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Shalanda Young, MHA
Acting Director, Office of Management and Budge
725 17th Street, NW
Washington, DC 20503

RE: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government [OMB-2021-0005-0001]

Dear Ms. Young:

On behalf of the Diabetes Advocacy Alliance (DAA), thank you for the opportunity to provide comments on the Office of Management and Budget's (OMB) Request for Information (RFI): Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government.

The DAA is a coalition of 27 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 with legislators and policymakers to increase awareness of, and action on, the diabetes epidemic. The organizations that comprise the DAA share a common goal of elevating diabetes on the national agenda so we may ultimately defeat this potentially devastating chronic disease.

The organizations that comprise the DAA share a common goal of elevating diabetes on the national agenda so we may ultimately defeat this treatable, but also potentially devastating chronic disease. We are committed to advancing policies and legislation that can improve the health and well-being of people with diabetes and prediabetes, and to combatting health disparities and addressing social determinants of health. We do this by informing policymakers about strategies to prevent, detect and control diabetes and care for those affected by it. We also educate about how to address the drivers of health inequities, and the health equity implications of existing or new policies, regulations, and legislation.

Since 2012, the DAA has had a partnership with the Office of Disease Prevention and Health Promotion (ODPHP) and its Healthy People 2020, and now 2030, programs. Through this partnership, the DAA brings the perspective of public, patient, corporate, and advocacy organizations to ODPHP and provides insight to issues relevant to health equity as it affects people with prediabetes and diabetes.

DAA Mission and Values
The **vision** of the DAA is to influence change in the US health care system, improve diabetes prevention, detection, and care, and to speed the development of pathways to cures for diabetes treated in America. Our **mission** is to unite and align key diabetes stakeholders and the larger diabetes community around key diabetes-related policy and legislative efforts to elevate diabetes on the national agenda.

We have three principles that guide our work in policy and advocacy:

- Inform about the drivers of health inequities and their implications for new or existing policies, regulations, and legislation.
- Address the ongoing impact of the COVID-19 pandemic on people with prediabetes and diabetes.
- Protect federal investments in research and programs for prediabetes and diabetes.

The Enormous Size and Scope of Diabetes
According to the most recent statistical report from the CDC, 34.2 million people in the U.S. have diabetes, of whom 14.3 million are age 65 and older. Health disparities and health equity are of great concern with diabetes, with the prevalence of diagnosed diabetes being much higher among American Indians/Alaska Natives (14.7%), people of Hispanic origin (12.5%), non-Hispanic blacks (11.7%) and non-Hispanic Asians (9.2%), versus non-Hispanic whites (7.5%). There are an additional 88 million (34.5%) US adults who have prediabetes, of whom 24.2 million are age 65 and older. From a health disparities standpoint, it is encouraging that the percentages of adults with prediabetes are similar across racial and ethnic populations, although equity issues persist in terms of access to prevention, care and education, specifically, diabetes prevention programs and Diabetes Self-Management Training (DSMT).

Prediabetes, Diabetes, and Health Equity
To achieve health equity in diabetes, we must address health disparities and social determinants of health (SDOH) that are obstacles for people from marginalized and minority groups who have prediabetes and diabetes. The CDC defines health disparities as "preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities."[1]
According to Healthy People 2030, SDOH are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[2] Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Access to clean air and water
- Language and literacy skills

For many people with prediabetes and diabetes, these obstacles are hindering improved health outcomes that are achievable through evidence-based interventions such as the National Diabetes Prevention Program, Medicare Diabetes Prevention Program, Diabetes Self-Management Training programs, and Medical Nutrition Therapy.

DAA Comments: Area and Questions
DAA comments are most relevant to these questions from the RFI's **Area 5. Stakeholder and Community Engagement**. "Approaches and methods for accessible and meaningful agency engagement with underserved communities."

- What processes should agencies have in place to engage proactively with the underserved individuals and communities that will be most affected by agency programs, policies, rules, processes, or operations?
- How can agencies design and implement community engagement practices that are accessible to underserved communities?
- How might affected communities be engaged pro-actively and early to shape agency policy priorities and strategies?
- What are some of the barriers or factors that challenge underserved communities' interactions with Federal agencies and programs?

Examples of How Federal Agencies Could Better Respond to Healthy Equity Issues in Programs and Services for People with Prediabetes and Diabetes

Prediabetes and the Medicare Diabetes Prevention Program

DAA members have provided information to the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) on multiple occasions, to explain how its Medicare Diabetes Prevention Program (MDPP) is failing to serve marginalized populations with prediabetes. CMMI has provided opportunities to the DAA to express its concerns in this area, but CMMI has not acted upon the DAA's recommendations.

The DAA is concerned that CMMI has not provided targeted solutions for special populations affected by health equity and health disparities. There are disincentives for serving special populations, including individuals dually eligible for Medicare and Medicaid among other, inherent in the current reimbursement approach. These disincentives directly contribute to growing health disparities, especially among low-income participants in the MDPP. The DAA views this issue is an important to improve health equity and it requires creative solutions. MDPP payments could be 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 who the evidence has shown may be less likely to achieve the 5% weight loss threshold.

The DAA also has pointed out to CMMI the need for including virtual diabetes prevention programs in the MDPP. While the DAA has appreciated the CMS waivers that have allowed MDPP suppliers to offer virtual services to people with prediabetes who had begun in-person sessions pre-COVID pandemic, CMMI still prohibits fully virtual providers from program participation. Virtual programs could serve the needs of some marginalized rural and urban populations that do not currently have an in-person program available to them.

The Diabetes-Obesity Connection

We would also like to bring to your attention the fact that since the majority of adults with prediabetes and type 2 diabetes are people with overweight or obesity, we believe that access to the full continuum of care to treat obesity would be another important tool to reduce new cases of type 2 diabetes and to help adults sustain weight loss in the longer term. Even though clinical guidelines recommend treatment of obesity through intensive behavioral therapy (delivered by all modalities: community, online and telephonic), pharmacotherapy, and/or surgery, Medicare does not currently cover the full spectrum of interventions for obesity – interventions that are also important to curbing cases of prediabetes and type 2 diabetes. The COVID-19 pandemic has clearly shown and reinforced the urgent need to address diabetes and

obesity, as these two conditions have been shown to be major risk factors for hospitalizations and death from COVID-19.

Diabetes Self-Management Training and Medical Nutrition Therapy

According to the CMS Office of Minority Health (CMS), among Medicare Fee-for-Service beneficiaries, prevalence of diabetes among Black (37 percent) and Hispanic (38 percent) beneficiaries was higher than among their White counterparts (25 percent) in 2012. Beneficiaries from marginalized populations are more likely to receive lower quality care, have diabetes-related complications, such as end-stage renal disease, chronic kidney disease, and amputations. The DAA is working with Congress on legislation to address a number of urgent issues with the Medicare benefit for diabetes self-management training (DSMT) -- issues that the DAA has addressed with CMS many times over the years via meetings and letters. The COVID-19 pandemic, as well as the disproportionate impact of diabetes on marginalized or minoritized populations and communities, has underscored the urgent need to ensure that Medicare beneficiaries have the support they need to self-manage their diabetes. Despite the undisputed benefits of DSMT for people with diabetes, including lower hemoglobin A1c, weight loss, improved quality of life, healthy coping skills, as well as reduced health care costs for the beneficiary and the health system as whole, only an estimated 5% of Medicare beneficiaries with newly diagnosed diabetes utilize this Medicare benefit.[3,4,5] In past communications, the DAA has urged CMS to implement regulatory reforms to improve beneficiary access to this important benefit. These recommended reforms include allowing the initial 10 hours of DSMT to remain available until fully utilized, removing restrictions to allow DSMT and MNT services to be covered and reimbursed when provided on the same day, and exploring options to expand coverage to include web-based platforms. The DAA remains committed to working with OMB, HHS and CMS to improve utilization of the DSMT benefit.

Also, DAA members are also working with Congress to expand access to MNT for patients with prediabetes. Currently, Medicare covers MNT for people with diabetes but does not cover this service for individuals with prediabetes, reducing the options that Medicare beneficiaries have for improving their health. MNT for individuals with prediabetes has been shown in numerous studies to decrease fasting blood glucose, body weight, blood pressure, and waist circumference for patients who received the intervention for at least 3 months.[6,7,8] Increased frequency of MNT visits correlated with greater improvements in these metrics. A review of 66 programs by the Community Preventive Services Task Force found that programs that combined diet and physical activity counseling decreased diabetes incidence, and that the most intensive programs—primarily led by registered dietitian nutritionists in those studies—were the most effective at obtaining these outcomes.[9,10] The DAA encourages CMS to review the body of literature on the effectiveness of MNT for treating prediabetes.

Making Telehealth Services Permanent

As made evident by the work of the DAA in expanding MDPP and DSMT to include virtual providers, the DAA also requests that OMB work with CMS make permanent the temporary telehealth provisions made available during the public health emergency, and work with stakeholders in the diabetes community, including the DAA, to ensure these policies continue to serve the Medicare beneficiaries with diabetes and those at risk for type 2 diabetes, especially individuals from marginalized populations who may be utilizing telehealth services. Increased access to telehealth services can serve to address health disparities and broaden access to important services for more individuals. This includes continuing to allow DSMT and MNT

services to be furnished via telehealth by all providers who delivery those services and waiving in-person requirements for certain diabetes technologies. The DAA has been working with Congress and the Administration around these efforts and hopes to continue to engage with CMS around these important issues.

We would like to thank the Administration for its strong focus on equity and we look forward to working together to achieve this goal. Please be in touch if you would like addition information on any of our recommendations."

Sincerely,

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