Senator Orrin Hatch
Senate Finance Committee Chair

The Honorable Ron Wyden
Senate Finance Committee Ranking Member

The Honorable Johnny Isakson
Senate Finance Committee

The Honorable Mark Warner
Senate Finance Committee

May 16, 2017

Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the Diabetes Advocacy Alliance (DAA), we appreciate the ongoing efforts of the Senate Finance Committee's (SFC) Chronic Care Working Group leading to the introduction of S. 870, the Creating High Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act of 2017.

The DAA is a coalition of 22 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.

While we applaud your efforts to address chronic conditions, we are concerned that S. 870 does not include provisions to increase access to Diabetes Self-Management Training (DSMT) for Medicare beneficiaries, which is critical to improve health outcomes for patients in this population living with Type 2 diabetes. While the working group's June 2015 Bipartisan Chronic Care Working Group Policy Option's Document recognized the importance of DSMT, the current bill does not address the regulatory impediments to quality diabetes care.

As you know, both the human and economic toll of diabetes is devastating. Nearly 30 million Americans have diabetes and an additional 86 million adults are at risk of developing the disease. By 2050, it is estimated that one out of every three Americans will have diabetes. In addition, the annual cost of this public health emergency has skyrocketed to $322 billion and will continue to rise unless something is done. Further, the Medicare program and older adults are disproportionately affected by diabetes. Approximately 11.2 million Americans over the age of 65 (nearly 30 percent) have diagnosed diabetes and half of all those over the age of 65 have prediabetes. Currently, one out of every three Medicare dollars is spent on care for people with prediabetes and diabetes.

DSMT delivered by qualified healthcare practitioners provides patients with diabetes critical knowledge and skills training to manage their disease and reduce health care costs. This evidence-based training covers techniques for self-monitoring blood glucose levels, medication management and insulin injection administration, individually tailored nutrition planning to manage diabetes control, appropriate exercise, and diabetes problem-solving designed to eliminate or reduce diabetes complications. The goal of DSMT is "a more engaged and informed patient," with proven benefits to clinical, psychosocial and behavioral outcomes of diabetes.[1]

Despite its proven effectiveness in reducing diabetes-related complications and associated costs, DSMT has been recognized by the Centers for Medicare & Medicaid Services (CMS) as a severely underutilized Medicare benefit. CMS first highlighted the "significant underutilization" of DSMT in the CY 2011 Medicare Physician Fee Schedule, 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 Medicare Physician Fee Schedule rule, CMS once again highlighted the low utilization of DSMT and solicited public comment on barriers contributing to access and the underutilization of the benefit. The DAA provided comments to the agency and commended CMS for recognizing the alarmingly low utilization of this critically important benefit, while also identifying barriers to improved utilization. The DAA is committed to help remove these barriers for patients.

Our comments to the work group in June 2015 and January 2016 underscored the current woeful underutilization of DSMT. We noted that the DAWN2 study (Diabetes Attitudes, Wishes and Needs), surveyed a random sample of over 500 people with diabetes, more than 120 family members and 280 health care professionals in the US and found that 45 percent of people with diabetes and 40 percent of their family members report that managing diabetes is stressful—and yet only 64 percent of people with diabetes and 35 percent of family members have ever participated in a diabetes education program. More than 60 percent of health care professionals reported that they believe there is a need for major improvement in the availability of DSMT. The Diabetes Self-Management Education algorithm of care, recommended in a joint position of the American Diabetes Association, American Association of Diabetes Educators and Academy of Nutrition and Dietetics, defines four critical times for delivery of DSMT: at diagnosis, annually for assessment of education, nutrition and emotional needs; when complicating factors arise that influence self-management; and when transitions in care occur.[2] 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 that only 5 percent of Medicare beneficiaries with newly diagnosed diabetes used DSMT services.[3] 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.[4]

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[1] 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.
[2] Ibid.
[3] Strawbridge LM, Lloyd JT, Meadow A, et al. Use of medicare's diabetes self-management training benefit. Health Education Behavior 2015;42:530-8.
[4] Statistic from Health Indicators Warehouse. Available at:

Due to the urgent need to enhance DSMT utilization, we urge the SFC to include the provisions noted below in S. 870:

1. **Require CMS to report to Congress within 90 days on CMS's plans to address access barriers to DSMT and improve utilization of the benefit.**
2. **Extend the initial hours of DSMT covered by Medicare beyond the first year until fully utilized and cover additional hours based on individual need.**

   Currently, Medicare covers up to 10 hours of initial DSMT within 12 months of the first DSMT referral and an additional 2 hours of DSMT per subsequent calendar year. If the full 10 hours are not utilized during the initial first year, those hours are lost. *The DAA recommends an extension of the initial hours of DSMT beyond the first 12 months until those hours are fully utilized and coverage of additional hours of DSMT for beneficiaries whose individual needs necessitate additional hours of the service.*
3. **Allow medical nutrition therapy (MNT) and DSMT to be provided on the same day**

   Medicare defines Medical Nutrition Therapy (MNT) as "nutritional diagnostic therapy and counseling services for the purposes of disease management, which are furnished by a registered dietitian or nutrition professional."[5] For people with diabetes, DSMT and MNT are complementary services that are necessary for improved beneficiary health outcomes, but current rules prohibit DSMT and MNT from being provided on the same day.[6] Many Medicare beneficiaries forego necessary, covered DSMT or MNT services due to this prohibition, which creates undue hardships for people with diabetes, particularly for populations already facing significant health disparities.[7] *The DAA recommends CMS allow DSMT and MNT to be provided to eligible beneficiaries on the same day,* which would allow beneficiaries to consolidate often difficult and increasingly expensive trips to ambulatory care settings to receive care. The same day provision would also allow for more effective, interdisciplinary care.
4. **Remove patient cost-sharing**

   For Medicare beneficiaries with diabetes, DSMT is covered under Medicare Part B and thus is subject to the Part B deductible and 20% coinsurance. Research has found health plans that reduce or eliminate cost-sharing for DSMT increase utilization, while at the same time accruing cost savings and improving patient health.[8] *The DAA recommends removing beneficiary cost-sharing for DSMT to*

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https://www.healthindicators.gov/Indicators/Diabetesmanagement-benefit-use-diabetic-older-adultspercent_1263/Profile/ClassicData

[5] 42 U.S.C. 1395x(s)(2)(vv)(1).

[6] 42 U.S.C. 1395x(s)(2)(v)(i).

[7] Senator Mark Kirk letter to Donald Berwick, MD MPP, dated 23 September 2011, attached hereto (Quoting Centers for Medicare & Medicaid Services. NCD Decision Memo for Medical Nutrition Therapy Benefit for Diabetes & ESRD (CAG-00097N). Centers for Medicare & Medicaid Services Website. http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=53&.

[8] Harvard Center for Health Law and Policy Innovation. "Reconsidering Cost-Sharing for Diabetes Self-Management Education: Recommendation for Policy Reform." June 2015. http://www.chlpi.org/wpcontent/uploads/2014/01/6.11.15-Reconsidering-Cost-Sharing-for-DSME.pdf

eliminate the financial barrier and improve access to this critical education benefit for beneficiaries with diabetes.

5. **Broaden scope of permissible referring providers for DSMT**

   Medicare beneficiaries with diabetes often have multiple health care providers and numerous touchpoints in the health care system, yet current policy limits the referring physician for ordering DSMT to the treating physician or treating qualified non-physician practitioner who is managing the patient's diabetes. This policy fails to recognize that multidisciplinary care team, including hospitalists, podiatrists, optometrists, nephrologists and other specialists that may identify a need for DSMT instruction, but are prohibited from ordering it for their patient. *The DAA recommends CMS expand the list of providers eligible to refer to DSMT services for their patients.*

6. **Clarify agency policy that hospital outpatient department-based DSMT programs can expand to community-based locations, including alternate non-hospital locations.**

   When the Medicare DSMT benefit was first enacted in 1997, DSMT was delivered in hospital-based outpatient classes. However, today hospitals that maintain traditional DSMT programs in the outpatient settings also provide DSMT in community and other convenient settings. Evidence has shown that DSMT provided in community settings and primary care practices has been just as effective as when provided in a hospital. There is also confusion about the types of settings and locations at which DSMT instruction can be provided under Medicare. *The DAA recommends that CMS allow for certified DSMT programs to be provided in community locations to maximize availability and participation. More specifically, CMS should clarify that hospital outpatient department-based DSMT programs can expand their certified DSMT programs to community-based locations, including alternate non-hospital locations.*

We would appreciate the opportunity to further these recommendations with you and your staff and to provide additional information as needed. We also respectfully request this letter be added to the hearing record on S. 870, currently scheduled for May 18. Thank you for your consideration as you work to improve the lives of Medicare beneficiaries with diabetes and diabetes-related chronic conditions.

Sincerely,
Undersigned members of the DAA:
Academy of Nutrition and Dietetics
American Association of Diabetes Educators
American Clinical Laboratory Association
American Diabetes Association
Diabetes Hands Foundation
Endocrine Society
National Community Pharmacists Association
National Council on Aging
National Kidney Foundation
Novo Nordisk