Establishing and Operationalizing Medicaid Coverage of Diabetes Self-Management Education and Support

A Resource Guide for State Medicaid and Public Health Agencies

April 2019

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

ChangeLab Solutions

ACKNOWLEDGMENTS

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National Association of Chronic Disease Directors (NACDD)

This publication was supported by the Grant or Cooperative Agreement Number 5U38OT000141-03 awarded to ChangeLab Solutions and funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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Introduction

This guide examines strategies for supporting state health department and Medicaid agency staff in their efforts to increase coverage and utilization of diabetes self-management education and support (DSMES) services in their states. For states that currently have Medicaid coverage of DSMES, this document offers additional information on increasing utilization of the benefit. It also provides stakeholders with information and resources to help promote the expansion of Medicaid coverage of DSMES services.

This guide is divided into five sections:

1. An overview of DSMES services, the evidence behind them, and accrediting and oversight requirements
2. The landscape of Medicaid coverage for DSMES
3. Pathways to Medicaid coverage of DSMES at the state level
4. Making a case for coverage and steps stakeholders can take to expand Medicaid coverage of DSMES
5. Addressing the challenge of low utilization rates for DSMES

Overview of Diabetes Self-Management Education and Support

Type 2 diabetes is a growing epidemic in the United States that has intensified in recent decades. The Centers for Disease Control and Prevention (CDC) estimates that currently 30.1 million adults (or about 9.3% of the US population) have type 2 diabetes and that about a quarter of these are unaware of their condition. People living with diabetes have to manage their condition on a daily basis and therefore require specific information and skills to protect their health.

Nationally, the costs associated with diabetes are staggering. In 2017, the estimated cost of diagnosed diabetes in the United States was $327 billion, of which $237 billion was direct medical costs and $90 billion was related to reduced productivity. On average, people with diagnosed diabetes accrue medical costs that are 2.3 times higher than the costs of those without the disease. Furthermore, approximately 1 in 3 adults in the United States is estimated to have prediabetes, a condition in which people have higher than normal levels of blood sugar and are at increased risk for type 2 diabetes, heart attack, and stroke. These numbers support a projection that the number of people with diabetes will exponentially increase in coming years. Diabetes Self-Management Education and Support (or DSMES, as it will be called throughout this guide) provides an opportunity to help manage the direct medical costs of diabetes and the cost of diabetes-related complications within this growing epidemic.

To help alleviate the health and fiscal consequences of diabetes, the 2017 National Standards for Diabetes Self-Management Education and Support provide guidance on evidence-based self-care for patients. DSMES is an integral yet evolving approach to improving disease management for people with diabetes. According to the 2017 National Standards for DSMES, the program "is a critical element of care for all people with diabetes." "[DSMES] is the ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training."[1] According to a joint position statement by the American Diabetes Association and the American Association of Diabetes Educators, "[DSMES] programs are designed to address the patient's health beliefs, cultural needs, current knowledge, physical limitations, emotional concerns, family support, financial status, medical history, health literacy, numeracy, and other factors that influence each person's ability to meet the challenges of self-management."[2]

Numerous studies have shown the benefits of standardized DSMES, which include improved clinical outcomes and quality of life and a reduction in hospitalizations and health care costs. Some of the demonstrated benefits of participation in DSMES include lower A1C levels, self-reported weight loss, a reduction in health care costs, fewer diabetes-related medical complications, and improved quality of life.[3] Many health care payers, including Medicare and most private insurers, provide DSMES as a covered benefit for eligible beneficiaries.

To ensure appropriate quality and standardized delivery of DSMES services, all certified programs are required to adhere to the National Standards for DSMES. These standards are revised by a team of stakeholders and subject matter experts every five years and were most recently updated in 2017. The current standards contain 10 requirements: Internal Structure, Stakeholder Input, Evaluation of Population Served, Quality Coordinator Overseeing DSMES Services, DSMES Team, Curriculum, Individualization, Ongoing Support, Participant Progress, and Quality Improvement.[1]

The National Standards for DSMES are used by both the American Association of Diabetes Educators (AADE) and the American Diabetes Association (ADA) in their DSMES certification processes. The Centers for Medicare & Medicaid Services (CMS) gave AADE and ADA authority as national accrediting organizations to "recognize" (ADA) or "accredit" (AADE) DSMES services.[4] This authority enables programs to bill CMS for delivering services to Medicare eligible beneficiaries. (Note: Diabetes self-management training (DSMT) is the billing term that is used when submitting claims to CMS for reimbursement.) DSMES services seeking certification are required to apply for recognition or accreditation through one of these two (or, in some cases, both) organizations. To become certified, programs must demonstrate adherence to the National Standards for DSMES, which include requirements for Health Insurance Portability and Accountability Act (HIPAA) compliance, staffing and curricula, access and individualization, and program audits. The program also must submit information on organizational structure, mission statement, and goals.

The National Standards for DSMES include staffing requirements for DSMES services, which are typically implemented by diabetes educators. Diabetes educators are health care professionals who have additional training or experience in working with people with diabetes. In general, diabetes educators come from various educational backgrounds and include nurses, dietitians, pharmacists, and others. A certified diabetes educator (CDE) requires advanced training, including a minimum number of hours in clinical diabetes practice and completion of the Certification Examination for Diabetes Educators (administered by the National Certification Board for Diabetes Educators).[5] CDE is not a required certification, but it is one that many diabetes educators pursue. There is also growing evidence on the role that community health workers or paraprofessionals can play in the delivery of DSMES.

DSMES is typically delivered in person, in small groups, or in a classroom-based setting. Some organizations—particularly those in rural locations—also deliver DSMES in a telehealth mode. *Telehealth* is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.[6] A growing number of programs are exploring virtual or online delivery of DSMES.

Implementation of DSMES follows requirements that ensure delivery of a standardized curriculum along with opportunities to tailor the education to meet the needs of individual participants. According to the National Standards for DSMES, the curriculum must reflect "current evidence and practice guidelines, with criteria for evaluating outcomes. . . . [T]he needs of the individual participant will determine which elements of the curriculum are required. Individuals with diabetes, and those supporting them, have much to learn to enable effective self-management. DSMES provides this education in an up-to-date, evidence based, and flexible curriculum."[7] The requirements for the curriculum include content on core topics such as healthy eating, physical activity, medication usage and problem solving as well as tools to help patients navigate the health care system and learn self-advocacy.

Medicaid Coverage of DSMES

Fifteen states have laws that require their state Medicaid programs to cover DSMES.[8] Another 18 states cover DSMES for some or all of their Medicaid beneficiaries through sub-regulatory Medicaid materials (e.g., administrative code, Medicaid State Plans, waivers).[9] Of the remaining 17 states (plus DC, the District of Columbia) that do not require their state Medicaid programs to cover DSMES, DC and Kentucky cover the services through Medicaid managed care—i.e., managed care organizations provide DSMES to their Medicaid enrollees as a value-added service in order to attract enrollees or improve health outcomes.

The states providing Medicaid coverage of DSMES have different definitions of coverage, including eligible beneficiaries, covered services, and provider qualifications. For example, Arkansas' Medicaid program covers DSMES for those in its Medicaid expansion population who are enrolled in a benefit plan offered on the state's marketplace. California's Medicaid program covers DSMES for Medicaid beneficiaries enrolled in a Medi-Cal health plan (i.e., a Medicaid managed care plan separate from the state Medicaid program). To further illustrate these differences, the CDC reviewed three state Medicaid programs. Highlights are provided in Table 1.

TABLE 1. Examples of Medicaid Coverage[10]

COLORADO	
Eligible Beneficiaries	Medicaid beneficiaries diagnosed with type 1 diabetes, type 2 diabetes, or gestational diabetes. Beneficiaries must 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."[11]
Covered Services	One hour of group or individual assessment and nine hours of group education within a 12-month period. Two hours of follow-up training each year after the initial 12-month period. The training can be performed in 30-minute increments.[12]
Provider Qualifications	DSMES programs and providers must be recognized or accredited by either ADA or AADE and cover the components outlined in the associated National Standards.
MISSISSIPPI	
Eligible Beneficiaries	Medicaid beneficiaries diagnosed by a physician who deems DSMES to be medically necessary.
Covered Services	Must be provided in outpatient settings. One hour of individual training and assessment and up to six additional hours of education in a group setting within a continuous six-month period. Additional individual education sessions may be covered if ordered by a physician with an explanation of why more individual sessions are needed. Follow-up education is covered following the initial training for a maximum of two hours per year (provided in increments of 30 minutes or more), if ordered by a physician.
Provider Qualifications	DSMES must be provided by a current Mississippi Medicaid-enrolled provider. Qualifying DSMES programs must be recognized or accredited by ADA or AADE.
NEW YORK	
Eligible Beneficiaries	Medicaid beneficiaries who are newly diagnosed with diabetes, beneficiaries with diabetes who are stable, or beneficiaries with diabetes who have a medically complex condition such as poor control of diabetes or another complicating factor.[13] Data show that uptake has been around 3.5% to 3.9% of eligible beneficiaries.[14]
Covered Services	Ten hours of DSMES over a six-month period, for each qualifying event (newly diagnosed or complex condition). One hour of DSMES over a six-month period, for patients who are considered medically stable.[12]
Provider Qualifications	DSMES providers must be licensed, registered, or certified professionals recognized or accredited by the ADA or the AADE. Providers can be (1) registered nurses; (2) registered nurse practitioners; (3) registered dietitians; (4) physicians (MD, DO); (5) pharmacists; (6) physician assistants; or (7) physical therapists.

For more information on these three states, visit www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-dsme.pdf.

For more information on different states' approaches to covering DSMES under Medicaid, visit http://lawatlas.org/datasets/diabetes-self-management-education-laws.

Pathways to Medicaid Coverage of DSMES

States have used different approaches to covering DSMES through Medicaid. While a variety of approaches can be used, three common pathways to coverage are described in this section.

1. Requiring coverage of DSMES through state law, administrative code, or budget documents

Many states secure coverage of DSMES through legislation or regulation. Indiana, for example, enacted DSMES coverage for all health insurance plans in 1997, using model state legislation developed by AADE, ADA, and the Academy of Nutrition and Dietetics (previously the American Dietetic Association).[15] Indiana Code §27-8-14.5-6(a) states, "A health insurance plan issued by an insurer must provide coverage for diabetes self-management training." Code §27-8-14.5-3 defines *insurer* as any entity that provides health insurance and issues health insurance plans in Indiana, including (1) a licensed insurance company; (2) a prepaid hospital or medical service plan; (3) a health maintenance organization; (4) a state employee health benefit plan; (5) the Medicaid State Plan; and (6) any person providing a plan of health insurance subject to state insurance law.

Some states may choose to secure coverage of DSMES through state regulation or rulemaking rather than the legislative process. For example, the state of Mississippi included DSMES coverage in its Administrative Code (Title 23 Division of Medicaid), which outlines the state's rules, policies, and procedures. Rulemaking processes vary by state, and different divisions within a state may be subject to different policies.

States can also secure coverage of DSMES through the state budget process. For example, a state's governor or legislature could include funding for DSMES as a line item in their proposed budget. The details of the budget are negotiated until a final budget is enacted through a budget bill. In developing the budget document, governors are bound by state-specific constitutional and statutory restrictions. The legislature is also bound by state-specific constitutional restrictions in passing the budget. Exhibit 1 shows detail from one agency in Washington State's 2013-2015 Operating Omnibus Budget Overview.[16] A line item for diabetes prevention and control and details about the purposes of the funding are included in the Administration & Supporting Services budget for the Department of Social and Health Services. Some state budgets may not include this level of detail, or DSMES funding may be incorporated into a more general budget line item that includes funding for other programs and services.

EXHIBIT 1. Detail from Washington State's 2013-2015 Operating Budget, Including Line Item for Diabetes Prevention and Control

Agency 300
Program 110

C 4, L 13, E2, PV, Sec 211

Department of Social and Health Services
Administration & Supporting Services

(Dollars in Thousands)

	NGF-P	Other	Total
2011-13 Expenditure Authority	**50,543**	**46,478**	**97,021**
2013 Supplemental *	1,827	2,540	4,367
Total 2011-13 Biennium	**52,370**	**49,018**	**101,388**
2013-15 Maintenance Level	**60,308**	**40,231**	**100,539**
Policy Changes - Other			
1.Improving Service Delivery	623	335	958
2.Diabetes Prevention	126	28	154
Policy -- Other Total	**749**	**363**	**1,112**
Policy Changes - Comp			
3.New Step M for Classified-Yr 1 Impl	844	88	932
4.New Step M for Classified-Yr 2 Impl	41	4	45
5.State Employee Health Insurance	-180	-24	-204
6.Wellness - Smoker Surcharge	-27	-4	-31
7.PEBB - Coverage Waiver Surcharge	-161	-22	-183
Policy -- Comp Total	**517**	**42**	**559**
Policy Changes - Transfers			
8.Transfer Office of Juvenile Justice	-2,114	-2,832	-4,946
Policy -- Transfer Total	**-2,114**	**-2,832**	**-4,946**
Total 2013-15 Biennium	**59,460**	**37,804**	**97,264**
Fiscal Year 2014 Total	30,127	18,938	49,065
Fiscal Year 2015 Total	29,333	18,866	48,199

Comments:

1. **Improving Service Delivery** - Staff and funding are provided to implement Chapter 320, Laws of 2013 (ESHB 1519) and Chapter 338, Laws of 2013 (2SSB 5732). This legislation requires the use of evidence-based practices and the creation of performance measures for service coordination organizations. (General Fund-State, General Fund-Federal)
2. **Diabetes Prevention** - Staff and funding are provided for the Health Care Authority, Department of Social and Health Services (DSHS), and the Department of Health to collaborate to identify goals, benchmarks, and plans for preventing and controlling diabetes. (General Fund-State, General Fund-Federal)
3. **New Step M for Classified-Yr 1 Impl** - Funding is provided in agency budgets for classified employees who have been at their top step for at least six years to move to a new top step during FY 2014. A new top step was included as part of several 2011-13 collective bargaining agreements. (General Fund-State, Other Funds)
4. **New Step M for Classified-Yr 2 Impl** - A new top step is included in several 2013-15 collective bargaining agreements. Funding is provided for additional classified employees to move to the new top step during FY 2015. The increase affects those who reach six years at the current top step during FY 2015 and were not yet eligible for the increase during FY 2014. (General Fund-State, Other Funds)
5. **State Employee Health Insurance** - Funding for state employee health insurance is reduced from $800 per month per employee to $782 per month in the first fiscal year and $791 per month in the second fiscal year , resulting in the identified savings. (The imposition of surcharges for tobacco use and for spouses and domestic partners who waive certain employer coverage reduces the necessary funding rate by $28 per month per employee in the second fiscal year, from $791 to $763.) (General Fund-State, Other Funds)
6. **Wellness - Smoker Surcharge** - State agency and higher education employer contributions for health insurance are reduced to reflect a $25 per month surcharge for PEBB members who use tobacco products beginning July 1, 2014. This reduces the employer funding rate in FY 2015 by approximately $4 per month. (General Fund-State, Other Funds)

Source: 2013-2015 Omnibus Budget Overview: Operating Only. State of Washington. Available at http://leap.leg.wa.gov/leap/budget/lbns/2013operating1315.pdf.

2. Including DSMES as a covered service in the Medicaid State Plan

Using state law, administrative code, or budget documents to require coverage of DSMES is often a first step in securing Medicaid coverage. The second step is updating the Medicaid State Plan to include DSMES as a covered service.[17] Medicaid benefits and services must be included in a state's Medicaid State Plan and approved by CMS in order for a state to draw down federal funding for those services (which makes providing the services more sustainable for the state over time). A Medicaid State Plan is a written agreement between a state and the federal government that contains the details of the state's Medicaid program. The state is then responsible for the full costs of any covered services that are not outlined in its approved Medicaid State Plan.

Medicaid is financed through a federal-state partnership in which the federal government matches state Medicaid spending according to a formula set in federal Medicaid law. Federal Medicaid matching funds can be claimed for both direct service costs and administrative costs. The federal government reimburses 50%-90% of direct service, as determined by the state's Federal Medical Assistance Percentage (FMAP).

To draw down federal funds for services provided to Medicaid beneficiaries, details about (1) the beneficiaries eligible for the services, (2) the services offered, (3) the providers qualified to provide the services, and (4) the reimbursement methodology must be outlined in the state's Medicaid State Plan.

Sample Language for DSMES Coverage in a Medicaid State Plan

Diabetes Self-Management Education and Support Services (DSMES)[18]

1. Effective for dates of service on or after [date], the [Medicaid agency or department] shall provide coverage of diabetes self-management education and support (DSMES) services rendered to Medicaid recipients diagnosed with diabetes.
2. Services
   a. Eligible recipients shall receive up to 10 hours of DSMES services during the first 12-month period beginning with the initial training date, including
      i. One hour of individual DSMES
      ii. Nine hours of group DSMES
   b. After the first 12-month period has ended, recipients shall be eligible for two hours of individual instruction on diabetes self-management per calendar year.
3. Provider Participation Standards
   a. To receive Medicaid reimbursement, a provider or program must meet the quality standards of one of the following organizations:
      i. American Diabetes Association
      ii. American Association of Diabetes Educators
   b. At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES or be another health care professional holding certification as a diabetes educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM).
   c. All providers must obtain the nationally recommended annual continuing education hours for diabetes management.
4. Reimbursement

   Payments for approved DSMES services are based on the state's established codes and fee schedule.

Sample Fee Schedule[10]

Initial 12-month period

Code[19]	Description	Allowable Units
G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes	Individual outpatient DSMES • Medicaid allows for 1 hour • Billable in 30-minute increments • 1 unit = 30 minutes	2 units = 1 hour
G0109 - Diabetes outpatient self-management training services, group session (two or more), per 30 minutes	Group outpatient DSMES • 2 or more participants in the group • Medicaid allows for 9 hours • Billable in 30-minute increments • 1 unit = 30 minutes	18 units = 9 hours

Each year after initial 12-month period

Code	Description	Allowable Units
G0108 and/or G0109	Individual and/or group outpatient DSMES • Any combination of 2 hours • Billable in 30-minute increments • 1 unit = 30 minutes	4 units = 2 hours

Reimbursement Example[10]

Note: The amounts in this example are based on Medicare DSMES rates. State Medicaid programs can provide a higher or lower reimbursement amount.

G0108 – Individual: $55 per patient x ½ hour (1 unit); $55 x 2 units x 10 patients = $1,100

G0109 – Group: $15 per patient x ½ hour (1 unit); $15 x 18 units x 10 patients = $2,700

Total: $1,100 + $2,700 = $3,800

If a state's Medicaid State Plan does not already cover DSMES services, the state will need to submit a State Plan Amendment (SPA) to CMS. SPAs document changes and updates to a state Medicaid program such as addition of new services, eligible populations, or providers; changes in how rates are calculated; or the costs and reimbursement methodologies of new services. SPAs can be submitted to CMS at any time, and there are no restrictions on when or how often Medicaid State Plans can be updated. CMS has 90 days to approve a SPA but can extend the timeline by requesting additional information. SPA submission requirements vary by state. Some states require public notice and a period for public comment. Some states require executive or legislative approval, while others require legislative approval only when the SPA affects the state's budget.[20]

CMS's SPA review and approval process is generally quick for standard changes, most of which can be enacted by the state in advance of formal approval by the federal government. These changes are retroactive to the first day of the quarter in which the SPA was submitted. SPAs are subject to the terms and conditions of the Medicaid program, including but not limited to these:

- Beneficiaries must have the freedom to choose their provider. (Providers must meet the standards outlined in the Medicaid State Plan.)
- Comparable services must be available to all eligibility groups to which the services apply (e.g., all Medicaid beneficiaries diagnosed with type 1 or type 2 diabetes).
- Services must be offered statewide. (States may consider allowing for delivery and reimbursement of DSMES services through telehealth to address limited access to DSMES providers in rural areas.)

3. Covering DSMES through Medicaid managed care

Many states deliver Medicaid services through managed care. In a managed care system, generally the state contracts with two or more health plans (i.e., managed care organizations [MCOs]) for the delivery and management of Medicaid members' health care services. MCOs are typically paid a capitated rate—a specified amount per member per month.

If DSMES is a covered service in the Medicaid State Plan, then MCOs are typically required to provide DSMES to their Medicaid members and are reimbursed through the capitated rate. Medicaid MCOs contract with DSMES providers that meet the provider participation standards outlined in the Medicaid State Plan and establish a reimbursement rate for these providers per state rules and regulations.

Example of DSMES Coverage Through Medicaid Managed Care

Molina Healthcare is a national health plan that primarily provides Medicaid, Medicare, and individual health insurance plans purchased through Healthcare.gov and through state marketplaces.

Molina offers a Healthy Living with Diabetes® program to its Medicaid members with a confirmed diagnosis of diabetes (non-gestational and/or non-steroid-induced). The program is provided at no cost, and members remain in the program for as long as they are enrolled in a Molina health plan (unless they opt out).

A collaborative team of health care professionals works closely with contracted practitioners to identify, assess, and implement appropriate interventions. The program also uses a diabetes registry comprising medical claims, pharmacy claims, lab results, member services information, information from nurse advice line services, and information from other health management programs to identify, auto-enroll, and stratify members into three levels of risk (low, medium, or high).[21]

All education provided through the Healthy Living with Diabetes® program is consistent with the National Standards for DSMES. Each identified member receives educational materials and other resources that align with their level of risk. For example, members who need a high-level intervention receive the following:

- An assessment that evaluates (1) the member's health status, medication compliance, and quality of life; and (2) the member's learning preferences and needs, to determine the most appropriate interventions (hospital-based group program, individual appointments with a diabetes educator, or telephonic education with an educator)
- A welcome letter and an enhanced education kit
- Appropriate education/intervention (e.g., group, individual, or telephonic)
- Access to other educational resources such as weight management and smoking cessation services
- Individualized care plans that include a nutritional assessment and meal plan completed by a registered dietitian[22]
- Periodic assessment of the member's health status and continued learning/resource needs and referral to medical case management as necessary
- Educational newsletters/mailings several times per year
- A formal six-month assessment

A secure data platform is used to track all member encounters in the program, assess individual member needs and learning preferences, and conduct interventions (including medication therapy management and member mailings). The data platform also tracks members' outcomes over time and includes all disease-associated inpatient, outpatient, and pharmacy claims incurred by the member during the preceding 12 months.

To engage providers in encouraging participation in the program, Molina sends its primary care physicians a list of eligible patients twice a year. Providers also receive patient profiles once a year. Each profile shows specific patient utilization information, including medication use, emergency department visits, and hospitalizations. Molina requests that the physicians provide the names of Molina Healthcare patients diagnosed with diabetes who are not included in the list or the profiles.[20]

If DSMES is not a covered service in the Medicaid State Plan, then MCOs may cover such services through alternative routes, including but not limited to the following:

Value-Added Services

As noted earlier, Medicaid MCOs in at least two states provide coverage of DSMES as a value-added service. MCOs offer value-added services to attract Medicaid enrollees to their plan or to improve health outcomes. Examples of these services vary across plans and states but typically include health education classes and dental or vision programs.

Value-added services can be medical or nonmedical. They fall outside of direct care costs and are paid for by the MCO. Some states mandate that MCOs provide value-added services as part of their contract with the state, while other states support their use as long as the services comply with applicable state and federal laws.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are federally mandated quality improvement projects conducted by all Medicaid MCOs. PIP topics are typically determined by the state Medicaid agency and can focus on clinical areas or on nonclinical areas like DSMES. Once a topic is selected, each MCO then develops its PIP plan, reports annually on its progress, and provides a final report to the state. PIPs provide a strong mechanism for encouraging MCOs to focus on improving quality outcomes associated with diabetes and to cover DSMES as part of the improvement strategy.

Fidelis Care, a Medicaid managed care plan in New York, conducted a DSMES-focused PIP in 2013 and 2014. The objective of the PIP was to understand whether participation in DSMES improved members' diabetes outcomes by reducing A1C levels by 0.5 percentage points for members with a baseline level of 7% and over and maintaining levels for those with a baseline under 7%.[23] The plan also provided participants with monetary payments to test whether incentives have a positive effect on participation. Results from the program were positive. Participation in DSMES reduced A1C levels by 1.0 percentage points for those with baseline levels of 7% and above. Thirteen of 21 participants who had baseline levels lower than 7% maintained levels lower than 7% after the DSMES intervention.

State health departments may consider promoting the development of DSMES-focused PIPs or supporting their state Medicaid agency and MCOs in such development. States and MCOs currently have some latitude in the number and topics of PIPs they undertake, although they must be developed within a set CMS protocol. This protocol specifies how a PIP is to be conducted and evaluated, including "methods for selecting the topic, defining the study question, selecting indicators and study population, sampling methodology, data collection, implementation of the improvement strategy, analysis of data and interpretation of results, and planning for sustaining improvement."[24] Costs associated with developing and implementing PIPs are included as part of the capitated MCO rate paid by the state, which is then eligible to claim federal Medicaid matching funds for appropriate services. PIPs generally last two years, and new projects are implemented each year.

Making a Case for Medicaid Coverage

This section provides guidance for public health professionals at state health departments who are working with their colleagues at state Medicaid agencies to make the case for covering DSMES. Five key steps can be taken:

Step 1: Build relationships and maintain communication between state health departments (public health) and state Medicaid agencies (Medicaid)

An emphasis on building relationships between public health and Medicaid has been at the center of recent initiatives focused on Medicaid coverage for evidence-based chronic disease prevention and management programs, such as CDC's 6|18 Initiative.[25] Several factors are important to keep in mind when establishing these relationships, including whom to reach out to, how to approach and engage colleagues, and how to establish and maintain collaboration.

General considerations in building a relationship between public health and Medicaid

- **Find the right person to connect with in Medicaid.** This person should be a colleague who has an interest in diabetes management and a place at the table for Medicaid coverage conversations in your state. A good place to look for a suitable contact is the "Benefits," "Planning," "Managed Care," "Population Health," "Quality Improvement," or "Innovation" section of your Medicaid state agency's website. If you have connections with the state Medicaid director, he or she may be able to direct you to the right person.
- **Engage leadership early in the support of a public health and Medicaid partnership**. Inform your agency leadership of your efforts and encourage them to reach out to their Medicaid counterparts. Continue to provide regular updates to your leadership about any collaboration between public health and Medicaid.
- **Take time to understand the other agency's mission, values, and goals.** For public health professionals, some helpful Medicaid 101 webinars are located on the "Using this Site" page of the National Diabetes Prevention Program Coverage Toolkit: *https://coveragetoolkit.org/using-this-site/.*
- **Extend invitations and attend each other's stakeholder meetings** (e.g., diabetes advisory group, Medicaid MCO, or quality improvement meetings) with the purpose of communicating and finding points of common interest.
- **Organize regular meetings outside of larger stakeholder meetings, to maintain communication and continue the relationship**. These meetings could focus on discussion and exchange of agency goals and agendas; ways that Medicaid and public health could work together to pursue common interests; or program development related to chronic disease prevention and management.

Keep in mind that although it is ultimately Medicaid that will implement any policy changes, public health can bring valuable expertise and resources to the collaboration. Given that Medicaid agencies often have limited staff and budgets, public health can contribute staff time and effort that might not be available within Medicaid. Public health can assist Medicaid in the following ways**:**

- Support Medicaid staff by providing information and analysis on factors such as costs associated with diabetes care, estimated return on investment of coverage, and the evidence supporting DSMES.

- Increase access to services for Medicaid beneficiaries through outreach and education to partners, health care providers, and beneficiaries.
- Be an innovation partner with Medicaid, increasing Medicaid's focus on alternative payment models and population health as well as Medicaid's use of managed care, care coordination, and social supports.

Step 2: Gather data and create a budget projection

For most Medicaid agencies, staying within budget is critical, so providing accurate cost projections and determining potential cost savings for covering DSMES is important. To produce budget projections, data will need to be gathered on the eligible Medicaid population, the cost of offering the service, and the expected cost savings in other areas of the budget. Colorado developed a DSMES brief that included a budget projection for DSMES in 2015, the year that the state began Medicaid coverage for DSMES services.[26]

Step 3: Assess Medicaid coverage options for DSMES

As discussed previously, Medicaid coverage of DSMES has been achieved in 33 states, and various pathways can be used to achieve Medicaid coverage, including (1) requiring coverage through state law, administrative code, or budget documents; (2) incorporating DSMES as a covered service in the Medicaid State Plan; and (3) delivering DSMES through Medicaid MCOs (e.g., state health departments may consider promoting the development of DSMES-focused PIPs and providing their state Medicaid agency and MCOs with support for such PIPs).

It is important to consider how Medicaid is delivered in a state as well as a state's political environment and governance factors when determining the most viable pathway for achieving Medicaid coverage of DSMES.

Step 4: Engage leadership and influence decision making

In making a case for Medicaid coverage of DSMES, communication with influential leaders is essential. Important considerations include what facts to use, whom to communicate with, when it will be most effective to make the case, and how Medicaid makes coverage decisions in a particular state.

What to Communicate

Once a relationship between public health and Medicaid has been established, it is important to consider which information and resources to share to make a case for coverage. Here are some suggestions on what to communicate and share:

- **Evidence-based reports.** Numerous resources detail the evidence that supports DSMES and can be used to advocate for DSMES coverage within Medicaid; helpful resources include ADA's Practice Resources,[27] the AADE's Value of Diabetes Education,[28] and CDC's DSMES Toolkit.[29]
- **Economic impact reports.** Potential economic impacts of covering DSMES are captured on the "advocacy tools and resources" page on AADE's website.[30] A key question to consider is, What is the cost of *not* covering DSMES services? How many Medicaid beneficiaries might develop complications of uncontrolled diabetes and incur higher costs associated with hospitalizations, emergency room visits, and other services if DSMES is not covered?
- **Economic burden.** In 2018, ADA published findings estimating that medical costs for individuals with diabetes are approximately 2.3 times higher than for those without the disease. The study also found that diabetes care accounts for more than 1 out of every 4 health care dollars spent in the United States.[31] CDC also created the Diabetes State Burden Toolkit,[32] which can be used to calculate the health, economic, and mortality burden of diabetes in each state. DSMES helps individuals manage their diabetes symptoms which, in turn, reduces their medical care costs.
- **State-specific budget projection.** See the discussion in Step 2.
- **Health equity considerations.** Increasing coverage for and access to services that are proven to control type 2 diabetes is a way to promote health equity for Medicaid beneficiaries, who are more likely to develop type 2 diabetes than non-Medicaid populations.[33] States that expanded Medicaid coverage have seen diabetes rates increase in their Medicaid populations,[34] underscoring the need to target prevention.
- **Quality measures.** State Medicaid agencies and MCOs are interested in improving quality of care and decreasing costs in their Medicaid beneficiary population, especially among those with expensive chronic diseases like diabetes. Diabetes quality measures can help elucidate whether additional efforts, such as adding Medicaid coverage for DSMES, are needed to improve patient outcomes. Portions of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care measures[35] are used by state Medicaid agencies as the diabetes performance measurement for the 2018 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set).[36] These state-level data can be communicated to emphasize the need to add DSMES to Medicaid coverage. As mentioned previously, improving patient outcomes by meeting these quality measures can be a key goal of MCO PIPs.

Whom to Communicate with

When planning communication strategies, it is important to determine who the state decision makers are and how to reach them. In some states, involving state decision makers could mean meeting with the state Medicaid director or the Medicaid medical director, engaging the state advisory committee,* or educating the state legislature through stakeholders or diabetes caucus opportunities.

It is also important to find someone in a leadership position from either public health or Medicaid who can be a champion for DSMES and bridge the gap between Medicaid and public health leadership. Having leadership talk to leadership is an important communication strategy when advocating for DSMES services.

Two channels of communication between public health and Medicaid agencies should be established: (1) communication at the *programmatic or operational level*—i.e., with the agency staff who would be responsible for operationalizing the benefit in the event of a decision to provide coverage; and (2) communication at the *leadership level*—i.e., with the agency staff responsible for approving the coverage decision.

A broader resource for states making Medicaid coverage decisions is the Center for Evidence-based Policy at the Oregon Health & Science University.[37] This center provides federal, state, and local policymakers across the United States with rigorous analysis and evidence to guide decisions and improve the health of constituents. The center runs a group called the Medicaid Evidence-based Decisions Project (MED), which publishes reports to help state Medicaid agencies and their stakeholders make sound decisions about coverage.[38]

**Note:* All Medicaid directors are required by federal regulation to have a state advisory committee in place.[39] Some representatives on the committee are included by statute, and some are appointed. In general, most of a state's major provider groups are included on the committee. Other advisory committee members might include representatives of the state hospital association, Medicaid beneficiaries, public advocacy organizations, or individual health care providers (e.g., an emergency room doctor).

When to Communicate

The timing of any communication is important. Communication about adding DSMES coverage is likely to be most effective at the following times:

- Prior to MCO contract renegotiations or request for proposal (RFP) deadlines
- In conjunction with a state Medicaid agency's decision-making process on coverage (see the next section)

Understanding Medicaid's Coverage Determination Policies

To know when and with whom to communicate about including DSMES coverage, it is important to understand your state's Medicaid leadership and its decision-making process for coverage of a service. These processes vary from state to state and are often not well documented. It is important for public health professionals to reach out to their Medicaid director to understand the coverage determination policy in their state.[40]

Step 5: After coverage is achieved, work with Medicaid to operationalize and sustain the benefit

Once a decision is made to cover DSMES, it will be critical for Medicaid and public health to continue working together in order to support the operationalization and systems needed to support the new benefit. State agencies may also be tasked with educating beneficiaries and health care providers, analyzing the use and outcomes of the benefit once it has rolled out, or providing ongoing expertise to define and strengthen the benefit, to ensure that it continues to align with the National Standards for DSMES. Here are some recommendations on how to produce success in this partnership:

- **Determine roles and responsibilities.** Define tasks to align with expertise and availability of time and resources. A likely scenario would be for Medicaid to determine benefit design, fee structure, and coding and billing procedures while public health takes the lead on developing communication and outreach tools to educate health care providers and beneficiaries about the benefit.
- **Create a shared work plan.** Establish specific tasks, reporting mechanisms, and timelines for each agency's responsibilities.
- **Enroll Medicaid providers.** Each new state covering DSMES services will need to determine how to enroll recognized or accredited DSMES programs and/or diabetes educators as Medicaid providers and ensure network adequacy in their state. These new providers may need to be educated about the benefit, and public health may be able to help with this communication.
- **Perform outreach activities.** Ensure that health care providers and Medicaid beneficiaries are aware of the benefit and know the pathways for referral and enrollment.
- **Analyze and evaluate results.** Investigation might include (1) looking at claims data to determine DSMES utilization rates and subsequent health outcomes; (2) creating a survey of recognized or accredited DSMES services and/or diabetes educators to obtain feedback on the benefit; and (3) creating a survey of health care providers to better understand and assess DSMES referral patterns.

Utilization of DSMES Services

As policymakers consider Medicaid DSMES coverage options, it is important to consider availability of DSMES services and how to address barriers and challenges related to utilization of those services. Multiple stakeholders will be needed at the table to ensure that DSMES services are utilized by beneficiaries, are supported by health care providers, and result in cost savings for Medicaid.

Low Utilization

Despite the documented health benefits of DSMES for people with diabetes, it tends to be underutilized even when covered by health insurance. DSMES has been an available Medicare benefit for two decades, yet overall uptake has been slow. Data from 2015 show that only 5% of Medicare beneficiaries who were recently diagnosed with diabetes used the DSMES benefit.[41]

Uptake of DSMES among individuals with commercial insurance coverage has also been slow, yet it has been slightly higher than among Medicare beneficiaries. Data from 2014 show that 6.8% of individuals aged 18-64 with newly diagnosed type 2 diabetes received DSMES within 12 months of diagnosis. The rate was slightly higher for adults aged 45-64 (7.2%).[42]

Research on Medicaid utilization of DSMES is not widely available. One study indicated that 8% of Medicaid recipients in one community participated in a hospital-based DSMES program, but that the vast majority of people with diabetes who were on Medicaid or underinsured did not receive diabetes education that meets the National Standards for DSMES.[43]

Factors Contributing to Low Utilization

Several factors likely contribute to the low utilization of DSMES, including unequal availability of programs, insufficient coverage and reimbursement, and lack of awareness and referrals.

DSMES programs are not equally available throughout the country; they tend to be more accessible in urban areas and in counties with higher rates of people covered by health insurance. A 2016 analysis of DSMES programs found that there are very few programs in "nonmetropolitan socially disadvantaged" counties.[44]

Reimbursement rates can also affect utilization of DSMES. From 2014 to September 2016, AADE reported that more than 200 of the 750 AADE-recognized DSMES programs had closed and that the top reason for closure identified by these programs was lack of reimbursement.[45] Additionally, public and private insurance plans may have only limited coverage of DSMES. Limited coverage can lead to poorer health outcomes, as research suggests that reaching target A1C levels is related to time spent in education and training. Group and individual classes can assist people with diabetes in achieving desired A1C levels, but 10 or more hours of education increases the likelihood of better diabetes management as measured by A1C levels.[46]

Lack of awareness of DSMES programs as well as lack of referrals pose additional challenges to DSMES utilization. Both health care providers and patients are often not aware of DSMES services due to lack of outreach by programs,[47] and physicians and other health care providers often do not refer patients for services.[48,49] These low referral rates persist despite the fact that Medicare and other insurers require a primary care referral to DSMES services.

Addressing Low Utilization

Medicaid agencies and public health can work together to address the factors contributing to low utilization when developing DSMES coverage or strengthening existing coverage to increase utilization of this vital benefit. Since 2013, many state public health departments have been addressing four key goals to increase the use of DSMES services: (1) increase availability and support for DSMES programs; (2) increase payers and payment mechanisms; (3) increase referral policies and practices in health systems; and (4) increase awareness and willingness of people with diabetes to participate in DSMES programs. More information on these goals can be found in the Centers for Disease Control and Prevention's *Diabetes Self-Management Education and Support (DSMES) Technical Assistance Guide*.[50] This guide outlines current gaps, assessment data, facilitating factors, barriers, and potential activities to address gaps.

Table 2 outlines considerations for state Medicaid agencies and public health departments as they develop coverage and work to increase use of DSMES. The utilization factors in the first column reflect state health departments' goals in the four key areas mentioned in the preceding paragraph: availability of DSMES, payers and payment, referrals, and awareness and willingness to participate. In the second column, "State Opportunities" outline areas for partners (e.g., Medicaid, state health departments, organizations providing DSMES services, advocacy groups, and other stakeholders who have an interest in ensuring that Medicaid beneficiaries with diabetes have access to and coverage of DSMES services) to consider as they work together to enhance existing coverage or develop new Medicaid coverage. The "Implementation Considerations" in the second column offer actions that public health agencies and partners can take to address utilization factors once coverage is strengthened or obtained.

Table 3 lists examples of how Colorado, New York, and Washington worked to increase utilization of covered DSMES services.[51] Additional information on how public health departments in Colorado, New York, and Mississippi worked with their state Medicaid agencies to cover DSMES for Medicaid beneficiaries can be found in the CDC resource *Emerging Practices in Diabetes Prevention and Control: Medicaid Coverage for Diabetes Self-Management Education,* available at *www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-dsme.pdf*.

TABLE 2. State Opportunities to Address Low Utilization of DSMES

UTILIZATION FACTORS	
AVAILABILITY	
Availability of DSMES Programs	• Increase access in rural communities through telehealth options. • Ensure that reimbursement rates are sustainable for DSMES programs. • Encourage DSMES programs to offer services at multiple community sites. • Encourage hospital-based programs to offer DSMES services at satellite sites. • Encourage pharmacists and other clinical providers to offer DSMES services. • Work with community pharmacies to start ADA-recognized or AADE-accredited DSMES programs. • If Medicaid is considering a new type of provider, address the onboarding process and add the new provider type to the Medicaid State Plan. • Provide support to DSMES programs that wish to obtain ADA recognition or AADE accreditation.
PAYERS AND PAYMENT	
Reimbursement Rates and Coinsurance/ Co-pays	• Ensure that reimbursement rates are sustainable for DSMES programs. • Eliminate the barrier of coinsurance or co-payments for DSMES services. • Include DSMES as part of a Medicaid Performance Improvement Project (PIP). • Provide health care provider incentives, and tie coverage to diabetes quality measures– NCQA 0057 (increase proportion of people with diabetes who get an A1C test) and NCQA 0059 (decrease proportion of people with diabetes with A1C > 9).[34]
Insufficient Coverage	• Ensure that DSMES programs that are ADA-recognized or AADE-accredited are covered. • Follow Medicare standards for minimum coverage, allowing at least 10 hours of education and training for the first year. • Ensure that people with diabetes have access to DSMES at four critical times outlined in a joint position paper by ADA, AADE, and the Academy of Nutrition and Dietetics: (1) when diagnosed; (2) yearly health care provider check-ins; (3) when a new challenge arises (e.g., financial, emotional, medication issues); (4) when a person's health care changes (e.g., new physician, change in insurance coverage, move to a new location, or age-related issues).[52]
REFERRALS	
Primary Care Provider Referral Mechanism	• Encourage Medicaid beneficiaries to self-refer to DSMES, and develop a verification process to determine eligibility. • If a health care provider referral is required by an insurance plan, allow referral by any provider involved in a patient's care (e.g., hospitalist, doctor at an ambulatory surgical center, emergency room doctor, or other specialty provider). • Provide health care providers with information on DSMES services, including Medicaid coverage (when applicable) and locations of local DSMES programs.
Lack of Provider Referrals	• Encourage use of Medicaid quality measures—NCQA 0057 (increase proportion of people with diabetes who get an A1C test) and NCQA 0059 (decrease proportion of people with diabetes with A1C > 9)[34]—as performance measures for MCO health plans. • As part of a Medicaid PIP, promote DSMES in order to improve performance on quality measures. • Promote DSMES programs, to increase awareness among health care providers.
AWARENESS AND WILLINGNESS TO PARTICIPATE	
Participants' Lack of Awareness of DSMES	• Consider promotion of DSMES and covered benefits as part of MCO contracts. • Emphasize the importance of DSMES to people with diabetes, especially prior to occurrence of complications. • Promote DSMES programs in the larger community. • Promote coverage benefits to beneficiaries.
Participant-Level Barriers (transportation, language, child care, and lack of interest)	• Cover transportation to and from DSMES classes. • Engage community health workers to help connect people with diabetes to DSMES services and to do outreach to better understand barriers to using these services. • Encourage DSMES programs to offer services at community sites. • Partner with community organizations to offer DSMES; support organizations as they obtain ADA recognition or AADE accreditation. • Offer classes in communities near public transportation or in convenient locations (e.g., health care provider offices, churches, or libraries). • Partner with community organizations that offer child care services. • Work with community organizations that can deliver culturally appropriate DSMES programs.

TABLE 3. State Examples of Partnering to Improve DSMES Utilization

COLORADO

The Colorado Department of Public Health and Environment partnered with Medicaid to increase utilization of the DSMES Medicaid benefit, which began July 1, 2015. Their activities included the following:

- Partnering with the Medicare Quality Improvement Network (QIN) and hosting peer-to-peer learning calls with DSMES services, including a billing expert made available by the QIN to augment DSMES
- Training DSMES program administrators on how to navigate reimbursement rules
- Engaging other providers, such as pharmacists (who are not eligible to bill in Colorado), to explore opportunities to refer their patients to DSMES providers.

NEW YORK

The New York State Department of Health (NY DOH) partnered with Medicaid to make the case for coverage and to increase use of the benefit once it was implemented. Some highlights of their collaboration include the following:

- To make the case for Medicaid coverage, the health department invited Medicaid to a federally qualified health center to witness the brief encounters that many people with diabetes have with health care providers. These visits allowed Medicaid representatives to witness firsthand that these encounters are not adequate to train people on the daily self-management of diabetes.
- After DSMES coverage was obtained in 2009, NY DOH and Medicaid collaborated to promote the new benefit by offering webinars to the CDE workforce and providing information to health care providers.
- The agencies conducted a workforce analysis of CDEs across the state and found large concentrations in urban areas and inadequate numbers across the state.
- Health system learning collaboratives created registries for patients with A1C > 9. Using this information, health system practices partnered with local health departments to identify people with diabetes and connect them with local DSMES services.
- NY DOH and Medicaid staff designed a survey for 6,000 Medicaid beneficiaries to assess barriers; the survey was distributed by the QIN.
- The agencies are exploring a new Medicaid telehealth benefit (i.e., telehealth parity legislation) to determine whether it might help increase utilization rates.

WASHINGTON STATE

Washington State has had Medicaid coverage of DSMES since 2003. The Washington State Department of Health has worked to increase utilization of this coverage through the following activities:

- Creating a DSMES billing guide for providers
- Educating DSMES providers, to ensure that they understand the benefit and how to bill for services; working with DSMES program staff to ensure that they connect with billing departments
- Building partnerships across the state to provide and support DSMES
- Promoting DSMES services to people with diabetes via social media and diabetes alert days

Conclusion

A growing number of people are expected to be diagnosed with diabetes in coming years, increasing the need to provide high-quality DSMES and reimburse its providers. Standardized DSMES has been proven to result in improved clinical outcomes, a better quality of life, and reduced hospitalizations and health care costs for persons diagnosed with diabetes. Many public and private payers, including Medicare and 33 state Medicaid programs, understand the benefits of covering DSMES and have chosen to provide it as a covered benefit for eligible beneficiaries.

Despite advances in DSMES coverage, there is room for improvement. Seventeen states currently do not provide DSMES as a Medicaid-covered benefit, and those that do have experienced challenges and barriers to implementation and utilization. Fortunately, due to the work that has been done to date, there are clear pathways for obtaining Medicaid coverage of DSMES, clear steps stakeholders can take to make the case for expanding Medicaid coverage of DSMES, and lessons learned on how best to address the challenges and barriers in implementing and sustaining coverage. This guide presents this information and related strategies for supporting state health department and Medicaid agency staff in their efforts to increase coverage and implementation of DSMES.

APPENDIX: Additional Information on DSMES Coverage

Medicare

Medicare Part B covers up to 10 hours of diabetes self-management training (DSMT) in the first year after diagnosis and two hours of follow-up training in subsequent calendar years.[53] CMS uses the term training instead of education and support in defining the reimbursable benefit. Coverage of DSMT was enacted in 1997 and is defined as "educational and training services furnished . . . to an individual with diabetes by a certified provider . . . in an outpatient setting by an individual or entity who meets the quality standards. . . ."[54] In order for an individual to qualify for DSMT services, their physician must certify that DSMT services are a necessary part of their comprehensive diabetes care plan.

To be reimbursed by Medicare, DSMT providers must be enrolled as Medicare providers and meet standards outlined by CMS. As noted earlier, the two accrediting organizations approved by CMS are ADA and AADE.

Commercial Plans

Most states (43) require commercial health insurance plans to cover DSMES.[6] Two of the remaining states (Missouri and Mississippi) require plans that choose to cover DSMES to adhere to specific standards.

For more information on different states' approaches to DSMES coverage in the commercial (private insurance) market, see http://lawatlas.org/datasets/diabetes-self-management-education-laws. This legal atlas identifies which states have laws that mandate DSMES coverage for private insurance plans and provides information on the required standards and on the specific activities that are covered.

Veterans Affairs Coverage

Veterans Affairs (VA) health benefits are not considered health insurance; like other health care providers, VA facilities and practitioners bill public and private health insurance for the medical care, supplies, and prescriptions they provide to veterans.[55] However, some VA facilities choose to provide access to DSMES for their patients. The VA has also established guidelines for management of type 2 diabetes by its clinics and practitioners, which includes diabetes education through comprehensive DSMES.[56]

TRICARE, a health care plan for active duty and retired members of the uniformed services and their families, provides coverage of DSMT as a limited benefit.[9] The DSMT program must be TRICARE-authorized and recognized by ADA or accredited and approved by CMS (which requires recognition by ADA or accreditation by AADE). For more information on covered services, see https://tricare.mil/CoveredServices/IsItCovered/DiabetesOutpatientSMTS.

Community-Based Health Organizations

Community health centers (CHCs), federally qualified health centers (FQHCs), rural health clinics (RHCs), and community/migrant health centers (C/MHC) are community-based organizations that provide comprehensive primary and preventive care to all persons, regardless of their ability to pay.[57] Some of these organizations provide DSMES services, and some are also certified DSMES providers for Medicare.

Reimbursement and coverage of DSMES services provided in community-based health organizations varies by payer. With respect to Medicare DSMES, community-based health organizations can be reimbursed for providing individual (one-on-one) training only and are reimbursed according to their respective payment system—e.g., FQHCs' Prospective Payment System or RHCs' All-Inclusive Rate.

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