America's Health Insurance Plans

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June 3, 2014

Leroy Richardson
1600 Clifton Road
MS D–74
Atlanta, GA 30333

Dear Mr. Richardson,

Thank you for the opportunity to comment on the Centers for Disease Control and Prevention's (CDC) Proposed Data Collections Submitted for Public Comment and Recommendations for the CDC Diabetes Prevention Recognition Program (DPRP). America's Health Insurance Plans (AHIP) is the national association for the health insurance industry. Our members provide coverage to more than 200 million Americans, offering a broad range of health insurance products in the commercial market and demonstrating a strong commitment to participation in public programs.

Background

AHIP is in year two of our *Health Plans Preventing Diabetes and Improving Well-Being* initiative as part of a four year cooperative agreement with the CDC to implement, scale, and sustain the National Diabetes Prevention Program in communities around the country. Through this initiative, AHIP is currently working with three member health plans, EmblemHealth, Florida Blue, and Molina Healthcare, Inc., to implement the program in Florida, New Mexico, and New York. In addition, many of AHIP's member health plans are implementing the National Diabetes Prevention Program in their communities. AHIP solicited feedback from member health plans on CDC's proposed updates to the DPRP data collection standards and we respectfully submit these comments to you on their behalf.

General Comments

Overall, AHIP and our member health plans support the changes the CDC is proposing to the Diabetes Prevention Recognition Program. Many of our member health plans have robust prediabetes programs in place across the country. While seeking CDC recognition does add burden initially in terms of infrastructure and program deployment (data collection), the changes being proposed will allow more flexibility for how programs can seek CDC recognition. Further, expanding the accepted modalities of how the program is offered (in person, online, telephonic, etc.) will better meet the needs of individuals who want to address their diabetes risk. Given the growing challenge of pre-diabetes, expanding recognition is important and our members support this program advancement.

Proposed Changes

Under the five proposed changes listed in the Federal Register notice, our member health plans agree that the additional collection of contact information and the option to add the participant's state of residence are reasonable additions to the data collection. Some of our members have requested clarification around the requirement for #3, "Change the Core Course Code to Class Code", and #4, "Simplify the codes for Participation Prediabetes Determination by reducing the number of required responses from five to three." These member health plans are not certain how these changes will impact the data.

Under #5, "Discontinue the collection of the Location Code, Lifestyle Coach ID, Session Type and Session ID," some members believe that the Location Code, Lifestyle Coach ID, Session Type and Session ID should not be removed, as this data helps in evaluating the coaches and in evaluating how classes are progressing in different locations.

Finally, we are asking for clarification on the effective date of these change; assuming these changes will go into effect in 2015, how will these changes impact data collection on classes that begin in 2014 and are ongoing when the changes are implemented?

Additional Suggestion

Some of our members have requested that the CDC remove the 50/50 ratio requirement on participant's enrollment between a blood test and the prediabetes risk quiz, based on the rationale that if a participant is at risk, either one of these requirements should suffice. The goal is to reach as many at risk participants as possible, including especially hard-to-reach populations such as low-income and/or racial and ethnically diverse populations. Requiring a blood test may limit how many participants will enroll into the lifestyle change program, and may add to the overall cost of delivering the program without enhancing quality.

Thank you for the opportunity to comment on this document. Our members would welcome the opportunity for further dialogue on this important issue.

Sincerely,

Barbara Lardy

Barbara Lardy, MPH
Senior Vice President, Clinical Affairs and Strategic Partnerships

CDC Response

Barbara Lardy
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Dear Ms. Lardy:

Thank you for taking the time to review and comment on the CDC Diabetes Prevention Recognition Program (DPRP) Standards. The Division of Diabetes Translation appreciates your commitment to improving the DPRP Standards. All of your comments were carefully considered. Included with this letter you will find specific responses to the suggestions and remarks outlined in your letter dated June 3, 2014.

With the growing number of new cases of type 2 diabetes, it is vital that we continue to implement proven interventions for preventing or postponing this serious disease. The DPRP is an important part of assuring that we meet the goal of reducing new cases of type 2 diabetes. Again, thank you for your interest in the DPRP.

Sincerely,

Division of Diabetes Translation
Centers for Disease Control and Prevention

Note: (C) indicates a comment, suggestion or request for clarification from your organization; (R) indicates a response from CDC (responses are also in blue font)

(C) General Comments
Overall, AHIP and our member health plans support the changes the CDC is proposing to the Diabetes Prevention Recognition Program. Many of our member health plans have robust prediabetes programs in place across the country. While seeking CDC recognition does add burden initially in terms of infrastructure and program deployment (data collection), the changes being proposed will allow more flexibility for how programs can seek CDC recognition. Further, expanding the accepted modalities of how the program is offered (in person, online, telephonic, etc.) will better meet the needs of individuals who want to address their diabetes risk. Given the growing challenge of pre-diabetes, expanding recognition is important and our members support this program advancement.

> (R) We appreciate the support your organization has shown to the DPRP. We are glad that you approve of the additional modes of delivery.

(C) Proposed Changes
Under the five proposed changes listed in the Federal Register notice, our member health plans agree that the additional collection of contact information and the option to add the participant's state of residence are reasonable additions to the data collection. Some of our members have requested clarification around the requirement for #3, "Change the Core Course Code to Class Code", and #4, "Simplify the codes for Participation Prediabetes Determination by reducing the number of required responses from five to three." These member health plans are not certain how these changes will impact the data.

> (R) After additional internal discussion, we decided not to change the Core Group Code to Class Code. The Core Group Code [Class Code] would not be meaningful to all organizations (e.g., organizations having a "class" of one individual). Thus, the Core Group Code will be discontinued. Organizations may continue to collect this data for internal use. However this data will no longer be accepted by the DPRP except as stipulated in a transition plan that will be provided to organizations awarded pending or full recognition prior to 12/1/14 (pending OMB approval). Technical assistance will also be available. The change in the participant prediabetes coding simply combines some of the fields. Under the previous standards, there were five separate fields to code for participant eligibility (fasting plasma glucose, oral glucose tolerance test or glycosylated hemoglobin (A1c), a previous diagnosis of gestational diabetes or a risk test). Under the proposed standards, there are only three fields for participant eligibility (blood test, a previous diagnosis of gestational diabetes or a risk test). Minor changes will need to be made to the datasets at recognized organizations and at the CDC. Otherwise, there will be no impact on the data.

(C) Under #5, "Discontinue the collection of the Location Code, Lifestyle Coach ID, Session Type and Session ID," some members believe that the Location Code, Lifestyle Coach ID, Session Type and Session ID should not be removed, as this data helps in evaluating the coaches and in evaluating how classes are progressing in different locations.

(R) The DPRP hoped to use this data for evaluation and technical assistance. However, this data has not been very useful in this regard. The 2014 DPRP standards are a bit more flexible and include new modes of delivery. With these revisions, the codes will no longer be meaningful for all organizations. Organizations may continue to collect all or part of this data for internal use. However, this data will no longer be accepted by the DPRP except as stipulated in a transition plan that will be provided to organizations awarded pending or full recognition prior to 12/1/14 (pending OMB approval).

Finally, we are asking for clarification on the effective date of these changes; assuming these changes will go into effect in 2015, how will these changes impact data collection on classes that begin in 2014 and are ongoing when the changes are implemented?

(R) The changes will be effective upon approval by the Office of Management and Budget. We anticipate approval in late November 2014. A transition plan will be provided to organizations awarded pending or full recognition prior to 12/1/14 (pending OMB approval). Technical assistance will also be available.

(C) Additional Suggestion
Some of our members have requested that the CDC remove the 50/50 ratio requirement on participant's enrollment between a blood test and the prediabetes risk quiz, based on the rationale that if a participant is at risk, either one of these requirements should suffice. The goal is to reach as many at risk participants as possible, including especially hard-to-reach populations such as low-income and/or racial and ethnically diverse populations. Requiring a blood test may limit how many participants will enroll into the lifestyle change program, and may add to the overall cost of delivering the program without enhancing quality.

(R) We agree that the program should reach as many people as possible. However, the DPRP must be faithful to the science. The DPRP's 50/50 ratio requirement is a compromise between blood tests and risk tests. With this ratio, we remain faithful to the science while increasing access to the program for populations at high risk. In addition, programs have always had the ability to accept participants who self-report that an acceptable blood test preformed in the last year indicated prediabetes. The text has been modified as follows "A minimum of 50% of a program's participants must have had a recent (within the past year) blood test (blood test may be self-reported) or claim code…." We certainly do appreciate your concerns with the blood tests and hard to reach groups. With this in mind, the DPRP expanded the list of acceptable blood tests. Tests such as fingersticks and point of service A1c tests may now be used. We hope the addition of these tests eases some of your concerns.