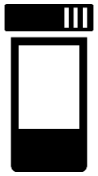
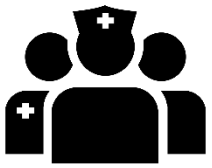
The diabetes care challenge: gaps in payment for screening

Medicare	Private Insurance	Medicaid & CHIP
Medicare Part B covers up to 2 diabetes screenings/year if the beneficiary is considered at risk by their doctor. •Medicare beneficiaries have limited awareness of the Medicare screening benefit. •There is low utilization of Medicare's Annual Wellness and Welcome to Medicare visits that include screening. •**No reimbursement for screening programs** located in a community setting. •**No reimbursement for patient education** on the importance of screening. •Gap between health screenings (including Health Risk Assessments) and entry to diabetes treatment.	• Because the United States Preventative Services Task Force gave a B rating for screening for abnormal blood glucose, private health insurance plans are required under the Affordable Care Act to provide this service.	• **37 states cover diabetes screening** for Medicaid beneficiaries. • States have the flexibility to design their own Children's Health Insurance Program (CHIP) plans. Most programs include coverage for Early and Periodic Screening, Diagnostic and Treatment Services.



The diabetes care challenge: gaps in payment for medication

Medicare	Private Insurance	Medicaid & CHIP
• Medicare Advantage (Part C) **Star Ratings include a measure for the percentage of plan members with prescriptions for diabetes medications who fill their prescriptions 80% of the time**. However, these medications do not include insulin. • Special Needs Plans are Medicare Advantage plans that cover extra services tailored to the special group they serve. They must provide prescription drug coverage, and the plan tailors the benefits, provider choices, and drug formularies to meet the needs of diabetics. • Medicare **Part D plans provide outpatient prescription drug coverage through private insurance companies**. These plans provide coverage for prescription drugs, including glucose, insulin (not administered with a pump), insulin pens and syringes, inhalers, needles, alcohol swabs, etc. Beneficiaries are responsible for co-pays or coinsurance and deductibles. • The Medicare Part D "base beneficiary premium" for 2016 is $34.10 per month. However, premiums vary significantly from one part D plan to another**. Part D benefits may also be subject to a coverage gap or "donut hole"** for any prescription drug purchases between $3,310 and $6,154; the program has a maximum out-of-pocket enrollee share of $4,850 in 2016. • Approximately 26 states provide some financial help (through state pharmacy assistance programs) to certain low and moderate income residents enrolled in Part D.	• Laws in 46 states and the District of Columbia require private health market insurance coverage for people diagnosed with diabetes. However, some diabetics in a mandate state may not be fully covered due to being in high deductible health plans, special mandate light plans, or bare bones plans.	• Medicaid benefits vary by state. Prescription drugs are included in all state plans but the formularies vary. • **Diabetes treatment and management is available to children enrolled through CHIP.** Diabetes treatment options are comparable to those available under Medicaid in most states, although patients may be responsible for higher payments and care defined as diabetes education services.



The diabetes care challenge: gaps in payment for care coordination

Medicare	Private Insurance	Medicaid & CHIP
• There **is no reimbursement** for remote care, care coordination, or coaching (e.g., phone visits, follow-up text messages, online reminders) for the care and management of diabetes. • **Certified Diabetes Educators are not authorized to provide Diabetes Self-Management Training (DSMT) Services**, including telehealth services, under Medicare Part B. • Medicare reimburses for DSMT but not Diabetes Self-Management Education (DSME). Medical Nutrition Therapy (MNT) and DSMT are not reimbursable on the same day. • There is **differential reimbursement for diabetes case managers and educators**. • New care coordination HCPCS G-code has not been interpreted to include remote care coordination or coaching. • Physicians are not incentivized to work in teams. • There is a lack of uniform quality metrics across the federal government. In addition, there are **limited diabetes quality measures and alignment across Medicare programs.** • Payment is not tied to meeting appropriate standards of care for all services delivered. • Medicare Part D offers a Medication Therapy Management (MTM) service, where a pharmacist or other health professional reviews the diabetic patient's medications and makes recommendations regarding adherence and safety. • Starting in 2017, **a new enhanced MTM service will better align the prescription drug plan and Medicare financial interests**, as well as create incentives for plan participation. • **Comprehensive Medication Management, which is more comprehensive and less product focused than MTM, is not currently paid for by Medicare Part B.**	• Private health insurance plans set their own standards regarding care coordination for diabetes. Some plans work with Patient-Centered Medical Homes (PCMHs) which are redesigned primary care practices that focus on preventative care, patient, education and care coordination.	• **Forty-four states have care coordination activities** underway for Medicaid. These strategies include health homes, patient-centered medical homes, and accountable care organizations. There are also initiatives to improve care for individuals dually eligible for Medicare and Medicaid. In addition, **states are coordinating physical and behavioral health services.**

The diabetes care challenge: gaps in payment for devices

Medicare	Private Insurance	Medicaid & CHIP
• In March 2017, CMS announced that Medicare coverage of therapeutic continuous glucose monitoring (CGM) applies to all Medicare beneficiaries who have Type 1 or Type 2 diabetes and who use intensive insulin therapy. • **Medicare Part B covers 80% of home glucose monitors** under Durable Medical Equipment (including test strips, lancet devices, and lancets). But there are limits on how much or how often the beneficiary gets supplies. In addition, Part B covers 80% of external insulin pumps and the insulin used by the device under Durable Medical Equipment. • The 2013 **competitive bidding program limits choices and access to certain types of diabetes testing supplies**, such as blood glucose testing strips, purchased through mail order. If beneficiaries have difficulty finding replacements for familiar products, they may be inappropriately influenced to switch test systems, which can have negative health and economic effects.	• Different states have different insurance mandates for diabetes supplies and equipment.	• Diabetes benefits such as insulin, disposable needles, syringes, monitors, and blood glucose strips are determined by each state's Medicaid policy and are listed by the state.