

Stakeholder Analysis: Medicare Diabetes Prevention Program Awareness and Implementation

Melanie T. Turk, PhD, RN; Natalie D. Ritchie, PhD; and Karen Jakub, PhD, RN

Population-level strategies to prevent type 2 diabetes are urgently needed for the more than 24 million older adults with prediabetes in the United States.¹ Evidence-based lifestyle interventions can prevent diabetes onset, per evidence from the landmark Diabetes Prevention Program trial.² Thus, the CDC launched the National Diabetes Prevention Program (NDPP) in 2010.³ Significant reductions in weight and medical spending were observed among Medicare beneficiaries who participated in the NDPP,⁴ prompting CMS to fully cover the Medicare Diabetes Prevention Program (MDPP) starting in 2018.⁵

Despite unprecedented Medicare coverage for a disease prevention program, MDPP uptake is limited. Only 1 MDPP site existed per 100,000 Medicare beneficiaries in 2019,⁶ increasing to 1.5 sites per 100,000 beneficiaries in 2021.⁷ Distance is another challenge; 43% of Medicare beneficiaries live more than 25 miles from an MDPP site,⁸ an insurmountable barrier for many older adults. Regarding awareness, national guidelines recommend referral to lifestyle intervention for adults aged 40 to 70 years with prediabetes.⁹ Yet less than 5% of adults eligible for a NDPP reported receiving a referral,¹⁰ which may stem from limited awareness among health care providers.¹¹ Thus, we conducted a qualitative stakeholder analysis to learn about regional awareness of, referral to, facilitators of, and barriers to the MDPP.

METHODS

We recruited program suppliers and health care providers in western Pennsylvania through local outreach among CDC-registered programs and referrals from participants. Program suppliers included organizations that are MDPP suppliers and organizations that are NDPP suppliers but not Medicare certified. The initial contact was with the chronic disease prevention program director of a YMCA. Subsequent stakeholder interviews stemmed from colleague introductions and word of mouth. The 8 interviewees included 5 program directors (3 from YMCAs, 1 from a private organization, and 1 from a hospital system) and 3 health care providers (2 family physicians and 1 dietitian). Interviews were conducted via Zoom

ABSTRACT

OBJECTIVES: The Medicare Diabetes Prevention Program (MDPP) provides unprecedented coverage of a behavior change program for older adult Medicare beneficiaries, but uptake has been extremely limited; only 1.5 sites deliver the program per 100,000 beneficiaries nationwide. Inadequate reach and utilization of the MDPP threaten its long-term success; thus, the purpose of this project was to determine facilitators and barriers to MDPP implementation and use in western Pennsylvania.

STUDY DESIGN: We conducted a qualitative stakeholder analysis project with suppliers of the MDPP and health care providers.

METHODS: Using an implementation science framework, we conducted individual interviews with 5 program suppliers and 3 health care providers (N=8) to determine their perspectives on positive aspects of the program and reasons for MDPP unavailability and lack of use. Data were analyzed using Thorne and colleagues' approach of interpretive description.

RESULTS: Three main themes emerged: (1) facilitators and attributes of the MDPP, (2) barriers to MDPP implementation, and (3) suggestions for improvement. Facilitators of the program included technical support and webinars from Medicare to assist with the application process. Barriers such as financial reimbursement constraints and a lack of a systematic referral process were noted. Stakeholders suggested refinements to participant eligibility and performance-based payments, a seamless method of flagging and referring patients through the electronic health record, and ongoing virtual program delivery options.

CONCLUSIONS: Findings from this project can be used to improve implementation of the MDPP in western Pennsylvania, support Medicare policy refinement, and inform implementation research to promote broader adoption of the MDPP across the United States.

Am J Manag Care. 2023;29(6):308-312. doi:10.37765/ajmc.2023.89372

from March to September 2021. Our project was designated as quality improvement in consultation with the Duquesne University Institutional Review Board. Participants provided verbal consent for interviews, knowing that aggregate, deidentified information would be used for program improvement.

We used the Consolidated Framework for Implementation Research (CFIR)¹² to inform our interview guide. CFIR has 5 domains: intervention characteristics (eg, cost), outer setting (eg, patient needs), inner setting (eg, resources), individual characteristics (eg, self-efficacy), and implementation processes (eg, executing). CFIR suggests that interacting individual-, organizational-, and societal-level constructs may influence the MDPP's reach and use.¹² Semistructured interview guides were developed for each stakeholder group. For example, to assess program design quality, program suppliers were asked, "What supports, such as online resources or marketing materials, are available to help you implement and use the program?" Program suppliers were asked, "Is cost a consideration for implementation?" to determine the financial aspects of MDPP implementation. Interviews of health care providers focused on knowledge of the MDPP and referrals. For example, providers were asked, "Do the health care providers within the organization refer older adults with prediabetes to the MDPP? What is the process for that to happen?" and "Do you believe there are things that should be changed to increase referrals to the MDPP?"

Individual interviews lasted 35 to 60 minutes, were recorded with permission, and were transcribed verbatim. Data were analyzed using interpretive description¹³ to understand patterns and individual variations in complex clinical phenomena, with CFIR as the organizing framework. Data analysis was concurrent with data collection. Two authors (M.T.T. and K.J.) coded the interviews using broad-based coding to organize data inductively (derived from the data) and deductively (derived from CFIR constructs). By comparing data elements within these coding structures, patterns and themes emerged. Notes kept during analysis aided in interpretation and facilitated consensus between analyzers.

RESULTS

Three main themes emerged: (1) facilitators and attributes of the MDPP, (2) barriers to MDPP implementation, and (3) suggestions for improvement (Table 1).

Facilitators and Attributes of MDPP

All program directors reported positive aspects of the program based on personal experiences and participant and facilitator feedback. They perceived that the curriculum allowed for topic reinforcement throughout the program. In-person sessions facilitated positive relationships between coaches and participants. MDPP participants enjoyed the support, connection to others, and motivation from

TAKEAWAY POINTS

More than 5 years after CMS enacted coverage of the CDC-approved Medicare Diabetes Prevention Program (MDPP) in 2018, little is known about why MDPP uptake is so limited.

- ▶ Findings of our stakeholder analysis with program suppliers and health care providers reinforced existing evidence on insufficient reimbursement and low awareness of the program.
- ▶ Newer insights include recommendations about lagged payments, ongoing virtual delivery, and formally diagnosing prediabetes among MDPP participants.
- ▶ Our findings on barriers and facilitators can inform policy to refine the MDPP and research on the MDPP, particularly within the field of implementation science.

group members. Program directors reported that many older adults were not comfortable enough with computers to engage in an online program and preferred face-to-face sessions. However, transitioning to virtual delivery during the COVID-19 pandemic was reported as successful. Suppliers further noted that MDPP participants appreciated connecting to others virtually during a time of greater social isolation.

MDPP suppliers and health care providers perceived increasing referrals in recent years (except during the COVID-19 pandemic). This uptick was partly attributed to new protocols to flag eligible patients within electronic health records (EHRs). One provider incorporated an automated approach of flagging and referring patients to a prediabetes program. Other providers stated they were informing patients of their prediabetes more frequently.

MDPP suppliers dedicated financial and personnel resources to marketing their program. They conducted information sessions at senior centers, health fairs, and community centers to recruit participants. In some instances, an incentive was offered. One supplier offered a 1-year free YMCA membership after participants were enrolled. Former MDPP participants also promoted recruitment through positive feedback to friends and family.

Barriers to MDPP Implementation

Program suppliers cited many bureaucratic difficulties. Some suppliers perceived the Medicare-designation process as complicated, including a lengthy process to become an MDPP provider (even if already a general Medicare provider), certify each program coach and have them obtain a National Provider Identifier number, and provide Social Security numbers for all board members.¹⁴ However, CMS did provide technical support and helpful webinars to assist with the application process if the suppliers actively sought assistance. Suppliers reported needing substantial resources to provide the program (eg, an employee to manage enrollment, physical space, personnel, and financial support). Different standards for participant eligibility were also challenging. For example, the NDPP does not require a blood test documenting prediabetes, whereas the MDPP does.

Barriers also included issues with payments. Program suppliers reported that CMS payments were not always timely or sufficient to cover costs, making it challenging to recoup initially uncompensated up-front costs and to manage their budgets. All MDPP

TRENDS FROM THE FIELD

TABLE 1. Themes Associated With Implementation of the Medicare Diabetes Implementation Program

Themes	Main ideas	Supporting quotes
Facilitators and attributes of MDPP	Well-organized, relatable curriculum	"...If people didn't feel that the curriculum was achievable and relatable, I don't think they would be coming back."
	In-person format provided personal relationships; online format worked well during COVID-19 restrictions	<ul style="list-style-type: none"> "We had older adults [who] wanted to repeat DPP. They wanted to keep doing it because they liked the interaction...being part of a group." "We had to switch everything to virtual, but it's been amazing for our participants...."
	Successful recruitment strategies	<ul style="list-style-type: none"> "So, we've done churches and schools...senior centers...any place that was willing to give us a room." "I just spent \$4000 on print ads. We have a digital ad campaign. I have collaborated with the Area Office on Aging."
	Use of electronic systems for referral to the program	<ul style="list-style-type: none"> "We have an [EHR]: Epic. So, we have all kinds of decision trees made.... Anybody who triggers positive for DPP eligibility, our referral is sent to the primary care physician." "We have a registry of patients with prediabetes that spits out a report of everyone with prediabetes who's coming into the office over the next week; and then our nurse navigators run the calculator on that patient."
Barriers to MDPP implementation	Challenging CMS application process	<ul style="list-style-type: none"> "The biggest challenge for us was getting our board members' Social Security numbers... as well as their birthdates, their addresses...." "Why are they making it so cumbersome? It's irritating to me, you know."
	Up-front funding and reimbursement criteria from CMS	<ul style="list-style-type: none"> "...The majority of the costs are up front; session[s] 1, 4, and 9 trigger the biggest payments." "I've been at this for 5 years. It is not worth it. It is not going to make one bit of difference on your [profit and loss] for your organization."
	Inadequate number of MDPPs for face-to-face delivery; travel	<ul style="list-style-type: none"> "I have a strong opinion on the biggest barrier. [It's] the CMS rules—'We [CMS] will pay you after the fact, if you prove to us that you make the patient lose weight.' People are saying, 'We're not investing the money in this.... There's no guarantee that the patients are going to perform.'" "Some barriers that we've seen are that [participants] don't like to drive at night. So having an evening class can be tough sometimes, but we try and offer daytime...even morning classes in the past."
	No systematic referral process across health care providers	<ul style="list-style-type: none"> "We just do a referral system with the physicians' offices currently. I have had a few people call in to me that they've seen that we are a Medicare supplier in their booklet." "...[I'm] going out to some of these primary care [practices], [and] some of them are still on paper medical records, and it's really hard."
Suggestions for improvement	Refine eligibility and payment criteria from CMS	<ul style="list-style-type: none"> "I think they need to decrease all those crazy regulations. It's not like we are giving out opioids here. We are providing health, disease prevention, information. Why make it so difficult?" "It's hard for me to say this in the middle of a pandemic knowing where all our federal resources are going, but you know, the coverage for the program would have to drastically change."
	Allow for MDPP delivery using both face-to-face and virtual options	<ul style="list-style-type: none"> "...A lot of seniors don't want to drive at night, you know. So, meeting them where they are. I know that sounds redundant, but we have to meet the seniors where they are and make it entertaining...." "We need to make access so simple that we're pushing it out where they are: churches, senior centers, their cell phones—if they are more savvy, their tablets—or whatever. It's probably going to take government funding to make it smoother."
	Develop systematic referral system across all providers and hospital systems	"...Listen, we did this at our little pocket of [agency name] in the eastern suburbs. This is something that needs to be implemented in the [health care system computer system]. This is an effort that we need to do all over western Pennsylvania...."
	Educate patients and providers about MDPP	<ul style="list-style-type: none"> "My plan before COVID-19 was to pair with the Area Agency on Aging, and to really have them help us get the word out. [That] is in the works." "We would go out to physicians' offices, specialty offices, and provide lunch for them, and then tell them what we have: We offer 7 disease prevention or management programs."

DPP, Diabetes Prevention Program; EHR, electronic health record, MDPP, Medicare DPP.

suppliers that we interviewed also provided the NDPP, which was reimbursed by private insurance companies; that reimbursement was seen as essential for balancing overall budgets because of inadequate Medicare payment. CMS maintains strict performance-based payments that prioritize at least 5% weight loss. However, participants often achieve less weight loss,¹⁵ leaving suppliers to absorb an increasing share of program costs. Additionally, CMS will cover the MDPP only once in a beneficiary's lifetime (as a supplier stated, "one and done"), and no payments are received if suppliers serve a beneficiary who needs to reenroll.

MDPP suppliers described difficulties faced by older-adult participants. Participants were expected to attend in-person sessions (per CMS requirements, except during the COVID-19 pandemic). Because of the limited number of MDPPs, this requirement likely necessitated driving a fair distance. Many older adults were unable to drive at night, requiring daytime sessions, even if inconvenient for others. Furthermore, MDPP suppliers reported that participants were often unaware that prediabetes is a diagnosed condition or that a prevention program is available at no cost.

Health care providers reported a lack of MDPP awareness among their colleagues. Even if providers were aware of the MDPP, the limited number of local programs impeded patient referrals. They also stated that some providers may be biased against lifestyle interventions, leading to fewer referrals. Additionally, there was often no systematic process for generating referrals based on diagnosed prediabetes. One provider indicated that recording a prediabetes diagnosis may even be avoided because patients are uncomfortable being labeled as such; thus, patient referral may be difficult if alternate diagnosis codes are used (eg, impaired fasting glucose).

Suggestions for Improvement

Stakeholders recommended multiple systematic changes for the program. They believed that health care providers needed to commit to recommending diabetes prevention programs. Strategies for consistently diagnosing prediabetes, such as using a risk calculator within the EHR to predict low, medium, or high risk of developing diabetes within 3 years and referring eligible patients to specific program suppliers, were considered essential. Stakeholders commented that a systematic referral process utilizing EHRs to seamlessly connect providers directly to suppliers would be beneficial.

MDPP suppliers suggested that CMS improve eligibility and payment criteria. Removing the once-in-a-lifetime limit would help those who drop out because of unforeseen circumstances but later wish to reenroll. Additionally, program suppliers recommended more flexible payment criteria. For example, if a participant achieved 4% weight loss instead of 5%, a payment schedule could be prorated accordingly (vs the current all-or-nothing payments for weight loss). Increasing payments to better align with private payers and providing payments to support up-front costs were suggested.

MDPP stakeholders believed that Medicare beneficiaries needed to be informed about prediabetes and the no-cost MDPP. Specific activities endorsed by stakeholders included community outreach to

TABLE 2. Stakeholder Recommendations to Improve MDPP Policy

Program reimbursement

- Provide payment up front for the start-up of an MDPP.
- Provide payments in a timely manner.
- Increase payment amounts to better align with private insurance providers.
- Adjust performance-based payments based on weight loss (eg, provide a prorated payment for 4% weight loss).

Program requirements

- Align CMS' MDPP participant eligibility with the CDC's NDPP eligibility requirements (eg, eliminate blood test documenting prediabetes).
- Allow beneficiaries to participate more than once if they need to reenroll in the future.
- Streamline the process to become an MDPP supplier (eg, remove requirements to obtain the Social Security number of each member from the board of directors of the organization).
- Allow virtual program delivery beyond the time frame of the current public health emergency.

MDPP, Medicare Diabetes Prevention Program; NDPP, National Diabetes Prevention Program.

present at senior centers or local health fairs and meeting with local primary care and specialist physician offices to promote their awareness of and referral to the MDPP. The COVID-19 pandemic required suppliers to deliver the MDPP virtually. Suppliers noted that virtual delivery was successful overall and especially helped participants who needed to maintain social distancing or experienced other barriers to in-person attendance. Because there are few or no suppliers who provide the MDPP near where many Medicare beneficiaries live,^{6,7} continuing to allow virtual MDPP delivery appears both necessary and appropriate to increase program access and uptake.

DISCUSSION

This project aimed to learn about awareness of, referrals to, facilitators of, and barriers to the MDPP from program suppliers and health care providers in western Pennsylvania. Results are largely consistent with previous findings, including major challenges of insufficient reimbursement, low awareness of and referrals to the program, and the need to accommodate priority populations.¹⁶⁻¹⁸ Newer insights include implementation facilitators/barriers regarding lagged payments, recommendations about formally diagnosing prediabetes among MDPP participants, and noted benefits specific to virtual delivery. Our findings support continued virtual delivery of the MDPP, which facilitated access and social support for older participants. Despite evidence supporting the effectiveness of virtual delivery,¹⁹ including among Medicare beneficiaries,²⁰ CMS recently refrained from allowing virtual MDPP delivery after the end of the COVID-19 public health emergency.²¹ In turn, our findings may aid future rulemaking, and policy recommendations from this stakeholder analysis are summarized in [Table 2](#).

The need for a systematic process to refer patients to the MDPP was highlighted. EHR systems that identify patients with prediabetes,

TRENDS FROM THE FIELD

flag them for the health care provider, and directly connect patients to an MDPP supplier could improve referral and use. Using EHRs to create a diabetes-risk registry²² of patients who meet MDPP eligibility criteria, along with decision trees to aid referrals, is recommended. All health care providers must demonstrate meaningful use of EHRs to receive Medicare reimbursement, and these EHR functions support meaningful use through care coordination.¹⁴ Automated messages can also encourage providers to document a prediabetes diagnosis, which is associated with improved outcomes in the general population.²³

CMS solicits public comments and uses reputable evidence for program refinement, so our data from stakeholders could be used accordingly. For example, the gap between MDPP costs and reimbursement became increasingly well documented following the initial launch of the MDPP.^{17,18} A subsequent recent policy change lowered costs and increased payments by eliminating requirements for a second year of MDPP sessions and shifting those payments to the first year of program delivery.²¹ Based on findings here, further recommendations include continuing to increase payments to fully cover costs and reducing payment wait times. In turn, the overall impact of any changes in CMS rulemaking may be assessed by examining whether (and if so, to what extent) there is a corresponding increase in the number of participating suppliers and beneficiaries.

Project limitations include focusing on perspectives from regional program suppliers and health care providers. Nonetheless, the issues and suggestions that were raised have potential to be broadly applicable and may still contribute to the body of literature that aids future CMS rulemaking. Future directions also include assessing the perspectives of older adults. Lastly, our findings on barriers and facilitators can help inform research on the MDPP within the field of implementation science, which focuses on adoption of evidence-based interventions into real-world practice.

CONCLUSIONS

Medicare beneficiary enrollment will peak over the next 10 years,²⁴ making MDPP reach and use even more important. The MDPP's success in preventing diabetes among eligible beneficiaries is dependent on robust enrollment in this evidence-based program. Our stakeholder analysis can help increase implementation of the MDPP in western Pennsylvania and inform policy refinement so that at-risk older adults may take advantage of this no-cost program to prevent type 2 diabetes. ■

Author Affiliations: Duquesne University School of Nursing (MTT, KJ), Pittsburgh, PA; Denver Health and Hospital Authority (NDR), Denver, CO.

Source of Funding: This project was not funded. Dr Ritchie acknowledges support from the National Institute of Diabetes and Digestive and Kidney Diseases (R01DK119478) and Denver Health.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (MTT, NDR, KJ); acquisition of data (MTT); analysis and interpretation of data (MTT, KJ); drafting of the manuscript (MTT, NDR, KJ); critical revision of the manuscript for important intellectual content (MTT, NDR, KJ); administrative, technical, or logistic support (MTT, NDR); and supervision (MTT).

Address Correspondence to: Melanie T. Turk, PhD, RN, Duquesne University School of Nursing, 518 Fisher Hall, 600 Forbes Ave, Pittsburgh, PA 15282. Email: turkm@duq.edu.

REFERENCES

1. National Diabetes Statistics Report: estimates of diabetes and its burden in the United States. CDC. 2020. Accessed May 19, 2022. <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>
2. Knowler WC, Barrett-Connor E, Fowler SE, et al; Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med*. 2002;346(6):393-403. doi:10.1056/NEJMoa012512
3. Albright A. The National Diabetes Prevention Program: from research to reality. *Diabetes Care Educ News*. 2012;33(4):4-7.
4. Hinant L, Razi S, Lewis R, et al. Evaluation of the Health Care Innovation Awards: community resource planning, prevention, and monitoring, annual report 2015. awardee-level findings: YMCA of the USA. CMS. March 2016. Accessed May 20, 2022. <https://innovation.cms.gov/files/reports/hcia-ymcaddp-evalrpt.pdf>
5. CMS, HHS. Medicare program; revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2018; Medicare Shared Savings Program requirements; and Medicare Diabetes Prevention Program. final rule. *Fed Regist*. 2017;82(219):52976-53371.
6. Ritchie ND, Sauder KA, Gritz RM. Medicare Diabetes Prevention Program: where are the suppliers? *Am J Manag Care*. 2020;26(6):e198-e201. doi:10.37765/ajmc.2020.43496
7. Yan A, Chen Z, Wang M, Mendez CE, Eggede LE. Accessibility of Medicare Diabetes Prevention Programs and variation by state, race, and ethnicity. *JAMA Netw Open*. 2021;4(10):e2128797. doi:10.1001/jamanetworkopen.2021.28797
8. Hoerger TJ, Jacobs S, Romaine M, et al. Evaluation of the Medicare Diabetes Prevention Program: first annual report. CMS. March 2021. Accessed May 19, 2022. <https://innovation.cms.gov/data-and-reports/2021/mdpp-firstannualrpt>
9. Siu AL; US Preventive Services Task Force. Screening for abnormal blood glucose and type 2 diabetes mellitus: US Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2015;163(11):861-868. doi:10.7326/M15-2345
10. Venkataramani M, Pollack CE, Yeh HC, Maruthur NM. Prevalence and correlates of diabetes prevention program referral and participation. *Am J Prev Med*. 2019;56(3):452-457. doi:10.1016/j.amepre.2018.10.005
11. Nhim K, Khan T, Gruss SM, et al. Primary care providers' prediabetes screening, testing, and referral behaviors. *Am J Prev Med*. 2018;55(2):e39-e47. doi:10.1016/j.amepre.2018.04.017
12. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009;4:50. doi:10.1186/1748-5908-4-50
13. Thorne S, Kirkham SR, MacDonald-Emes J. Interpretive description: a noncategorical qualitative alternative for developing nursing knowledge. *Res Nurs Health*. 1997;20(2):169-177. doi:10.1002/(sici)1098-240x(199704)20:2<169::aid-nur9>3.0.co;2-i
14. CMS, HHS. Medicare and Medicaid programs; Electronic Health Record Incentive Program—stage 3 and modifications to meaningful use in 2015 through 2017. *Fed Regist*. 2015;80(200):62761-62955.
15. Ely EK, Gruss SM, Luman ET, et al. A national effort to prevent type 2 diabetes: participant-level evaluation of CDC's National Diabetes Prevention Program. *Diabetes Care*. 2017;40(10):1331-1341. doi:10.2337/dc16-2099
16. Grub I, Firemark A, Papajorgji-Taylor D, Fitzpatrick SL. Challenges with implementing the Diabetes Prevention Program for Medicare beneficiaries in an integrated health system. *Am J Manag Care*. 2021;27(11):e400-e403. doi:10.37765/ajmc.2021.88784
17. Parsons AS, Raman V, Starr B, Zezza M, Rehm CD. Medicare underpayment for diabetes prevention program: implications for DPP suppliers. *Am J Manag Care*. 2018;24(10):475-478.
18. Ritchie ND, Gritz RM. New Medicare diabetes prevention coverage may limit beneficiary access and widen health disparities. *Med Care*. 2018;56(11):908-911. doi:10.1097/MLR.0000000000000981
19. Kirtley K, Sachdev N. Digital health-supported lifestyle change programs to prevent type 2 diabetes. *Diabetes Spectr*. 2018;31(4):303-309. doi:10.2337/ds18-0019
20. Castro Sweet CM, Chiguluri V, Gumpina R, et al. Outcomes of a digital health program with human coaching for diabetes risk reduction in a Medicare population. *J Aging Health*. 2018;30(5):692-710. doi:10.1177/0898264316688791
21. CMS, HHS. Medicare program; CY 2022 payment policies under the Physician Fee Schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; provider enrollment regulation updates; and provider and supplier prepayment and post-payment medical review requirements. *Fed Regist*. 2021;86(221):64996-66031.
22. Ritchie ND, Swigert TJ. Establishing an effective primary care provider referral network for the National Diabetes Prevention Program. *AADE Pract*. 2016;4(4):20-25. doi:10.1177/2325160316647707
23. Johnson JM Jr, Fishbein HA, Birch RJ, et al. HbA1c evidence for a prediabetes diagnosis delays onset of type 2 diabetes. *J Endocrinol Sci*. 2021;3(1):1-15. doi:10.29245/2767-5157/2021/1.1114
24. 2021 annual report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. CMS. August 31, 2021. Accessed January 24, 2022. <https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf>

Visit ajmc.com/link/89372 to download PDF