August 12, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

On behalf of the 27 member organizations of the Diabetes Advocacy Alliance (DAA), we congratulate you on your new role as Administrator of the Centers for Medicare and Medicaid Services (CMS). Several of our members have worked on critical issues with you and look forward to doing so in your new capacity.

The DAA is diverse in scope, with our members representing patient, professional and trade associations, other non-profit organizations, and corporations, all united 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 DAA organizational members share a common goal of elevating diabetes on the national agenda so we may ultimately defeat this treatable, but also potentially deadly chronic disease. We are committed to advancing person-centered policies, practical models, and legislation that can improve the health and well-being of people with diabetes and prediabetes. An essential component to our goal is combatting health disparities and addressing social determinants of health. Our advocacy to policymakers highlights key strategies to prevent, detect and manage diabetes and care for those affected by it. Our educational outreach also illustrates the health equity implications of existing or new policies, regulations, and legislation, and provides alternatives to address the drivers of these inequities.

We are encouraged by your testimony and meetings with your colleagues since the Biden Administration has been in place. To highlight:

- In March 2021, the DAA met with Juliana Tiongson, Acting Director, Division of Healthcare Delivery, and Amanda Rhee, Medicare Diabetes Prevention Program (MDPP) Model Lead and other staff from the Center for Medicare and Medicaid Innovation (CMMI);
- On April 19, 2021, during your confirmation hearing, you pledged to Senator Warner to work to improve the number of MDPP suppliers;
- In May 2021, the DAA met with CMMI Director Liz Fowler and her key staff regarding our serious and time-sensitive concerns regarding the MDPP expanded model (see attached letters); and

- In June 2021, the DAA met with Nina Ashford, Deputy Director of the Program Alignment Group of the Medicare-Medicaid Coordination Office, and discussed urgent issues that are hindering the MDPP, diabetes self-management services, and medical nutrition therapy (MNT) services to beneficiaries who are dually eligible.

Comments Related to Our Review of the Recently Issued Calendar Year (CY) 2022 Physician Fee Schedule Proposed Rule

The DAA was very pleased to see that some, although not all, of the urgent issues discussed in previous correspondence and meetings are addressed in the CY 2022 Physician Fee Schedule (PFS) proposed rule that was issued on July 13, 2021. We also are pleased to see some important issues related to MNT addressed in the proposed rule.

The DAA strongly supports the proposal to shorten the MDPP services period to one year, which is in alignment with the CDC's National DPP curriculum and the original CMMI model. The DAA also strongly supports the proposal to increase the first-year payment amounts to suppliers, which is another change for which the DAA has long advocated. Finally, the DAA agrees with CMS that waiving the MDPP supplier application fee could help increase the number and range of suppliers that apply to become MDPP provider organizations and could help broaden the reach of the MDPP to serve more people affected by health inequity. The DAA will more fully address the MDPP section in submitted comments to the CY 2022 PFS proposed rule.

Additional Areas to Address in Medicare DPP

We remain concerned about other urgent issues related to the MDPP for the viability of the MDPP and to maximize the chances for success of the expanded model. The MDPP expanded model is one with the potential to achieve your triple aims of improved patient care, advances in health equity, and lowered patient costs – but MDPP cannot achieve those aims until some urgent issues are addressed. The DAA has prioritized these additional changes as most urgent for the viability of the MDPP program:

1) Eradicate disincentives embedded in the current model to serving lower income individuals;
2) Eliminate the high-risk designation in place for MDPP suppliers, which would increase MDPP supplier enrollment from community-based organizations that serve some of the most vulnerable populations; and
3) Permanently expand coverage of virtual DPP programs to Medicare and Medicaid to create more equitable access, dramatically increase uptake and expand program reach.

The DAA also urges CMS to align with the CDC's National DPP evidence and data for the tests and diagnostic ranges that can be used to identify prediabetes. Currently, there are different diagnostic ranges required to qualify for the National DPP and the Medicare DPP – a disconnect that creates confusion for program suppliers.

While we note these ongoing issues, we approach the new CMS leadership with renewed energy. We want to work with you to solve problems that have plagued government-sponsored prediabetes and diabetes programs for the benefit of millions of Medicare beneficiaries, and those dually eligible for Medicare and Medicaid. Specifically, we ask CMS to use its full authority to enact these recommended changes suggested by experts such as the DAA members.

We are especially concerned with how MDPP achieves health equity, which we know is a major objective for the Biden Administration. The MDPP Evaluation Report[1] data show the current program is

not reaching those most impacted by prediabetes and diabetes, most notably African-American, Latinx, Asian-American, and Native American populations. The MDPP is also not impacting large numbers of people as was intended.

We have attached to this letter previous relevant correspondence where we have laid out the problems and possible solutions related to the most urgent MDPP issues. We ask to work with you and your colleagues in CMS and CMMI to determine the best ways to remedy these most pressing barriers to services.

The Diabetes-Obesity Connection

Since the majority of adults with prediabetes and type 2 diabetes are people with overweight or obesity, access to the full continuum of care to treat obesity is another important tool to reduce new cases of type 2 diabetes and to help adults sustain weight loss in the longer term. 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. It has also demonstrated that different modalities can be effective in delivering therapy and treating medical conditions. The DAA would like to see coverage of the full continuum of care to treat obesity and is available to provide you with more information on this issue.

Diabetes Self-Management Training and Medical Nutrition Therapy

Despite the undisputed benefits of diabetes self-management training (DSMT) for people with diabetes, only an estimated 5% of Medicare beneficiaries with newly diagnosed diabetes utilize this Medicare benefit.[2, 3, 4] 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. In past communications, the DAA has urged CMS to implement regulatory reforms to improve beneficiary access to this important benefit. The DAA remains committed to working with HHS and CMS to improve utilization of the DSMT benefit.

DAA members are also working with Congress to expand access to medical nutrition therapy (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.[5, 6,7] 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.[8, 9] The DAA encourages CMS to review the body of literature on the effectiveness of MNT for treating prediabetes, and to cover MNT for Medicare beneficiaries diagnosed with prediabetes.

Making Telehealth Services Permanent for MDPP and DSMT

As made evident by DAA's advocacy to expand MDPP and DSMT to include virtual providers, the DAA also urges that CMS make permanent the telehealth provisions made available on a temporary basis during the COVID-19 public health emergency. This includes continuing DSMT and MNT services furnished via telehealth by all providers who deliver those services and waiving in-person requirements for certain diabetes technologies. Accessing services and appointments continues to be a challenge for those who have low incomes, live in rural communities, or have transportation challenges. However,

telehealth presents viable, secure, and cost-effective options for beneficiaries to receive MDPP or DSMT. The DAA encourages CMS to focus on the service, and not to become saddled with the modality.

Overall Improvement of Diabetes Prevention, Treatment and Care

We look forward to working with you to continue to improve the MDPP Expanded Model, DSMT, and MNT, as described above. But we remain most urgently concerned about the viability of the MDPP. The DAA will continue to advocate for additional changes that would help reach our shared goal: innovative programs for Medicare beneficiaries that prevent diabetes and stabilize health in a cost-effective, health equitable manner.

We would like to meet with you to discuss our issues and determine what can be done to meet our stated goals. We thank you for your interest in diabetes prevention and care. We wish you great success as you pursue your overarching priorities of expanding insurance coverage and ensuring health equity.

Sincerely,

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References:

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[2] Powers M.A., Bardsley J.K., Cypress M., et al. Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care and Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association. The Diabetes Educator June 2020. DOI: 10.1177/0145721720930959.

[3] Chrvala, C.A., Sherr, D, Lipman R.D. Diabetes self-management education for adults with type 2 diabetes mellitus: A systematic review of the effect on glycemic control. Patient Education and Counseling 99 (2016) 926–943.

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