SDC

Exploring Reimbursement Options for the National Diabetes Prevention Program: Lessons Learned From a Pilot Project in Los Angeles, 2014-2018

Jennifer Torres Mosst, PhD, MScPh, MSSW; Amelia DeFosset, MPH; Megala Sivashanmugam, MPH; Tony Kuo, MD, MSHS

ABSTRACT

Context: Although Medicare and several state Medicaid programs are beginning to cover the cost of delivering the National Diabetes Prevention Program (National DPP), little is known about the logistical challenges to establishing reimbursement options for these services.

Objective: To describe Los Angeles' experience working with payers to identify and establish reimbursement pathways for National DPP providers.

Design: A case study was conducted to identify regional options for covering the costs of the National DPP.

Setting: Los Angeles.

Participants: A managed care organization along with selected National DPP providers (those that provide in-person and/or online services) participated in this regional pilot project.

Intervention: The Los Angeles County Department of Public Health explored and prototyped reimbursement options for the National DPP, using input from and participation by target health plans (payers) and program providers.

Main Outcome Measure: The establishment of a regional reimbursement approach for the National DPP.

Results: Pilot project participants weighed the pros and cons of billing (Medicare/Medicaid)/reimbursing for program services directly, ultimately choosing to go with a third-party integrator that worked with payers to handle the administrative process of reimbursing program providers for their services. The integrator negotiated and obtained reimbursements on the behalf of the National DPP providers.

Conclusions: Lessons from this case study suggest an emerging need to build further capacity among National DPP providers, as they are often community-based organizations that are not equipped to bill Medicare/Medicaid directly for services. A third-party integrator represents a viable approach for addressing this logistical issue.

KEY WORDS: access to care, diabetes prevention, Medicaid Managed Care Plan, National Diabetes Prevention Program, reimbursement

Author Affiliations: *Division of Chronic Disease and Injury Prevention, Los Angeles Department of Public Health, Los Angeles, California (Drs Mosst and Kuo and Mss DeFosset and Sivashanmugam); Department of Epidemiology, UCLA Fielding School of Public Health, Los Angeles, California (Dr Kuo); Department of Family Medicine, David Geffen School of Medicine at UCLA, Los Angeles, California (Dr Kuo); and Population Health Program, UCLA Clinical and Translational Science Institute, Los Angeles, California (Dr Kuo).*

This project was supported, in part, by a cooperative agreement from the Centers for Disease Control and Prevention (# U58DP005509). The authors acknowledge the contributions of other project partners, including the LA Care Health Education team and the Black Women for Wellness Diabetes team.

The authors have no conflicts of interest to disclose.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (http://www.JPHMP.com).

Correspondence: *Jennifer Torres Mosst, PhD, MScPh, MSSW, Division of Chronic Disease and Injury Prevention, Los Angeles County Department of Public Health, 3530 Wilshire Blvd, 8th Floor, Los Angeles, CA 90010 (jmosst@ph.lacounty.gov).*

DOI: 10.1097/PHH.0000000000001136

The prevention of type 2 diabetes is a public health priority in the United States.[1] In 2012, the economic burden of prediabetes and diabetes was estimated to be $245 billion nationally; in California, this cost was $32.3 million.[2-4] This burden can be mitigated through expansion of the National Diabetes Prevention Program (National DPP), a yearlong lifestyle change program focused on improving diet and physical activity among prediabetic participants. The program is well studied and has been shown to effectively delay or prevent the onset of diabetes.[3-5] Nationally, efforts have been underway to scale the National DPP, including significant investments by the Centers for Disease Control and Prevention (CDC) at the state and local levels to translate this program into community settings, and build infrastructure to support large-scale uptake.[6-8] In 2014, with support from the CDC, the Los Angeles

County Department of Public Health launched the *Chronic Disease Prevention Strategy* (CDPS), a primary goal of which was to expand the National DPP to reach safety-net populations disproportionately impacted by diabetes (eg, low-income and race/ethnic minority groups).[9]

At the start of the CDPS initiative, the cost of participating in the National DPP was approximately $500 per person. This cost was prohibitive to both safety-net audiences and the community-based organizations (CBOs) frequently tasked with delivering the program to them (even when offset by grant funding, CBOs often absorbed at least part of program costs).[10,11] There were very few options by which National DPP providers could receive reimbursement for these services.[10-13] Although much needed, establishing reimbursement mechanisms for the National DPP was highly complex, requiring simultaneous action at the national, state, and local levels (see Table 1). Specifically, there was a need for processes, policies, and systems to enable Medicare/Medicaid to cover services provided outside of the traditional health care settings (eg, clinics, hospitals). Locally, there was a parallel need to build/strengthen infrastructure that would allow organizations providing the National DPP, with little to no experience with medical billing, to leverage forthcoming reimbursement options. When the CDPS was launched, there were no existing models or practical guidance around how best to navigate this process.

The present case study describes the experience of the CDPS in helping regional payers and National DPP providers conceptualize reimbursement/billing approaches for National DPP services that could meet their needs. The case study describes the 3-stage process involved in conducting this pilot project and discusses key considerations and steps taken to navigate the unique complexities at each stage: stage 1—identifying the right partners; stage 2—identifying an appropriate reimbursement approach; and stage 3—prototyping select reimbursement options. Ethical approval for this research was obtained from the Los Angeles Department of Public Health institutional review board (IRB No. 2015.08.589).

Stage 1: Identifying the Right Partners

To identify and engage a payer (insurer/funder) to partner on the pilot project, the CDPS staff weighed potential options among those available in the region

TABLE 1
Understanding National and Regional Reimbursement Options for the National Diabetes Prevention Program

Coverage Options	Federal and Statewide Coverage Opportunities/Implementation Efforts	Local Coverage Opportunities/Implementation Efforts
Medicare	*Federal Coverage Options:* *Medicare Demonstration Project*: Launched in 2015 to establish the cost-effectiveness of the program for public payers. The project's intent was to determine whether an expanded and high-quality DPP model (reaching a target population such as seniors or low-income individuals) could reduce long-term spending due to diabetes and its medical complications.	Partnered with key stakeholders (statewide and locally) to develop comments for the CMS to influence the development of the rule-making process for establishing MDPP. Provided insight into the local impact to implementing polices at the state and local levels. Comments developed included best practices and lessons learned from local providers on implementing and billing for National DPP services.
Medicaid	*Federal Coverage Options:* In partnership with the NACDD, the CDC launched the Medicaid Demonstration Project, which awarded funds to 2 states (Maryland and Oregon) to develop and/or test reimbursement options for increasing coverage of the National DPP with the long-term goal of using their experience to influence policy that could make the National DPP a covered benefit under Medicaid.	Partnered with a large managed care organization to develop and/or test reimbursement options for increasing coverage of the National DPP with the long-term goal of using their experience to influence policy that could make the National DPP a covered benefit under Medicaid.
	State Coverage Options (California): The State Department of Public Health in partnership with statewide advocacy groups worked together with the state legislature to create an item in the 2017-2018 governor's budget; it earmarked and allocated funding for Medi-Cal (California's Medicaid Plan) to pay for beneficiaries' participation in the National DPP. The governor's budget was approved by the State Legislature in July 2017.	Shared best practices and lessons learned with state partners to assist with the development of the Medi-Cal National Diabetes Prevention Program (Medi-Cal DPP) reimbursement efforts. Participated in statewide key stakeholder coalition efforts to develop guidance for developing guidelines for billing and reimbursement practices for Medi-Cal DPP.

Abbreviations: CDC, Centers for Disease Control and Prevention; CMS, Centers for Medicare & Medicaid Services; DPP, Diabetes Prevention Program; MDPP, Medicare DPP; NACDD, National Association of Chronic Disease Directors.

(see Table, Supplemental Digital Content 1, available at http://links.lww.com/JPHMP/A635, partners considered for piloting billing and reimbursement options) and selected a large regional Medicaid managed care organization (MCO). The MCO, through discussion with the CDPS team, then identified available National DPP modalities (eg, in-person, online) and local provider organizations that could fit the needs of their clients (see Table, Supplemental Digital Content 1, available at http://links.lww.com/JPHMP/A635, partners considered for piloting billing and reimbursement options). Ultimately, 2 providers were engaged as potential partners, one small local CBO offering the program in-person and one national company offering online services within the Los Angeles area. The local CBO was seen as well positioned to participate, with more than 10 years of experience delivering National DPP services (in English and Spanish) to underserved communities in Los Angeles and prior experience contracting with the MCO. The online provider (the only operating in the area at the time) had ample experiences working with other MCOs generally and also offered Spanish and English content tailored it to a low-literacy audience.

Stage 2: Identifying and Selecting a Reimbursement Approach

After partners signed on to the project, they began working to identify available reimbursement options (eg, fee structures or payment pathways) wherein the MCO could reimburse for National DPP services delivered by the providers. Informed by the National Association of Chronic Disease Directors National DPP Medicaid Coverage Learning Collaborative (of which the CDPS was a part),[14] the group considered 3 potential mechanisms: (1) use of a *fee-for-service* payment schedule; (2) alternative contractual arrangements that use Requests for Proposal, Memorandum of Understanding, and/or direct invoicing services to bundle services packages; and (3) use of a third-party integrator to recover reimbursements. Results and lessons learned from the identification and selection process can be found in Table 2. Fee for service was immediately ruled out because this option has been found to disincentivize prevention services for payers (with high cost associated with delays in seeking services by patients, especially among high-need populations)[15]; contracting and third-party integrator options were explored in the prototyping phase.

Stage 3: Prototyping Reimbursement Options

In consideration of anticipated facilitators and barriers to implementing billing and reimbursement practices for National DPP services among payers and program providers in Los Angeles (see Table 2), the CDPS staff worked closely with the MCO to test and implement potential reimbursement options. First, the MCO explored contracting with program providers directly. This option appeared to provide the most flexibility for establishing service delivery and program performance benchmarks that were manageable to providers, while ensuring quality and fidelity. However, in the course of contracting, they encountered a number of challenges including lengthy administrative delays, challenges with establishing set cost for program delivery, and agreeing to terms around sharing participant/patient data between entities (a detailed description can be found in Table 2). In particular, although the selected providers were relatively experienced at delivering the National DPP, they generally lacked sophisticated data management and tracking systems required to efficiently bill and receive reimbursements for their services. They also lacked familiarity with the length and complexity of payer's contracting processes. Given the number of challenges the MCO experienced in executing this approach with the local program providers, the MCO settled on the use of a third-party integrator to facilitate billing and reimbursement of services rendered by National DPP providers. The integrator that was eventually selected for this project had extensive experience in contracting with various MCOs and already had established relationships with many of the National DPP providers in the region, including the CBO engaged for the pilot project. The third-party integrator also had extensive experience in addressing some of the challenges encounter by the MCO in attempting to secure multiple contracts with National DPP service providers, which included lack of contracting experience with payers and lack of infrastructure to track and submit data to payers.

Contracting experience

As described earlier, contracting experience played a vital role in deciding how the MCO would move forward with establishing a reimbursement model for National DPP services. During the project, contracting was the only mechanism that could be used to directly bill and reimburse for National DPP services. Therefore, selecting a partner with this experience was crucial. As described in Table, Supplemental Digital Content 1 (available at http://links.lww.com/JPHMP/A635, partners considered for piloting billing and reimbursement options), many of the National DPP providers in the region lacked or had limited experience contracting with payers and

TABLE 2
Options for Reimbursement of the National Diabetes Prevention Program in Los Angeles County

Payment Option (Approach)	Characteristics	Facilitators to Implementing This Reimbursement Option	Barriers to Implementing This Reimbursement Option	Role of the Option in the Pilot Project
Fee for service	A reimbursement approach in which a provider is paid a fee for each service rendered.	Rewards providers for caring for sicker patients. Affords patients and providers with greater choice and flexibility of services that can be provided.	Incentivizes toward a greater volume of care (potentially leading to unnecessary services) and/or costlier care (potentially driving up costs). Disincentivizes prevention. Costs (risks) to payers are particularly inflated with the high-need population because of delays in seeking services and number of test and procedures that may be needed.	Approach was not selected because it would have been too expensive for program participants, given the level and number of contacts involved with the yearlong DPP program (out of reach of the priority population). Approach works better for higher-income people than for lower-income people. Generally, a better approach for commercial insurance than for public payer insurance or related options.
Alternative administrative mechanisms: using contractual mechanisms such as a Request for Proposal, Memorandum of Understanding, and/or other invoicing arrangements	Contract can specify specific payment schedules and processes, such as number of participants to be served, weight loss requirements. Approach provided payment in one lump sum, and providers could use these funds to cover the cost of the program. Administrative cost to both the payer and the provider. Preestablished pricing may not cover the cost of program.	Flexibility to develop program-specific delivery schedules and performance benchmarks. Can support various program formats (no a priori restrictions). Flexibility in selecting partners within the contracting process.	Because prices are established via a negotiation process, final reimbursement rates may not cover the cost of program. Administrative processes to execute contract between the provider and the payer can be lengthy and there are not many models for how to navigate complexities (eg, confusion over who would "own" a client's data, when both organizations are classified as protected entities and thereby subject to HIPAA). Not all National DPP providers have experience with contracting at the level of payers, especially smaller CBOs.	Contracting was initially selected as the best reimbursement approach for the pilot project, and a direct contract negotiation process was initiated between an in-person CBO provider and the managed care organization. Contracting was seen as promising because it allowed the provider and the payer to develop a process for covering the National DPP that met both their needs (eg, included mutually agreed-upon payment benchmarks and price per service delivery unit).

(*continues*)

TABLE 2
Options for Reimbursement of the National Diabetes Prevention Program in Los Angeles County (*Continued*)

Payment Option (Approach)	Characteristics	Facilitators to Implementing This Reimbursement Option	Barriers to Implementing This Reimbursement Option	Role of the Option in the Pilot Project
Third-party payer/integrator	Private company that specializes in serving as an administrative go-between for payers and National DPP providers, in exchange for a percentage of the provider's revenue from reimbursement and a set fee for the payer (one company was operating nationally during the project period). Requires that payers and service providers separately contract with the integrator before they can interface. The integrator works with the payer to establish payment benchmarks and service delivery schedules. The integrator works with the service provider to establish processes to be able to bill payers for services.	Removes administrative burden for participating partners. Experience/flexibility in contracting with multiple types of partners. Experience with information sharing and privacy issues. Knowledgeable on the reimbursement process and options and can help tailor arrangement to meet the needs of all parties to the contract.	Administrative cost to both the payer and the provider. Established pricing may not cover the cost of program for service providers since reimbursement is based on rates established nationally and does not take into account any unique services the program provider may offer to participants. The national company may have limited access to regional providers or knowledge of practice landscape. Process for patient identification and referral creates competition for limited resources among program providers.	After attempting to develop direct contracts between partners, a third-party integrator was selected as the best option for the project because it removed the administrative hurdles from the payer and the service provider and allowed them to focus on growing the program. The integrator provided both parties with support in establishing infrastructure for billing and reimbursement. Working with the third-party payer/administrator provided National DPP providers the support to navigate the administrative approvals of the health plan or Medicaid managed care organization directly. Making partnerships with payers possible to smaller CBOs.

Abbreviations: CBO, community-based organization; DPP, Diabetes Prevention Program.

encountered challenges in executing a contract with the MCO. In contrast, the third-party integrator had tremendous amount of experience in partnering not just with payers (both public and private) but also with various types of National DPP service providers (an essential element the MCO lacked). Therefore, a contract between the MCO and the third-party integrator meant access to a partner with the ability to work with and contract with a variety of organizations (eg, employers [both large and small], health care providers, CBOs, and other health plans), a partner with the capacity to establish multiple contracts, and a partner with the data systems and infrastructure in place to handle all of the administrative processes involved with reimbursing for National DPP services (eg, ensuring program providers were in good standing with CDC recognition standards, are providing services to plan members, and receiving and checking for accuracy of bills generated), making this contract advantageous by both the payer and the service providers. For the payer, it provided them with the freedom of only having to negotiate one contract for billing and reimbursement of National DPP services. They worked directly with the third-party payer to establish program eligibility for billing, establish benchmarks for reimbursement, and negotiate payment and reimbursement terms (see Table 3 for sample payment schedule). While from the service provider standpoint, working with the integrator reduced the administrative challenge of executing a direct contract with the MCO, it also paved the way to receive reimbursement from other payers in the integrator's network (which otherwise would have required individual contracts/negotiations).

TABLE 3
Centers for Medicare & Medicaid Services: Fee-for-Service Schedule for the Reimbursement of the Medicare Diabetes Prevention Program[a]

Service Provided in the First Year	Reimbursement Amount (in US Dollars)
Core sessions	
1 Session attended	$25
4 Sessions attended	+$50
9 Sessions attended	+$100
5% Weight loss baseline	+$160
9% Weight loss from baseline	+25
Maximum total for core sessions in the first year	**$360**
Maintenance sessions (maximum of 6 monthly sessions over 6 mo in the first year)	
3 Maintenance sessions attended with maintenance of 5% weight loss	$45
6 Maintenance sessions attended with maintenance of 5% weight loss	+$45
Maximum total for maintenance sessions in year 1	**$90**
Maximum total for the first year	**$450**

[a] *Several states, including California's Medi-Cal program, are planning to use or are already using a similar arrangement as the Centers for Medicare & Medicaid Services' fee schedule to reimburse for services delivered by providers of the National Diabetes Prevention Program. These providers must be a Centers for Disease Control and Prevention–recognized entity.*

Data infrastructure

In addition, agreeing on the data that could be shared and systems for ensuring the quality of data to support billing were seen as a major challenge for the MCO in trying to execute a contract with local service providers. For the CBO participating in the pilot, although it had worked with payers in the past, it was through grants or mini contracts that did not require it to establish rigorous systems for tracking and submitting data to the payer. For the MCO, the third-party integrator served as a type of quality assurance agent/intermediary who could work directly with providers to ensure that all data related to payment benchmarks and billing were submitted in a timely and accurate manner. From the provider standpoint, as part of the fee paid to the third-party integrator, it could access tools (eg, reporting data portals and templates) and technical assistance to support and streamline the data collection and reporting process needed to successfully reimburse for services.

Despite the associated benefits, participants of the pilot identified some challenges to working with a third-party integrator. First, working with a third-party integrator would restrict the number and types of service providers the MCO could work with. Operationally, only programs that had contracted with the third-party integrator could receive reimbursement. However, not all service providers in the region had the option to work or would choose to do so. For instance, health care systems typically have restrictions against these types of arrangements. Consequently, the MCO would lose some control in building out a network of service providers tailored to meet the needs of their members, prioritizing instead the administrative ease of working with providers in the integrator's network. Another, a challenge identified by both the MCO and the service provider working on this pilot project was the additional administrative cost associated with contracting with the third-party integrator. For the service provider associated with this pilot, the additional cost

was prohibitive when weighed against the cost associated with program implementation (ie, paying the coaches, materials/supplies, incentives) and the reimbursement amounts received for providing the program. Ultimately, accommodating the profit margin reduction associated with working through the third party caused the provider to seek additional streams of funding such as grants to cover the cost of sustaining the program over time.

Lessons Learned

The objective of this case study was to highlight how a local public health department worked with a large MCO and local community-based services providers to identify a reimbursement approach that could be used to cover the costs of delivering the National DPP to a safety-net population. The planning process described in the case study represents a novel effort in the field of diabetes prevention. In 2015 (at the time this pilot project was initiated), few, if any, comparable approaches or models existed; just bringing partners to the table to discuss this issue was a significant step forward. The resulting discussions highlighted important considerations around 2 key stages: (*a*) establishing partnerships that fit the intended goal of the pilot and (*b*) selecting a reimbursement approach (option) that fits. In regard to the first, the project was guided by the funder's goal to reach safety-net populations, which helped focus partner selection and engagement and facilitated critical reflections around associated benefits and challenges (eg, working with CBOs with deeper reach among underserved groups but often with undeveloped administrative infrastructure). In regard to reimbursement options, the importance of flexibility in setting terms that would mutually benefit both the payer and the provider (eg, mutually agreed upon reporting/quality assurance standards, services benchmarks, and fee schedules for reimbursement) was key to ensuring the pilot's success.

After engaging in collaborative learning and planning for several years, the partners in Los Angeles ultimately determined that the administrative burdens of partnering directly were too great and that a third-party integrator was the most feasible and sustainable approach, although it resulted in less revenue to the providers. In particular, the providers that participated in this project struggled to navigate the payer's administrative processes. As practice landscapes vary across jurisdictions (different organizational players, different populations, different regulatory environments), other jurisdictions may encounter different or unique challenges. While the process described for Los Angeles may not address all of the issues that other jurisdictions may encounter, the key considerations that emerged throughout the pilot project could provide a road map for others to follow, as they build provider-payer networks in their own communities.

References

1. Office of Disease Prevention and Health Promotion. Healthy People 2020: diabetes. https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives. Accessed August 1, 2016.
2. Centers for Disease Control and Prevention. National Diabetes Fact Sheet. http://www.cdc.gov/diabetes/pubs/pdf/methods11.pdf. Published 2011. Accessed August 1, 2019.
3. Centers for Disease Control and Prevention. Prediabetes: could it be you? https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf. Accessed August 1, 2016.
4. Babey SH, Wolstein J, Diamant AL, Goldstein H. Prediabetes in California: nearly half of California adults on path to diabetes. *Policy Brief UCLA Cent Health Policy Res*. 2016;(PB2016-1):1-8.
5. Diabetes Prevention Research Group. The Diabetes Prevention Program (DPP). *Diabetes Care*. 2002;25(12):2165-2171.
6. Diabetes Prevention Program (DPP) Research Group; Hamman RF, Horton E, Barrett-Conner E, et al. Factors affecting the decline in incidence of diabetes in the Diabetes Prevention Program Outcomes Study (DPPOS). *Diabetes*. 2015;64(3):989-998.
7. Edwards N. Scaling-up health innovations and interventions in public health: a brief review of the current state-of-the-science. Paper presented at: Conference to Advance the State of the Science and Practice on Scale-up and Spread of Effective Health Programs; July 6-8, 2010; Washington, DC.
8. World Health Organization. *Beginning With the End in Mind: Planning Pilot Projects and Other Programmatic Research for Successful Scale up*. Switzerland, Geneva: World Health Organization; 2011.
9. Mosst JT, DeFosset A, Gase L, Baetscher L, Kuo T. A framework for implementing the National Diabetes Prevention Program in Los Angeles County. *Prev Chronic Dis*. 2017;14:E69.
10. Konckak JN, Moran MR, O'Brien MJ, Kandula NR, Ackerman RT. The state of diabetes prevention policy in the USA following the Affordable Care Act. *Curr Diab Rep*. 2016;16(6):55.
11. Khan T, Tsipas S, Wozniak G. Medical care expenditures for individuals with prediabetes: the potential cost savings in reducing the risk of developing diabetes. *Popul Health Manag*. 2017;20:389-396.
12. Kappagoda M, Wunsch B. *Expanding Health Insurance Coverage in California for the National Diabetes Prevention Program*. Oakland CA: Change Lab Solutions; 2016.
13. American Health Insurance Plans. Health plans preventing diabetes and improving well-being. www.ahip.org/prediabetes. Accessed August 1, 2019.
14. National Association of Chronic Disease Directors. Medicaid coverage for the National Diabetes Prevention Program. https://www.chronicdisease.org/page/Medicaid_NDPP. Accessed August 1, 2019.
15. National Association of Chronic Disease Directors. National Diabetes Prevention Program Coverage Toolkit. https://coveragetoolkit.org/. Accessed August 1, 2019.

Table, Supplemental Digital Content 1. Partners Considered for Piloting Billing and Reimbursement Options for the National Diabetes Prevention Program: Payers and Provider Types in Los Angeles County

Types of National Diabetes Prevention Program Payer				
Partner Type[a]	**Partner Characteristics**	**Partnership Advantages**	**Partnership Disadvantages**	**How partner was included in the pilot project**
Private Health Plan/Commercial Insurer *Health Maintenance Organization* (patient must select a Primary Care Provider who coordinates care). *Preferred Provider Organization* (patient can access doctors of choice without referral)	Membership available on the commercial market sold by broker/agent. Typically, available through employers or can be purchased by individuals.	Invested in prevention as a cost-control strategy (view investment as a long-term positive investment for company's bottom line). Having commercial insurers on board as advocates for National Diabetes Prevention Program (DPP) coverage lends credibility to idea that coverage is good investment and paves the way for public payers to participate. Typically have enough capital for investment in DPP coverage to be sustainable	Typically, do not cover priority population: private health plans are generally expensive when purchased individually or are provided by employers that do not work with safety-net populations.	Provided insight during early discussions on the priorities of the commercial insurance sector (i.e. importance of the financial bottom line for covering prevention programs). Not included as partner for pilot project because they had limited access to the priority population that was a target of this pilot project.
Medicare	Federal health insurance program for people who are over 65 and certain younger people with disabilities or end stage renal disease.	Covers almost all individuals over 65, a group with a high burden of diabetes. Lessons learned a from Medicare Diabetes Prevention Program pilot project would be broadly applicable to other states and jurisdictions because the program is national.	Does not cover majority of priority population under 65. Would require National DPP providers to sign up as Medicare vendors through a complicated and lengthy application process. Certain providers left out of reimbursement arrangement (i.e., digital providers).	Opted to focus the pilot project on Medicaid recipients, and not Medicare, as federal coverage through Medicare was expected during the project period.
Medicaid Managed Care Plan	Provides delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid	Typically cover large segments of the priority population. Experience contracting with different provider types (private, CBO).	Process for establishing a new reimbursement program can take quite a bit of time.	Selected as payer type to participate in the pilot project.

	agencies and MCOs that accept a set number of members per month for a fixed fee (capitation). Have arrangements with certain physicians, hospitals and health care providers to serve patients at a reduced rate.	Experience in establishing contracts and reimbursement processes such as benchmarks, reimbursement eligibility, data collection requirements.	Must receive approval from board for all actions and payments to be made. Contracting among the various providers can be difficult depending the level of capacity to engage in MCO's administrative processes.	The specific Medicaid Managed Care plan selected to partner on the pilot had developed a strategic agenda focused on growing prevention programs and improving offerings to members.

Types of National Diabetes Prevention Program Provider

Provider Type	Partner Characteristics	Partnership Advantages	Partnership Disadvantages	How Provider Type was included in Pilot Project
In-person: Community- Based Organization	National DPP delivered via in-person group meetings facilitated by a lifestyle coach. Low literacy options. Uses the CDC *Prevent T2 Curriculum*. Often conducted at partner sites (i.e. employer site, health clinic, community center) or on-site at CBO. Strong ties to communities, can engage potential participants at local events. Social engagement/support is key	Engagement between lifestyle coach and participants. Facilitates peer-to-peer learning and collaboration. Flexibility as to where the program is delivered. CBOs tend to be trusted by community members with whom they have existing relationships. Often CBOs are smaller organizations with greater flexibility to establish contracting with a variety of partners (relative to private organizations or health systems). Consistent accessibility to lifestyle coach and other program participants.	Lack of contracting experience in working directly with payers. Lack of infrastructure to track and submit data to potential partners. Potential need to address competing priority such as childcare, work schedules, and distance.	Selected as partners in the pilot project because of reach among, and background of working with, the priority population. DPH had established partnerships with several in-person providers as part of 1422 efforts. Specific CBO partner also had experience contracting with payers.
In-person: Health System	National DPP delivered via in-person group meetings facilitated by a lifestyle coach. Low literacy options. Uses the CDC *Prevent T2 Curriculum*. Social engagement/support is key	Built in referral infrastructure (EMR). Medical provider engagement in referral improves enrollment rates in the program. Physician and administrative engagement can facilitate program development and/or payer partnerships.	Lengthy administrative processes (legal review and contracting issues). Challenges with data sharing/virtual information exchange. Not all community members could participate, if program	Partner not selected due to potential administrative delays such as contracting and legal issues that would need to be addressed.

	Conducted on-site at administering health system offices/clinics. Trusted partner by community and other organizations.	Engagement between medical staff, lifestyle coach and participants. Facilitated peer to peer learning and collaboration. Consistent accessibility to lifestyle coach and other program participants. Capacity to work with a variety of payers.	is only offered to health system patients. Identifying space and soliciting administrative buy-in within individual clinics hosting classes anticipated to be a challenge.	
Online/Digital (group based)	National DPP is delivered 100% web-based/online. Virtual lifestyle coach. Web-based/telephonic chat options with coach. May try to connect participants to participatory program components (forums, events) based on region. Offered in English and Spanish. Low literacy options. Uses the CDC *Prevent T2 Curriculum*.	Program can be done anywhere (location/transportation not a restriction). Reduced scheduling barriers that keep participants from starting/finishing the program (competing priorities). Used targeted digital outreach to attract wide group to program.	Administrative issues (legal review and contracting issues). Issues with data sharing/virtual information exchange (online provider engaged in the pilot project considered to be a "health provider", invoking HIPAA issues) Limited access among those without computer or smart phone or with low literacy or limited technical capacity.	Initially selected as partners in the pilot project because MCO thoughts digital format would be of interest to their members (due to flexibility and ease of participating). Although an ideal partner for this project contracting with a digital provider proved to be a challenge. Most of the challenges were administrative that were difficult to overcome such as data sharing.

Abbreviations: National DPP, National Diabetes Prevention Program; CBO, Community-based organization; MCO, Managed Care Organization; CDC, Centers for Disease Control and Prevention; DPH, Los Angeles County Department of Public Health; EMR, Electronic Medical Record; HIPAA, Health Insurance Portability and Accountability Act;

[a]Medicaid Fee for Service - A joint federal program that provides health coverage to certain categories of low asset people, including children, pregnant women, parents of eligible children, people with disability and elderly needing nursing home care. Although this is a payer option nationally, this option was not selected as there are a limited number of Medicaid Fee for Service eligible individuals in CA as many participants are typically enrolled into Medicaid managed plans.