



VIA ELECTRONIC SUBMISSION: <http://www.regulations.gov>

August 31, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1693-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The American Association of Diabetes Educators (AADE) appreciates the opportunity to offer comments in response to the *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program* proposed rule (CMS-1693-P) as published in the *Federal Register* on July 27, 2018 (the "Proposed Rule"). AADE is a multi-disciplinary association of healthcare professionals dedicated to integrated self-management as a key outcome in the care of people with diabetes and related chronic conditions. Representing over 14,000 professional members including nurses, dietitians, pharmacists, exercise specialists, and others, AADE has a vast network of practitioners working with people who have, are affected by, or are at risk for diabetes.

Valuation for Diabetes Self-Management Training (DSMT) Codes (G0108 and G0109)

Supporting diabetes self-management is central to AADE's mission. AADE is one of two National Accredited Organizations (NAO) approved by CMS to certify DSMT programs for Medicare. As such, AADE is pleased to see that CMS accepted the HCPAC-recommended work RVUs for HCPCS codes G0108 and G0109. AADE also applauds CMS for recognizing and addressing the significant disparity in direct Practice Expense (PE) inputs between the specialty recommendations and the final recommendations submitted to CMS by the HCPAC. We shared the agency's concerns regarding the proposed decrease in direct PE inputs and support CMS' recommendation to maintain the current direct PE inputs.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

AADE appreciates CMS' efforts to expand coverage for telehealth services and remote patient monitoring and evaluation services, especially in RHCs and FQHCs. We believe this approach helps to

expand access and connect Medicare beneficiaries with important services. However, AADE seeks confirmation that the proposed communication technology-based and remote evaluation services codes can be used by RHC and FQHC practitioners to help beneficiaries determine whether they should visit an RHC or FQHC for DSMT services. DSMT provides a range of benefits for people with diabetes including lower hemoglobin A1C, weight loss, improved quality of life, and healthy coping skills, resulting in reduced healthcare costs for the Medicare program. Despite these benefits, only five percent of Medicare beneficiaries with newly diagnosed diabetes use DSMT services. AADE believes that allowing RHC and FQHC practitioners to more readily reach beneficiaries in both rural and urban medically underserved areas will improve beneficiary access to, and awareness of, these critical services to drive down diabetes-related healthcare costs and improve the lives of beneficiaries living with diabetes.

Quality Payment Program Future Reporting Considerations: Public Health Priority Sets

AADE supports CMS' focus on promoting quality measurement that provides clinicians with measures that are meaningful to their practices. AADE is most interested in CMS' proposal to engage in future rulemaking to develop MIPS public health priority sets across the four performance categories. In the proposed rule, CMS indicates that they intend to initially focus on patient wellness priorities, such as diabetes. We request that CMS consider AADE's expertise and resources when creating the public health priority set related to diabetes. AADE is a ready resource to support the agency in this endeavor. AADE also believes there is an opportunity for CMS to take a more comprehensive approach to how we address chronic diseases, especially diabetes management. Priority sets for diabetes could include measures that look beyond measurement for A1C and address and monitor other glycemic outcomes like hypoglycemia, time in range, and glycemic variability. In addition, AADE suggests that CMS include common comorbidities like obesity, hypertension, cardiovascular disease, and chronic kidney disease when developing measures related to chronic diseases like diabetes.

AADE also strongly recommends that CMS include measures that evaluate outcomes related to referrals and participation in DSMT for Medicare beneficiaries. Both in person and virtual DSMT programs should be included in the development of these measures. Public health priority sets built across all performance categories and incentivizing health IT functionalities could serve as an important foundation to leverage the use of digital technologies in providing DSMT to people with diabetes. AADE has long advocated for expanding Medicare coverage for virtual DSMT provided through a qualified online platform, and the development of public health priority sets may provide the opportunity to explore this further. AADE looks forward to working with CMS on the future development of a public health priority set for diabetes care.

Addressing Barriers to DSMT

In anticipation of the Proposed Rule, AADE was hopeful that CMS would address the known barriers that prevent Medicare beneficiaries from utilizing the Medicare DSMT benefit. AADE wishes to express our disappointment that these barriers were not addressed, especially given the ongoing conversations between AADE, CMS, and other stakeholders. AADE has articulated our concerns to CMS and outlined barriers and proposed solutions in our CY 2017 Medicare Physician Fee Schedule proposed rule comments. We believe CMS has the authority to address at least some of the barriers that Medicare beneficiaries face when accessing DSMT, including the number of hours covered for the DSMT service and the inability to carry over a beneficiary's initial 10 hours of DSMT beyond the first 12 months, the

Administrator Verma

August 31, 2018

Page 3

non-coverage of DSMT and Medical Nutrition Therapy (MNT) on the same day of service, and the lack of clarity for the delivery of DSMT by a hospital outpatient department at a nonhospital site, like a community-based location. AADE looks forward to continued dialogue with CMS to address the known barriers to DSMT and improve access for Medicare beneficiaries.

Virtual Medicare Diabetes Prevention Program

AADE also hoped the establishment of a virtual Medicare Diabetes Prevention Program (MDPP) pilot would be included in the Proposed Rule, as referenced in the CY 2017 Medicare Physician Fee Schedule final rule. AADE strongly supports Medicare coverage of the diabetes prevention program and MDPP, and believes that the availability of virtual programs strengthens access for those that may not be able to attend an in-person program. This directly aligns with CMS' focus on addressing the social determinants of health, as the populations who could most benefit from virtual MDPP include Medicare beneficiaries living in rural areas, those who are unable to readily access transportation in urban areas to attend in-person sessions, and those that face other factors that present barriers to accessing the new MDPP benefit. AADE strongly supports the agency in the development of a model test of virtual MDPP services as we share the common goal of ensuring access for Medicare beneficiaries.

* * * * *

AADE appreciates the opportunity to comment on this Proposed Rule. Please contact Kate Thomas, Director of Advocacy, by phone at 312-601-4821 or via email at kthomas@aadenet.org should you have any questions regarding AADE's comment letter.

Sincerely,



Charles MacFarlane, FACHE, CAE, Chief Executive Officer



Leslie E. Kolb, RN, BSN, MBA, Chief Science and Practice Officer