Medicare Diabetes Prevention Program Model Expansion Listening Session

Moderated by: Leah Nguyen
August 16, 2017, 1:30 pm ET

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network listening session on the Medicare Diabetes Prevention Program Model Expansion.

The calendar year 2018 Medicare Physician Fee Schedule proposed rule makes additional proposals to implement the Medicare Diabetes Prevention Program Expanded Model starting in 2018, including the payment structure as well as additional supplier enrollment requirements and compliance standards to ensure program integrity.

During this call, CMS experts provide a high-level overview of the proposed policies. Please note that feedback received during this listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the comment period on September 11th, 2017.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL – go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I would like to turn the call over to Carlye Burd, Team Lead for the Diabetes Prevention Program Model Expansion at CMS.

Presentation

Carlye Burd: Great. Thank you so much, Leah.

And thank you, everyone, for joining today's call. I'm joined today by some colleagues from the Innovation Center here at CMS as well as some colleagues from the Centers for Disease Control as well.

And what I'm going to be doing is walking through the PDF that you can find on the link that Leah just mentioned. And I'll be letting you know what slide number I am on and when we're going to go from one slide to the next so that you can follow along.

So, we'll start on slide 2 of the presentation. This is just a list of acronyms that we will be using throughout the presentation and will be really just a reference for you as you look back at this presentation.

How we're going to go through this presentation is we're going to provide a brief background on how we got here with the Medicare Diabetes Prevention Program Expanded Model. We're going to provide a brief recap of previously finalized rules in last year's Physician Fee Schedule.

And then, we're going to do a deep dive of the current proposed policies in this year's Physician Fee Schedule. And I have them listed here on slide 3. And I will go into each of the proposals in detail.

The actual rule provides a lot more detail than what I will be providing during today's presentation. So, I'm aiming to provide everyone with kind of a high-level overview to really educate everyone on the line on what we're attempting to do here with our proposals.

At the end, we will take some time to answer everyone's questions. Hopefully, we can get to most of them but probably not all of them. So, I look forward to answering those questions. But we'll just note that I can only speak to what's been proposed in the rule and what is described in the preamble of the rule and nothing much beyond that. So, I will be limited in some ways as to the information that I can share with everyone today.

I also want to note that at the end of the presentation, there is a link to a webinar that CDC will be offering next Wednesday, August 23, from 2:30 to 3:30. And as I go through the presentation, you'll find if you are new to MDPP and learning about what we're doing here that we are very closely aligned with what CDC is doing with their National Diabetes Prevention Program and the standards that they developed. So I really do encourage folks to sign up for that webinar, which is happening next Wednesday. And there is a link at the end of the presentation for that.

Background

On to slide 4. I'm just going to go over a brief background on how we arrived where we are at.

On to slide 5. So, most of you are probably aware of the very significant problem of type 2 diabetes, not just in the United States but across the world. In the United States, 25 percent of Americans over 65 have type 2 diabetes. So, this is a huge problem at the population level within the Medicare population specifically. And not only is this a problem for population health, but it's also been a huge problem for rising health care costs.

There has been estimates that diabetes contributes to about $104 billion of health care cost annually. And this number is expected to continue to grow unless we get a handle on the incidents.

So since the Innovation Center was established after the Affordable Care Act passed, CMS has been testing new health care delivery models to both improve health care quality and lower costs. And one of these models that the Innovation Center tested was DPP. And the DPP model test was among Medicare beneficiaries who received the Diabetes Prevention Program through the Y-USA across 17 different sites around the country. And this enrolled about 8,000 – almost 8,000 beneficiaries into the model test between 2013 and 2015.

The results of this model test were strong enough to show both cost savings and improvement in quality of care among those Medicare beneficiaries who participated in this model test, which resulted in the certification by the Chief Actuary at CMS and the subsequent announcement by the Secretary of Health and Human

Services back in the spring of 2016. That announcement was that DPP had met the statutory criteria for expansion and that we would engage in subsequent rulemakings, which is what we are doing now.

So last year we proposed and finalized one round of rulemaking to really establish the framework for MDPP. And this year, we are proposing and hope to finalize the remaining policies in order to go live with this new service and new covered preventive benefit for beneficiaries in 2018.

****Post-Call Clarification: And this year, we are proposing and hope to finalize the remaining policies in order to go live with this new service and new covered preventive service for beneficiaries in 2018****

Brief Recap of Previously Finalized Policies

So I'll be going on to slide 6, which is just a heading that we are now going to cover what – briefly what we finalized in last year's Physician Fee Schedule.

We'll go on to slide 7. We published the Physician Fee Schedule last November. And this final rule included a lot of policies that really established the MDPP as an expanded model and a set of services that Medicare would cover for all eligible beneficiaries.

So some of the policies that we finalized in that rule included the authority to expand the original DPP model test that I mentioned just a minute or so ago and the timing of this expansion and that it would begin in January 2018. This also included establishing the MDPP services as a preventive service, meaning there would be no copay for eligible beneficiaries participating in this service.

We also established policies around what the services actually were. We – and I'll get to this in a minute. But the service description includes 1 year of core benefit followed by maintenance sessions, which are available to beneficiaries regardless – at least the core benefit – regardless of weight loss.

We also established beneficiary eligibility policies, including that the beneficiary has to be enrolled in Part B Medicare, that they have to meet certain criteria for BMI and their blood test results and exclusion criteria such as they couldn't have a history or a current ESRD, which is end-stage renal disease, and also that this – these services would be once per lifetime and that a beneficiary could only receive the services under Medicare once per – in their lifetime.

We also established the criteria for these organizations that currently have CDC recognition to enroll in Medicare. So the CDC has a set of standards for organizations to meet full recognition. We are able to establish full recognition as one of the eligibility criteria for enrollment in Medicare. And we alluded to this preliminary recognition criteria, which I will talk about later in the presentation.

We also established that the organizations would enroll as suppliers, and that CMS would be establishing a new MDPP-specific supplier class in order to onboard and enroll these organizations who met the CDC criteria into Medicare. We established that the coaches that would be rendering the services for MDPP would be required to obtain National Provider Identifiers or NPIs but that they would not have to enroll in Medicare.

We also established that if an organization didn't continue to meet the CDC standards, the recognition standards, that their Medicare enrollment would no longer be valid and that the supplier would be revoked.

And, finally, we established that the suppliers participating in MDPP would have to adhere to certain requirements around the evaluation of the expanded model. And this really is a requirement that CMS has because this is an expanded model that is being expanded through CMMI authority.

We are required to continue to evaluate the model. So there are some requirements around some data that we need to collect from the participating suppliers. And I will get into that a bit more later in this presentation since there were some additional details that we provided in this last proposed rule around that policy.

So I will be going on to slide 8 now. Slide 8 presents a schematic for the structure of MDPP services. And if you've participated on any of our previous webinars, you probably recognize this diagram. And it really just tries to lay out what the MDPP services are.

So the services follow the CDC DPP curricula. The services include a 12-month core set of services and also maintenance sessions following those services. The first 6 months of the core benefit include 16 core sessions, which happen at a greater frequency. Oftentimes it's weekly and followed by monthly maintenance sessions in the second 6 months.

****Post-Call Clarification: The first 6 months of the core services include 16 core sessions, which happen at a greater frequency ****

In our last rule, we established that maintenance sessions – ongoing maintenance sessions after the first year would be available if the patient achieves and maintains the minimum weight loss of 5 percent. And I will speak in a minute to how we've adjusted that policy around maintenance sessions in this current proposed rule.

So, hopefully, that provides a nice refresher for anyone who is – was involved in last year's round of rulemaking. Or if you're new to learning about MDPP, this really is what we are offering in terms of the services provided to eligible beneficiaries.

And with that, I think I will go on to our current proposals in the 2018 Physician Fee Schedule. So, if everyone could turn to slide 10; I will start there.

Proposed MDPP Policies in CY 2018 Physician Fee Schedule

So our policies for the Physician Fee Schedule this year, importantly, included a proposed revised expanded model start date. In last year's rule, we proposed and finalized that we would make the services available starting in January 2018. And in this rule, we are proposing to postpone that start date to April 1st, 2018.

This final rule, if all policies are finalized, would be published November 1st with an effective date of January 1st, which means the soonest that suppliers could enroll in Medicare is January 1st. So we wanted to create enough time for suppliers – these new suppliers new to Medicare to enroll in Medicare prior to the services being rendered.

So all of the services are – excuse me – all of the policies related to furnishing and billing MDPP services will be effective April 1st, 2018. So this includes the beneficiary eligibility policies, the policies around the services themselves, the payment policies, and the beneficiary engagement incentive policies.

And those policies that are effective January 1st with the effective date of the Physician Fee Schedule include the supplier enrollment and compliance policies, which will allow sufficient time for organizations to enroll in Medicare prior to that April 1st start date.

We also proposed a series of terminology revisions, which are largely technical in nature but important in terms of our nomenclature and to clarify how these services are actually described in the regulation. So in our last round of rulemaking, we had described MDPP as a benefit, and we talked about the core benefit being the first year and the maintenance sessions following that core benefit.

We are now using the terminology "set of services" to describe the entire MDPP. What we used to call the "benefit" we're calling the "set of services." And this set of services is delivered over the MDPP services period. And that first year that was called the "core benefit" is now being referred to as the "core services," and those are delivered over the core services period.

The ongoing maintenance sessions – and I'll get to this again in a minute – have been – we are proposing to limit those to 2 years. So we are, again, going from "ongoing maintenance sessions" to describing these as "ongoing services period" to really describe that 2-year period of time in which these services are described.

In the last round of rulemaking, we used the term "bundle" to describe the 3-month intervals in which the core or ongoing maintenance sessions are furnished. And in this year's rule, we are using the term "interval" to describe those 3-month periods of time. And we are grouping them in this way because of how the payment is structured, which is something that I'm going to spend some time talking about during this presentation.

So moving on to slide 11 to talk about the proposed changes to the MDPP services and beneficiary eligibility policies. So many of these policies on this slide are responsive to both comments that we received in last year's rule as well as stakeholder meetings that we had throughout the last year.

So first is something we alluded to in last year's final rule around ongoing maintenance sessions. We heard from commenters that to offer ongoing maintenance sessions in perpetuity with no end would not fit into the business model for a lot of organizations.

So in this year's rule, we are proposing to limit those ongoing maintenance sessions to 2 years – to a 2-year ongoing services period, making the total MDPP services period 3 years.

Beneficiaries must attend three sessions within a 3-month interval of ongoing maintenance sessions in addition to maintaining that 5-percent weight loss goal in order to be eligible for additional intervals after the first. And this is not something that's required for the core services period.

During that period, we do not require that the beneficiary meets any attendance or weight loss goals in order to access those services. So the ongoing maintenance sessions have slightly different requirements in terms of beneficiary eligibility, and I think that's important to point out here.

We also extended the once-per-lifetime policy to the proposed 2 years of ongoing maintenance sessions during that period following the core services. So this really just takes the policy that we finalized last year around the once-per-lifetime services and applies it to the new proposed 2 years of ongoing maintenance sessions.

We also proposed changes in response to stakeholder feedback on how to handle beneficiaries who developed diabetes while receiving MDPP services. And we are proposing that individuals who do develop diabetes while receiving services will be allowed to continue receiving MDPP services throughout the time that they are covered under Medicare.

So this is really based on the DPP model test, which did not exclude individuals who developed diabetes during the program and also based on the fact that we believe it would be unduly burdensome and really just impractical to remove individuals who develop diabetes during the program.

We did consider excluding individuals who develop diabetes during the program because of other services such as DSMT that are available to individuals who have a diagnosis of diabetes. But we do point out in the rule that the services for Diabetes Self-Management Training are okay to receive at the same time as MDPP because they are substantially different enough and apply different principles and teach different techniques to individuals.

So we do state that it is okay for an individual to receive both services at the same time. However, we are seeking comments on this policy as well as the other policies I just mentioned.

In terms of make-up sessions, this again was something that we heard a lot that suppliers may offer make-up sessions to MDPP services virtually. So, we are proposing to allow a limited number of make-up – of virtual make-up sessions to beneficiaries who missed an in-person session. And we do propose limits on the numbers of virtual make-up sessions to make sure that the services that are provided are mostly in-person.

And I'll get to this later at the end of the presentation talking about the exclusion of virtual-only services from the MDPP Expanded Model. But, this does provide some flexibility to in-person organizations who offer make-up sessions virtually.

The limitations include – and these are, again, written out very clearly in the proposed rule – that a supplier can offer no more than four make-up sessions virtually within the core services period. And no more than two of those virtual make-up sessions can be during the core maintenance session, so those second 6 months of monthly maintenance sessions.

Virtual make-up sessions can include a limit of three virtual make-up sessions per year during that ongoing services period. So the limits are four in the core services period and three per year during the ongoing services period.

And the rationale behind this policy is that, again, we – you know, we knew that this was happening. CDC had given us a lot of information about organizations that offer virtual make-up sessions. And, also, within the CDC

standards, this has been included to – in that in-person organizations are allowed to provide virtual make-up sessions.

And when we looked at – when that policy was enacted under the DPRP standards, the CDC standards, or the DPP program, we found that the data that we used to evaluate and certify the DPP model test for expansion did include data after that policy had been released under CDC's standards. So there is – it is likely that some of the data that we used did include organizations that were offering these types of virtual make-up sessions.

Okay. So I am going to move on to slide 12, which is the proposed payment policy. And this schematic lays out the proposed payment structure, which is a performance-based payment structure. There is a table in the proposed rule that lays these out in a slightly different way. But we found that this schematic was helpful in tying together the set of services and the payments.

So if you start over on the left side, you can see that there's a $25 payment for the first session. Following the first session, there are three types of performance goals in which the payments are made for. The first is attendance-only–based performance goals, the second is weight-loss-based goals, and the third type of performance goal is a weight loss and attendance goal.

So with the attendance-only payments, these occur during the first 6 months, and payments are based on the achievement of attendance goals alone. So as you can see, the dollar amounts increase with the more sessions a beneficiary attends.

And this really is due to the fact that in the model test, we found that increased attendance in the DPP model test was strongly associated with a greater likelihood of increased weight loss. So, as you can see, you start with a $25 payment for the first session. And then, for the fourth session it increases to $30. For the ninth session, this payment increases to $50.

During the second 6 months, the payments are larger if a beneficiary can both meet the attendance requirements and meet that weight loss requirement. So for the attendance and weight loss requirement payments, there is a $60 payment. And then there is a $10 payment if just attendance goals are met.

So if you remember how the core maintenance sessions are structured, there are three sessions per 3-month intervals. So if all three of those sessions are met and that 5-percent weight loss goal is achieved or maintained, the supplier can receive a $60 payment for that 3-month interval.

A second $60 payment can be received if the following 3-month interval during that core services period is achieved. So those $60 payments, again, tied to both attendance and weight loss.

In the previous payment structure that we put out in last year's proposed rule, we did not include payment for attendance only during the core maintenance sessions. But we did do – we did provide a $10 payment in this proposed rule for attendance only because we do place some emphasis on attendance during that period and we recognize that beneficiaries may not achieve weight loss until sometime in month 7, 8, or 9.

So we do seek comment on these amounts, and we – because they are a slight departure from the original payment structure, we definitely want to hear everyone's feedback.

As you can see, the ongoing maintenance sessions following the core services period include a $50 payment for every three sessions attended in an ongoing maintenance session interval. And this also requires the individual to meet that 5-percent weight loss.

So these, again, are both attendance and weight loss goal payment and would require both those two performance goals to be met. There is no payment for a beneficiary to attend ongoing maintenance sessions only without achieving that 5-percent – or maintaining that 5-percent weight loss.

The weight loss payments are $160 for achievement of 5-percent weight loss. And this can be paid out at any time during the core services period. This is the largest payment that is available to suppliers in MDPP. And it constitutes almost a quarter of the total payment. And it is the largest because it is – that 5-percent weight loss is the most important outcome for the MDPP Expanded Model.

And this is really based on strong body – a strong body of evidence linking the association between that 5-percent weight loss and the reduction in the incidence of type 2 diabetes. So, you'll see that, you know, $160 can be submitted at any time during that core services period.

We know that it takes individuals varying amounts of time to lose that 5-percent weight loss. So, that payment can be received anytime within the first year. There is also a $25 bonus incentive payment for achievement of 9-percent weight loss. And that payment can be received at any time during the set of services, so any time during the 3 years of the MDPP services.

So that is the payment structure.

I'm going to move on to slide 13 where we talk about a couple of other payment policies.

One new policy that was not mentioned in last year's rule is this proposal to provide a bridge payment of $25 to suppliers for furnishing the first session to a beneficiary that is switching into the supplier's program from a previous supplier. And this proposal is really based on the fact that the new supplier receiving an individual and starting them in the middle of the program does take on some financial risk when that beneficiary switches.

And so this kind of helps cover that initial financial risk for that new beneficiary while preserving freedom of choice for beneficiaries to switch suppliers. We have heard from CDC that this is not a very common occurrence for individuals to switch suppliers. But we did feel that it was important to provide some cushion for a new supplier that takes on a beneficiary during the services period.

We are also proposing to establish a series of G-codes. These are commonly referred to as HCPCS codes or Healthcare Common Procedure Coding System codes. So HCPCS code is really the common term around here at CMS. And we are establishing 19 of these HCPCS codes that suppliers will use to submit claims for payment once all the requirement for the billing codes – for billing these codes have been met.

I do want to emphasize here that – and I'll get to this a little bit more on the next page. But these – going back to that once-per-lifetime policy, there will be a limit of one claim paid per beneficiary. And it will be the first valid claim that is paid, and the second would be denied.

So it's really important for suppliers to become familiar with billing and submitting of claims and to do so in a timely manner. And this can eliminate some backlogging or recruitment that might happen if a beneficiary does switch suppliers.

So on to the next slide, slide 14. This slide provides a table of the proposed HCPCS codes that we plan to establish and the corresponding payment amounts for each of those codes. Now, you'll see there is a bunch of Xs in the Gs. That's because these are placeholders. We will release the actual HCPCS codes if these policies are finalized after the final rule is published in November.

So as you can see there is a HCPCS code for each of the different payments that are associated with MDPP services. And there are 18 that are payable, and there is one HCPCS code that is a non-payable code. And this is meant to be used as a reporting code for claims that are furnished by a billing supplier that count towards achievement of attendance and performance goals.

So it's easier to talk about this as an example. So for HCPCS code GXXX3, which is associated with that $50 payment for achievement of nine core sessions attended, there would be four corresponding HCPCS codes that are GXX19 submitted on that claim that would include the NPI and the coach – the NPI of the coach who rendered each of those sessions and the date it was rendered.

So this is really a reporting code that will be included on each of the claims for payments that include attendance in previous sessions that aren't accounted for in that first code. So I'm happy to answer more questions on this. And I also have our resident payment expert in the room who can also answer questions because I know that there were a lot of questions on coding and claim submission during previous webinars.

So I'll be moving on now to slide 15 to talk about the proposed supplier enrollment and compliance policy. The first we have alluded to many times in webinars in our last final rule. And this is the proposal around MDPP preliminary recognition. And this proposal creates a new MDPP interim preliminary recognition standard that will allow DPP organizations to enroll until the new CDC standards become effective.

And for those of you that are connected to the CDC DPRP standards, you'll probably know that the updated DPRP standards were released the day after the Physician Fee Schedule was published. So now that those standards are on the street in their proposed form, we know and can talk about the CDC's preliminary standard, which mirrors what we propose in our rule.

And we really had to propose it in our rule in case there's any time lag between when our rule is finalized and effective and when these new CDC standards become effective. If these CDC standards that have been proposed become effective January 1st, 2018, which is what we expect to happen, we won't need to use the CMS interim preliminary recognition standard.

However, if there is any time between when our rules become effective January 1st and when the new CDC standards become effective, we will use the CMS interim – the MDPP interim preliminary recognition standard. And the two standards really are the same.

They propose the same requirements in terms of what organizations have to – what performance data organizations have to submit and what standards they have to meet in order to achieve this preliminary recognition standard.

So the standard is that an organization can fulfill and meet this preliminary recognition standard if they submit to CDC a 12-month data submission with at least one completed cohort and at least 60 percent of participants in that cohort must have attended at least nine sessions during the core session, which is during months 1 through 6, and at least 60 percent of those participants must have attended at least three core maintenance sessions during months 7 through 12.

Our standard that we put out in our proposed rule is the same standard as CDC laid out in their rule. Again, it's really just ours is to allow organizations to enroll under this standard in that interim time if needed.

And I do want to mention because we do get a lot of questions on preliminary recognition that we intended to propose this policy to allow more organizations to enroll in Medicare. We established full recognition as eligibility criteria for Medicare enrollment in our last rule. Full recognition, from what we've heard from CDC, is challenging for organizations to meet in a timely fashion.

So we believe that this preliminary recognition standard, which is attendance-based, will allow a greater number of organizations to meet the standard and enroll in Medicare in a timely fashion in order to begin offering MDPP services sooner than if they had to meet that full recognition.

We also propose a set of supplier enrollment policies. This includes proposing to use an MDPP supplier-specific enrollment form. And we are creating this new form so that suppliers can be more easily navigated when they are filling out the enrollment form.

And we are hoping that this new form will reduce the burden, especially considering that organizations that will be enrolling in Medicare will – many of whom will be enrolling for the first time can use a form that's really specific to the MDPP program.

So on this form, we are going to be soliciting information that's specific to MDPP suppliers such as the coach information and administration – administrative locations where coaches are located and where MDPP services may be delivered.

And you'll find in the rule that there is a description of what an administration – administrative location is and we attempt to define the differences between an administrative location and the community setting in the rule so that organizations who are going to be filling this enrollment form out will know which location they are required to report on this enrollment form.

We also – I alluded to our finalization of the NPI requirement for coaches in our last rule. And in this rule, we are really expanding upon how we're going to use that information. So suppliers will be including a list of coach NPIs that the – of the coach NPIs that are going to be servicing individuals for MDPP on their enrollment application.

And the purpose of this collection of information through the enrollment process is so CMS can verify that the coaches who will be furnishing these services do not meet any of the eligibility criteria which we spell out in our rule. So, for example, to make sure that the coaches are not excluded from any other Federal health care programs or have any – or have certain Federal or State felony convictions in the previous 10 years.

If a supplier does submit an enrollment form and a coach roster that includes an ineligible coach, CMS can deny or revoke the supplier's enrollment. But the supplier does have the opportunity to submit a corrective action plan to remove the coach from its roster and effectively remove that coach from furnishing MDPP services.

We also propose that for enrollment in Medicare, organizations will be subject to a $560 fee for calendar year – excuse me – this is the calendar year 2017 fee. This might be slightly different for 2018.

So we are proposing that this would apply to the initial enrollment for an organization as well as the revalidation. There is a hardship exemption policy, which I have included here as a link in the presentation for organizations that are interested in exploring that.

On to slide 16. The proposed supplier enrollment and compliance policy is continued. And, again, these are really centered around program integrity. We propose a series of supplier standards that are – that intend to ensure beneficiaries have access to MDPP and access to a high quality of service from organizations that are furnishing these services in their communities.

So we propose that suppliers must meet and remain in compliance with these standards as a condition of initial and ongoing enrollment. And some examples of these standards include that suppliers cannot **be terminated from Medicaid**, that suppliers cannot deny access to MDPP services to beneficiaries except in rare circumstances such as the organization has met its capacity limit or a beneficiary has been disruptive during a session.

****Post-Call Clarification: And some examples of these standards include that suppliers cannot have their billing privileges terminated for-cause or be excluded by a State Medicaid agency … ****

We also outline standards for suppliers in terms of responding to beneficiary complaints, including what a reasonable timeframe is for responding to those complaints. And we propose that the organizations who are enrolled in MDPP would have to submit a crosswalk to CMS quarterly.

And this crosswalk requirement is – starts 6 months following the start date and would include – and we talk about this more in the rule – a list of the beneficiary identifiers from CMS next to the corresponding list of beneficiary identifiers used for CDC submission. And we would collect this information from suppliers on a quarterly basis in order to conduct our evaluation.

We also are proposing to require suppliers to revalidate under moderate risk screening, not high risk screening. And this is important since we were able to finalize high risk screening last year, which has a number of requirements around individuals who need to be screened and fingerprinted. And this moderate screening would not require that same level of screening. So we are hoping that this can alleviate some of the burden that we heard from individuals and through the comment period around the high risk screening

requirement. We did put out an FAQ on the high risk screening requirement for fingerprinting, which can be found on the link that's included on this slide.

We also outlined a number of documentation requirements in this proposed rule. And this really just attempts to lay out some of the requirements in terms of supplier's medical records and what information needs to be captured on each of those medical records for each beneficiary.

So going on to slide 17. We are proposing a new policy around beneficiary engagement incentives. And, again, this is another policy that we are proposing in response to stakeholder input. We are proposing that suppliers may choose to provide items or services as in-kind beneficiary engagement incentives. But, we do propose certain restrictions around what services can be provided and the dollar amounts of those services.

So the services that can be provided in kind to beneficiaries as part of MDPP must be preventive care items that advance a clinical goal of MDPP. So, for example, the item or service must promote attendance in MDPP. It must promote weight loss or long-term dietary change.

And some examples that we talk about in the preamble of the rule are gym memberships, onsite child care for beneficiaries who may have children that need to be taken care of while they're attending the sessions, and also transportation.

We do specifically call out things that are not considered beneficiary engagement incentives such as theater tickets or gift cards. These do not advance any of the clinical goals of MDPP. And we also call out meal replacements, which we believe don't help an individual engage in their own health and learning how to create long-term sustainable behavior change.

We are also proposing that items or services involving technology may not exceed $1,000 in retail value for any one beneficiary and that any items of technology exceeding $100 in retail value must be retrieved from the beneficiary and remain the property of the supplier. We also are proposing documentation requirements for these items that are above $25 in value.

These arrangements that suppliers might have with beneficiaries as a result of these beneficiary engagement incentive policies do – they may implicate certain fraud and abuse laws. And I wanted to mention that HHS does have the authority to waive these as necessary for the purpose of testing models. And the requirements that are laid out in this rule provide the scope for any kind of fraud and abuse waiver that may be issued for MDPP.

However, any waivers that would be necessary for the purposes of this model test would be promulgated separately from this rule by the Office of the Inspector General. So you won't see any fraud and abuse waivers contained in this rulemaking. We will finalize policies related to the beneficiary engagement policies proposed in this rule. But any subsequent fraud and abuse waiver would be handled separately.

Finally, we went on to speak about virtual DPP. We did receive many, many, many comments on the inclusion of virtual DPP. Unfortunately, we did not propose to include DPP that is furnished exclusively through remote technologies with no in-person delivery of MDPP. The reasoning behind this is that there are – there were no data in our evaluation or certification that included virtual-only organizations' data. And we, therefore, weren't

able to have the evaluation criteria and the data to support inclusion of the virtual-only DPP services in the expanded model.

However, we do indicate in this proposed rule that we intend to conduct a model test that we are aiming to closely align with the start date of the in-person model. And this model test would – information about it would be released in a separate venue other than rulemaking. CMMI follows a request for application process for model tests that are conducted. So that process is separate from rulemaking, and I'm happy to answer questions on that as well.

So this concludes our policy portion of the presentation. And at this point, I just wanted to mention a couple of things before we turn over to questions and answers from the audience.

We do include some resources and information on slide 19, including contact information, a link to our webpage, and the link to register for CDC's upcoming listening session. And I will note again that any comments that we receive during this listening session won't be considered formal comments, and we really do encourage everyone to submit those formally through the *Federal Register* process. And these are due September 11th.

And with that, I will turn it over to questions from the audience.

Question & Answer Session

Leah Nguyen: Thank you, Carlye.

We will now take your questions and listen to your feedback. As a reminder, this event is being recorded and transcribed.

All right, Dorothy. We are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star, one, to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster. Your first question comes from the line of Arlene Guindon.

Arlene Guindon: from the National Kidney Foundation of Michigan. The question that we have here is in trying to understand the performance payment per beneficiary. For the whole 3-year period, it seems like the

minimum payment would be $225 per DPP participant or beneficiary if they didn't hit the weight loss goal, with a max of $810 if they did. Is that correct?

Carlye Burd: So you're probably doing the math better than I. The two numbers that I wrote down are the maximum payment is $810 for achievement of all attendance and weight loss goals and $125 being the minimum payment for attendance only. So I would have to sit down and do some math to make sure that what you said about attendance and weight loss was correct. But, those two numbers, I know, are correct and are in the rule.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sue McLaughlin.

Sue McLaughlin: Yes, this is Sue McLaughlin from Burgess Diabetes Center in Onawa, Iowa. And I just wanted to clarify one more time on the preliminary recognition standard that that will be only attendance-based and that there's not weight loss included in that.

Carlye Burd: Thanks for the question. And, yes, you are correct. The preliminary recognition standard is only based on attendance. And the full recognition standard does include requirements around weight loss. But preliminary is attendance-based.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Andrea Jewel.

Sandra Leal: Hi. This is Sandra with Reedsburg, Wisconsin. And if you could just clarify if a facility is already a Medicare-approved facility, what would be the next step in order to be able to provide this program.

Carlye Burd: Sure. That's a really great question. So the first step would be gaining that CDC recognition. And that is a process in and of itself that follows the Diabetes Prevention Recognition Program standards. So the minimum requirements is to have that preliminary recognition, which requires at least 12 months' worth of data. And following receipt of that recognition, enrollment in Medicare as an MDPP supplier would be the next step.

Leah Nguyen: Thank you.

Sandra Leal: Thank you.

Operator: Your next question comes from the line of Mimi Tran.

Mimi Tran: Hi. It's Mimi Tran. I am a dietician and actually have been seeing the diabetic patients. And, I have actually enrolled in MDP Program even though I am in the system with the unit. Correct?

Carlye Burd: It's a little hard to hear you. Would you mind repeating the question?

Leah Nguyen: Could you pick up your handset if you're on speaker?

Mimi Tran: Yes. I am right now. I am a provider for diabetic patients, and I am within the CMS system – Medicare system. So according to your answer that I have to re-enroll into MDP Program in order to provide the service. Correct?

Carlye Burd: That is correct. The enrollment is at the organizational level. And the requirements that CDC has are also at an organizational level. So this isn't a program that an individual can enroll in. It really requires an organization, and the organization does have to meet certain standards.

Leah Nguyen: Thank you.

Mimi Tran: Okay. All right. Thanks.

Operator: Your next question comes from the line of Julie Dalton.

Julie Dalton: Hi. Thanks for taking my question. You mentioned a coach roster. And I was wondering if this is a new form or list and if it's available currently – whether or not it's available.

Carlye Burd: Sure. Thanks for that question. It is not available yet, but it will be available before enrollment begins.

Julie Dalton: Okay.

Operator: Your next question comes from the line of Adam Brickman.

Adam Brickman: Hi. This is Adam Brickman with (inaudible).

Adam Brickman: Hey, how's it going? So, you said something that I thought was really interesting in regard to the virtual make-up session that CMS has proposed to allow. You mentioned that in making the decision about allowing those, your group, CMS, went back to the CDC DPRP data set to investigate that. I'm curious if there was a conversation about doing the same type of analysis for all virtual programs on which CDC now has a pretty substantial data set of how seniors engage with that.

Carlye Burd: So, thank you for that question. We went back to the CDC at the time when we were making the policy decisions to determine whether there was any virtual data that were included in the evaluation or the data use for the certification of the expanded model. And that certification took place in – I think it was the beginning of 2016. I don't know the exact date.

So that certification that the Chief Actuary put out is timestamped, and the subsequent decision from the Secretary is also timestamped. So there wasn't really an opportunity for us to go back and reopen that certification. The certification had to include data that supported the in-person expanded model.

****Post-Call Clarification: The certification only included data that supported in-person delivery with virtual make ups permitted****

Carlye Burd: Thank you.

Operator: Your next question comes from the line of Fatema Mirza.

Fatema Mirza: My name is Fatema Mirza. I am – run an organization in Glendale Heights, Illinois, called Worry-Free Community. We have several dieticians and community health educators that provide health care counseling, sometimes one on one and sometimes in groups, to the hypertensive and diabetic patients. I would like to know what would be the process to enroll my organization in this program.

Carlye Burd: Sure. So, I mentioned – I kind of answered this question previously. So the first step is to get that CDC recognition, the minimum standard being preliminary recognition. And then the second step would be to enroll in Medicare as an MDPP supplier.

Leah Nguyen: Thank you.

Fatima Mirza: Even though….

Operator: Your next question comes from the line of Chuck Palm.

Chuck Palm: Hi. This is Chuck Palm. I'm with the Banner Diabetes Clinic here in Tucson. So, you've already started answering the question about becoming a new provider. One thing I want to ask, though, is we're in the process of working on our DPRP recognition. Do we need to have a full DPRP recognition before we can get started on the MDPP registration?

Carlye Burd: No. So what we've proposed currently, if it is finalized, you will have to meet that preliminary recognition standard, which is attendance-based only. The full recognition is both attendance- and weight loss–based. But that preliminary is really meant to allow more organizations that have demonstrated capacity to offer MDPP to enroll sooner before meeting that full recognition standard.

Operator: Your next question comes from the line of Claire Brockbank.

Claire Brockbank: Hi. This is Claire. I wondered whether – does all of this apply to Medicare Advantage as well?

Carlye Burd: So thank you so much for that question. I anticipated it coming up. There was a – what I'll say about Medicare Advantage is that there was a memo that was released back in November of last year through the Health Plan Management System, commonly known as the HPMS System, that outlines the requirements for Medicare Advantage organizations.

And just briefly, it does require MA plans to provide this benefit and requires that a Medicare health plan, in order to provide these services, may choose to contract with an organization that is Medicare-enrolled as a supplier or become Medicare-enrolled as a supplier itself. And I know there's been a lot of questions about Medicare Advantage. We are hoping we can release some guidance soon. And it would be through the same system, the HPMS System or Health Plan Management System for MA plans. Thank you for that question.

****Post-Call Clarification: And just briefly, it does require MA plans to provide MDPP services…****

Claire Brockbank: Thank you.

Operator: Your next question comes from the line of Alissa Singer.

Alissa Singer: Hi. I just have a question about the NPI numbers for the coaches. So we utilize community health workers to do our education. I'm wondering if there's going to be any guidance coming out on how to apply for NPI numbers because I know I've tried to do that and I never heard anything back from – like after I'd submitted my application.

Carlye Burd: Sure. I actually will kick this over to my colleague Arielle Zina, who's our Program Integrity Design Lead. Arielle?

All right. If Arielle joins the line, I know she's in an area where there's not great reception. So she might just be having trouble on the line. But what I'll say…

Carlye Burd: Okay. Great.

What I'll say about NPI numbers is there is – there's information on the CMS website currently. And we are working on putting together some supplier support information to further educate. But you should be able to go online and apply to get an NPI number currently. It's definitely something that an organization can do now. And there is some additional information about that in our proposed rule.

Okay. Great. And I heard that Arielle is on. So, Arielle, do you want to add anything to that?

Well, we're not able to hear you, Arielle. So I think we'll go to the next question.

Operator: Your next question comes from the line of Carrie Shoyer.

Carrie Shoyer: I had a question that's actually a two-fold question about the coach program. Does one need to go through the coach training program even if you are a certified diabetes educator in order to start providing the NDPP? And the second part of that question is if you do need to go through the coach training program, must you do that during the time that you're trying to get your certification?

Carlye Burd: So I'm going to ask CDC to address this question, if you don't mind.

Patricia Shea: So this is Pat Shea, and I'm the Acting Team Lead for the National DPP Team. And as part of the CDC recognition process, we do require that coaches are trained. And I would refer you to the standards, especially the proposed standards where there are some new requirements regarding training coaches.

So that is part of the CDC recognition process. So – and the fact that someone is a CDE does not, by itself, meet the lifestyle coach training requirements.

Operator: Your next question comes from the line of Kelly Young.

Kelly Young: Hello. I'm calling from Sharp Rees Stealy in San Diego. If we were to become an NDPP supplier in January when we can officially apply and were approved as an MDPP provider, it sounds like we can't actually start billing until April 1st. So if we had a cohort start in February or March, we cannot submit charges on those attendance visits? It would be only visits moving forward from April? I just want to make sure I understand.

Carlye Burd: Sure. That's a really good question, actually. So the first payment that can be submitted is for services that are rendered following April 1st.

Kelly Young: Okay.

Carlye Burd: And we won't be able to retroactively pay any payments for dates prior to April 1st. But, I will point out after April 1st, for suppliers that are enrolling in Medicare, if their enrollment application is approved, their start date is their enrollment application date. So there will be an opportunity for retroactive billing. It just isn't possible to do that before April 1st. Does that make sense?

Kelly Young: Yes, that makes sense. Thank you.

Carlye Burd: Okay, great.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Annette McClenahan.

Annette McClenahan: Hi. Yes. I'm calling from Lee Health Systems. I work in a diabetes education center with a hospital. And one of the questions I had about preliminary recognition status is that our submission data will be the month of May 2018 and our first cohort did not start until July of this year. So we're not going to have the full 12 months. We're going to be a month or two too early to do that. So are we going to have to wait a whole another year to get preliminary recognition or is there something we'd be able to do so we don't have to wait 2 years to be able to be MDP ...

Carlye Burd: Yes. Thank you for that question. CDC, do you want to take that one?

Elizabeth Ely: Yes. This is Elizabeth Ely with the CDC. If you have looked at the proposed DPRP standards, we are proposing that as of January 1st organizations will move to 6-month submissions rather than annual submissions. So this will assist organizations in being able to submit that 12-month data a little bit sooner than they are under the current standards.

Annette McClenahan: Okay. So we might not be able to – we won't have to wait a whole year. We might have to push it out another 6 months based on how the submission will change, then. Is that right?

Elizabeth Ely: If data is being submitted every 6 months, then at whatever 6-months where you have 12 months, meaning that a full 12 months have lapsed since your first session was held, then you'll be eligible for preliminary.

Annette McClenahan: Perfect. That's very understandable. Thank you very much.

Operator: Your next question comes from the line of Jessica McDaniel.

Jessica McDaniel: Hi. I have a question about the billing. We use a 1500 – that's how we draft it. It's the 1500 code, I guess. I know it's a 1500 and a UB way to drop code. And I'm just wondering what these 19 G-codes will be drafting under.

Carlye Burd: So we're going to be using the CMS 1500 form for claims submission.

Jessica McDaniel: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jill Robinson.

Jill Robinson: Good afternoon. Hi there. I am interested in finding out who can write an order.

Are you still there?

Jill Robinson: I'm interested in finding out who can write an order…

Carlye Burd: You mean a referral?

Jill Robinson: ...for the – yes – for the diabetes – I mean, for these services because the medical nutrition therapy – you can't – the only one who can write an order for it is a doctor. And for the diabetes management, nurse practitioners and physician assistants can write orders for that. So I'm wondering who can write order for this service now.

Carlye Burd: Sure. So this is actually a policy that we finalized in last year's rule. There is no referral required for MDPP. So the beneficiary has to have the blood test results, which do require referrals in order to get those blood test results or – excuse me – to take those blood tests.

Jill Robinson: Yes.

Carlye Burd: But the actual program itself doesn't require a referral.

Leah Nguyen: Thank you.

Jill Robinson: Thank you very, very much. That's good to know.

Carlye Burd: Yes. We're hoping that increases beneficiaries' access to the program.

Jill Robinson: Great. Thank you.

Carlye Burd: Thank you.

Operator: Your next question comes from the line of Cathy Gomez.

Cathy Gomez: Hi. Good afternoon. We just – we've been running the program now for what – almost 2 years. And so we've got a lot of different sessions running.

And our concern comes in – is charging clients for this program in order to get the reimbursements. And so, therefore, if we have a lot of people who are not Medicare-eligible in that class, I mean, what's the standard here of how we standardize our charging? Does that make sense?

Carlye Burd: Yes. And I, unfortunately, can't really speak a lot to this because I think that there's such varying practices in the market around how organizations handle individuals who don't have coverage from their insurer.

But I will just clarify that for Medicare beneficiaries, there will be no copay. So the services will be available to them. Payments will be made directly to the suppliers, but the services will be available to them without any cost sharing.

I don't know if CDC wants to add anything to this.

Cathy Gomez: Or can I just add, too? We don't charge anything right now. Can we continue that?

Carlye Burd: I don't see any reason why not to. And we don't – you know, we don't comment necessarily on that. That's really just – that's up to the organization how they want to continue to offer the services in their community.

Cathy Gomez: So, it would be okay if we still offered it free but we were able to pull in Medicare payments?

Carlye Burd: Correct.

Cathy Gomez: Well, that would help because we were trying to come up with a fair and equitable way.

Leah Nguyen: Great. Thank you.

Operator: Your next question comes from the line of Anne Alexander.

Anne Alexander: Hi. I have a similar question on the payment policy. And, I guess, based on the previous one, there's two questions here. First of all, it looks like you are setting up kind of carrot system for the suppliers in that they get paid based on the performance of the participants.

What's the motivation for the participants? If they come and they show up at all the sessions, but they don't achieve any of the goals, can you tell them they can no longer come? Or are you just supposed to take the loss? Or can you charge them? Or how does that work if they're not working and you are?

Carlye Burd: Right.

Anne Alexander: And, also, your answer to the other question, why would that not be Medicare fraud if you're taking money from Medicare but not charging other people? So I guess I'm kind of confused about this whole payment thing.

Carlye Burd: Okay. So, I'll answer the first question, which is about our payment structure. So we are utilizing a performance-based payment structure. This is something that – this is a direction that CMS is moving generally to move away from kind of volume-based payments and toward value-based payments. And we are not proposing any kind of incentives that Medicare will provide to beneficiaries directly.

This is really a supplier payment. We are – you know, I went over some of the beneficiary engagement incentives that can be provided to beneficiaries. And I know from speaking to stakeholders and learning from CDC that a lot of organizations are using things like gym memberships to provide an incentive to individuals to facilitate them with both the weight loss and attendance.

So we realize that this program definitely requires organizations to take on some financial risk. But that is the proposed payment structure that fits into the paradigm of the value-based payment that we're proposing.

Anne Alexander: But, you can't dismiss anyone...

Carlye Burd: And then…

Anne Alexander: You can't dismiss anyone from the program if they aren't trying, right? They have to be disruptive to be dismissed.

Carlye Burd: No. So – correct. That would be lemon-dropping. And that's definitely a violation of our supplier standards. So we – individuals do have to be – have access to the services that they're eligible for, both within the core services period and the ongoing services period.

And I think Amanda, our payment expert, wants to add something.

Amanda VanVleet: Yes. I was just going to clarify that since the CDC program is 12 months, the beneficiary is eligible to 12 months of the program without needing to lose weight. And so that's why we have attendance-only payments that suppliers can get for the first 12 months.

But after that, for the following 2 years, if the beneficiary does not achieve weight loss, then they're no longer eligible. So the supplier doesn't have to keep offering services.

Anne Alexander: Okay.

Carlye Burd: Thank you. That's a really important point. So that first year requires suppliers to offer services. But after that first year, the onus is on beneficiary to really keep up with that weight loss and attendance in order to stay eligible.

And, then, to your second point, I'm not sure I'm fully understanding. But I will just state that we are paying suppliers for providing a service to beneficiaries, which is how Medicare typically pays providers that are enrolled.

And we oftentimes – you know, Medicare payments do have an effect on how other insurers choose to pay for services. But we won't comment on or regulate any payments beyond those that are for Medicare beneficiaries, if that makes sense.

Anne Alexander: Well, I just know that all the instruction that we've gotten on Medicare fraud is you can't offer something free to the population and then charge Medicare is what I've heard in answer to the previous question.

Carlye Burd: So, all additional – I mean, to be clear, the services aren't free. Medicare beneficiaries oftentimes have to pay a premium every month and, then, they have covered services under that benefit. So I didn't to imply that the services are free in any way. But they just don't require any copay. So there's no requirement for a beneficiary to pay, you know, a $20 copay for each session attended, for example.

Anne Alexander: Okay.

Carlye Burd: And that's how other additional preventive services, such as mammographies, work for Medicare as well. So, thank you for that question.

Operator: Your next question comes from the line of Bushra Singh.

Bushra Singh: Hi. I have a question in relation to the location. Hello?

Carlye Burd: To the what?

Bushra Singh: Yes. I have a question related to the location of these sessions. Are there any guidelines for those?

Carlye Burd: Yes, actually. And I'm hoping Arielle can maybe come online.

Arielle Zina: Yes. Can you hear me?

Carlye Burd: Yes. We can hear you now. Do you want to talk about the administrative location requirement?

Arielle Zina: Sure. So in our current proposed rule, we have indicated that, unlike clinics or other currently involved suppliers who practice under their practice location, MDPP services are often furnished in community settings. They are furnished in group settings. And so we have proposed to require that every involved MDPP supplier include – have at least one administrative location. And that is where the organization is

headquartered and where MDPP services may or may not be furnished. But MDPP sessions may also be furnished in locations outside of these sessions, which we've defined – proposed to define as community settings.

So, for an example, if an organization is providing – is offering MDPP services that wants to increase community access and is providing – furnishing these sessions in a community center in a multipurpose room, that would be considered a community setting. But the headquarters for that organization would be considered its administrative location.

For each of these settings, we are proposing to require that all of these locations be reported on the enrollment application, and any changes to these locations must be reported to CMS within 90 days of any changes. So, if an organization is – upon enrollment, they would list all of their administrative locations and any community setting addresses that they may have at that time.

But, if through the – after being enrolled they are furnishing services in additional community settings, there would be a 90-day period with which the organization could update its enrollment application to reflect the new location change.

And any details on how the administrative location and the community setting locations are defined and how an organization may discern between the two of them can be found in our proposed rule.

Bushra Singh: So, I think – I just want to know is there any restriction of having – what about residential locations?

Carlye Burd: I'm sorry. Could you say that again?

Bushra Singh: Could one of the locations be a residential location, for instance, like if we want to do some make-up classes? And can these locations be changing over – for instance, like if we – so, the community locations like libraries or some sort of community centers – can they be interchangeably used based on the availability or it has to be a fixed location?

Arielle Zina: We have provided some flexibility there. We have not stipulated any requirements for community settings in terms of how consistently that you're using them, simply that you must report them on your enrollment application. So as long as you're updating and reporting through your enrollment application any new locations where you're furnishing services, we have not specified any additional requirements.

However, for the administrative locations, we have stipulated a few requirements around them. Some of them are that they must have signages outside and must be available to the public. For example, not within in a gated community would be an example. But, also, we have stipulated that an administrative location may not be a private residence.

And I think any other further questions around personal residences as for make-up sessions, it would be helpful to include any comments or additional questions about circumstances in which that might be desired and any comments to our proposed rule.

Bushra Singh: All right. Great. Thank you.

Operator: Your next question comes from the line of Randi Belhumeur.

Randi Belhumeur: Hi. This is Randi Belhumeur, Program Administrator at the Rhode Island Department of Health for the DPP program. And our Program Coordinator who oversees our DPP program here has a few questions for you. I'm going to turn it over to Michelle.

Michelle: Hi.

Carlye Burd: Hi.

Michelle: So, my first question is, you continued throughout the presentation to talk about suppliers. So do you mean DPRPs? Because that's the language that we've always used. So throughout the State, we use the term "DPRPs" based on the national language. So those are all of our delivery sites for the program.

Carlye Burd: Right.

Michelle: Is that what you…?

Carlye Burd: Yes. So, "supplier" is the CMS terminology. Before enrolling in Medicare, these organizations are going to be the DPRP organizations. And once they have met the requirements for enrollment, they will become suppliers. That's just a statutory term to describe one type of health care provider within CMS. That's why we use that term.

Michelle: So, it is DPRP.

Carlye Burd: Yes. So, the DPRP organizations that you referred to around the State of Rhode Island, those that meet that preliminary recognition standard and enroll in Medicare would become MDPP suppliers.

Michelle: Okay. So, for instance, we have three on our list of – now we have, I think, 13 right now as we speak. So three that are providers – so, Clinica Esperanza, Diabetes Care Solutions – as an example, those are provider groups. So...

Carlye Burd: So, they don't have to be providers necessarily. They don't have – like we know that MDPP will be – will include a lot of non-traditional organizations that are enrolling in Medicare for the first time. So it does not have to be a current Medicare provider or current health care provider that enrolls in Medicare.

The requirements are really that the organization has that CDC recognition and then becomes a Medicare supplier and, therefore, becomes part of the paradigm of health care providers for – from CMS's perspective. Does that make sense?

Michelle: Yes. That's great news because we have a lot of concern about – you know, we have a lot of little mom and pop CBOs on our list that are delivering these...

Carlye Burd: Right. And I think it's just important to note that typically in Medicare, preventive services are delivered in clinical settings. This is a departure from that traditional policy in that MDPP will be available in community settings and non-traditional settings outside of the clinic.

Leah Nguyen: Thank you.

Dorothy, we have time for one final question.

Michelle: Thank you.

Operator: Your final question comes from the line of Rosalina Butao.

Ms. Butao, your line is open.

Rosalina Butao: Hi. Good afternoon. Thank you for the presentation. My question has been answered. But this is just more sort of clarification. So, before you can enroll in the MDPP, you have to be DPP CDC–recognized first, right? And once the preliminary recognition is given by CDC, then that's the time that as a supplier you could enroll in the MDPP program, right?

Carlye Burd: That's correct. Yes. On point.

Rosalina Butao: Okay. Is there any contact information for CDC just, you know, so offline I could...

Carlye Burd: Sure. So, Pat, do you have a mailbox you want to share or some way of...

Patricia Shea: Well, there's two ways to do this. You can either register for the webinar next week, which we would recommend because that will be about the standards that will be required for CDC recognition starting in January 2018.

And if you register for that webinar, we'll have information there on how to apply for CDC recognition. Otherwise, you can send an inquiry to dprpask@cdc.gov or just go to the National DPP website at CDC. And any of those will provide you information on how to apply for CDC recognition.

Rosalina Butao: Okay. Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have today. If we did not get to your question, you can email it to the address listed on slide 19.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network Event on the Medicare Diabetes Prevention Program Model. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.