POTENTIAL DRAFT PRESIDENTIAL MESSAGE FOR THE AM. DIABETES ASSN ANNUAL PUBLIC POLICY LEADERSHIP FORUM - MARCH 10 -12

I am delighted to greet the participants of the American Diabetes Association's annual Public Policy Forum.

Since its inception, the American Diabetes Assn has worked to address the causes, treatment, prevention, and health insurance coverage of diabetes. The strength of your organization today exemplifies the ongoing commitment to dedicated research and treatment, and I pledge my support to work with you to improve health insurance coverage for Americans with diabetes.

I extend my best wishes for a successful Forum.

American Diabetes Association.

National Center
1660 Duke Street
Alexandria, Virginia 22314
Tel: 703 549-1500
Fax:703 836-7439

This is included in your Medicare Reform proposal. I hope you can sign this since you're already doing it.

February 1, 1996

Bill Clinton
2100 M Street, NW
Suite 700
Washington, DC 20036

Dear Mr. President:

On behalf of the American Diabetes Association, I am writing to urge you to sign the attached Diabetes Pledge and save billions of tax dollars by improving the health of Americans with diabetes.

Medical research clearly shows that when a person with diabetes has supplies (like syringes, insulin and test strips) and has been trained how to use them, complications (like blindness, stroke, kidney failure and amputations) can be prevented or avoided altogether.

But, for some reason, many health insurance plans, including Medicare, don't cover these absolutely necessary supplies and training. They will, however, pay a $5,000 hospital visit to treat complications. Research shows that improving insurance coverage for people with diabetes could save billions of tax dollars by preventing complications. Even the Congressional Budget Office agrees that money can be saved by improving diabetes coverage!

The 16 million Americans with diabetes, including 50,000 residents of New Hampshire, need your support. They need you to help change this ineffective system which wastes billions of tax dollars every year on complications that could easily be avoided, or prevented, with inexpensive medical care.

Again, on behalf of the American Diabetes Association, I urge you to sign the attached Diabetes Pledge. I look forward to your reply outlining your position in this matter. I can be reached at (603) 434-9897. Thank you.

Sincerely,

Donna Chretien

Donna Chretien
Immediate Past Chair of the Board
American Diabetes Association, New Hampshire Affiliate

The Diabetes Pledge

WHEREAS Diabetes is a serious disease. The sixteen million Americans with diabetes are at higher risk for a heart attack, stroke, kidney failure, amputation and blindness. Consequently, diabetes is the fourth leading cause of death by disease in America and a major cause of disability.

WHEREAS Diabetes is the only major disease that is managed on a daily basis by the affected individual. In order to effectively manage diabetes, a person must have supplies, such as insulin, test strips and syringes, specialty care and training to learn how to manage their condition.

WHEREAS Medical research shows that when people with diabetes do not have supplies, care and education, they are highly likely to develop diabetes' life-threatening and costly complications.

WHEREAS Many health insurance policies, including Medicare, do not provide appropriate coverage for necessary supplies, care and education. This is one reason why diabetes consumes 1 of every 7 health care dollars in America, nearly $92 billion annually. Medicare alone spends $28.6 billion a year, nearly 30% of its budget, on diabetes' complications.

WHEREAS Studies demonstrate that providing supplies, care and education to people with diabetes reduces health care costs by preventing complications. It is estimated that Medicare could save up to $10 billion a year by improving coverage for diabetes supplies, care and education.

THEREFORE I pledge my support to legislation that improves health insurance coverage for Americans with diabetes.

Signed this day, _____, 19____

_____

Candidate's name

American Diabetes Association.

National Center
1660 Duke Street
Alexandria, Virginia 22314
Tel: 703 549-1500
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Statement

of

Philip E. Cryer, MD

President-Elect

of the

American Diabetes Association

before the

House Ways and Means Subcommittee on Health

Regarding Medicare and Budget Issues

Tuesday, July 25, 1995

The Association gratefully accepts grants for research

Chairman Thomas, Ranking Member Stark, and members of the subcommittee, I am Philip Cryer, MD, President-elect of the American Diabetes Association. I appreciate the opportunity to testify before you today on the American Diabetes Association's recommendations for Medicare reform. You have an extremely difficult task before you, but I am confident that we can provide constructive ideas for your efforts.

Before I begin my formal presentation, I would like to relate a quote of House Speaker Newt Gingrich. On July 27, 1994, as Minority Whip, Mr. Gingrich stated on Good Morning America that

> [W]e don't today pay for training you, as a diabetic, how to take care of yourself. We will pay to put you in the hospital [and to] amputate your leg when you fail to take care of yourself. But literally, the government bias today is to not pay for the preventive and educational experience that will lower your costs.[1]

The American Diabetes Association whole-heartedly agrees with Speaker Gingrich in this matter. As the American Diabetes Association's President-elect, I am here today to describe to you how to remove that "government bias" and expand coverage of diabetes-related supplies and education while simultaneously saving the U.S. Treasury billions of dollars. But in order to understand how this can be done, it is important to have a general understanding of the disease.

Diabetes is a disease that affects the body's ability to convert blood sugar into energy. There are two forms of diabetes, type I, known as insulin-dependent diabetes, and type II, known as non-insulin dependent diabetes. Type I is what the public usually equates with diabetes. This may be due to the peculiarities of this form of the disease. Type I usually strikes children and young adults and is characterized by the body's inability to produce insulin. Since the body does not produce insulin, multiple daily injections of insulin are required in order to survive. Type I diabetes develops rapidly, usually over the span of several weeks and has severe and recognizable symptoms. For these reasons, nearly everyone with type I diabetes has been diagnosed with the disease. Roughly 5% of the nearly 14 million people with diabetes have type I.

Type II diabetes is the far more prevalent form of the disease. It is different in many ways from type I. For example, type II diabetes usually strikes individuals who are over age forty. While most individuals with type II are able to produce insulin, their body is not able to use it effectively. While insulin injections may be required in advanced stages, type II can often be regulated through modification of diet, exercise and oral drugs. Type II diabetes develops over an extended period of time, sometimes a span of many years. The clearly identifiable warning signs typified by type I diabetes are not necessarily associated with type II. Because of this, more

than 6 million Americans have undiagnosed type II diabetes, and are usually diagnosed through one of the resulting complications of diabetes, if they are diagnosed at all.

Despite these major differences, both type I and type II diabetes can be effectively managed by the afflicted individual. The medical research which led to the development of insulin in 1921 has enabled millions of individuals with type I diabetes to live long and productive lives. Medical research has also resulted in, and continues to result in, effective treatment regimens for the many millions of Americans with type II, enabling them to live longer, healthier lives. But one of the central paradoxes of diabetes hinges on the fact that because one can live for many years with the disease, its consequences are severely under-appreciated by the general public and health care professionals.

One of the commonalities of type I and type II diabetes is that both are characterized by elevated blood sugar levels. These elevated blood sugar levels, when left untreated by an outside agent such as insulin or oral medication, are the primary cause of the complications of diabetes. Because both types of diabetes obstruct the body's ability to produce or use insulin, which converts blood sugar into energy, nearly *all* individuals with diabetes must rely on an outside mechanism to regulate their blood sugar levels.

Elevated blood sugar levels are found in all people with diabetes, particularly in those who remain undiagnosed or who do not manage their condition properly. And in the 13 million Americans with type II diabetes, elevated blood sugar levels can be sustained for extended periods of time, with an insidiously silent effect on their health. This is a reason why so many millions of Americans remain undiagnosed. These elevated blood sugar levels cause substantial long-term damage to the body's blood vessel system. Damage to this network of vessels, in turn, causes extensive damage to many of the body's essential organ systems. This damage to major organ systems is what we refer to when we talk about the complications of diabetes.

The complications resulting from elevated blood sugar levels are staggering. Each year the complications of diabetes result in the deaths of more than 160,000 Americans. That is equivalent to the combined populations of Olean, New York; Wauconda, Illinois; Papillion, Nebraska; Windsor Locks, Connecticut; Bastrop, Louisiana; Lamont, California; Allen, Texas; Union City, California; Franklin, Wisconsin; and Grambling, Louisiana.[2] And because diabetes is a disease that one can have for many years, the effect of elevated blood sugar levels are devastating in the individual and in the aggregate. Many hundreds of thousands of Americans suffer from these complications of diabetes:

Blindness – Elevated blood sugar levels cause extensive damage to the tiny blood vessels in the human eye. Consequently, diabetes is the leading cause of blindness in people ages 25-74. The Centers for Disease Control and Prevention estimate that approximately 27,000 people go blind each year because of diabetes.[3] *This is roughly equivalent to the combined populations of Corning and Olean, New York.*[4]

Amputations – High blood sugar levels cause extensive damage to the circulatory system in lower body extremities. Consequently, the risk of a leg amputation is 27.7 times greater for a person with diabetes than the general U.S. population. Approximately 54,000 people lose their leg or foot each year because of their diabetes.[5] *This is roughly equivalent to the population of Monroe, Louisiana.*[6]

Heart disease – Above average blood sugar levels cause major damage to the blood vessels of the human heart. Therefore, people with diabetes are approximately 2 to 4 times more likely to have heart disease than individuals without diabetes. It is estimated that more than 77,000 people die each year from heart disease caused by their diabetes.[7] *This is roughly equivalent to the population of Visalia, California.*[8]

Stroke – Strokes are caused by ruptures in the tiny blood vessels of the brain. These vessels can be extensively damaged by elevated blood sugar levels. Therefore, people with diabetes are 5 times more likely to suffer a stroke than individuals who do not have diabetes. It is estimated that nearly 11,000 people die each year from stroke caused by their diabetes.[9] *This is roughly equivalent to the population of Papillion, Nebraska.*[10]

Kidney disease – Elevated blood sugar levels also cause damage to the blood vessels of the human kidney. Consequently, each year diabetes accounts for nearly 1/3 of all cases of kidney failure requiring a transplant or dialysis. Last year, nearly 13,000 people initiated treatment for kidney failure because of their diabetes.[11] *This is roughly equivalent to the population of Windsor Locks, Connecticut.*[12]

THE BURDEN OF DIABETES AMONG SENIOR CITIZENS

Diabetes is a truly devastating disease among those Americans over age 65. Because diabetes prevalence increases with age, approximately 50% of all cases of the disease occur in people over age 55. By ages 65-74, nearly 17% of the US white population, 25% of African Americans and 33% of Hispanics have diabetes.[13] This number will continue to increase as the population growth rate of African Americans and Hispanics outpaces that of white Americans.

However, despite the fact that 19% of the Medicare population has diabetes, approximately 27% of the Medicare budget is used in treating diabetes and its resultant complications. This represents $28.6 billion spent each year by Medicare for treatment of diabetes among those Americans over age 65. It is clear that if the prevalence of diabetes and diabetes-related complications can be reduced, substantial cost savings in Medicare can be realized.[14]

DIABETES CONTROL AND COMPLICATIONS TRIAL (DCCT)

Fortunately, recent medical research has found that the costly complications of diabetes can be reduced through routine medical care. The Diabetes Control and Complications Trial (DCCT), a clinical trial funded by the National Institutes of Health, was a landmark examination of diabetes-related complications.

The ten-year study, the results of which were published in the *New England Journal of Medicine* sought to demonstrate that keeping one's blood glucose levels as close to normal as possible prevented the onset of diabetes-related complications. The results of this study were better than almost anyone had imagined. This intensive treatment strategy, better known as "tight control," was found to reduce kidney disease by 56%, blindness by 60% and microvascular nerve disease, a leading cause of lower-extremity amputation, by 61%.[15] The DCCT proved conclusively that through close blood glucose monitoring, tight control of blood glucose levels can greatly reduce diabetes-related complications and decrease the cost of care.
The results of the DCCT have tremendous implications not only for Medicare, but for the entire U.S. health care system and all Americans with diabetes. Diabetes is responsible for 1 in every 7 health care dollars spent, consuming over $100 billion annually.[16] If applied universally among all Americans with diabetes, the results of the DCCT imply that tens of billions of dollars could be saved every year through normalization of blood glucose levels.

DIABETES SELF-MANAGEMENT TRAINING

It is a widely accepted standard of medical care that people with diabetes must have diabetes self-management training on an on-going, as-needed basis. According to the American Diabetes Association's *Standards of Medical Care*, the authoritative reference guide on the treatment and care of people with diabetes

> [C]ontinuing patient education for self-management is an integral component of diabetes treatment. This is particularly so for diabetes; successful management of diabetes is greatly dependent on the patient's own efforts. Therefore, all people with diabetes must have access to affordable patient education services.[17]

And according to *Healthy People 2000*, the national health promotion and disease prevention report prepared under the direction of the Bush Administration

> Patient education is generally considered an integral aspect of patient management and a mainstay of patient self-care. It is so widely accepted as standard diabetes management that a rigorous study design that denies education to a control group would be unethical.[18]

However, despite the overwhelming recognition of the necessity of diabetes education, Medicare does not currently reimburse for the outpatient training people with diabetes must receive in order to control their disease. Unless the training is received during an inpatient hospital stay, a hospital outpatient visit or in selected rural settings, a person with diabetes who relies on Medicare cannot receive diabetes self-management training. The result of this short-sighted policy is that millions of people with diabetes are denied access to the education they need to stay healthy and avoid diabetes complications.

Given the Medicare restrictions on training, it is estimated that very few people with diabetes who rely on Medicare as their health insurance have received the education necessary to care for their disease. In fact, a recent study found that just 35% of all people with all types of diabetes have actually attended a diabetes management program. These statistics have grave implications not only for Medicare, but for the U.S. health care system in general.[19]

Studies conclusively prove that providing coverage for diabetes self-management training not only keeps people healthy, it saves money by helping people with diabetes avoid complications and hospitalizations. For example:

State of Maine – The State of Maine and the CDC sponsored a diabetes self-management training program in 30 hospitals and health centers, following 1,488 patients over 3 years. *Result:* A 32% reduction in hospital admissions with a savings of $293 per participant, or $3 saved for every $1 spent on diabetes self-management training.[20]

Los Angeles, California – As reported in the *New England Journal of Medicine*, an integrated system of diabetes self-management training and care resulted in a 73% reduction in hospitalization and 78% reduction in average length of stay for 6,000 people with diabetes. *Result:* An estimated savings of $2,319 per patient each year.[21]

Atlanta, Georgia – An intensive diabetes self-management training and care program was implemented in a county hospital setting. The study included 12,950 individuals with diabetes, of which 10,500 were treated, evaluated and followed up. *Result:* Severe ketoacidosis was reduced by 65% and lower extremity amputations were reduced by 49%. Savings were estimated to be $437,500 per year.[22]

According to *Diabetes Outpatient Education: The Evidence of Cost Savings*, published jointly by the American Association of Diabetes Educators, American Diabetes Association, American Dietetic Association, Centers for Disease Control and the National Diabetes Advisory Board,

> [L]ack of reimbursement is probably the most significant impediment to the development of diabetes outpatient education programs. It is simpler to receive reimbursement for inpatient care and bury the costs of education; but it is far more expensive and far less effective.[23]

The American Diabetes Association has worked for years to alter the current government bias inherent in Medicare's refusal to provide coverage for diabetes self-management training. Earlier this year, Representative Elizabeth Furse introduced H.R. 1073, the Medicare Diabetes Outpatient Self-Management Training Act of 1995. This legislation would require Medicare to reimburse for diabetes self-management training provided in a quality outpatient care setting. The American Diabetes Association is pleased to note that several members of this subcommittee are among the 98 cosponsors of this legislation, including Representatives Nancy Johnson, Jim McDermott, Ben Cardin, and John Lewis. We thank them for supporting this important legislation and strongly encourage all members of the subcommittee, as well as the full committee, to cosponsor this important legislation.

One of the most important elements for the Medicare type II population, provided for under H.R. 1073, will be access to nutrition therapy. Nutrition therapy will empower people with diabetes on Medicare to monitor what they eat and understand how their diet impacts their diabetes. According to the American Diabetes Association's *Standards of Medical Care*, nutrition therapy is a vital component for the care of diabetes.[24]

If enacted into law, H.R. 1073 will save Medicare billions of dollars annually from the avoidance of costly complications and hospitalizations. However, despite the importance of providing coverage for diabetes self-management training, it will not be fully effective unless it is coupled with other structural changes for people with diabetes in the Medicare program. As with expanding coverage for education, these changes will also save Medicare billions.

COVERAGE FOR PRESCRIPTION DRUGS & INSULIN, SYRINGES, SUPPLIES, EQUIPMENT, AND RELATED PREVENTION SERVICES

The regulation of blood glucose monitoring is a complicated process. In order for people with diabetes to be healthy, it is vital to teach them how to care for themselves, as the self-management training bill would help achieve. However, it is also of vital importance to provide people with diabetes a means to purchase the tools necessary to control their disease. This needs to occur through comprehensive coverage of prescription drugs and insulin, syringes, supplies and equipment.

Currently, Medicare reimburses only for blood-glucose monitoring strips and meters for those individuals using insulin to manage their disease. Medicare does not cover insulin, syringes, insulin pumps, oral agents, blood glucose meters or blood glucose testing strips (for those not using insulin) and other necessary supplies. These items, however, are necessary for people with diabetes to stay healthy and avoid complications. By providing comprehensive coverage of these supplies, Medicare will save billions of dollars.

The current government bias in supply coverage results in a situation where people are not able to take appropriate care of themselves. This leads to individuals with diabetes seeking care in the most expensive and overutilized location of all, the hospital emergency room. A recent study conducted in a major urban hospital found that 43% of patients with diabetes were hospitalized with diabetic ketoacidosis, a life-threatening condition caused by excessively high blood glucose levels, because the patients could not afford insulin. The study also found that over 95% of the hospitalized patients with diabetes were admitted through the emergency room.[25] Although this study focused on people of all ages with diabetes, the ramifications for the Medicare system are quite clear: inappropriate coverage for diabetes-related supplies and services results in increased hospitalizations, physician utilization and expenditures.

A comprehensive care package for people with diabetes will also save Medicare money by keeping people out of the hospital. For example, under current reimbursement guidelines, Medicare will reimburse 100% of the costs associated with the dialysis required for kidney failure. As noted earlier, diabetes accounts for nearly 1/3 of all cases of kidney failure requiring a transplant or dialysis. Last year nearly 13,000 people initiated treatment for kidney failure because of their diabetes. This treatment averages $38,000 per participant, per year. However, if Medicare covered the necessary prescription, medical and dietary interventions, at an estimated annual cost of roughly $1,200, most of these dialysis interventions could be prevented.[26]

Preventing blindness caused by diabetes provides another example of how a comprehensive care package will save taxpayers' money. Diabetes is the leading cause of new cases of blindess in working age adults. Yet, it is estimated that 40% of people with type II diabetes are not receiving appropriate eye care for the treatment of diabetic retinopathy. Researchers conclude that the application of quality standards for screenings of diabetic eye disease among people with diabetes would result in a net savings of $472.1 million a year, even if all costs are borne directly by the federal government.[27]

Clearly, expanding Medicare coverage for prescription drugs & insulin, syringes, supplies, equipment and related prevention services can save Medicare many billions of dollars. Even Speaker Gingrich has acknowledged this fact during a speech to the Seniors Coalition on April 28, 1995

> I had a doctor approach me a year ago who's a specialist in diabetes who believes we can save $10 billion [per year] in diabetes alone just by having more preventive care so people take care of themselves, so they don't go blind, they don't have their legs amputated, they don't end up on disability. That is not a cut. That is a genuine improvement.[28]

QUALITY CARE FROM A DIABETES CARE TEAM

The role of a diabetes care team in the treatment of a patient's diabetes is another vital component of diabetes care and cannot be over-emphasized. A patient's diabetes care can only be monitored effectively through the use of a well-educated diabetes team.

A person with diabetes must be acutely aware of many complications, including heart attack, stroke, kidney failure, amputations and blindness. By utilizing a diabetes care team, adjustments can be made in the individual's regimen which can prevent the long-term consequences of poor diabetes control. Only through the use of a team approach (which includes consultations with a nurse educator, dietitian, endocrinologist, and other specialists as needed) can a patient's medical history be analyzed, necessary tests be conducted and appropriately analyzed, and a diabetes management plan be established and adjusted.

Claresa Levetan, MD, a diabetes expert at the Washington Hospital Center, recently analyzed the effectiveness of providing a diabetes care team approach in the treatment of hospitalized patients with diabetes. Published in the July 1995 edition of the *American Journal of Medicine*, Levetan's study compared the length of hospitalization between patients who received care from a diabetes care team and those patients who received care solely by a general internist. The results of the study were astounding: those patients with diabetes that utilized the health care team approach reduced their hospital stay by 56% or 5 days.[29] Considering that 1.6 million diabetes-related hospitalizations occur each year among those individuals over age 65, a diabetes care team approach translates into billions of dollars in potential cost savings.[30]

MANAGED CARE

Managed care is here to stay for the treatment of disease. A managed care environment has the as-yet unfulfilled potential to provide an opportunity for the empowerment of all people with diabetes to care for themselves.

The managed care industry should be acutely aware of the need to manage diabetes more aggressively. In its March 1995 issue, *The Genesis Report/MCx Managed Care Strategic Briefing*, a managed care journal, reported the need for HMOs to begin to control the costs of diabetes by reducing the risks of complications. Upon completion of an in-depth analysis of the DCCT, the journal concluded that in order to reduce the costs associated with diabetes-related complications it is time to "radically redefine" the approach to diabetes treatment by applying a "detailed management plan" to the disease. The report says a new technique known as "disease management may be the ideal approach to treat diabetes. Treating diabetes is expensive. The risk of complications are extensive [but] diabetes can be controlled which reduces both cost and complications."[31]

Despite this realization, the managed care community has been slow to empower people with diabetes.

A recent study investigating diabetes care in a managed care setting shows that intensive diabetes management has so far failed to take hold. This analysis of hundreds of charts for patients with diabetes among one of the largest HMOs in California suggest that the patients in this particular HMO are receiving grossly substandard care. Among the most disturbing elements of this study were the discoveries that only 8% of people with diabetes attended a self-management training class, only 5% were referred to an endocrinologist, and only 10% were directed to a dietitian.

When analyzing the procedures performed, even more startling trends emerge. Of the people with diabetes included in the study, 96% did not receive a primary care eye exam, 56% of the patients did not have the necessary blood work performed, 78% were not referred to an ophthalmologist, 94% did not receive a foot exam, and 71% did not have their cholesterol measured. It is noteworthy that the average age of the patient in this survey was 52, just 13 years shy of Medicare eligibility.[32]

It is critically important that health maintenance organizations that serve people with diabetes guarantee a level of care at least comparable to the American Diabetes Association *Standards of Medical Care*. Because of the long-term development of type II diabetes and the fact that diabetes prevalence increases with age, the federal government has a vested interest in ensuring that people with diabetes enrolled in health maintenance organizations receive proper care. Without the necessary and appropriate care, people with diabetes will enter into the Medicare system just as the long-term complications of the disease begin to emerge. By ensuring that health maintenance organizations provide comprehensive care, Congress can help Medicare avoid having to pay the extensive costs associated with complications.

GENERAL POPULATION

It is important to recognize that every improvement we recommend for the Medicare program can be incorporated into reform of the private insurance and Medicaid populations. For all the same reasons which apply to Medicare, the federal government has a vested interest in ensuring that all people with diabetes have access to the supplies and services they need to stay healthy and avoid costly complications and hospitalizations. While the American Diabetes Association understands that this subcommittee can only address Medicare Part A during this hearing, it is important to recognize the potential cost savings to the federal treasury if all people with diabetes received the treatments necessary to effectively manage their disease.

In Wisconsin, a study of the insurance benefits provided to individuals in accordance with state law resulted in some remarkable conclusions. The Office of the Commissioner of Insurance studied the costs of a standard benefits package for diabetes care similar to what we are are recommending today. The insurance commissioner found that directing the private insurance

community to offer a comprehensive diabetes benefit did not increase claims filed, did not increase disbursements by the insurer, did not increase costs when compared to other benefits and did not increase premiums.[33] These conclusions are critical for you to consider when contemplating broad based insurance reforms for the private sector.

CONCLUSION

Mr. Chairman and members of the Subcommittee, the task of reforming the Medicare program is daunting. However, when it comes to diabetes, there is a way to save the system money while simultaneously expanding coverage and improving health. Because of the results of the DCCT and the many other studies in the field, we know this can be accomplished by providing comprehensive coverage of diabetes outpatient self-management training, supplies and prescription coverage and guaranteed care by a diabetes team. As Speaker Gingrich has noted, this approach could save $10 billion each year for the Medicare program alone.

Congress has a golden opportunity to dramatically improve the lives of the millions of Americans with diabetes who rely on Medicare for their health insurance. The American Diabetes Association wants to assist in this effort and looks forward to working with you. I will be pleased to answer any questions you may have at this time.

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FAX 2/21/96

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

TO: Jen Klein

FROM: John Richardson

Fax Destination
Organization:
Phone Number: 6-2878

Number of Attached Pages: 4

Notes:

"Diabetes benefit (Medicare) legislative language.

HD Fax Number: 202/395-3910
Voice Confirmation:

202/395-4922	Health Division Front Office
202/395-4925	Health & Human Services Unit
202/395-4926	Health Programs & Services Branch
202/395-4930	Health Financing Branch

section 4071(b) of the Omnibus Reconciliation Act of 1987,".

(2) OBRA-1987.- Section 4071(b) of the Omnibus Budget Reconciliation Act of 1987 is repealed.

SEC. 11134. DIABETES SCREENING BENEFITS.

(a) DIABETES OUTPATIENT SELF MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), is amended—

(A) by striking "and" at the end of subparagraph (Q);

(B) by adding "and" at the end of subparagraph (R); and

(C) by adding at the end the following new subparagraph:

"(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and".

(2) DEFINITION.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES"

"(qq) (1) The term "diabetes outpatient self-management training services" means educational and training services furnished to an individual with diabetes by or under arrangements with a certified

provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administrations of injectable drugs) to participate in the management of the individual's condition.

"(2) In paragraph (1)—

"(A) a "certified provider" is an individual or entity that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

"(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met

such standards if the individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by the American Diabetes Association as meeting standards for furnishing the services"."

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including the American Diabetes Association, in determining the relative value for such services under section 1848(c)(2)of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AS DURABLE MEDICAL EQUIPMENT.—Section 1861(n) of such Act (42 U.S.C. 1395x(n)) is amended by striking the semicolon in the first sentence and inserting the following: "and includes blood-testing strips for individuals with diabetes without regard to

whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the American Diabetes Association);".

(2) PAYMENT FOR STRIPS BASED ON METHODOLOGY FOR INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT.—Section 1834(a)(2)(A) of such Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking "or" at the end of clause (ii);

(B) by adding "or" at the end of clause (iii); and

(C) by inserting after clause (iii) the following new clause:

"(iv) which is a blood-testing strip for an individual with diabetes,".

(c) EFFECTIVE DATE.—The amendments made by this Act shall apply to items and services furnished on or after January 1, 1998.

SEC. 11135. RESPITE BENEFIT.

(a) ENTITLEMENT.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended by—

(1) striking "and" at the end of subparagraph (I), (2) striking the period at the end of subparagraph (J) and