CMS Diabetes Strategy — Impact Report 2024

CMS is taking action to reduce the burden of diabetes-related illness among all Medicare beneficiaries. A large and growing health concern, diabetes and pre-diabetes now affect 44 million, or 3 of every 4 Americans ages 65 and older.[1] Of the estimated 17 million adults ages 65 and older who meet the criteria for diabetes, 1 out of 6—3 million—do not know they have diabetes.[1] Only 1 in 4 adults aged 65 and older with prediabetes are aware of their condition.[1] People in rural areas and from racial and ethnic minority communities often have higher rates of diabetes and face a higher rate of complications from the diagnosis.[1] Diabetes can lead to complications such as heart disease, stroke, kidney disease, and vision loss. Medical expenses for people diagnosed with diabetes were more than double those for people without a diagnosis of diabetes.

Since announcing the CMS Diabetes Strategy in 2023, CMS has taken the following actions:

Prevention, Screening, & Diagnosis:

Expanded Coverage of Diabetes Screening: CMS expanded Medicare coverage of diabetes screening from one test annually to up to two tests annually for all patients at risk for diabetes—e.g., if 65 or older and overweight. In addition, Medicare added the hemoglobin A1C test as another test that could be used for diabetes screening without coinsurance.

Impact: Screening of people at risk for diabetes, and diagnosis of diabetes and prediabetes are essential first steps to preventing and managing these conditions. Three tests are typically recommended for diabetes and prediabetes screening—fasting plasma glucose, hemoglobin A1C, and oral glucose tolerance testing. Typically, two positive tests are recommended to confirm a diagnosis of diabetes.[2] Historically, Medicare covered only one diabetes screening test per year for patients not previously diagnosed with prediabetes and did not cover the hemoglobin A1C test for screening. These policy updates to expand coverage of diabetes screening will reduce barriers and increase Medicare beneficiaries' options for timely screening, enabling early detection and prompt intervention to prevent or delay complications.

Simplified Diabetes Diagnosis Requirements: The regulatory definition of diabetes can now be based upon a doctor's diagnosis, as opposed to more restrictive tests specified in the earlier regulations.

Impact: Guidelines for diagnosing diabetes have changed over time, to reflect the most recent research. These guidelines have typically included physician judgment based upon patient circumstances, such as the presence of symptoms and whether the patient has fasted prior to testing. Differences between these guidelines and Medicare's definition of diabetes could lead to confusion about patient eligibility for diabetes-related services. Simplifying the Medicare regulatory definition of diabetes at § 410.18(a), § 410.130, and § 410.140 eliminates potential confusion and removes a barrier to patient participation in diabetes screening, as well as Medical Nutrition Therapy and Diabetes Self-Management Training (on the following page).

Extension of the Medicare Diabetes Prevention Program (MDPP) Expanded Model: CMS extended the MDPP Expanded Model through December 31, 2027, and continued allowing certain MDPP suppliers to deliver the set of MDPP services either virtually or in-person (or a combination of both). CMS also simplified supplier billing and clarified payment based upon participant attendance. In addition, screening hemoglobin A1C, required to determine MDPP eligibility, was added to Medicare coverage for diabetes screening without beneficiary cost-sharing.

Impact: The Diabetes Prevention Program has been demonstrated to reduce the incidence of new onset type 2 diabetes among adults ages 60 and older with overweight or obesity and prediabetes by 70 percent.[3] Despite this impact, less than 1% of the estimated 16 million eligible Medicare beneficiaries have participated in the MDPP Expanded Model.[4] Historical barriers to participation include insufficient participation by MDPP suppliers, and lack of coverage of screening hemoglobin A1C testing. While MDPP services are covered by Medicare Part B without cost sharing from eligible beneficiaries, coverage for virtual visits may increase receipt of MDPP services by overcoming barriers to in-person visits, such as transportation, dependent care, and time-off from work.

Access to Treatment, Services, & Supports:

Making Insulin and Other Diabetes Medications More Affordable: Implementing the historic Inflation Reduction Act of 2022 (IRA), CMS capped a Medicare beneficiary's cost-sharing for insulin at $35 for a month's supply of each covered insulin product. Under the IRA, CMS has also begun requiring that drug companies pay Medicare a rebate if they raise their prices for certain drugs covered under Medicare Part B or Part D faster than the rate of inflation. In addition, the first cycle of drugs selected for manufacturer negotiations under the new Medicare Drug Price Negotiation Program is underway, which includes several drugs used to treat diabetes.

Impact: Approximately 1 out of 6 adult Americans with diabetes reported non-adherence with their diabetes medications due to their cost.[5] Multiple studies have demonstrated people with diabetes who were non-adherent and non-persistent with their diabetes medications were more likely to experience adverse impacts, including: worse glucose control, emergency department visits, hospital admissions, and mortality. Increasing affordability of diabetes medications can prevent these negative outcomes.

Extended Telehealth Coverage of Intensive Behavioral Therapy for Obesity (IBTO): CMS extended Medicare coverage for IBTO furnished via telehealth through 2024 in accordance with statutory extensions, which include access via telehealth in any geographic area and from any site in the U.S. where a beneficiary is located, including from home.

Impact: Obesity is a major risk factor for developing type 2 diabetes. Two out of five adults ages 60 and older have obesity, with even higher prevalence among non-Hispanic Black Americans and Hispanic Americans.[6] IBTO refers to evidence-based intensive, multicomponent behavior change programs that can effectively help people with obesity lose and control weight by changing their diet and physical activity. While IBTO is covered by Medicare Part B without beneficiary cost sharing, less than 1% of traditional Medicare enrollees have received IBTO. Broader access to services furnished via telehealth may increase receipt of IBTO by allowing beneficiaries to overcome barriers to in-person visits, such as transportation, dependent care, and time-off from work.

Expanded Eligible Providers and Telehealth Flexibilities for Diabetes Self-Management Training (DSMT) Services: To improve access to telehealth services, CMS now allows any distant site practitioner who can bill for DSMT services to do so on behalf of others who personally furnish the services as part of the DSMT entity. CMS also enabled Medicare payment for injection training for insulin-dependent beneficiaries when furnished via telehealth, which means that all DSMT sessions can be furnished via telehealth. Additionally, CMS continues to allow outpatient hospitals and other providers—in much the same way they could during the Public Health Emergency for COVID-19—to bill for DSMT, medical nutrition therapy (MNT), and other services furnished remotely by institutional staff to patients in their homes at least through the end of CY 2024.

Impact: DSMT, also known as Diabetes Self-Management Education and Support (DSMES), has been found to reduce deaths among people with diabetes by 25%.[7] Despite this dramatic impact, only 5% of Traditional Medicare enrollees with newly diagnosed diabetes use DSMT services. Historically, limited screening coverage and more rigorous requirements for diabetes diagnosis may have contributed to lower utilization of DSMT. Addressing these issues may increase receipt of DSMT. In addition, expanding coverage for telehealth visits may increase access to DSMT by overcoming barriers to in-person visits, such as transportation, dependent care, and time off from work.

Increased Support for Social Determinants of Health: CMS is expanding support for social determinants of health (SDOH) and health-related social needs (HRSN) by introducing new coding and payment for Community Health Integration (CHI) services in the Medicare Physician Fee Schedule to help address non-medical factors that may be impacting beneficiaries' health. These include services such as care coordination and health education. CMS is also offering advance investment payments that may be used to help address beneficiary HRSNs in the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) program; and allowing Medicare Advantage Plans the flexibility to address member HRSNs through supplemental benefits. In addition, CMS has introduced coding and payment for SDOH risk assessments, including assessments via telehealth, and introduced requirements for SDOH risk screening in acute care hospitals and other selected care settings.

Impact: Almost one-half of Medicare Advantage beneficiaries report having one or more health-related social needs.[7] By expanding support for SDOHs, CMS is helping Medicare enrollees overcome these barriers to health care access and improve health outcomes.

Increased access to the Medicare Savings Programs (MSPs) and Medicare Part D Low Income Subsidy (LIS or "Extra Help"): Starting October 1, 2024, CMS will allow states to auto-enroll certain individuals into the MSPs, streamlining the transfer of application information from the Social Security Administration (for LIS) to states (for MSPs), and mitigating unnecessary disenrollments. In addition, the IRA expanded eligibility for the Extra Help program beginning in 2024 so more people are receiving more assistance in paying for their drug costs.

Impact: Medicare cost-sharing can be a barrier to accessing diabetes-related care and services, especially for people with lower incomes and without robust secondary coverage. Access to health insurance is the strongest single predictor of whether adults with diabetes are likely to receive high quality diabetes care.[8] Enrollment in the Medicare Part D Extra Help program reduces Part D drug costs for beneficiaries who are eligible for the Low-Income Subsidy. The MSPs' Qualified Medicare Beneficiary (QMB) eligibility group provides low-income Medicare beneficiaries coverage for Medicare premiums and cost sharing, while other MSPs help with Medicare premiums, deductibles, copayments, and coinsurance. However, millions of people are eligible for, but not enrolled in, the Extra Help program and/or an MSP. Improving enrollment in these programs will reduce financial barriers to diabetes-related treatment for low-income individuals.

CMS continues its commitment to improving care and advancing health equity for the people it serves who are at risk for and living with diabetes, whether they are covered by Medicare, Medicaid & CHIP, or the Marketplace.

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