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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Alabama: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Alabama.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Alabama

As of 2015, nearly 1 in 8 adults in Alabama had been diagnosed with diabetes—more than 506,000 individuals in total.[30] African Americans in the state are significantly more likely than whites to have diabetes,[31] and African American females have the highest mortality rate among all adults with diabetes in the state.[32] According to the ADA, an additional 1.33 million individuals—37% of the state's adult population—have prediabetes.[33]

Alabama adults with diabetes are nearly 3 times more likely than those without the disease to have a heart attack.[31] Less than 20% of Alabamians with diabetes eat 5 or more servings of fruits and vegetables every day.[31] In 2015, 43.4% of Alabama adults with the disease reported "fair or poor" general health, and 39% reported an inability to do usual activities at least 1 day in the past 30 days.[30] The annual medical and economic costs attributable to diabetes in Alabama exceeds $8.5 billion.[34]

AL Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	AL	U.S.
% of Adults with Diagnosed Diabetes (2015)	12.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.6	6.5
Completed a DSME/T Class [ii] (2010)	58.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	76.2%	63.6%
Overweight or Obese [ii] (2010)	82.7%	84.7%
Physical Inactivity [ii] (2010)	44.7%	36.1%
High Blood Pressure [ii] (2015)	65.2%	57.9%[iii]
High Cholesterol [ii] (2015)	55.6%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	52%	15%	19%
Coverage Required	No	Part B only	No
Cost Sharing	-	Up to 20% copay Deductible	-
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Alabama does not require private health insurance plans to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[40,41] Subject to limited exception,[42] recipients may receive 1 hour of private training and 9 hours of group training.[43] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[44] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[45,46] and receive the training from an ADA- or AADE-accredited program.[45,47] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[45,48]

Medicaid Coverage

Alabama's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[38,49,50] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Alabama Medicaid Information
www.medicaid.alabama.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Alabama DSME/T Website
http://j.mp/2ckgO2Y

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42. 42 C.F.R. § 410.141(c)(1)(ii).

43. 42 C.F.R. §§ 410.141(c)(1)(i)(D), (F).

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Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Alaska

As of 2015, approximately 1 in 13 adults in Alaska had been diagnosed with diabetes—more than 42,000 individuals in total.[30] According to the ADA, an additional 194,000 individuals—36.7% of the state's adult population—have prediabetes.[31] Alaska Natives in the state are more likely than the general population to have prediabetes.[32]

In 2015, nearly 38% of Alaska adults with diabetes reported having "fair or poor" general health, and 41.9% reported an inability to do usual activities at least 1 day in the past 30 days.[30] In 2013, Alaska incurred an estimated $865 million in medical and economic costs attributable to diabetes.[33] A 2014 study found health care costs dropped by 21.7% among Alaska Medicaid beneficiaries receiving DSME/T.[34] The study concluded that Alaska could save up to $36 million per year if all adult Medicaid beneficiaries received DSME/T services.[34]

AK Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	AK	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.2	6.5
Completed a DSME/T Class [ii] (2010)	63.9%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	73.8%	63.6%
Overweight or Obese [ii] (2010)	63.8%	84.7%
Physical Inactivity [ii] (2010)	24.6%	36.1%
High Blood Pressure [ii] (2015)	53.6%	57.9%[iii]
High Cholesterol [ii] (2015)	36.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	53%	9%	18%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Alaska requires all private health insurance plans to provide coverage for outpatient DSME/T, including medical nutrition therapy.[40] Coverage requires a prescription from a health care provider, and a health care professional with training in treating diabetes must provide the DSME/T.[40] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Alaska's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $42,000 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,51] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Alaska Medicaid Information
http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Alaska DSME/T Website
http://j.mp/2ckhZ2f

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Arizona: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Arizona.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Arizona

As of 2015, approximately 1 in 11 adults in Arizona had been diagnosed with diabetes—more than 520,000 individuals in total.[30] African Americans in Arizona are nearly 3 times more likely than non-Hispanic whites to have diabetes, and American Indians, Asian Americans, Pacific Islanders, and Hispanic individuals in the state are also more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.8 million individuals—37.5% of the state's adult population—have prediabetes.[32]

In 2015, nearly half of Arizona adults with diabetes reported "fair or poor" general health, and 64.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, 15.8% of adults with diabetes in the state did not visit a health professional for their diabetes, and only 66.8% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Arizona exceeds $8 billion.[33]

AZ Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	AZ	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.2	6.5
Completed a DSME/T Class [ii] (2010)	51.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	54.3%	63.6%
Overweight or Obese [ii] (2010)	88%	84.7%
Physical Inactivity [ii] (2010)	24.6%	36.1%
High Blood Pressure [ii] (2015)	51.4%	57.9%[iii]
High Cholesterol [ii] (2015)	60.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	45%	14%	25%
Coverage Required	No	Part B only	No
Cost Sharing	-	Up to 20% copay Deductible	-
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Diabetes education available for American Indians and Alaska Natives

Private Insurance

Arizona does not require private health insurance plans to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[39,40] Subject to limited exception,[41] recipients may receive 1 hour of private training and 9 hours of group training.[42] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[43] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[44,45] and receive the training from an ADA- or AADE-accredited program.[44,46] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[44,47]

Medicaid Coverage

Arizona's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[48] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,49] The program does not cover DSME/T for most beneficiaries. However, it does provide diabetes education to American Indian and Alaska Native populations under a special waiver from the federal government.[50] This education must cover problem-solving, exercise, medication use, communication, nutrition, decision-making, and evaluation of new treatments.[50]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Arizona Medicaid Information
www.azahcccs.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Arizona DSME/T Website
http://j.mp/2ckiUjh

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Arkansas: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Arkansas.

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Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

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Diabetes in Arkansas

As of 2015, approximately 1 in 9 adults in Arkansas had been diagnosed with diabetes—more than 286,000 people in total.[30] African Americans in the state are significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 797,000 individuals—36.4% of the state's adult population—have prediabetes.[32] The incidence of new diabetes diagnoses among Arkansas adults is almost double the national rate.[30]

In 2015, more than 57% of Arkansas adults with the disease reported "fair or poor" general health, and 36.2% reported an inability to do usual activities at least 1 day in the past 30 days.[30] In 2013, nearly 20% of Arkansas adults with diabetes did not visit a health professional for their diabetes, and only 53.3% had 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Arkansas exceeds $4 billion.[33]

AR Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	AR	U.S.
% of Adults with Diagnosed Diabetes (2015)	11.2%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	12.5	6.5
Completed a DSME/T Class [ii] (2007)	54.4%	56.5%
Daily Self-Monitoring Blood Glucose [ii] (2007)	65.3%	63.7%
Overweight or Obese [ii] (2010)	87.3%	84.7%
Physical Inactivity [ii] (2010)	33.7%	36.1%
High Blood Pressure [ii] (2015)	%	57.9%[iii]
High Cholesterol [ii] (2015)	%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	51%	16%	22%
Coverage Required	Yes	Part B only	Yes* (See below)
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Must complete DSME/T for coverage to apply	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* Applies only to beneficiaries receiving an Alternative Benefit Plan

Private Insurance

Arkansas requires private health insurance policies to provide coverage for medically necessary DSME/T, including medical nutrition therapy.[39–41] Private insurance covers a one-time training program when a physician prescribes DSME/T for a patient.[39,42] It covers additional DSME/T services when a physician prescribes it after a significant change in a patient's symptoms or condition.[39,42] DSME/T must be provided by a licensed health care professional with expertise in diabetes care and treatment and who has completed an educational program in compliance with the National Standards.[39,41,42]

DSME/T should comply with the National Standards[41] and include an individualized needs assessment, education plan, education intervention, evaluation of learner outcomes, and plan for any necessary follow-up education.[43] Coverage is available only if the insured individual successfully completes the DSME/T program.[42] Insurers may impose requirements regarding cost sharing, referrals, prior authorization, and other policy limitations similar to those applicable to other benefits.[42]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Arkansas' Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[53] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,54] The program specifically indicates coverage only for populations receiving Medicaid benefits through an Alternative Benefit Plan, such as newly eligible adults under the Affordable Care Act.[55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Arkansas Medicaid Information
www.medicaid.state.ar.us

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Arkansas DSME/T Website
http://j.mp/2caq3S8

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Law & policy innovation for the common good.

A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

California: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in California.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in California

As of 2015, nearly 1 in 10 adults in California had been diagnosed with diabetes—more than 3 million people in total.[30] Hispanics and African Americans in the state are nearly twice as likely as non-Hispanic whites to have the disease.[31] A study published in March 2016 found that nearly half of adults in California have prediabetes, including 33% of adults ages 18 to 39, 49% of adults ages 40 to 59, and 60% of adults ages 55 and older.[32]

Californian adults with diabetes are more likely to have hypertension, cardiovascular disease, and arthritis.[31] In 2015, 48.6% of Californian adults diagnosed with diabetes reported "fair or poor" general health and 35.1% reported an inability to do usual activities at least 1 day in the past 30 days.[30] The annual medical and economic costs attributable to diabetes in California exceeds $50 billion.[33] Yet, California spends less per capita on diabetes prevention than any other state.[34]

CA Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,35]	CA	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	10.1	6.5
Completed a DSME/T Class [ii] (2010)	59.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	61.9%	63.6%
Overweight or Obese [ii] (2010)	78.2%	84.7%
Physical Inactivity [ii] (2010)	27.1%	36.1%
High Blood Pressure [ii] (2015)	54.9%	57.9%[iii]
High Cholesterol [ii] (2015)	50.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	54%	10%	26%
Coverage Required	Yes	Part B only	Yes* (See below)
Cost Sharing	Copayment	Up to 20% copay Deductible	Varies
Limitations	Referral or prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* Medi-Cal Health Plans only

Private Insurance

California state law requires all private health insurance plans to provide coverage for outpatient DSME/T and medical nutrition therapy.[40] This includes, at minimum, "instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications."[41] Any appropriately licensed or registered health care professional may provide DSME/T services,[41] and a patient's copayment cannot exceed their copayment for physician office visits.[42]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[43,44] Subject to limited exception,[45] recipients may receive 1 hour of private training and 9 hours of group training.[46] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[47] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[48,49] and receive the training from an ADA- or AADE-accredited program.[48,50] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[48,51]

Medicaid Coverage

California's Medicaid program, Medi-Cal, covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[52] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[53,54] Medi-Cal covers more than 13 million people in California, and approximately 80% of those individuals are in Medi-Cal Managed Care Health Plans.[55] These plans are required to provide DSME/T services upon a patient's request or when presented with a referral from the patient's provider.[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

California Medicaid Information
www.dhcs.ca.gov/services/medi-cal/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas California DSME/T Website
http://j.mp/2capVC3

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Colorado: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Colorado.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Colorado

As of 2015, nearly 1 in 15 adults in Colorado had been diagnosed with diabetes—more than 283,000 people in total.[30] African Americans and Hispanic individuals in Colorado are twice as likely as non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.34 million individuals—34.8% of the state's adult population—have prediabetes.[32]

Compared with Colorado residents without diabetes, Coloradans with diabetes are at least 5.7 times more likely to have a heart attack, 3.7 times more likely to be diagnosed with kidney disease, and twice as likely to have a stroke.[31] Individuals in the state with the disease are also significantly less likely to be physically active and more likely to be obese.[31] Roughly 66% of individuals with diabetes in Colorado are covered by public health insurance programs like Medicaid and Medicare.[31] The annual medical and economic costs attributable to diabetes in Colorado exceeds $4.3 billion.[33]

CO Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	CO	U.S.
% of Adults with Diagnosed Diabetes (2015)	6.4%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	4.9	6.5
Completed a DSME/T Class [ii] (2009)	64%	55.7%
Daily Self-Monitoring Blood Glucose [ii] (2009)	65.6%	61.5%
Overweight or Obese [ii] (2010)	81.2%	84.7%
Physical Inactivity [ii] (2010)	22.7%	36.1%
High Blood Pressure [ii] (2015)	49.8%	57.9%[iii]
High Cholesterol [ii] (2015)	54.7%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	56%	13%	19%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Prescription required Provider network may be limited	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial training 2 hours annual follow-up training Referral required

Private Insurance

Colorado requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[39] DSME/T must be ordered for a patient by a Colorado-licensed health care provider with prescriptive authority,[39] and the services must be provided by a certified, registered, or licensed health care professional with expertise in diabetes.[40] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Colorado's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,52] The program covers up to 10 hours of DSME/T in the year following a beneficiary's initial DSME/T training, including up to 1 hour for group or individual assessment and 9 hours of group DSME/T.[53] Beneficiaries may also receive up to 2 hours of individual or group follow-up training in subsequent years.[53]

To be eligible for DSME/T coverage, a beneficiary must be diagnosed with diabetes and receive a written referral from a physician or "a nurse practitioner, clinical nurse specialist, advanced practice nurse, physician assistant, nurse midwife, clinical psychologist or clinical social worker who is managing [the beneficiary's] diabetes condition."[53] DSME/T programs must be accredited by either the ADA or the AADE and cover the components outlined in the National Standards.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Colorado Medicaid Information
www.colorado.gov/pacific/hcpf/colorado-medicaid

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Colorado DSME/T Website
http://j.mp/2cap3NI

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Connecticut: Background, Benefits, and Insurance Coverage of DSME/T

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Diabetes in Connecticut

As of 2015, nearly 1 in 12 adults in Connecticut had been diagnosed with diabetes—more than 262,000 people in total.[30] African Americans and Hispanic individuals in Connecticut are more than twice as likely as non-Hispanic whites to have the disease.[31] According to the ADA, an additional 997,000 individuals—36.5% of the state's adult population—have prediabetes.[32]

In 2015, more than 40% of Connecticut adults with diabetes reported "fair or poor" general health, and 61.2% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 38.1% of Connecticut adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] The annual medical and economic costs attributable to diabetes in Connecticut exceeds $4.6 billion.[33] The Connecticut Department of Public Health supports increasing the use of DSME/T as a key strategy "to promote diabetes prevention and high quality disease management."[31]

CT Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	CT	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.8	6.5
Completed a DSME/T Class [ii] (2010)	55.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	55.8%	63.6%
Overweight or Obese [ii] (2010)	83.6%	84.7%
Physical Inactivity [ii] (2010)	33%	36.1%
High Blood Pressure [ii] (2015)	67.2%	57.9%[iii]
High Cholesterol [ii] (2015)	65.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	60%	13%	19%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	10 hours initial training 4 hours follow-up training Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Connecticut requires private health insurance policies to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy.[39,40] Private insurance covers up to 10 hours of initial training after an individual is first diagnosed with diabetes, and up to 4 hours of follow-up training.[41,42] Follow-up training is available only when there is a significant change in the individual's symptoms or condition or when new diabetes treatment techniques necessitate additional DSME/T services.[41,42]

DSME/T must be prescribed by a licensed health care professional and provided by a certified, registered, or licensed health care professional trained in diabetes care and management.[39,40] Insurers may impose the same requirements, such as cost sharing, applicable to other covered benefits.[43,44]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[45,46] Subject to limited exception,[47] recipients may receive 1 hour of private training and 9 hours of group training.[48] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[49] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[50,51] and receive the training from an ADA- or AADE-accredited program.[50,52] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[50,53]

Medicaid Coverage

Connecticut's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[54] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,55] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, the Healthy Living with Diabetes program uses "nurse care managers" to help teach self-management techniques to Connecticut Medicaid beneficiaries with diabetes.[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Connecticut Medicaid Information
www.ct.gov/hh/site/default.asp

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Connecticut DSME/T Website
http://j.mp/2ckkd1P

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ChangeLab Solutions
Law & policy innovation for the common good.

A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

District of Columbia: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in the District of Columbia.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in the District of Columbia

As of 2015, more than 1 in 11 adults in the District of Columbia had been diagnosed with diabetes—more than 47,000 individuals in total.[30] African Americans in D.C. are more than 5 times as likely as non-Hispanic whites to have the disease; Hispanics in D.C. are more than twice as likely as non-Hispanic whites to have the disease.[31] According to the ADA, an additional 172,000 individuals—34.2% of the District's adult population—have prediabetes.[32]

In 2015, 42% of adults with diabetes in the District of Columbia reported "fair or poor" general health, and 65.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2014, more than 21% of adults with the disease did not visit a health professional for their diabetes, and only 62.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in the District of Columbia exceeds $1.2 billion.[33]

DC Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,34]	DC	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.3%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.8	6.5
Completed a DSME/T Class [ii] (2010)	62.6%	56.5%
Daily Self-Monitoring Blood Glucose [ii] (2010)	67.2%	63.7%
Overweight or Obese [ii] (2010)	84.5%	84.7%
Physical Inactivity [ii] (2010)	33.8%	36.1%
High Blood Pressure [ii] (2015)	57.9%	57.9%[iii]
High Cholesterol [ii] (2015)	58.2%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	60%	10%	26%
Coverage Required	Yes	Part B only	No* (See below)
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* All Medicaid managed care providers in D.C. provide coverage for DSME/T or diabetes education.

Private Insurance

The District of Columbia requires all private health insurance plans to provide coverage for outpatient DSME/T, including medical nutrition therapy.[39,40] Private insurance covers DSME/T when prescribed by a health care professional.[40] Insurers may impose cost-sharing and other requirements so long as they are not more expensive or more restrictive than those applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

The District of Columbia's Medicaid program covers all individuals at or below 215% of the federal poverty level ($52,890 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,52] The 3 Medicaid managed care organizations in the District of Columbia—Amerihealth, MedStar Family Choice, and Trusted Health Plan[53]—all indicate they provide diabetes education. Amerihealth explicitly discusses DSME/T coverage,[54] while MedStar Family Choice and Trusted Health Plan reference diabetes education as a component of their general disease management program.[55,56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

District of Columbia Medicaid Information
www.dc-medicaid.com

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas District of Columbia DSME/T Website
http://bit.ly/2cgQJBm

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Delaware: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Delaware.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Delaware

As of 2015, nearly 1 in 10 adults in Delaware had been diagnosed with diabetes—more than 84,000 people in total.[30] African Americans in the state are roughly 33% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 261,000 individuals—37.7% of the state's adult population—have prediabetes.[32]

In 2015, 37.5% of Delaware adults with diabetes reported "fair or poor" general health, and 64.5% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, Delawareans with diabetes are more than twice as likely as those without the disease to report having a disability.[31] However, in 2015, nearly 9% of adults with diabetes in the state did not visit a health professional for their diabetes, and only 72.2% received 2 or more A1c tests in the last past year.[30] The annual medical and economic costs attributable to diabetes in Delaware exceeds $1.5 billion.[33]

DE Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	DE	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	10.7	6.5
Completed a DSME/T Class [ii] (2010)	49.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	67.7%	63.6%
Overweight or Obese [ii] (2010)	85.6%	84.7%
Physical Inactivity [ii] (2010)	31.9%	36.1%
High Blood Pressure [ii] (2015)	69.9%	57.9%[iii]
High Cholesterol [ii] (2015)	66.6%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	58%	14%	18%
Coverage Required	-	Part B only	-
Cost Sharing	-	Up to 20% copay Deductible	-
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Delaware does not require private health insurance policies to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[39,40] Subject to limited exception,[41] recipients may receive 1 hour of private training and 9 hours of group training.[42] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[43] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[44,45] and receive the training from an ADA- or AADE-accredited program.[44,46] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[44,47]

Medicaid Coverage

Delaware's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[48] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,49] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Delaware Medicaid Information
http://dhss.delaware.gov/dhss/dmma/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Delaware DSME/T Website
http://j.mp/2ckkJgl

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Florida: Background, Benefits, and Insurance Coverage of DSME/T

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Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Florida

As of 2015, approximately 1 in 10 adults in Florida had been diagnosed with diabetes—more than 1.82 million people in total.[30] According to the ADA, an additional 5.8 million people—38.7% of the state's adult population—have prediabetes.[31] Between 2012 and 2014, African Americans and individuals from other communities of color in the state died from diabetes at a rate nearly twice that of non-Hispanic whites.[32]

In 2015, more than 40% of Florida adults diagnosed with diabetes reported "fair or poor" general health, and 47.1% reported an inability to do usual activities at least 1 day in the past 30 days.[30] Despite this high burden, in 2015, more than 20% of Florida adults with the disease did not visit a health professional for their diabetes, and only 74.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Florida exceeds $26 billion.[33]

FL Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,34]	FL	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.3%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.2	6.5
Completed a DSME/T Class [ii] (2010)	54.9%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	57.1%	63.6%
Overweight or Obese [ii] (2010)	90.3%	84.7%
Physical Inactivity [ii] (2010)	38.2%	36.1%
High Blood Pressure [ii] (2015)	58.4%	57.9%[iii]
High Cholesterol [ii] (2015)	59.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	49%	18%	18%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	HMOs may not impose financial caps on DSME/T coverage	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Florida law requires all private health insurance plans to provide coverage for outpatient DSME/T.[39–41] Coverage is available if "the patient's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary."[39–41] DSME/T services must follow the ADA's National Standards,[42] and HMOs may not impose financial caps on medically necessary DSME/T.[43] However, plans may require that DSME/T "be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist" and that a DSME/T recipient receive nutrition counseling from a licensed dietitian.[39–41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Florida's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, noncitizens with medical emergencies, individuals 65 or older, and individuals with disabilities.[53,54] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, Florida Medicaid managed care organizations, which provide services to most Medicaid beneficiaries in the state, are required to provide coverage for disease management and education more generally.[55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Florida Medicaid Information
www.fdhc.state.fl.us

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Florida DSME/T Website
http://j.mp/2ckmyJX

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Georgia: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Georgia.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Georgia

As of 2015, nearly 1 in 9 adults in Georgia had been diagnosed with diabetes—more than 869,000 individuals in total.[30] African Americans in the state are more than 50% more likely than non-Hispanic whites to have diabetes; African American women in the state are nearly 63% more likely than non-Hispanic white women to have the disease.[31] According to the ADA, an additional 2.6 million individuals—36.1% of the state's adult population—have prediabetes.[32]

In 2015, 54.8% of Georgia adults with diabetes reported "fair or poor" general health, and 66.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 40.3% of adults with diabetes in the state reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 12.2% of Georgia adults with the disease did not visit a health professional for their diabetes, and only 63.5% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Georgia exceeds $12 billion.[33]

GA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	GA	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.7%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.5	6.5
Completed a DSME/T Class [ii] (2010)	60.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	66.7%	63.6%
Overweight or Obese [ii] (2010)	86.3%	84.7%
Physical Inactivity [ii] (2010)	33.8%	36.1%
High Blood Pressure [ii] (2015)	75.6%	57.9%[iii]
High Cholesterol [ii] (2015)	63.7%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	52%	13%	19%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	10 hours within 1 year of qualifying event Follow-up training only available in the year after primary training	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Georgia requires all private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[39,40] Private insurance covers DSME/T upon certain qualifying events, such as a patient's diabetes diagnosis, a significant change in a patient's diabetes-related condition, or a change in a patient's diagnostic levels or treatment regimen.[41] Policies cover 10 hours of primary DSME/T in the year following a qualifying event.[42] Subject to limited exception, primary DSME/T is delivered in group settings.[42] Private insurance also covers individual follow-up training in the year following a patient's completion of primary DSME/T.[43]

A Georgia-licensed physician must prescribe DSME/T for a patient.[39,40] DSME/T programs must be recognized by the federal Centers for Medicare & Medicaid Services or a national DSME/T-accrediting organization.[44] DSME/T and medical nutrition therapy services must be provided by an interdisciplinary team of certified, registered, or licensed health care professionals.[45,46] The team must include, at a minimum, a licensed dietitian and a registered nurse or other health care professional who is a Certified Diabetes Educator.[45,46] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[47]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[48,49] Subject to limited exception,[50] recipients may receive 1 hour of private training and 9 hours of group training.[51] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[52] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[53,54] and receive the training from an ADA- or AADE-accredited program.[53,55] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[53,56]

Medicaid Coverage

Georgia's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[37,57,58] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Georgia Medicaid Information
https://dch.georgia.gov/medicaid

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Georgia DSME/T Website
http://j.mp/2car6kS

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Hawaii: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Hawaii.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Hawaii

As of 2015, nearly 1 in 12 adults in Hawaii has been diagnosed with diabetes—more than 95,000 individuals in total.[30] Native Hawaiians in the state are more than twice as likely as white adults in the state to be diagnosed with the disease.[31] According to the ADA, an additional 442,000 individuals—41.5% of the state's adult population—have prediabetes.[32]

In 2015, 30.8% of Hawaii adults with diabetes reported "fair or poor" general health, and 54.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 26.2% of adults with diabetes in the state reported an inability to do usual activities at least 1 day in the previous 30 days.[30] However, in 2015, 9.4% of Hawaii adults with the disease did not visit a health professional for their diabetes and only 73.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Hawaii exceeds $1.4 billion.[33]

HI Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,34]	HI	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.6	6.5
Completed a DSME/T Class [ii] (2010)	47.8%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	63%	63.6%
Overweight or Obese [ii] (2010)	81.3%	84.7%
Physical Inactivity [ii] (2010)	28.3%	36.1%
High Blood Pressure [ii] (2015)	62.1%	57.9%[iii]
High Cholesterol [ii] (2015)	56.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	55%	15%	18%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies	Up to 20% copay Deductible	Varies
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial training 2 hours annual follow-up training Referral required

Private Insurance

Hawaii requires most private health insurance plans to cover medically necessary outpatient DSME/T.[39,40] Any health care professional authorized by the state to prescribe medicine and medical treatment may prescribe DSME/T for their patient.[39] Certain limited-benefit health insurance policies—such as accident-only, specified disease, hospital indemnity, Medicare supplement, and long-term care policies—are not required to cover DSME/T.[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Hawaii's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $39,040 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[51,52] When a beneficiary with diabetes receives a DSME/T referral from their health care provider, the beneficiary may receive up to 10 hours of services in the year following the initial training and up to 2 hours of follow-up training each subsequent year.[53]

DSME/T must be provided by a program recognized by the ADA or AADE.[53,54] In general, beneficiaries participate in DSME/T through group training sessions.[53] Individual DSME/T is permitted with prior authorization when "the patient's condition does not allow for effective learning in a group training session" because of, for example, "deficits in hearing and vision, homebound status, mental [disabilities], or learning disabilities."[53] DSME/T includes medical nutrition therapy.[53,54]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Hawaii Medicaid Information
http://humanservices.hawaii.gov/mqd/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Hawaii DSME/T Website
http://j.mp/2ckmhXJ

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Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

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Diabetes in Idaho

As of 2015, nearly 1 in 13 adults in Idaho had been diagnosed with diabetes—more than 99,000 people in total.[30] Adults in Idaho without a high school degree are approximately 1.6 times more likely than adults with a postsecondary degree to have the disease.[30] According to the ADA, an additional 397,000 Idahoans—34.9% of the state's adult population—have prediabetes.[31]

Idaho adults with diabetes are 3 times as likely to have high blood pressure and twice as likely to have high cholesterol as Idaho adults without the disease.[32] Moreover, Idaho adults with the disease are significantly more likely to experience heart disease, heart attacks, and strokes.[32] In 2015, more than 36% of adults with diabetes in the state reported "fair or poor" general health, and 68.4% reported poor mental or physical health at least 1 day in the past 30 days.[30] The annual medical and economic costs attributable to diabetes in Idaho exceeds $1.4 billion.[33]

ID Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	ID	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.3%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	5.9	6.5
Completed a DSME/T Class [ii] (2010)	55.1%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	59.5%	63.6%
Overweight or Obese [ii] (2010)	89%	84.7%
Physical Inactivity [ii] (2010)	31.2%	36.1%
High Blood Pressure [ii] (2015)	62.5%	57.9%[iii]
High Cholesterol [ii] (2015)	54.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	56%	14%	18%
Coverage Required	No	Part B only	Yes
Cost Sharing	-	Up to 20% copay Deductible	Varies
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	24 hours of group DSME/T and 12 hours of individual DSME/T every 5 years Referral required

Private Insurance

Idaho does not require private health insurance plans to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[39,40] Subject to limited exception,[41] recipients may receive 1 hour of private training and 9 hours of group training.[42] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[43] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[44,45] and receive the training from an ADA- or AADE-accredited program.[44,46] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[44,47]

Medicaid Coverage

Idaho's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[37,48,49] When DSME/T is deemed medically necessary for a Medicaid beneficiary, the program covers up to 24 hours of group DSME/T and 12 hours of individual DSME/T every 5 years for that individual.[50,51]

DSME/T is considered medically necessary in 3 scenarios:[52]

1. When a beneficiary has not previously received DSME/T and enrolls in DSME/T within 90 days of receiving a diabetes diagnosis[52]
2. When a beneficiary has "[u]ncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations"[52]
3. When a beneficiary suffers from recent conditions caused by poor diabetes control[52]

A beneficiary's primary care provider must issue a written order for DSME/T,[53] and a state-licensed health professional identified as a Certified Diabetes Educator according to the national standards of the National Certification Board for Diabetes Educators must provide the DSME/T.[54,55] DSME/T programs must meet ADA standards[55] and address healthy eating, medication use, self-monitoring glucose, administering insulin, foot care, or the effects of other illnesses or complications.[51]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Idaho Medicaid Information
http://medicaid.idaho.gov

Medicare DSME/T Information
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LawAtlas Idaho DSME/T Website
http://j.mp/2casl3q

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Illinois: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Illinois.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Illinois

As of 2015, nearly 1 in 10 adults in Illinois had been diagnosed with diabetes—more than 983,000 people in total.[30] African Americans and Hispanic individuals in the state are significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 3.59 million Illinoisans—37.5% of the state's adult population—have prediabetes,[32] including 10% of adults older than 65.[33]

Illinois adults with diabetes are significantly more likely than those without diabetes to have other chronic health conditions, including high blood pressure, high cholesterol, chronic obstructive pulmonary disease, asthma, arthritis, and cancer.[33] A 2014 report from the Illinois Department of Public Health noted that in 2011, 17.6% of individuals with diabetes in the state avoided medical care due to cost.[33] As part of a multipronged effort to combat diabetes, the state aims to promote coverage for, access to, and use of DSME/T.[33]

IL Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	IL	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.5	6.5
Completed a DSME/T Class [ii] (2010)	63.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	70.7%	63.6%
Overweight or Obese [ii] (2010)	85.3%	84.7%
Physical Inactivity [ii] (2010)	37.1%	36.1%
High Blood Pressure [ii] (2015)	54%	57.9%[iii]
High Cholesterol [ii] (2015)	60.2%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	60%	14%	19%
Coverage Required	Group policies only	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	3 visits upon initial diagnosis 2 visits upon a significant change in the patient's symptoms or condition	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Illinois requires group accident and health insurance policies to cover medically necessary outpatient DSME/T, including medical nutrition therapy.[39] These policies cover up to 3 visits after an initial diabetes diagnosis and up to 2 visits when an individual's physician detects a significant change in the individual's symptoms or condition.[39] DSME/T must cover all content areas listed in the National Standards, and it may be provided by either a licensed physician or a health care professional with expertise in diabetes management.[39] Insurers may impose the same cost sharing requirements applicable to "other services provided by the same type of provider."[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[40,41] Subject to limited exception,[42] recipients may receive 1 hour of private training and 9 hours of group training.[43] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[44] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[45,46] and receive the training from an ADA- or AADE-accredited program.[45,47] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[45,48]

Medicaid Coverage

Illinois' Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[49] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,50] Illinois does not specifically require Medicaid coverage for DSME/T. However, Illinois Medicaid managed care organizations, which provide services to most Medicaid beneficiaries in the state, are required to provide coverage for disease management and health education more generally.[51]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Illinois Medicaid Information
www.illinois.gov/hfs/Pages/default.aspx

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Illinois DSME/T Website
http://j.mp/2ckoJ0b

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The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Indiana

As of 2015, nearly 1 in 9 adults in Indiana had been diagnosed with diabetes—more than 578,000 people in total.[30] African Americans in Indiana are more than 70% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.7 million individuals—35.6% of the state's adult population—have prediabetes.[32]

In 2015, 37.8% of Indiana adults with diabetes reported "fair or poor" general health, and 70.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, 32.8% of adults with diabetes in Indiana reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, 14.5% of adults with diabetes in the state did not visit a health professional for their diabetes, and only 73.1% received 2 or more A1c tests within the last year.[30] The annual medical and economic costs attributable to diabetes in Indiana exceeds $8.9 billion.[33]

IN Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	IN	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.1	6.5
Completed a DSME/T Class [ii] (2010)	61.9%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	70.2%	63.6%
Overweight or Obese [ii] (2010)	86.4%	84.7%
Physical Inactivity [ii] (2010)	39.1%	36.1%
High Blood Pressure [ii] (2015)	50.9%	57.9%[iii]
High Cholesterol [ii] (2015)	61.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	57%	14%	19%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	4 hours per year without prior authorization Prescription Required

Private Insurance

Indiana requires private health insurance policies to provide coverage for medically necessary DSME/T.[39] Private insurance covers 1 or more visits after a diabetes diagnosis, 1 or more visits after a significant change in an individual's symptoms or condition, and 1 or more visits when the individual needs reeducation or a refresher training.[39] DSME/T must be ordered by a physician or podiatrist and provided by a licensed, registered, or certified health care professional with specialized training in managing diabetes.[39] Insurers may impose the same cost sharing requirements applicable to similar benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Indiana's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,51] The program provides coverage for medically necessary DSME/T.[39,52] This includes 1 or more visits after a diabetes diagnosis, 1 or more visits after a significant change in an individual's symptoms or condition, and 1 or more visits for reeducation or a refresher training.[39,53] Without prior authorization, a beneficiary receives coverage for up to 4 hours of DSME/T per rolling calendar year.[53] However, additional hours may be covered with prior authorization.[53] DSME/T must be ordered by a physician or podiatrist and provided by a licensed, registered, or certified health care professional with specialized training in managing diabetes.[39,54]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Indiana Medicaid Information
www.indianamedicaid.com

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Indiana DSME/T Website
http://j.mp/2c8hUgV

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Law & policy innovation for the common good.

A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Iowa: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Iowa.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Iowa

As of 2015, roughly 1 in 13 adults in Iowa had been diagnosed with diabetes—more than 211,000 individuals in total.[30] African Americans in the state are nearly 60% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 810,000 individuals—35.2% of the state's adult population—have prediabetes.[32]

In 2015, 40.6% of Iowa adults with diabetes reported "fair or poor" general health, and 61.2% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, 24.1% of adults with diabetes in the state reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, more than 6% of Iowa adults with the disease did not visit a health professional for their diabetes, and only 78.7% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Iowa exceeds $3.4 billion.[33]

IA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	IA	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.7%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.2	6.5
Completed a DSME/T Class [ii] (2010)	60.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	70.1%	63.6%
Overweight or Obese [ii] (2010)	86.8%	84.7%
Physical Inactivity [ii] (2010)	38%	36.1%
High Blood Pressure [ii] (2015)	51.8%	57.9%[iii]
High Cholesterol [ii] (2015)	59.4%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	61%	15%	17%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Not specified	Up to 20% copay Deductible	None
Limitations	At least 10 hours initial training 2 hours annual follow-up training Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	1 complete diabetes education program per lifetime Referral required

Private Insurance

Iowa requires private health insurance plans to cover outpatient DSME/T when the physician managing the patient's diabetes orders DSME/T services.[39] Private insurance must cover at least 10 hours of initial training received within 1 year and 2 hours of follow-up training each subsequent year.[39] DSME/T programs must be certified by the Iowa Department of Public Health,[39] and a physician, registered nurse, licensed dietitian, or pharmacist must serve as the primary DSME/T instructor.[40] Programs with one primary instructor must have at least one supporting instructor who a) is not the same type of medical professional as the primary instructor, and b) is a physician, registered nurse, licensed dietitian, or pharmacist.[40] Primary and supporting instructors must demonstrate sufficient knowledge about diabetes through continuing education, equivalent training or experience, or current certification as a certified diabetes educator.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Iowa's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,51] The program covers outpatient DSME/T[52] when a beneficiary's attending physician provides a referral for services.[53] The program covers 1 complete diabetes education program in a beneficiary's lifetime as well as follow-up assessments 3 months and 12 months after the initial program ends.[54] DSME/T programs must be certified by the department for Medicaid and the Iowa Department of Public Health.[55] A DSME/T program must directly employ, contract with, or provide referrals to a physician, a registered nurse, a registered dietitian, and a licensed pharmacist.[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Iowa Medicaid Information
http://dhs.iowa.gov/iahealthlink

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Iowa DSME/T Website
http://j.mp/2cko1A5

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Kansas: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Kansas.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Kansas

As of 2015, nearly 1 in 11 adults in Kansas had been diagnosed with diabetes—more than 212,000 people in total.[30] African American individuals in Kansas are nearly 79% more likely than non-Hispanic whites to have the disease; Hispanic individuals in Kansas are nearly 64% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 749,000 individuals—35.5% of the state's adult population—have prediabetes.[32]

In 2015, 43.9% of Kansas adults with diabetes reported "fair or poor" general health, and 64.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, nearly 15% of adults with diabetes in the state did not visit a health professional for their diabetes, and only 71.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Kansas exceeds $3.3 billion.[33]

KS Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	KS	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.5	6.5
Completed a DSME/T Class [ii] (2010)	57.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	61.7%	63.6%
Overweight or Obese [ii] (2010)	84.9%	84.7%
Physical Inactivity [ii] (2010)	34.2%	36.1%
High Blood Pressure [ii] (2015)	57.6%	57.9%[iii]
High Cholesterol [ii] (2015)	55.4%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	61%	13%	13%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required Insurers may require referral from primary care physician	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Kansas requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[39] DSME/T must be ordered by a health care professional. DSME/T services must be provided by a health care professional who has expertise in diabetes and who is certified by the National Certification Board for Diabetes Educators.[40] A licensed dietitian must provide any nutrition education, and the DSME/T program must be approved by the ADA.[40] Insurers may impose the same requirements regarding cost sharing, medical necessity, and referrals applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Kansas' Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[37,51,52] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Kansas Medicaid Information
www.kmap-state-ks.us/Public/Beneficiary/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Kansas DSME/T Website
http://j.mp/2c8hbfE

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Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Kentucky

As of 2015, approximately 1 in 8 adults in Kentucky had been diagnosed with diabetes—more than 458,000 people in total.[30] African Americans in Kentucky have the highest prevalence of diabetes,[31] and Kentucky adults receiving Medicaid are nearly twice as likely as those not receiving Medicaid to have the disease.[32] According to the ADA, an additional 1.17 million individuals—35.5% of the state's adult population—have prediabetes.[33]

In 2013, 42% of all people hospitalized in Kentucky due to cardiovascular diseases had diabetes.[32] In 2015, more than half of Kentucky adults with diabetes reported "fair or poor" general health, and 71.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] The annual medical and economic costs associated with diabetes in Kentucky exceeds $6 billion.[34] The 2015 Kentucky Diabetes Report identified increasing DSME/T participation as a "significant area of opportunity for improvement."[32]

KY Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	KY	U.S.
% of Adults with Diagnosed Diabetes (2015)	12.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	11.6	6.5
Completed a DSME/T Class [ii] (2010)	58%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	73.8%	63.6%
Overweight or Obese [ii] (2010)	90.6%	84.7%
Physical Inactivity [ii] (2010)	40.2%	36.1%
High Blood Pressure [ii] (2015)	61.5%	57.9%[iii]
High Cholesterol [ii] (2015)	62.2%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	54%	16%	22%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Kentucky requires all private health insurance plans to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy, when prescribed by a health care provider.[40] The DSME/T must be provided by a health care professional with expertise in diabetes.[41] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[42]

Kentucky formally licenses diabetes educators and master diabetes educators[43–45] who are authorized to develop DSME/T programs, provide DSME/T, and monitor patient progress.[46] The ADA Educators Core Concepts Course is approved by the Kentucky Board of Licensed Diabetes Educators, and equivalent courses may be approved on a case-by-case basis.[47]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[48,49] Subject to limited exception,[50] recipients may receive 1 hour of private training and 9 hours of group training.[51] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[52] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[53,54] and receive the training from an ADA- or AADE-accredited program.[53,55] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[53,56]

Medicaid Coverage

Kentucky's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[57] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,58] At least two Medicaid managed care organizations in the state (PassPort & Wellcare) provide beneficiaries coverage for at least some diabetes education.[59,60] The state also encourages Medicaid managed care providers "to work with the [Illinois] Department for Public Health on the Diabetes Self-Management Program and the Diabetes Prevention Program."[61]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Kentucky Medicaid Information
www.chfs.ky.gov/dms/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Kentucky DSME/T Website
http://j.mp/2ccLZfd

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Louisiana: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Louisiana.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Louisiana

As of 2015, 1 in 9 adults in Louisiana had been diagnosed with diabetes—more than 451,000 people in total.[30] Louisiana has the 12th highest diabetes prevalence among the 50 states.[31] African Americans in Louisiana are approximately 40% more likely than non-Hispanic whites to have the disease.[32] According to the ADA, an additional 1.27 million individuals—37.5% of the state's adult population—have prediabetes.[33]

Louisiana's diabetes-related death rate ranks seventh in the nation.[34] In 2015, nearly half of adults with diabetes in Louisiana reported "fair or poor" general health, and 68% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, more than 14% of Louisiana adults with the disease did not visit a health professional for their diabetes, and only 64.8% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Louisiana exceeds $6.9 billion.[35]

LA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,36]	LA	U.S.
% of Adults with Diagnosed Diabetes (2015)	11.8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.9	6.5
Completed a DSME/T Class[ii] (2010)	56.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	75.7%	63.6%
Overweight or Obese [ii] (2010)	81.4%	84.7%
Physical Inactivity [ii] (2010)	49.3%	36.1%
High Blood Pressure [ii] (2015)	59.4%	57.9%[iii]
High Cholesterol [ii] (2015)	51.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[37] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[38] These limitations, as well as the services Medicaid covers, vary among the states.[39]

Insurance Type	Private	Medicare	Medicaid
% of State Population[40]	53%	13%	20%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Referral or prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial training 2 hours annual follow-up training

Private Insurance

Louisiana requires all private health insurance policies to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy.[41] Private insurance covers up to $500 for a one-time training program[42] and up to $100 per year in follow-up training when there is a significant change in an individual's symptoms or condition.[43] Follow-up training is also subject to a $2,000 lifetime limit.[43] DSME/T must be provided by a health care professional with expertise in diabetes care and treatment, and DSME/T programs must comply with the National Standards.[42,44] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[45]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[46,47] Subject to limited exception,[48] recipients may receive 1 hour of private training and 9 hours of group training.[49] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[50] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[51,52] and receive the training from an ADA- or AADE-accredited program.[51,53] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[51,54]

Medicaid Coverage

Louisiana's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[55] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some children.[39,56] Beneficiaries with a diabetes diagnosis may receive up to 1 hour of individual DSME/T and 9 hours of group DSME/T in the 12-month period following the initial training date.[57,58] The program also covers up to 2 hours of individual follow-up instruction each subsequent year.[57]

DSME/T programs must be accredited by the AADE, ADA, or Indian Health Services (IHS)[59] and comply with the National Standards.[60] DSME/T providers must be certified by the National Certification Board for Diabetes Educators as Certified Diabetes Educators (CDE) or have "recent didactic and experimental preparation in education and diabetes management."[61] DSME/T instruction teams must include at least one CDE who is a registered dietitian, registered nurse, or pharmacist.[62]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Louisiana Medicaid Information
http://dhh.louisiana.gov/index.cfm/subhome/1

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Louisiana DSME/T Website
http://j.mp/2cnuJFu

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Maine: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Maine.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Maine

As of 2015, nearly 1 in 12 adults in Maine had been diagnosed with diabetes—more than 106,000 individuals in total.[30] Mainers without a high school degree are more likely than individuals with a high school degree or postsecondary degree to have the disease.[30] According to the ADA, an additional 386,000 individuals—37.2% of the state's adult population—have prediabetes.[31]

The diabetes prevalence rate is 6 times higher among Maine adults who are obese.[32] In 2009, a quarter of Mainers hospitalized with cardiovascular disease had diabetes.[33] In 2015, 46.1% of Maine adults with diabetes reported "fair or poor" general health, and 71.5% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2014, 12.1% of Maine adults with the disease did not visit a health professional for their diabetes.[30] The annual medical and economic costs attributable to diabetes in Maine exceeds $1.8 billion.[34]

ME Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	ME	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.2%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.7	6.5
Completed a DSME/T Class [ii] (2010)	64.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	68.9%	63.6%
Overweight or Obese [ii] (2010)	84.4%	84.7%
Physical Inactivity [ii] (2010)	33.5%	36.1%
High Blood Pressure [ii] (2015)	61.3%	57.9%[iii]
High Cholesterol [ii] (2015)	62.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	52%	18%	23%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Not specified	Up to 20% copay Deductible	Varies
Limitations	Certification of medical necessity required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Prescription required

Private Insurance

Maine requires private health insurance policies to provide coverage for outpatient DSME/T. To receive coverage for DSME/T through private insurance, a patient must acquire a certification of medical necessity from the individual's treating physician or a physician specializing in diabetes treatment.[40–43] DSME/T must be provided "through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health."[40–43]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Maine's Medicaid program, MaineCare, covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, and individuals with disabilities.[38,53] MaineCare provides coverage for outpatient DSME/T when a beneficiary's physician or primary care provider prescribes DSME/T and the beneficiary receives DSME/T from "a provider enrolled with the Maine Diabetes Control Project."[54]

MaineCare's DSME/T coverage includes a pre-assessment interview, an individualized education plan with behavior change goals, group class instruction, a meal planning interview, an individualized meal plan with behavior change goals, a post-service interview, and follow-up visits.[54] A minimum of 3 follow-up visits are required—at 3 months, 6 months, and 1 year following the beneficiary's final DSME/T class.[54] DSME/T group class instruction must cover the comprehensive curriculum outlined by the Maine Diabetes Control Project.[54] This outlined curriculum is consistent with the National Standards.[55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Maine Medicaid Information
www.maine.gov/dhhs/oms/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Maine DSME/T Website
http://j.mp/2ccMrKo

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Maryland: Background, Benefits, and Insurance Coverage of DSME/T

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Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Maryland

As of 2015, nearly 1 in 10 adults in Maryland had been diagnosed with diabetes—more than 481,000 individuals in total.[30] African Americans in Maryland are more than twice as likely as non-Hispanic whites to have the disease.[31] Hispanic individuals ages 65 and older in Maryland are 1.7 times more likely than non-Hispanic whites to have the disease.[32] According to the ADA, an additional 1.63 million people—36.9% of the state's adult population—have prediabetes.[33]

In 2015, 38.9% of Maryland adults with diabetes reported "fair or poor" general health, and 69.5% reported having poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 7% of Maryland adults with the disease did not visit a health professional for their diabetes, and only 75.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Maryland exceeds $8.3 billion.[34]

MD Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	MD	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.4%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.6	6.5
Completed a DSME/T Class [ii] (2010)	48.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	61.5%	63.6%
Overweight or Obese [ii] (2010)	90.9%	84.7%
Physical Inactivity [ii] (2010)	42.8%	36.1%
High Blood Pressure [ii] (2015)	71.5%	57.9%[iii]
High Cholesterol [ii] (2015)	54.2%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	64%	12%	15%
Coverage Required	Yes	Part B only	Yes* (See below)
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Not specified
Limitations	Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* Managed care only

Private Insurance

Maryland requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[40] Before receiving DSME/T, an individual must receive a certification of medical necessity from their treating physician or another appropriately licensed health care provider.[40] DSME/T, including medical nutrition therapy, must be "provided through a program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management."[41] Insurers may impose the same cost-sharing requirements applicable to similar covered benefits.[42]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[43,44] Subject to limited exception,[45] recipients may receive 1 hour of private training and 9 hours of group training.[46] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[47] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[48,49] and receive the training from an ADA- or AADE-accredited program.[48,50] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[48,51]

Medicaid Coverage

Maryland's Medicaid program covers all individuals at or below 138% of the federal poverty level ((approximately $33,948 for a family of four in 2017)[52] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,53] Most Medicaid beneficiaries in Maryland receive coverage through HealthChoice, a Medicaid managed care program.[54] Managed care organizations participating in HealthChoice are required to provide beneficiaries diagnosed with diabetes with both diabetes nutrition counseling[55] and diabetes outpatient education.[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Maryland Medicaid Information
https://mmcp.dhmh.maryland.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Maryland DSME/T Website
http://j.mp/2cnxero

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Massachusetts: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Massachusetts.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Massachusetts

As of 2015, nearly 1 in 12 adults in Massachusetts had been diagnosed with diabetes—more than 482,000 individuals in total.[30] African American, Hispanic, and Asian individuals in Massachusetts are all significantly more likely than non-Hispanic whites to have the disease.[31] Moreover, African Americans in the state are more than twice as likely as non-Hispanic whites to die from diabetes.[31] According to the ADA, an additional 1.78 million individuals—35% of the state's adult population—have prediabetes.[32]

In 2015, 39% of Massachusetts adults with diabetes reported "fair or poor" general health, and 66.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] Massachusetts adults who are older than 45 and have diabetes are twice as likely as those without the disease to be diagnosed with heart disease or have a stroke.[33] The annual medical and economic costs attributable to diabetes in Massachusetts exceeds $9.6 billion.[34]

MA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	MA	U.S.
% of Adults with Diagnosed Diabetes (2015)	8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	5.5	6.5
Completed a DSME/T Class [ii] (2010)	53%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	63.6%	63.6%
Overweight or Obese [ii] (2010)	87.7%	84.7%
Physical Inactivity [ii] (2010)	29.9%	36.1%
High Blood Pressure [ii] (2015)	57.3%	57.9%[iii]
High Cholesterol [ii] (2015)	56.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	59%	12%	23%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Prescription required Provider network restrictions may apply	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Prescription required

Private Insurance

Massachusetts requires most private health insurance policies to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy.[40] DSME/T must be prescribed by a health care professional and provided by "a licensed health care professional with expertise in diabetes, a registered dietician, or a health care provider certified by the National Certification Board of Diabetes Educators (NCBDE) as a certified diabetes educator."[40] An insurer may require a patient to receive DSME/T from a health care provider within the insurance plan's provider network.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Massachusetts' Medicaid program, MassHealth, covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,51] MassHealth covers individual and group DSME/T, including medical nutrition therapy, for beneficiaries with diabetes or prediabetes who receive a prescription from a health care professional.[52–55] DSME/T may be provided by a physician, an appropriately licensed or registered dietitian or nutritionist, or a midlevel practitioner, such as a nurse practitioner or physician assistant, who is credentialed by the NCBDE.[52–55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Massachusetts Medicaid Information
www.mass.gov/eohhs/gov/departments/masshealth/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Massachusetts DSME/T Website
http://j.mp/2cnxo1Q

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Michigan: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Michigan.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Michigan

As of 2015, nearly 1 in 10 adults in Michigan had been diagnosed with diabetes—more than 827,000 individuals in total.[30] African Americans and Hispanic individuals in Michigan are twice as likely as non-Hispanic whites to have the disease.[31] According to the ADA, an additional 2.74 million individuals—37% of the state's adult population—have prediabetes.[32]

Michigan adults with diabetes are 2.5 times more likely to have high blood pressure and 1.8 times more likely to have high cholesterol than those without the disease.[33] More than a quarter of adults with diabetes in the state have had a heart attack or stroke.[31] Between 2011 and 2013, Michigan adults with diabetes who received DSME/T were 61% more likely than those who did not receive DSME/T to receive 3 key preventive services: 2 A1c measurements, an eye examination, and a foot examination.[33] The annual medical and economic costs attributable to diabetes in Michigan exceeds $13.5 billion.[34]

MI Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	MI	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.5	6.5
Completed a DSME/T Class [ii] (2010)	60.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	65.1%	63.6%
Overweight or Obese [ii] (2010)	82.4%	84.7%
Physical Inactivity [ii] (2010)	33.2%	36.1%
High Blood Pressure [ii] (2015)	54.6%	57.9%[iii]
High Cholesterol [ii] (2015)	52.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diabetes Diagnosis

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	59%	16%	19%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Available only upon diabetes diagnosis or a significant change in symptoms or condition	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required

Private Insurance

Michigan requires private health insurance policies to provide coverage for outpatient DSME/T.[40,41] Private insurance covers DSME/T if the physician managing an individual's diabetes finds DSME/T medically necessary upon a diabetes diagnosis or upon a significant change in the individual's symptoms or condition.[42,43] When practicable, DSME/T should be provided in group settings.[44,45] DSME/T programs must be either certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Health and Human Services.[44,45] Insurers may impose cost-sharing requirements that do not exceed "those for physical illness generally."[46,47]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[48,49] Subject to limited exception,[50] recipients may receive 1 hour of private training and 9 hours of group training.[51] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[52] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[53,54] and receive the training from an ADA- or AADE-accredited program.[53,55] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[53,56]

Medicaid Coverage

Michigan's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[57] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,58] The program covers DSME/T when ordered by a physician or a qualified non-physician medical practitioner responsible for a beneficiary's diabetic care.[59] DSME/T must be provided by diabetes educators in a Medicaid-enrolled outpatient hospital or Local Health Department that is: (1) certified as a DSME program by the Michigan Department of Health and Human Services Population Health Administration; (2) AADE-accredited; or (3) ADA-recognized.[59] The program follows Medicare billing guidelines and allows DSME/T by telemedicine.[59]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Michigan Medicaid Information
www.michigan.gov/mdhhs

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Michigan DSME/T Website
http://j.mp/2ccN4no

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Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Minnesota

As of 2015, nearly 1 in 14 adults in Minnesota had been diagnosed with diabetes—more than 318,000 individuals in total.[30] Individuals from many communities of color in Minnesota are less likely than white individuals to meet key indicators of "optimal diabetes care," such as lower blood pressure, cholesterol, and HbA1c levels, and documented tobacco-free status.[31] According to the ADA, an additional 1.4 million individuals—35.1% of the state's adult population—have prediabetes.[32]

The prevalence of diabetes in Minnesota is nearly 3 times higher among individuals living in households that earn less than $35,000 per year. In addition, 33% of Minnesota adults with the disease are either out of work or unable to work.[33] In 2015, 39.8% of Minnesota adults with diabetes reported "fair or poor" general health.[30] The annual medical and economic costs attributable to diabetes in Minnesota exceeds $5.3 billion.[34]

MN Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	MN	U.S.
% of Adults with Diagnosed Diabetes (2015)	6.9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	4.8	6.5
Completed a DSME/T Class [ii] (2010)	81.2%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	60.8%	63.6%
Overweight or Obese [ii] (2010)	92.3%	84.7%
Physical Inactivity [ii] (2010)	22.9%	36.1%
High Blood Pressure [ii] (2015)	51.3%	57.9%[iii]
High Cholesterol [ii] (2015)	50.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	64%	15%	14%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	None specified	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required

Private Insurance

Minnesota requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[40] DSME/T services must be consistent with the National Standards and provided by a certified, registered, or licensed health care professional.[40] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Minnesota's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,51] The program covers a beneficiary's DSME/T when a physician orders DSME/T in writing for that individual.[52–57] It covers up to 10 hours of initial training provided within a 1 year period and up to 2 hours of follow-up training each subsequent year.[55]

DSME/T should include an overview of diabetes, diabetes management techniques, nutrition counseling, exercise and activity education, and other relevant information, such as the "[u]se of health care system and community resources."[55] Generally, a physician or registered nurse must provide the diabetes care instructions, and a physician, licensed dietitian, or licensed nutritionist must provide any nutrition counseling.[55] However, individuals dually eligible for both Medicare and Minnesota's Medicaid program must receive DSME/T from a provider meeting the National Diabetes Advisory Board Standards.[55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Minnesota Medicaid Information
http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Minnesota DSME/T Website
http://j.mp/2cnxExL

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Mississippi: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Mississippi.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Mississippi

As of 2015, more than 1 in 8 adults in Mississippi had been diagnosed with diabetes—more than 334,000 individuals in total.[30] According to the ADA, an additional 810,000 people—37.5% of the state's adult population—have prediabetes.[31] African Americans with diabetes in Mississippi are at least 2.5 times more likely than white individuals with diabetes in the state to die from the disease.[32]

In 2015, more than half of Mississippi adults with diabetes reported "fair or poor" general health, and 65.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2014, nearly 10% of adults with diabetes in Mississippi did not visit a health professional for their diabetes.[30] The annual medical and economic costs attributable to diabetes in Mississippi exceeds $4.7 billion.[33] As part of a multipronged effort to combat the disease, the state is seeking to increase the number of DSME/T providers, awareness of DSME/T programs, and the number of persons referred to and participating in DSME/T.[32]

MS Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	MS	U.S.
% of Adults with Diagnosed Diabetes (2015)	13.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	13.7	6.5
Completed a DSME/T Class [ii] (2010)	44.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	74.2%	63.6%
Overweight or Obese [ii] (2010)	88.2%	84.7%
Physical Inactivity [ii] (2010)	51.3%	36.1%
High Blood Pressure [ii] (2015)	66%	57.9%[iii]
High Cholesterol [ii] (2015)	55.3%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	46%	15%	23%
Coverage Required	No	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	$250 coverage limit	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Prior authorization 7 hours within 6 months of initial visit 2 hours annual follow-up training

Private Insurance

Mississippi requires most private health insurance policies to offer an option to receive DSME/T coverage.[39] This coverage is limited to $250 annually, and a patient must obtain a prescription for DSME/T before receiving coverage for services.[39] DSME/T may be delivered in outpatient, inpatient, or home health settings and should follow nationally recognized standards.[40] The DSME/T provider must be a Certified Diabetes Educator, and the medical nutrition therapy provider must be an appropriately licensed Registered Dietitian.[40] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Mississippi's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or caretakers of minor children, children, and individuals with disabilities.[37,51,52] The program covers medically necessary DSME/T if a beneficiary has been diagnosed with diabetes, receives an order for DSME/T from the health professional actively managing the beneficiary's disease, and receives prior authorization for the services.[53] The program covers up to 7 hours of initial training and up to 2 hours of annual follow-up training.[54]

DSME/T must be provided "under the direct supervision of a physician, physician assistant, nurse practitioner, pharmacist or a registered nurse certified as a diabetes educator,"[53] and the provider seeking reimbursement must be ADA- or AADE-accredited.[55] The DSME/T program must meet ADA training standards and include an individualized needs and goals assessment.[53,56] Subject to limited exception, a beneficiary may receive 1 hour of private initial training; the beneficiary receives the remaining DSME/T services in group settings.[54]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Mississippi Medicaid Information
https://medicaid.ms.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Mississippi DSME/T Website
http://j.mp/2chrhfn

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Missouri: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Missouri.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Missouri

As of 2015, 1 in 10 adults in Missouri had been diagnosed with diabetes—more than 537,000 individuals in total.[30] Compared with non-Hispanic whites in the state, African Americans in Missouri are roughly 65% more likely to have diabetes, 3 times more likely to be hospitalized for diabetes, and twice as likely to die from diabetes.[31] According to the ADA, an additional 1,625,000 individuals—35.9% of the state's adult population—have prediabetes.[32]

In 2015, 39.4% of Missouri adults with diabetes reported "fair or poor" general health, and 68.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, 36.8% of Missouri adults with the disease reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2013, 21.4% of Missouri adults with the disease did not visit a health professional for their diabetes.[30] The annual medical and economic costs attributable to diabetes in Missouri exceeds $7 8 billion.[33]

MO Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	MO	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.2%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.2	6.5
Completed a DSME/T Class [ii] (2009)	61.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2009)	59.1%	63.6%
Overweight or Obese [ii] (2010)	90.2%	84.7%
Physical Inactivity [ii] (2010)	46.2%	36.1%
High Blood Pressure [ii] (2015)	55%	57.9%[iii]
High Cholesterol [ii] (2015)	49.3%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	63%	15%	13%
Coverage Required	No	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Initial assessment once per lifetime Up to 2 visits per year without prior authorization Prescription required

Private Insurance

Missouri requires private health insurance providers to offer policies that cover DSME/T, but it does not require all private health insurance policies to include DSME/T as a covered benefit.[39] If a policy provides coverage for DSME/T, the insurer may impose cost-sharing requirements that do not exceed those applicable to other covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Missouri's Medicaid program, MO HealthNet, covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[50,51] The program covers DSME/T when prescribed by a health care professional with prescribing authority.[52] Coverage is available after an initial diabetes diagnosis and upon a significant change in the beneficiary's symptoms, condition, or treatment.[52] The program covers 1 initial assessment per lifetime and up to 2 subsequent visits per rolling year.[52] Additional visits may be covered with a "Certificate of Medical Necessity."[52]

A physician or certified diabetes educator must complete the initial assessment, which should look at the beneficiary's medical and diet history, medication use, mental health status, lifestyle practices, physical and psychological issues, barriers and support structure, and previous diabetes education.[52] Subsequent DSME/T services must be provided by a certified diabetes educator, registered dietitian, or registered pharmacist "approved and enrolled as a diabetes self-management provider with MO HealthNet."[52]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Missouri Medicaid Information
http://dss.mo.gov/mhd/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Missouri DSME/T Website
http://j.mp/2ccODSs

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Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Montana

As of 2015, roughly 1 in 15 adults in Montana had been diagnosed with diabetes—more than 63,000 individuals in total.[30] In Montana, American Indians and Alaska Natives are more than twice as likely as the general population to have the disease.[31] According to the ADA, an additional 279,000 individuals—36.4% of the state's adult population—have prediabetes.[32]

In 2015, 35.9% of Montana adults with diabetes reported "fair or poor" general health, and 59.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] The state's Quality Diabetes Education Initiative works with providers and programs to increase the number of Certified Diabetes Educators and recognized or accredited DSME/T programs.[33] Montana adults with diabetes are significantly more likely than adults with diabetes in other states to receive DSME/T.[30] The annual medical and economic costs attributable to diabetes in Montana exceeds $900 million.[34]

MT Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	MT	U.S.
% of Adults with Diagnosed Diabetes (2015)	6.7%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.5	6.5
Completed a DSME/T Class [ii] (2010)	72.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	60.6%	63.6%
Overweight or Obese [ii] (2010)	88.4%	84.7%
Physical Inactivity [ii] (2010)	23.8%	36.1%
High Blood Pressure [ii] (2015)	53.7%	57.9%[iii]
High Cholesterol [ii] (2015)	49.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	52%	17%	16%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Not specified	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required

Private Insurance

Montana requires all private group health insurance policies, HMOs, state employee benefit plans, and the Montana university system group benefits plans to provide coverage for outpatient DSME/T.[40–42] These plans must cover, at minimum, $250 per person each year for DSME/T.[43,44] A licensed health care professional with expertise in diabetes must provide DSME/T services.[40,41] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[45,46]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[47,48] Subject to limited exception,[49] recipients may receive 1 hour of private training and 9 hours of group training.[50] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[51] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[52,53] and receive the training from an ADA- or AADE-accredited program.[52,54] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[52,55]

Medicaid Coverage

Montana's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[56] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,57] The program provides coverage for DSME/T in accordance with federal Medicare DSME/T standards.[58]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Montana Medicaid Information
http://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Montana DSME/T Website
http://j.mp/2cnyKtA

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Nebraska: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Nebraska.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Nebraska

As of 2015, approximately 1 in 12 adults in Nebraska had been diagnosed with diabetes—more than 125,000 individuals in total.[30] Hispanic individuals, American Indians, and African Americans in Nebraska are about twice as likely as non-Hispanic whites to have the disease.[31] American Indians in Nebraska are more than 4 times more likely and African Americans in the state are nearly 3 times more likely than non-Hispanic whites to die from diabetes.[31] According to the ADA, an additional 487,000 individuals—35.8% of the state's adult population—have prediabetes.[32]

In 2015, 31.9% of Nebraska adults with diabetes reported "fair or poor" general health, and 56.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, 12.4% of Nebraska adults with diabetes did not visit a health professional for their diabetes.[30] The annual medical and economic costs attributable to diabetes in Nebraska exceeds $2 billion.[33]

NE Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	NE	U.S.
% of Adults with Diagnosed Diabetes (2015)	8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.3	6.5
Completed a DSME/T Class [ii] (2010)	61%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	75.8%	63.6%
Overweight or Obese [ii] (2010)	84%	84.7%
Physical Inactivity [ii] (2010)	45.7%	36.1%
High Blood Pressure [ii] (2015)	58.5%	57.9%[iii]
High Cholesterol [ii] (2015)	55.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	62%	13%	13%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required $500 limit every 2 years	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Nebraska requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy, when prescribed by a health care professional with prescriptive authority.[39,40] Private insurance covers medically necessary DSME/T for a patient upon their diabetes diagnosis, a change in their symptoms or condition, when new medications or treatments are prescribed, or when refresher training is necessary.[40,41] Coverage may not exceed $500 in a 2-year period.[41]

DSME/T must be provided by an ADA-recognized program or a health professional certified as a diabetes educator by the National Certification Board for Diabetes Educators.[42] Services may be conducted individually or in group sessions,[40] and home visits are permitted when medically necessary.[40] Insurers may impose cost-sharing requirements such as deductibles, copayments, and network incentives.[43]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Nebraska's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[53,54] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, the state's Medicaid managed care organizations are required to provide general preventive care services, such as "engag[ing] members in self-management strategies to monitor their disease process and improve their health."[55] These strategies seek to help individuals "effectively manage conditions and prevent complications" by ensuring they take their medication as prescribed, monitor their vital signs, and make healthier choices about eating and exercising.[55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Nebraska Medicaid Information
www.accessnebraska.ne.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Nebraska DSME/T Website
http://j.mp/2cnyrPC

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Nevada: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Nevada.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Nevada

As of 2015, nearly 1 in 11 adults in Nevada had been diagnosed with diabetes—more than 215,000 individuals in total.[30] There is no statistically significant difference in the prevalence of diabetes among African Americans, Hispanic individuals, and non-Hispanic whites in the state.[31] However, African American females in Nevada are more than twice as likely as non-Hispanic white females to have the disease.[31] According to the ADA, an additional 787,000 individuals—38.5% of the state's adult population—have prediabetes.[32]

In 2015, 45.5% of Nevada adults with diabetes reported "fair or poor" general health, and 61.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, 13.7% of Nevada adults with the disease did not visit a health professional for their diabetes, and only 69.6% had 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Nevada exceeds $3.2 billion.[33]

NV Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	NV	U.S.
% of Adults with Diagnosed Diabetes (2015)	9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7	6.5
Completed a DSME/T Class [ii] (2010)	54.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	60.9%	63.6%
Overweight or Obese [ii] (2010)	76.8%	84.7%
Physical Inactivity [ii] (2010)	31.5%	36.1%
High Blood Pressure [ii] (2015)	58.2%	57.9%[iii]
High Cholesterol [ii] (2015)	51.7%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	53%	13%	17%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Not specified	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Initial training up to 10 hours Additional initial or follow-up training requires prior authorization

Private Insurance

Nevada requires private health insurance policies to provide coverage for medically necessary DSME/T.[39] Private insurance covers nutrition counseling and other DSME/T services upon an initial diabetes diagnosis, upon a significant change in an individual's symptoms or condition, or when needed because new methods of treating or managing diabetes are introduced.[40] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Nevada's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[52,53] The program provides coverage for outpatient DSME/T.[54] This includes up to 10 hours of initial training in a group setting; additional hours for the initial training or follow-up trainings require prior authorization.[54]

DSME/T programs must "meet the National Diabetes Advisory Board (NDAB) standards, and hold an Education Recognition Program (ERP) certificate from the [ADA] and/or the [AADE]."[54] Diabetes educators certified by the National Board of Diabetes Educators must provide DSME/T services, and the DSME/T instruction team "should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues."[54] Subject to additional requirements, DSME/T may be provided as a telehealth service.[54]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Nevada Medicaid Information
http://dhcfp.nv.gov/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Nevada DSME/T Website
http://j.mp/2cnzm2b

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

New Hampshire: Background, Benefits, and Insurance Coverage of DSME/T

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Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

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Diabetes in New Hampshire

As of 2015, approximately 1 in 15 adults in New Hampshire had been diagnosed with diabetes—more than 86,000 individuals in total.[30] Individuals from racial and ethnic minority groups in New Hampshire are at least 1.7 times more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 370,000 individuals—36.2% of the state's adult population—have prediabetes.[32]

In 2015, 35.7% of New Hampshire adults with diabetes reported "fair or poor" general health, and 60.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 10% of New Hampshire adults with the disease did not visit a health professional for their diabetes, and only 80% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in New Hampshire exceeds $1.6 billion.[33]

NH Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	NH	U.S.
% of Adults with Diagnosed Diabetes (2015)	6.8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	4.9	6.5
Completed a DSME/T Class [ii] (2010)	72.9%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	70.1%	63.6%
Overweight or Obese [ii] (2010)	88.2%	84.7%
Physical Inactivity [ii] (2010)	29.6%	36.1%
High Blood Pressure [ii] (2015)	48.9%	57.9%[iii]
High Cholesterol [ii] (2015)	76.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	66%	14%	13%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

New Hampshire requires private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy.[39] DSME/T must be ordered by a primary care physician or practitioner and provided by a certified, registered, or licensed health care professional with expertise in diabetes.[39] Insurers may impose the same requirements and limitations applicable to other covered benefits.[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[40,41] Subject to limited exception,[42] recipients may receive 1 hour of private training and 9 hours of group training.[43] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[44] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[45,46] and receive the training from an ADA- or AADE-accredited program.[45,47] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[45,48]

Medicaid Coverage

New Hampshire's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[49] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,50] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

New Hampshire Medicaid Information
www.dhhs.nh.gov/ombp/medicaid/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas New Hampshire DSME/T Website
http://j.mp/2ccPVww

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

New Jersey: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in New Jersey.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in New Jersey

As of 2015, nearly 1 in 12 adults in New Jersey had been diagnosed with diabetes—more than 626,000 individuals in total.[30] African Americans in New Jersey are roughly 33.7% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 2.48 million individuals—37.1% of the state's adult population—have prediabetes.[32]

In 2015, 51% of New Jersey adults with diabetes reported "fair or poor" general health, and 62.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, 15.5% of New Jersey adults with the disease did not visit a health professional for their diabetes, and only 65.8% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in New Jersey exceeds $11.8 billion.[33] In its 2016 report, the New Jersey Diabetes Action Plan Committee recommended that individuals with diabetes in the state receive "evidence-based diabetes self-management education, training, and services."[31]

NJ Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	NJ	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6	6.5
Completed a DSME/T Class [ii] (2010)	46.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	59.6%	63.6%
Overweight or Obese [ii] (2010)	78.7%	84.7%
Physical Inactivity [ii] (2010)	32.8%	36.1%
High Blood Pressure [ii] (2015)	49.8%	57.9%[iii]
High Cholesterol [ii] (2015)	66.7%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	61%	13%	18%
Coverage Required	Yes	Part B only	Yes* (See below)
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Referral or prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* Managed care only

Private Insurance

New Jersey requires most private health insurance policies to provide coverage for medically necessary DSME/T "to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet."[39] Private insurance covers DSME/T upon an initial diabetes diagnosis.[39] It also covers services when a physician, nurse practitioner, or clinical nurse specialist either diagnoses a significant change in an individual's symptoms or condition or determines that the individual needs reeducation or refresher education.[39] DSME/T must be provided by a registered dietitian, a health care professional recognized by the AADE as a Certified Diabetes Educator, or a registered pharmacist "qualified with regard to management education for diabetes by any institution recognized by the [New Jersey] board of pharmacy."[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[40,41] Subject to limited exception,[42] recipients may receive 1 hour of private training and 9 hours of group training.[43] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[44] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[45,46] and receive the training from an ADA- or AADE-accredited program.[45,47] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[45,48]

Medicaid Coverage

New Jersey's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[49] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,50] The state requires Medicaid managed care organizations to promote "[s]elf-management of chronic conditions through evidence-based programs such as Stanford University's … Diabetes Self-Management Program (DSMP)."[51] However, the state Medicaid program does not explicitly indicate that beneficiaries receive coverage for any other DSME/T services.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

New Jersey Medicaid Information
www.njfamilycare.org

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas New Jersey DSME/T Website
http://j.mp/2ccPy5h

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

New Mexico: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in New Mexico.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in New Mexico

As of 2015, approximately 1 in 10 adults in New Mexico had been diagnosed with diabetes—more than 181,000 individuals in total.[30] American Indians and Alaska Natives in New Mexico are nearly 3 times more likely than non-Hispanic whites to have the disease. Hispanic individuals, African Americans, as well as Asians, Native Hawaiians, and Pacific Islanders in the state are also more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 603,000 individuals— 39.7% of the state's adult population—have prediabetes.[32]

In 2015, 53.9% of New Mexico adults with diabetes reported "fair or poor" general health, and 68.5% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 9% of New Mexico adults with the disease did not visit a health professional for their diabetes, and only 73.6% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in New Mexico exceeds $2.6 billion.[33]

NM Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	NM	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.3	6.5
Completed a DSME/T Class [ii] (2010)	58.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	73.9%	63.6%
Overweight or Obese [ii] (2010)	80.5%	84.7%
Physical Inactivity [ii] (2010)	37.2%	36.1%
High Blood Pressure [ii] (2015)	60.2%	57.9%[iii]
High Cholesterol [ii] (2015)	44.3%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	42%	15%	27%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription or referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	

Private Insurance

New Mexico requires private health insurance policies to provide coverage for medically necessary DSME/T, including medical nutrition therapy related to diabetes management.[39] Private insurance covers DSME/T services upon an individual's diabetes diagnosis, upon a significant change in an individual's symptoms or condition, or when a physician prescribes reeducation or a refresher training.[40] Before a patient can receive DSME/T, a health care professional with prescribing authority must either prescribe DSME/T or diagnose the individual with a qualifying condition.[39] DSME/T must be provided by "a certified, registered or licensed health care professional with recent education in diabetes management."[40] Insurers may impose the same cost-sharing requirements applicable to similar covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

New Mexico's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[52] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, for certain beneficiaries with chronic health conditions, Medicaid managed care organizations must provide education about the beneficiary's chronic conditions, develop self-management plans, provide lifestyle interventions, and "reinforce strategies that support the [individual's] motivation to better understand and actively self-manage [their] chronic health condition."[53] Additionally, New Mexico Medicaid beneficiaries receive coverage for diabetes education.[54–58]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

New Mexico Medicaid Information
https://nmmedicaid.acs-inc.com

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas New Mexico DSME/T Website
http://j.mp/2chpGGD

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Diabetes in New York

As of 2015, approximately 1 in 11 adults in New York had been diagnosed with diabetes—more than 1.5 million people in total.[30] Both African Americans and Hispanic individuals in New York are significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 5.4 million individuals—36.2% of the state's adult population—have prediabetes.[32]

In 2015, 43.4% of New York adults with diabetes reported "fair or poor" general health, and 65.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, approximately 9% of adults with diabetes in the state did not visit a health professional for their diabetes, and only 77.3% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in New York exceeds $32.7 billion.[33]

NY Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[34,30]	NY	U.S.
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New Cases of Diabetes /1,000 Adults (2015)	8.2	6.5
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Daily Self-Monitoring Blood Glucose [ii] (2010)	70.1%	63.6%
Overweight or Obese [ii] (2010)	83.2%	84.7%
Physical Inactivity [ii] (2010)	38.9%	36.1%
High Blood Pressure [ii] (2015)	58.2%	57.9%[iii]
High Cholesterol [ii] (2015)	68.8%	55.5%[iii]

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[ii] Adults with Self-reported Diagnosed Diabetes

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Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	56%	13%	24%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Coinsurance Deductibles	Up to 20% copay Deductible	Varies
Limitations	Referral required when the DSME/T is not provided by a licensed health care provider legally authorized to prescribe	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	*New diagnosis or complex condition:* 10 hours within 6 months *Medically stable:* 1 hour every 6 months

Private Insurance

New York requires all private health insurance plans to provide coverage for medically necessary DSME/T, including information on proper diets.[39] Coverage is available under different circumstances: when an individually is initially diagnosed with diabetes; if reeducation or a refresher training is needed; or if there is a significant change in the individual's symptoms or condition.[39] DSME/T provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian, or registered dietitian may generally be limited to group settings, but coverage must also include medically necessary home visits.[39] Insurers may impose cost-sharing requirements consistent with other covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

New York's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,51] Beneficiaries with a new diabetes diagnosis, or those with "a medically complex condition such as poor control of diabetes or other complicating factor," may receive up to 10 hours of DSME/T within a 6-month period.[52] Medically stable beneficiaries with an existing diabetes diagnosis may receive up to an hour of DSME/T within a 6-month period.[52] The health care professional providing the DSME/T must either be a diabetes educator certified by the National Certification Board for Diabetes Educators or be affiliated with a program certified by the Indian Health Services, ADA, or AADE.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

New York Medicaid Information
www.health.ny.gov/health_care/medicaid/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas New York DSME/T Website
http://j.mp/2ccQg2w

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

North Carolina: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in North Carolina.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in North Carolina

As of 2015, approximately 1 in 10 adults in North Carolina had been diagnosed with diabetes—more than 829,000 people in total.[30] American Indians and African Americans in North Carolina are significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 2.6 million individuals—36.1% of the state's adult population—have prediabetes.[32]

North Carolina adults with diabetes are more likely to have hypertension and high cholesterol.[31] In 2015, 52.1% of adults with diabetes in the state reported "fair or poor" general health, and 69.2% reported poor mental or physical health at least 1 day in the past 30 days.[30] The annual medical and economic costs attributable to diabetes in North Carolina exceeds $13.6 billion.[33] In the state, diabetes "is the leading cause of death due to heart attacks and strokes, and it is the leading cause of blindness and kidney failure."[34]

NC Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,35]	NC	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.5	6.5
Completed a DSME/T Class [ii] (2010)	54.5%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	63.4%	63.6%
Overweight or Obese [ii] (2010)	86.8%	84.7%
Physical Inactivity [ii] (2010)	37.1%	36.1%
High Blood Pressure [ii] (2015)	58.4%	57.9%[iii]
High Cholesterol [ii] (2015)	56.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	55%	13%	18%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Varies by plan	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours within 12 months of initial training 2 hours annual follow-up training Referral or prescription required

Private Insurance

North Carolina requires all private health insurance plans to provide coverage for medically necessary outpatient DSME/T.[40] Any physician or health care professional designated by a physician may provide DSME/T.[40] However, insurers are authorized to determine who will provide and be reimbursed for DSME/T.[40] Any deductibles, coinsurance, or other limitations that apply to similar services covered by the health insurance plan also apply to DSME/T.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

North Carolina's Medicaid program covers certain low-income populations, including low-income pregnant women, blind individuals, individuals with disabilities, individuals 65 or older, and individuals with dependent children.[38,50] Beneficiaries with a diabetes diagnosis may receive up to 10 hours of initial DSME/T within a 12-month period as well as up to 2 hours of follow-up training each year.[51] Beneficiaries must obtain a physician referral or prescription before receiving DSME/T, but do not need prior approval from the Medicaid program.[51]

DSME/T must be provided in accordance with the National Standards, and services must be administered by a provider and program recognized by the ADA.[51] Providers must conduct an individualized assessment and develop "an individualized education plan based on the assessment … in collaboration with each beneficiary."[51] Diet therapy and dietary counseling are covered if they are not billed separately from the DSME/T.[51]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

North Carolina Medicaid Information
https://dma.ncdhhs.gov/

Medicare DSME/T Information
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Diabetes Information from the CDC
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LawAtlas North Carolina DSME/T Website
http://j.mp/2cnA5kd

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

North Dakota: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in North Dakota.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in North Dakota

As of 2015, nearly 1 in 12 adults in North Dakota had been diagnosed with diabetes—more than 51,000 individuals in total.[30] American Indians in North Dakota are more than twice as likely as the state's general population to have the disease.[31] According to the ADA, an additional 188,000 individuals—35.4% of the state's adult population—have prediabetes.[32]

In 2015, 33.7% of North Dakota adults with diabetes reported "fair or poor" general health, and 60.9% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, 30.4% of adults with diabetes in the state reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2014, more than 14% of North Dakota adults with the disease did not visit a health professional for their diabetes, and only 66.1% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in North Dakota exceeds $832 million.[33]

ND Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	ND	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.1%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.4	6.5
Completed a DSME/T Class [ii] (2010)	58.8%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	62.7%	63.6%
Overweight or Obese [ii] (2010)	82.7%	84.7%
Physical Inactivity [ii] (2010)	32.1%	36.1%
High Blood Pressure [ii] (2015)	55.3%	57.9%[iii]
High Cholesterol [ii] (2015)	50.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	65%	14%	10%
Coverage Required	No	Part B only	Yes
Cost Sharing	-	Up to 20% copay Deductible	Varies
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Referral required **Traditional:** 16 hours DSME/T per lifetime; 4 visits per year for medical nutrition therapy **ABPs:** 2 comprehensive education programs per lifetime; 8 DSME/T follow-up visits per year

Private Insurance

North Dakota does not require private health insurance policies to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[39,40] Subject to limited exception,[41] recipients may receive 1 hour of private training and 9 hours of group training.[42] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[43] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[44,45] and receive the training from an ADA- or AADE-accredited program.[44,46] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[44,47]

Medicaid Coverage

North Dakota's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[48] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,49] For traditional Medicaid beneficiaries, the program covers up to 16 hours of DSME/T per lifetime and up to 4 visits per calendar year for medical nutrition therapy.[50–52] Beneficiaries must receive a referral from a physician before receiving DSME/T,[52] and the services must be provided by Certified Diabetes Educators meeting ADA criteria.[50]

Beneficiaries receiving Medicaid coverage through an Alternative Benefits Plan, such as adults newly eligible for Medicaid under the Affordable Care Act, are eligible for up to 2 comprehensive education programs per lifetime and 8 follow-up visits per year.[53] DSME/T coverage is available when an individual is diagnosed with diabetes, requires a change in current therapy, has a comorbid condition, or has unstable diabetes.[53] DSME/T services must be provided by a physician, nurse, dietitian, pharmacist, or similar licensed health care professional who a) satisfies the National Certification Board for Diabetic Educators' academic eligibility requirements and b) has either completed a course in DSME/T or been certified as a diabetes educator.[53] DSME/T programs must follow a curriculum approved by either the ADA or the North Dakota Department of Health.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

North Dakota Medicaid Information
www.nd.gov/dhs/services/medicalserv/medicaid/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas North Dakota DSME/T Website
http://j.mp/2ccQE0I

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Diabetes in Ohio

As of 2015, roughly 1 in 10 adults in Ohio had been diagnosed with diabetes—more than 993,000 individuals in total.[30] African Americans in the state are nearly 42% more likely than non-Hispanic whites to have the disease.[31] African American women in Ohio die from diabetes at a rate 82% higher than non-Hispanic white women.[31] According to the ADA, an additional 3 million individuals—35.3% of the state's adult population—have prediabetes.[32]

In 2015, 34.3% of Ohio adults with diabetes reported "fair or poor" general health, and 69.8% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2014, 16.2% of Ohio adults with the disease did not visit a health professional for their diabetes.[30] Moreover, a 2014 analysis found that more than 40% of Ohioans do not live within a 30-minute drive of a diabetes prevention program provider recognized by the Centers for Disease Control and Prevention.[31] The annual medical and economic costs attributable to diabetes in Ohio exceeds $15.8 billion.[33]

OH Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	OH	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.2	6.5
Completed a DSME/T Class [ii] (2010)	52.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	56%	63.6%
Overweight or Obese [ii] (2010)	75.1%	84.7%
Physical Inactivity [ii] (2010)	39.8%	36.1%
High Blood Pressure [ii] (2015)	56.6%	57.9%[iii]
High Cholesterol [ii] (2015)	54.3%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

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Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	57%	15%	21%
Coverage Required	No	Part B only	No
Cost Sharing	-	Up to 20% copay Deductible	-
Limitations	-	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Ohio does not require private health insurance policies to provide coverage for DSME/T.

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[39,40] Subject to limited exception,[41] recipients may receive 1 hour of private training and 9 hours of group training.[42] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[43] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[44,45] and receive the training from an ADA- or AADE-accredited program.[44,46] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[44,47]

Medicaid Coverage

Ohio's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[48] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,49] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, several Medicaid managed care providers in Ohio indicate that they cover general self-management and diabetes education.[50,51]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Ohio Medicaid Information
http://medicaid.ohio.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Ohio DSME/T Website
http://j.mp/2c8mBaJ

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Law & policy innovation for the common good.

A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Oklahoma: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Oklahoma.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Oklahoma

As of 2015, nearly 1 in 9 adults in Oklahoma had been diagnosed with diabetes—more than 345,000 individuals in total.[30] American Indians in the state are roughly 41% more likely than non-Hispanic whites to have the disease.[31] Both African Americans and American Indians in Oklahoma are significantly more likely than Hispanic individuals and non-Hispanic whites to die from the disease.[31] According to the ADA, an additional 1.04 million individuals—36.9% of the state's adult population—have prediabetes.[32]

In 2015, 56.1% of Oklahoma adults with diabetes reported "fair or poor" general health, and 76.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 15% of Oklahoma adults with the disease did not visit a health professional for their diabetes, and only 65% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Oklahoma exceeds $5.6 billion.[33]

OK Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	OK	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.7%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	10.2	6.5
Completed a DSME/T Class [ii] (2010)	59.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	69%	63.6%
Overweight or Obese [ii] (2010)	82.3%	84.7%
Physical Inactivity [ii] (2010)	39.8%	36.1%
High Blood Pressure [ii] (2015)	69.8%	57.9%[iii]
High Cholesterol [ii] (2015)	49.3%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	53%	14%	17%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Oklahoma requires private health insurance policies to provide coverage for medically necessary DSME/T, including medical nutrition therapy, when those services are "prescribed by a physician or health care provider with prescribing authority working under the supervision of a physician."[39–41] Private insurance covers DSME/T upon an individual's diabetes diagnosis, upon a significant change in an individual's symptoms or condition, or when an individual needs reeducation or a refresher training.[39,42]

DSME/T must be provided by an appropriately credentialed health care professional.[43] The services can include individual or group sessions in any setting, including inpatient, outpatient, office, community, and home settings.[41,43,44] A licensed registered dietician or licensed certified nutritionist must provide the medical nutrition therapy.[44] DSME/T must include a needs assessment, an education plan, an education intervention, an evaluation of learner outcomes, and a plan for follow-up learning.[45] Insurers may impose the same cost-sharing requirements applicable to other covered benefits,[46] and they may require individuals to complete a DSME/T program as a condition of receiving coverage.[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[47,48] Subject to limited exception,[49] recipients may receive 1 hour of private training and 9 hours of group training.[50] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[51] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[52,53] and receive the training from an ADA- or AADE-accredited program.[52,54] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[52,55]

Medicaid Coverage

Oklahoma's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[56,57] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, the state's Medicaid Health Management Program employs health coaches that "provide education, support and self-management tools" for beneficiaries "who have, or are at risk, for developing a chronic disease."[58]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

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www.okhca.org

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Oregon: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Oregon.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Oregon

As of 2015, nearly 1 in 10 adults in Oregon had been diagnosed with diabetes—more than 336,000 individuals in total.[30] African Americans in Oregon are more than 3 times more likely than non-Hispanic whites to have diabetes; American Indians, Alaska Natives, and Hispanic individuals in the state are twice as likely as non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.07 million individuals—36.1% of the state's adult population—have prediabetes.[32]

Obese adults in Oregon are roughly 5 times more likely than those at a healthy weight to have diabetes.[31] In 2015, 45.4% of Oregon adults with diabetes reported "fair or poor" general health, and 75.5% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2013, 12.5% of Oregon adults with the disease did not visit a health professional for their diabetes, and only 67.1% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Oregon exceeds $4.7 billion.[33]

OR Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	OR	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7	6.5
Completed a DSME/T Class [ii] (2010)	62.8%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	62.4%	63.6%
Overweight or Obese [ii] (2010)	87.9%	84.7%
Physical Inactivity [ii] (2010)	34.2%	36.1%
High Blood Pressure [ii] (2015)	59.9%	57.9%[iii]
High Cholesterol [ii] (2015)	62.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	53%	14%	24%
Coverage Required	Yes (group plans only)	Part B only	No
Cost Sharing	Varies by plan Prohibited for pregnant women	Up to 20% copay Deductible	-
Limitations	Initial training and assessment 3 hours annual follow-up Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Oregon requires private group health insurance policies to provide coverage for DSME/T when prescribed by a health care professional.[39,40] Private insurance covers "one program of assessment and training" after an individual's diabetes diagnosis and up to 3 hours of annual follow-up assessments and training "upon a material change of condition, medication or treatment."[41]

DSME/T must be provided by either a credentialed or accredited program or "a physician [], a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes."[41] DSME/T may be delivered by telemedicine.[42] With limited exception, insurers may not impose cost-sharing requirements on DSME/T received by a woman during the period between conception and 6 weeks postpartum.[43]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Oregon's Medicaid program, the Oregon Health Plan, covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[53] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,54] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, Oregon Medicaid managed care organizations are required to provide beneficiaries with general education about self-management and self-care.[55] They also must develop and maintain "an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention."[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Oregon Medicaid Information
www.oregon.gov/oha/healthplan/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Oregon DSME/T Website
http://j.mp/2cnB2ZI

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Pennsylvania: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Pennsylvania.

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Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Pennsylvania

As of 2015, nearly 1 in 11 adults in Pennsylvania had been diagnosed with diabetes—more than 1.04 million individuals in total.[30] According to the ADA, an additional 3.5 million individuals—35.8% of the state's adult population—have prediabetes.[31] A 2016 report found that in Pennsylvania, African American adults with diabetes were 5 times as likely to be hospitalized for end-stage renal disease as non-Hispanic whites with diabetes.[32]

In 2015, 39.8% of Pennsylvania adults with diabetes reported "fair or poor" general health, and 69.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] Pennsylvania adults with diabetes who have health insurance are less likely to employ self-management practices, such as checking their blood glucose level daily.[33] They're also less likely to have their A1c levels checked or to have received DSME/T.[33] The annual medical and economic costs attributable to diabetes in Pennsylvania exceeds $18.4 billion.[34]

PA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	PA	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.8%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.7	6.5
Completed a DSME/T Class [ii] (2010)	58.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	65.4%	63.6%
Overweight or Obese [ii] (2010)	86.5%	84.7%
Physical Inactivity [ii] (2010)	38.9%	36.1%
High Blood Pressure [ii] (2015)	75.3%	57.9%[iii]
High Cholesterol [ii] (2015)	51%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	60%	16%	18%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Not specified

Private Insurance

Pennsylvania requires most private health insurance policies to provide coverage for outpatient DSME/T, including medical nutrition therapy,[40] "to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets."[41] Private insurance covers medically necessary DSME/T visits upon a patient's initial diabetes diagnosis, upon a significant change in the patient's symptoms or condition, or when a licensed physician changes a patient's diabetes medication or therapeutic processes.[41]

A licensed physician must prescribe DSME/T before an individual receives services, and DSME/T must be "provided under the supervision of a licensed health care professional with expertise in diabetes."[41] Insurers may impose the same cost-sharing requirements applicable to similar covered benefits.[42]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[43,44] Subject to limited exception,[45] recipients may receive 1 hour of private training and 9 hours of group training.[46] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[47] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[48,49] and receive the training from an ADA- or AADE-accredited program.[48,50] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[48,51]

Medicaid Coverage

Pennsylvania's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[52] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[38,53] The program covers outpatient DSME/T "to ensure that all [Medicaid] recipients with diabetes are educated on the proper self-management and treatment of their diabetes, including information on proper diets."[54] DSME/T must be provided by a licensed health care professional with expertise in diabetes, and DSME/T programs must be recognized by "the ADA or other national [Centers for Medicare & Medicaid Services]-approved accreditation organization,"[54] such as the AADE.[50]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Pennsylvania Medicaid Information
www.dhs.pa.gov/citizens/healthcaremedicalassistance/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Pennsylvania DSME/T Website
http://j.mp/2ccQC9h

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Rhode Island: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Rhode Island.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Rhode Island

As of 2015, approximately 1 in 12 adults in Rhode Island had been diagnosed with diabetes—more than 76,000 individuals in total.[30] Compared with non-Hispanic whites, African Americans in Rhode Island are roughly 2.3 times more likely to have diabetes, and Hispanic individuals in the state are 1.7 times more likely to have it.[31] According to the ADA, an additional 294,000 individuals—36.4% of the state's adult population—have prediabetes.[32]

In 2015, 44% of Rhode Island adults with diabetes reported "fair or poor" general health, and 74.8% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 46.2% of Rhode Island adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, more than 10% of Rhode Island adults with the disease did not visit a health professional for their diabetes, and only 80.3% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Rhode Island exceeds $1.5 billion.[33]

RI Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	RI	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.9%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.7	6.5
Completed a DSME/T Class [ii] (2009)	42.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2009)	54.8%	63.6%
Overweight or Obese [ii] (2010)	86%	84.7%
Physical Inactivity [ii] (2010)	41.6%	36.1%
High Blood Pressure [ii] (2015)	52.1%	57.9%[iii]
High Cholesterol [ii] (2015)	52.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	64%	13%	17%
Coverage Required	Yes	Part B only	-
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription or referral required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Rhode Island requires private health insurance policies to provide coverage for medically necessary DSME/T, including nutrition counseling[39] Private insurance covers DSME/T upon an individual's diabetes diagnosis, a significant change in an individual's symptoms or condition, or when an individual needs reeducation or a refresher training.[39]

A physician must prescribe DSME/T, and the services must be provided by either a) the physician or b) an appropriately licensed and certified health care provider to whom the physician refers the patient.[39] DSME/T may be provided in group settings, but private insurance must cover home visits when medically necessary.[39] Insurers may impose cost-sharing requirements equal to or less than those applicable to other covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Rhode Island's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[50] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,51] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T. However, multiple Medicaid managed care organizations in the state indicate that beneficiaries receive coverage for general diabetes education, including self-management.[53–55]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Rhode Island Medicaid Information
www.dhs.ri.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Rhode Island DSME/T Website
http://j.mp/2ccQIOi

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

South Carolina: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in South Carolina.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in South Carolina

As of 2015, approximately 1 in 10 adults in South Carolina had been diagnosed with diabetes—more than 450,000 individuals in total.[30] Compared with non-Hispanic whites, African Americans in South Carolina are 1.5 times more likely to have the disease and more than twice as likely to die from it.[31,32] According to the ADA, an additional 1.3 million individuals—37.2% of the state's adult population—have prediabetes.[33]

In 2015, 46.5% of South Carolina adults with diabetes reported "fair or poor" general health, and 67.6% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 42.5% of South Carolina adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 13.4% of South Carolina adults with the disease did not visit a health professional for their diabetes, and only 69.2% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes exceeds $7 billion.[34]

SC Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,35]	SC	U.S.
% of Adults with Diagnosed Diabetes (2015)	10.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.2	6.5
Completed a DSME/T Class [ii] (2010)	61.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	65%	63.6%
Overweight or Obese [ii] (2010)	86.4%	84.7%
Physical Inactivity [ii] (2010)	36.1%	36.1%
High Blood Pressure [ii] (2015)	73.7%	57.9%[iii]
High Cholesterol [ii] (2015)	50.6%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[36] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[37] These limitations, as well as the services Medicaid covers, vary among the states.[38]

Insurance Type	Private	Medicare	Medicaid
% of State Population[39]	52%	16%	19%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Up to 20% copay Deductible	Up to 20% copay Deductible	Varies
Limitations	Prescription required Follows Medicare standards	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours initial education 6 hours annual follow-up training

Private Insurance

South Carolina requires private health insurance policies and the group health plan for state employees to provide coverage for medically necessary outpatient DSME/T.[40,41] DSME/T must be prescribed by a health care professional "who demonstrates adherence to minimum standards of care for diabetes [] as adopted and published by the Diabetes Initiative of South Carolina."[40] DSME/T must be provided by either a) a health care professional certified by the National Certification Board of Diabetes Educators or b) an accredited program approved by the Diabetes Initiative of South Carolina or the Diabetes Control Program of the South Carolina Department of Health and Environmental Control.[42] South Carolina requires DSME/T services and payment to conform to the federal Medicare standards.[42]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[43,44] Subject to limited exception,[45] recipients may receive 1 hour of private training and 9 hours of group training.[46] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[47] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[48,49] and receive the training from an ADA- or AADE-accredited program.[48,50] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[48,51]

Medicaid Coverage

South Carolina's Medicaid program covers certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[52,53] The program provides coverage for medically necessary outpatient DSME/T when the beneficiary has been diagnosed with diabetes and referred by their primary care provider.[54] The program covers up to 10 hours of individual or group initial education and up to 6 hours of individual follow-up training per state fiscal year (July 1 through June 30).[54]

DSME/T must be provided by an appropriately licensed health care professional, such as a physician, pharmacist, nurse practitioner, registered dietitian, social worker, practical nurse, or physician assistant.[54] DSME/T programs must adhere to the National Standards and either be managed by a Certified Diabetes Educator or be recognized by the ADA, AADE, or Indian Health Services (IHS).[54]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

South Carolina Medicaid Information
www.scdhhs.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas South Carolina DSME/T Website
http://j.mp/2cnAGCr

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Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self- Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

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Diabetes in South Dakota

As of 2015, approximately 1 in 12 adults in South Dakota had been diagnosed with diabetes—more than 60,000 individuals in total.[30] American Indians in South Dakota are more than 3 times more likely than non-Hispanic whites to have the disease.[31] On average, American Indians in the state die from diabetes 16 years earlier than non-Hispanic whites with the disease.[31]According to the ADA, an additional 218,000 individuals—35.5% of the state's adult population—have prediabetes.[32]

In 2015, 33.6% of South Dakota adults with diabetes reported "fair or poor" general health, and 57.8% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2014, nearly 10% of South Dakota adults with the disease did not visit a health professional for their diabetes, and only 76.8% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in South Dakota exceeds $832 million.[33]

SD Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	SD	U.S.
% of Adults with Diagnosed Diabetes (2015)	8.4%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	8.1	6.5
Completed a DSME/T Class [ii] (2010)	56.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	51.7%	63.6%
Overweight or Obese [ii] (2010)	82.2%	84.7%
Physical Inactivity [ii] (2010)	35%	36.1%
High Blood Pressure [ii] (2015)	52.6%	57.9%[iii]
High Cholesterol [ii] (2015)	55.5%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	62%	14%	14%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	2 complete programs 8 follow-up visits annually Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	10 hours initial training 2 hours annual follow-up training

Private Insurance

South Dakota requires private health insurance plans to cover DSME/T, including medical nutrition therapy, when prescribed by a licensed health care provider.[39] Private insurance covers DSME/T upon an individual's diabetes diagnosis, upon a change in an individual's current therapy, or when an individual has received no prior diabetes education, has comorbid conditions, or has unstable diabetes.[39] An individual may receive 2 comprehensive DSME/T programs in their life and 8 follow-up visits annually.[39] DSME/T must be provided by a qualified health care provider,[40] and must be based on an ADA-recognized program or use "a curriculum approved by the [ADA] or the South Dakota Department of Health [SDDOH]."[39] Insurers may impose the same cost-sharing requirements applicable to other covered benefits, and "[c]overage is limited to the closest available qualified education program that provides the necessary management training to accomplish the prescribed treatment."[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

South Dakota's Medicaid program provides coverage for certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[50,51] The program covers outpatient DSME/T when ordered for a beneficiary by a physician,[52–54] including 10 hours of initial education and 2 hours of annual follow-up training without prior authorization.[55] The program covers DSME/T upon a diabetes diagnosis, upon a change in treatment regimen, or when an individual has received no prior diabetes education, has poor glycemic control, is at high risk because of health complications, or "has documented episodes of acute, severe hypoglycemia or hyperglycemia occurring in the past year that required third-party assistance."[53] DSME/T must be provided by a program recognized by either the ADA or the SDDOH.[56]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

South Dakota Medicaid Information
http://dss.sd.gov/medicaid/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas South Dakota DSME/T Website
http://j.mp/2ccR7jJ

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Tennessee: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Tennessee.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Tennessee

As of 2015, more than 1 in 9 adults in Tennessee had been diagnosed with diabetes—more than 644,000 individuals in total.[30] Individuals in Tennessee without a high school degree are approximately 50% more likely than those with a high school degree or postsecondary degree to have the disease.[30] According to the ADA, an additional 1.73 million individuals—35.8% of the state's adult population—have prediabetes.[31]

In 2015, 48% of Tennessee adults with diabetes reported "fair or poor" general health, and 75.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 31.9% of Tennessee adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 13.7% of Tennessee adults with the disease did not visit a health professional for their diabetes, and only 67.2% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Tennessee exceeds $10.2 billion.[32]

TN Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,33]	TN	U.S.
% of Adults with Diagnosed Diabetes (2015)	11.4%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.2	6.5
Completed a DSME/T Class [ii] (2010)	55.9%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	75.2%	63.6%
Overweight or Obese [ii] (2010)	88.1%	84.7%
Physical Inactivity [ii] (2010)	45.8%	36.1%
High Blood Pressure [ii] (2015)	71.5%	57.9%[iii]
High Cholesterol [ii] (2015)	61.7%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[34] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[35] These limitations, as well as the services Medicaid covers, vary among the states.[36]

Insurance Type	Private	Medicare	Medicaid
% of State Population[37]	51%	16%	19%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Prescription required

Private Insurance

Tennessee requires private health insurance policies to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy, when prescribed by a physician.[38] Private insurance covers DSME/T upon a diabetes diagnosis, upon a significant change in an individual's symptoms or condition, and when reeducation or a refresher training is necessary.[38]

DSME/T must be provided by a physician or, upon referral by a physician, a registered nurse, a registered dietitian, a pharmacist with specified training, or another health professional with expertise in diabetes management.[38] Generally, DSME/T may be provided in group settings, but private insurance must also cover medically necessary home visits.[39] Insurers may impose cost-sharing requirements equal to or less than those applicable to similar covered benefits.[40]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[41,42] Subject to limited exception,[43] recipients may receive 1 hour of private training and 9 hours of group training.[44] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[45] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[46,47] and receive the training from an ADA- or AADE-accredited program.[46,48] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[46,49]

Medicaid Coverage

Tennessee's Medicaid program, TennCare, provides coverage for certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, and individuals with disabilities.[50,51] TennCare beneficiaries receive coverage for medically necessary outpatient DSME/T, including medical nutrition therapy, when prescribed by a physician.[38] Coverage is available upon a diabetes diagnosis, upon a significant change in an individual's symptoms or condition, and when reeducation or a refresher training is necessary.[38] DSME/T must be provided by a physician or, upon referral by a physician, a registered nurse, a registered dietitian, a pharmacist with specified training, or another health professional with expertise in diabetes management.[38]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Tennessee Medicaid Information
www.tn.gov/tenncare/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Tennessee DSME/T Website
http://j.mp/2cnDkI4

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The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Texas

As of 2015, approximately 1 in 9 adults in Texas had been diagnosed with diabetes—more than 2.32 million individuals in total.[30] African Americans and Hispanic individuals in Texas are roughly 30% more likely than non-Hispanic whites to have diabetes and more than twice as likely as non-Hispanic whites to die from the disease.[31] According to the ADA, an additional 6.88 million individuals—37.2% of the state's adult population—have prediabetes.[32]

In 2015, 49.8% of Texas adults with diabetes reported "fair or poor" general health, and 59.4% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 30.3% of Texas adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 11.4% of Texas adults with the disease did not visit a health professional for their diabetes, and only 59.7% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Texas exceeds $33.9 billion.[33]

TX Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	TX	U.S.
% of Adults with Diagnosed Diabetes (2015)	11.2%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	11.1	6.5
Completed a DSME/T Class [ii] (2010)	63.2%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	59.6%	63.6%
Overweight or Obese [ii] (2010)	86.1%	84.7%
Physical Inactivity [ii] (2010)	36%	36.1%
High Blood Pressure [ii] (2015)	50.5%	57.9%[iii]
High Cholesterol [ii] (2015)	55.6%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	55%	11%	16%
Coverage Required	Yes	Part B only	Yes* (See below)
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Not Specified
Limitations	Not specified	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	* Managed care only

Private Insurance

Texas requires private health insurance policies to provide coverage for DSME/T,[39,40] including medical nutrition therapy.[41] Private insurance covers DSME/T upon an initial diabetes diagnosis, upon a significant change in an individual's symptoms or condition, or when "warranted by the development of new [diabetes] techniques or treatments."[42] DSME/T must be provided by a licensed, registered, or certified health care practitioner acting within their scope of practice.[43,44] The provider also must meet certain "education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health."[44]

When a physician or health care provider orders DSME/T for a patient, the services must satisfy certain criteria. The patient can receive coverage for DSME/T that is delivered through an ADA-recognized program, provided by specified multidisciplinary teams, or "provided by a diabetes educator certified by the National Certification Board for Diabetes Educators."[45] Insurers may impose cost-sharing requirements equal to or less than those applicable to similar covered benefits.[46]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[47,48] Subject to limited exception,[49] recipients may receive 1 hour of private training and 9 hours of group training.[50] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[51] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[52,53] and receive the training from an ADA- or AADE-accredited program.[52,54] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[52,55]

Medicaid Coverage

Texas' Medicaid program provides coverage for certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[56,57] The state's Medicaid managed care providers, who provide care to more than 78% of Texas Medicaid beneficiaries,[58] are required to provide disease management services, including patient self-management education.[59] Moreover, the Texas Medicaid Wellness Program provides select high-cost/high-risk beneficiaries who have diabetes with up to 10 hours of DSME/T and 3 hours of nutritional counseling.[60] More generally, the program covers group clinical services and educational counseling for beneficiaries with diabetes.[61]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Texas Medicaid Information
https://hhs.texas.gov/services/health/medicaid-chip

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Texas DSME/T Website
http://j.mp/2ckhWDU

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Utah: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Utah.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Utah

As of 2015, approximately 1 in 13 adults in Utah had been diagnosed with diabetes—more than 146,000 individuals in total.[30] Native Hawaiians and Pacific Islanders, African Americans, and American Indians and Alaska Natives in Utah are all significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 619,000 individuals—32.7% of the state's adult population—have prediabetes.[32]

In 2015, 39.7% of Utah adults with diabetes reported "fair or poor" general health, and 69.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 15% of Utah adults with the disease did not visit a health professional for their diabetes, and only 69.8% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Utah exceeds $2 billion.[33]

UT Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	UT	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7	6.5
Completed a DSME/T Class [ii] (2010)	62.1%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	66.5%	63.6%
Overweight or Obese [ii] (2010)	79.8%	84.7%
Physical Inactivity [ii] (2010)	26.6%	36.1%
High Blood Pressure [ii] (2015)	53.6%	57.9%[iii]
High Cholesterol [ii] (2015)	52.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	66%	10%	12%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Duration and amount limitations vary by plan Referral or prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Prior authorization Referral required

Private Insurance

Utah requires private health insurance policies to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy, when ordered or prescribed by a physician.[39–41] Private insurance covers DSME/T upon a diabetes diagnosis, a significant change in an individual's condition or diagnostic levels, or a change in an individual's treatment regimen.[42] DSME/T must be provided by a program recognized by the federal Centers for Medicare and Medicaid Services, certified by the Utah Department of Health (DOH), or recognized by a national DSME/T accrediting organization.[39,43] Insurers may impose cost-sharing requirements, durational limits, and amount limits similar or equal to those applicable to other covered benefits.[44,45]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[46,47] Subject to limited exception,[48] recipients may receive 1 hour of private training and 9 hours of group training.[49] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[50] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[51,52] and receive the training from an ADA- or AADE-accredited program.[51,53] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[51,54]

Medicaid Coverage

Utah's Medicaid program provides coverage for certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[55,56] The program provides coverage for up to 10 outpatient DSME/T sessions per year when a beneficiary receives approval from a physician and prior authorization from Medicaid.[57–60] Group sessions are permitted so long as they allow "direct, face to face interaction."[61]

DSME/T programs must be recognized by the AADE or certified by the Utah DOH.[62] They must meet the National Diabetes Advisory Board's standards, which address the 15 main components of the ADA curriculum. [62] Registered nurses, registered pharmacists, and certified dietitians may provide DSME/T if they are "certified or recognized by the [AADE] or approved through the Utah [DOH] as diabetes instructors."[63] DSME/T offered through a Home Health Agency must be provided by an ADA-certified or DOH-approved licensed health care provider.[64,65]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Utah Medicaid Information
https://medicaid.utah.gov/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Utah DSME/T Website
http://j.mp/2cnC3kB

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Vermont: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Vermont.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Vermont

As of 2015, nearly 1 in 14 adults in Vermont had been diagnosed with diabetes—more than 41,000 individuals in total.[30] The prevalence of diabetes in the state increased from 2002 to 2010, though it remains lower than the diabetes prevalence in the United States overall.[31] In Vermont, diabetes incidence and prevalence are higher among adults aged 45 and older and among households with an income less than 250% of the federal poverty level.[31] According to the ADA, an additional 174,000 people in Vermont—35.7% of the state's adult population—have prediabetes.[32]

In 2015, 35.6% of Vermont adults with diabetes reported "fair or poor" general health, and 67.7% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 8% of Vermont adults with the disease did not visit a health professional for their diabetes, and only 71.6% received 2 or more A1c tests in the past year[30] The annual medical and economic costs attributable to diabetes in Vermont exceeds $694 million.[33]

VT Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,34]	VT	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.1%	9.1%[iii]
New Cases of Diabetes /1,000 Adults (2015)	5	6.5
Completed a DSME/T Class [ii] (2010)	51%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	64.3%	63.6%
Overweight or Obese [ii] (2010)	93.8%	84.7%
Physical Inactivity [ii] (2010)	33%	36.1%
High Blood Pressure [ii] (2015)	54.7%	57.9%[iii]
High Cholesterol [ii] (2015)	56.1%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	58%	14%	20%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies	Up to 20% copay Deductible	No
Limitations	Prescription required Provider network restrictions may apply	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	1 diabetes education course per lifetime 12 additional counseling sessions per year

Private Insurance

Vermont requires all private health insurance plans to provide coverage for outpatient DSME/T, including medical nutrition therapy, if prescribed by a health care professional.[39] DSME/T must be provided "by a certified, registered, or licensed health care professional with specialized training in the education and management of diabetes."[40] An insurer may require a patient to receive DSME/T from a health care professional within the insurer's provider network.[39] Insurers may impose cost-sharing requirements applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Vermont's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,52] For each beneficiary, the program covers 1 diabetes education course per lifetime if provided by a hospital-sponsored outpatient program, as well as 12 counseling sessions per calendar year if provided by a certified diabetes educator.[53] Additional counseling sessions with a diabetes educator may be covered with prior authorization.[53] Medicaid also covers one membership in the American Diabetes Association per lifetime.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Vermont Medicaid Information
http://ovha.vermont.gov/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Vermont DSME/T Website
http://j.mp/2cnCMCb

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Virginia: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Virginia.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Virginia

As of 2015, nearly 1 in 10 adults in Virginia had been diagnosed with diabetes—more than 676,000 individuals in total.[30] African Americans in the state are approximately 57% more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 2.2 million individuals—36% of the state's adult population—have prediabetes.[32]

In 2015, 36% of Virginia adults with diabetes reported "fair or poor" general health, and 63% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 29.6% of Virginia adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 14.5% of Virginia adults with the disease did not visit a health professional for their diabetes, and only 69.4% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Virginia exceeds $11 billion.[33]

VA Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	VA	U.S.
% of Adults with Diagnosed Diabetes (2015)	9.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.3	6.5
Completed a DSME/T Class [ii] (2010)	63.6%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	62.4%	63.6%
Overweight or Obese [ii] (2010)	87%	84.7%
Physical Inactivity [ii] (2010)	37.7%	36.1%
High Blood Pressure [ii] (2015)	62.7%	57.9%[iii]
High Cholesterol [ii] (2015)	51.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	61%	14%	11%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	No annual benefit limits permitted Prescription required	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Virginia requires private health insurance policies to provide coverage for in-person outpatient DSME/T, including medical nutrition therapy, when prescribed by a health care professional.[39] DSME/T must be provided by a certified, registered, or licensed health care professional.[40] Insurers may impose the same cost-sharing requirements applicable to similar covered benefits; however, insurers may not impose annual limits on DSME/T coverage.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Virginia's Medicaid program provides coverage for certain low-income populations, including low-income pregnant women, parents or other caretaker relatives, children, individuals 65 years of age or older, and individuals with disabilities.[51,52] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Virginia Medicaid Information
www.dmas.virginia.gov

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Virginia DSME/T Website
http://j.mp/2ccRNWj

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Washington State: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Washington State.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Washington State

As of 2015, roughly 1 in 13 adults in Washington State had been diagnosed with diabetes—more than 466,000 people in total.[30] American Indians, Alaska Natives, African Americans, and Hispanic individuals in Washington State are all significantly more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.87 million individuals—36.1% of the state's adult population—have prediabetes.[32]

Washington adults with diabetes are 4 times more likely to report having high blood pressure and 3 times more likely to report having high cholesterol.[31] The annual medical and economic costs attributable to diabetes in Washington exceeds $7.8 billion.[33] In response to this epidemic, a 2014 report commissioned by the Washington State legislature recommended that "all people with diabetes receive self-management education."[31] It also called for increasing community health workers' involvement in working with populations most affected by diabetes.[31]

WA Diabetes Burden Compared With National Diabetes Burden (Age-Adjusted)[30,34]	WA	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.7%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	5.1	6.5
Completed a DSME/T Class [ii] (2009)	65.7%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2009)	64.7%	63.6%
Overweight or Obese [ii] (2010)	79.2%	84.7%
Physical Inactivity [ii] (2010)	23.8%	36.1%
High Blood Pressure [ii] (2015)	51.7%	57.9%[iii]
High Cholesterol [ii] (2015)	51.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	56%	14%	22%
Coverage Required	Yes* (See below)	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Certain plans excluded (Explained below)	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	6 hours per calendar year Must be provided at approved diabetes education centers Referral required

Private Insurance

Washington State requires most private health insurance plans to provide coverage for medically necessary outpatient DSME/T services, including medical nutrition therapy.[39] This requirement does not apply to certain self-insured group contracts[40] or to plans "that provide benefits identical to the schedule of services covered by the basic health plan."[41,42] DSME/T must be provided by a qualified health care professional with expertise in diabetes.[39] Insurers may impose the same cost-sharing requirements applicable to similar services covered by the policy.[43]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[44,45] Subject to limited exception,[46] recipients may receive 1 hour of private training and 9 hours of group training.[47] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[48] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[49,50] and receive the training from an ADA- or AADE-accredited program.[49,51] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[49,52]

Medicaid Coverage

Washington State's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[53] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[37,54] If referred by a licensed health care provider, a beneficiary may receive up to 6 hours of DSME/T per calendar year.[55] DSME/T must be provided in a "diabetes education center" approved by the Washington State Department of Health.[56]

State law requires DSME/T to provide an overview of diabetes and to address certain "core" topics, including nutrition, exercise, preventing acute and chronic complications, monitoring, and medication management.[57] The nutrition component must include an individualized meal plan, and the exercise component must include an individualized physical activity plan.[57]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Washington State Medicaid Information
www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Washington State DSME/T Website
http://j.mp/2cnBQ0E

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

West Virginia: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in West Virginia.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in West Virginia

As of 2015, 1 in 8 adults in West Virginia had been diagnosed with diabetes—more than 212,000 individuals in total.[30] There is no statistically significant difference in diabetes prevalence among different racial groups in West Virginia.[31] According to the ADA, an additional 518,000 individuals—35.9% of the state's adult population—have prediabetes.[32]

In 2015, more than half of West Virginia adults with diabetes reported "fair or poor" general health, and 72.1% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 44.5% of West Virginia adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2014, 12.3% of West Virginia adults with the disease did not visit a health professional for their diabetes, and only 77.9% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in West Virginia exceeds $3.3 billion.[33]

WV Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	WV	U.S.
% of Adults with Diagnosed Diabetes (2015)	12.5%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	9.4	6.5
Completed a DSME/T Class [ii] (2010)	47.4%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	61.9%	63.6%
Overweight or Obese [ii] (2010)	92.3%	84.7%
Physical Inactivity [ii] (2010)	45.5%	36.1%
High Blood Pressure [ii] (2015)	63.7%	57.9%[iii]
High Cholesterol [ii] (2015)	59%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	44%	19%	29%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	Reeducation and refresher training limited to $100 per year	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	2 extended office visits 8.5 hours per year

Private Insurance

West Virginia requires private health insurance policies to provide coverage for medically necessary DSME/T, including information on proper diets, when prescribed by a licensed physician.[39] Private insurance covers DSME/T upon a diabetes diagnosis, a significant change in an individual's symptoms or condition, or when a licensed physician identifies a new treatment option as medically necessary for treating or managing an individual's diabetes.[39] Insurers may impose cost-sharing requirements equal to those applicable to other covered benefits,[40] and coverage for reeducation or a refresher training is limited to $100 per year.[39]

DSME/T may be provided by an individual's physician; a Certified Diabetes Educator certified by a national diabetes educator certification program; or, upon the referral of a physician, a registered dietitian registered by a nationally recognized professional association of dietitians.[41] A licensed pharmacist may provide instruction on using diabetes-related equipment, supplies, and medications.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

West Virginia's Medicaid program covers all individuals at or below 138% of the federal poverty level (approximately $33,948 for a family of four in 2017)[51] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some pregnant women.[52] The Diabetes Disease State Management program provides beneficiaries coverage for DSME/T.[53] DSME/T must be based on ADA guidelines and provided by a physician, a Medicaid-enrolled nurse practitioner, or a Certified Diabetes Educator.[53] Annual coverage is limited to 2 extended office visits with the beneficiary's managing provider, 8.5 hours of individual or group DSME/T, and 2 follow-up/reassessment visits.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

West Virginia Medicaid Information
www.dhhr.wv.gov/bms/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas West Virginia DSME/T Website
http://j.mp/2cnCL0Z

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Wisconsin: Background, Benefits, and Insurance Coverage of DSME/T

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The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Wisconsin

As of 2015, nearly 1 in 13 Wisconsin adults had been diagnosed with diabetes—more than 374,000 people in total.[30] American Indians and Alaska Natives in Wisconsin are nearly 5 times more likely than non-Hispanic whites to have the disease.[31] According to the ADA, an additional 1.5 million individuals—36.1% of the state's adult population—have prediabetes.[32]

In 2015, more than 39% of Wisconsin adults with diabetes reported "fair or poor" general health, and 66.5% reported poor mental or physical health at least 1 day in the past 30 days.[30] However, in 2015, more than 5% Wisconsin adults with the disease did not visit a health professional for their diabetes, and only 72.1% received 2 or more A1c tests in the past year.[30] Wisconsinites with diabetes are significantly more likely than those without diabetes to receive coverage through public health insurance programs.[31] The annual medical and economic costs attributable to diabetes in Wisconsin exceeds $5.8 billion.[33]

WI Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	WI	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.4%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	7.1	6.5
Completed a DSME/T Class [ii] (2010)	59.2%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	64.7%	63.6%
Overweight or Obese [ii] (2010)	82.4%	84.7%
Physical Inactivity [ii] (2010)	32.3%	36.1%
High Blood Pressure [ii] (2015)	54.7%	57.9%[iii]
High Cholesterol [ii] (2015)	52.9%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	61%	14%	17%
Coverage Required	Yes	Part B only	No
Cost Sharing	Varies by plan	Up to 20% copay Deductible	-
Limitations	Varies by plan	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	-

Private Insurance

Wisconsin requires private health insurance plans and insurance for state employees to provide coverage for DSME/T.[39] DSME/T coverage is subject to the same exclusions, limitations, and cost sharing requirements applicable to other covered benefits.[39]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[40,41] Subject to limited exception,[42] recipients may receive 1 hour of private training and 9 hours of group training.[43] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[44] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[45,46] and receive the training from an ADA- or AADE-accredited program.[45,47] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[45,48]

Medicaid Coverage

Wisconsin's Medicaid program provides coverage for all individuals at or below 100% of the federal poverty level ($24,600 for a family of four in 2017)[49] as well as certain populations that do not otherwise meet the income eligibility requirements, such as some children and pregnant women.[37,50,51] The program does not explicitly indicate that beneficiaries receive coverage for DSME/T.

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Wisconsin Medicaid Information
www.dhs.wisconsin.gov/forwardhealth/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Wisconsin DSME/T Website
http://j.mp/2cnCyen

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A Key Tool in Health Care: Diabetes Self-Management Education and Training (DSME/T)

Wyoming: Background, Benefits, and Insurance Coverage of DSME/T

This fact sheet provides information about public and private insurance coverage for diabetes self-management education and training (DSME/T)[i] services in Wyoming.

Diabetes and DSME/T in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2015, 1.5 million adults were diagnosed—more than 4,100 every day.[1] One in 3 adults has prediabetes, which often leads to diabetes.[1]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[3] Further, people of color disproportionately bear the burden of type 2 diabetes and the related health effects. They are more likely to be diagnosed with the disease,[1] are less likely to have positive diabetes control indicators, such as lower A1c levels,[4] and experience worse health outcomes overall.[5–7]

Effective diabetes management depends largely on individual self-care,[8,9] making DSME/T critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[10] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[10] These solutions include healthy eating, physical activity, self-monitoring, medication use, risk reduction, management of acute and chronic complications, and problem-solving strategies to address psychosocial issues and establish healthy habits.[11]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[12–15] and reduces health care expenditures.[8,9,16–23] Indeed, "persons with diabetes who do not receive [DSME/T] are four times as likely as those who do to develop a major diabetes complication."[24]

Despite this evidence, participation in DSME/T remains low,[25,26] particularly among rural populations,[12] Medicare[27] and Medicaid beneficiaries,[16] uninsured or underinsured persons,[28,29] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[24] Moreover, DSME/T services often do not conform to best practices.[28] To offer the most effective care, providers may consider patterning DSME/T services after the National Standards for Diabetes Self-Management Education and Support, developed by the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE).[11]

Insurance coverage presents one lever for facilitating delivery of and access to high-quality DSME/T. In many states, statutes and regulations require public and private insurers to cover DSME/T services. Some Medicaid materials, including managed care contracts and Medicaid agency guidance, have specific DSME/T coverage requirements. Public health professionals and policymakers may use these statutes, regulations, and Medicaid materials to understand the patterns, trends, and gaps in DSME/T coverage and to identify opportunities for reform.

Diabetes in Wyoming

As of 2015, approximately 1 in 13 adults in Wyoming had been diagnosed with diabetes—more than 37,000 individuals in total.[30] American Indians, African Americans, and Hispanic individuals in Wyoming are all more likely than non-Hispanic whites to die from diabetes.[31] According to the ADA, an additional 153,000 individuals—35.7% of the state's adult population—have prediabetes.[32]

In 2015, 42.3% of Wyoming adults with diabetes reported "fair or poor" general health, and 76.3% reported poor mental or physical health at least 1 day in the past 30 days.[30] Moreover, in 2015, 46.1% of Wyoming adults with diabetes reported an inability to do usual activities at least 1 day in the past 30 days.[30] However, in 2015, 16.5% of Wyoming adults with the disease did not visit a health professional for their diabetes, and only 69.5% received 2 or more A1c tests in the past year.[30] The annual medical and economic costs attributable to diabetes in Wyoming exceeds $628 million.[33]

WY Diabetes Burden Compared with National Diabetes Burden (Age-Adjusted)[30,34]	WY	U.S.
% of Adults with Diagnosed Diabetes (2015)	7.6%	9.1%[iii]
New Cases of Diabetes / 1,000 Adults (2015)	6.6	6.5
Completed a DSME/T Class [ii] (2010)	55.3%	57.4%
Daily Self-Monitoring Blood Glucose [ii] (2010)	54.3%	63.6%
Overweight or Obese [ii] (2010)	85.6%	84.7%
Physical Inactivity [ii] (2010)	30.5%	36.1%
High Blood Pressure [ii] (2015)	57.6%	57.9%[iii]
High Cholesterol [ii] (2015)	54.8%	55.5%[iii]

[i] DSME/T may also be referred to as diabetes self-management education (DSME), diabetes self-management training (DSMT), or diabetes self-management education and support.

[ii] Adults with Self-reported Diagnosed Diabetes

[iii] 50 States + DC: US Median

Current State Insurance Coverage for DSME/T

This section examines DSME/T coverage by the 3 primary sources of health insurance: private insurance, Medicare, and Medicaid. Private insurance includes coverage provided by an employer, purchased through an Affordable Care Act Marketplace, or purchased directly from an insurer. Medicare is a public health insurance program that provides coverage for most individuals ages 65 or older, as well as certain individuals with disabilities.[35] Medicaid is a public health insurance program for many low-income populations, certain individuals with disabilities, and pregnant women. Unlike Medicare, Medicaid limits eligibility based upon an individual's income and assets.[36] These limitations, as well as the services Medicaid covers, vary among the states.[37]

Insurance Type	Private	Medicare	Medicaid
% of State Population[38]	63%	14%	10%
Coverage Required	Yes	Part B only	Yes
Cost Sharing	Varies by plan	Up to 20% copay Deductible	Varies
Limitations	One-time training program within 1 year of diagnosis 3 hours annual follow-up training (additional requirements apply)	10 hours within 12 months of initial referral 2 hours annual follow-up training Referral required	Referral required

Private Insurance

Wyoming requires all private health insurance plans to provide coverage for medically necessary outpatient DSME/T, including medical nutrition therapy.[39] Private insurance covers a one-time training program in the year following a diabetes diagnosis and up to 3 hours of follow-up training each subsequent year if there is a significant change in the individual's symptoms, condition, or treatment.[40] Before receiving DSME/T, an individual must receive a prescription from a health care professional.[39] DSME/T services must be provided by a health care professional with expertise in diabetes.[39] Insurers may impose the same cost-sharing requirements applicable to other covered benefits.[41]

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[42,43] Subject to limited exception,[44] recipients may receive 1 hour of private training and 9 hours of group training.[45] Recipients may qualify for up to 2 hours of follow-up training each year after they receive initial training.[46] To receive coverage for DSME/T, a Medicare recipient must obtain a referral from the health care professional treating the recipient's diabetes[47,48] and receive the training from an ADA- or AADE-accredited program.[47,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[47,50]

Medicaid Coverage

Wyoming's Medicaid program covers certain low-income populations, including low-income pregnant women, children, families with children, and individuals with disabilities.[51,52] The program covers DSME/T when the physician, public health nurse, or nurse practitioner managing a beneficiary's diabetes orders DSME/T and the beneficiary receives DSME/T from a Certified Diabetes Educator or a dietician.[53] Beneficiaries may receive up to 1 hour of individual training; the beneficiary receives any additional DSME/T services in group settings.[53]

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[12–23] Private insurance and Medicaid coverage for DSME/T services may help with the provision of and access to DSME/T. States that already require such coverage might consider building on those efforts by ensuring covered DSME/T services comply with the National Standards. They may also consider reducing barriers to access, such as pre-authorization requirements, cost sharing, and utilization limitations; raising awareness about the availability of DSME/T; and increasing the frequency and duration of DSME/T services.

Resources

Wyoming Medicaid Information
https://health.wyo.gov/healthcarefin/medicaid/

Medicare DSME/T Information
http://bit.ly/2wC4pRE

Diabetes Information from the CDC
www.cdc.gov/diabetes/

LawAtlas Wyoming DSME/T Website
http://j.mp/2ccTzqg

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