April 16, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Secretary Becerra,

The members of the Diabetes Advocacy Alliance (DAA) congratulate you on your appointment as Secretary of the Department of Health and Human Services. We greatly appreciate that you have hit the ground running in support of COVID-19 relief and vaccinations. As you know, this pandemic has taken a disproportionate toll on people with diabetes and obesity, especially people from many racial and ethnic minority groups. We also are grateful that you continue to work to protect and expand the Affordable Care Act, which has been critical to the health and well-being of people with diabetes and prediabetes. In addition, we thank you for your past service as a co-leader of the Congressional Diabetes Caucus, where you were a champion for all people affected by diabetes.

We write to you today because we have grave concerns about the viability of the Medicare Diabetes Prevention Program (MDPP), and ongoing serious concerns with Medicare coverage of diabetes self-management training (DSMT). The DAA would like to work with your office and others at HHS to address these urgent issues and to advance diabetes prevention, detection, and care.

The DAA is diverse in scope, with its 27 members 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 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 also 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.

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 are a 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 DSMT.[1]

Medicare Diabetes Prevention Program

In a recent letter to Elizabeth Fowler, Director of the Center for Medicare and Medicaid Innovation (CMMI), the DAA described specific problems that threaten the existence of the MDPP – problems that the DAA believes can be fixed in this year's Medicare Physician Fee Schedule (MPFS). In 2016, the Secretary of HHS created the MDPP by expanding the CMS Diabetes Prevention Program model nationwide through the CY 2017 and 2018 MPFS proposed and final rules. The DAA is hopeful that many of the current barriers can also be addressed through MPFS rulemaking for CY 2022.

Addressing these barriers will help CMS address the health disparities embedded in our health system with a high-impact, health-improving, cost saving program. These MDPP barriers have a disproportionate impact on high-risk populations and further deepen health disparities:

- Misalignment with the science of the CDC National DPP (including requiring a second year of program delivery, a once per lifetime participation limit, and differing blood test measures)
- Lack of targeted support and solutions for special populations of beneficiaries at higher risk of developing type 2 diabetes and facing greater challenges achieving weight loss. The program currently creates a disincentive to serve these populations, or by serving them, suppliers risk maintaining their supplier status and CDC recognition.
- Exclusion of virtual-only DPP suppliers, which deprives beneficiaries of the option of accessing the MDPP in a format that best meets their needs, especially for those who are disabled or live in rural or other areas without access to MDPP in-person programs. In this regard, the DAA recommends that CMS use its authority to allow **all** CDC fully recognized DPPs (in-person, asynchronous, and synchronous/video) to become suppliers in the MDPP program for the remainder of the public health emergency (PHE) and permanently, and as soon as possible so that we can expand supply during the PHE.
- Reimbursement that does not cover reasonable costs and is not-aligned with the costs in the original pilot.
- Requirement that suppliers be in the "high-risk" category for a non-invasive wellness program with clear, measurable outcomes and cost-savings. This category entails unique barriers to supplier enrollment, participation, and retention (including requirement for Social Security numbers in Form CMS-20134, information requirement for coaches via Form CMS-20134, and other administrative burdens).

We are meeting with CMMI staff on April 20 and remain committed to finding solutions for these problems, which we believe could be solved through this year's rulemaking process.

Diabetes Self-Management Training (DSMT)

Likewise, with DSMT, the DAA has interacted with CMS many times over the years via meetings and letters to address urgent concerns facing DSMT. 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. The COVID-19 pandemic, as well as the disproportionate impact of diabetes on racial and ethnic minority groups, 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. These recommended reforms include allowing the initial 10 hours of DSMT to remain available until fully utilized, removing restrictions to allow

DSMT and Medical Nutrition Therapy (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 HHS and CMS to improve utilization of the DSMT benefit.

The Diabetes and Obesity Connection

The National DPP and the MDPP are evidence-based, proven interventions for prevention of diabetes that we should seek to strengthen. We also note that Medicare beneficiaries still lack access to other proven interventions for the prevention and management of diabetes. 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 Medicare beneficiaries manage type 2 diabetes. 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.

In conclusion, we recognize that you have an enormous challenge with the ongoing pandemic and helping to ensure that all people in our country get access to care. We would very much like to work with you to improve the MDPP this year, improve and continue to expand the National DPP, and improve access to obesity treatment for Medicare beneficiaries in order to ensure that we are using all of the tools at our disposal to prevent diabetes.

We would appreciate your kind consideration of our issues and would be pleased to meet and discuss our recommendations for moving forward. If you have any questions, please contact Hannah Martin, DAA co-chair (hmartin@eatright.org) or Kate Thomas, DAA co-chair (kthomas@adces.org).

Sincerely,

Academy of Nutrition and Dietetics
American Diabetes Association
American Medical Association
American Podiatric Medical Association
Association of Diabetes Care & Education Specialists
Black Women's Health Imperative
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Endocrine Society
Healthcare Leadership Council
National Council on Aging
National Kidney Foundation
Novo Nordisk Inc.
Omada Health
Pediatric Endocrine Society
Teladoc Health
WW (formerly Weight Watchers)
YMCA of the USA

[1] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Diabetes Statistics Report 2020. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed March 27, 2021.