May 13, 2020

Elizabeth-Ashley Matthews, MPA
Director, Division of Health Care Delivery
Prevention and Population Health Group
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Matthews:

Thank you for hosting a productive conference-call meeting with members of the Diabetes Advocacy Alliance (DAA) on March 12, 2020, during which we had a robust discussion of some of the challenges facing the Medicare Diabetes Prevention Program (MDPP). We appreciated the opportunity to continue our dialogue with you as we work together to address issues facing MDPP suppliers and programs, with a goal of increasing uptake of the MDPP benefit in order to help prevent or delay the onset of new cases of type 2 diabetes among Medicare beneficiaries. In this letter, we are sharing a summary of what was discussed and how we might move forward.

This letter supplements what was included in the meeting summary that we sent to you recently and includes additional information that we believe is useful in supporting the recommendations and comments we made during our call.

Reasons to Align the MDPP Expanded Model with the Pilot Test Model and Original Diabetes Prevention Program Clinical Trial

The DAA continues to believe the expansion of the Diabetes Prevention Program (DPP) to Medicare beneficiaries has the potential to completely transform the trajectory of type 2 diabetes. However, we also believe that in the course of expanding the model, CMS made what were well-intentioned modifications to the Medicare DPP pilot. With these modifications, the Model has not achieved the increased supplier and beneficiary participation envisioned at its launch.

The DAA counts among its membership several organizations that can attest firsthand to challenges with the Expanded Model. We are concerned with the low uptake rates of the MDPP benefit and believe that CMMI needs to make changes to the expanded model as quickly as possible to ensure that the current CMMI test is a success. Otherwise, the DAA is concerned that the MDPP benefit could be eliminated.

We believe that our recommendations could quickly help improve expanded model program participation to help obtain adequate numbers of beneficiary participants for CMMI to conduct a proper program evaluation. As a first step, the DAA recommends that, in certain key respects, CMMI revert to the model used in the Medicare DPP pilot conducted by the YMCA of the USA (Y-USA) and partners under a Health Care Innovation Award. This pilot

was based on the science of the original DPP clinical trial that resulted in reduction in the risk of developing type 2 diabetes by over 70 percent among Medicare-age adults.

<u>Recommendation #1</u>: CMMI should modify the expanded model to become a one-year program, with payment levels at least equivalent to the levels provided in the CMMI pilot test. Today, we estimate the average payment per participant in the first year is 56 percent of what was paid in the one-year pilot program (*Note: Please see Recommendation #5 for more in-depth rationale for improving reimbursement to cover suppliers' reasonable costs.*)

While we have learned from you that extending the expanded model to two years was well intentioned, the second year of the MDPP has proven to be a barrier to success. This change has made delivering Medicare DPP both financially unattractive and unsustainable for suppliers of the program.

First, we have heard from suppliers that it is very difficult to engage and retain beneficiaries in a second program year. Second, the reimbursement levels for a second year are inadequate to cover program supplier costs. Reimbursement for year-two costs, which require substantial levels of outreach to ensure attendance on the defined schedule, does not cover the costs associated with delivering the required services. Programs have the same fixed costs, yet there are a diminishing number of participants eligible to participate. This means the per-participant cost is higher. And third, since a second year of the MDPP deviates from both the CMMI pilot test and the original DPP clinical trial protocol, the DAA believes a second program year is unnecessary and should be eliminated. Further, we recommend that the current budget allocation for year-two costs should be allocated and added to year-one funds. We believe the Expanded Model's curriculum should be the same as that of the CDC's National Diabetes Prevention Program (National DPP), namely 16 core weeks followed by monthly maintenance sessions.

<u>Recommendation #2</u>: CMMI should modify the expanded model to change the expanded model's fasting plasma glucose (FPG) range of 110-125 mg/dL for beneficiary eligibility to align with the FPG range specified in the National DPP's Diabetes Prevention Recognition Program standard of 100-125 mg/dL.

The fasting glucose range specified in the Diabetes Prevention Recognition Program (DPRP) of the CDC's National DPP is 100-125 mg/dL. While you indicated during our recent meeting that CMS follows the World Health Organization's (WHO) diagnostic criteria for prediabetes and thus is using FPG of 110-125 mg/dL in the expanded model, the DAA believes using the WHO range prevents patients who could benefit from the program from being eligible for it, causes confusion for suppliers and referring physicians, and prevents clinicians who are committed to improving their patients' health outcomes from adhering to diagnostic criteria generally accepted in the United States, specifically those set forth by the American Diabetes Association.

An additional concern is that Medicare does not cover an HbA1c test for the purpose of evaluating prediabetes, even though this is one of the test results that can be used to assess eligibility in the National DPP and is generally accepted by U.S. health professionals for prediabetes and diabetes diagnosis.

The DAA urges CMMI to reexamine these diagnostic discrepancies as part of the work to be performed in the upcoming 5-year MDPP evaluation.

Barriers to Supplier Participation and Retention in the MDPP Expanded Model

DAA member organizations that are DPP suppliers have encountered challenges to enrollment, participation, and retention in the MDPP expanded model program. We estimate that there are many organizations that are National DPP suppliers, but not MDPP suppliers due to programmatic challenges, as well as the potential for financial loss.

We recognize that there are many administrative challenges to becoming a supplier. The additional requirements have even proved burdensome for established sites that have been billing Medicare for other services for decades. These sites must establish a new NPI, complete a separate application process, pay an application fee, establish highest categorical risk, etc. These administrative burdens are on top of setting up the program and delivering the service. Sites that already bill Medicare could benefit from some type of parity to allow them to more readily start billing for the MDPP. They could include documentation to show they have achieved preliminary or full recognition with CDC.

Also, consider the many sites that are federally qualified health centers (FQHCs.) FQHCs, and other HRSA-funded health centers, serve 1 in 12 people in the United States, with a focus on underserved communities with populations at greatest risk of developing type 2 diabetes. Although the number of Medicare beneficiaries seen at FQHCs has more than doubled since 2001, Medicare beneficiaries comprise a minority of the overall patient population served by these safety-net health centers. Because they don't serve a large population of eligible Medicare beneficiaries, FQHCs, and FQHC look-alike clinics, do not see the value in undertaking the work required to become an MDPP supplier, including making the required internal changes to an EHR for such a small population. Efficiency comes from having larger numbers of cohorts and participants, and, if you serve a small senior population, you are unlikely to achieve that efficiency with your program. Given the current value-based reimbursement, a supplier would need to have a highly efficient program in place serving cohorts for under $300/person so it would not lose money delivering MDPP as it is set up today. We recognize CMS' concerns over fraud and abuse related to over-utilization, but the actual issue is massive underutilization due to heavy administrative burden on top of an already costly-to-implement program.

<u>Recommendation #3</u>: CMMI should modify Form CMS-20134 to eliminate the Social Security Number (SSN) requirement that is causing many local community-based entities to stop the application process to becoming an MDPP supplier under the expanded model.

In the MDPP Enrollment Checklist (available here), the instructions state: "Collect information on organizations and individuals with 5% or more ownership of, partnership in, or managing control of the organization (if applicable)." The instructions further state that "Organizations or individuals with ownership interest or partnership interest of 5% or more (direct or indirect) must be reported. An organization or individual with managing control exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier. An organization does not need ownership interest to qualify as a managing organization."

For a community-based organization which is delivering many types of services and is not primarily delivering DPP, such as a local Y-USA chapter, individual volunteers, who are members of the local Board of Directors, do not fit the definition of having "managerial control" over the local Y's operation of the MDPP program, and therefore should not be held to Form CMS-20134's requirements for individuals fitting this category: "Provide the full

name, date and place of birth, Social Security Number (SSN), NPI, relationship with supplier, effective date, and final adverse legal action history."

This requirement, especially for SSNs, is causing many multi-service community organizations and others to stop the application process. In their volunteer roles, board members are not actively managing the organization; instead, they are providing a service to the community. Similar community-based organizations, such as churches or local governments, that do not have health or DPP as their primary book of business and are not "owned" but have voluntary boards, will likely face similar challenges with applications.

The DAA understands the need for CMS to monitor MDPP suppliers and protect the integrity of the program. However, since MDPP suppliers must also be held to the high standard of securing and maintaining CDC recognition to provide DPP services, we believe these suppliers are more analogous to low categorical risk diabetes self-management training (DSMT) providers than high categorical risk home health agencies. Therefore, the DAA recommends that CMS classify as low-risk all MDPP suppliers that have achieved and maintained Diabetes Prevention Recognition Program (DPRP) recognition.

If the above is not possible, the DAA requests an administrative interpretation for relief from the requirement to provide volunteer board member SSNs in one of the following ways:

- CMS could classify as low-risk all community based MDPP suppliers that have achieved DPRP recognition.
- CMS could waive the requirement in section 6 of the MDPP supplier application for volunteer (i.e., unpaid) board member SSNs; or
- CMS could modify the background information request in section 6 to require SSNs from the board chairperson and the executive committee of the board only. (Since this is usually the "governing" committee on most YMCA boards, for example, it would provide the necessary background information on key members of the board.); or
- CMS could delete the SSN requirement and instead only require identifying information such as names, addresses and date of birth of board members. Once an application is submitted, if the Medicare Administrative Contractor (MAC) determined that additional information on one (or more) of these individuals were warranted, the MAC could request such information on a case by case basis.

Recommendation #4: CMMI should modify the information it requires MDPP suppliers to provide for coaches via Form CMS-20134.

The coach roster information requirements are extensive and represent information that is being collected both via the NPI application process as well as through bureaucratic coach roster requirements. Streamlining information collection so that it is only collected once would be helpful. Also, the DAA anticipates that CDC, in its next round of DPRP requirements, will require organizations to track coach training. This requirement will be a significant additional burden to suppliers.

Recommendation #5: CMMI should modify the expanded model to cover reasonable costs incurred by suppliers.

The DAA is concerned that current MDPP reimbursement levels do not cover MDPP supplier reasonable costs. We encourage CMS to modify MDPP reimbursement to ensure payments for core and maintenance sessions are structured and resourced in a way that supports

patients and enables them to get the services they need. We urge CMS to consider payment levels that adequately cover the cost of providing core and maintenance session services, respectively.

For example, in the MDPP pilot program, suppliers were paid on average $462 for a one-year program (based on outcomes from the CMMI model test). In the current expanded model, an ideal cohort, where all members achieved all payment markers (e.g. they achieved 5% WL by the end of month 9 AND 9%WL by the end of month 12), would yield $492 in the first year. Our suppliers, according to CMS guidance, are welcoming all participants who have a variety of challenges to achieving attendance, engagement, and weight loss goals during this intensive program. We have heard from many of our suppliers that even with better than average performance the reimbursement per participant is approximately $334, where half of the group is achieving the 5% weight loss goal (See Appendix A for a more detailed payment breakdown).

According to the YMCA of the USA, a DAA member, DAA understands that CMS has fixed its systems and is issuing payment more quickly, and we commend CMS for these actions. But the DAA reiterates that lower reimbursement remains a major problem to be addressed.

The DAA also urges CMS to consider the *distribution* (as opposed to the amount) of payments over the course of the program. For example, most supplier costs (e.g., administrative costs, staffing, beneficiary engagement, recruitment, etc.) are incurred up front or in the initial weeks of the program. This requires MDPP suppliers to amass enough capital to pay for this largely on their own until they receive the first outcomes-based payments. Addressing these capital-related concerns will allow for a greater variety and number of MDPP suppliers (i.e., more community-based suppliers) to offer DPP to Medicare beneficiaries.

We recognize and appreciate that CMS has already taken some steps to address these issues, but we urge CMS to reconsider reimbursement so that it better reflects evidence and Medicare DPP reimbursement levels from the Medicare DPP pilot test, with appropriate adjustments for cost trends. Also, DAA members are encouraging MDPP suppliers to contact CMMI directly through your online channels, to provide examples of hardships being routinely faced due to lower-than-actual-cost levels of reimbursement.

Recommendation #6: CMMI should provide targeted solutions for special populations of beneficiaries at higher risk of developing type 2 diabetes.

The DAA is concerned the existing MDPP benefit does not allow for targeted solutions for special populations including, but not limited to, individuals dually eligible for Medicare and Medicaid. The DAA urges CMS to continue to align with CDC and the DPRP and to encourage and/or incentivize suppliers, through fully transparent policy, to deliver MDPP in low-income areas.

The current payment structure does not consider socioeconomic status. As noted in MDPP rule-making, low-income participants lose, on average, one percentage point less weight than other participants**.** Given that evidence shows that type 2 diabetes is most prevalent in underserved communities and the CDC has identified this issue as a priority area for DPP expansion,[1] we strongly urge CMS to allow for targeted solutions that would encourage MDPP suppliers to offer the program to the patient populations that need it most.

[1] https://www.cdc.gov/diabetes/programs/stateandlocal/funded-programs/1705.html

This issue is an important one of health equity and it requires creative solutions. The DAA can be a resource to CMMI for brainstorming and developing creative solutions for CMMI to consider in adjusting the MDPP program for social risk.

In previous communication with CMMI, the DAA has discussed the possibility of MDPP payments being risk-adjusted – for example, to help suppliers cover the cost of providing the program to patient populations that may face transportation and other barriers to attendance and/or for whom the evidence has shown that achievement of the 5% weight loss threshold may be much less likely.

The DAA urges CMMI to address the disincentive to serve special populations that is inherent in the current reimbursement approach. In New York, for example, Medicaid pays for attendance, not weight loss, with a bonus payment at the end for weight loss. Additionally, evidence shows that patients who achieve weight loss of just 2% to 5% reap health benefits including improved glucose, systolic blood pressure, and triglycerides.[2] The DAA is pleased that the CDC has previously acknowledged the impact of socioeconomic status on achieving National DPP goals but specific solutions must be identified for special populations across MDPP and National DPP.

While the DAA knows the goal of the DPP is 5% weight loss for the reduction in new cases of type 2 diabetes, it is essential to understand that almost any sustained weight loss yields risk reduction. Some of the original researchers from the NIDDK/NIH clinical trial who worked with the Y-USA in the pilot test helped us understand that for every 2.2 pounds of weight loss, diabetes risk was reduced 13%. This point will be important as Medicaid also begins to look at replicating the Medicare policy for the DPP. To whatever degree this trend is consistent across suppliers, organizations working hardest to reach underserved populations may observe a decreased lower average weight loss that pushes them below the threshold required for CDC's Diabetes Prevention Recognition Program, especially when they are providing services to a high percentage of participants who are below the federal poverty guidelines. If these organizations do not believe they will be paid adequately to cover the cost of providing these services, they may not offer Medicare DPP programs, or they may view this as a disincentive for serving individuals with financial need and the highest disease burden.

As you know, CDC's DPRP Standards are due for revision in coming months. The DAA is hopeful that the CDC will make changes that address our concerns. However, the DPRP Standards may evolve, Medicare, as a payer for DPP services, has a responsibility and the opportunity to assure Medicare beneficiary access in communities where individuals are at higher risk of type 2 diabetes. The DAA is anxious to work with CMMI to identify creative solutions that meet this challenge. Potential solutions could include providing higher payments to suppliers for patients with greater social determinants of health (SDOH) risk, targeted relief from the weight loss threshold in order to obtain certain per-beneficiary performance payments, and/or help with transportation or other costs for participating beneficiaries. If SDOH data are lacking, perhaps proxies could be used such as dual eligible status or geographic location, or proof of income.

[2] Wing RR, Lang W, Wadden TA, et al. Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with type 2 diabetes. Diabetes Care 2011; 34: 1481-1486.

<u>Recommendation #7</u>: CMMI should remove the once-per-lifetime limit for the MDPP benefit.

The DAA is seriously concerned about the once-per-lifetime limit for MDPP. The once-per-lifetime limit punitively denies some beneficiaries the benefits of a program that reduces Medicare expenditures while also improving health outcomes and quality of life for those at risk for diabetes. Research demonstrates that weight loss is extremely difficult and complex, and some beneficiaries may need multiple attempts to be successful at either achieving or maintaining weight loss.[3]

In its current coverage policy for obesity counseling, Medicare specifically acknowledges the science showing the need for repeated use of healthy lifestyle counseling for weight management. The Medicare obesity counseling benefit states that, "For beneficiaries who do not achieve a weight loss of at least 3kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period."[4]

The majority of private payers that cover and reimburse diabetes prevention programs consider the intervention an annual benefit and the DPP model test allowed participants to reenroll after the year-long program if they were still eligible.

Medicare coverage of smoking and tobacco use cessation counseling similarly recognizes that patients may need to attempt this important behavior change as often as annually. (*Medicare will cover 2 cessation attempts per year. Each attempt may include a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. The practitioner and patient have flexibility to choose between intermediate or intensive cessation strategies for each attempt.)*

The DAA strongly urges CMS to rescind the once-per-lifetime limit and, similar to Medicare coverage of obesity counseling and tobacco cessation, provide beneficiaries additional opportunities to participate in and benefit from MDPP. This will also better align Medicare coverage with the commercial market. The DAA urges CMS to allow beneficiaries who did not successfully complete the MDPP to reenroll following a 6-month waiting period as long as they meet eligibility criteria. Instituting a 6-month waiting period between attempts would align this benefit with the Medicare obesity counseling benefit and address concerns that suppliers might abuse the system by automatically reenrolling participants.

At a minimum, the DAA encourages CMS to include an exception for participants who experience a major life event that may impact their ability to attend MDPP sessions. We recognize and appreciate that CMS has already taken steps to address some concerns with the allowance for four make-up sessions, but we believe there may be circumstances that prevent or derail participation for longer than those four sessions. Examples of major life events may include (but are not limited to): a newly-developed health condition (not

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[3] Wing RR and Phelan S. Long-term weight loss maintenance. American Journal of Clinical Nutrition 2005; 82: 2225-2255.

[4] Centers for Medicare & Medicaid Services. National coverage determination (NCD) for intensive behavioral therapy for obesity, November 2011. Available online: https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=353&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=obesity&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABAAAAAA

diabetes-related) by the participant; newly-developed health condition of a loved one; surgery or injury of participant or a loved one; and death of a loved one.

Far from a problem of overuse of MDPP services, we are facing a serious problem of underuse. The DAA strongly believes the once-per-lifetime policy should be eliminated.

Recommendation #8: CMMI should add coverage for virtual programs to the expanded MDPP model.

Currently, virtual DPP providers recognized by the CDC are excluded from reimbursement under the MDPP expanded model benefit. Virtual programs include those delivered in any of the following modes permitted by the CDC DPRP: online, distance learning, and combination.

According to the CDC's National Diabetes Statistics Report 2020, nearly half of all Medicare-aged beneficiaries – about 24 million – have prediabetes and thus are eligible to participate in MDPP (after obtaining a qualifying blood test). Many of these beneficiaries live in frontier and remote, exurban and suburban areas that lack a DPP provider with preliminary or full recognition from the CDC, making those providers ineligible to *apply* to serve Medicare beneficiaries. Additionally, in urban areas, providers face challenges in providing sufficient, culturally tailored programming for the large numbers of Medicare beneficiaries among the populations they serve. AND, all of these beneficiaries lack access to start an MDPP during the COVID-19 public health emergency (PHE).

When looking at the Medicare population, mobility also becomes a significant issue and represents the most common disability among older Americans.[5] 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. Although CMS provides for this possibility through the bridge payment, given the larger capacity issues of MDPP, it can be challenging for seniors to connect with an in-person Medicare DPP supplier in their new seasonal home areas. This type of arrangement would only work with a great deal of luck, such as if patients identify a close, convenient MDPP supplier that is currently providing services, at a time/location that works for them in their new seasonal location — along with sophisticated patient navigation and data sharing on the part of the originating provider. The DAA believes a better solution would be to allow "snowbirds" to remain with their original in-person group when they move, and participate through distance learning. Another option would be for CMS to allow a virtual MDPP option that would enable beneficiaries to participate regardless of their location. Qualified virtual DPP providers have the potential to fill gaps in coverage for these beneficiaries.

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.

[5] https://www.census.gov/newsroom/press-releases/2014/cb14-218.html

Lack of widespread access for eligible beneficiaries will also result in decreased cost savings for the Medicare program. The continued exclusion of qualified virtual programs will be felt most by Medicare's most vulnerable populations.

CMS has stated the HHS Secretary lacks the authority to include virtual programs, as the demonstration project was conducted via in-person DPP. However, this rationale conflicts with the separate decision to include virtual make-up sessions in the expanded model, as virtual make-up sessions were not included in the demonstration.

Furthermore, the stated purpose of the demonstration was to test the impact of the CDC-approved curriculum by a recognized DPP provider and layperson health coaches in preventing type 2 diabetes, not to test a specific location or class schedule. Virtual DPP providers recognized by CDC fulfill all these requirements. In addition, virtual DPP programs have installed a range of program integrity safeguards and can be fully audited on a range of participant measures (e.g., Bluetooth scales that provide ongoing weight measurements). Additionally, the data collected from the CDC National DPP now include information on thousands of Medicare-age participants who have received the DPP from qualified virtual providers.

DAA recommends that all CDC-recognized Diabetes Prevention Program providers that are delivering services virtually (either by converting in person sessions to virtual per CDC guidelines OR as a virtual program) with preliminary or full recognition be eligible for MDPP at least during this public health emergency, and that CMS should allow new cohorts to begin the program without a first in-person session. In addition , DAA member organizations urge CMS and the CMS Actuary to consider data CDC has already gathered from virtual DPP providers and reevaluate the decision to prohibit virtual delivery of MDPP. The data for virtual DPP demonstrate comparable efficacy to that of in-person DPP providers in the CDC database. This CDC database is the same data source CMS relied upon when making a determination for expansion of the in-person program.

In-person MDPP suppliers do not 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.

Special Considerations: The Coronavirus and COVID-19

DAA members are focused now on addressing the impact of the coronavirus and COVID-19 on their organizations and constituents, and of course CMMI and CMS staff members are similarly focused and engaged. We read with great interest the recent guidance that CMS issued ("Participants in the Medicare Diabetes Prevention Program: CMS Flexibilities to Fight COVID-19"), which shows great concern for MDPP suppliers and beneficiaries due to the exceptional circumstances all are facing due to the fight against COVID-19. We commend CMS for now allowing current suppliers to use virtual technology for additional make-up sessions, or to deliver regular sessions, and for temporarily eliminating the once-per-lifetime benefit restriction, to allow MDPP beneficiaries, whose sessions were recently suspended, to either resume sessions or to start the program over.

As far as concerns related to COVID-19 create an impact on current suppliers of MDPP, the DAA urges CMMI to consider the need for relief, forgiveness or waivers of some type for suppliers that cannot serve their MDPP populations because of the impact of the coronavirus. We understand that the CDC has issued guidance on these issues and is now working with CMS staff members on how to address them. One special concern we have is

that the CDC guidance made no provision for suppliers that started programs on March 1, 2020, or shortly thereafter. The DAA requests that CMS provide relief, forgiveness, or waivers for these suppliers as well.

Also, the DAA hopes that virtual delivery of MDPP sessions during this public health emergency (PHE) will demonstrate the value of virtual and add support for allowing virtual program suppliers to become MDPP suppliers once this PHE is over. Also, as mentioned previously, the DAA supports, in general, elimination of the once-per-lifetime restriction for MDPP beneficiaries, but especially now, given the COVID-19 pandemic. We are hopeful that CMS will also reconsider the once-per-lifetime restriction allowing beneficiaries additional opportunities to participate in and benefit from MDPP.

Questions from the DAA Moving Forward

As part of DAA member preparations for our March 12, 2020 conference call meeting, we had prepared a number of questions for CMMI. We had the opportunity to address a few of these questions during the meeting, but we also promised to give you a list of our questions in follow-up.

- **Does CMMI share the DAA's concern that some changes are needed quickly in order to address low beneficiary uptake of the MDPP benefit and improve the chances for success of the expanded model 5-year test period?**

- **The original model was a one-year program, so why is the Expanded Model based on a two-year program?**

- **Help us understand why you feel you don't have regulatory authority to add virtual?**
    - **What steps are you taking to address virtual?**
    - **Will CMMI reply to the Senate letter?**

- **From CMMI's perspective, what do you believe can be accomplished via the regulatory process and how we can move forward with this process?**

Conclusion

We thank you for being open to our many recommendations and suggestions. We share your belief in the value of the MDPP and we want to work with you on continuous improvement of the MDPP expanded model. We look forward to our next conversation, and we wish you all the best in this very trying time for our nation.

Sincerely,

Academy of Nutrition and Dietetics

Association for Diabetes Care and Education Specialists

American Diabetes Association

American Medical Association

Diabetes Patient Advocacy Coalition

Endocrine Society

National Council on Aging

Novo Nordisk Inc.

Omada Health

WW (formerly Weight Watchers)

Y-USA

Appendix A

Estimated Payment Breakdown

DPP Services	MDPP Final		
Attendance Reimbursement	Wo/5% WL	w/5% WL	w/9% WL
Weeks 1-24 (6 mos.) ***Min 16 sessions to be provided***			
Session 1	$26	$26	$26
Sessions 2-4 (3+ sessions)	$52	$52	$52
Sessions 5-9 (5+sessions)	$94	$94	$94
Weeks 25-52 ***Min 6 sessions to be offered***			
Mos 7-9, 2 sessions attended	$15	$63	$63
Mos 10-12, 2 sessions attended	$15	$63	$63
Max Reimbursement for Attendance ***Min. 22 sessions to be provided***	$202	$298	$298
Outcome Milestone Payments:			
5% Weight Loss	NA	$168	$168
9% Weight Loss	NA	NA	$26
TOTAL PAYMENT w/12 mos service	$202	$466	$492
Maintenance: MDPP Services (Offer Monthly Sessions)			
Attend 2 sessions over 3 mos Mos. 13-24 (bill 4x max)	NA	$52 mos13-18 $53 mos19-24 ($210MAX)	$52 mos13-18

			$53 mos19-24 ($210MAX)
Total Max Payment (TWO YEARS SERVICE)	$202	$676	$702
MIN SESSIONS – MUST PROVIDE	22 Over 12 mos.	34 Over 24 mos.	34 Over 24 mos.

One year of service w/5% WL: $466
One year of service wo/5% WL: $202
One year of service w/9% WL: $492

At Average Performance*: $294 per person
35% enrollees* achieve 5%WL and attends all sessions (($466*0.35)+($202*.65))= $294

At Above Average Performance: $334 per person
50% enrollees achieve 5%WL and attend all sessions ($466+ $202)/2 = $334