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VIA ELECTRONIC SUBMISSION TO: chronic_care@finance.senate.gov

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Senator
Committee on Finance
United States Senate

The Honorable Mark Warner
Senator
Committee on Finance
United States Senate

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the American Association of Diabetes Educators (AADE), we appreciate the opportunity to comment on the December 2015 Senate Committee on Finance (SFC) Bipartisan Chronic Care Working Group Policy Options Document ("Document").

We recognize the significant time and efforts that have gone into producing this Document and we applaud the Working Group's dedication toward finding cost effective and practical policy solutions to improving care for those Americans with diabetes and other chronic diseases.

Founded in 1973, AADE is a unique multi-disciplinary professional membership organization dedicated to improving diabetes care through self-management education. With more than 14,000 professional members including nurses, dietitians, pharmacists, and other healthcare professionals, AADE has a vast network of practitioners involved in the daily treatment of individuals with diabetes. We are one of only two Nationally Accredited Organizations (NAO) accredited by the Centers of Medicare & Medicaid Services (CMS) to provide accreditation to Diabetes Self-Management Training and Education Programs (DSMT), also known outside of the Medicare program as 'DSME'.

In 2012, AADE entered into a four year cooperative agreement with the Centers of Disease Control and Prevention (CDC). Through this cooperative agreement, AADE was charged with utilizing our vast networks of diabetes educators and nationally accredited DSMT sites to implement the CDC led National Diabetes Prevention Program (DPP) and work towards sustainability of these programs. As of 2015, AADE Diabetes Prevention Program (AADE DPP) is the second largest in person delivery network for the National DPP. The AADE DPP implementation model for the National DPP within an accredited DSMT program with oversight from a Diabetes Educator has proven to be widely successful and similarly cost effective as other DPP delivery settings.

It is quite common for diabetes educators to treat patients with complex health needs involving multiple chronic conditions. Diabetes requires the ongoing and active involvement of the person with diabetes in order to successfully manage the disease. For this reason, we believe we bring a unique perspective to the issues surrounding chronic care treatment and care coordination.

We recognize the significant time and efforts that have gone into producing this Document and we applaud the Working Group's dedication toward finding cost effective and practical policy solutions to improving care those Americans with diabetes and other chronic diseases. While we generally support many of the policies outlined in the Document, our comments will focus on the key areas of most importance to our members and the patients with diabetes we treat, outlined below.

Expanding Access to Prediabetes Education

The Document makes a passing reference to the DSMT program under Medicare with no specific policy recommendations to address existing DSMT gaps. In the same section, the Document appears to envision expanding diabetes prevention to endorse the National Diabetes Prevention Program (HHS would establish criteria 'in accordance' with standards in the DPP), and requests feedback as to whether the program should be delivered by entities that are currently not providers under Medicare. This section also requests feedback on supporting services that are 'analogous' to DSMT.

AADE respectfully notes the following concerns in response to this provision:

1) The Document should clarify that the DPP program and the DSMT program are separate and distinct, with different timelines for completion, different goals, and different program requirements.

2) Since a diagnosis of diabetes also serves as a precursor to other chronic conditions (e.g. hypertension, heart disease), AADE members are accustomed to addressing a myriad of health conditions that require behavior modification techniques similar to that inherent in DSMT. However, in order to be successful and ensure an optimal patient outcome, such an expanded program intended to address these types of other health challenges should have a separate and distinct benefit term in addition to the prescribed term for DSMT. It should also be noted that the Medicare program provides a total of only 10 hours of DSMT services in the first 12 months of referral. Many times, individuals with diabetes are not ready to truly begin their education due to anxiety and other barriers. If a person with diabetes does not complete their 10 hours in the first 12 months they will essentially 'lose' the opportunity for most DSMT education and may only receive 2 additional hours in the following year if it is determined to be medically necessary by the treating physician. As contrasted with the DSMT benefit, the DPP provides a person with prediabetes 22-24 weeks of training in the first 12 months. The scope of the DSMT benefit of 10 hours needs to be reassessed.

3) The Medicare statute does not define a qualified "Diabetes Educator" for purposes of either in-house or telehealth DSMT. While the SFC already vetted and approved bipartisan legislation in 2009-2010, endorsed by the SFC Chair and Ranking Member (and CBO 'asterisk' scored at virtually no cost), which would correct this long overdue update to the 1997 Medicare statute, we are puzzled as to why this imminently practical and virtually deficit-neutral provision was not included in the Document.

CMS has noted in public rulemaking that DSMT remains a woefully underutilized service. As well, the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA) issued new recommendations to promote DSMT in 2014. *The recommendations noted that 90% of diabetes care is delivered by primary care providers, often without the involvement of a qualified diabetes educator.*

And, the CDC analyzed data from the Marketscan Commercial Claims and Encounters database to estimate the claim-based proportion of privately insured adults (aged 18-64 years) with newly diagnosed diabetes who participated in DSMT during the first year after diagnosis. During 2011-2012, an estimated mere 6.8% of privately insured, newly diagnosed adults participated in DSMT. The data strongly suggests that there is a large gap between the recommended guidelines and current practice, and that there is both an opportunity and a need to enhance rates of DSMT participation among persons newly diagnosed with diabetes.

For these reasons, inclusion of the relevant provisions in S. 1345 would go a long way to facilitating access to DSMT and addressing the serious underutilization of DSMT by defining the term "Diabetes Educator.' Another provision in S. 1345 would require HHS to convene a workshop and report to Congress on ways to increase primary care physicians' and other providers' awareness of the value of DSMT. As contained in our earlier comments to the SFC Working Group, we respectfully encourage this provision to be included in any final chronic care legislation or other policy recommendations issued by the SFC Working Group.

Additionally, as a nationally accredited organization, we see diabetes programs struggle every day. Last year AADE accredited over 100 new programs, yet over 60 programs closed during this same time. Many times these closures are caused by confusion in reimbursement, lack of a robust physician referral system, and inappropriate Medicare claim denials. For example, a DSMT claim by a pharmacist in New Jersey could be denied yet the same information provided by a pharmacist in Texas is approved. We believe that a contributing factor to a lack of access to DSMT services is caused by inconsistent and faulty information provided by the local Medicare Administrative Contractors (MACs).

4) AADE believes a qualified DSMT program should be included as recommended program providers of diabetes prevention programs. AADE, through our cooperative agreement with the CDC since 2012, has established the National Diabetes Prevention Program in accredited DSMT programs in 16 states. Our model focuses on already- established, accredited and recognized DSMT programs and oversight from Diabetes Educators,

which provides a successful, sustainable, and cost effective quality implementation of the National DPP.

All states are working on CDC funded projects (1305 and 1422 funding) which complement the AADE model of delivery of both DSMT and DSME. As an example, the Virginia Department of Health (VDH)-Office Family Health Services (OFHS)-Division of Prevention and Health Promotion (DPHP)-Chronic Disease Unit (CDU) located in Richmond, Virginia is releasing two (2) funding opportunities to organizations that offer ADA/AADE Certified Diabetes Self-Management Education (DSME) Programs.

5) Also, the AMA initiative "Prevent Diabetes STAT" encourages physicians to screen, test and refer patients to a National DPP provider, whereas an AADE DPP sites could receive referrals for both DSMT and DPP

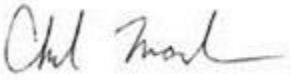
Expanding Access to Digital Coaching

The Document appears to envision expanding access to DSMT and similar services, but in so doing relies only on the availability of web-based information. In order to be effective, any 'digital coaching' related to diabetes care and management must utilize the involvement of a qualified diabetes educator, at least once during the provision of such coaching, much as CMS requires at least one in-person encounter with a healthcare professional during the provision of DSMT by telehealth.

In support of our position, for example, a patient with diabetes cannot adequately learn how to administer insulin simply through 'web based' coaching.

Thank you for the opportunity to provide these comments. We look forward to continuing to work with the SFC as this Document is refined and would be happy to provide any additional information that may be helpful.

Sincerely,



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