Association of
Diabetes Care & Education
Specialists

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VIA ELECTRONIC SUBMISSION: http://www.regulations.gov

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

The Association of Diabetes Care & Education Specialists (ADCES) appreciates the opportunity to comment in response to the *Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments* (*CMS–1807–P*) as published in the *Federal Register* on July 31, 2024 (the "proposed rule").

ADCES is an interdisciplinary professional membership organization dedicated to improving prediabetes, diabetes, and cardiometabolic care through innovative education, management, and support. With more than 12,000 professional members including nurses, dietitians, pharmacists, and others, ADCES has a vast and diverse network of practitioners working to optimize care and reduce complications. ADCES supports an integrated care model that lowers the cost of care, improves experiences, and helps its members lead so better outcomes follow.

ADCES thanks the agency for the numerous steps taken in this rule to permanently secure or temporarily extend various policies related to telehealth. We also appreciate the updates made to the Medicare Diabetes Prevention Program. Below we provide comments related to items found within the following sections of the proposed rule:

- Section II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
- Section II.E. Valuation of Specific Codes
- Section II.J. Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services
- Section III.B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Section III.E. Medicare Diabetes Prevention Program (MDPP)
- Section IV. Updates to the Quality Payment Program

- Section VII. Regulatory Impact Analysis

Section II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

e. Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

ADCES supports the update to redefine interactive telecommunications systems to include two-way, real-time audio-only communications for any telehealth service furnished to a beneficiary in their home. ADCES appreciates CMS's recognition that, under four and a half years of temporary telehealth flexibilities allowing audio-only telehealth in many circumstances, that providers have demonstrated sound judgement in offering and conducting audio-video telehealth when needed and consented to and audio-only when that is the best option for the patient. ADCES supports the requirement that distant site providers continue to maintain the technical capability to offer audio-video telehealth but agree with the flexibility of allowing audio-only when the patient is not capable of, or does not consent to, the use of video technology.

f. Distant Site Requirements

ADCES thanks CMS for the extension through CY25 of the provision permitting distant site practitioners to use their currently enrolled practice locations instead of their home address when providing telehealth services from their home. ADCES echoes prior feedback about the safety risks and administrative burden posed by requiring distant site providers to bill from their home address if providing care from that location and implore CMS to adopt a permanent solution that fully protects the safety and privacy of practitioners who provide telehealth services from their home.

2.a.(1) Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025

ADCES supports CMS's proposal to temporarily extend through 2025 the definition of "direct supervision" to continue to consider the "immediate availability" requirement as being met when the physician or supervising provider is accessible via audio-video communication. And we encourage CMS to adopt rules in the future to make this modality of supervision permanent when clinically appropriate.

4. Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy when Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology

ADCES thanks CMS for the proposal put forth in the CY25 Outpatient Prospective Payment System to align coverage rules in that setting with the Physician Fee Schedule. As highlighted in our comments to that rule, this will provide consistency for providers and beneficiaries alike and will avoid the significant access issues that would have come to fruition if DSMT and MNT were no longer able to be billed for when provided via telehealth from the HOPD setting by institutional staff.

Section II.E. Valuation of Specific Codes

(30) Behavioral Counseling & Therapy

ADCES supports CMS's contention that G0447 (IBT for obesity) "may benefit from additional review to recognize the intensity of these services" because, as CMS states, this code and others "may be undervalued as their respective intensities may be lower than what is warranted for these services" and that the intensive "may be more in line with the intensity of HCPCS code G0443 which we noted had an increase in intensity as recommended by the RUC."

G0447 and the associated G0473 (group IBT for obesity) are highly underutilized codes, with fewer than 1% of Medicare beneficiaries with obesity receiving billable IBT each year.[1] Under a largely fee-for-service model, utilization of services is partially driven by the rate at which the associated codes are reimbursed for. CMS should consider revising the payment rate for G0447 to both reflect the intensity of the service and as a means to stimulate additional access to IBT for obesity.

CMS should also revise the National Coverage Determination for this benefit (NCD 210.12) to expand which providers can provide the service and in which settings to allow registered dietitians and other qualified providers to provide and bill for this service upon referral. CMS should also allow care to occur in out-patient settings other than the primary care setting, to include the Hospital Outpatient Department Setting and specialty offices.

(39) Payment for Caregiver Training Services
(A) Proposed Direct Care Caregiver Training Services
Caregivers are an essential part of diabetes management for people with diabetes of all ages and it is essential that they have access to training that may go beyond what is able to be provided during the limited time available for DSMT. In the pediatric population with type 1 diabetes in particular, the skills that parents and other caregivers need to learn can include how to use a blood glucose meter, administer insulin, administer glucagon, place and use a continuous glucose monitor, place and use an insulin pump, and how to use automated insulin delivery systems, including re-learning new devices and systems as medical science advances. These same skills may apply to caregivers of adults who cannot manage their diabetes independently due to cognitive or physical limitations.

ADCES supports the creation of the GCTB1 and GCBT2 caregiver training codes and respectfully requests that CMS add registered dietitians as qualified healthcare providers for these services or recognize RDNs as rendering providers for these services. ADCES also requests that RDNs billing on behalf of members of an accredited/recognized DSMT care team be able to bill for these caregiver training services when provided by other members of the DSMT care team just as they can when core DSMT services are performed by other members of the DSMT care team.

Section II.J. Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services

[1] Centers for Medicare and Medicaid Services. Obesity Disparities in Medicare Fee-For-Service Beneficiaries. Data Snap Shot 2022. https://www.cms.gov/files/document/omh-datasnapshot-obesity.pdf

ADCES thanks the agency for continuing to pursue the question of what dental services may be covered under Medicare Parts A and B. We appreciate that CMS is under significant statutory constraints that only allow the agency to cover dental services when they are a medically necessary component or precursor to other covered medical treatments. ADCES supports the agency's proposal to begin covering dental or oral examination prior to Medicare-covered dialysis services for ESRD and medically necessary diagnostic and treatment services to mitigate infection prior to Medicare-covered dialysis for ESRD.

Section III.B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

3. Telecommunication Services

As stated above, ADCES supports the proposal to maintain the virtual presence flexibility that allows physicians and other supervising practitioners to be available through audio-video as a means of satisfying the "immediately available" requirement for direct supervision, and we support the extension of this to the RHC and FQHC settings.

Section III.E. Medicare Diabetes Prevention Program (MDPP)

ADCES thanks the agency for its continued efforts to better align the requirements of the Medicare Diabetes Prevention Program (MDPP) with the standards of CDC's National Diabetes Prevention Recognition Program (DPRP).

Specifically, ADCES thanks CMS for aligning its definitions of delivery modalities with CDC's DPRP. In addition to covering MDPP when delivered via modalities 1-3 (in person, distance learning, and in person with a distance learning component), we echo the request of the Diabetes Advocacy Alliance (DAA) for CMS to also cover modalities 4-5 (online/fully virtual and combination with an online component) to increase beneficiary access to MDPP. ADCES also supports the allowance for same-day make-up sessions and again echoes the DAA's call for CMS to allow make-up sessions to occur via any modality.

We encourage CMS to further align MDPP with the National DPP in future years by including the full set of risk-reduction metrics used in National DPP: 1) weight loss in the range of 5-7% of baseline body weight; 2) a combination of a loss of 4% of baseline body weight and at least 8 sessions associated with an average of 150 minutes/week of physical activity; 3) a combination of a loss of 4% of baseline body weight and at least 17 sessions attended; or 4) a modest reduction in hemoglobin A1C (A1C) of 0.2%.[2]

ADCES further requests that CMS remove the one-in-a-lifetime limitation on the MDPP. Other counseling benefits such as Medicare's Intensive Behavioral Therapy for Obesity benefit have no

[2] Centers for Disease Control and Prevention. Diabetes Prevention Recognition Program: Standards and Operating Procedures. p.10. June 1, 2024. https://www.cdc.gov/diabetes-prevention/media/pdfs/legacy/dprp-standards.pdf. Accessed September 5, 2024.

such limitations. The Medical Nutrition Therapy benefit allows 2 hours in out-years with additional hours available based on a change in diagnosis/treatment plan, and the Diabetes Self-Management Training benefit allows 2 hours in out-years, though with no pathway for more. While these benefits are not all perfect in their availability to beneficiaries who need them, their access far exceeds that of MDPP.

Lastly, we echo our repeated call for CMS to make MDPP a permanent benefit within Medicare to give suppliers the long-term assurances that many need to invest in enrolling their National DPP with Medicare or to create a DPP program from scratch, as was recently made easier for DSMT programs to do.

Section IV. Updates to the Quality Payment Program

Proposed Quality Measure Changes

#001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):

ADCES supports the proposed changes to this quality measure. The inclusion of the glucose management indicator (GMI) in addition to HbA1c as an acceptable method for monitoring the glycemic status of patients with diabetes aligns with advancements in care and CMS's policy change in 2023 to allow more beneficiaries with diabetes to access continuous glucose monitors. ADCES also thanks CMS for updating the name of the measure to "Diabetes: Glycemic Status Assessment Greater Than 9%" as this is a positive step towards removing the stigmatizing language that pervades the diabetes and obesity care landscape.

Section VII. Regulatory Impact Analysis

ADCES appreciates the statutory constraints that require CMS to maintain budget neutrality when making regulatory changes through the Physician Fee Schedule rule. We do, however, encourage CMS to take a more equitable approach when seeking to apply cuts to payment rates for certain services when necessitated by increases within other areas of the rule. DSMT and MNT are relatively low-paid services that are often the sole codes being billed by the providers who bill them, meaning they do not have the ability to realign the mix of services they provide in favor of higher value codes to make up for losses in revenue from these services. Cuts to payment rates for these services threaten to cause providers/programs to exit the Medicare program (or to not join in the first place) or to stop offering these services altogether if the reimbursement rate no longer covers their costs. As the provider association for diabetes care and education specialists and one of the two accrediting agencies for DSMT, we routinely hear reports of DSMT programs closing due, in part, to insufficient reimbursement, which is a trend CMS should strongly consider how to help reverse.

Additional Recommendations Related to DSMT

While we thank CMS for the improvements in telehealth policy related to DSMT delivered from the hospital outpatient department setting found in the CY25 OPPS proposed rule and the improvements made to the benefit in the CY24 MPFS final rule, there are many additional aspects of the program that CMS could improve to bolster utilization. We seek to reiterate these needed changes, as submitted alongside our comments to the CY24 MPFS proposed rule. The key issues we recommend CMS address in the CY26 MPFS proposed rule include streamlining referral orders,

increasing flexibilities for group vs individual care determinations, increasing the availability and flexibility of hours, and simplifying aspects of the regulations governing program accreditation—all of which CMS already has the statutory authority to enact. A copy of our previously submitted list of recommendations is attached to our comment submission to this proposed rule in the Federal Register with the file name "DSMT Recommendations for CMS_230731."

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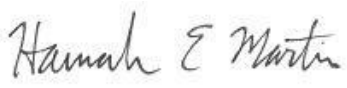
ADCES appreciates the opportunity to comment on this proposed rule. We hope to work with CMS to support the proposed policies contained within this rule as well as future policies to improve access to care for people with diabetes, prediabetes, obesity, and other cardiometabolic conditions. Please contact ADCES director of advocacy Hannah Martin at hmartin@adces.org should you have any questions regarding ADCES' comments.

Sincerely,

Matthew Hornberger, MBA, Chief Executive Officer



Hannah Martin, MPH, RDN, Director of Advocacy