DAA Comments to the Task Force on Telehealth Policy
FINAL, as submitted
July 13, 2020 (4:00 PM EDST)

Comments submitted as instructed, online, in the box under this "Broader Policy Questions" question:

• *What have we learned during the pandemic that can be applied to policy on access, quality, safety, cost effectiveness, and outcomes?*

My name is Karin Gillespie and I am submitting these comments as a co-chair of the Diabetes Advocacy Alliance (DAA), a coalition of twenty-four 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 DAA advocates on behalf of people with diagnosed diabetes (type 1, type 2, gestational) and people at risk for type 2 diabetes with prediabetes. During the current coronavirus pandemic, we have learned that telehealth services have been crucial for meeting the continuing medical and diabetes self-management training (DSMT) needs of many people with diagnosed diabetes, and for providing continuing access to diabetes prevention programs for many individuals with prediabetes.

The DAA commends HHS Secretary Azar and CMS Director Verma for moving quickly in the early days of the U.S. pandemic to adjust and expand telehealth offerings in Medicare and Medicaid through issuance of waivers. These waivers have helped people with diabetes and those at risk to continue receiving care from the comfort and safety of their homes, which has been especially important since these individuals are at higher risk of serious complications from COVID-19. The DAA supports efforts of the Taskforce on Telehealth Policy (TTP) to make permanent CMS COVID-19 telehealth waivers post-Public Health Emergency (PHE) but also points out (see below) these waivers have not solved some important, ongoing issues for people with diabetes and prediabetes. The DAA urges the TTP to advocate for adequate compensation for telehealth services provided both during and post-PHE. Overall, the DAA urges the TTP to advocate for the normalization of telehealth services as vital, ongoing components of U.S. healthcare.

The DAA has three main points to share with the TTF: 1.) CMS waivers and private insurance policy changes that have made telehealth services available for people with diabetes and prediabetes more broadly available during the pandemic public health emergency (PHE) should be continued post-pandemic. However, the current CMS waivers do not solve some ongoing issues with DSMT and diabetes prevention programs, and these insufficiencies need to be addressed. 2.) The CMS definition of "telehealth" is too narrow to support the healthcare needs

of people with diabetes and prediabetes. The DAA views what is statutorily defined as "telehealth" as one component of the broader area of digital health care. 3.) The DAA recognizes two overarching equity policy issues that affect the ability of many patients with diabetes and prediabetes to access telehealth/e-health services – the lack of universal broadband availability in rural areas and in some urban areas as well, and for those individuals with primary internet access via Web-enable cell phones, the cost of minutes of use for telehealth appointments.

1. Advocating for Extending CMS Waivers – Good, But Not Good Enough

Regarding diabetes prevention: CMS waivers have allowed Medicare Diabetes Prevention Programs (MDPP) that began pre-PHE to switch to virtual group sessions for program completion. However, CMS is still requiring any new MDPP program that would start during the PHE to hold its first session in person, which has not been possible in most of the U.S. due to prohibitions of in-person educational gatherings. Even if MDPP programs were allowed by their states and counties to begin MDPP in-person programs again, many if not most Medicare beneficiaries would likely not wish to attend due to being at high risk of serious COVID-19 complications. The DAA requests the TTF advocate for making virtual MDPP programs an equal option to in-person programs for beneficiaries with prediabetes, both during and post-PHE.

Regarding diabetes care: During the COVID-19 public health emergency (PHE), diabetes health care providers have worked under expanded statutory and regulatory telehealth flexibilities to provide diabetes care to Medicare beneficiaries. These flexibilities have included the delivery of diabetes self-management training (DSMT), clinical diabetes management services, and services that support the use of diabetes technologies, such as continuous glucose monitoring (CGM) and insulin pumps. The telehealth flexibilities afforded during the PHE, including the ability for providers to deliver telehealth services to beneficiaries in their homes and the use of audio only communications, have helped ensure that many Medicare beneficiaries with diabetes and prediabetes receive essential support and care during this critical time. The DAA urges the TTP to advocate for making these flexibilities permanent to ensure that Medicare beneficiaries with diabetes have improved access to critical services via telehealth. (Individual members of the DAA, including Academy of Nutrition and Dietetics, American Medical Association, Association of Diabetes Education and Care Specialists, and Omada Health have separately submitted detailed comments to the TTF regarding making waiver extensions permanent, and identifying insufficiencies in these waivers that need addressing.)

2. Advocating for Expansion of What Is Considered as Telehealth

The DAA also views what is statutorily defined as "telehealth" as one component of the broader area of digital healthcare. This category can include a combination of synchronous telehealth visits, remote patient monitoring, or asynchronous interaction with a healthcare professional or licensed specialist via internet-based services. To date, this mode of digital care has been applied for virtual diabetes prevention programs (DPP), as well as diabetes self-management

training (DSMT). It has also been utilized for remote monitoring of patient blood glucose and blood pressure levels, and medication management.

The DAA urges the TTP to add a focus on digital care, including those care programs that utilize asynchronous program features to drive education, behavior change, and support for prevention or management of diabetes. Adding this type of care to the list of items for which the TTP advocates will both expand the impact of the group, and begin the process of making this care more accessible for the millions who could benefit from it.

For people at risk of diabetes with prediabetes, there are evidence-based diabetes prevention programs administered by the Centers for Disease Control and Prevention (CDC) with its National Diabetes Prevention Program (National DPP) and at the CMS with its Medicare Diabetes Prevention Program (MDPP). Currently, the CDC's National DPP recognizes both in-person and virtual diabetes prevention programs, while CMS's MDPP excludes recognized virtual providers from delivering needed services – even during the COVID-19 PHE.

While CMS has allowed MDPP programs that began pre-PHE to switch to virtual group sessions for program completion, CMS is still requiring any new MDPP program started during the PHE to hold its first session in person. This represents both an unnecessary barrier, and unneeded risk, for those Medicare beneficiaries in need of these services.

For people with diagnosed diabetes, CMS's telehealth expansion has been piecemeal regarding diabetes self-management training (DSMT). Beneficiaries can access DSMT benefits via telehealth, but only when provided by *some* health care providers in *some* practice settings. For example, any DSMT provider in an FQHC/RHC can provide DSMT via telehealth to patients in their homes. CMS has recently allowed clinical staff, like nurses and pharmacists, to provide DSMT in the hospital outpatient setting to the patient in their home; however, RNs and pharmacists are not on the list of eligible telehealth providers outside those practice settings, so a DSMT program lead by a pharmacist in a pharmacy setting would not be eligible. CMS also does not cover DSMT when provided asynchronously through a virtual DSMT program, even if the virtual program is accredited or recognized by one of the National Accrediting Organizations for DSMES.

3. Advocating for Broadband Access/Use and Affordability of Cell and Smartphone Minutes for Telehealth Appointments as Overarching Issues

The DAA urges the TTF to advocate for expanded broadband access and use in the U.S. According to a Pew Research Center study from 2019, 79% of urban adults but only 63% of rural adults are home broadband users, showing large gaps if telehealth services are to be universally accessible and used. However, an additional Pew Research Center study shows that legislators and policymakers that advocate for universal broadband coverage through federal funding might face opposition from constituents. According to a survey conducted by the Center's American Trends Panel in April 2020, "a majority of American adults (62%) do **not** think it is the federal government's responsibility to ensure that all Americans have a high-speed internet

connection at home during the COVID-19 outbreak." Also, only 53% of adults would describe the internet as "essential" for them personally during the pandemic.

Also, according to Pew Research Center data from June 2019, 96% of U.S. adults own a cell phone of any kind, with 81% owning a smartphone. However, for adults 65+, only 53% own a smartphone. For many cell and smartphone users, the DAA believes from anecdotal reports that the cost of minutes used to access telehealth services is unaffordable for those who might want to use do so. The DAA urges the TTP to explore this area and advocate for solutions that would address this barrier to use of telehealth services.