
Managing the Diabetic Medicare Patient Today

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About 85% of seniors over age 65 who are diagnosed with diabetes take outpatient prescription medications for the disease. Since the introduction of Medicare Part D, accessing antidiabetes agents through prescription drug plans (PDPs) has become somewhat more challenging for physicians and their patients, yet claims data suggest that Medicare Part D has improved access to diabetes medications.¹ Management of diabetes requires working with and through Medicare's Part D PDPs.

Working with PDPs in an efficient and effective manner is essential for physicians, not only because they have taken the Hippocratic Oath, but also because reimbursement increasingly is tied to outcomes through pay-for-performance measures. In many cases, these outcomes are dependent on making the correct diagnosis and writing the correct prescription, but they also require accessing and adhering to the needed medication regimen.

Pay-for-Performance for Diabetes

On July 1, 2007, Medicare began its first pay-for-performance program for physicians. The program, Medicare's Physician Quality Reporting Initiative (PQRI), enables physicians to earn extra revenue from Medicare based on their reporting of quality measures. And while many diseases and conditions are covered, several initia-

tives focus specifically on diabetes.²

PQRI establishes a financial incentive for physicians and other health care practitioners to participate in a voluntary quality reporting program. Eligible professionals who successfully report data for a designated set of quality measures may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services provided during the reporting period.²

The PQRI quality measures relate to important processes of care that are linked to improved health care quality outcomes. They are evidence- and consensus-based measures that reflect the work of national organizations involved in quality measure development, consensus endorsement, and adoption. While Medicare started the program with 74 measures, it currently has 118 measures that can be reported. However, some are specific

to certain specialties.²

Eligible professionals need not enroll or file an intent to participate in the PQRI. Eligible professionals can participate by reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. These eligible professionals include physician assistants; nurse practitioners; clinical nurse specialists; clinical social workers; clinical psychologists; registered dietitians; nutrition professionals; and physical, occupational, and qualified speech-language therapists.³

A review of the PQRI diabetes measures illustrates the importance of medication access because each of the 3 measures (Table 1) can be dependent on this factor. As a result, ensuring access to antidiabetes medications is important for physicians who are focused on achieving success with these PQRI measures.²

Pushing Coverage of a Treatment Plan

The starting point for ensuring access to medically necessary treatment options for diabetic patients is the selection of a Medicare Part D plan. This process ideally begins with collaboration between patient and physician to identify the medications currently required to control the disease, as well as those likely to be needed over the course of the year.

This list of medications can then be entered into www.Medicare.gov. Here patients and physicians can compare Part D plans according to the patient's zip code. This Medicare tool provides a list of those plans providing the greatest level of access at the least expensive price.

Those patients who have both Medicare and Medicaid (dually eligible) can perform this evaluation for their current medications because they have the ability to change plans if needed each month. The same is true for residents of skilled nursing facilities. This means that the medication regimens of these beneficiaries are not controlled by the insurance plan.

Unfortunately, those patients who are not eligible for this special enrollment period are locked into their plans for the entire year, unable to make changes until their annual enrollment period rolls around. The annual enrollment period occurs each year between November 15 and December 31, and new plans start January 1 of the next year.

Because many beneficiaries are locked into their plans for a year, physicians and these patients may be forced to work through an appeals and exceptions process to gain access to treatments needed to care appropriately for patients' diabetes.

Antidiabetes Medication Formulary Design

In a detailed examination of formularies and other features of Medicare drug plans, the Kaiser Family Foundation determined that Medicare PDPs cover about 82% of oral hypoglycemics.⁴ Interestingly, 18% of the PDPs used in the analysis did not cover oral hypoglycemics at all. The analysis also

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found that utilization restrictions for oral hypoglycemics, though uncommon, are sometimes imposed.

Five separate drug types are included in the oral hypoglycemic drug class. Four of these subgroups (glucosidase inhibitors, biguanides, meglitinide, and thiazolidinediones) contain only one or two drugs. The USP model guidelines are still followed by most plans. CMS requires plans that follow these guidelines to cover two drugs in each category and class. As of January 1, 2008, CMS dropped the requirement that one drug be covered in each of the Formulary Key Drug Types.

United States Pharmacopeia's Model Guideline

Antidiabetes Medication Utilization

The Lewin Group⁵ analyzed costs of antidiabetes agents for Medicare beneficiaries with chronic conditions, a population whose drug costs are higher on average. It is estimated that 86% of Medicare beneficiaries have at least one chronic condition, and 65% have two or more chronic conditions. The study revealed that Medicare beneficiaries with chronic conditions who enroll in a Medicare drug plan would save money, with savings increasing exponentially with the number of chronic conditions. Those with a single condition can expect to save approximately \$400 per year with a Medicare drug plan; those with four or more chronic conditions may save an average of \$1774 per year. Conditions associated with higher average drug costs yielded the highest average savings: diabetes ranked third among chronic conditions expected to yield the highest savings from the Medicare Part D benefit.

Table 1. Diabetes Measures²

Hemoglobin A1C Poor Control in Types 1 or 2 Diabetes Mellitus

Description

Percentage of patients aged 18 to 75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1C greater than 9%

Low Density Lipoprotein Cholesterol (LDL-C) Control in Types 1 or 2 Diabetes Mellitus

Description

Percentage of patients aged 18 to 75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (<100 mg/dl)

High Blood Pressure Control in Types 1 or 2 Diabetes Mellitus

Description

Percentage of patients aged 18 to 75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (<140/80 mm Hg)

In a separate investigation of the impact of Medicare Part D on beneficiaries with diabetes sponsored by the American Diabetes Association,¹ analysts created a model to estimate the average cost sharing for Medicare beneficiaries with diabetes at various income levels. The model included four patient profiles with varying treatment regimens to account for variations in medications used within this population.

Under this model, individual beneficiaries with incomes of at least \$14,355 and couples with incomes of at least \$19,245 (more than 150% of federal poverty level [FPL]) were expected to face substantial out-of-pocket spending to manage diabetes under Part D coverage. Those prescribed three oral antidiabetic medications, an angiotensin-converting enzyme (ACE) inhibitor, and a statin are expected to spend \$2244 per year with Medicare Part D, but are unlikely to fall into the gap or “donut hole” of 100% coinsurance.

These individuals with incomes above the FPL limit for receiving Medicare’s “extra help” may need to spend up to 21% of their annual income on diabetes medications under Part D. Beneficiaries in other income ranges may spend from 2% to 10% of their income on health care expenses, such as Part B and D premiums, prescription copayments, and Part B supplies and services.

In an issue brief released by *The Commonwealth Fund* examining Medicare beneficiaries with diabetes, author Bruce Stuart⁶ found that adherence rates for diabetes medications are lower at the extremes of the range of disease burden compared with the middle range, and the differentials are large.

In percentage terms, according to Stuart, users of oral hypoglycemic agents in decile 10 had 33% fewer annual fills compared with users in the peak decile. In addition, they had 26% fewer fills for dyslipidemic agents and 33% fewer fills for insulin. Stuart concluded that these observer treatment patterns suggest that Medicare beneficiaries with diabetes are much less likely to follow optimal medication therapy if they happen to be at either extreme of the disease burden spectrum.

The reason for this could be related to the fact that beneficiaries at the low end of the disease burden spectrum do not have additional health system contacts, which may result in undertreatment. At the far end of the disease burden spectrum, low adherence rates could be the result of patients’ perceptions that they are overloaded with medications and they discontinue using necessary diabetes medications. This study highlights the importance of working to ensure appropriate access and adherence to antidiabetic therapy.

Ensuring Appropriate Antidiabetes Medication Coverage

To ensure appropriate antidiabetes medication coverage, physicians and their patients must be proactive and aggressive, both individually and collectively. Collectively, physicians can work through their national associations or directly to reach their federal legislators. So too can patients contact their federal legislators. These legislators have the power to force Medicare to hold prescription drug plans ac-

countable for providing necessary access to antidiabetes agents.

Other groups, such as mental health, HIV, and cancer advocacy groups, have won significant protection for needed medications for patients with these disorders. The drugs to treat these disorders fall into six protected classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics that must be covered by prescription drug plans. These drugs are protected primarily because advocacy groups have vigorously argued that these classes do not have a class effect,⁷ meaning the medications within these classes provide unique benefits. Therefore, all of them need to be available to Medicare patients to prevent an adverse event that could arise if a beneficiary were required to switch to a different drug or had limited access to a specific drug because of a plan formulary.

It is important that physicians and patients work together to hold prescription plans accountable because these plans have no financial incentive to provide open access to antidiabetes agents. To the contrary, in fact, these plans have financial incentives to restrict access to medications whenever possible. Ultimately, the power for managing care and accessing medication lies with each diabetic patient and physician. The winners in this environment will be those patients and physicians who are proactive and advocate for the right to access all medications that are medically necessary to manage diabetes in an effective and efficient manner. This approach will reward both the patients with diabetes and their physicians. **MPM**

PROVIDER ACTION

Impact to You

Since about 85% of seniors over age 65 who are diagnosed with diabetes take outpatient prescription medications for the disease, a knowledge of the Medicare Part D plans is essential to ensure that these medications are accessible for patients. Accessibility of these antidiabetes agents directly contributes to provider reimbursement under Medicare's pay-for-performance system and improves patient outcomes.

What You Need to Know

Providers need to know those prescription drug plans (PDPs) that provide the greatest access to antidiabetes agents as well as how to navigate PDP systems to access these medications for their patients. This is especially critical given Medicare's move to reimburse providers for diabetic management based on outcomes such as hemoglobin A1C, blood pressure, and low-density lipoprotein levels. These measured outcomes are clearly dependent on medication access.

What You Need to Do

Providers should assess the plans that are available to their patients using either the Medicare Web site or by working with a pharmacist to analyze available plans. In addition to identifying the plans, providers should have a system in place to efficiently and effectively access these agents through the plans in which their patients are enrolled. Getting patients in the right plans and knowing how to navigate the others is critical to ensuring access to these vital medications.

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