BY ELECTRONIC DELIVERY

Eric Hargan
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20301

October 27, 2017

RE: Draft HHS Strategic Plan FY2018 – 2022

Dear Acting Secretary Wright:

The Diabetes Advocacy Alliance (DAA) appreciates the opportunity to provide comments on the Department of Health and Human Services (HHS) draft Strategic Plan FY 2018 – 2022. 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.

Over 30 million Americans have diabetes and an additional 84 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 12 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. Medicare currently spends one out of every three dollars on care for people with diabetes.[1]

The DAA appreciates HHS' strong commitment to diabetes including prevention of the disease which is apparent throughout the Strategic Plan. The DAA provides the following comments on the HHS draft Strategic Plan:

Diabetes Screening
Multiple HHS objectives and strategies address the need to improve and incentivize value-based care and preventive health services such as screening including Objective 2.2 which seeks to "prevent, treat, and control communicable diseases and chronic conditions." The DAA supports HHS' strategy to improve early detection and treatment of those with, or at risk for, a

[1] Centers for Medicare and Medicaid Services. Medicare Health Support Overview. Baltimore, MD: CMS. Available at: http://www.cms.gov/ccip.downloads/overview_ketchum_70116.pdf

range of diseases including diabetes through widespread implementation of evidence-based interventions. The DAA encourages HHS to focus efforts on improving diabetes screening rates in both private and public health programs. This effort will help reduce the number of Americans with undiagnosed diabetes and prediabetes, allowing these individuals to seek treatment or enroll in diabetes prevention programs.

As previously mentioned, over 30 million Americans have diabetes. Unfortunately, 24% of people with diabetes – 7.2 million – are undiagnosed. In addition, only 11.6% of the 84 million Americans with prediabetes know they have it. Despite the fact that the U.S. Preventive Services Task Force (USPSTF) recommends screening adults aged 40 to 70 years who are overweight or obese for diabetes[2] and Medicare covers two diabetes screening tests a year for eligible beneficiaries, millions of Americans remain undiagnosed and are not receiving the care and treatment they need. Given the sheer number of people living with diabetes, or at risk of the disease, and the hundreds of billions of dollars spent on diabetes, the DAA recommends HHS focus efforts on promoting both the USPSTF diabetes screening guideline and existing Medicare coverage for diabetes screening.

Diabetes Prevention Program

The DAA supports multiple objectives and strategies in the draft Strategic Plan which seek to improve and promote evidence-based disease prevention. While the need to promote evidence-based disease prevention behaviors, activities, and services appears in Objective 1.1 of the plan, Objective 2.2 in the draft Strategic Plan addresses the need to prevent, treat, and control communicable diseases and chronic conditions. However, the strategies outlined by HHS in Objective 2.2 do not address the need to support prevention of chronic diseases. The human and economic toll of diabetes in the U.S. is devastating. Thus, the DAA recommends HHS add a focus on preventing chronic diseases like diabetes under Objective 2.2 which aligns with efforts currently underway at HHS.

As you are aware, the Centers for Medicare & Medicaid Services (CMS) is currently moving forward with an expanded model that will allow seniors at risk for diabetes to participate in an evidence-based diabetes prevention program (DPP). The DAA has been a longtime supporter of DPP, including providing Medicare beneficiaries with coverage and access to the intervention. Medicare coverage of DPP is set to go into effect in April 2018; however, coverage alone is not enough. HHS and CMS must commit to promoting DPP, both in-person and virtual modalities, with the help of external stakeholders, to drive utilization of the benefit. Because diabetes prevention is valuable not only to our nation's seniors, but also to the broader population, the DAA recommends HHS consider additional strategies to expand and promote coverage of DPP to individuals at risk of developing type 2 diabetes in private insurance.

[2] Sui AL, on behalf of the U.S. Preventive Services Task Force. Screening for abnormal blood glucose and type 2 diabetes mellitus: U.S. preventive services task force recommendation statement. Ann Intern Med 2015; 163(11):861-868.

Diabetes Self-Management Training

Again, multiple HHS strategies address the need to increase the use of primary and secondary preventive health services like diabetes self-management training (DSMT), including Objectives 1.1 and 2.2. The DAA supports HHS' strategy to expand participation by older adults and adults with disabilities in self-management education interventions like DSMT.

Diabetes is a complex disease that requires ongoing self-management by patients, including making numerous decisions throughout the day, as part of their management and treatment regimen. Diabetes self-management training (DSMT) is an evidence-based service that teaches people with diabetes how to effectively self-manage their diabetes and cope with the disease. The service, covered by Medicare Part B and most private health insurance plans, includes teaching the person with diabetes how to self-manage through healthy eating, physical activity, monitoring blood glucose levels and using the results for self-management decision making, adhering to medications, coping and problem solving with every day struggles to help reduce risks for diabetes complications.

The benefits of DSMT are undisputed. Studies have found that DSMT is associated with improved diabetes knowledge and self-care behaviors, lower hemoglobin A1c, lower self-reported weight, improved quality of life, healthy coping and reduced health care costs.[3] The Diabetes Self-Management Education and Support algorithm of care, recommended in a joint position statement of the American Diabetes Association, American Association of Diabetes Educators, and Academy of Nutrition and Dietetics, defines four critical points of time for Diabetes Self-Management Education and Support delivery: at diagnosis; annually for assessment of education, nutrition and emotional needs; when complicating factors arise that influence self-management; and when transition in care occur.[4] Unfortunately, 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 only five percent of Medicare beneficiaries with newly diagnosed diabetes used DSMT services.[5] According to another source, among fee-for-service Medicare beneficiaries age 65 and older with diagnosed diabetes, only 1.7% had a Medicare claim for DSMT in 2012.[6]

CMS 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 under-utilization of the

[3] American Diabetes Association. Standards of Medical Care in Diabetes – 2017. Diabetes Care 2017; 40 (Suppl.1): S34.
[4] 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.
[5] Strawbridge LM, Lloyd JT, Meadow A, et al. Use of Medicare's diabetes self-management training benefit. Health Education Behavior 2015;42:530-8.
[6] Statistic from Health Indicators Warehouse. Available at: https://www.healthindicators.gov/Indicators/Diabetesmanagement-benefit-use-diabetic-older-adults-percent_1263/Profile/ClassicData

benefit. The DAA has identified five barriers that impact Medicare beneficiaries' ability to access and utilize the DSMT benefit.

The DAA strongly supports HHS' intent to increase the use of secondary preventive health services like DSMT but addressing these known barriers is critical if HHS seeks to increase the use of DSMT in Medicare. We look forward to continuing to work with HHS and CMS to reduce barriers to access and utilization and educate Medicare beneficiaries about the benefits of DSMT.

High-quality and Affordable Insurance

Individuals with chronic diseases like diabetes depend on high-quality and affordable insurance to manage their conditions. Thus, it is critical that the Strategic Plan outline strategies to ensure coverage is available and accessible to people with chronic disease. While the Strategic Plan includes objectives to promote affordable health care and expand high-quality healthcare options, it is silent with regard to how these objectives and the strategies proposed intersect with the Affordable Care Act (ACA). People with diabetes, and those at-risk of developing diabetes, have benefited from reforms in the ACA so it is concerning to the DAA that the Strategic Plan does not address the Department's plan to implement the law. The DAA strongly urges HHS to provide clarity on how the ACA fits into the Strategic Plan and how HHS intends to implement the law within the Strategic Plan framework. The DAA further recommends that provisions and policies that have benefitted people with diabetes and prediabetes be maintained and incorporated into the Strategic Plan.

Health Disparities

Social, economic and environmental factors can influence a person's health. For people with diabetes, and those at-risk for developing the disease, efforts to address health disparities and social determinants of health have the potential to improve health outcomes. Racial and ethnic minorities are disproportionately impacted by diabetes; they have higher prevalence rates, worse diabetes control, and higher rates of serious and costly complications. Because of the significant diabetes disparities that exist, racial and ethnic minorities face worse health outcomes and quality of care.

The DAA is concerned the Strategic Plan does not provide the appropriate level of attention to health disparities, including no mention of how race and ethnicity impact disparities in healthcare or how to address racial and ethnic health disparities. DAA suggests HHS improve and increase efforts to address health disparities, including those that exist in diabetes, in the final Strategic Plan. While the draft plan mentions reducing disparities in quality and safety under Objective 1.2, the DAA suggests reducing health disparities should underpin virtually all HHS objectives and strategies. Additionally, DAA requests that HHS recognize the impact race and ethnicity play in healthcare disparities and develop strategies to address these factors.

National Clinical Care Commission Act

Finally, the DAA encourages the Department to implement the National Clinical Care Commission Act which was recently passed by Congress and is awaiting the President's

signature. The purpose of the legislation, to identify inefficiencies and gaps in federal government diabetes programs and provide recommendations to HHS and Congress, aligns with objectives in the Strategic Plan focused on promoting effective and efficient management and stewardship (Goal 5). The DAA has been a strong proponent of the legislation and looks forward to working with HHS to get it implemented.

***

Thank you the opportunity to provide comments on the draft HHS Strategic Plan 2018 – 2022 and for considering our comments. We look forward to continuing to engage with HHS to help advance the Strategic Plan. If you have any questions or need additional information, please free to contact one of the DAA Co-chairs: Karin Gillespie at kgil@novonordisk.com, Meghan Riley at mriley@diabetes.org or Dr. Henry Rodriguez at hrodrig1@health.usf.edu.

Sincerely,

Academy of Nutrition and Dietetics

American Association of Clinical Endocrinologists

American Association of Diabetes Educators

American Diabetes Association

American Medical Association

American Podiatric Medical Association

Endocrine Society

Healthcare Leadership Council

National Coalition on Aging

National Kidney Foundation

Novo Nordisk, Inc

Pediatric Endocrine Society

Weight Watchers International, Inc