APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

Headquarters:
450 Sutter Street
Suite 600
San Francisco CA 94108
Main 415-954-9988
Fax 415-954-9999
www.apiahf.org

Washington D.C. Office:
1828 L Street N.W.
Suite 802
Washington, D.C. 20036
Main 202-466-7772
Fax 202-466-6444

National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

COMMENTS TO THE DME MAC'S ON GLUCOSE MONITORING

Paul J. Hughes, M.D.
Medical Director, DME MAC – Jurisdiction A
NHIC

Adrian M. Oleck, M.D.
Medical Director, DME MAC – Jurisdiction B
National Government Solutions

Robert D. Hoover, Jr., M.D., MPH, FACP
Medical Director, DME MAC – Jurisdiction C
CIGNA Government Services

Richard W. Whitten, M.D., MBA
Medical Director, DME MAC – Jurisdiction D
Noridian Administrative Services

The Asian & Pacific Islander American Health Forum (APIAHF) respectfully submits its comments on the Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) proposed revisions for blood glucose local coverage determination (LCD). APIAHF welcomes the opportunity and is pleased to submit comments for your consideration.

APIAHF is a national non-profit organization dedicated to influencing policy, mobilizing communities, and strengthening programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders. The AAPI community confronts unique challenges as it represents the fastest growing segment of the aging population in the nation. Along with answering medical questions regarding care, the uncertainty is magnified for the AAPI elderly, who must also ask, "Will the doctors speak my language? How do I communicate my concerns? What if I didn't get proper care?" APIAHF channels these concerns to ameliorate the distress AAPI seniors may encounter.

APIAHF commends both the Centers for Medicare and Medicaid Services (CMS) and the Medicare Advisory Committee (MAC) regarding its efforts to promulgate effective solutions related to self management of diabetes among beneficiaries. We would, however, like to express concern over the proposed change in coverage criteria as the changes do not allow for greater flexibility needed to provide appropriate testing for the AAPI senior community.

The prevalence of diabetes within the AAPI and aging community is alarming; for example:

- Nearly 25 percent of people over the age of 60 have diabetes[i]
- Asian Americans are twice as likely as the general American population to develop diabetes[ii]
- In Hawaii, Asian-Americans, Native Hawaiians and other Pacific Islanders, aged 20

years or older, are more than twice as likely as whites after adjusting for population age differences[iii]

- After adjusting for BMI, Asian women have a 2.26 higher risk of diabetes compared to whites[iv]

- Japanese are twice as likely to develop diabetes as whites[v]

- After adjusting for age, sex, and BMI, the likelihood of having diabetes is 60% higher for Asians, 80% higher for Native Hawaiians and 300% higher for Pacific Islanders, when compared to whites.[vi]

- In a seven-year study of a sample of Medicare beneficiaries ages 65 and older, Asians showed the greatest increase in prevalence of diabetes[vii]

Self-monitoring of blood glucose is invaluable as it relates to self-management education. The monitoring process provides patients with critical information on the consequences of daily activity (e.g. taking medication, meals, and physical activity).[viii] Myriad complications arise from the onset of diabetes and can lead to serious complications for pregnancy, mobility, and overall health.[ix] Of particular concern to the senior community at large, and AAPI elders specifically is that uncontrolled diabetes can often lead to biochemical imbalances that can cause life threatening events (e.g. diabetic ketoacidosis and hyperosmolar [nonketotic] coma); susceptibility to other illnesses, increasing a likelihood of death with the onset of pneumonia or influenza than people who do not have diabetes; and an inability to maintain basic mobility: persons with diabetes aged 60 years or older are 2-3 times more likely to report an inability to walk one-quarter of a mile, climb stairs, do housework, or use a mobility ability aid compared with persons without diabetes in the same age group.[x]

The current CMS coverage policy covers 100 strips/lancets every three months for patients not on insulin and 300 strips/lancets per 3 months if the patient is on insulin. The new policy makes no change to the non-insulin taking patients but differentiates the insulin taking patients into two groups. The proposed policy would provide:

- Non-insulin taking patients: 100 strips/lancets every three months

- Patient's using one injection per day: 200 strips/lancets every three months (this is a reduction from the current policy of 300 strips/lancets every three months)

- Patient's using three or more injections per day (or pump): 400 strips/lancets every three months (with an option of 600 strips/lancets per three months)

APIAHF is concerned that the proposed policy change will add significant self-management barriers to the AAPI senior population who require insulin less frequently. APIAHF is also concerned that the draft LCD interferes with the physician-patient partnership, which is essential to the treatment of Diabetes. The draft LCD sets arbitrary testing limits that remove physicians' autonomy in determining what is best for their patients. Current policy allows physicians to have flexibility to manage such patients as individuals. The Draft LCD would change that. There is evidence that suggests that frequent testing is related to better clinical outcomes.[xi] Furthermore, we are concerned that documentation required by the patients will cause an undue burden. In particular, AAPI elders, who face significant barriers to accessing healthcare due to limited English proficiency and unfamiliarity with a complicated healthcare system, may

be disproportionately impacted by this documentation requirement. As mentioned in the aforementioned paragraphs, the needs of the AAPI community regarding diabetes treatment, diagnosis, and awareness are unique. The proposed change would amount to a "one size fits all" when it comes to diabetes self-management; such approaches are never successful when dealing with AAPI seniors. We ask the Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) to reconsider the proposed revisions for glucose monitors, and to take into serious consideration the effects of such a broad policy change on a community and people who are disproportionately affected by the diabetes.

Educating the AAPI population about self-management of blood glucose levels can result in improvements in their quality of life. The current policy change may lead to an out-of-pocket increase to the patient and serve as a barrier to care. Coupled with the unique cultural and linguistic challenges that AAPI seniors face, the proposed change likely will compound an already difficult problem. APIAHF believes that self-management of blood glucose is essential to effective self-care for AAPI seniors. AAPI seniors are already highly susceptible to diabetes; access to strips, lancets and other tools will allow each to manage their illness, maximize their lives, and continue to age unfettered with concerns over affordability of self-management care.

Sincerely,

Priscilla Huang
Associate Policy Director

---

[i] American Diabetes Association, Introduction to Disparities, available at http//www.diabetes.org/advocate/our-priorities/disparities (last visited Nov. 4, 2010).

[ii] Asian & Pacific Islander American Health Forum (APIAHF), Health Brief, available at http://apiahf.org/index.php/component/content/article/197.html, citing *Asian Americans and Diabetes*, Joslin Diabetes Center, 2008, available at http://aadi.joslin.harvard.edu/intro_asian_epidemic.asp (last visited Nov. 4, 2010).

[iii] American Diabetes Association, Introduction to Disparities, available at http//www.diabetes.org/advocate/our-priorities/disparities (last visited Nov. 4, 2010).

[iv] Shai, I et al., Ethnicity, Obesity, and Risk of Type 2 Diabetes in Women,. *Diabetes Care*. 2006;29(7)1585-1590.

[v] McNeely, MJ & Boyko, EJ. Type 2 Diabetes Prevalence in Asian Americans: Results of a National Survey. *Diabetes Care.* 2004; 27(1):66-69.

[vi] McNeely, MJ & Boyko, EJ. Type 2 Diabetes Prevalence in Asian Americans: Results of a National Survey. *Diabetes Care.* 2004; 27(1):66-69.

[vii] McBean, AM et al. Differences in Diabetes Prevalence, Incidence, and Mortality Among the Elderly of Four Racial Ethnic Groups: Whites, Blacks, Hispanics, and Asians. *Diabetes Care*. 2004; 27(10):2317-2324

[viii] The Writing Team for the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications Research Group. Sustained Effect of Intensive Treatment of Type 1 Diabetes Mellitus on Development and Progression of Diabetic Nephropathy: The Epidemiology of Diabetes Interventions and Complications (EDIC) Study. *JAMA* 2003; 290(16): 2159-67.

[ix] Centers for Disease Control and Prevention, National diabetes fact sheet. 2007. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008

[x] Centers for Disease Control and Prevention, National diabetes fact sheet. 2007. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008

[xi] Poolsup, N, et al. Meta-analysis of the benefits of self-monitoring of blood glucose on glycemic control in type 2 diabetes patients: an update. *Diabetes Technol Ther*. 2009; 11(12)775-784.