White House Office of Science and Technology Policy
1600 Pennsylvania Avenue, N.W.
Washington, D.C.

RE: Connected Health Request for Information

ATTN: Stacy Murphy, Operations Manager
Submitted electronically to: connectedhealth@ostp.eop.gov

On behalf of the 28 member organizations of the Diabetes Advocacy Alliance (DAA), we are writing in response to the White House Office of Science and Technology Policy's (OSTP) request for information for "how digital health technologies are used, or could be used in the future, to transform community health, individual wellness, and health equity." The DAA commends the OSTP for its pursuit of a new initiative dedicated to Community Connected Health, and we agree with your assessment that there is great promise for "how innovation in science and technology can lower the barriers for all Americans to access quality healthcare and lead healthier lives by meeting people where they are in their communities."

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 and obesity are 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.

Category of Stakeholder

The RFI asks those who respond to state which category of stakeholder, listed in the "Instructions" section, best describes them. **While the DAA does not fit directly into any of the stakeholder types that the RFI lists in the "Instructions" section, many of our member organizations represent types that are mentioned, including:**

- Health care providers
- Community-based organizations
- State government
- Technology developers
- Individuals who have used, or are interested in using, digital health technologies or telehealth services

Digital Health Technologies and Diabetes Prevention, Treatment, and Care

For evidence-based recommendations related to how digital technologies can and should be used to improve diabetes prevention, treatment, and care, the DAA directs OSTP's attention to

the recently issued (January 2022) final report to Congress of the legislatively authorized National Clinical Care Commission (NCCC). The DAA supports the Commission's recommendations, which "address (1) diabetes prevention and control in the general population, (2) diabetes prevention in populations who are at high risk of developing type 2 diabetes, and (3) treatment of diabetes and its complications."

For **diabetes prevention**, the DAA supports the Commission recommendations for "improving access to, participation in, and sustainability of type 2 diabetes prevention interventions" including "providing adequate insurance coverage for all effective delivery modalities for diabetes prevention (that is, in-person, telehealth, and virtual)."

- Technology is being underused today for diabetes prevention among adults ages 65+ due to CMS exclusion of evidence-based fully virtual diabetes prevention programs from the CMS Innovation Center's Medicare Diabetes Prevention Program (MDPP) expanded model. The DAA has advocated strongly to CMS to include coverage in Medicare for fully virtual programs but to no avail, and hence is currently pursuing legislation (the PREVENT Act; H.R.2807, S.2173) to ensure such coverage.
- Adding evidence-based fully virtual diabetes prevention programs that have achieved recognition from the CDC's Diabetes Prevention Recognition Program (DPRP) would give Medicare beneficiaries the option to participate in diabetes prevention programs from their homes – especially individuals who live in rural and urban areas that are underserved by in-person prevention programs.

For **treatment and care for people with diabetes**, the DAA supports the Commission's recommendations for expanding access to virtual care because "diabetes prevalence is higher in rural and underserved communities than in urban areas."

- "People with diabetes living in rural and/or underserved communities have limited access to health care facilities and specialty care and often endure long and difficult commutes or lack the transportation needed to access guideline-recommended care.
- Travel and time constraints keep many individuals from receiving diabetes education services, adequate primary care, and specialty care.
- Additionally, Medicare beneficiaries using diabetes devices (for example, insulin pumps and continuous glucose monitors) are required to have regular interim medical visits to be approved for their ongoing use. The required in-person visits pose additional challenges to individuals with work or family demands or disabilities."

The DAA supports the Commission's recommendations that Congress support use of virtual care modalities in the following ways:

- "Remove geographic and originating site restrictions so that CMS can provide access to telehealth services as appropriate.
- Make permanent the ability for Federally Qualified Health Centers and Rural Health Centers to provide services by telehealth.
- Make permanent the telehealth waiver for Diabetes Self-management Education and Support (DSMES)/Diabetes Self-Management Training (DSMT); and

- Maintain coverage for audio-only visits to comply with the Executive Order on *Advancing Racial Equity and Support for Underserved Communities."*

Additionally, the Commission points out that "the biggest gap in diabetes treatment and preventing its complications is mismatch between available resources and the needs of persons living with diabetes."

- "At the patient level, the Commission recommends reducing barriers and streamlining administrative processes for receipt of diabetes self-management training and diabetes technologies and devices, expanding access to virtual care."
- "CMS eligibility requirements for diabetes technologies need to be updated to better reflect the patient population for whom these technologies are 'medically reasonable and necessary.' In-person follow-up visits should not be required to maintain eligibility for diabetes devices. Virtual care (for example, telephone or video visits) may be sufficient to accomplish the same monitoring goals."

Finally, since OSTP has requested information on successful models, the DAA points out one example of a federal program cited by the Commission that has shown great potential in helping deliver virtual care to a wide range of patients:

- **"The VA/DoD Virtual Medical Center (VA-VMC) Program,** developed jointly by the Department of Veterans Affairs and Department of Defense, is a virtual approach to diabetes self-management education and support (DSMES) that helps patients overcome travel and schedule barriers by providing access to real-time DSMES and peer support groups and a wealth of educational materials. This program became the first *nationally* certified DSMES program recognized by the American Diabetes Association. If used across federal agencies (for example, through collaborative agreements), this program can deliver virtual DSMES to patients who otherwise do not have access to DSMES services or have travel and time constraints."

In summary, the DAA appreciates the opportunity to provide comments and encourages OSTP to look to diabetes as an example of how digital health technologies are being used to improve primary prevention, treatment, and care for one of the most significant chronic illnesses facing America today.

Sincerely,

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