January 26, 2016

The Honorable Orrin Hatch  The Honorable Ron Wyden
Chairman  Ranking Member
Committee on Finance  Committee on Finance
United States Senate  United States Senate

The Honorable Johnny Isakson  The Honorable Mark Warner
Senator  Senator
Committee on Finance  Committee on Finance
United States Senate  United States Senate

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Re: Bipartisan Chronic Care Working Group Policy Options Document

The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to submit comments on the Bipartisan Chronic Care Working Group Policy Options Document (the “Policy Options Document”) released in late December 2015. Representing more than 100,000 registered dietitian nutritionists (RDNs),1 dietetic technicians, registered (DTRs), and advanced-degree nutritionist researchers, the Academy is the largest association of food and nutrition professionals in the United States and is committed to improving the nation’s health through food and nutrition across the lifecycle. Every day we work with Americans in all walks of life—from birth through old age—providing professional services such as medical nutrition therapy (MNT)2 under Medicare Part B, some state Medicaid programs, and all major private payers.

The Academy looks forward to working with you and our various coalition partners in developing legislative solutions that decrease costs and improve health outcomes. In our previous comments (which are attached) to the Senate Finance Committee’s Chronic Care Working Group (the “Working Group”), we detailed the economic and physical costs of chronic disease in the United States, and how our health care system fails to fund preventive nutrition care services for these chronic conditions. Below, the Academy offers

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1 The Academy recently approved the optional use of the credential “registered dietitian nutritionist (RDN)” by “registered dietitians (RDs)” to more accurately convey who they are and what they do as the nation’s food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

2 Medical nutrition therapy (MNT) is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/ reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. Academy of Nutrition and Dietetics’ Definition of Terms list. Available at http://www.eatrightpro.org/resources/practice/quality-management/scope-of-practice. Accessed January 25, 2016. The term MNT is sometimes used interchangeably with, but is sometimes considered different from, nutrition counseling in health insurance plans.
concrete recommendations in response to the specific policy proposals suggested by the Working Group.

I. IMPROVING CARE MANAGEMENT FOR INDIVIDUALS WITH MULTIPLE CHRONIC CONDITIONS

A. Chronic Care Management Code

The workgroup is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. The Academy agrees that managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit and that clinicians should be able to be reimbursed for this important and labor-intensive cost. While we recognize the need to carefully define such codes to achieve the intended goal of improving quality of care provided to chronic care patients, the Academy does not believe a new code needs to be established. Rather, the Academy recommends adopting the existing CPT® codes for Complex Chronic Care Management Services (99487 and 99489). These codes were rigorously vetted by the CPT Editorial Panel and valued by the RUC, yet have not been adopted by CMS for payment under the Medicare Physician Fee Schedule. The Academy recommends these existing codes be adopted on a temporary basis while giving the Secretary of the Department of Health and Human Services authority to continue or discontinue the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors. Payment for chronic care management services is a new endeavor for CMS and we recognize the prudence of building in an evaluation mechanism to ensure such policy meets its intended goal.

The Academy recommends a wide variety of provider types be eligible to bill for chronic care management (CCM) services, both with the existing CCM CPT code (99490) as well as this new code. As the workgroup notes in its policy options document, patients with multiple chronic conditions typically receive care from an inter-professional team that may include social workers, dietitians, nurses and behavioral specialists in addition to primary and specialty physicians. These non-physician team members are critical to achieving successful patient and population health outcomes and controlling the progression of chronic and complex chronic disease. Thus, there needs to be a payment mechanism for these essential services that is not exclusively tied to the primary care provider.

Specifically, the Academy recommends that registered dietitian nutritionists (RDNs) be eligible to bill for chronic care management services. RDNs’ training and qualifications enable them to provide effective care management, particularly for patients with complex health needs. Data show that MNT provided by an RDN is linked to improved clinical outcomes and reduced costs related to physician time, medication use and hospital admissions for people with obesity, diabetes, and disorders of lipid metabolism, as well as other chronic diseases. The Academy recommends that registered dietitian nutritionists (RDNs) be eligible to bill for chronic care management services.

and to refer and facilitate access to appropriate health care and/or community-based resources (e.g., facilitating post-discharge nutrition care plans with post-acute care providers and community agencies such as Meals on Wheels). Such activities are time consuming but serve a necessary role in supporting patients’ self-management of their chronic conditions.

Finally, the Academy associates itself with the comments submitted by the Obesity Care Advocacy Network (OCAN) related to the high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. Specifically, we hope that the Working Group will address the fact that when policymakers at CMS proposed new Medicare payments for non-face-to-face chronic care management services beginning in 2015, obesity was left out of the discussion because it was not on Medicare’s list of chronic conditions eligible for this new enhanced payment, which are listed in the Medicare Chronic Conditions Chartbook. We hope that the working group will address this and other payment issues associated with obesity in its recommendations.

B. Include and Reimburse RDNs in Medicare Advantage Provider Networks

The Working Group is considering adjustments to provider networks that would include new providers to treat chronic conditions and prevent their progression. We recommend that RDNs should be included as providers in Medicare Advantage (MA) provider networks, including in Special Needs Plans, and allow them to be reimbursed for treating chronic conditions, including malnutrition as a symptom of and a cause of these chronic illnesses. In addition, the Working Group should consider including obesity as a major treatment area as part of the process by which chronic diseases would be identified and for which MA plans benefits would be tailored.

II. Telehealth

Policies regarding telehealth services under the current Medicare program are antiquated and do not adequately address the needs of Medicare patients, providers, and the Medicare program itself. The emergence and rapid growth of telehealth and mobile technologies designed to improve the health of individuals, enhance patient engagement, and lower costs should be recognized in new payment and delivery models as they offer new opportunities to increase access to care in urban, suburban, and rural areas. Time spent by all qualified health care professionals (both physician and non-physician providers) using such technologies for assessment, treatment, evaluation and monitoring functions needs to be recognized in the payment model.

We encourage the Working Group to help CMS expand its current policies related to telehealth services to go beyond their current restrictions to rural Health Professional

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Shortage Areas (HPSA) or counties outside of a Metropolitan Statistical Area (MSA), as many Medicare beneficiaries living in urban and suburban areas have limited mobility and transportation issues. Beneficiaries should be able to receive health care services amenable to telehealth technology in their homes, taking advantage of the wide range of emerging e-health technology. Home-based access to services becomes even more important with the population's desire to "age in place" as well as the recognition of the cost savings of keeping people at home rather than in expensive institutional settings when possible. The use of technology to help beneficiaries increase self-monitoring skills is an effective strategy to address policy categories 5, 6, and 7 as outlined in the letter.

Although RDNs are already approved telehealth providers under the limited traditional Medicare model, that is not presently the case for MA plans. The Academy encourages the Working Group to include RDN telehealth appointments as a regular benefit under MA plans.

Lastly, the Academy supports the proposal to expand access to home hemodialysis therapy by expanding Medicare’s qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area. The proposal, if drafted such that all clinicians included in the bundled payment for renal services are able to provide services to their patients, can save money and provide patients with greater flexibility and autonomy.

III. QUALITY MEASURES FOR CHRONIC CONDITIONS

As stated in the Policy Options Document, the Working Group is considering requiring that CMS include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease, as well as considering recommending that GAO conducts a report on community-level measures as they relate to chronic care management. Topic areas related to chronic conditions that the Working Group is specifically considering include community-level measures in areas such as obesity, diabetes and smoking prevalence. We enthusiastically support inclusion of the specified topic areas and additionally recommend that malnutrition be part of these community-level measures. When malnutrition is effectively measured, it can be effectively treated; further, it is important to know where the system is failing patients in this regard.

Although it is important to focus on outcomes, some process measures are needed, such as number of patients with one or more chronic diseases who receive nutrition care from a RDN. Nutrition and RDNs should be a required part of any care delivery model in any setting where Medicare beneficiaries receive services. The number of hours or visits per year should not artificially be limited; instead, providers should use evidence-based and expert-informed clinical practice guidelines to determine the frequency and dose of nutrition care, in collaboration with the patient. In short, the working group could effect tremendous positive change by recognizing the importance of nutrition in the prevention and treatment of chronic disease, continuing to collect data showing the benefits of RDN-provided care, and paying only for what has been shown to be effective.
The importance of healthcare quality measurement to improve outcomes is clear. However, there are very few quality measures presently established to drive optimal outcomes for people with obesity. In recognition of these gaps, a diverse group of stakeholders from obesity, diabetes, and primary care organizations recently convened to discuss obesity quality measurement. The roundtable discussion focused on understanding the evolving quality landscape, particularly how quality measures are developed, used and integrated into private and public reporting programs. In addition, participants evaluated what current measures exist surrounding obesity and how they are being used, as well as the main opportunities for adaptation. Finally, the group discussed opportunities around measurement gaps and what efforts related to quality measurement should be prioritized.

Until appropriate quality measures for obesity care and management exist, health care providers treating people affected with obesity won’t be able to measure and improve health outcomes. We urge the Senate Finance Committee to continue to think about potential ways to ensure that adequate quality measures exist for all chronic conditions and we look forward to working with our coalition partners, other stakeholders, and the Working Group on such proposals.

IV. Enhance Access to Effective Medical Nutrition Therapy (MNT)

The single most transformative policy to improve outcomes with patients living with four of the top six leading causes of death is cost-effective nutrition and diet counseling and interventions provided by RDNs. Thus, any meaningful reform must include services that demonstrably improve the nutritional status of Americans and reduce the rates of obesity, cardiovascular disease, renal disease, hypertension, diabetes, HIV, forms of cancer, celiac disease, stroke, and other medical conditions. As detailed in the MNT Effectiveness Project published in the Academy’s Evidence Analysis Library, MNT and other evidence-based nutrition services, from pre-conception through end-of-life, are an essential component of comprehensive health care, whether provided as frontline therapy to prevent disease, delay disease progression, or as an intervention in chronic care management.5

Virtually all prevalent chronic illnesses have a nutrition component, yet there remain huge gaps in the way our health care system addresses the important role of nutrition in preventing and treating such diseases — particularly in the Medicare program. Under current law, Medicare only covers outpatient medical nutrition therapy services provided by RDNs for beneficiaries with diabetes, chronic renal insufficiency/non-end-stage renal

5 Grade 1 data. Academy Evidence Analysis Library. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, “Good evidence is defined as: ‘The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power.”].
disease (non-dialysis) or post kidney transplant. The current Medicare program offers too little nutrition care too late and does not incentivize the use of other members of the health care team with specific expertise in areas such as nutrition counseling (i.e., RDNs).

RDNs’ evidence-based national practice guidelines and Evidence Analysis Library are leading, respected tools for effecting positive health outcomes. The Academy urges the working group to support a legislative solution to ensure coverage of cost-effective MNT provided by RDNs for all nutrition-related chronic diseases, including hypertension, obesity, cancer, and prediabetes, consistent with USPSTF recommendations and national clinical guidelines.

A. Include MNT as an Evidence-Based Intervention to Treat Obesity

We very much appreciate the hard work that went into producing this Policy Options Document and were encouraged that the Working Group included consideration of the impact that U.S. obesity rates have on the prevalence of chronic conditions. Numerous healthcare professional and patient organizations recognize that obesity is a chronic medical condition that is associated with, or a precursor to, more than 90 other chronic medical conditions including cardiovascular disease, diabetes, and cancer.

As you know, obesity rates in America have reached epic proportions. Today, more than one in three U.S. adults have obesity and more than 40 percent of adults between the ages of 65 to 74 have obesity, costing American taxpayers hundreds of billions of dollars every year. The annual medical costs for an individual with obesity are $2,741 higher than medical costs for a patient of normal weight. This results in over $300 billion in direct healthcare spending attributable to obesity every year, including $55 billion paid by Medicare treating beneficiaries with obesity. Clearly, this is a problem we can no longer afford to ignore.

The Academy urges CMS to enhance beneficiary access to RDN-provided treatments for obesity, including MNT and intensive behavioral therapy (IBT) for obesity, which will result in decreased healthcare costs and lower obesity rates among older adults.

B. Include MNT as an Evidence-Based Intervention to Prevent Diabetes

As stated in the Policy Options Document, the Working Group “is considering recommending that Medicare Part B provide payment for evidence-based lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes.” The Academy urges the Working Group to include medical nutrition therapy (MNT) provided by registered dietitian nutritionists (RDNs) as an evidence-based lifestyle intervention to prevent or delay the development of diabetes for people with prediabetes. A growing evidence-base shows that MNT provided by RDNs for prediabetes has been shown to cost-effectively prevent onset of Type 2 diabetes. The Lewin Group documented a 9.5 percent reduction

6 Id.

in hospital utilization and a 23.5 percent reduction in physician visits when MNT was provided to persons with diabetes mellitus. A well-designed randomized controlled clinical research trial published last year by Parker, et al showed that individualized MNT provided by RDNs resulted in weight loss and improved blood glucose which are key outcomes for diabetes prevention programs. A 2015 Journal of the Academy of Nutrition and Dietetics study found that participants enrolled in a 16-week group lifestyle intervention had significant long-term weight loss (continuing after the program) if they were able to achieve that weight loss by week five. This study also found that it is critical to have the option of an individualized program, such as MNT, as well as a group approach, since patients will respond based on their individual needs. Furthermore, MNT is not only beneficial for the patient, but is also cost-effective and cost-saving according to a 2012 JAND study, which found that MNT is more cost effective and more individualized than other intensive lifestyle intervention programs.

The American Association of Clinical Endocrinologists/American College of Endocrinology recently issued Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan published in Endocrine Practice April 2015, concluding:

Medical nutrition therapy (MNT) is recommended for all people with prediabetes and diabetes. MNT must be individualized, generally via evaluation and teaching by a trained nutritionist or registered dietitian or a physician knowledgeable in nutrition.

The United States Preventive Services Task Force (USPSTF) recently issued a final recommendation on screening for type 2 diabetes, which concluded that, “Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.”

The American Diabetes Association’s 2016 Standards of Care also stated that, “MNT is an integral component of

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diabetes prevention, management and self-management education.”

Medicare currently covers MNT provided by RDNs and other qualified health professionals for beneficiaries with diabetes and end-stage renal disease. **To prevent the onset of diabetes and the extraordinary costs associated with the disease, the Working Group should include coverage of MNT for patients with prediabetes, rather than simply waiting for their status to worsen to diabetes before they receive the care they need.**

The Working Group is also soliciting feedback on whether there is evidence to support coverage of services analogous to diabetes self-management training (DSMT) for beneficiaries who are at risk of complications from other chronic conditions. **We agree with this recommendation and urge the Working Group to strongly consider obesity not only as a primary chronic disease state under this policy option, but as a risk factor for diabetes and other diseases.** We also support the idea of patients with malnutrition and at risk of malnutrition being allowed to access services analogous to DSMT.

CMS has already noted that DSMT and MNT are unique and complementary services that each independently provide benefits to Medicare beneficiaries. The Academy therefore urges the Working Group to make available to Medicare Part B beneficiaries at risk of complications from a wide variety of chronic diseases both MNT and services analogous to DSMT.

**C. Include MNT as an Evidence-Based Intervention to Treat CVD**

When the Centers for Medicare and Medicaid Services (CMS) in 2011 decided to initiate coverage for the new preventive service of Intensive Behavioral Therapy for cardiovascular disease (CVD), the substance of the covered benefit was fundamentally different from the USPSTF recommendations. Not only did this new coverage fail to cover explicitly recommended referrals to the most qualified, effective, and cost-effective providers of this therapy — registered dietitian nutritionists — but the limit of just one covered 15 minute "face-to-face CVD risk reduction visit every two years" is wholly irreconcilable with the USPSTF’s recommendation for intensive behavioral dietary counseling. Moreover, CMS inexplicably limited provision of the intensive behavioral therapy (IBT) for CVD benefit to the primary care setting despite the USPSTF’s recommendation that patients be referred to RDNs or other qualified providers, limiting patients access to RDNs, who frequently provide care in non-primary care settings throughout the medical neighborhood.

**We urge the Working Group to ensure that CMS’s coverage in Medicare does not substantially redefine the USPSTF’s recommendations so as to compromise their benefits**, given that Congress has declared USPSTF’s recommendations mandated coverage across the country.

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D. Permit MNT and DSMT Services on the Same Day

The Social Security Act provides, in part, that the determination of the provision of Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services is deferred to the discretion of the Secretary. In a 2002 national coverage determination, CMS indicated that MNT and DSMT cannot be provided on the same date of service. Senator Mark Kirk’s attached letter identifies problems with the burdensome, costly regulation and its negative impact on patient care:

This current regulation burdens quality and access to care and creates undue hardships for persons with diabetes, especially those for disparate populations. Many beneficiaries forego necessary DSMT and MNT care because they cannot schedule services on the same day. A regulatory change would allow beneficiaries to consolidate often-difficult and increasingly expensive trips to ambulatory care settings to receive care.

CMS has cited the dual positive impact of both DSMT and MNT Medicare services for qualifying individuals with diabetes, and has acknowledged data indicating that, “provision of both Medicare benefits may be more medically effective for some beneficiaries than receipt of just one of the benefits.” MNT and DSMT are distinct from each other, but are both necessary for improved beneficiary health outcomes. Further, same day provision allows for more effective multidisciplinary care.

The MNT and DSMT benefits act synergistically to improve beneficiaries’ quality of care, allowing for individualized and general nutrition planning and blood glucose monitoring by qualified non-physician providers such as registered dietitians. The current regulation limiting same day DSMT/MNT services creates burdensome impediments to quality patient-centered care and increases health care costs at both the individual and systems level. If the 2002 coverage determination were reformed to allow for the provision of same day service for DSMT and MNT in this circumstance, a beneficiary would be more likely to receive ample disease management and education. Associated diabetes education and disease management by non-physician providers saves money and decreases healthcare utilization. Compared to no prevention, self-management reduces a high-risk person’s

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15 42 U.S.C. 1395x(s)(2)(V)(i). “Medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who - (i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary . . .”


30-year chances of getting diabetes by about 11%, the chances of a serious complication by 8% and the chances of dying of a complication of diabetes by 2.3%.\textsuperscript{19} With the flexibility of having both services available on the same day, the likelihood of beneficiaries maintaining their appointments will increase. Preventive self-management, combined with reduced numbers of no-shows and lost days from work and school will result in significant cost savings to the health care system. We thus encourage the Working Group to specifically permit the same-day provision of these differently valuable, synergistic services.

V. EXPAND COVERAGE OF THE NATIONAL DIABETES PREVENTION PROGRAM (NDPP)

The Policy Options Document states the Working Group “is considering recommending that Medicare Part B provide payment for evidence-based lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes.” The Academy, in conjunction with our partners in the Diabetes Advocacy Alliance (DAA), is very pleased to see this policy under consideration. The DAA’s comments submitted to the Working Group in June 2015 shared the importance of preventing or delaying type 2 diabetes among people in Medicare to avoid and/or mitigate the human and economic toll of diabetes. Specifically, the DAA recommended the Working Group support Medicare coverage for the National Diabetes Prevention Program (NDPP), which is an evidence-based lifestyle intervention, for Medicare beneficiaries with prediabetes. We note a recent study by Avalere Health found this policy could reduce federal spending by $1.3 billion over 10 years.\textsuperscript{6} This amount reflects a combination of an estimated $7.7 billion in new spending on the diabetes prevention program offset by an estimated $9.1 billion in savings. Savings from preventing diabetes would likely continue to increase beyond 10 years, suggesting even greater impact on longer-term federal spending.\textsuperscript{6}

In response to the Working Group’s request for feedback on whether to allow a diabetes prevention program to be delivered by entities that are currently not reimbursable providers under the Medicare statute, the Academy strongly urges the Working Group to enable entities to deliver the National DPP when the entity’s program is led or developed by a qualified Medicare provider, such as an RDN, and meets the standards of the Centers for Disease Control and Prevention (CDC) for eligible providers. This requirement comports with state licensure laws limiting the provision of such services by unlicensed practitioners unless “the program has been reviewed by, consultation is available from, and no program change can be initiated without prior approval by a licensed dietitian/nutritionist, a dietitian or nutritionist licensed in another state that has licensure requirements considered by the council to be at least as stringent as the requirements for licensure under this part, or a registered dietitian.”\textsuperscript{20} We note that

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\textsuperscript{19} Ibid.
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aligning the Social Security Act’s definition of “registered dietitian or nutrition professional” largely mirrors that of “licensed dietitian nutritionist” across the country.\textsuperscript{21}

The Working Group is also considering the specific requirements entities delivering evidence-based lifestyle interventions like the National DPP must meet in order to be reimbursed in Medicare. The CDC’s National DPP has a set of standards\textsuperscript{22} in place that entities are required to meet in order to deliver the program and be recognized as an eligible provider of the National DPP. Prevention program providers are trained in delivering an intervention that is faithful to the one used in the original clinical trial, and the CDC encourages program providers to submit aggregate patient outcomes data before program recognition is officially granted. Currently, the CDC evaluates and then recognizes applicants that demonstrate clinical results, data reporting capability, and program delivery capability. Recognized National DPPs either follow the curriculum that was tested in the translational clinical trial or conduct a clinical trial to demonstrate that the alternative program curriculum leads to clinically significant outcomes. Including RDNs in the NDPP standards would deliver even more success. The Academy encourages the Working Group to require entities to meet the standards and achieve the outcomes set out by the CDC for the NDPP.

VI. STUDY ON OBESITY DRUGS

The Chronic Care Working Group is considering requiring a study to determine the use and impact of obesity drugs in the Medicare and non-Medicare populations. The study could: specifically detail the utilization of such drugs and any subsequent impact on medical services that are directly related to obesity, including by subpopulations determined by the extent of obesity; examine medical interventions for individuals not taking obesity drugs; and examine the experience of MA-PDs that cover obesity drugs as a supplemental benefit.

We agree that our country’s obesity epidemic is a serious issue. Today, more than one in three U.S. adults have obesity and more than 40 percent of adults between the ages of 65 to 74 have obesity, costing American taxpayers hundreds of billions of dollars every year. These sobering facts and the growing science surrounding obesity underscore the importance of developing a policy approach that facilitates patient access to the full continuum of care of evidence-based obesity preventive and treatment modalities including behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions. While the Work Group’s initial policy options paper recognizes this by its inclusion of a study to evaluate the utilization and impact of pharmaceutical therapies for individuals with obesity, we are concerned regarding how such a study would work given the lack of coverage for obesity drugs. We would encourage the Work Group to include aspects of the Treat and Reduce Obesity Act into the final legislative package. Securing Medicare Part D

\textsuperscript{21} 42 U.S.C. 1395x(vv)(2).
coverage for obesity drugs will spur greater patient access to this treatment avenue both inside and outside of the Medicare program.

We note that any study examining these issues should account for the fact that approved obesity drugs are used as an adjunct therapy to nutrition and behavioral therapy; thus, any studies should also look at the use and impact of drugs in conjunction with MNT and intensive behavioral therapy. Naturally, given the fact that obesity pharmacotherapy is used only with nutrition and behavioral therapies, Medicare coverage of pharmacotherapy should be concomitant with rational coverage of nutrition and behavioral therapy (i.e., providers and intensities that deliver the desired result, rather than coverage associated with the existing intensive behavioral therapy for obesity benefit).

Finally, we urge the Working Group to revisit the full comments submitted by the Academy on June 22, 2015 (also attached). These comments include additional recommendations provided by the Academy that were not included in the policy options document and cost effective and clinically effective evidence-based address policies that are crucial to improving health outcomes for people with diabetes.

**Conclusion**
The Academy sincerely appreciates the ongoing opportunity to offer comments to the Working Group on the policy proposals. Please contact either Jeanne Blankenship by telephone at 202-775-8277 ext. 1730 or by email at jblankenship@eatright.org or Pepin Tuma by telephone at 202-775-8277 ext. 6001 or by email at ptuma@eatright.org with any questions or requests for additional information.

Sincerely,

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