American Association of Diabetes Educators
200 West Madison Street, Suite 800, Chicago, Illinois 60606 800.338.3633 Fax 312.424.2427
www.diabeteseducator.org

IMPROVE ACCESS TO DIABETES SELF-MANAGEMENT TRAINING (DSMT): ADDRESS THE NATIONAL DIABETES CRISIS AND SAVE MEDICARE $2 BILLION

ISSUE:

Currently, Certified Diabetes Educators (CDEs), the primary providers of DSMT services, are not statutorily recognized as DSMT providers under Medicare. As such, they are unable to establish the type of DSMT programs needed to reach individuals and communities in need.

This also means that CDEs are prohibited from providing DSMT via telehealth, despite the fact that CMS named DSMT last year as an 'allowable telehealth service' in order to help facilitate availability and address the serious underutilization of DSMT.

SOLUTION:

H.R. 2787, the `Medicare Diabetes Self-Management Training Act of 2011' would amend title XVIII of the Social Security Act to improve access to diabetes self-management training by authorizing CDEs to provide diabetes self-management training services, including as part of telehealth services, under Part B of the Medicare program.

IMPLEMENTING H.R. 2787 COULD SAVE MEDICARE $2 BILLION IN YEARS 2013-2022.

Legislative efforts in the 111th Congress to include these state-licensed health professionals who are certified by HHS as DSMT providers was supported on a strong bipartisan basis by the leadership of the House Diabetes Caucus, as well as House and Senate Committee Chairs and Minority members.

RATIONALE:

Diabetes self-management training (DSMT) is a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify their behavior and more successfully manage their disease and/or its complications. Since diabetes is a chronic disease that requires the active participation of individuals, the goal of DSMT is to help the diabetic achieve and maintain optimal health and better quality of life, while reducing the need for expensive medical treatment. DSMT is a crucial service in that it seeks to empower people with diabetes to engage in self-management throughout the rest of their lives and avoid, among other things, ambulatory care sensitive hospital admissions.

In our review of the literature, we found a solid base of research supporting the effectiveness of Diabetes Education in improving metabolic outcomes in diabetes patients.[1] A recent study found

[1] Norris SL, *Engelgau MM, Narayan KM: Effectiveness of self-management training in type 2 diabetes: a systematic review of randomized controlled trials.* Diabetes Care 24:561 *–587*, 2001.

that total Medicare spending for Medicare beneficiaries who received DSMT was $135 less per member per month than spending for beneficiaries who had not received DSMT.[2]

CMS noted that "After more than a decade of Medicare coverage, the most recent information shows that DSMT continues to be significantly underutilized in the context of the eligible population of Medicare beneficiaries."[3] Our analysis of the Medicare claims demonstrates this assertion.

Figure 1: Number of Medicare Allowed Services and Denied Services: 2006 - 2011

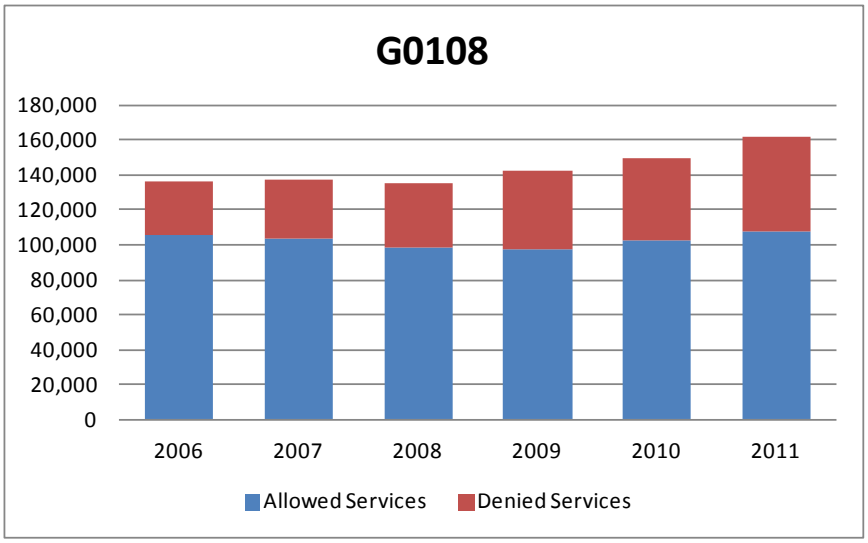
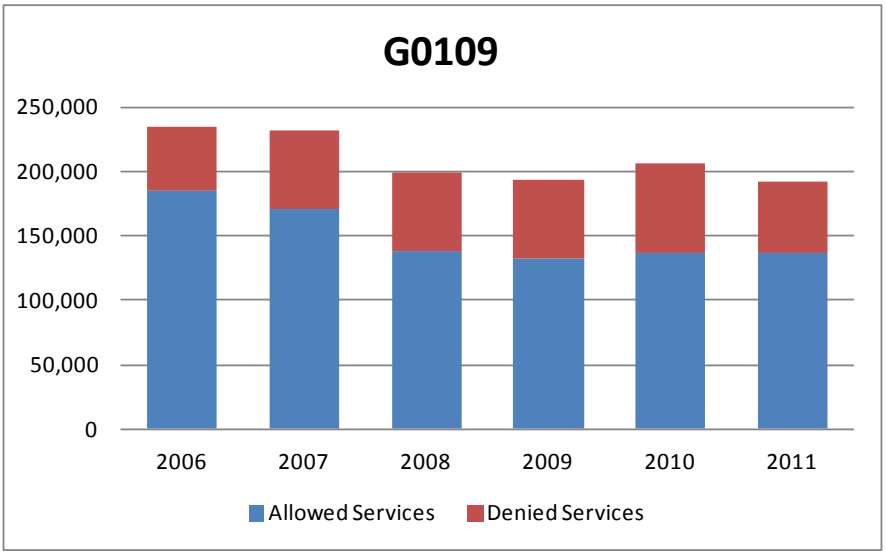


Figure 2: Number of Medicare Allowed Services and Denied Services: 2006 – 2011



[2] Duncan I, Birkmeyer C, Coughlin S, et al. (2009) Assessing the value of diabetes education. *The Diabetes Educator*; 35(5):752-760.

[3] Federal Register; Volume 75, No. 228: p. 73313. November 29, 2010.

Our rationale for a slow growth trajectory in baseline utilization and Medicare spending for DSMT is based upon two factors: 1) a highly constrained supply of Certified Diabetes Educators (CDEs), and 2) historical patterns of slow uptake of preventive benefits under Medicare.

Dobson DaVanzo & Associates, LLC was commissioned by AADE to estimate the financial impact of implementing H.R. 2787. Our estimates are based on the premise that individuals with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than what expenditures would be in the absence of diabetes.[4]

We assumed that annual Medicare spending for those beneficiaries who received ten hours of DSMT according to clinical guidelines would fall from $13,882 to $12,262.[5] Medicare spending for these beneficiaries who continue to receive two hours of DSMT each year thereafter would be less than it otherwise would have been without DSMT. These findings assume that this cohort of beneficiaries would receive services provided by a CDE according to guidelines.

Our analyses of current DSMT utilization paid by Medicare found that on average, beneficiaries were not receiving DSMT according to guidelines. On average, beneficiaries received approximately 1.2 services per year. Because DSMT has the potential to produce lifelong behavior change, it is critical that Medicare beneficiaries receive the full course of DSMT. Furthermore, it is critical that beneficiaries receive DSMT that is provided by CDEs, who have been specially trained to help people with diabetes achieve lifelong behavior change.

Therefore, we estimate that implementing this legislation (H.R. 2787) would save Medicare $51 million in 2013, and $2 billion over ten years (2013-2022).

[4] American Diabetes Association: Economic costs of diabetes in the U.S. in 2007. *Diabetes Care* March 2008; vol. 31 no. 3: 596-615.

[5] CMS created four datasets (the Datasets) using the new Geographic Variation in Medicare Spending and Utilization (GV) database, which uses Medicare claims data to calculate utilization measures and total, standardized, and risk-adjusted spending. Data are organized by Hospital Referral Region (HRR) and span 2007-2010. Standardized, risk adjusted per capita Medicare spending in 2010 was $8,217.