

# **EMERGING PRACTICES IN DIABETES PREVENTION AND CONTROL: MEDICAID COVERAGE FOR DIABETES SELF-MANAGEMENT EDUCATION**



National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

TTASC | Training and Technical Assistance Support Center

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## OVERVIEW

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Historically, the Centers for Disease Control and Prevention’s (CDC’s) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has provided funding for state chronic disease programs on a disease-specific level, releasing separate funding opportunity announcements (FOAs) to address chronic conditions such as cardiovascular disease, diabetes, and obesity. However, chronic diseases have a high incidence of comorbidity, and the burden of these diseases has continued to escalate. In recognition of these issues, CDC has adopted a more integrated approach to chronic disease prevention and control, increasing opportunities for coordination across related diseases and risk factors so that public health programs can work together to be more efficient and achieve more significant and lasting outcomes. One recent FOA that embraces this approach is the State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health program (CDC-RFA-DP13-1305, hereafter referred to as 1305).

State health departments serve on the front lines of coordinated chronic disease public health prevention efforts. Therefore, grantees are exploring and testing new approaches that will provide critical insight and lessons learned. The goal of the Emerging Practices in Diabetes series is to summarize and share information on these practices to inform the work of other grantees working in these same areas.

This document describes the recent experiences of three states—Colorado, Mississippi, and New York—with state health departments that have collaborated with state Medicaid agencies to make Diabetes Self-Management Education (DSME) reimbursement a reality. Although each state faced unique challenges along the way, they shared similar success factors, including:

- strong relationships between the two agencies at both program/staff and executive levels,
- compelling use of public health and cost data to make the case, and
- ongoing support and contributions from other partners that shared their goals.

See Exhibit 1 for a description of the 1305 strategies and short-term performance measures related to this topic.

### The Four Domains of Chronic Disease Prevention

To optimize public health’s efficiency and effectiveness, CDC recommends coordinating chronic disease prevention efforts in four key domains<sup>1</sup>:

1. Epidemiology and surveillance—to monitor trends and track progress.
2. Environmental approaches—to promote health and support healthy behaviors.
3. Health care system interventions—to improve the effective delivery and use of clinical and other high-value preventive services.
4. Community programs linked to clinical services—to improve and sustain management of chronic conditions.

The four domains help organize and focus the effective work the public health community has undertaken for many years. At the same time, they help concentrate efforts to strengthen programs and build expertise to address gaps in services. Finally, they help government agencies, state and local grantees, and diverse public and private partners find new ways to work together and support each other’s efforts.

## Exhibit 1: 1305 Strategy and Short-Term Performance Measure Related to Medicaid Coverage for Diabetes Self-Management Education

1305 Strategy	Short-Term Performance Measure
4.1: Increase access, referrals, and reimbursement for American Association of Diabetes Educators (AADE)-accredited, American Diabetes Association (ADA)-recognized, state-accredited/certified, or Stanford-licensed DSME programs	4.1.05: Number of Medicaid recipients with diabetes who have DSME as a covered Medicaid benefit

### Medicaid Coverage for Diabetes Self-Management Education

DSME is an evidence-based program that helps individuals with diabetes acquire the knowledge, skill, and ability needed for self-care of their condition. DSME follows national standards<sup>2,3</sup> and is delivered by certified diabetes educators or other licensed health professionals with diabetes self-management training and experience. Community health workers may also contribute to the provision of DSME with appropriate training and supervision. DSME incorporates behavioral and psychosocial strategies to help individuals set goals and manage their disease. The program focuses on seven key self-care behaviors associated with improved clinical outcomes (particularly glycemic control and prevention of complications) and improved quality of life. In 2012, the American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE) reported a total of 983,171 people participating in an ADA-recognized or AADE-accredited DSME program. This was 4.7% of the 21 million people with diagnosed diabetes in 2012.

In 2015, ADA, AADE, and the Academy of Nutrition and Dietetics issued a joint position statement indicating that DSME be provided to all individuals with diabetes at the time of diagnosis and as needed thereafter.<sup>3</sup> To achieve their call to action, reimbursement for DSME as a health benefit is essential. Although DSME delivered by ADA-recognized or AADE-accredited programs is reimbursed under Medicare and many private health plans, reimbursement for Medicaid beneficiaries has varied from state to state. Interest has grown in making DSME more accessible to Medicaid beneficiaries with diabetes—both to improve their health outcomes and quality of life and to reduce spiraling costs that accrue quickly when diabetes is managed poorly or not at all.

## Description

Effective July 1, 2015, DSME became a covered benefit for Medicaid beneficiaries with a diagnosis of type 1, type 2, or gestational diabetes in Colorado. The benefit (which is comparable to the Medicare benefit for DSME) allows for one hour of group or individual assessment and nine hours of group education within a 12-month period. It also covers up to two hours of follow-up training each year after the initial 12-month period. The Colorado Department of Health Care Policy and Financing (which administers Colorado Medicaid) currently uses a managed fee-for-service payment system. However, through the state's Accountable Care Collaborative model, Colorado Medicaid is moving to a more value-based reimbursement system.

Achievement of Medicaid coverage for DSME was the result of a collaborative effort between the Colorado Department of Public Health and Environment (CDPHE), Colorado Medicaid, and a number of other key stakeholders.

Approval for DSME coverage was just the beginning. Since DSME coverage has only been in place for a few months, uptake data are not yet available. However, CDPHE is working closely with Colorado Medicaid to support promotion and implementation of this new benefit. Colorado Medicaid and CDPHE collaborated in developing a toolkit for providers that describes the reimbursement policy and procedures for billing (see the Resources section for more information). The toolkit was adapted from similar resources developed by the Centers for Medicare and Medicaid Services (CMS). The group worked with their state Quality Improvement Organization, Telligen, to make the toolkit specific to Colorado.

Colorado Medicaid's Provider Relations Department is also reaching out to providers across the state through its networks. Within CDPHE, the Clinical Community Health Network, which has oversight for the state's Federally Qualified Health Centers (FQHCs), is engaged in promoting the benefit. The state ADA chapter and AADE coordinating body also reached out to a network of more than 40 recognized or accredited programs to inform diabetes educators about the benefit.

## Collaboration Between the State Health Department and Medicaid

In the wake of the Affordable Care Act, Colorado Medicaid began implementing changes within the organization to place a greater emphasis on prevention. Within their Health Programs Office, Colorado Medicaid created a position for a staff person with the charge of better integrating public health and Medicaid. They hired a former staff person from CDPHE's Chronic Disease Division for this position.

Colorado Medicaid also formed a workgroup that began meeting monthly in August 2014 with the explicit goal of obtaining Medicaid coverage for DSME. The workgroup included staff from the Colorado Medicaid Health Programs Office, Colorado Medicaid Benefits Office, Colorado Medicaid Budget Office, and CDPHE's Prevention Services Division. CDPHE worked with

workgroup members to present evidence to the Colorado Medicaid senior executive team using state data to make a case for DSME coverage. The case was strong enough to persuade the executive team to support initiating a new benefit. This was a rare occurrence, given that leaders are wary of anything that might increase spending with limited short-term returns on investment.

### Role of the State Health Department

CDPHE played several key roles in the planning, development, and implementation of this project:

- **Workgroup member.** As previously noted, CDPHE staff were active members of Colorado Medicaid’s workgroup to expand Medicaid coverage for DSME.
- **Data provider.** An important first step was to use CDPHE data to help make the case for DSME—particularly the implications for cost savings. Working with claims and cost data supplied by the Medicaid agency, a CDPHE health economist analyzed the data to project savings. In addition, CDPHE staff developed maps showing the burden of diabetes across the state and the availability of current DSME programs to paint a statewide picture of both burden and gaps. These data helped Colorado Medicaid and other partners make the case to key stakeholders.
- **Promotion and implementation partner.** CDPHE maintains an inventory of recognized/accredited DSME programs through its network of key partners and providers. CDPHE is working to expand the availability of recognized/accredited DSME programs throughout the state by supporting organizations and providers in obtaining recognition/accreditation. CDPHE is also reviewing a proposal to pay the recognition/accreditation fees for FQHCs or other organizations serving large Medicaid populations as an incentive to expand the availability of DSME programs that could serve the state’s Medicaid population. CDPHE staff have also provided input on a toolkit for providers to promote the benefit.

### Role of Other Partners

Colorado Medicaid and CDPHE were supported throughout this effort by other partners (described in Exhibit 2) who helped reinforce the importance of Medicaid coverage for DSME to make the case to key stakeholders and state legislators to secure the benefit.

## Exhibit 2: Roles and Responsibilities of Other Partners

Partners	Roles and Responsibilities
<b><i>State and local chapters of ADA</i></b>	State and local chapters of ADA independently chose DSME coverage as a priority as well. In 2014, they convened a diabetes caucus within the state legislature—a natural role for an advocacy group. Throughout the spring of 2014, ADA representatives organized three events for legislators and staffers using the CDPHE and Colorado Medicaid data to present the burden of diabetes in Colorado, the number of Medicaid recipients affected, the costs incurred, and the potential savings if DSME were more widely available to this population.
<b><i>Provider groups</i></b>	As DSME coverage efforts gained traction, a physicians’ group in Aurora, Colorado (University Physicians, Inc. [UPI]) wrote a joint letter recommending DSME coverage. When Medicaid staff learned of the letter, they were able to share it with the joint CDPHE workgroups, ADA chapters, and other partners, lending more credibility and support to the effort.

## The State Health Department’s Experience with the Initiative

### Facilitators

Key stakeholders in this effort describe this experience as a “perfect storm” of activities that led to Medicaid coverage for DSME. Colorado Medicaid and CDPHE staff highlighted the following as key facilitators in their efforts:

- ***Colorado Medicaid’s emphasis on prevention and integration.*** Colorado Medicaid and CDPHE indicated that this effort was primarily influenced by a cultural shift within Colorado Medicaid (spearheaded by agency leadership). The shift was away from an exclusive emphasis on medical treatment to approaches emphasizing prevention and population health. Colorado Medicaid noted the value of having a liaison between the agencies and created a position explicitly for this purpose.
- ***Communication and collaboration between Colorado Medicaid and CDPHE.*** CDPHE and Colorado Medicaid staff highlighted the importance of active communication and collaboration across the agencies around the issue of Medicaid coverage for DSME. Communication involved internal newsletters and making sure that supervisors several levels up the chain of command were aware of the workgroup’s activities. They also noted that having a Medicaid staff member whose job description is fully dedicated to integrating public health and Medicaid greatly supported the collaboration. Colorado Medicaid and CDPHE staff also noted that stronger collaborations between CMS and CDC could help further these types of collaborations at the state level.
- ***Partner advocacy.*** The state chapter of ADA convened a diabetes caucus to educate legislators on the importance of Medicaid coverage for DSME. These efforts, combined with the support from provider groups in the state (e.g., a physician’s group [UPI]), helped make this issue a priority.
- ***Support from the governor’s office.*** CDPHE and Colorado Medicaid staff noted the support they had from the governor’s office, which influenced the agencies’ leadership investment in collaborating on this issue.

## Challenges

Colorado Medicaid and CDPHE staff also noted the following challenges that they faced in their efforts:

- **Staff time.** CDPHE and Colorado Medicaid staff noted that having enough time is almost always a challenge in this type of effort. Staff are often pulled in many different directions with multiple initiatives and programs. However, this type of effort requires dedicated time to be thoughtful about the work.
- **Competing priorities for leadership.** Individuals in leadership and key decision-making positions related to the issue of Medicaid coverage for DSME are also pulled in multiple directions. CDPHE and Colorado Medicaid staff emphasized the need to continuously stress the importance of this issue to leadership in order to secure and maintain their attention and support.

## Lessons Learned

Asked to reflect on lessons learned from their recent experience gaining Medicaid reimbursement for DSME, CDPHE partners offered the following:

- **Be patient.** Colorado was fortunate to have a “perfect storm” of converging interest and priorities among partners and good timing—but it still took a great deal of time and effort to keep the momentum going.
- **Understand each agency’s goals and work within common ground.** For both CDPHE and Colorado’s Medicaid agency, prevention potential and cost savings data were compelling—and coincided with each agency’s priorities. Staff recognized this overlap and made the case to each agency’s leadership for elevating DSME coverage among other priorities.
- **Keep the communication flowing—constantly.** Communication was strong, not only between the two agencies, but also across other partners, particularly ADA. With their workgroup structure and representation from different interested groups, the players acted quickly when they learned of opportunities (such as the UPI letter supporting DSME coverage or the opportunity to convene a diabetes caucus within the state legislature).

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## Resources

- CMS DSME [Reimbursement Toolkit](#)
- [Colorado Medicaid Diabetes Self-Management Reimbursement Toolkit](#)

# MISSISSIPPI

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## Description

On April 1, 2015, the Mississippi Division of Medicaid (DOM) established an administrative code that provided coverage for DSME for Medicaid beneficiaries. The policy was posted through the Mississippi Secretary of State following a mandatory 60-day public comment period. The new administrative code is under the umbrella of the outpatient hospital services section of Mississippi Medicaid administrative code. It covers DSME in outpatient hospital settings, but is contingent on the following provisions:

- The beneficiary is diagnosed by a physician, and DSME is deemed medically necessary.
- DSME is provided by a current Mississippi Medicaid provider.
- The DSME program is recognized by ADA or accredited by AADE.

The benefit covers an hour of individual training and assessment and up to six additional hours of education in a group setting within a continuous six-month period. Individual education sessions may be covered if ordered by a physician with an explanation of the need for individual sessions. Follow-up education is covered for a year 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.

This milestone was achieved through the dedication and collaborative efforts of members of the Diabetes Coalition of Mississippi (DCM). In April 2014, the state department of health relaunched DCM with a focus on scaling diabetes prevention and control programs statewide. The coalition has 60 to 75 members, including the following:

- clinical providers,
- diabetes educators, and representatives from academic centers,
- the Mississippi State Department of Health (MSDH),
- local health departments, and
- Mississippi DOM.

The coalition's policy workgroup identified Medicaid coverage for DSME as an opportunity to help scale diabetes management efforts statewide.

The state health department designed a course for providers (*The Business of Diabetes*) to help promote the benefit. *The Business of Diabetes* covers topics related to becoming a recognized (ADA) or accredited (AADE) program, program management, marketing program services, reporting required to maintain DSME recognition or accreditation, and billing and reimbursement for DSME services. MSDH staff also reached out to hospitals and other recognized/accredited DSME providers to guide them through billing procedures. Coalition members developed and distributed a brochure that lists the 37 recognized or accredited DSME

programs across the state to key stakeholders, such as the Mississippi State Medical Association, the state’s primary care association, nursing professional groups, and hospitals. Finally, to reach patients directly, MDSH staff developed public service announcements to be broadcasted via radio.

## Collaboration Between the State Health Department and Medicaid

The Deputy of Health Services for the Mississippi DOM was invited and became actively involved as a member of the DCM. As the coalition brought the issue of Medicaid coverage for DSME to the forefront, staff at the Mississippi DOM examined their reimbursement methodologies approved by CMS to identify how they could modify the policy to cover DSME. Mississippi DOM staff observed that DSME is often provided by nonphysicians (e.g., nurses, dietitians, pharmacists), and they did not have the capability to directly fund these types of providers. Because they had mechanisms to reimburse for hospital services, they identified outpatient hospital services as a starting point for expanding coverage for DSME. The policy, in effect, reimburses the hospital for the diabetes educator’s time (whether a nurse, dietitian, or other hospital staff person).

Mississippi DOM worked closely with MSDH to make the case for the policy and to craft the policy. Staff from Mississippi DOM spoke to the coalition about the importance of budget neutrality and to explain their policy approach. The approach involved expanding coverage under the umbrella of hospital outpatient services to allow them to get a “quick win” that would, ultimately, allow Mississippi DOM to collect the policy data needed to expand the coverage more broadly.

### Role of the State Health Department

Mississippi State Health Department staff played the following key roles in this effort:

- **Convener.** The state health department facilitates the Diabetes Coalition of Mississippi. Health department staff played a key role in identifying, recruiting, and engaging key stakeholders in this effort.
- **Data provider.** A state health department epidemiologist analyzed and compiled data on diabetes costs and prevalence for coalition members. The data were shared with Mississippi DOM and third-party insurers (including those who are part of the state employee benefits plan) to help make the case for DSME coverage.
- **Implementation supporter.** MSHD staff worked with partners to promote DSME programs across the state. They sponsored *The Business of Diabetes* course for DSME providers and reached out to hospitals and recognized/accredited DSME providers to offer technical assistance.

### Role of Other Partners

More than 50 organizations are represented on the DCM, which spearheaded this effort. The director of state government affairs and state programs for Sanofi-Aventis (a pharmaceutical organization) is the chair of the coalition’s policy work group. She is involved in similar

coalitions in the states of Arkansas, Louisiana, and Oklahoma and shared lessons learned and resources (including a template for preparing documentation that supports the case for Medicaid coverage for DSME) from her work in Arkansas on a similar effort.

## The State Health Department's Experience with the Initiative

### Facilitators

DCM members highlighted the following as key facilitators in their efforts:

- **Commitment of members of DCM.** MSDH staff felt that the timing was right for this effort. Coverage for DSME fit within the coalition's goals and priorities. Coalition members contributed energy, commitment, and expertise.
- **Support and engagement from staff in the Mississippi DOM.** The Director of Health Services in the Division of Medicaid was an active member of the Diabetes Coalition of Mississippi.
- **Expert leadership in DCM's policy workgroup.** The chair of the DCM's policy workgroup had the knowledge and experience that helped guide the workgroup and coalition through the process of making the case for Medicaid coverage for DSME.

### Challenges

Coalition members also noted the following challenges:

- **It takes time to develop Medicaid policy.** Staff at the Mississippi DOM emphasized that it takes time to develop good Medicaid policy, but state health department staff were patient in working with them.
- **A stepwise policy approach can be disappointing or frustrating to those who would like to see more immediate and sweeping policy changes.** Some members of the Diabetes Coalition of Mississippi were notably disappointed and frustrated with the initial proposal of expanding coverage only in hospital outpatient settings. Staff from the Mississippi DOM took the time to speak directly with coalition members to explain their policy approach. MSDH staff also emphasized the importance of using this process to obtain the data needed to take the policy to the next level to achieve the coalition's ultimate goals.

### Next Steps

Mississippi DOM staff are moving forward with efforts to expand coverage to all enrolled Medicaid providers (not limited to hospital outpatient services). They examined Medicaid claims data that were submitted since April and found that (1) there were a minimal number of claims submitted in the initial months following implementation of the new policy, and (2) a number of claims were being denied from DSME programs that were not in the approved setting. Given the numbers of Medicaid beneficiaries potentially eligible for the benefit (the anticipated need for the service), Mississippi DOM is proceeding with a policy to expand the number of DSME provider sites where beneficiaries can access services. Mississippi DOM staff likened this approach to other services offered to Medicaid beneficiaries to enhance access,

such as transportation. MSDH is also moving towards establishing recognized DSME programs in local health departments across the state to further expand access to DSME.

## Lessons Learned

DCM members offered the following lessons learned from their experience expanding Medicaid coverage:

- **Strong coalitions may impact policy change.** A strong, diverse statewide coalition helps establish shared goals, ensure buy-in from different individuals and groups, and offers built-in channels for promoting and marketing the new benefit once it is achieved.
- **Data are compelling.** A state epidemiologist was instrumental in compiling relevant data (specifically, cost data) for Mississippi's effort.
- **Medicaid staff may be champions.** Mississippi was fortunate to have champions as partners within the Medicaid agency. Such champions are instrumental in moving the policy change process forward.

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## Resources

- [2015 Mississippi Diabetes Action Plan](#)

# NEW YORK

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## Description

The New York State Department of Health (NYSDOH) Diabetes Prevention and Control Program (DPCP) staff worked with New York State Medicaid (NYS Medicaid) policy staff in the Office of Health Insurance Programs (OHIP) and partners to help make a case for Medicaid reimbursement for DSME. The policy was introduced in the 2008–2009 budget as an amendment to social service law. It went into effect in January 2009. The original legislation required that DSME be delivered by certified diabetes educators. In 2011, the reimbursement policy expanded to include other licensed, registered, or certified professionals who provide DSME in an ADA recognized or AADE accredited program (e.g., registered nurses, nurse practitioners, registered dietitians, physicians, pharmacists, physician assistants, and physical therapists).

Uptake has been modest to date (approximately 3.5% to 3.9% of eligible patients). To promote the benefit, NYSDOH and NYS Medicaid staff jointly hosted conference calls with certified diabetes educators to discuss ways to encourage participation. Staff collected and distributed questions and answers from the calls. NYSDOH and NYS Medicaid also disseminate information on the benefit and reimbursement through regular distribution of a Medicaid Update newsletter. From 2009–2014, NYSDOH also maintained an e-mail list for certified diabetes educators and disseminated information through email.

## Collaboration Between the State Health Department and Medicaid

The DPCP has a long history of working closely with NYS Medicaid staff. In 1999, DPCP staff arranged for NYS Medicaid staff to shadow practitioners working in busy, high-volume community health centers. This was so they could see firsthand the barriers and challenges providers and patients faced in offering and receiving high-quality diabetes education. Soon thereafter, in 2001, OHIP contracted with the State’s QIO on a diabetes quality improvement project in 15 New York City community health clinics.

This close contact continued over the years. For example, NYS Medicaid staff attended the CDC Division of Diabetes Translation’s conferences (with fiscal support from NYSDOH) to learn more about diabetes-related issues and needs from a public health perspective. Other interactions included sharing evaluation findings across programs in both agencies, as well as a strong relationship between leaders at both agencies.

### Role of the State Health Department

DPCP staff played the following roles in this effort:

- **Data provider.** In 2004, NYSDOH requested an analysis of cost data to document the previous five-year annual costs incurred by Medicaid beneficiaries with diabetes. The total was an impressive \$5.5 billion. Paired with other state and national data, the 2004 costs

were compelling. These and other findings were shared with members of the New York State Diabetes Task Force, among others, and eventually packaged in a white paper completed in 2007, “Making the Case for Reimbursement for Diabetes Self-Management Training”. Using a series of fairly conservative cost assumptions, the paper estimated net annual savings of approximately \$21.9 million (see Exhibit 3).

**Exhibit 3: New York State’s Cost Savings Estimates**

Assumptions and Cost Estimates (per year)	Projected Costs Savings (per year)
<ul style="list-style-type: none"> <li>▪ In 2004, approximately 284,000 fee-for-service Medicaid recipients were treated for diabetes.</li> <li>▪ Approximately 30% of Medicaid fee-for-service recipients (85,200) will participate in DSME training annually.</li> <li>▪ The hourly DSME reimbursement rate is \$60, comparable to the Medicare reimbursement rate.</li> <li>▪ 10% (8,520) of the eligible Medicaid beneficiaries will receive maximum benefit of 12 hours (cost: \$6,134,400).</li> <li>▪ 15% (12,780) of the eligible Medicaid beneficiaries will receive 9 hours of DSME (cost: \$6,901,200).</li> <li>▪ 30% (25,560) of the eligible Medicaid beneficiaries will receive 6 hours of DSME (cost: \$9,201,600).</li> <li>▪ 45% (38,340) of the eligible Medicaid beneficiaries will receive 3 hours of DSME (cost: \$6,901,200).</li> <li>▪ Estimated costs include one public health representative position (cost estimate \$81,000 including fringe benefits) to be placed in the Bureau of Chronic Disease Services, Diabetes Prevention and Control Program. This position would be responsible for conducting outreach and education efforts related to this new initiative with the health care provider community and people with diabetes.</li> </ul> <p><i>Total costs for providing DSME services to Medicaid beneficiaries, including one staff member: <b>\$29,219,400 per year.</b></i></p>	<ul style="list-style-type: none"> <li>▪ Medicaid fee-for-service beneficiaries who engage in DSME will experience an improvement in glycemic control.</li> <li>▪ A 1% reduction in A1C level for the 85,200 Medicaid fee-for-service beneficiaries with diabetes who engage in DSME could produce a health care cost savings of \$102,240,000 (based on conservative estimate of \$1,200 savings/year).</li> <li>▪ A more conservative estimate citing a 1% reduction in A1C levels for 50% of the fee-for-service Medicaid beneficiaries with diabetes who engage in DSME (42,600) could produce a health care cost savings of <b>\$51,120,000 per year.</b></li> </ul> <p><i>Accounting for total costs for providing DSME services, New York estimated a <b>potential net savings of \$21,900,600 per year.</b></i></p>

- **Convener.** During this time, NYSDOH convened a Diabetes Task Force including the following:
  - OHIP and other state agency staff,
  - hospitals and health care providers,
  - community-based organizations,
  - diabetes educators,
  - registered dietitians, and
  - other professional groups (including an advocacy group) to explain the DSME benefit and the reimbursement process to representatives from large endocrinology centers, community-based organizations, professional groups (including certified diabetes educators and registered dietitians), and advocacy groups.

## Role of Other Partners

As described in Exhibit 4, NYSDOH and NYS Medicaid had support from other partners.

**Exhibit 4: Roles and Responsibilities of Other Partners**

Partners	Roles and Responsibilities
<b>New York State Health Foundation</b>	As part of its extensive \$35 million diabetes campaign, the New York State Health Foundation (NYSHealth) hosted forums in every part of the state, in conjunction with ADA chapters.
<b>University of Albany School of Public Health's Center for Health Workforce Studies</b>	The University of Albany School of Public Health's Center for Health Workforce Studies conducted a market analysis of certified diabetes educators in New York, which quickly revealed gaps across the state and pipeline issues related to workforce development. Documentation of these gaps prompted expansion of the legislation to include other licensed providers besides certified diabetes educators in the DSME reimbursement provision to enable more patients to access this service.
<b>American Diabetes Association</b>	Local ADA chapters supported the NYSHealth's awareness campaign.

## The State Health Department's Experience with the Initiative

### Facilitators

NYSDOH staff identified the following as facilitators in the success of their efforts to expand and promote the Medicaid benefit for DSME.

- **OHIP leadership's background in endocrinology.** The Medical Director for OHIP at the time was an endocrinologist. Because of this specialty training, and other factors, OHIP was already experiencing a cultural shift toward a focus on primary care, wellness, and prevention, along with changes in Medicaid reimbursement to support investments in primary care.
- **Strong relationships between program staff in NYSDOH and NYS Medicaid facilitated by personal connections.** Because of their shared interests and goals, NYSDOH and NYS Medicaid program staff established strong relationships that helped them work together throughout this initiative. These relationships developed quickly when NYSDOH staff learned that a key program staff person in NYS Medicaid had a personal family connection to diabetes. DPCP staff reported that they did not have to do much to convince NYS Medicaid program staff of the importance of expanding coverage for DSME.
- **The broader context of Medicaid reform and redesign.** NYS Medicaid was under pressure from the governor's office to implement payment reforms that would reduce costs by avoiding unnecessary hospitalizations and emergency department use by Medicaid patients and allow projected savings to be reinvested. NYSDOH staff informed NYS Medicaid stakeholders of the benefits of DSME in managing diabetes, which would ultimately affect health care utilization and costs (e.g., emergency room claims).

## Challenges

DPCP staff also noted the following challenges:

- **Some patients still face barriers in accessing DSME.** NYSDOH staff believe that this may be due to factors that include the social determinants of health. Staff have heard firsthand from Medicaid beneficiaries that they do not have time for DSME. NYSDOH staff indicate that challenges with health literacy, access and transportation logistics, language barriers, and other priorities can get in the way of patients using the benefit.
- **Availability of diabetes educators.** Prior to the DSME reimbursement policy change, a number of diabetes health centers in New York City and across the state, which often employed diabetes educators, closed. The centers were never replaced, which ultimately affected the options available to patients.

NYSDOH staff feel that one way to address these barriers is to potentially supplement DSME with other forms of self-management support, such as Stanford’s peer-support version of DSME (the Stanford Diabetes Self-Management Program). CMS currently funds an innovation pilot program in the state that combines the Medicaid-reimbursed DSME benefit with participation in the peer support version, so that patients may benefit from both. The peer support programs do not have to be led by a health professional or offered in clinical settings. Patients can access these programs in community venues that may be more conveniently located, such as public libraries, churches, or community centers. Generally, this involves one DSME session provided by a certified diabetes educator followed by the six-session peer support program. In this program, the DSME provider can bill Medicaid using their Medicaid billing number for the combined program and then share a portion of the funds with the peer-support program provider.

## Lessons Learned

Through their experience facilitating policy change that expanded Medicaid coverage for DSME, NYSDOH staff identified the following lessons learned:

- **Develop relationships with Medicaid staff.** Professional and personal relationships/friendships may help facilitate collaboration between Medicaid and state health department staff.
- **Find and take advantage of opportunities to interact with Medicaid staff.** State health department staff can enhance familiarity and further establish relationships with Medicaid by engaging in a range of collaborative efforts such as sharing data, attending each other’s meetings and conferences, sharing items for newsletters, sponsoring Medicaid staff attendance at relevant conferences/trainings, and participating in conference calls.
- **Share data to build the case.** Staff from the DPCP and Medicaid shared data from different sources and weaved these data together to build a strong case for Medicaid coverage for DSME.

### For More Information

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## Resources

[Using Data to Advance Policy](#) Webinar

[NYSDOH Quality Connection: Diabetes Self-Management Education/Training Use Among Medicaid Recipients, June 2015](#)

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