

# Coverage to Quality: Utilizing Coverage to Improve Outcomes for Diabetes, Breast, Cervical, and Lung cancer

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What does “quality” in  
healthcare mean to you?



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**MPCA**

# Connecting guidelines, data, and coverage:

- United States Preventative Task Service
- Cancer Screening
  - Breast
  - Cervical
  - Colorectal
  - Lung
- Diabetes Management

# United States Preventative Services Task Force

- The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine.
- The primary goal of the USPSTF is to develop and disseminate evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.
- Recommendations are developed based on rigorous review of existing peer-reviewed evidence, and evaluation of benefits and harms.
- Recommendations address only services offered in the primary care setting or services referred by a primary care clinician.
- Recommendations apply only to people who have no signs or symptoms of the specific disease or condition that the screening, counseling, or preventive medication targets.
- Recommendations are available online and in peer-reviewed literature.

# USPSTF

- Every USPSTF recommendation is assigned a letter grade
- These grades are based on the strength of the evidence on a specific preventive service

Grade	Definition	Suggestions for Practice
<b>A</b>	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
<b>B</b>	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
<b>C</b>	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
<b>D</b>	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
<b>I</b> Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

# USPSTF-Relation to the Patient Protection and Affordable Care Act (ACA)

- Under the law, preventive services with a USPSTF Grade of A or B are covered without cost-sharing (e.g., copayment or deductible) by many health insurance plans or policies
- **Medicare** – Under the ACA, USPSTF services with a Grade “A” or “B” must be covered without cost sharing if the Secretary determines they are a) reasonable and necessary for the prevention or early detection of an illness or disability, and b) appropriate for individuals entitled to benefits under part A or enrolled under part B preventive care recommendations
- **Medicaid expansion plans** – Medicaid expansion plans offered by states that extend Medicaid eligibility to non-elderly individuals with annual incomes at or below 133 percent of the federal poverty level (\$16,611 for an individual or \$34,247 for a family of 4 in 2019) **are required to cover the full range of preventive services required in the essential health benefits (EHB) final rule.** This encompasses coverage without cost sharing for all services outlined in Section 2713 of the PHS Act (see above under “Non-grandfathered private health insurance plans”)

# Braidwood Management v. Becerra

- Plaintiffs assert that (1) the requirements in the law for specific expert committees and a federal government agency to recommend covered preventive services is unconstitutional, and that (2) the requirement to cover preexposure prophylaxis (PrEP), medication for HIV prevention, violates their religious rights.
- If the plaintiffs prevail on either the constitutional or the religious claims, the government's ability to require insurance plans to cover evidence-based preventive services without cost-sharing may be limited.
- **As of now, the federal government can continue enforcing the preventive services requirement.**

# Poll

A decorative graphic in the bottom-left corner consisting of several overlapping triangles in shades of green and light blue, resembling a mountain range.

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# Coverage for Quality- Cancer Screening



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# Breast Cancer Screening

## Recommendation Summary

Population	Recommendation	Grade
Women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	<b>B</b>
Women aged 40 to 49 years	<p>The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.</p> <p>. For women who are at average risk for breast cancer, most of the benefit of mammography results from biennial screening during ages 50 to 74 years. Of all of the age groups, women aged 60 to 69 years are most likely to avoid breast cancer death through mammography screening. While screening mammography in women aged 40 to 49 years may reduce the risk for breast cancer death, the number of deaths averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to late 40s.</p> <p>. In addition to false-positive results and unnecessary biopsies, all women undergoing regular screening mammography are at risk for the diagnosis and treatment of noninvasive and invasive breast cancer that would otherwise not have become a threat to their health, or even apparent, during their lifetime (known as "overdiagnosis"). Beginning mammography screening at a younger age and screening more frequently may increase the risk for overdiagnosis and subsequent overtreatment.</p> <p>. Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and thus may benefit more than average-risk women from beginning screening in their 40s.</p> <p>Go to the Clinical Considerations section for information on implementation of the C recommendation.</p>	<b>C</b>

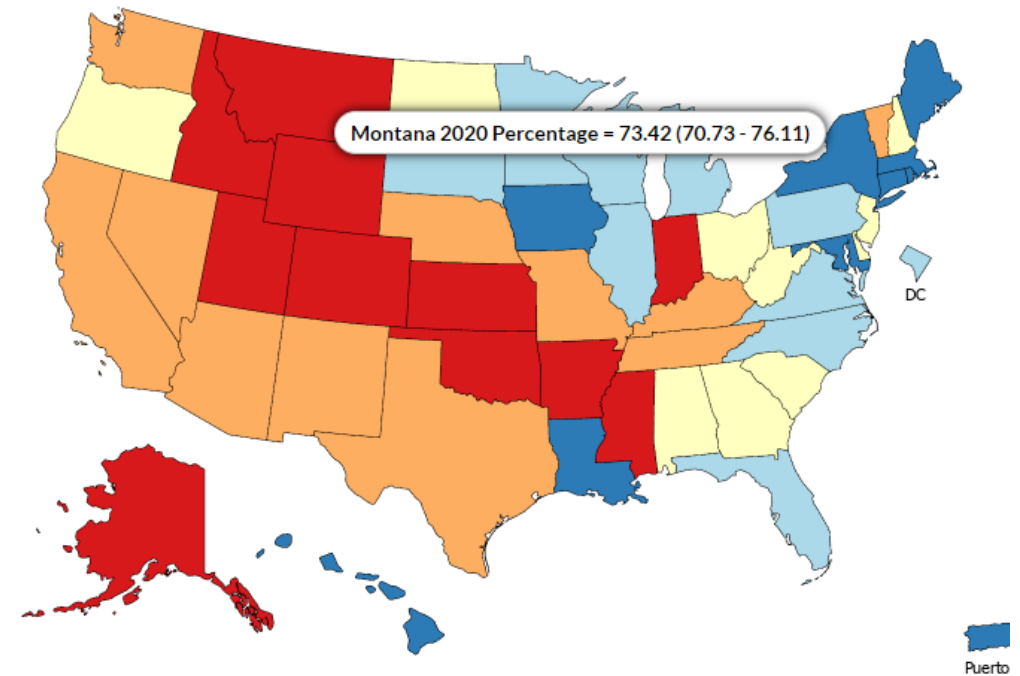
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# Breast Cancer Screening

- 2020 BRFSS Data- 73.42%
- TY September 2023 CHC Data- 46.2%

Screening and Risk Factors for United States by State  
(Directly Estimated 2020 BRFSS Data)  
Had a Mammogram in Past 2 Years  
All Races (includes Hispanic), Female, Ages 50-74



**Notes:**

Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.

BRFSS Survey Data is the source for this data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the [Centers for Disease Control and Prevention](#). BRFSS Prevalence estimates presented here may vary from other published estimates due to differences in the methodology used. Data for the United States does not include data from Puerto Rico.

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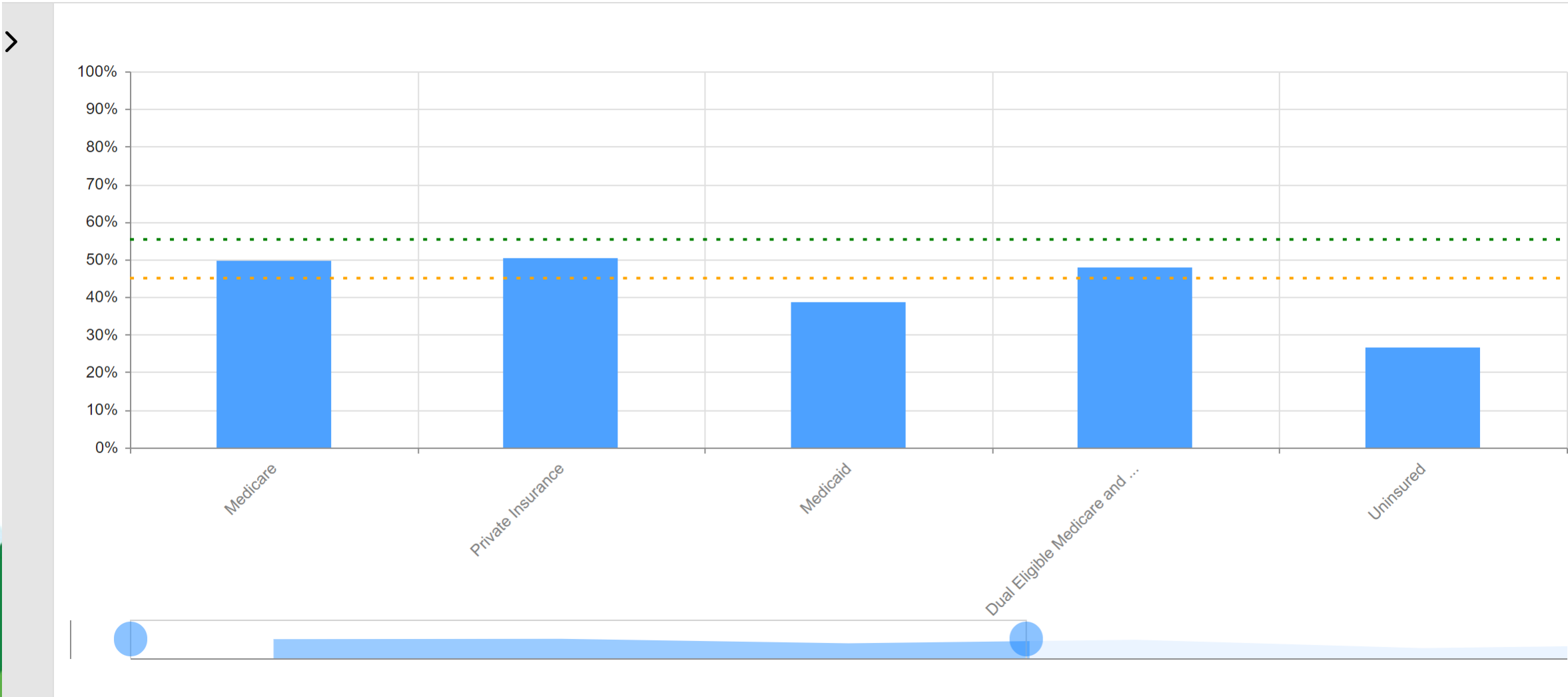
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Grouped by UDS Financial Classes

Breast Cancer Screening Ages 50-74 (CMS 125v11)

PRIMARY 55.3% SECONDARY 45% X



# Diagnostic Imaging Poll

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# No-cost-share breast cancer diagnostic and imaging requirements

## HB 665:

- ▶ Sponsored by Rep. Jodee Etchart (R-Billings)

## Key Provisions:

- ▶ No-cost-sharing means deductible, coinsurance, copayment, or similar out-of-pocket expense
- ▶ Diagnostic breast examinations include mammography, MRI, or ultrasound.
- ▶ Only applies to state-regulated insurance plans

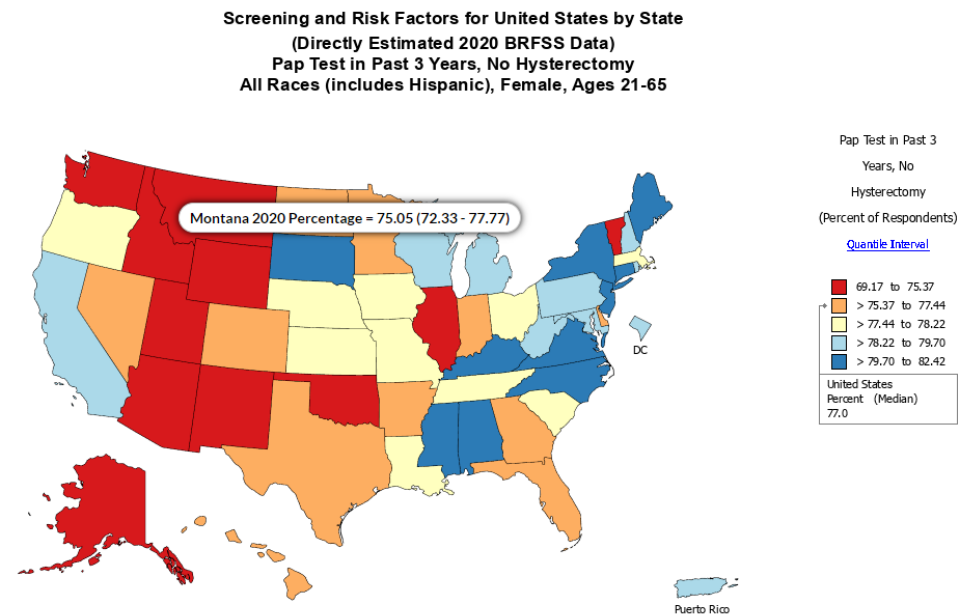
# Cervical Cancer Screening

## Recommendation Summary

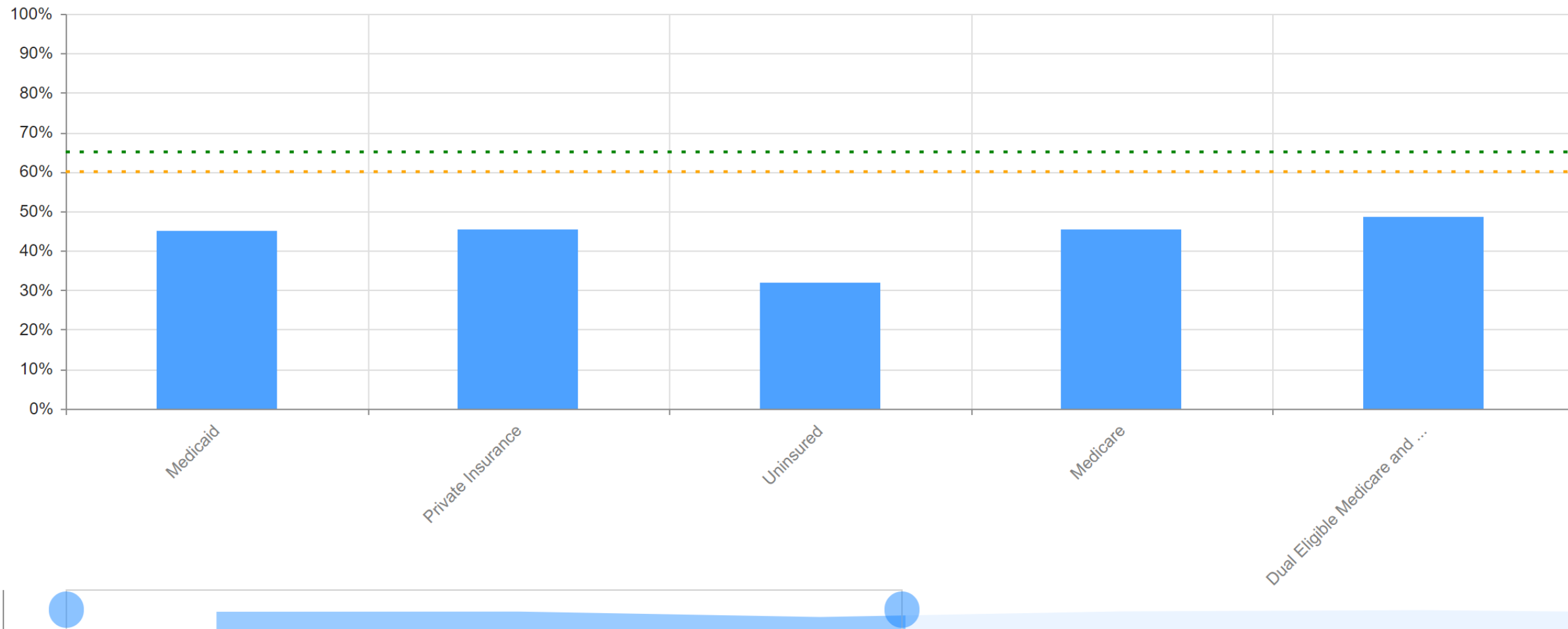
Population	Recommendation	Grade
Women aged 21 to 65 years	<p>The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).</p> <p>See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.</p>	<b>A</b>
Women younger than 21 years	The USPSTF recommends against screening for cervical cancer in women younger than 21 years.	<b>D</b>
Women who have had a hysterectomy	The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (ie, cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.	<b>D</b>
Women older than 65 years	<p>The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer.</p> <p>See the Clinical Considerations section for discussion of adequate prior screening and risk factors that support screening after age 65 years.</p>	<b>D</b>

# Cervical Cancer Screening

- 2020 BRFSS Data- 75.05%
- TY September 2023 CHC Data- 43.6%





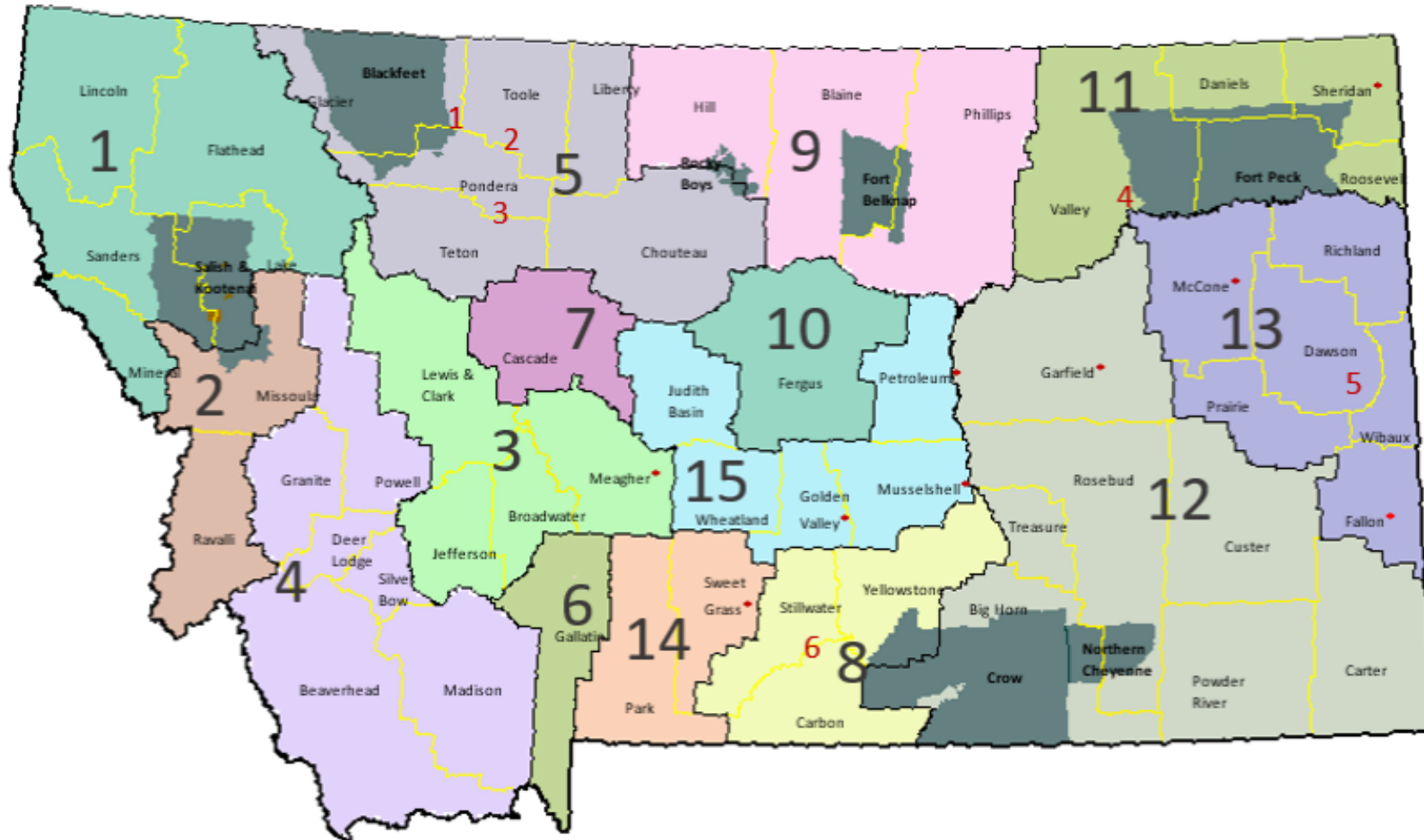


# Breast and Cervical Program

- The Breast and Cervical Program provides access to timely breast and cervical cancer screening and diagnostic services to women who have low incomes and are uninsured and underserved.

Program eligibility:

- Un/Under-insured
- Income at or below 250% of the federal poverty level
- Aged 40- 64 years of age for breast cancer screening.
- Aged 21- 64 years of age for cervical cancer screening.
- Certain people who are younger or older may qualify for screening services.



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# Poll



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# Colorectal Cancer Screening

## Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.  See the "Practice Considerations" section and Table 1 for details about screening strategies.	<b>A</b>
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.  See the "Practice Considerations" section and Table 1 for details about screening strategies.	<b>B</b>
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	<b>C</b>

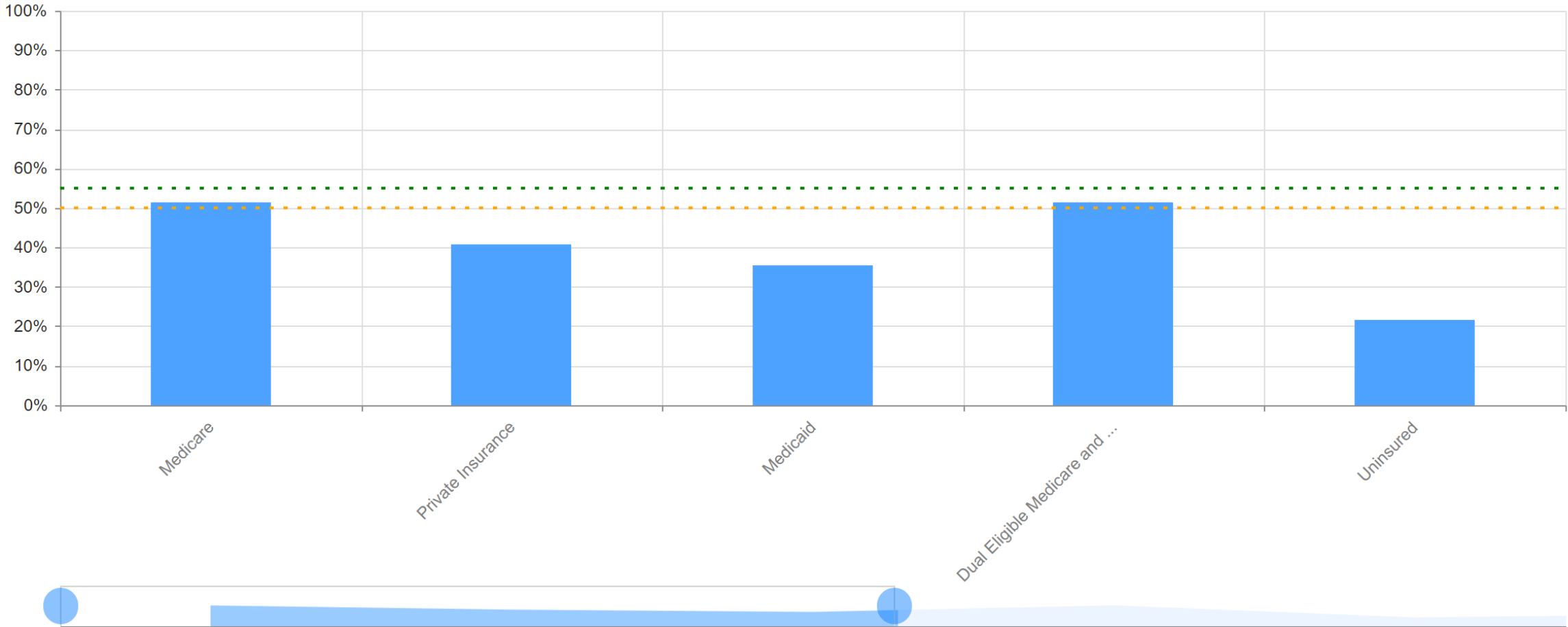
# Types of Colorectal Cancer Screening

- **Fecal occult blood test (FOBT)** or **fecal immunochemical test (FIT)** once every 12 months.
- **Stool DNA test** (Cologuard) every 3 years for people 45 to 85 years old who do not have symptoms of colorectal cancer and who do not have an increased risk of colorectal cancer.
- **Flexible sigmoidoscopy** every 4 years, but not within 10 years of a previous colonoscopy.
- **Colonoscopy**
  - Once every 10 years for those who are at average risk

# Screening vs. Diagnostic Coverage Implications

If you have a screening test other than colonoscopy and the result is positive (abnormal), you will need to have a colonoscopy. Some insurers consider this to be a **diagnostic** (not screening) colonoscopy, so you may have to pay the usual deductible and co-pay.

- Medicare will cover the cost of a follow-up screening colonoscopy if someone has a positive result on a screening FOBT, FIT, or stool DNA lab test.





# Lung Cancer Screening

## Recommendation Summary

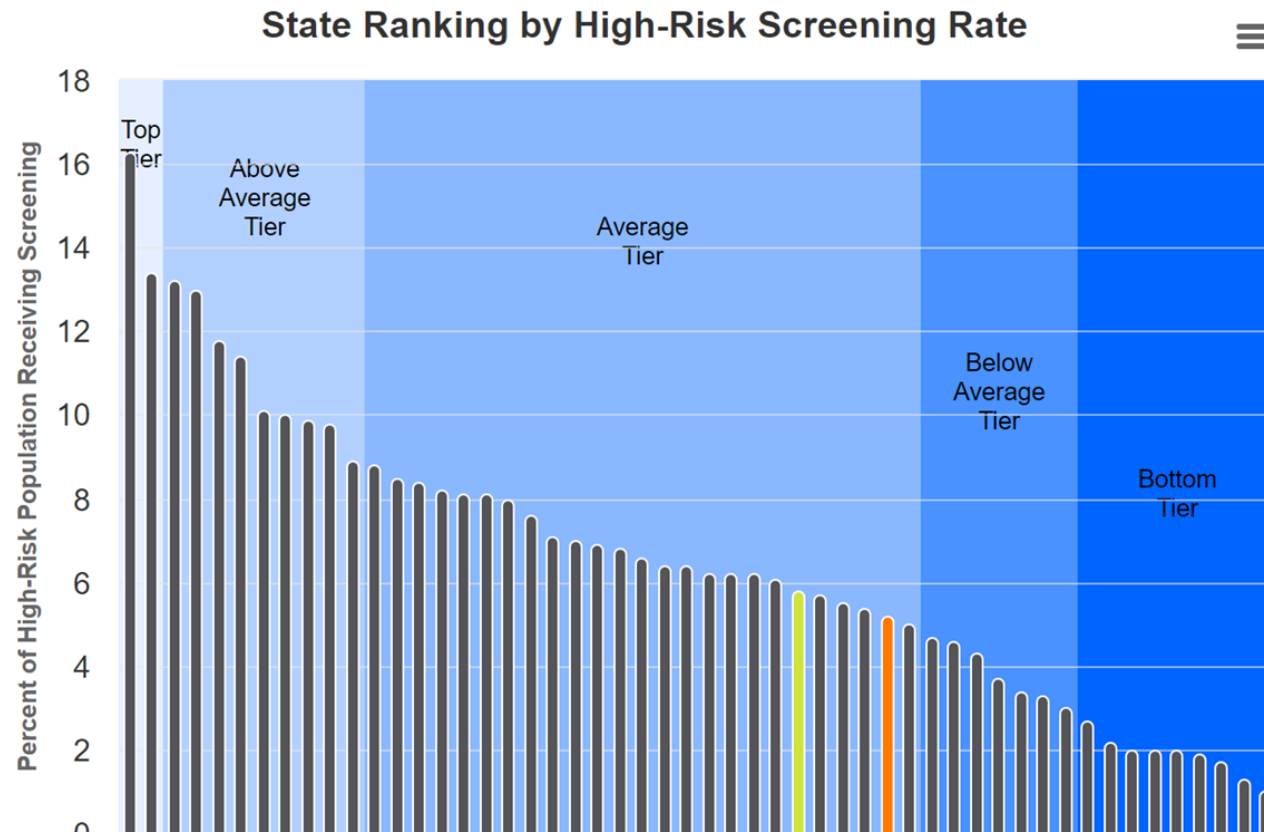
Population	Recommendation	Grade
Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	<b>B</b>

# Lung Cancer Screening Coverage

- Medicare

- Eligibility for initial lung cancer screening coverage includes:
  - Being between the ages of 55-77;
  - Having a 20 pack-year history of smoking (this means 1 pack a day for 20 years, 2 packs a day for 10 years, etc.);
  - Are a current smoker, or have quit within the last 15 years; AND
  - Have no signs or symptoms of lung cancer

# American Lung Association- State of Lung Cancer Report



## Screening for High Risk:

- In Montana, **5%** of those at high risk were screened, which was not significantly different than the national rate of 6%.
- It ranks **34th** among all states, placing it in the **average tier**.
- Screening rates may be higher in states with large, regional managed care providers that did not share screening data.

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# Diabetes Management

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0 percent) CMS122v11

## Measure Description

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

## Denominator:

Patients 18 through 75 years of age by the end of the measurement period with diabetes with an eligible countable visit during the measurement period, as specified in the measure criteria

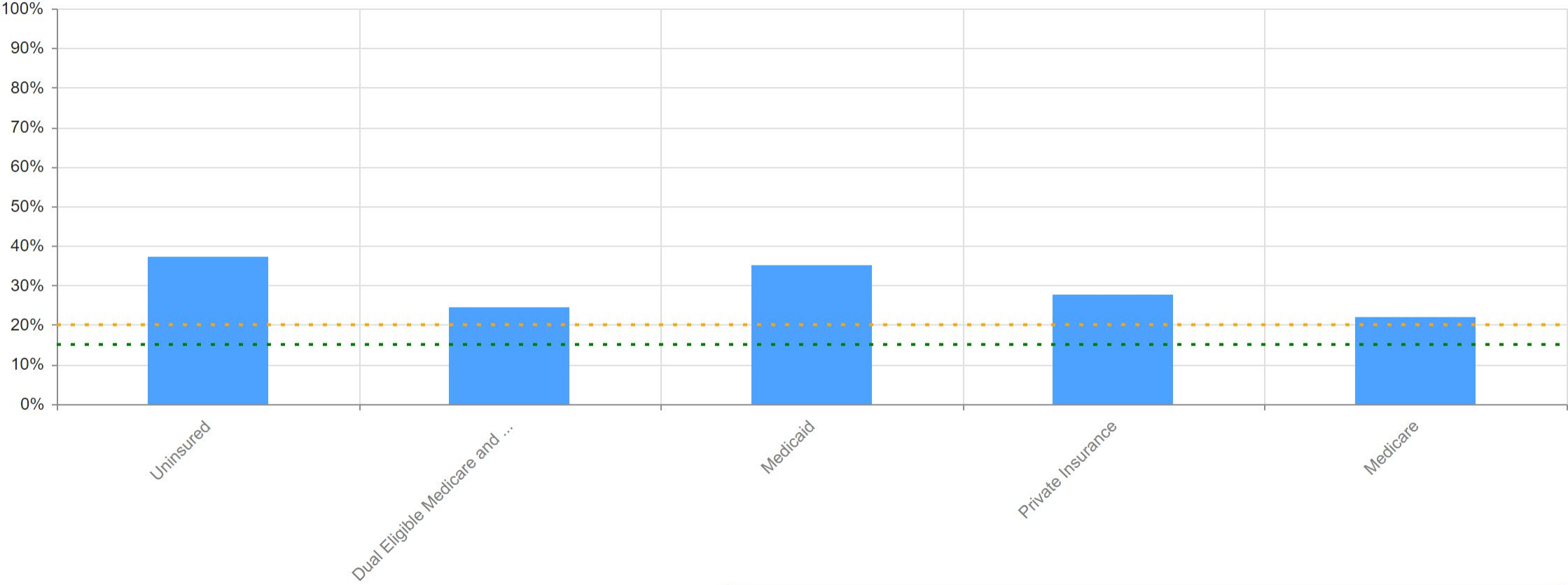
## Numerator:

Patients whose most recent HbA1c level performed during the measurement period was greater than 9.0%, or was missing, or was not performed during the measurement period

Grouped by UDS Financial Classes

Diabetes A1c > 9 or Untested (CMS 122v11)

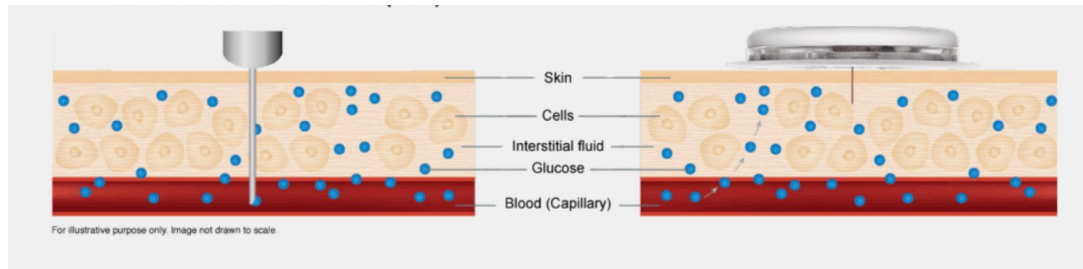
PRIMARY 15% SECONDARY 20% X



# Assessing Glycemic Control

- Five main ways of assessing glycemic control
  - A1c
  - CGM using time in range
  - CGM and Glucose Management Indicator (GMI)
  - Blood Glucose Monitoring (BGM)
  - CGM Trends

# Continuous Glucose Monitors- CGMs



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# Association of Diabetes Care and Education Specialists (ADCES) tool



[Danatech](#) [Contact Us](#) [CGM Resources](#) [Privacy](#) [FAQ](#)

This site is intended for U.S. audiences only

## CGM Insurance Coverage Tool from danatech

Welcome to the Continuous Glucose Monitor (CGM) insurance coverage tool brought to you by danatech, powered by ADCES. Just select the payer, plan information and state you are working with and if a policy is published, coverage information will appear. If you do not see the payer you need, the company does not have a published policy and could not be included in this tool. Please contact them directly for more info. We highly encourage you to read all documents provided in the coverage results which will clarify specific details pertaining to coverage by diabetes type, and benefit specifics.

Payer

Plan Type

State

All payers

All plan types

Montana \*

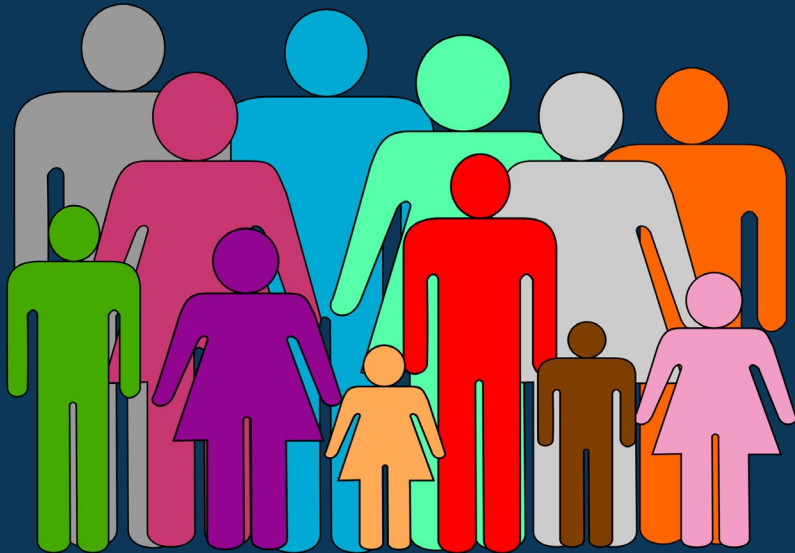
Search

Payer	Plan Type	State	Covered	Prior Authorization	Coverage Summary	Documents	Contact
Aetna	Commercial	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">1-800-624-0736</a> <a href="#">N/A</a>
BCE Federal Employee Plan	Federal Employer	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">(877)-727-3784</a> <a href="#">1-877-378-4727</a>
BCE Montana	Commercial	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">310-453-4000</a> <a href="#">N/A</a>
Cigna	Commercial	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-833-7677</a> <a href="#">833-238-6437</a>
Express Scripts	Commercial	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-733-2831</a> <a href="#">1-877-231-3896</a>
Fallon Health Plan of Massachusetts	Medicare Advantage	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">1-866-273-3247</a> <a href="#">N/A</a>
HCSC	Commercial	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">310-453-6000</a> <a href="#">N/A</a>
Healthink	Commercial	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-424-0356</a> <a href="#">N/A</a>
Humana	Medicare Supplemental	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-923-0023</a> <a href="#">N/A</a>
Humana	Self Funded/Employer Sponsored	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-923-0023</a> <a href="#">N/A</a>
Humana	Medicare	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-923-0023</a> <a href="#">N/A</a>
Humana	Medicare-Medicaid Dual-Eligibles	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-923-0023</a> <a href="#">N/A</a>
Humana	Commercial	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-923-0023</a> <a href="#">N/A</a>
Noridian	Medicare PPS	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">N/A</a> <a href="#">N/A</a>
Noridian	Medicare PPS	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">N/A</a> <a href="#">N/A</a>
Northwood	Commercial	MT	Yes	Unspecified		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">(800) 393-4432</a> <a href="#">(586) 733-3878</a>
Point32Health	Commercial	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">888-237-1983</a> <a href="#">N/A</a>
Point32Health	Medicare Advantage	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">N/A</a> <a href="#">817-673-0936</a>
Point32Health	Medicare-Medicaid Dual-Eligibles	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">N/A</a> <a href="#">817-673-0936</a>
Prime Therapeutics	Commercial	MT	Yes	Yes		<a href="#">PA Form</a> <a href="#">Coverage Document</a>	<a href="#">800-821-4793</a> <a href="#">877-243-6130</a>





# Medicaid & CGMs

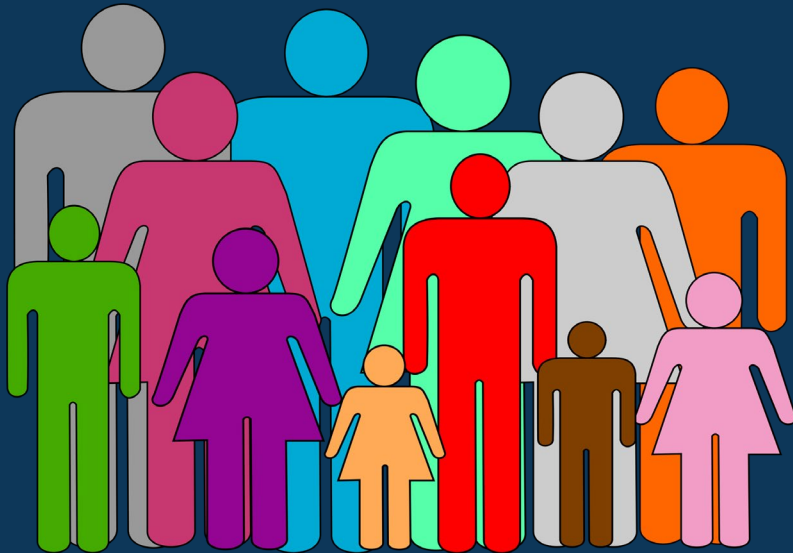


Montana Medicaid covers  
Therapeutic Continuous Glucose  
Monitor (CGM) devices that are  
classified by CMS as “therapeutic  
CGMs” for members ages 4 and up  
without prior authorization.  
Children under the age of 4 will  
require prior authorization.

<https://medicaidprovider.mt.gov/docs/providernotices/2021PN/TherapeuticContinuousGlucoseMonitorDevices11022021.pdf>



# Medicaid & CGMs



Your Search for  
Manufacturer/Distributor:  
HCPCS Code:  
Product Name:  
Product Model:  
Classification(s): Glucose Monitor

Product Name	Manufacturer/Distributor	Model Number	HCPCS Code	Effective Begin Date	Effective End Date	Comments
DEXCOM G5 MOBILE CONTINUOUS GLUCOSE MONITORING (CGM) SYSTEM	DEXCOM INC		E2103	01/01/2023		THE SUPPLY ALLOWANCE MUST BE BILLED WITH A4239; INCLUDES ALL ITEMS NECESSARY FOR USE OF THE NON-ADJUNCTIVE CGM SYSTEM.
FREESTYLE LIBRE 2 FLASH GLUCOSE MONITORING SYSTEM	ABBOTT DIABETES CARE INC	71951-01 (TAA)	E2103	01/01/2023		THE SUPPLY ALLOWANCE MUST BE BILLED WITH A4239; INCLUDES ALL ITEMS NECESSARY FOR USE OF THE NON-ADJUNCTIVE CGM SYSTEM.



# Medicare & CGMs



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If your doctor determines that you meet all the coverage requirements, Medicare covers continuous glucose monitors and related supplies for making diabetes treatment decisions, (like changes in diet and insulin dosage).

<https://www.medicare.gov/coverage/therapeutic-continuous-glucose-monitors>



# Medicare & CGMs



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## Coverage Requirements

1. Must have Diabetes
2. Training to Use CGM
3. CGM Prescribed with FDA indications for use.
4. A) Insulin-Treated OR;  
B) History of problematic hypoglycemia with documentation.
5. Treating practitioner 6 mos prior to ordering has in-person/approved telehealth visit to evaluate and determine criteria 1-4 are met, and every 6 mos after.

<https://www.medicare.gov/coverage/therapeutic-continuous-glucose-monitors>





## Overview:

Private plans are all different and coverage of CGMs is evolving. CGMs may be covered.

## Tips:

- Have patients talk to their health insurer about CGM coverage and read plan documents.
- It can be confusing because CGMs are covered under DME or pharmacy benefits and it can be tricky to figure out.



# Questions?

[cbuys@mtpca.org](mailto:cbuys@mtpca.org)

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