



January 26, 2015

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 appreciate 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, we would like to focus on the key areas of most importance to our members and patients which we believe will strengthen the document: specifically, the need to define Certified Diabetes Educators (CDEs) as providers of DSMT, and the need to include CDEs as providers of DPP as well as the proposed expansions of DSMT to other analogous chronic conditions.

Recognizing that the Committee may be hesitant to address scope of practice or so-called ‘provider issues’, we would like to highlight the following:

We believe our request to define a diabetes educator in statute is unique in that the proposed CDE definition was already approved on a bipartisan basis by the SFC, it has been scored by CBO as virtually a non-coster, and it simply updates the 1997 statute to define a practitioner of DSMT services. However, it does not require a provider of DSMT to be a CDE, so it does not create ‘turf’ battles among providers.

Founded in 1973, AADE is a 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 others, AADE has a vast network of practitioners involved in the daily treatment of diabetes patients. 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’.

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.

While the Document does not specifically address barriers to *diabetes* care, AADE would like to note the following recommendations from the *2015 Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics: Diabetes Self-management Education and Support in Type 2 Diabetes*. We believe these recommendations support both the general efficacy of DSMT, as well as highlight some existing barriers to care which we hope the SFC final document may address:

- Engaging adults with Type 2 diabetes in DSMT results in clinically significant and meaningful reductions in blood sugar levels, a critically important measurement for diabetes control;
- A team approach for DSMT is particularly valuable and may show more improved health outcomes than DSMT provided by only one person;
- The most optimal DSMT health outcomes result from a combination of group and individualized classes;
- Diabetes Health Care Providers need to ensure a systematic referral process to ensure that patients with Type 2 diabetes receive DSMT in a timely manner;
- Primary care providers should refer patients for DSMT: 1) at the time of diagnosis, 2) as an annual evaluation to determine educational, nutritional and emotional needs, 3) when new complicating factors influence the self-management techniques to be utilized to manage diabetes, and 4) when transitions in care occur.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

The Document references the potential need to waive beneficiary cost sharing, such as co-payments, for services to treat a chronic disease or prevent its progression.

Eliminating barriers to care coordination in ACOs is a multi-dimensional issue; however, adoption of two important policies would serve to significantly enhance care coordination: 1) Define a CDE for purposes of the Medicare DSMT program in order to foster greater utilization of CDEs in ACOs, and 2) Waive beneficiary co-pay for DSMT services.

As part of its support for policy efforts which encourage the inclusion of CDEs in ACOs, AADE notes that only an extremely small percentage of individuals with diabetes are ever referred for DSMT care upon diagnosis, thus contributing to the ever-increasing prevalence of diabetes-

related complications, rising health costs attributable to diabetes, and reduction in patient quality of life.

Defining a diabetes educator in the Medicare statute for purposes of DSMT can contribute to a greater utilization of CDEs in ACOs. We also believe that waiving beneficiary co pays for DSMT bill could encourage greater utilization of this important service for the reasons noted in the Document.

Expanding Access to Prediabetes Education

The Document references the DSMT program under Medicare but offers 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, 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) Since a diagnosis of diabetes also serves as a precursor to other chronic conditions (e.g. hypertension, obesity), AADE members are accustomed to addressing a myriad of health conditions that require behavior modification techniques similar to that inherent in DSMT. This model could be easily adopted to address other chronic disease conditions in the Medicare program. 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 from that prescribed for DSMT, which is 10 hours in the first 12 months of referral. As contrasted with the DSMT benefit, the DPP provides a person with prediabetes 22-24 one-hour sessions of training in the first 12 months.
- 2) The Medicare statute does not currently define a qualified “diabetes educator” for purposes of either in-house or telehealth DSMT. The 1997 statute authorizing DSMT needs to be updated to reflect the way diabetes self-management care is predominantly provided today: namely, in small, community-based settings, as well as physician offices, and not in hospital outpatient settings when the provider definition was not as important.

While the SFC already vetted and approved bipartisan legislation endorsed by the SFC Chair and Ranking Member 2009-2010 to define the term ‘certified diabetes educator’ (and CBO ‘asterisk’ scored at virtually no cost), 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.

AADE believes a qualified DSMT program should be included as recommended program providers of diabetes prevention programs due to our long standing active involvement with the DPP. By way of background, AADE entered into a four year cooperative agreement with the Centers of Disease Control and Prevention (CDC) in 2012. Through this cooperative agreement, AADE was charged with utilizing our vast networks of diabetes educators and nationally certified 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 among the largest in-person delivery networks 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.

Though our cooperative agreement with CDC, AADE, has established the DPP 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. 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.

- 3) 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 health professional during the provision of DSMT by telehealth.

In support of our position, for example, a diabetes patient cannot adequately learn how to administer insulin simply through ‘web based’ coaching. For these reasons, digital coaching is one of many approaches that has value to promote effective diabetes self-management, but it cannot take the place of a qualified diabetes educator.

Thank you for the opportunity to provide these comments. We are attaching our earlier comments to the Committee as well as the relevant legislative provision already vetted and supported by SFC, discussed earlier, that would define a qualified diabetes educator. 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,



Charles Macfarlane, FACHE, CAE
Chief Executive Officer
American Association of Diabetes Educators

Suggested statutory language to define a diabetes educator for purposes of DSMT

(a) In General- Section 1861(qq) of the Social Security Act (42 U.S.C. 1395x(qq)) is amended--

(1) in paragraph (1), by striking `by a certified provider (as described in paragraph (2)(A)) in an outpatient setting' and inserting `in an outpatient setting by a certified diabetes educator (as defined in paragraph (3)) or by a certified provider (as described in paragraph (2)(A))'; and

(2) by adding at the end the following new paragraphs:

`(3) For purposes of paragraph (1), the term `certified diabetes educator' means an individual--

`(A) who is licensed or registered by the State in which the services are performed as a certified diabetes educator; or

`(B) who--

`(i) is licensed or registered by the State in which the services are performed as a health care professional;

`(ii) specializes in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual's diabetic condition; and

`(iii) is certified as a diabetes educator by a recognized certifying body (as defined in paragraph (4)).

`(4) For purposes of paragraph (3)(B)(iii), the term `recognized certifying body' means a certifying body for diabetes educators which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary.'

(b) Treatment as a Practitioner, Including for Telehealth Services- Section 1842(b)(18)(C) of the such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

`(vii) A certified diabetes educator (as defined in section 1861(qq)(3)).'