coaches who

are really well-trained and good facilitators and able to, you know, work well with the participants in the program is really, really important.

Ms. Perlot: And what are those backgrounds usually in? Are anybody with a bachelor level or it has to be master level or what kind of providers?

Ms. Schumacher: Um, we really have a variety of folks who serve as lifestyle coaches. It doesn't have to be a health care professional. We've also found that peer educators, community health representatives, and folks like that can actually be excellent lifestyle coaches, but again, they do need some basic training in not only the program curriculum and how to, you know, kind of run and facilitate the group, but also in related skills like motivational interviewing and how to basically get the most out of the group sessions.

Ms. Perlot: Oh, that's good. Thank you.

Ms. Schumacher: Sure.

Operator: Your next question comes from the line of Ms. Beverly Cook from Mohawk. Please ask your question.

Chief Cook: Hi. Um, I'm just trying to play a little bit catch up here. So, I'm assuming that if someone who is receiving Medicare payments for medical services, that if they're receiving diabetes prevention services from another program, that Medicare will still reimburse or are you saying that it has to be your diabetes prevention program?

Ms. Bird: Um, am I understanding your question correctly, um, that if someone is receiving diabetes related services, whether they would also be covered still for our program?

Chief Cook: No; diabetes prevention services. If there's another existing diabetes prevention program at the...

Ms. Bird: So, Medicare is covering MDPP and I'm not aware of any other Medicare benefit that exists that covers any prevention service. Yeah, so there are like obesity counseling services. Those are fine to be receiving in tandem with MDPP. The same with medical nutrition therapy, um, other things that might address pre-diabetes in a primary care setting, but this is the only Medicare Diabetes Prevention Program that Medicare will be covering. That doesn't mean that the *** (*unclear* - 27:40) go to another diabetes prevention program. It just wouldn't be paid for by Medicare.

Chief Cook: Okay. So, somebody coming to our clinic who's being counseled and who is receiving, you know, participating in an exercise program and so on for diabetes prevention and they're Medicare eligible, Medicare won't reimburse for those services?

Ms. Bird: So, they would only reimburse for those services if that program was following the...was recognized by CDC and it was a PC... Oh, I'm sorry. They were enrolled in CMS as an MDPP supplier, but this benefit doesn't open up for reimbursement of related services unless those are already reimbursable under some other code which I can't speak to. So does that help?

Chief Cook: Well, the picture that it's painting is that Medicare is only going to pay for diabetes prevention if patients are enrolled in your program and that in order to cover MDPP you have to meet CDC requirements and there's many programs who can't meet those requirements or can't sustain those requirements. So, I'm just seeing a lot of people that are not... I'm envisioning many people that aren't going to be able to...in clinics that aren't going to be able to receive reimbursement for providing services from Medicare.

Ms. Bird: Yeah. Okay.

Chief Cook: And that just seems wrong to me.

Ms. Bird: So, I hear what you're saying and I think I'm going to go back to something that Pat was saying earlier that the CDC program provides a certain standard for quality and data collection and that was the model that CMS tested and approved for expansion into the Medicare program because of its heavy reliance on high quality standards. So, we can't... CMS has an obligation to, you know, put in place coverage decisions based on a certain standard of care and for this particular benefit CDC's recognition, um, CDC's program is our standard for diabetes prevention programs. So, we hope that clinics, like the one that you're referring to, consider applying for a CDC recognition. I'm looking at the standards that are online that CDC has on their website and assessing whether their organizations can supplement care with fee services and build an infrastructure around the CDC standards.

Chief Cook: Okay. Thank you.

Operator: The next question comes from the line of Ms. Rae Johnson from KIC Tribal. Please ask your question.

(Silence.)

Operator: Ms. Rae Johnson, please ask your question.

Ms. Johnson: Um, my question was already asked and answered. Thank you. Can you hear me?

Ms. Bird: Yes, thank you. You can go to the next question, Nick.

Operator: The next question comes from...

Ms. Smith: I have a question. Uh, sorry Nick, I have a question. This is Shanara Smith from CMS. We were looking forward to learning more about SDPI. Is there anyone on the line that can share some information with us about SDPI and how it intersects with MDPP?

Dr. Bullock: Um, this is Ann Bullock with Indian Health Service. Are you looking for an overview of SDPI?

Ms. Smith: Yes, I think that will be great. We have quite a few members from our CPT team from CMS and that would be good for us just to, you know, kind of hear. Um, just a general quick...just a quick overview or anything that you think we might need to know.

Dr. Bullock: Sure, so SDPI or the Special Diabetes Program for Indians was first authorized by Congress in 1997 to enable to fund diabetes prevention treatment programs at Indian Health Service, tribal, and urban sites across the country. Those funds started at \$30 million per year and then were increased in subset by the year 2004; they were increased \$150 million per year and at that time we were also tasked not only with our general community directed grant program, but also to create a competitive grant program that will allow a select number of sites who applied successively to implement two main parts, uh, two main clinical kinds of projects that would look at recent science around diabetes prevention or treatment, one related to cardiovascular disease risk reduction with people with diabetes and the other, and the one relevant here, was one related to diabetes prevention. So, at that time 36 sites across Indian Country successfully applied for and then helped design and implement a DPP adaptation for, uh, across Indian Country called a Native Lifestyle Balance Program and that curriculum still exists and I believe is one of those CDC accepted curricula for the recognition program now. So, those 36 sites implemented the DPP, collected a lot of data. They were called demonstration projects to show that they were able to successfully translate the DPP to their communities. By 2010 with the new Funding Opportunity Announcement for a CPI, it shifted a little from proving that we could implement it to developing tools for other communities who wish to follow in this path of, for the most part, very successful programs. So, in 2010, they started work on some

toolkits and that toolkit for the diabetes prevention program is available on our website now. So, SDPI was allowed these 36, now 38 sites which are actually closing out because they've been successful in what they were charged with doing and now we're encouraging sites across the country to implement DPP, particularly through the CDC recognition program. So, the link between the two, is that we've been doing the DPP for years in Indian Country successfully and we have high hopes that those programs and hopefully many more will be able to fit into the CDC recognition program, achieve that recognition and to be able to bill for services. I hear Chief Cook's concern about some sites, especially smaller sites that may not have the numbers that will meet the criteria that CDC has put out there. I think that's a concern for everyone in small and rural areas who don't have the number of patients that they can draw from in order to perhaps meet some of those target required numbers. But, SDPI has certainly helped all of us in Indian Country to be more ready to go with the rest of the country into this whole new era of recognition and now reimbursement.

Ms. Bird: Great, thank you so much, Dr. Bullock. That's very helpful to connect the dots there. I'm happy to open it back up to questions and concerns from the remaining folks. I think it just helps to hear a little bit more context of how SDPI may fit, you know, intersects with DPP and now it becomes clear to me that SDPI can help organizations kind of prepare or establish that infrastructure to become ready for MDPP enrollment. So Nick, if you want to open it back up for questions, I'm happy to take more.

Operator: The next question comes from the line of Joanne Leonard. Please ask your question.

Ms. Leonard: Um, hello. We're actually a SDPI demonstration DP project; so, my question is about the beneficiary eligibility and this is for the medical DPP that's for Medicare Part B only, is that correct?

Ms. Bird: That's correct.

Ms. Leonard: Um, is there any way that will be changed down the road? I mean...

Ms. Bird: Oh, I'm sorry. Are you talking... Are you referring between like Medicare Advantage and fee-for-service?

Ms. Leonard: Well, I'm not sure because what I know here is that in our communities, our Medicare patients, a lot of them can't afford Medicare Part B. So, we were just trying to figure out if this is just for the Medicare Part B only people, then that's going to be tough for us here in our community. So, maybe my lack of understanding is on the Medicare part, but if it says Medicare is that the ones that just get Medicare A and B or just Medicare A only or Medicare B only?

Ms. Bird: Okay. Thank you so much for that clarification. It is a Part B service. Um, and it will not be covered unless the Medicare beneficiary does have Part B. I really appreciate this concern and I'm going to take it back to the team to see if we can address through guidance, you know, what those implications are and just think through it a little bit. So, thank you so much for that concern.

Ms. Leonard: Yeah, because I mean just through... I know you understand this but our people... We're like in one of the top five poorest counties in the nation. We don't want to not be able to... We're still going to provide this service regardless, but we would like to be able to bill for it, but it's like we can't because they just can't afford that Part B and I think it's unfair. And, I'm hoping that they would look at that and see if maybe they would make some kind of special exception for that, noting the disparity here. And then, my other question was, in the medical DPP was it...is there a target number for enrollment that you have to meet?

Ms. Bird: So, I can't speak to our target enrollment numbers, because for a lot of reasons, we're not... We're just unsure as much numbers as probably the rest of everyone else is. We are hoping they are high. That's all I can say. We are really hoping that we can work with stakeholders to get the word out and increase awareness of these new benefits, uh, about this new benefit and that suppliers begin enrolling across the country and we're really hoping that, you know, organizations that think they could meet the eligibility criteria for enrollment begin working on their CDC recognition now so that when it comes to the time to enroll as the benefit going live in 2018, there will be more suppliers or more organizations offering these services than there currently are and then your... I did have another... I just wanted to follow up on the Part A question. Are you talking about patients that are only on Part A or that are duly eligible for Medicaid?

Ms. Leonard: Medicare, right?

Ms. Bird: Yeah, but sometimes based on income they can be enrolled in both Medicaid and Medicare.

Ms. Leonard: I think we are both situation. We have a lot of elderly people here that are on Medicare...

Ms. Bird: Right.

Ms. Leonard: ...that aren't and they can't afford the Part B and so, the rest of the services are provided through the Indian Health Service and I'm sure that there's also the other mix of people that are on Medicare that also do get Medicaid as well.

Ms. Bird: Great. Thank you so much for that concern and I'm going to take this one back.

Ms. Leonard: Okay. We're actually working on our recognition status now, so we're going to kind of track some data on that too.

Ms. Bird: Oh, that's wonderful. And where are you located?

Ms. Leonard: We're in Pine Ridge. The Oglala Sioux Tribe, the Indian Health Service hospital.

Ms. Bird: Great, thank you so much.

Ms. Leonard: Ann Bullock knows of us. She remembers us.

Dr. Bullock: Absolutely. You guys are wonderful and that's South Dakota.

Ms. Leonard: That's right. Oh, yeah, South Dakota. Okay. Thank you.

Ms. Bird: Thank you so much.

Operator: The next question comes from the line of Ms. Ann Albright from CDC. Please ask your question.

Ms. Albright: Yeah, hi. No, I just needed to put a comment in there and it was addressed sometime back. So, thank you.

Operator: Next line comes from the line of Ms. Candace Krugensky from Shoalwater Bay Tribe. Please ask your question.

Ms. Krugensky: Hi, this Candace Krugensky from Shoalwater Tribe in Tokeland, Washington. I needed clarification on the NPI number. I'm a registered nurse, but I don't currently have an NPI number. Is there going to be a way for other personnel to get an NPI number, I'm assuming?

Ms. Bird: Yeah. Thanks so much for that question. We are aware that there is kind of a discrepancy between, you know, we're requiring the coaches to get NPI's and then other healthcare personnel that don't currently have NPI's. Um, so I can say right now is that if you are an existing provider and you become a lifestyle coach for the purposes of furnishing MDPP services, you will be required to obtain an NPI for the purposes of MDPP. Um, and then the supplier would submit that information as part of their enrollment. So, it would be applicable

just to your function as a lifestyle coach for MDPP, but not... It would be separate from, you know, if you're a nurse or other practitioner, um, it would not have any bearing on that other profession.

Ms. Krugensky: Okay. I have one more question. We're an FQHC. Is that going to affect our ability to bill for this service?

Ms. Bird: Thanks so much for asking that question. It's something that I actually skipped over when I was doing my overview. So, FQHC's are eligible to enroll as MDPP suppliers in the same way that other existing providers enroll. So, you would have to obtain CDC recognition and re-enroll as an MDPP supplier and there's some more details about that in our final rule. So if you just go to the final rule and Control F, um, FQHC's or Federally Qualified Health Centers, you will find that items there.

Ms. Krugensky: Okay. And is there a cost to becoming CDC recognized?

Ms. Schumacher: Hi, this is Pat. No, there's no cost involved in that.

Ms. Krugensky: Okay. That was my question. Thank you.

Operator: The next question comes from the line of Jemoli Opten (*sp?*) from Lake County Tribal. Please ask your question.

Ms. Opten: Hi, my question was already answered. Thank you.

Operator: Next question comes from the line of Ms. Alberta Rand from Navajo. Please ask your question.

(Silence.)

Operator: Ms. Alberta Rand, please ask your question.

Ms. Philigan: Uh, this is Alicia Philigan (*sp?*) from PIMC with Alberta. I had a question regarding the curriculum. I believe I read that there are three curriculums that are appropriate for

use, the CDC curriculum, the National DPP curriculum, and then there was a Native Lifestyle curriculum and I'm wondering, is there a website where that Native Lifestyle Program curriculum is available for other people, or is that just individual sites programs that have already been developed?

Dr. Bullock: This is Ann Bullock. It is available online. I'll get you the website here in just a minute. But yes, it is available. There are a few aspects of some of the nutrition recommendations that have been updated in other curricula, but otherwise it is still a very useful curriculum. You might just look for those little areas. We'll try to get out a web address for that.

Ms. Philigan: Okay, thank you.

Operator: Next question comes from Ms. Sarah Freeman. Please ask your question.

Ms. Freeman: Hi, good afternoon. This is Sarah Freeman from the National Indian Health Board. I did just want to mention a comment before I ask my question, but you know the reasoning behind the tribal perspective of obviously getting grandfathered in with the SDPI program is obviously because these programs have been successfully implemented already and it seems that you know, CMS and CDC, you know, failed to consult with IHS as well as tribal programs who already have these programs established and when you think of the disadvantage of the American Indian and Alaska Native population, especially when it comes to a chronic disease such as diabetes, that prevention is key and you know, really, it would have been wonderful if, you know, CDC and CMS had consulted with tribes prior to the proposal that was sent out, you know, due to Executive Order 13175. It's necessary to establish regular and meaningful consultation in the development of federal policies that have tribal implications and this is definitely obviously one of them. So, that's why, you know, we're already very concerned

about the potential of this program and, you know, we really believe that to be an incentivized program that maybe we don't have to have the SDPI program put forth, grandfathered fully, but is there are partial grandfathering such as maybe down alignment or just thinking about the measures of what's been successful in the SDPI program; you know, for example, BMI isn't always the best way to measure that and we understand that that's in the CCDPP program, that that's necessary, but that's not always something that tribes and I believe would probably prefer to be consulted with for future rulemaking, especially since this is so crucial with the effects on the ground and the rest of the Alaska Native population. But my question is, how long does it take to get certified? Because I've heard up to two years and I think that's a little long.

Ms. Bird: Thanks for your comment. Pat, do you want to talk about the certification process?

Ms. Schumacher: Yeah, sure. So, in terms of CDC recognition under our current national standards, it is... The National DPP, the Diabetes Prevention Lifestyle intervention is a 12 month, basically a year program. So, the program has to be delivered for a year and then data submitted on those participants to the recognition program in order to apply for a CDC recognition. So, as organizations come in, they submit an initial application. They're giving pending recognition based on that initial application and then they deliver classes. They deliver classes for a year. They submit data and based on the data then we make recognition determination. Now I will say, that our national standards are reviewed and updated every year, I mean every three years. So, we're going through that process now. So, we will be making some changes to the national standards again in alignment with our work that we're doing with CMS and to ensure that there's an adequate supply of programs across the US that can apply and maintain CDC recognition and deliver the program with quality and fidelity. So, those standards

as we go through that revision process, they'll be available for public comment as well in 2017. So, please look for those links.

Ms. Bird: And, I'll just add to that, what I mentioned earlier and it is more thoroughly outlined in the final rule, um, CMS is intending on proposing an interim preliminary recognition standard. That the intent of that standard is—and you know, it's outlined as such in the rule—is to be less of a...to be a lower bar than full recognition. And, we do provide an example of what that might look like and CMS will, you know, work... As we're working through both of our kind of rulemaking process in tandem with CDC's DPRP update process, CMS will propose specifics around that for the interim between 2017 and 2018 before CDC standards go into place. So, that is also a place to look at the new standards.

Dr. Bullock: This is Ann Bullock. If I might, that website where you can find the Native Lifestyle Balance Curriculum and information about it is nlb.hncpartners.org or you can actually just Google Native Lifestyle Balance Curriculum and that will bring you to this website as well. Just wanted those who were interested in finding the NLB Curriculum, it's there. And Ms. Schumacher, if you would, correct if I'm wrong, but I believe that that is considered to be an approved CDC curriculum for the purpose of recognition, is that correct?

Ms. Schumacher: Yes, that's correct.

Dr. Bullock: Thank you.

Operator: Your next question comes from the line of Ms. Cary Joseph. Please ask your question.

Ms. Joseph: Thank you. This is Cary Joseph with the National Indian Health Board and reading in the rule and talking about access to and disparities in access, um, the rule states that, "We acknowledge comments or concerns regarding potential unintended consequences if the MDPP

extended model results in low income or other disadvantaged populations having less access to ongoing maintenance sessions. We may consider making adjustments as appropriate. If we are monitoring an evaluation and through tribal consultation we find that such assessments are warranted to adjust disparities in access.” So my question is, what are your plans for monitoring and evaluating basically unintended consequences and measuring just how we can measure those disparities in access?

Ms. Bird: So, I can only speak to what’s in the rule. But I will say, this is why we want to engage with you all is to...for you to give us some, you know, recommendations of how we could monitor and evaluate to look for potential adverse effects of our policies on tribal groups and we would really welcome your recommendations on specifically around the evaluation and our monitoring plans. So, I hate to kick it back to you, but you know, we are doing our own internal planning for evaluation and you know, we consult with components of CMS and HHS through that process, but we also are open to stakeholders, like all of you on the phone, in a consultative manner that we are required to do under Executive Order to receive some of your consult.

Ms. Joseph: Okay. Thank you and so that would happen at a later date is what I’m hearing?

Ms. Bird: Um, so...

Ms. Joseph: Or is that to happen now? (*Chuckle.*)

Ms. Bird: So Rachel, I’m going to put this back to you. I’m not sure how it typically works. You know, we’re... If there is a way that Rachel can help facilitate something additional, um, but you feel is necessary for us to do here, then I think you can work through the CMS TTAG component to make that happen. Rachel, do you have anything to add there?

Ms. Ryan: Sure and actually this, um, sort of speaking to what... We have about a minute left. I’m going to go ahead and wrap things up and we have a Tribal Affairs mailbox. It’s

tribalaffairs, all one word, at CMS.HHS.gov. And, if you just want to send us an email, maybe kind of summarizing your comments, we can try to set something up off-line with the CMS office or try to kind of work through these issues and come up with some follow-up actions if that works for everybody. Again, that's tribalaffairs, all one word, at CMS.HHS.gov. And I am afraid that we are out of time, so we're going to go ahead and wrap things up. If anyone has any questions that you didn't have a chance to ask or any comments, again, that's what the mailbox is for. So, please send us those questions or comments, and we'll forward them to the appropriate people. And, I just want to thank you again for joining our All Tribes Call. A recording of this call is going to be available in about 10 days and you can access that by going to our website and a short link to that is go.cms.gov/AIAN. And that will be under the All Tribes Call on your left hand side and if you have trouble finding it, you can always just email us at the mailbox and we can send you the direct link. And again, that's about 10 days it takes for those to be ready. So, thank you again for everybody joining. Thank you to all of our speakers from IHS, CMS, and the CDC and we look forward to following up with everybody and working together on this program.

(End of webinar - 56:32.)