September 30, 2022

To: Ad Hoc Committee
National Academies of Sciences, Engineering, and Medicine

From: Hannah Martin, Academy of Nutrition and Dietetics, Co-Chair, Diabetes Advocacy Alliance
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Re: Comments on Federal Policies that Contribute to Racial and Ethnic Health Inequities, as Well as Potential Solutions that Could Improve Health Equity.

On behalf of the 29 member organizations of the Diabetes Advocacy Alliance (DAA), we are pleased to submit comments to the Ad Hoc Committee of the National Academies of Sciences, Engineering, and Medicine regarding federal policies that contribute to racial and ethnic health inequities, as well as potential solutions that could improve health equity.

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.

DAA 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.

The recent White House Conference on Hunger, Nutrition and Health, held on September 28, 2022, was designed to bring attention to ways to end hunger in America and increase healthy eating and physical activity by 2030 so fewer Americans experience diet-related diseases. The DAA supports the strategies the Biden-Harris Administration described in its National Strategy on Hunger, Nutrition, and Health, which address social determinants of health (SDOH) but also notes that we can't ignore or forget the millions of people living today with the chronic diseases of obesity and diabetes. While collectively we work to end hunger and increase physical activity, there are many actions that are needed now to improve the health and quality of life for people living with obesity, prediabetes, and diabetes.

Introduction: Prediabetes, Diabetes, and Obesity, and Social Determinants of Health and Health Inequities

Most descriptions of social determinants of health (SDOH) include five categories:[1]

- Socioeconomic status
- Neighborhood and physical environment
- Food environment
- Health care, including access to affordable, quality care
- Social cohesion and capital

In these comments, the DAA will focus on health care as part of SDOH, examining populations disproportionately affected by prediabetes, diabetes, and obesity, and identifying policy changes that could help address health disparities and inequities related to these conditions and diseases. We are including obesity because it is a significant factor in the development of prediabetes, and it is estimated that nearly 90% of individuals with type 2 diabetes have either overweight or obesity.[2]

In the final section of our comments, the DAA describes some recommendations in the final report of the Congressionally mandated National Clinical Care Commission (NCCC) that address other SDOH elements and diabetes. These recommendations include policy proscriptions from an independent commission that examined diabetes-related policies in all federal agencies, and we believe the Ad Hoc Committee could benefit from their perspective.

Prediabetes

According to the Centers for Disease Control and Prevention (CDC), 96 million adults ages 18 and older have prediabetes, representing 38% of all U.S. adults, with only one in five (19%) of these adults being aware of their condition. Of the 96 million adults with prediabetes, 26.4 million are adults ages 65 and older, representing 48.8% percent of all adults in this age category.[3]

Rates of prediabetes prevalence among all U.S. adults are statistically similar among racial/ethnic groups: White, non-Hispanic (35.7%); Black, non-Hispanic (38.6%); Asian, non-Hispanic (36.8%); and Hispanic (34.6%). However, significant differences are seen by educational level, with 34.6% of those adults having more than high school education having prediabetes, versus 41.9% of those with high school and 39.1% of those with less than high school education.[3]

The CDC cites a study that showed the annual risk of developing diabetes in those with prediabetes was 4.5% among adults aged 64 to 79[4], a rate which if applied to current estimates of prediabetes, suggests that about 1.2 million older adults annually could convert to diabetes without intervention, such as participation in the Centers for Medicare and Medicaid Services' (CMS) Medicare Diabetes Prevention Program (MDPP).

For adults under the age of 65, the CDC recognizes entities that deliver evidence-based diabetes prevention programs as part of the National Diabetes Prevention Program (National DPP). Expanding the reach of these programs is critical, as researchers have estimated that people "with an A1C value of ≥6.0% (above normal, but not yet in the range for diabetes) have a very high risk of developing clinically defined diabetes in the near future with 5-year risks ranging from 25 to 50%." The study authors also

note that people "with an A1C between 5.5 and 6.0% (below 5.7 is normal) also have a substantially increased risk of diabetes with 5-year incidences ranging from 9 to 25%."[5]

Inequities in Federal Health Care Policies and Solutions

The DAA has identified the following actions that CMS could take now that would have significant impact on increasing access to evidence-based diabetes prevention services offered by suppliers of National Diabetes Prevention Program (National DPP) and Medicare Diabetes Prevention Program (MDPP) programs. These actions would also reduce health inequities caused by lack of available programs in desired formats and in urban and rural areas and would permit more national and community-based program suppliers to enter the market to reach populations affected by health disparities.

Additional support for the DAA's points of view can be found in a policy paper released on September 28, 2022, by the White House, in advance of the start of its Conference on Hunger, Nutrition, and Health:[6]

- Pillar 2—Integrate Nutrition and Health: *Prioritize the role of nutrition and food security in overall health—including disease prevention and management—and ensure that our health care system addresses the nutrition needs of all people.*
    - *Provide greater access to nutrition services to better prevent, manage, and treat diet-related diseases.*
- This document states that "HHS CMS will develop a strategy to increase access to diabetes prevention and treatment services for individuals with Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Marketplace coverage. The Administration will also work with Congress to make the Medicare Diabetes Prevention Program a cost-effective permanent Medicare preventive service benefit."

DAA recommendations:

1. CMS should provide coverage for the A1c test without a deductible when used to screen for prediabetes. CMS lists "screening for diabetes" as a service that is high value and potentially underutilized in its list of underutilized services in the RFI within the CY 2023 Medicare PFS. In addition to NCCC support for this recommendation, the American Medical Association also supports coverage for the A1c test when used to screen for prediabetes as documented in their quality measure, "Screening for Abnormal Glucose." (The NCCC also recommends this action in its report to Congress: Recommendation 5.2 on p. 63)[7]

2. Congress should promote coverage for all proven-effective modes of delivery (for example, in-person, online, and distance learning [telehealth]) for evidence-based interventions that produce successful participant outcomes that meet or exceed those of the National DPP quality standards. For fully virtual diabetes prevention programs, DAA members believe that CMS has the authority under section 3021 of the Affordable Care Act (and as established by section 1115A of the Social Security Act) to expand the model test such that fully virtual programs that have met the CDCs National DPP standards can apply to become MDPP providers. But since CMS has not acted, DAA members continue to support passage of the **PREVENT DIABETES Act** (H.R. 2807, S. 2173), which would require CMS to modify the MDPP Expanded Model to allow fully virtual program that have met National DPP standards to apply.

CMS should also approve the MDPP as a permanent covered benefit – not only a model expansion service – and as noted above, coverage of MDPP should be expanded to include ALL CDC fully recognized National Diabetes Prevention Program providers, regardless of the delivery modality of care. Furthermore, the "once in a lifetime" limit on participation in the MDPP should be removed. (The NCCC also recommends these actions in its report to Congress: Recommendations 5.6 and 5.7 on pp. 66-67.)[7]

3. CMS should reduce or eliminate differences in program eligibility, delivery modalities, and duration between the National DPP and the Medicare Diabetes Prevention Program (MDPP). (The NCCC also recommends these actions in its report to Congress: Recommendation 5.8 p. 68.)[7]

4. CMS should provide funding to support the testing of new payment models that allow for greater upfront payments and more equitable risk-sharing between CMS and MDPP program delivery organizations. In addition, there should be an increase in payment levels to MDPP program delivery organizations to make MDPP financially stable. (The NCCC also recommends these actions in its report to Congress: Recommendation 5.9 p. 69.)[7]

5. DAA members remain very concerned about CMS requirements regarding submission of social security numbers and other personally identifiable information by volunteer board members of community-based nonprofit organizations, such as the YMCA of the USA, a DAA member, that apply for participation in the MDPP. CMS acknowledges that the MDPP benefit is underutilized yet has not addressed the concerns expressed by potential MDPP suppliers that are non-clinical, community-based nonprofit organizations.

Diagnosed Diabetes

According to the CDC, 37.3 million people in the U.S. have been diagnosed with diabetes, with adults representing 37.1 million. (3) Of the 37.1 million U.S. adults with diabetes, 28.5 million have been diagnosed with diabetes, while 8.6 million remain undiagnosed. (3) Among U.S. adult ages 65 and older, 15.9 million (29.2%) have diabetes, with 13.3 million diagnosed and 2.6 million undiagnosed.

Comparing prevalence for **total diabetes** by race and ethnicity, the CDC provides these estimates for the U.S. adult population, the percentages of which show disparities by race/ethnicity:[3]

- White, non-Hispanic: 22.2 million (13.6%)
- Black, non-Hispanic: 5.4 million (17.4%)
- Asian, non-Hispanic: 2.7 million (16.7%)
- Hispanic: 6.5 million (15.5%)

Comparing age-adjusted prevalence rates for **diagnosed diabetes** by race and ethnicity, the CDC provides these estimates for the U.S. adult population, showing disparities by race/ethnicity:[3]

- American Indians and Alaska Natives: 14.5%
- Black, non-Hispanic: 12.2%
- Hispanic: 11.8%
- Asian, non-Hispanic: 9.5%
- White, non-Hispanic: 7.4%

Similarly, racial/ethnic disparities are seen in comparisons of the percentage of adults with diabetes who are undiagnosed, with non-White U.S. adults more likely than White adults to be undiagnosed.[3]

Inequities in Federal Policies and Solutions: Diabetes Self-Management Training

CMS lists "diabetes self-management training" as a service that is high value and potentially underutilized in its list of underutilized services in the RFI within the CY 2023 Medicare PFS. To address this problem, CMS should update the 2000 Medicare Quality Standards that govern diabetes self-management training (DSMT) and establish a process for ongoing review, updating, and revision, with broad input from persons and parties affected by these standards. (The NCCC also recommends these actions in its report to Congress: Recommendation 6.1 on p.79.)[7]

The DAA and the NCCC recommend the following changes in CMS regulations related to DSMT to improve access and engage more people with diabetes:

1. Allow the initial 10 hours of DSMT to remain available beyond the first 12 months from diagnosis until fully utilized.
2. Allow for six additional hours (instead of two hours) of DSMT, if necessary.
3. Allow MNT and DSMT to be delivered on the same day.
4. Eliminate copays and deductibles (cost sharing) for DSMT.
5. Increase referrals for this service. Currently only the provider treating the person's diabetes can refer for this service. Allow more providers to refer for DSMT.
6. Allow community-based sites to provide DSMT.
7. Standardize the data collection required to simplify the process and ensure consistency across DSMT programs. CMS should ensure that all relevant partners including claims adjudicators follow a consistent approach throughout the audit and oversight processes to ensure better alignment with the purpose and scope of high-quality DSMT programs of all types and sizes.

To the extent that the above changes require Congressional action for statutory changes, CMS could communicate the need to stakeholders who can propose expeditious action by Congress to make these necessary changes, which are included in the Expanding Access to Diabetes Self-Management Training Act (S. 2203; H.R. 5804).

Inequities in Federal Policies and Solutions: Medical Nutrition Therapy

Minority populations have long faced chronic disease health disparities due to socioeconomic inequalities and reduced access to health care, healthy foods, and safe places to be active. These same groups are disproportionately impacted by COVID-19. The compounding impacts of systemic inequalities, food insecurity, reduced access to care and now COVID-19, underscore the need to provide equitable access to medical nutrition therapy in Medicare.

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.[8] 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, and to cover MNT for Medicare beneficiaries diagnosed with prediabetes.

Obesity and Disparities

According to the CDC and based on 2020 data, 31.9% of all U.S. adults have obesity, and 34.8% are classified as overweight. Among adults ages 65 and older, 29.3% have obesity and 38.4% have overweight.[11]

Looking at **obesity data** by race and ethnicity, CDC estimates show racial and ethnic disparities:

- White, non-Hispanic: 30.7%
- Black, non-Hispanic: 41.6%
- American Indian and Alaska Native: 38.8%
- Hawaiian and Pacific Islander: 38.5%
- Hispanic: 36.6%
- Asian: 11.8%

Looking at **overweight data** by race and ethnicity, CDC estimates show similarity of percentages by race and ethnicity:

- White, non-Hispanic: 35.4%
- Black, non-Hispanic: 32.6%
- American Indian and Alaska Native: 31.4%
- Hawaiian and Pacific Islander: 34.5%
- Hispanic: 35.7%
- Asian: 31.0%

There are clear disparities by education in CDC obesity data: Those adults with less than high school education have an obesity rate of 38.8%; high school graduates, a rate of 34.0%; and college graduates, a rate of 25.0%. A similar trend is seen in obesity data by income: The lower the income bracket, the higher the obesity rate.

Data from one study that examined racial and ethnic disparities in prediabetes and diabetes prevalence by BMI category showed that "racial and ethnic minorities had a higher burden of diabetes and prediabetes at lower BMI levels than Whites." The study's authors suggest that there may be factors in addition to weight that are involved in the risk for prediabetes and diabetes in racial and ethnic populations.[12]

The Obesity-Diabetes Connection

Nearly 9 of 10 (85.2%) adults with diagnosed diabetes are affected by overweight or obesity (with 54.8% having obesity)[13] and could benefit from weight loss that could help reduce not only their blood glucose levels, but also their blood pressure and cholesterol levels. Access to the full continuum of care to treat obesity is vital to reduce new cases of type 2 diabetes and to help most adults with type 2 diabetes lose weight or maintain a healthy weight in the long term. The full continuum includes intensive behavioral therapy, anti-obesity medications, surgery, and weight loss devices.

Inequities in Federal Policies and Solutions: Treatments for Obesity

Medicare covers intensive behavioral therapy provided by physicians, nurse practitioners, physician assistants, or clinical nurse specialists in clinical care settings. It also covers bariatric surgery for people

with severe obesity. For people with prediabetes, Medicare offers the Medicare Diabetes Prevention Program, but significant efforts are needed to build awareness, increase uptake, and reduce barriers to accessing this important program.

While there are FDA-approved medications for treating obesity (with medications approved in the past few years, or in the FDA approval process, showing increased efficacy[14,15]), Medicare does not cover any of these medications. One study that examined use of anti-obesity medications by adults ages 20 and older found that only 2.2% of adults who qualified for such medications were taking them, leading the study's authors to conclude that "this study documents that patients are not on guideline-directed weight loss therapy."[2]

DAA members believe that CMS should update its regulations to allow access to the full continuum of obesity care available to patients. Current CMS guidance does not permit coverage for drugs that treat obesity under Part D, on the grounds that such drugs are excluded under the Part D statute as agents "used for anorexia, weight loss, or weight gain." CMS has held this policy for almost two decades, and in the meantime our scientific understanding of obesity and how to treat it have evolved substantially. The DAA believes that the CMS Part D policy which currently denies coverage of anti-obesity medications has the unintended effect of creating and perpetuating an unnecessary gap in access to an important standard of care. The DAA urges CMS to change its current policy to allow the full continuum of obesity treatments to patients.

Medicare can improve coverage for the full spectrum of evidence-based treatments for obesity by:

- Following other federal programs like the Federal Employee Health Benefit (FEHB) plans and VA in specifying coverage of anti-obesity medications.
- Aligning the Medicare Diabetes Prevention Program (CMS) with the National Diabetes Prevention Program (CDC) and making necessary improvements to the program to increase the number of beneficiaries enrolled in the program.

National Clinical Care Commission Report Recommendations: SDOH

In 2018, the National Clinical Care Commission (NCCC), referenced earlier in these comments, began its work to examine U.S. federal government agency programs related to diabetes prevention and control, define current progress and gaps in these programs, assess opportunities for better inter-agency coordination and use of resources, and make recommendations to Congress for needed actions. The NCCC completed its work at the end of 2021 and its final report of recommendations was sent to Congress in January 2022.

According to the report, the NCCC's "approach to its charge recognized that diabetes in the U.S. is not simply a health condition that requires medical care but also is a societal problem that requires a trans-sectoral approach to prevention and treatment."[6] Accordingly, some of the NCCC's recommendations, which we have highlighted below, are concerned with "upstream" policies and activities to address SDOH.

These recommendations address elements of SDOH apart from direct health care and one-on-one prevention efforts, including socioeconomic status, neighborhood and physical environment, food environment, and social cohesion and capital. We believe the Ad Hoc Committee may find relevance for its work in these NCCC recommendations.

Recommendation 3.1 on p. 23: NCCC recommends the creation of the Office of National Diabetes Policy (ONDP) to develop and implement a national diabetes strategy that leverages and coordinates work across federal agencies and departments to positively change the social and environmental conditions that are promoting the type 2 diabetes epidemic. NCCC further recommends that the ONDP be established at a level above the U.S. Department of Health and Human Services (HHS) and be provided with funding to facilitate its effectiveness and accountability.[7]

Recommendation 3.2 on p.26: The National Clinical Care Commission recommends that federal policies and programs be designed to ensure that all people at risk for and with diabetes have access to comprehensive, high-quality, and affordable health care and that no one at risk for or with diabetes who needs health care cannot get it because of cost.[7]

Recommendation 3.3 on p.27: The National Clinical Care Commission recommends that achieving health equity be a component of all federal policies and programs that affect people at risk for or with diabetes. Specifically, the National Clinical Care Commission recommends:

- 3.3a. Federal agencies consider and evaluate the impact on health disparities of all new, all revised, and selected existing policies and programs that affect diabetes prevention, diabetes, and the complications of diabetes.
- 3.3b. Federal agencies ensure the collection and use of data to assess the impact of those policies and programs on health disparities and modify the policies and/or programs as needed to reduce health disparities.[7]

Recommendation 4.1 on p. 32: NCCC recommends that the USDA SNAP program be enhanced to both reduce food insecurity and improve nutrition sufficiency, both of which will help prevent type 2 diabetes and diabetes complications.[7]

Recommendation 4.2 on p.35: The National Clinical Care Commission recommends that USDA non-SNAP feeding programs be better leveraged to prevent type 2 diabetes in women, children, and adolescents by (1) enhancing Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); (2) further harnessing the National School Lunch and Breakfast Programs to improve dietary quality; and (3) expanding the Summer Nutrition Programs and the Fresh Fruit and Vegetable Program.[7]

Recommendation 4.3 on p. 37: The National Clinical Care Commission recommends that resources be provided to USDA to create an environmentally friendly and sustainable U.S. food system promoting the production, supply, and accessibility of foods such as “specialty crops” (fresh fruits, dried fruits, vegetables, tree nuts) that will attenuate the risk for type 2 diabetes and the complications of diabetes.[7]

Recommendation 4.4 on p. 40: NCCC recommends that all relevant federal agencies promote the consumption of water and reduce the consumption of sugar- sweetened beverages in the U.S. population.[7]

Recommendation 4.5 on p. 43: The National Clinical Care Commission recommends that the U.S. Food and Drug Administration (FDA) improve its food and beverage labeling regulations that influence both food and beverage industry practices and consumer behavior to better prevent and control diabetes.[7]

Recommendation 4.6 on p. 45: The National Clinical Care Commission recommends that the Federal Trade Commission—in order to prevent children’s exposure to, and consumption of, calorie-

dense and nutrient-poor foods and beverages that can lead to obesity and type 2 diabetes—be provided the authority, mandate, and requisite resources to (a) create guidelines and rules regarding the marketing and advertising practices of the food and beverage industry and associated communication networks and platforms targeted to children younger than 13 years old, (b) restrict industry practices based on these rules, (c) fully monitor these practices, and (d) enforce such rules.[7]

Recommendation 4.7 on p. 48: The National Clinical Care Commission recommends that federal agencies promote and support breastfeeding to (a) increase breastfeeding rates, (b) enhance the intensity and duration of breastfeeding among mothers who breastfeed, and (c) reduce disparities in breastfeeding rates, duration, and intensity. Additional funding should be provided for federal programs that promote and support breastfeeding to overcome persistent societal and employment-based obstacles to breastfeeding.[7]

Recommendation 4.8 on p. 51: The National Clinical Care Commission recommends that all federal agencies whose work influences the ambient (air, water, land, and chemical) and built environments modify their policies, practices, regulations, and funding decisions to lead to environmental changes to prevent and control diabetes.[7]

Recommendation 4.9 on p. 53: The National Clinical Care Commission recommends that, to reduce type 2 diabetes incidence and diabetes complications, housing opportunities for low-income individuals and families be expanded, and that such individuals and families be housed in health-promoting environments.[7]

Recommendation 4.10 on p. 56: The National Clinical Care Commission recommends federal investments in research that will yield discoveries that generate population-level benefits in the prevention and control of type 2 diabetes, with a particular focus on elucidating and changing the social and environmental conditions associated with greater risk of diabetes and its complications.[7]

Conclusion

The DAA greatly appreciates this opportunity to provide comments to the Ad Hoc Committee and we value the work that your committee has undertaken. We stand ready to provide more information if requested and would be available for consultation as it relates to any questions you may have. To contact the DAA, please connect with one of us at our email addresses, which appear below.

Sincerely,

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