June 27, 2016

Andrew M. Slavitt,
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Washington, D.C. 20201

Sylvia M. Burwell
Secretary, Department of Health and Human Services
200 Independence Ave SW
Washington, D.C. 20201

BY ELECTRONIC DELIVERY

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule [CMS–5517–P]

Dear Secretary Burwell and Acting Administrator Slavitt:

The Diabetes Advocacy Alliance (DAA) appreciates the opportunity to provide comments related to the Centers for Medicare and Medicaid Services' (CMS) Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Model (APM) Incentives under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models Proposed rule (the "Proposed Rule"), released May 9, 2016.

The DAA is a coalition of 21 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.

The DAA provides the following comments on the Proposed Rule.

Clinical Practice Improvement Activities Component
The DAA commends CMS for providing clinicians with a wide range of activities that will satisfy the Clinical Practice Improvement Activity (CPIA) component. We believe that, in this category, CMS succeeded in its goals of providing flexibility and simplicity for providers, which will increase their ability to succeed in this component. We appreciate that CMS has proposed to award full credit to practices that are NCQA Patient-Centered Medical Homes (PCMH) or PCMH-Neighbors (PCMH-N). Care coordination is essential to providing the best possible care and reducing redundant tests and services.

We do have several specific recommendations for CMS to consider expanding the CPIA options for endocrinologists, primary care physicians and other specialists.

CMS should consider diabetes self-management training (DSMT) as a CPIA. DSMT provides critical knowledge and skills training to patients with diabetes, helping them manage medications, address nutritional issues, facilitate diabetes-related problem solving, and make other critical lifestyle changes to effectively manage their diabetes. Evidence shows that individuals participating in DSMT programs are able to progress along the continuum necessary to make sustained behavioral changes in order to manage their diabetes. DSMT has been proven effective in helping to reduce the risks and complications of diabetes and is a vital component of an overall diabetes treatment regimen. In addition, DSMT has been found to save $135 per month in health care costs for each Medicare beneficiary completing a program.[1] Patients who have received training from a qualified diabetes educator are better able to implement the treatment plan received from a clinician skilled in diabetes treatment.

Despite its effectiveness in reducing diabetes-related complications and associated costs, DSMT has been recognized by CMS as an underutilized Medicare benefit, even after more than a decade of coverage. Only 4 percent of Medicare beneficiaries newly diagnosed with diabetes are referred to DSMT within 12 months of diagnosis. Providing credit through the MIPS program for practices that offer DSMT to their patients may encourage more providers to offer this service. In June 2015, the Academy of Nutrition and Dietetics, American Association of Diabetes Educators, and the American Diabetes Association released a joint position statement on DSMT highlighting the significant benefits of DSMT. The position statement included an algorithm of care to assist health care professionals in determining when, what, and how DSMT should be provided to adults with type 2 diabetes.[2] The statement outlines four critical times when DSMT should be provided: at diagnosis; as part of an annual assessment; when new complicating factors arise; and when transitions of care occur.

Recently, the U.S. Preventive Services Task Force issued a new diabetes screening guideline and CMS announced Medicare coverage of diabetes prevention programs. We believe that patient referral to lifestyle intervention programs like the National Diabetes Prevention Program (National DPP) should also be included in the CPIA category. The expansion of screening for diabetes will result in more patients being diagnosed with prediabetes, a disease that can be prevented with modest weight loss and increased physical activity. Studies have shown that a 5-7% reduction in weight can prevent or delay the onset of diabetes by 71% in the Medicare population. It is critical that these programs are effectively utilized to stop the diabetes epidemic in America. Currently 86 million Americans have prediabetes and nearly 30 million have diabetes in the United States alone.

The National DPP has proven to be a cost-effective program that can reduce healthcare expenditures stemming from diabetes. Annual medical costs for people with diabetes average $13,700, with $7,900 being directly attributable to the disease. The annual cost for a lifestyle intervention program, on the other hand, averages around $500 and can reduce a person's risk for getting diabetes significantly. In addition, the CMS Actuary found Medicare beneficiaries participating in a diabetes prevention program saved $2,650 over 15 months in reduced health care costs. These findings were the result of a demonstration project by the YMCA of the USA through the CMS Innovation Center. Screening for diabetes and referral to a lifestyle intervention programs for at-risk patients is one of the many important activities that can help improve care and reduce healthcare costs.

---

[1] Duncan I, Birkmeyer C, Coughlin S, et al. Assessing the value of diabetes education. *The Diabetes Educator 2009*; 35(5):752-760.

[2] 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, the American association of diabetes educators, and the academy of nutrition and dietetics. Diabetes Care 2015 Jun: dc150730.

The DAA requests that these activities be included in the CPIA category and that CMS consider the inclusion of a quality measure to track these activities in the future.

Thank you the opportunity to provide comments on the Proposed Rule and for considering our comments. We look forward to continuing to engage with the agency as the regulatory process proceeds. Please feel free to contact Amy Wotring at awot@novonordisk.com with any questions.

Sincerely,

Karin Gillespie
Novo Nordisk
DAA Co-chair

Henry Rodriguez, MD
Pediatric Endocrine Society
DAA Co-chair