March 27, 2019

Dear Congressional Telehealth Caucus Co-Chairs:

The Diabetes Advocacy Alliance (DAA) appreciates the opportunity to provide comments to the Congressional Telehealth Caucus on comprehensive telehealth legislation for the 116th Congress. The DAA is a coalition of 24 diverse member organizations, representing patient, professional and trade associations, other non-profit organizations, and corporations, all united in the desire to change the way diabetes is viewed and treated in America. Since 2010, the DAA has worked to increase awareness of, and action on, the diabetes epidemic among legislators and policymakers. The organizations that comprise the DAA share a common goal of elevating diabetes on the national agenda so we may ultimately defeat diabetes.

As you may know, over 30 million Americans have diabetes and an additional 84 million adults are at risk of developing the disease. In addition, the annual cost of diagnosed diabetes has skyrocketed to $327 billion and will continue to rise unless something is done. Annual spending on this public health emergency has increased 26 percent over a five-year period. Health care spending for Americans with diabetes are 2.3 times greater than those without diabetes. Finally, one out of every seven healthcare dollars is spent treating diabetes and its complications and Medicare spends one out of every three dollars on people with diabetes. Both the human and economic toll of this disease is devastating.

Allow virtual programs to participate in MDPP

Prevention of type 2 diabetes is a priority for the DAA and it must be a priority for the Congressional Telehealth Caucus, Congress, and other health care stakeholders in the U.S. if we are to address rising health care costs and spending and work to improve the health of millions of Americans. The DAA urges the Congressional Telehealth Caucus to include language in its telehealth legislation which permits virtual programs to participate in the Medicare Diabetes Prevention Program (MDPP).

Scientific research has demonstrated conclusively that type 2 diabetes can be prevented or delayed in adults with prediabetes through both community-based and online settings. The Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (National DPP) is a public-private partnership that seeks to reduce the growing problem of prediabetes and type 2 diabetes in the United States. The National DPP is an evidence-based lifestyle intervention that helps combat the diabetes epidemic. Approximately 1,700 organizations nationwide now offer CDC-recognized diabetes prevention lifestyle change programs, both in-person and virtually, to individuals at risk for type 2 diabetes. In addition, Medicare began covering CDC-recognized in-person diabetes prevention programs on April 1, 2018 for Medicare beneficiaries with prediabetes.

While Medicare began covering in-person diabetes prevention programs last year, the number of organizations enrolling as MDPP suppliers has been low and thus so has uptake of the new benefit. As of January 31, 2019, only ~100 suppliers have enrolled in MDPP. CMS launched a MDPP finder tool/website[1] recently, and for example, a search for MDPP within 250 miles of Nashville yielded sites only in Chattanooga (140 miles away) and Huntington (114 miles away).

MDPP has the potential to be transformative to the Medicare program but we knew from the beginning that it would take time to get it off the ground. However, Congress and the Administration can and should take steps now to improve accessibility and uptake of the benefit which will help prevent diabetes and thus reduce spending on the disease. The DAA recommends the Congressional Telehealth Caucus include language in its legislation allowing virtual programs to participate in MDPP. Virtual diabetes prevention programs have similar outcomes to in-person programs and are essential for beneficiary choice as well as access (particularly for vulnerable populations, individuals with transportation needs or those in rural areas with no access to an in-person program). Additionally, in urban areas providers face challenges in providing sufficient, culturally tailored programming for the large population. When looking at the Medicare population, mobility also becomes a significant issue and represents the most common disability among older Americans.[2] This makes getting to medical appointments or weekly in-person DPP sessions especially challenging. Lastly, many seniors consider themselves "snowbirds" and find themselves living in two different locations throughout the year and thus would be unable to complete a year-long in-person diabetes prevention course. A virtual MDPP option would enable them to participate regardless of their location.

Without the addition of virtual MDPP suppliers, large rural areas or underserved communities will not have reasonable access to MDPP suppliers. The fundamental value of community-based programs is delivery of needed services where consumers live and work, and the success of DPP programs relies heavily on lowering barriers to participant access. In the final Medicare Physician Fee Schedule (MPFS) rule, CMS estimated enrollment in MDPP for the initial year between 65,000 and 110,000 Medicare beneficiaries with demand leveling to 50,000 participants per year moving forward. The CMS Actuary calculated an estimated savings of $182 million based on these projections, with greater enrollment directly correlated with higher savings. Lack of widespread access for eligible beneficiaries will not only result in less access for beneficiaries, but decreased cost savings for the Medicare program. The continued exclusion of qualified virtual programs will be felt most by Medicare's most vulnerable populations.

In-person MDPP suppliers do not yet have the capacity to serve millions of seniors; allowing virtual providers to participate in MDPP will ensure Medicare beneficiaries have access to MDPP in the format of their choosing, regardless of where they live. Slowing the number of

[1] Centers for Medicare and Medicaid Services. Accessed February 5, 2019. https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/mdpp-map.html
[2] https://www.census.gov/newsroom/press-releases/2014/cb14-218.html

new cases of diabetes is vital to decreasing the human and economic burden of diabetes in America. While we have made great strides in promoting awareness, access and coverage for diabetes prevention programs, much more needs to be accomplished to slow the current diabetes trajectory both in terms of costs and number of lives impacted.

Pilot virtual diabetes self-management training

Diabetes is a complex disease that requires ongoing self-management by patients, including making numerous decisions throughout the day, as part of their management and treatment regimen. People with diabetes need access to a range of tools, technologies and services including innovations like remote-monitoring that help them and their caregivers monitor and manage their disease. The DAA urges the Congressional Telehealth Caucus to include a CMMI demonstration on virtual diabetes self-management training (DSMT) in its legislation.

DSMT is an evidence-based service that teaches people with diabetes how to effectively self-manage their diabetes and cope with the disease. The service, covered by Medicare Part B and most private health insurance plans, includes teaching the person with diabetes how to self-manage healthy eating, physical activity, monitoring blood glucose levels and using the results for self-management decision making, adhering to medications, coping and problem solving with every day struggles to help reduce risks for diabetes complications. A patient-centered approach to care is vital for DSMT.

The benefits of DSMT are undisputed. Studies have found that DSMT is associated with improved diabetes knowledge and self-care behaviors, lower hemoglobin A1c, lower self-reported weight, improved quality of life, healthy coping and reduced health care costs.[3] The Diabetes Self-Management Education and Support algorithm of care, recommended in a joint position statement of the American Diabetes Association, American Association of Diabetes Educators, and Academy of Nutrition and Dietetics, defines four critical points of time for Diabetes Self-Management Education and Support delivery: at diagnosis; annually for assessment of education, nutrition and emotional needs; when complicating factors arise that influence self-management; and when transition in care occur.[4] Unfortunately, despite its critical importance for people with diabetes and the fact that DSMT has been a covered benefit under Medicare for over 15 years, a recent study found only five percent of Medicare beneficiaries with newly diagnosed diabetes used DSMT services.[5] According to another source, among fee-for-service Medicare beneficiaries age 65 and older with diagnosed diabetes, only 1.7 percent had a Medicare claim for DSMT in 2012.[6]

[3] American Diabetes Association. Standards of Medical Care in Diabetes – 2019. Diabetes Care 2019; 42 (Suppl.1): S46.
[4] Powers MA, Bardsley J, Cypress M, et al. Diabetes self-management education and support in type 2 diabetes; a joint position statement of the American Diabetes Association, American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Care 2015;38:1372-1382.
[5] Strawbridge LM, Lloyd JT, Meadow A, et al. Use of medicare's diabetes self-management training benefit. Health Education Behavior 2015;42:530-8.
[6] Statistic from Health Indicators Warehouse. Available at: https://www.healthindicators.gov/Indicators/Diabetesmanagement-benefit-use-diabetic-older-adults-percent_1263/Profile/ClassicData

CMS highlighted the "significant underutilization" of DSMT in the CY 2011 MPFS, in which the agency noted the effectiveness of DSMT services and the importance of facilitating access to DSMT. In July 2016, as part of the proposed CY 2017 MPFS rule, CMS once again highlighted the low utilization of DSMT and solicited public comment on barriers contributing to access and the under-utilization of the benefit. The DAA provided comments to the agency and commended CMS for recognizing the alarmingly low utilization of this critically important benefit.

Ensuring that Medicare beneficiaries with diabetes understand that DSMT is a covered benefit and utilize this benefit is a priority for the DAA and we look forward to exploring ways we can partner with CMS to advance this goal. From the DAA's perspective, to improve DSMT access and utilization rates, several critical barriers must be addressed. The DAA worked with Congressional leaders in the 116th Congress to introduce S. 814/HR 1840, the *"Expanding Access to DSMT Act"* which addressed barriers to DSMT in Medicare. In addition, and of interest to the Congressional Telehealth Caucus, the legislation includes a request for the Department of Health and Human Services to conduct a demonstration to test virtual DSMT in Medicare beneficiaries with diabetes. For a multitude of reasons, in-person DSMT programs may be inadequate or inaccessible for certain Medicare beneficiaries and allowing Medicare to cover and reimburse virtual DSMT programs would have a positive impact on patients and uptake of the DSMT benefit. We urge the Congressional Telehealth Caucus to include a demonstration on virtual DSMT in its legislation.

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Again, thank you for the opportunity to provide comments on issues the Congressional Telehealth Caucus should include in comprehensive telehealth legislation for the 116th Congress. The DAA looks forward to engaging with the Congressional Telehealth Caucus on this legislation moving forward. Should you have any questions, feel free to reach out to Amy Wotring at awot@novonordisk.com.

Sincerely,

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DAA Co-chair	DAA Co-chair	DAA Co-chair
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