SUBJECT: Medicaid diabetes self-management training pilot program

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Kolkhorst, Naishtat, J. Davis, Gonzales, Hopson, S. King, McReynolds, Truitt, Zerwas

0 nays

2 absent — Coleman, Laubenberg

WITNESSES: For — Gene Bell, Texas Diabetes Council; Veronica DeLaGarza, American Diabetes Association; (*Registered, but did not testify:* Ed Berger, Seton Family of Hospitals; Miryam Bujanda, Methodist Healthcare Ministries; Stephen Lummus, Texas Academy of Physician Assistants; Amber Pearce, Texas Healthcare & Bioscience Institute; Denise Rose, Texas Hospital Association; Gabriela Saenz, CHRISTUS Health; Jane Van Praag; Lynda Woolbert, Coalition for Nurses in Advanced Practice)

Against — None

On — Charles Bell, Texas Health and Human Services Commission

BACKGROUND: Texas Medicaid covers diabetes diagnosis, medication, and treatment but does not cover diabetes self-management training (DSMT). DSMT is intended to provide individualized information to diabetics about diabetes treatment options, ways to prevent chronic complications, proper use of medication, blood-glucose monitoring, and proper diet and exercise.

Texas Medicaid has two types of care models — traditional fee-for-service and managed care. In the fee-for-service model, Medicaid reimburses health care providers for each Medicaid service they provide. Medicaid managed care includes HMO-style programs administered in nine urban areas of the state and a primary care case management (PCCM) model that provides Medicaid services in the rest of the state. PCCM participants are assigned a primary care provider who must authorize most health services, such as specialty care, before they can be reimbursed by Medicaid.

In 2004 and 2005, HHSC began disease management programs for certain Medicaid fee-for service and PCCM clients with one of five chronic diseases, including diabetes. HHSC contracts with a private vendor for disease management services intended to improve or maintain health and quality of life of enrolled clients and reduce their health-care costs.

DIGEST:

CSHB 1990 would require HHSC to implement and report on a diabetes self-management training pilot program, expiring September 1, 2013, that would provide diabetes self-management training (DSMT) to selected Medicaid PCCM and fee-for-service clients who had diabetes and were enrolled in the disease management program. Federal waivers or authorizations would be requested to implement the pilot program, as necessary.

The DSMT would be conducted either by a provider that was certified in accordance with Medicare standards to provide the training or by a certified diabetes educator. If DSMT were provided to a group, individual participants would have to receive face-to-face interaction with the diabetes educator and receive enough individual sessions to meet the participant's cultural and educational needs.

An assessment would be performed on each potential participant and all participants would receive an initial 10 hours of DSMT and three hours of nutrition education with a registered dietician or diabetes educator. After the initial training, program participants could receive at least two hours of DSMT and two hours of nutrition education each year.

By December 1, 2012, HHSC would report to the governor, the lieutenant governor, the speaker of the House, the appropriate standing committees of the Legislature, and the Texas Diabetes Council on data and specific health outcomes from the DSMT pilot program and any other information determined relevant by HHSC. No individually identifiable information about program participants could be disclosed.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2009.

SUPPORTERS SAY:

CSHB 1990 would create a diabetes self-management training pilot program that could improve the health of Texas Medicaid clients, save the

state in long-term health costs, and provide data that could lead to expansion of the program if it were beneficial and cost effective.

As of 2007, more than 10 percent of Texans 18 years old and older had been diagnosed with diabetes. Another 460,000 Texans were estimated to be undiagnosed. In 2005, nearly 6,000 deaths were directly attributed to diabetes, the sixth leading cause of death that year. Complications of diabetes, including heart disease, stroke, blindness, amputation, kidney disease, and nervous system disease, can reduce a diabetic's quality of life and be costly to treat.

DSMT for Medicaid clients would teach diabetics how to treat their disease and make lifestyle changes to prevent the onset of serious health complications. By controlling blood sugar, people can lower their risk of diabetes-related blindness and nerve damage by more than 50 percent. Diabetes often runs in families, and people who received DSMT could teach family members at risk of developing the disease how to avoid or delay onset.

Declines in diabetes complications among Medicaid patients would eliminate some long-term state costs for expensive treatments. A recent report from the legislatively established Texas Diabetes Council estimated that Texas state and federal expenditures for diabetes prevention activities are just over $3 million, yet state programs spend an estimated $459 million a year to provide health care and rehabilitative services for people with diabetes with advanced complications.

The importance of DSMT has been acknowledged at the federal and state level. The bill would provide the same benefits for DSMT provided through Medicare. New York and Arkansas have developed similar programs. In 1997, Texas enacted legislation that requires coverage in private health plans for DSMT, and the state should consider conferring this same benefit to all Medicaid patients.

Because the CSHB 1990 program would be a pilot, it would be appropriate to limit the program only to certain populations. If it were shown to be beneficial and cost-effective, the pilot could be expanded to other areas of the state. The most appropriate population on which to test the DSMT pilot program would be the fee-for-service and PCCM client-base because they do not receive any DSMT services, while two of the state's managed care HMOs in urban areas do provide these services. In

general, the HMOs in urban areas already have more incentive to provide services that would reduce long-term costs because they are paid a capped monthly fee for each client served, rather than for each service provided.

It is preferable that CSHB 1990 not require HHSC to extend the opportunity to participate in the DSMT pilot program to every eligible client in the disease management program, because a smaller number of initial participants would allow HHSC to focus on measuring specific cost-savings and health outcomes to identify best practices before the program was expanded. Participation in the existing disease management program is voluntary, yet only about 20 percent of eligible people elect to participate. If the DSMT pilot had a similar acceptance rate, HHSC should be able to accommodate everyone who wants to participate. The bill simply would retain the right for HHSC to limit pilot enrollment if interest greatly exceeded participation projections.

OPPONENTS SAY:

Because the CSHB 1990 pilot program would apply only to fee-for-service and PCCM Medicaid clients, it would not serve any Medicaid clients in urban areas, who instead are served under an HMO-style managed care model. DSMT services are provided in the urban managed care areas only at the discretion of the HMO. The pilot should serve Medicaid clients in all regions of the state. In addition, it should be mandatory that HHSC extend the opportunity to participate in the DSMT pilot to eligible Medicaid clients in the disease management program, because it could improve the health of these individuals and reduce long-term Medicaid costs.

NOTES:

The committee substitute differs from the bill as filed by allowing certified diabetes educators to provide DSMT.