MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Diabetes Prevention Program Model Expansion Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
November 30, 2016
1:30 pm ET

Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. 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 and Introduction

Leah Nguyen: I am Leah Nguyen from the provider communications group here at CMS and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Diabetes Prevention Program Model. MLN Connects Calls are part of the Medicare Learning Network®. The calendar year 2017 Medicare Physician Fee Schedule final rule includes the expansion of the Medicare Diabetes Prevention Program Model beginning January 1st, 2018.

During this call, CMS experts provide a high-level overview of the finalized policies. The goal of the model expansion is to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes through a structured behavioral change intervention.

MDPP services will be furnished in community and health-care settings by coaches that are trained community health workers or health professionals. The rule finalizes aspects of the expansion that will enable organizations new to Medicare to prepare for enrollment into Medicare as MDPP suppliers. Subsequent rulemaking in 2017 will propose additional policies. A question-and-answer session will follow the presentation.

Before we begin, I have a few announcements. You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL, go.cms.gov/npc. Again, that URL is go.cms.go/npc.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. And finally, registrants were given an opportunity to submit questions in advance of today's call. We will address many of your questions today, and we'll also use them to develop future resources. And finally, there will be a brief pause during the presentation for a polling question.

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 hi, everyone. It's great to be here today talking about the Medicare Diabetes Prevention Program Model Expansion.

We were thrilled to finalize our rule a few weeks ago and the Physician Fee Schedule. And today, what I'm going to do—and I'm on Slide 3 for those of you who are following along—I'm going to provide some background information on kind of how we got here and I'm going to go through each of the policies that we finalized in the previous rule and also talk through some of the policies that were deferred to future rulemaking. Then I'm going to discuss next steps for organizations that are looking to prepare for Medicare enrollment. And finally, we are going to open up the line to answer some of your questions regarding this final rule.

Context

So, on to Slide 4. This slide provides the context of how we got here. And I wanted to go through this – we went through this in our last webinar, but I think it's just important to remind everyone of the process of – that happened previous to this rule being proposed. Based on the rising prevalence and cost of type 2 diabetes, CMS granted the Y-USA a – what was called a Health Care Innovation Award to test the effectiveness of the National DPP among Medicare beneficiaries.

Now, many of you are probably familiar with the National DPP. This is a program that's been in existence for about a decade and now is being administered more recently by the CDC through their diabetes prevention recognition program. Between 2013 and 2015, the Y-USA enrolled over 7,800 beneficiaries into the model test. The results of this model test showed that a majority of participants attended at least four sessions and there was an average weight loss of about 9 pounds. With the results of those – of that model test, CMS was able to expand this model into Medicare, which led to the rulemaking that we proposed earlier this summer.

So, if we go on to Slide 5. I'm going to breakdown kind of what's happened since the Secretary announced the expansion back in the spring. In the rule that was proposed last summer, we proposed to expand the DPP model test under Innovation Center authority that is put in place by the Affordable Care Act. Because of the great success of the Health Care Innovation Award and the statutory requirements of Section 1115A(c) of the act, we finalized in this rule that was published a few weeks ago that we will be undertaking the MDPP model expansion.

Between when the rule was proposed this summer and September 6th—so July 15th to September 6th—we accepted public comments on this rule. We received approximately 700 timely pieces of correspondence. All of – the correspondence contained many comments on the expanded model, and we are very happy to have received all of this great feedback from the public. Commenters included professional organizations, health

plans, advocacy groups, individual physicians, and numerous individuals who have direct experience with the national DPP.

We also received several personal comments from actual individuals and people with diabetes, which was also greatly informative and touching to see that level of engagement with the rule-making process. Commenters raised key considerations, and I will go through some of the ways that we can – incorporated those considerations into our policies in this presentation.

We published the final rule November 2nd, and future rulemaking will address the remaining policies, big bucket areas that include supplier enrollment, virtual providers, aspects of the MDPP benefit, and several other policies – smaller policies that I will highlight throughout this presentation. This additional rulemaking allows us at CMS to carefully consider some of the options that were raised by the public, and we hope to receive comments from folks that are on this call and several other stakeholders in that future comments – future rule as well.

Overview

So, on to Slide 6. To continue on with the agenda, now I'm going to move on to an overview of the MDPP policies that have been finalized in this year's Physician Fee Schedule.

So, everyone, Slide 7. This slide is a visual of the MDPP core benefits. We proposed this benefit to mirror the National DPP as closely as possible. We proposed that the MDPP core benefit would be 12 months of core sessions using a CDC-approved DPP curriculum with the option of going on to maintenance – ongoing maintenance sessions for beneficiaries who achieved minimum weight loss.

We proposed the core benefit consisted of at least 16 core sessions furnished over the first 6 months and at least six monthly core maintenance sessions over weeks – over the second 6 months. We proposed that beneficiaries who completed the 12-month core benefit and achieved and maintained a required minimum weight loss of 5 percent from – would be able to go on to ongoing maintenance sessions as long as the weight loss is maintained.

There were a couple clarifications that we laid out in the final rule. Firstly and very importantly—and this is highlighted on the slide—we clarified – many commenters requested clarification around whether this would indeed be a preventative service, and we clarified that in the rule that MDPP is considered a preventive service and, therefore, will not be subject to co-pay for the core benefit. Anyone eligible for ongoing maintenance sessions would not have to pay a co-pay as well. So, I think that's a really important thing to clarify here.

We also got a lot of comments because we had proposed that the sessions be an hour in duration. We changed this language to state that the session should be approximately 1 hour in duration. We received comments because we had indicated in the rule that the curriculum to be used was the CDC curriculum, and we clarified that organizations should be using *a* CDC-approved DPP curriculum in order to offer and furnish this benefit.

And we also clarified that core maintenance sessions in the second 6 months are furnished as part of the 12-month core benefit regardless of weight loss. So, what that means is all eligible beneficiaries do have access to all 12 months of the core benefit, regardless of whether they lose that weight or not. And this is in alignment with how CDC currently operates the program.

We are also adding a definition for maintenance session bundle to refer to each 3-month interval of core maintenance or ongoing maintenance sessions. Each bundle must include at least one maintenance session per month for a minimum of three sessions in each bundle. And this is important when it comes to assessing eligibility for ongoing maintenance sessions as well as payment, and we intend to address the payment for these services related to the maintenance sessions bundles in our future rulemaking.

So, on to Slide 8, where we discuss beneficiary eligibility. We finalized beneficiary eligibility largely as proposed. So, that is to enroll in this program, they have to be enrolled in Medicare Part B. They have to have as the date of attendance at the first core session a BMI of at least 25 and 23 for a self-identified Asian-American.

They have to have at least 12 months – within the 12 months prior to attending the first core session a blood test result that falls within the ranges indicated here. They cannot have a previous diagnosis of type 1 or type 2 diabetes, with the exception of gestational diabetes. We did clarify that gestational diabetes is not in and of itself a condition for participation but that beneficiaries would also have to meet the other eligibility criteria listed here.

We did receive a lot of comments on how to handle diabetes diagnosis that happens during the program administration, and we intend to address this policy in our next round of rulemaking. And finally, we finalized that patients with end-stage renal disease would not be eligible for this benefit.

On to the next slide, Slide 9. We also proposed that beneficiaries who meet the beneficiary eligibility criteria would be able to receive MDPP services only once in their lifetime, and we did finalize that proposal. However, we acknowledged that commenters' concerns around exceptions to the once-per-lifetime restriction – once-per-lifetime limit may be a barrier to access for many beneficiaries if they have some kind of extenuating circumstance. But we did not propose to restrict – to allow

beneficiaries to restart the benefit, and we are going to consider the comments that we received and address attribution and its intended effect on payment in our next round of rulemaking. So, look out for that in the next rule.

We also received several comments on ongoing maintenance sessions. We did clarify that ongoing maintenance sessions are only available if the eligible beneficiary has achieved maintenance of the 5-percent weight loss. And we did also clarify—and this is not written on the slide, so it's important to note here—that the achievement of the weight loss must be in 1 of the last 3 months of the core benefit.

So, as I mentioned earlier, maintenance session bundles are now defined as 3-month bundles. A beneficiary has to have achieved the minimum weight loss at least once in that 3-month bundle in those last 3 months of the core benefit to be eligible for ongoing maintenance sessions.

We also received many comments on placing a limit on the duration of ongoing maintenance sessions. So, placing a cap on the number of maintenance – ongoing maintenance sessions or the duration of maintenance sessions. We didn't propose a specific limit, but we do intend to do so in future rulemakings.

On to Slide 10. We finalized our referrals policy largely as proposed. We proposed to permit beneficiaries who meet our eligibility criteria to obtain MDPP services through community referrals, self-referral, or referral from their physician. Commenters generally suggested that there should be broad program access and we should not require a referral, and we, in our final rule, agreed with those commenters and are not going to be requiring any specific type of referral for this expanded model test.

We do clarify that non-physician practitioners can order or refer eligible beneficiaries to MDPP services. We did have some nurse practitioners and other stakeholders, non-physician stakeholders make that comment. So we did clarify that in the final rule.

Another thing that is important to note is the blood tests that are currently covered by Medicare do require a physician referral for those pre-diabetes screenings. So, those blood tests, although they can happen any time in the last 12 months, is sort of a de-facto referral for this program, but the program itself does not need a physician referral on record.

So, I'm going to pause here and allow Leah to take a quick poll of the audience.

Keypad Polling

Leah Nguyen: Thank you, Carlye.

At this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results. Holley, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants currently listening in. If you are the only one in the room, enter 1. If there are between 2 and 8 of you listening in, enter the corresponding number. If there are 9 or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between 2 and 8 of you listening in, enter the corresponding number. If there are 9 or more of you in the room, enter 9. Please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'll turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. I'll now turn the call back over to Carlye to continue the presentation.

Presentation Continued

Carlye Burd: Great. Thank you, Leah. I'm now on to Slide 11, enrollment of MDPP suppliers. I'm going to spend a little bit of time talking through this slide because there were a lot of comments on preliminary recognition. So, we proposed that DPP organizations must have either preliminary or full CDC DPRP recognition in order to be eligible to enroll in Medicare as MDPP suppliers. And for those of you, just a reminder, DPRP stands for Diabetes Prevention Recognition Program, and it is the CDC program that recognizes organizations as under the National DPP.

So, we were able to finalize our proposal that an entity must have full CDC DPRP recognition as a requirement to enroll, but we weren't able to finalize at this time our proposal around preliminary recognition. And I'm going to spend some time here talking about preliminary recognition. We proposed this additional CDC recognition status. We – DPP organizations can – and we proposed that for preliminary recognition that they would – that DPP organizations would have to meet reporting requirements for 12 months after applying for recognition and full recognition after demonstrating program effectiveness for 24 to 36 months after applying for CDC recognition.

In the rule, what we lay out around preliminary recognition and our kind of reasoning for proposing this, this is not current CDC standard. That was the biggest comment that we got. "This doesn't currently exist. Why is CMS proposing to introduce a new standard? CDC should be proposing these standards." And we agree with all of that, and we recognize most of the organizations that are currently in pending recognition, it may take up to 36 months for them to meet full recognition.

When we were proposing this, we proposed preliminary as a middle ground to allow organizations that have demonstrated a capacity to deliver DPP to enroll in Medicare. So this was our way of kind of compromising so that pending – organizations in pending recognition could begin to enroll in Medicare sooner instead of waiting 36 months – up to 36 months to enroll – to get full recognition.

Because CDC standards won't be updated until 2018, CMS intends to propose interim preliminary recognition standards in our next round of rulemaking and be very specific about those standards. And we intend this to only be in effect for the period of time between the next final rule and when CDC's new standards take – go into place.

As many of you may know, but some of you probably don't know, the CDC standards are being updated and they get updated every 3 years. Those updates will not go into effect until 2018. However, we want to begin enrollment in 2017. Therefore, CMS is going to propose this interim standard but still be reliant on CDC to provide us with some of the data that will help us assess who is and is not falling into this preliminary category.

We've laid out an example in the final rule what we are considering for the standard, the preliminary standard, and that is that pending organizations would be required to meet a performance standard threshold of 60 percent participant attendance in at least 9 core sessions in months 1 through 6 and 60 percent participant attendance in at least 3 core maintenance sessions in month 7 through 12.

As I mentioned, and as we stated in the rule, we will still rely on CDC's data to make these determinations and intend on transitioning to their standard once their standard becomes effective in 2018. We're really encouraging organizations to take these considerations and help – so that it can prepare them to enroll in Medicare sometime next year.

If you're currently in pending, you should probably think about starting classes as soon as you can so then CDC can have enough data to make their assessment around this time next year as to whether your organization meets preliminary or full recognition. CDC will also be publishing their updated standards sometime next year, and all of you should feel – that are interested should feel welcome to comment on those standards as well because they go through similar comment – notice and comment period.

Okay. On to Slide 12. So we did finalize our proposal that we would rely on CDC recognition as our contingency factor for enrollment. We also proposed and finalized that the high categorical risk screening for newly enrolling suppliers into Medicare. CMS believes that this is the most appropriate level for suppliers in the MDPP expanded model since organizations – most organizations are new to Medicare and those that are existing will be new to providing this service and new to becoming an MDPP supplier.

We received some questions about how this applies to not-for-profits with board members, and we intend to release guidance or clarify this in future rulemaking. And I want to note, and this is noted in the rule, that CMS assigns risk levels based not on the nature of the benefit that the supplier furnishes, but on the level of risk that the supplier may pose to the Medicare program, and we will assess this as we open up enrollment and in the future years as this program is being implemented to see how this will impact the organizations enrolling in Medicare. But for this upcoming enrollment next year, we did finalize the high-risk screening.

We also – we proposed our policy around existing Medicare providers that they would not need to enroll a second time. We ended up finalizing our alternative proposal that would require existing providers to enroll separately as an MDPP supplier and meet all MDPP supplier requirements, including CDC recognition. And there are a couple of reasons for this that are outlined in the rule.

This is the standard for other CMS suppliers, such as home health agencies, and this would ultimately protect existing providers from revocation actions against their enrollment and their ability to furnish services outside of MDPP.

With the targeted enrollment, CMS has the discretion to target any revocation action against this MDPP supplier enrollment alone rather than affecting the existing provider or supplier's other Medicare enrollments. I also want to clarify that we – what we clarified in the rule, that FQHCs—federally qualified health centers—in rural health centers would also be eligible to enroll as an MDPP supplier, but they would have to do so separately, similar to other existing Medicare providers.

Okay, on to Slide 13. We proposed and finalized that all MDPP suppliers would have to comply with requirements laid out in 42 CFR Part 424. These include timing limits for filing claims, requirements to report and overturn overpayments – return overpayments – excuse me – procedures for suspending, offsetting, or recouping Medicare payments in certain situations.

Slide 14. We proposed coaches would obtain an NPI to help ensure coaches meet program integrity standards, and we solicited comment on require – on whether coaches should also enroll in the Medicare program in addition to obtaining an NPI. We proposed also if MDPP suppliers – excuse me – we proposed that suppliers would be required to submit a roster of coach-identifying information to CMS. And if suppliers

failed to provide an active and valid NPI of their coaches or if coaches failed to obtain or lose their active and valid NPIs that the MDPP supplier may be subject to compliance action or revocation of MDPP supplier status.

We did finalize that coaches will not have to enroll but will have to obtain NPIs and suppliers, upon enrollment, will submit a roster of coach NPIs and other identifying information upon enrollment and update it when there is turnover in their coaches. Because we did not propose how we intend to use the coach information during and after enrollment and how it might affect MDPP supplier enrollment, we intend to propose and finalize these actions in future rulemaking, as appropriate.

And we note in the rule that, unfortunately because we were not able to propose specific standards related to the coach roster and the use of this information, that we will not be able to begin supplier enrollment until the public has had an opportunity to comment on these specific proposals related to the coach roster and how CMS will use it. So look out for that. That'll be a big section of the next rule, and we look forward to your comments on that as well.

On to Slide 15. We proposed suppliers would be subject to Medicare supplier requirements and would lose their ability to bill Medicare for MDPP services but would not automatically lose its CDC DPRP recognition. And we clarified that MDPP supplier enrollment would be revoked upon the loss of CDC recognition or noncompliance with Medicare requirements. And we also finalized that suppliers may appeal these decisions in accordance with standard revocation and appeal regulations that are listed here.

Okay, on to Slide 16. We proposed in our rule to commit virtual DPP organizations to furnish services as part of MDPP. In our comment and response period, what we found was that there are many differences between the ways that virtual MDPP organizations and in-person organizations operate, and there's also another layer of hybrid virtual and in-person programs that provide both in-person services and virtual services. Because these organizations operate differently than in-person organizations, we did not have enough information at the time to finalize this proposal, but we expect to continue gathering information on the virtual delivery of DPP services.

We are really committed to this, but we need more time to carefully consider all of the policy options, and we intend to use future rulemaking to address detailed policies on future – on virtual providers' eligibility to enroll, furnish, and bill for MDPP services.

On to Slide 15. We proposed and finalized the standards for claims submission using standard claims forms and procedures. The standard for claims submission is electronic, and CMS only allows for providers to submit claims through paper form in very limited circumstances. We proposed and finalized that suppliers maintain a crosswalk between the beneficiary identifiers and to the purchase identifiers they provide to CDC.

So, what that means is the identifier that's listed on the claim forms for the beneficiary and the participant identifier that organizations submit to CDC, a crosswalk between those two identifiers needs to be maintained by the supplier. And this is for the purposes of evaluation, and we will also require suppliers to submit this data to CMS on a regular basis once the evaluation begins. And we intend to provide further details on the frequency and format of this crosswalk submission in our next round of rulemaking.

Slide 16. We proposed to – and finalized most of these policies related to IT infrastructure and really meet – these are related to maintenance of records and recordkeeping. We proposed to maintain records that contain detailed documentation of the furnish – of the services furnished to beneficiaries, and we also proposed that these can be maintained or we clarified—we did not propose this—we clarified that these records could be contained within a larger medical record or within a medical record that the MDPP supplier establishes for the purposes of MDPP. We encourage but do not require the use of any EHR in this rule. We understand many of the DPP organizations are new to the health care system and, therefore, also new to medical recordkeeping and may not have that infrastructure set up. But we do encourage organizations to explore the use of electronic health records for the purposes of MDPP.

We proposed and finalized the detailed documentation that is required to keep on record regarding beneficiaries eligibility for the program, blood test results, sessions attended, the coach furnishing, the sessions attended and the date and location of the service, the weights recorded of the beneficiary. And we realized that there's many different types and formats of documentation that exist for the blood test results, and we will provide clarification and details on whether specific records are required in future rulemaking, as appropriate. We also finalized that all beneficiary identifying information and health information must be in compliance with the Health Insurance Portability and Accountability Act, otherwise known as HIPAA.

On to Slide 19. So these are the major policies that we intend to finalize in future rulemaking. These include, and I mentioned this earlier, how information on the coach roster will affect the MDPP supplier. So, specifically how CMS intends to use the information on the coach roster during and after supplier enrollment. We will propose the payment structure formally. We did include it in the first round of rulemaking so that commenters would be able to provide us comments, and we will respond to those comments in the next round of rulemaking.

The same is true for additional policies related to maintaining program integrity, as applicable, and these policies related to virtual providers, the program integrity policies that is. will be addressed in future rulemaking. The comments that we received on virtual providers will also be responded to in our next round of rulemaking.

Preparing for Enrollment

Okay. So, on to Slide 20. Now that we've gone through the major policies that were and were not finalized in this rule, I want to provide some tangible resources for organizations out there that are part of DPP, current DPP organizations, prospective DPP organizations, and those that are looking to prepare to enroll in Medicare as a supplier.

Slide 21. So, this slide talks about what you can do right now to help your organization prepare to become an MDPP supplier. So, despite the supplier enrollment timing, we encourage all of the organizations out there intending to be suppliers to become CDC-recognized and apply as soon as you can. And if you should – you have not started the process, we have provided the link here.

And based on the information I shared earlier about preliminary and full recognition standards, we are encouraging organizations to begin classes as soon as possible to ensure that CDC will have adequate data to look at around this time next year to make an assessment of the eligibility status.

You should also familiarize yourself and your organization, your coaches, with the NPI requirements, and we've included a link here for you to get started. You should also familiarize yourself and your organization with the PECOS system, which stands for Provider Enrollment Chain and Ownership System. This is the system where Medicare providers go and enroll in Medicare.

So, you'd create an account and then you would use that system to actually enroll. You will not be able to start that yet, and if you – please do not start that yet, but you may want to go on to their website and just review some of the material that they have and any other information that you can learn about that system would be probably helpful in your preparation.

You should also – if you have – do not have a claims submission software, begin researching what software may be most effective for your organization. CMS does offer a free software package. We've provided a link here to that software package, and it creates a patient database that allows organizations to submit claims to Medicare Parts A and B.

On to Slide 22, which I believe is my last slide. So what should you do in 2017? Well, you should continue to look out for guidance and communications from CMS regarding enrollment preparation, and we've included a link to our website on the last page where you can – I believe it's on the last page. A link to our website where you can actually enroll – oh, it's on this slide.

So, you should visit our website and sign up to receive updates. There's actually a spot on the website where you can put your – where you can type in your email address, and we will use that list of people along with the other listservs that CMS has and CDC has

been using to send out updates, materials, information about webinars that we will have through the spring.

You should also read and comment on the next rules, and you should plan to begin enrollment in 2017 before the benefit goes live in 2018 if you think you will be eligible. And I just want to note here that enrollment into Medicare typically takes 45 to 60 days if all information is submitted correctly.

So, at this time we will go to our question-and-answer session. Before we do that, I just want to mention that there are some resources here in the last few slides. You can check those out to get updates and learn more and ask questions if you have them.

So with that, I will turn it over to the operator and the moderator to facilitate the question-and-answer session.

Question and Answer Session

Leah Nguyen: Thank you, Carlye.

We will now take your questions, but before we begin, I would like to remind, everyone, that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits.

All right, Holley, we are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference.

And our first question comes from the line of Jill Robinson.

Jill Robinson: Good afternoon, folks. This is Jill Robinson. I was wondering what qualifications a practitioner might need to be the coach. And would they be considered a non-physician practitioner?

Carlye Burd: Thank you for that question, Jill. So the qualifications for coaches are listed on the CDC's standards. So I will not go through them right now, but you can find them on CDC's website. So the suppliers are the ones that actually obtain the CDC recognition,

and there are some training requirements laid out in the CDC DPRP standards that you can find online that specify what those requirements are.

But generally there's no required credentialing or specific licensure for a coach, and that's just a broad kind of summary. There are some, you know, trainings that are required that suppliers have to provide the coaches. And those – the curriculum and the training is listed in the CDC DPRP standards.

Jill Robinson: Thank you very much. Our hospital should like to start the program.

Leah Nguyen: Thank you.

Carlye Burd: That's great.

Operator: And our next question will come from the line of James Webster.

James Webster: Hi. I wanted to know if there's going to be a $500 fee associated with enrollment like our other applications.

Carlye Burd: So, thanks so much for that question. That was something that we received a lot of comments on, and there will be an enrollment fee associated with the enrollments. So, unfortunately, that is standard practice. There is, however, and we included this in the final rule, a link to a hardship exemption for waiving that enrollment fee. So for organizations, we know a lot of smaller community-based organizations will be enrolling in Medicare, and we made that available in the final rule, so they could check if they were eligible for that exemption.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Louise Ingraham.

Louise Ingraham: Hello, this is Louise Ingraham. I have a question about our coaches applying for the NPI number. Many of our coaches are not credentialed, but they are not trained community health workers either. Some of them are medical assistants. We have volunteers who have no medical background at all, and I'm wondering if there's going to be a separate taxonomy for those people who apply for an NPI.

Carlye Burd: Thank you so much for that question. So, the short answer is I cannot say right now at this time, but please look out for more guidance on this. We do intend to help suppliers and their coaches obtain NPIs in the correct format, and we have indicated in the rule that a taxonomy for – that would be appropriate would be health educator. But we have not finalized that in any form in the rule. So at this point, please just wait for guidance on that specific taxonomy.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Mary Papadoplos.

Mary Papadoplos: Hi, this is Mary Papadoplos from Penn Medicine, Lancaster General Health. I have a question specific to Slide 8 under Beneficiary Eligibility. The fasting plasma glucose is listed as 110 to 125. I believe typically we think of it as 100 to 125.

Carlye Burd: Thank you for that, and yes, there is a difference between what we have proposed and finalized here for eligibility criteria between our criteria and what the CDC allows. And we acknowledge that and lay out some of our rationale for that in the final rule. So, that was not a mistake. It is part of the actuarial certification and the determination for this program to be expanded. So, we appreciate the comments. At this time, we are keeping it as 110.

Leah Nguyen: Thank you.

Mary Papadoplos: Thank you.

Operator: And our next question will come from the line of Sue McLaughlin.

Sue McLaughlin: Hi. This is Sue McLaughlin from Burgess Health Center in Onawa, Iowa, and I was wanting to just have some further clarification on if our hospital is currently a Medicare-enrolled provider needing to re-enroll for the Medicare diabetes provision if that – as a separate supplier. I'm taking it that we do, but I just wanted some clarification on that. Thank you.

Carlye Burd: Yes, you are correct. We had actually proposed initially that existing providers would not need to enroll, but as we looked into it further, we ended up finalizing our alternative proposal, which was to require a separate enrollment. And the reason for this is that this is kind of the standard for other suppliers right now in the market, that there is another re-enrollment, such as home health agencies. If a hospital spins off a health home agency line of business, they have to re-enroll in Medicare. And ultimately, this would allow CMS, if an existing provider for example lost their CDC recognition, if they were not enrolled separately, the entire Medicare enrollment would be revoked. So that means if a hospital was enrolled and did not re-enroll as an MDPP supplier, the entire hospital would be removed from Medicare and revoked for Medicare based on loss of CDC recognition.

So this is a separate enrollment allows us to target any revocation action on just the MDPP supplier enrollment and not the larger enrollment. So while it does seem like an initial burden up front, we do feel that ultimately it would prevent an administratively difficult situation later on.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Jon Fritz.

Jon Fritz: Hello, this is Jon Fritz from the Heart of the Rockies Regional Medical Center in Salida, Colorado. I just want to get clarification. So, hosting a virtual class is not going to be reimbursable starting January 2018? Specifically, I'm in a rural area and will have in-person classes, but we have the option for people to use a webcam to participate with the group. We've done that in the past. So, just clarification on that – you're not ready yet for virtual with something of that situation?

Carlye Burd: So, we did not – we did not state that virtual providers would not be eligible to bill come 2018. What we did in the rule was kind of lay out some of our reasoning for why we don't have enough information to finalize at this time. There are a lot of differences in the way that virtual DPP organizations deliver the services, and we intend to address some of these differences in the next round of rulemaking. However, I cannot confirm or deny that they will be able to deliver in furnished services come 2018. I can just say that our intent is to allow that to happen, but I cannot say that with any certainty.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Christopher Lopez.

Christopher Lopez: Hello, this is Chris Lopez. I'm calling from New London Hospital in Newport Health Center in New Hampshire. We already have preliminary CDC recognition and plan to start offering our first cohort in probably April of next year. I'm wondering if there's any determination about the billing codes that'll be used, whether there're new G-codes or certain CPT codes of – whether there'll be something that's already existing or whether there will be new codes that are specific to the DPP.

And also if a cohort is in the middle of being offered, the 1-year cohort, and once 2018 rolls around, can we start billing for the cohort that's already pre-existed and not being billed for?

Carlye Burd: Thank you for both of those questions. Firstly, you may be talking about pending recognition.

Christopher Lopez: Correct. Yes.

Carlye Burd: Okay, so there's a difference. So, pending is what currently exists. And preliminary is what we – we're not able to finalize in this year's rulemaking but intend to propose the specific standards for in our next round. And we lay out some examples of what the performance standard would be in this rule. So, it may be that your

organization would meet that standard by this time next year, but I just want to make that clarification.

And then as far as the G codes go and the billing. Those are both really great questions. I can say right now that we are working on the payment structure and working with the MACs to identify all the requirements to implement the payment and are also working on what our proposal will be for the payments in the next round of rulemaking. So those details, I can't disclose right now, but we will propose in future rulemaking.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Linda Volin.

Linda Volin: Hello. I'm with Desert Senita Community Health Center. Can you hear me?

Carlye Burd: Yes, we can, thank you.

Linda Volin: Okay. My question was, there's a lot of things still pending in rulemaking. Do you have a timetable for when we can start watching for these rules to be …

Carlye Burd: Yes. I wish I could tell you all and commit to a timeline. Unfortunately, I can't. All I can say is that our intent is to propose and finalize rulemaking in time for suppliers to begin enrollment before 2018. That's as much information as I can give at this point.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Debby Finch.

Debby Finch: Yes, this is – we're from Summit Health Care Hospital in rural Arizona. The PECOS system, will we need to do that individually as well as an organization or not?

Carlye Burd: So organizations – DPP organizations at the organizational level will enroll in Medicare and will undergo, you know, the account creation in PECOS and go through that system. However, coaches that are furnishing the services will be required to obtain NPIs and, per the final rule, a roster of those coaches, NPIs, and other and identifying information would be submitted with the DPP organization's enrollment in PECOS.

Leah Nguyen: Thank you.

Debby Finch: Okay, thank you.

Operator: Our next question will come from the line of Amber Letz.

Amber Letz: Hi, my name is Amber Letz, and I'm calling to ask, I am a certified lifestyle coach for the National Diabetic Prevention Program, so does that qualify me as a coach for the MDPP?

Carlye Burd: Do you work for an organization that has CDC recognition?

Amber Letz: No, but we were planning on heading in that direction in the coming year.

Carlye Burd: Great. So, what we clarified in the rule is that DPP organizations at the organizational level will obtain CDC recognition and be eligible to enroll in Medicare…

(Feedback on participant line).

Amber Letz: Yes.

Carlye Burd:…feedback on your line. So, as a lifestyle coach, you know, you'll have to – you cannot enroll individually into Medicare. You would have to have an organization under which you would work and furnish services as a lifestyle coach.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Teresa Dolit. Teresa, your line is open.

Teresa Dolit: Oh, I'm sorry. I had it on mute. I'm from Jefferson Hospital in the suburbs of Pittsburgh, Pennsylvania, and my question is, if we are already an ADA-recognized site with certified diabetes educators, we would still need to do the CDC recognition?

Carlye Burd: Yes. So, Medicare authorized the expansion of the national DPP program, and we are relying on CDC's program – CDC's recognition program as a contingency for Medicare enrollment.

Teresa Dolit: Okay, thank you.

Operator: And our next question will come from the line of Jeril Goss.

Jeril Goss: My question is what you had talked about on Page 10, and it was that blood tests require physician referrals. And so I am from the Penn Highlands Health Care in DuBois, Pennsylvania, and I'm wondering about multiphasic blood screenings. These aren't ordered by a physician, but the result goes to a physician.

Carlye Burd: Thanks for that question. I actually – I'm not familiar with multiphasic blood testing.

Jeril Goss: For example, a Lions Club. They might have a community blood glucose – a community screening that would have a number of different tests done as part of that blood screening and then there – and people pay a fee.

Carlye Burd: Okay. Yes.

Jeril Goss: And then the result goes to their doctor.

Carlye Burd: Thank you. So, thanks for bringing this up because I should have clarified. In order for Medicare to cover the blood tests, the oral glucose test and the fasting blood glucose test, the provider has to order and refer the patient to receive that test. And that's a record keeping, auditing requirement.

Beneficiaries can receive these tests in clinics on their own. We know that that happens a lot and, you know, we're not requiring them to get a provider referral to get the blood test, but that is a typical way that someone would probably receive the blood test so that it is covered by their insurance. So, maybe what you're talking about would not be covered by Medicare but would – if they do have the qualifying blood test results, then they could enter the program that way.

Leah Nguyen: Thank you.

Operator: Our next question will come from Courtney Nalivka.

Courtney Nalivka: Yes, this is Courtney Nalivka from Northeastern Nevada Regional Hospital, and I was curious, where I'm – the area that I live in, we do have a lot of strong private-paying insurance. And so in this initial phase where the CDC is wanting to collect this data, would it be wise to only include the Medicare Part B patients or would it be okay to include those other people in the program that have other private-paying insurances?

Carlye Burd: I'm not – are you talking about private paying like commercial…

Courtney Nalivka: Right. Like Anthem Blue Cross or – right.

Carlye Burd: Okay. You know, that – I can't advise on that, but we are aware that a lot of private payers in the market, you know, CMS is usually kind of the last to the party when it comes to implementing new kinds of benefits like this, and there are many, many private payers in the market that are currently offering DPP, many of whom are recognized by the CDC. So, you know, hospitals, it's up to them what kind of – you know, what kinds of private payers you want to contract with. So, we can't necessarily advise on that, but I will say that there are many private payers out there currently offering DPP as part of their benefits package.

Courtney Nalivka: Okay.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Kim Simmers.

Allison: Hi. This is Allison. We're here from Central State in Freehold, New Jersey. We have a question about fees. If we are charging a fee during 2017 for community enrollees, would that have any kind of impact on reimbursement in 2018?

Carlye Burd: Can you clarify what you mean by community enrollees?

Allison: So if – so, right now, if we have a person enrolled and we're charging, let's say, $50 for enrollment into our DPP program, come 2018, would that have any kind of impact, like we've been billing all along patients for $50 and now we're getting reimbursement from CMS that may be at a higher rate? You know, we just want to be sure that that wouldn't have any kind of impact.

Carlye Burd: Okay. Thank you for that question. This goes back to the core benefit slide on Slide 7 and also clarified in the final rule that Medicare is covering this as an additional preventive service. And under the Affordable Care Act, additional preventive services are available to eligible beneficiaries at no co-pay. So, anyone that is eligible under our eligibility criteria and an MDPP supplier has enrolled in Medicare to provide this service would have to provide the service at no co-pay. Does that help?

Allison: As a followup to that then, but for clarification, during 2017 when we have to do classes as soon as possible in order to submit our data…

Carlye Burd: Okay. Yes. Oh, thank you…

Allison: …cost.

Carlye Burd: That is – that we will not advise you on how to handle your payment structure or – and how – and what participants have to pay to participate. We are aware that many participants do pay a fee to participate in the program. We will not advise, you know, whether or not to do that. But come – you know, once the program is covered under Medicare and claims are being submitted, no co-pays.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Sally Belles.

Sally Belles: Hi. Thank you. I'm calling from Straub Medical Center in Honolulu, Hawaii. And my question is specifically related to documentation. So, we are a large center that

does use the Epic system. So, we're already in place for documentation and outcomes tracking, but – and claim submission. So, I was just curious about exploring other software and CMS's own software, if that was necessary or for health facilities that were already set up with Epic. Would that be essential – would it be recommended to use CMS…?

Carlye Burd: Thank you so much for that question. No. So, if you have a system of record already set up, if you are an existing Medicare provider, you are submitting claims to Medicare on a regular basis, you do not have to purchase or establish any special type of infrastructure to administer this program. We just are providing this information because a lot of organizations are new to Medicare and do not currently have those types of infrastructure set up. And so, we have provided some information. But if you already have it, keep it, use it. It's standard claim submission. So, I don't think you should have a problem.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Erin Audiss.

Erin Audiss: Hi. Am I on?

Leah Nguyen: Yes. Thank you.

Erin Audiss: So, I'm calling from the Cow Creek Health and Wellness Center in Roseburg, Oregon, and my question is in regards to Slide 8. Prior to the start of the program, is there a timeframe that the participants need to have their labs done?

Carlye Burd: Thanks for that question. Yes, within 12 months prior to attending the first core session is the timeframe for that.

Erin Audiss: Okay. Thank you.

Operator: And our next question will come from the line of Anthony Bolus.

Anthony Bolus: Yes, ma'am. Thank you. This is Anthony Bolus from Bessemer, Alabama with FMS Pharmacy. I'm a pharmacist. You guys actually already answered my question. But I guess just to clarify, if we had patient came in, we did a blood sugar check on them, it fit the criteria, we could actually use it without the provider having it referred to us? I do believe you already answered that, but that was my question.

Carlye Burd: Yes. That's correct. And, you know, it sounds like you're referring to if the pharmacy was actually offering the benefit.

Anthony Bolus: As in the – right. We are right now in terms of in pending status looking to get in terms of …

Carlye Burd: Got it.

Anthony Bolus: … MDPP, right.

Carlye Burd: Yes.

Anthony Bolus: Okay.

Carlye Burd: So, we will – we will – we will provide some clarification in either guidance or rulemaking around the documentation of these eligibility tests because we do recognize that there are circumstances where the blood test might be taken right there at the pharmacy or clinic or hospital where the MDPP services are actually furnished.

So, we intend to provide some of that clarification. But we – all I can say right now is as long as it is clearly documented in the medical record, the blood test – and not just the results but the actual blood test is there, then you'll be fine, and be thorough with your documentation. That is all I can say right now.

Leah Nguyen: Thank you.

Anthony Bolus: Okay. Thank you.

Operator: Our next question will come from the line of Sharon Jackson.

Sharon Jackson: Good afternoon, everyone. I believe my question has already been answered, but I think I will ask just for clarification. Is the free software package that CMS offers compatible with EHRs or if you already have an EHR billing mechanism you should use that?

Carlye Burd: Thank you for that question. I will have to – we will have to look into this one. I don't – do not know actually off the top of my head what the compatibility is. So, I will take this one back and see if we can use and provide – answer this question in some upcoming materials that we will be putting forth.

Sharon Jackson: Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Serena Onte.

Serena Onte: Hi. Thank you. I think you already answered my question about the timeline for the next rule. Thanks.

Leah Nguyen: Thank you.

Operator: Thank you. And our next question will come from the line of Katherine Dallow.

Katherine Dallow: Hi. This is Katherine Dallow from Blue Cross and Blue Shield of Rhode Island. A few of my questions did get answered. However, I just wanted to clarify some things based on the document that we had seen from the *Federal Register* back in July regarding a potential draft reimbursement structure for a pay for performance type contract. So, am I right in saying then that that kind of a model is still possible? There was no mention of it in this presentation other than the after 12 months having …

Carlye Burd: Right. Thanks for bringing this up. This is one of the large policy areas that we intend to actually formally propose in our next round of rulemaking. In the final rule, there is – I think there are four sections at the end where we outline the policies where we have – where we didn't actually explicitly propose in last year's rule or this – I guess it was this summer's rule. So that payment structure that you saw and – was actually included also in the final rule is a consideration that Medicare has put forth to the public and also through the comment period we did receive comments on that and we'll be processing and addressing comments related to the payment structure in our upcoming rulemaking. So, you know, look for that in the next rule. We did want to just signal to the market what CMS is currently considering.

Leah Nguyen: Thank you.

Operator: Thank you. Ladies and gentlemen, if you would like to withdraw your question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question will come from the line of Lawrence Rubin.

Lawrence Rubin: Yes, thank you very much. This is Lawrence Rubin, in Las Vegas, Nevada. We have an organization – it is a 501(c)(3) organization. I'm the director of that organization, it's the LEAP Alliance, Lower Extremity Amputation Prevention. We are not a medical organization. Our membership consists of some certainly medical individuals, providers, but we are a 501(c)(3) group that is concentrating our efforts on diabetes awareness and action. So, my question is, would a group of this sort that is not inherently a medical organization be able to qualify as a supplier?

Carlye Burd: Thank you so much for that – that very concrete example. I think there are probably a lot of organizations like yours out there that are wondering the same thing.

And we – what we recommend you do is look into the CDC Recognition Standards. We provided a link in this presentation, and there's an email at the end of this presentation for CDC for recognition-related questions.

Our policy for Medicare enrollment is that organizations have to meet those – the preliminary – the soon to be preliminary and/or the full recognition standards that CDC lays forth. So, we very much recognize that organizations that are nontraditionally – not traditional medical providers will be enrolling in Medicare, which is part of the novelty of this program.

Just to go off on a little bit of a public health spin here, this is a community-based program, has been for a long time, and it's intended to continue to be that way. And we encourage small community-based organizations like yours that are 501(c)(3)s to look into the standards that CDC has put forth and determine whether your organization has the capacity to meet those standards and the requirements that are laid out in this rule. So, thank you very much for that great question.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Rene Kridler.

Renee Kridler: Hello, thank you for taking my call. I also work with a 501(c)(3), but we are a Medicare provider. And I guess our question, because we are in a very heavily – we're in the Phoenix area in the Sun City, for those of you who might know, is a very heavily retirement community and people are not here full time. And so we have individuals that come and go throughout the year as they – we call snowbirds. So is an individual able to start and stop a DPP program according – like if it's during core or post core, at multiple locations?

That is our biggest, I guess, hurdle that we deal with in our population, individuals cannot commit to the full year in one location. So are they going to be able to do this at multiple locations and find a second site to continue?

Carlye Burd: Yes, so thanks so much for that question. It's definitely something that we – we know is going to be a common occurrence, and because it's very much intertwined with payment, we intend to propose specific attribution, beneficiary attribution policies in future rulemaking.

We did state in this final rule that beneficiaries would be able to switch providers, excuse me, suppliers throughout the program, but we didn't elaborate on specifics around kind of when and how and what the supplier would do if they were taking on someone new. So, we do intend to address those issues in future rulemaking and recognize that it is an issue. So thank you for bringing it up.

Rene Kridler: Thank you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Jessica McDaniel.

Jessica McDaniel: Hi, we are from Wyoming, Michigan, and currently are a recognized program. And we have been trying to deal with Priority Health, who wants us to bill under a 0403T code, and our hospital is kind of waiting for the CMS to move forward so that they can do one billing of code for the DPP program. Any idea if that would be a potential as a billing code?

Carlye Burd: Yes, I can't comment on that at this time. All I can say is that we will propose, you know, CMS will put forth specifics around the payment and billing requirements in our next rule, and along with any kind of new payment that CMS put forth there is the corresponding MLN article that is generated that provides the specific coding requirements for providers. So you will have to wait until we finalize the next rule to see that, which will be until probably you know next year sometime, late next year. So, I'm sorry, I can't provide more details to help you make your decision at this time.

Jessica McDaniel: So when you say late – when you say late, because for like our Epic systems, it takes time to get all of that built. So are they going to give us like a good 6 months to at least get this all in place?

Carlye Burd: I wish I could provide more concrete details on the timeline, but I unfortunately can't at this time. All I can say is that we intend to provide rulemaking in 2017, and I have to leave it at that. I'm so sorry.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Mike Jawer.

Mike Jawer: Oh hi, I'm here in Washington D.C., and I'm on staff with an association of integrative physicians. And my question is, you know, we're a membership organization, we're 501(c)(6) and, you know, we provide education and information and networking for our members, who are individual physicians, small businesses, they may, you know, run clinics together and may work for a larger health-care organizations. But predominantly, they're either sole providers or they work in tandem, so they're small businesses. And is there any role for our association, should we be looking in – I mean beyond providing education about this opportunity, because many of our members do want to become DPP coaches. Is there a role for us as far as exploring the CDC recognition as an association of those individual physicians?

Carlye Burd: Right. So I again will have to refer you to the CDC's website and to their inbox to answer specific questions around the recognition program. But essentially, you know, if you're – if associations like yours do become CDC-recognized, then you can – that is the prerequisite. You know, as long as you meet the standards, that is the prerequisite to begin the Medicare supplier enrollment.

Mike Jawer: Well, one quick followup. I appreciate that. If we're not a health-care provider ourselves, is that – is that a viable avenue for us?

Carlye Burd: That is – that's fine – yes.

Mike Jawer: Okay.

Carlye Burd: You know, the YMCA is not typically thought of as a health-care provider, although they are, you know, leaning into the health-care space as the definition of the health-care provider and the health-care system kind of shifts gears towards prevention.

So, you know, the YMCA is where the model test was performed. They are, you know, one of the biggest providers of DPP and, similarly, you know, would not be necessarily considered a health-care provider. But because if, you know, those YMCAs that are fully – that are recognized by CDC could enroll in Medicare.

Leah Nguyen: Thank you.

Mike Jawer: Perfect, thank you.

Operator: And our next question will come from the line of Sara Dandinidis.

Sara Dandinidis: Hi there, good afternoon. This is Sara from Chicago, Illinois, with Dietitians at Home. I'm a registered dietitian/nutritionist, and I have a question about those on Medicare disability. Obviously, there are some people that are below the age of 65. Would this MDPP also apply to them?

Carlye Burd: Thank you so much for that. I do not believe we have indicated any guidance around that population. So, we will have to take this one back and see if we can either propose in our next round of rulemaking or release some kind of guidance around that population. So thank you.

Sara Dandinidis: That would be great because we service a lot of patients on that plan and they're in their 40s and 50s. And we did a poll for our DPP because we are applying. And the majority of people are between the ages of 40 and 56, not 65 and older. Not to mention clinically speaking and metabolically speaking, it's harder to lose weight over the age of 70 even.

So, just curious as to how, you know, these guidelines are arranged and if we can include those who are younger. Thank you.

Carlye Burd: What was the name of your organization?

Sara Dandinidis: Oh, we are at Dietitians at Home.

Carlye Burd: Okay, thank you. Thanks so much for that question and consideration.

Sara Dandinidis: Yes.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Lorraine Porcaro.

Lorraine Porcaro: Good afternoon, everyone. I'm calling from Orange Regional Medical Center, Middletown, New York. We just received our pending recognition. We're very excited about it. But I did hear something that I'd like you to clarify please.

You mentioned that we would need – because we are a hospital here and we certainly we have a – we do bill Medicare, I understand that we will have to bill as a separate entity as the DR piece. So tell me, do we need to have a separate name, because we applied under the name of our medical center?

Carlye Burd: Thank you so much for that, and I don't want to speak out of turn here but I – all I can say right now is that you will – I want to clarify that you do have to enroll as a MDPP supplier separately outside of your existing Medicare enrollment.

The specifics around what name is used for that enrollment, I don't want to comment on that technical detail right now, but I'm going to write it down so that when we do have some of – some more kind of resources to share around technical assistance, we can address that issue. Thank you.

Lorraine Porcaro: Thank you very much.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Lynn Hendrickson.

Lynn Hendrickson: Good afternoon, Lynn Hendrickson from the Tribal Health Department in St. Ignatius.

Leah Nguyen: Thank you.

Carlye Burd: Great.

Lynn Hendrickson: Am I coming through?

Carlye Burd: Yes, we hear you.

Lynn Hendrickson: Okay, I was trying to download that software package and wasn't able to. I just keep getting error messages.

Carlye Burd: That is not good. Thank you for noticing that, and we will take that back and figure out what is wrong with the link and with the package.

Lynn Hendrickson: Okay, yes, I'll read you the message.

Leah Nguyen: That's okay, if you want …

Lynn Hendrickson: Okay.

Carlye Burd: Yes, we'll just try it. Thank you.

Leah Nguyen: If you're not able to download it, you can send us an email at the address on Slide 26.

Carlye Burd: Yes. Did you click on the link off of the slide and try to download it from there?

Lynn Hendrickson: Yes.

Carlye Burd: Okay, thank you. We will look into it.

Leah Nguyen: Thank you.

Lynn Hendrickson: Will you email that out then?

Carlye Burd: We plan to put together several types of materials in the next coming – in the coming months, kind of providing step-by-step instructions. So I would just hold off on, you know –we're not going to – we're not going to just mass email like one thing, but we're going to try to consolidate information into more usable pieces for our stakeholders.

Lynn Hendrickson: All right. Thank you very much.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Rose.

Rose: Hi, I wanted to check and see – sorry, you totally caught me off guard, it was really a long line. I wanted to check in and see if you guys had any news about insurance companies for non-Medicare and there's also a company, Solera Network, I'm not sure if you guys are looking to or would be able to work with them to have clients go through the same thing regarding accepting insurance, but yes.

Carlye Burd: Thanks for that. Yes, we are aware that both private insurers will provide and contract with DPP organizations to provide the service to their members. And we are also aware with – aware of Solera. We actually mentioned in the rule, although we used a different term, we should have used the term integrator. We used the term third-party administrator and stated in the rule that we would address any policy pertinent to integrators like Solera, although we did not call them out specifically, but integrators such as Solera, anything like that we would address in our next round rulemaking.

Leah Nguyen: Thank you.

Rose: Okay, great.

Operator: And our next question is going to come from the line of Janice Haile.

Janice Haile: Hi I'm Janice from the Kentucky Diabetes Prevention and Control Program, and I just had a question surrounding coaches trainings. Right now in the CDC standards it doesn't really require that people have to go through coaches training. And I'm wondering if CMS is planning to offer any guidance regarding any kind of formal coaches training that might have to be listed as people sign up as an MDPP supplier, coach, etc.

Carlye Burd: Yes, thank you for that. We do not intend to require any additional training of the coaches beyond what the CDC lays out. And just as frame for that, you know, we are really relying on the CDC recognition program as setting the quality standards for the program, and we do talk about coach training in the rule. We did get a lot of comments on this.

What, you know, overarching – what has been found is that there isn't a lot of differences in outcomes when you train or credential coaches in specific training versus train them to provide a curriculum, and that is kind of the standard that CDC has moved forward with. So we are not imposing additional requirements at this time.

Leah Nguyen: Thank you. Holley, we have time for one final question.

Operator: Okay, and that question will come from the line of Andrea Haugen.

Andrea Haugen: Hi, this is Andrea Haugen from Sanford in North Dakota, and we are currently offering our classes for free. And a lot of our insurance companies around here are not covering the cost of the class. So I'm wondering if we are charging – going to start billing Medicare for the $450 fee, are we going have to bill all – everyone else in the class, their insurance for the $450?

Carlye Burd: Thank you for that question and by the way I'm from Fargo, so I'm really happy to have one person calling from North Dakota, my home state. So, I will clarify for you that we are – you know, we will propose the payment structure in our next round of rulemaking, and we will not be advising or making any specific proposals pertinent to the commercial payer market.

However, we – as many of you may notice – may have noticed, we do not make mention of Medicare Advantage in this rule. It is out of scope of the physician – Medicare Physician Fee Schedule to talk about Medicare Advantage. So you may see guidance coming out around Medicare Advantage in the coming months, but we will not, you know, Medicare will not comment on or advise how hospital should handle commercial payers really in our rules. But thank you for that question. And go North Dakota.

Leah Nguyen: Thank you.

Additional Information

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to one of the addresses listed on Slide 26 of the presentation. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On Slide 25 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

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

Operator: This concludes today's call. Presenters, please hold.

-END-


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


Medicare
Learning
Network
Official Information Health Care
Professionals Can Trust


MLN Connects®