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

National Landscape: Background, Benefits, and Insurance Coverage of DSME/T

Diabetes and DSME/T[i] in the United States

The nation is in the grips of a diabetes epidemic. According to the Centers for Disease Control and Prevention, 29.1 million Americans have diabetes,[1] exceeding the entire population of Texas.[2] In 2014, 1.4 million adults were diagnosed with the disease—more than 3,900 every day.[3,4] One in 3 adults has prediabetes, which often leads to diabetes.[5]

Some risk factors for developing type 2 diabetes are increased age, higher weight, high blood pressure, high cholesterol, and physical inactivity.[6] 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,[7,8] are less likely to have positive diabetes control indicators, such as lower A1c levels,[9] and experience worse health outcomes overall.[10–12] Low-income populations and populations without a high school degree or postsecondary education also experience disproportionately high type 2 diabetes prevalence, incidence, and complication rates.[13]

Effective diabetes management depends largely on individual self-care,[14,15] making diabetes self-management education and training (DSME/T)[i] critical to addressing this epidemic. DSME/T is "the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."[16] This process requires incorporating patients' unique needs and experiences into individualized education and support plans that promote new behaviors and solutions.[16] 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.[17]

Research shows that by giving patients the tools necessary to better manage their diabetes, DSME/T significantly improves health outcomes[18–21] and reduces health care expenditures.[14,15,22–29] 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."[30]

Despite this evidence, participation in DSME/T remains low,[31,32] particularly among rural populations,[18] Medicare[33] and Medicaid beneficiaries,[22] uninsured or underinsured persons,[34,35] and "ethnic minorities, older persons, and persons with language barriers and low literacy."[30] Moreover, DSME/T services often do not conform to best practices.[34] 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).[17]

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 as well as to identify opportunities for reform.

Diabetes Burden in the United States (Age-Adjusted)[13,36,37]	Overall	Male	Female	White	Black	Hispanic	Educational Achievement		
							Less than High School	High School	Greater than High School
% of Adults with Diagnosed Diabetes (2014)	8.4%	6.6%	5.9%	5.8%	9.5%	8.7%	12.9%	9.5%	6.7%
New Cases of Diabetes / 1,000 Adults (2014)	6.6	6.8	6.5	6.4	8.4	8.5	11.1	7.8	5.3
Completed a DSME/T Class [ii] (2010)	57.4%	56.5%	58.3%	58.7%	57.8%	45.8%	41.1%	56.0%	63.2%
Daily Self-Monitoring Blood Glucose [ii] (2010)	63.6%	59.6%	67.8%	63.5%	69.8%	56.9%	59.6%	66.2%	63.4%
Received 2+ A1c Tests in Last Year [ii] (2010)	68.5%	67.5%	69.5%	68.9%	71.1%	59.1%	54.4%	67.5%	72.8%
Overweight or Obese [ii] (2010)	84.7%	85.1%	84.3%	83.7%	89.9%	85.4%	84.4%	85.8%	84%
High Blood Pressure [ii] (2009)	57.1%	57.5%	56.4%	53.8%	71.5%	53.2%	62.2%	59.9%	53.7%
High Cholesterol [ii] (2009)	58.4%	59.3%	57.4%	58%	60.7%	55.1%	65.0%	60.7%	55.3%
Fair or Poor General Health [ii] (2011)	46.8%	45.0%	48.6%	44.1%	51.5%	61.3%	N/A	N/A	N/A

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

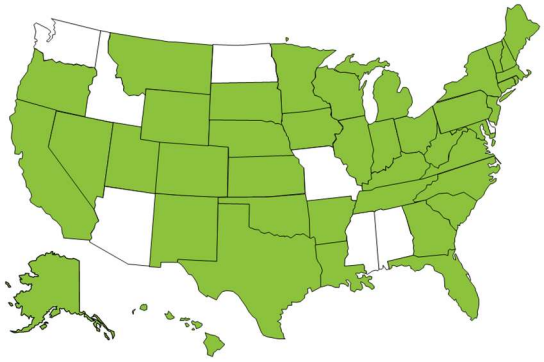
[ii] Adults with Self-reported Diagnosed Diabetes

State Insurance Coverage Overview

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.[38] 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.[39] These limitations, as well as the services Medicaid covers, vary among the states.[40]

Private Insurance

Forty-one states and the District of Columbia require most or all private insurance policies to provide coverage for DSME/T. Two other states (MS & MO) require only that health insurers offer plans that provide such coverage. More than half of these states (23 out of 44 total) explicitly require coverage for follow-up DSME/T in certain cases, such as: a significant change in a patient's health status (20/23), a change in a patient's treatment (10/23), and when a patient requires reeducation or refresher training (9/23). Ten states explicitly limit coverage for initial DSME/T, and 9 impose limitations on follow-up DSME/T. Only 2 states (FL & VA) explicitly prohibit some or all coverage limitations. No states explicitly require DSME/T coverage for individuals with prediabetes.



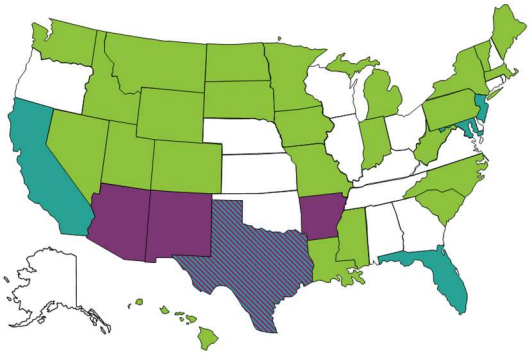
Require all or nearly all private insurance policies to cover DSME/T

Medicare Coverage

Medicare provides recipients with up to 10 hours of outpatient DSME/T in the year following their first referral for DSME/T.[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.[48,49] Recipients may be responsible for any applicable deductible and a copay up to 20% of the total cost of DSME/T services.[50,51]

Medicaid Coverage

Twenty-five states provide DSME/T coverage to most or all Medicaid beneficiaries. Five other states require Medicaid managed care organizations (MCOs) to offer DSME/T to their members, and 3 states cover DSME/T for specific populations. Two-thirds of these states (22 out of 33 total) explicitly provide coverage for follow-up DSME/T, but 21 of the 33 impose quantitative limits on coverage for initial or follow-up DSME/T. Two states (MS & UT) require prior authorization for all DSME/T covered by Medicaid. Nine other states either provide programmatic diabetes education, contract with MCOs that provide DSME/T, or offer general health education services.



Require DSME/T coverage for all or nearly all Medicaid beneficiaries
Require DSME/T coverage for beneficiaries enrolled with an MCO
Other Medicaid DSME/T coverage

Conclusion

Research suggests that by empowering patients to manage their diabetes, DSME/T can improve health outcomes and reduce treatment costs.[18–29] 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

Diabetes Information from the CDC
www.cdc.gov/diabetes/new/index.html

ChangeLab Solutions
www.changelabsolutions.org

LawAtlas DSME/T Website
http://lawatlas.org/datasets/diabetes-self-management-education-laws

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