Third-Party Reimbursement Coverage for Diabetes Outpatient Education Programs

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The purpose of this study was to report on current third-party reimbursement coverage for diabetes outpatient education programs. In 1986, the Centers for Disease Control began to collect and analyze information about reimbursement of outpatient diabetes education programs. Data compiled in the Diabetes Outpatient Education Reimbursement Database represented various information sources, including contact people in 42 states, surveys, government publications, the American Diabetes Association, the American Association of Diabetes Educators, and *Communicating for Agriculture*. The purpose of the data base was twofold: *1*) to track national reimbursement trends and *2*) to support health-care professional efforts in obtaining third-party reimbursement for education services.
This article analyzes the Diabetes Outpatient Education Reimbursement Database. This study is a descriptive analysis of the major carriers that reimburse, legislation for reimbursement of education programs, and state risk-sharing insurance pools. Currently, Medicaid (in 37 states), Medicare (in 49 states), Blue Cross/Blue Shield (in 43 states), and private carriers (in 48 states) reimburse diabetes outpatient education programs. Sixteen states have operational pooled risk health insurance plans. This represents an increase in the number of states that report reimbursement from 1986. Progress has been made in procuring reimbursement coverage for diabetes outpatient education programs. However, progress does not imply that third-party reimbursement is uniform nationwide or effortlessly achieved. Many challenges must be addressed before reimbursement is no longer an issue in the management of diabetes education programs and the provision of essential services for people with diabetes.

In 1982, the National Diabetes Advisory Board established a steering committee to develop national standards for diabetes education programs. An outcome of this committee was an initiative for studying finance and reimbursement issues. In 1984, the Airlie Conference was one of the first collaborations between public and private sectors interested in health-care financing. This conference recognized patient education as an integral component of quality care (1).

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In 1984, health-care professionals and members of the insurance community formed the Task Force for Financing Quality Care for Persons with Diabetes under the auspices of the American Diabetes Association (ADA). In 1986, the ADA Task Force collected information from insurers and educators at a workshop. The result was a manual, *Third-Party Reimbursement for Diabetes Outpatient Education—A Manual for Health Care Professionals*. At that time, the Centers for Disease Control began to collect and disseminate information on third-party reimbursement. The National Diabetes Advisory Board's "1987 National Long-Range Plan to Combat Diabetes" recommended that the Centers for Disease Control compile, analyze, and disseminate information on third-party reimbursement for diabetes patient education and on the costs of providing essential services (2).

In response to the recommendation, the Division of Diabetes Translation at the Centers for Disease Control has compiled information on outpatient education programs that bill and receive reimbursement for educational services since 1986. This information is reported from contacts in 42 states and is compiled in the Diabetes Outpatient Education Reimbursement Database (3). Last year, 243 copies of the data base were requested, principally from nurse educators and education program coordinators.

DATA BASE—The data base is organized by state. A contact person, address, and telephone number are supplied for each. The data base has five elements: *1*) a list of the insurers that reimburse in a particular state; *2*) number and type of programs reimbursed; *3*) legislation affecting people with diabetes; *4*) the charge to the person with diabetes for the program service, and *5*) a list of quality assurance standards in the state for diabetes education programs. Standards indicate a local mechanism for quality

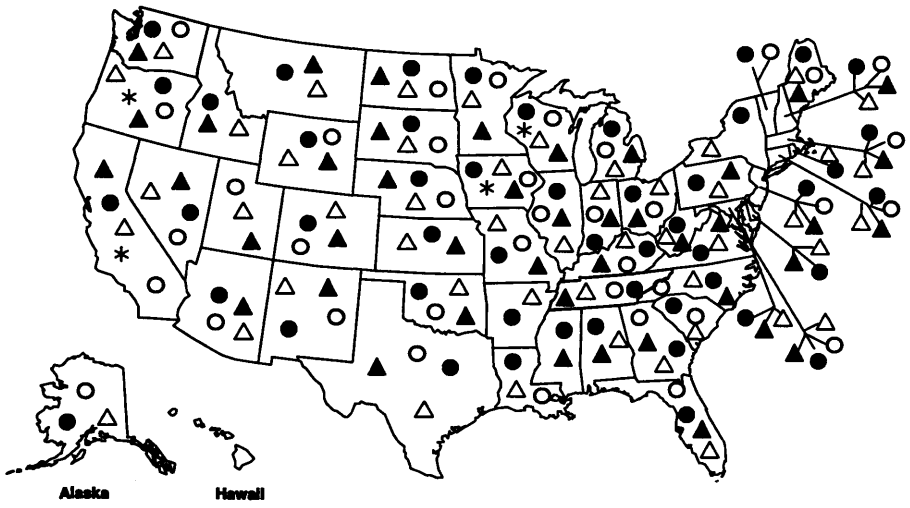

Figure 1—*Reimbursement for diabetes outpatient education programs (coverage may not be statewide). ○, Medicaid = 37; ●, Medicare = 49; ▲, Blue Cross/Blue Shield = 43; △, private = 48; *, legislation = 4. From Tobin (3). © by the Centers for Disease Control.*

assurance of education programs or if the state recommends programs that received ADA Quality Recognition.

Currently, 49 states report at least one program receiving reimbursement from Medicare, Medicaid, Blue Cross/Blue Shield, or private insurers for diabetes outpatient education (Fig. 1). These programs have met the insurer's criteria. Although these criteria vary among insurers, certain principles apply universally. First, programs must meet quality assurance standards. Second, programs frequently are asked to demonstrate that educational services result in cost savings through data collection and analysis, pilot studies, or research projects.

Of the 50 states reporting, 49 report receiving Medicare reimbursement for outpatient education. Medicare regulations, which are set by the Health Care Financing Administration, are intended to be uniform. However, interpretation of national regulations varies among regional offices and Medicare intermediaries in each state. Medicare policy states coverage determinations should be made to outpatient diabetes education services, facilities, or providers that are Medicare approved. Only services provided by outpatient hospital programs and rural health clinics are reimbursed (4).

Thirty-seven states report Medicaid reimbursement for outpatient education programs, which are administered by each state. In addition to basic benefits, each state has options to provide coverage for "preventive services." The definition of "preventive" and the income limit at which one can obtain Medicaid eligibility vary state to state. As a result of the income limit, the medically indigent are often excluded from receiving benefits.

Five states (Iowa, Ohio, Maine, Michigan, and Pennsylvania) have developed local state standards and recognition (3). States' recognition of diabetes education programs has been developed, piloted, implemented, and administered by the state health department to meet quality assurance standards.

The database shows that four states (California, Oregon, Iowa, and Wisconsin) have legislation for reimbursement of outpatient education. Legislation is generally the least desirable method of obtaining reimbursement; it often includes restrictions, limitations, and costly premiums that frequently deny access to some persons with diabetes.

The database tracks health insurance risk-sharing pools. In the United States, health-care delivery heavily relies on the health insurance system. Insurance pools have been operating for nearly 12 yr; they are a proven mechanism for providing the opportunity to purchase health insurance protection for everyone. Because insurance premiums are expensive, pooled risk does not solve all the problems of accessing health insurance, especially among the poor. Premiums would be even higher without state-imposed limits capping premiums at a fixed percentage (usually 125–150%) of the standard individual premium in a state. The capped premiums are expected to cover most claims paid by the pool; but, in practice, they are generally insufficient because of the poor health status of the insured individuals (5). Twenty-four states have passed legislation to introduce health insurance risk-sharing pools for individuals who have difficulty purchasing adequate health insurance coverage because of preexisting health conditions. Sixteen of these plans are operational.

EVALUATION OF THE DATA BASE

—Several weaknesses in the reimbursement data base have been identified and changes for improvement have begun. For example, information in the current data base is reported voluntarily; therefore, much of the information is anecdotal in nature and cannot be verified. Also, not every state is represented by a contact person. The Centers for Disease Control expects to change the format and formalize the reporting systems to provide a more reliable tool.

Another weakness is the method of data collection. The Division of Diabetes Translation conducted several sur-

Table 1—*Number of states reimbursing outpatient education programs*

	1986	1987	1988	1989	1990
N STATES	17	22	40	42	50
MEDICARE	14	18	21	32	49
MEDICAID	6	8	11	13	37
BLUE CROSS/ BLUE SHIELD	13	16	20	21	43
PRIVATE	9	15	26	28	48

Based on ref. 3.

veys of education programs to expand the information in the data base. One survey attempted to discern both direct and indirect costs for diabetes education programs and determine what the programs were charging. However, the survey showed that only 24% of the programs provided their costs and charges. Many respondents did not discriminate between costs and charges. This observation was somewhat unexpected and demonstrated both a limited understanding of the financial aspects of program management and a lack of knowledge of economic terminology. An instructional guide is being developed that addresses cost identification and cost finding.

A recent unpublished survey of diabetes educators by the American Association of Diabetes Educators has been difficult to analyze because of the heterogeneous education programs and the personnel involved. Although the survey did provide some interesting anecdotal information, it could not produce consistent aggregate data to expand the database.

In an attempt to gather more useful cost information on diabetes education, the Division of Diabetes Translation has compiled a "Bibliography of Articles on Economic Aspects of Diabetes Care" (6). However, from an economic perspective, the conclusions that can be drawn from the articles are limited. Although most of the studies of diabetes intervention programs conclude that they are effective in reducing the morbidity and mortality associated with diabetes, the strength of the conclusions are limited by problems with design, incomplete enumeration of costs, and failure to include indirect costs.

The data on the number of states reimbursing diabetes outpatient education programs demonstrate that a great deal of progress has been made in obtaining coverage (Table 1). The number of programs that receive reimbursement from Medicare, Medicaid, Blue Cross/Blue Shield, and the private carriers continues to increase. Thus, some financial barriers to obtaining diabetes outpatient education have been lowered. However, this does not indicate statewide or nationwide coverage.

CHALLENGES FOR THE FUTURE— Many challenges exist for the health-care system: *1*) Medicare regulations and policy under the Health Care Financing Administration are not uniformly interpreted; *2*) diabetes education programs lack heterogeneity, making it difficult for policymakers to analyze and compare; and *3*) health insurance is not available to many individuals with diabetes.

To address these challenges, communications must be improved between third-party payors and the diabetes health-care professionals. Health-care professionals need coaching in common economic terminology and awareness of the financial aspects of diabetes education program management. Although financial management traditionally has not been a part of hospital program management, it is becoming an integral component of total management. Good financial management will help to provide communities with needed services at acceptable levels of quality and at the lowest possible cost.

Cost analyses that use appropriate methods are needed to evaluate diabetes education programs. The cost-evaluation process can employ analytic techniques used by business and government for health care. Economic evaluations of preventive programs should adhere to health economic standards, including complete enumeration of costs and consequences, assessment of direct and indirect costs (medical and nonmedical costs), and appropriate use of discounting and sensitivity analysis. Collaboration with major third-party payors on the design and analysis of cost data can lead to the documentation of cost savings, cost-effectiveness, and cost benefit of diabetes education programs.

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