May 10, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Verma:

We, the undersigned organizations, commend the Centers for Medicare & Medicaid Services (CMS) for expanding the Medicare Diabetes Prevention Program (MDPP) model on April 1, 2018. The expansion of the National Diabetes Prevention Program (National DPP) to eligible Medicare beneficiaries has the potential to completely transform the trajectory of a pervasive and costly chronic disease. CMS has taken an important step to empower beneficiaries at risk for type 2 diabetes to prevent or delay the disease's onset and reach their full health potential through this program. The MDPP provides an important avenue to bend an alarming cost curve in public health spending. Successful implementation of this benefit is a top priority for our organizations, and we are committed to working with CMS to ensure that eligible beneficiaries have access to qualified programs that suit their individual needs and drive better health outcomes.

To that end, we are writing to express our continued concern that virtual DPP providers (which include the programs delivered in any of the following modes permitted by the Centers for Disease Control and Prevention's (CDC) National Diabetes Recognition Standards - online, distance learning, and combination) recognized by the CDC are excluded from reimbursement under the expanded model. Nearly half of all Medicare beneficiaries – 23 million – have prediabetes and thus are eligible to participate in MDPP (after obtaining a qualifying blood test). Many of these beneficiaries live in rural or 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. 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 likely 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. In the final Medicare Physician Fee Schedule (MPFS) rule, CMS estimated enrollment in MDPP for the initial year between 65,000 and 110,000 Medicare beneficiaries with demand leveling to 50,000 participants per year moving forward. The CMS Actuary calculated an estimated savings of $182 million based on these projections, with greater enrollment directly correlated with higher savings. Lack of widespread access for eligible beneficiaries will not only result in less access for beneficiaries, but decreased cost savings for the Medicare program. The exclusion of qualified virtual programs will be felt most by Medicare's most vulnerable populations.

In the final MPFS rule, CMS stated the Secretary lacked 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.

Additionally, the data collected from the CDC National DPP now includes information on thousands of Medicare-age participants who have received the DPP from qualified virtual providers. Therefore, our 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 demonstrates comparable efficacy to that of the in-person DPP providers in the CDC database and is the same data source CMS relied upon when making a determination for expansion of the in-person program. Our organizations strongly support inclusion of virtual DPP in the expanded model. At a minimum, Medicare Advantage plans should have the flexibility to include virtual DPP to meet their obligations under the expanded model.

In-person MDPP suppliers do not have the capacity to serve millions of seniors; allowing virtual providers to participate in the expanded model will ensure Medicare beneficiaries have access to MDPP in the format of their choosing, regardless of where they live. If CMS feels it necessary to move forward with a separate virtual model test, we emphasize the need for it to happen quickly, and we urge the CMS Innovation Center to work closely with stakeholders to ensure a successful test and future implementation.

We look forward to continuing to engage with the agency on successful implementation of the MDPP expanded model. If you have any questions or need additional information, please free to contact Amy Wotring at awot@novonordisk.com.

Sincerely,

Academy of Nutrition and Dietetics

American Association of Diabetes Educators

American College of Preventive Medicine

American Diabetes Association

Better Medicare Alliance

Blue Mesa Health

Canary Health

Connected Health Initiative

Diabetes Patient Advocacy Coalition

Fruit Street

Healthcare Leadership Council

Healthletix Management, LLC

HealthSlate

Melsao USA, Inc.

Michigan Health Improvement Alliance, Inc. (MiHIA)

National Council on Aging

National Kidney Foundation

Newtopia, Inc.

Noom, Inc.

Novo Nordisk, Inc.

Omada Health

Retrofit

Senior Helpers

United Concierge Medicine

U.S. Preventive Medicine

Weight Watchers

YMCA of the USA