May 5, 2014

TEXAS DIABETES COUNCIL

Diabetes in Texas: A Call to Action

Diabetes Continues to Challenge the Physical and Fiscal Health of Texas

The prevalence of diabetes in Texas has increased by 57 percent over the past decade[1] and the projected future increase is dramatic.

- In 2012, more than 2.1 million (10.6%) adult Texans were estimated to have diagnosed diabetes, and another 1.2 million (6.2%) were estimated to have diagnosed prediabetes.[2]
- In 2011, an estimated 11.5 percent of pregnant women in Texas developed gestational diabetes compared to 1.9 percent who had pre-existing diabetes before the pregnancy.[3]
- Many more Texans are likely to have prediabetes, but aren't diagnosed. Results of national studies indicate that as many as 35 percent of U.S. adults have prediabetes (diagnosed and undiagnosed), a condition that makes them more likely to develop type 2 diabetes within the next ten years, and more likely to have a heart attack or stroke.[4]
- The State Demographer projects a quadrupling of the number of adult Texans with diabetes to almost 8 million by 2040.[5]

In 2012, diabetes cost an estimated $18.5 billion in Texas, including $12.3 billion in direct medical costs and $6.2 billion in indirect costs. The cost to Texas will increase substantially as the number of Texans with diabetes quadruples over the next 25 years.[6]

- Based on assessments of state agency programs and services in 2011-12, almost 400,000 Texans with diabetes received diabetes-related services through state Health and Human Services Commission programs, with identified costs reaching almost $312 million.[7]
- Almost 27,000 health care providers treated diabetes patients under state agency programs.[8]
- According to analysis of United Healthcare plan members, the average total annual cost for an adult plan member with employer coverage and diagnosed diabetes who interacted with the health care system in 2009 was approximately $11,700, compared to $4,400 for an adult with employer coverage not known to have diabetes. The average yearly total costs for a person with diabetes who developed complications were $20,700 – almost three times the average cost of $7,800 for diabetes patients without complications.[9]
- People with diabetes who do not have health insurance have 79 percent fewer physician office visits and are prescribed 68 percent fewer medications than people with insurance coverage—but they also have 55 percent more emergency department visits than people who have insurance.[10]
- Total costs of hospitalization for all diabetes in pregnancy was over $1.4 billion, or 7.8 percent of all maternal hospitalization costs in 2010.[11]
- Complications of diabetes include heart disease and stroke, blindness, amputations, and kidney disease. The largest components of medical expenditures for diabetes are:

- Hospital inpatient care (43% of the total medical cost),
- Prescription medications to treat complications of diabetes (18%),
- Anti-diabetic agents and diabetes supplies (12%),
- Physician office visits (9%), and
- Nursing/residential facility stays (8%).[12]

Texas Diabetes Council Accomplishments

Established to address the growing prevalence of diabetes in Texas, and accompanying cost, the Texas Diabetes Council (TDC) consists of Governor-appointed volunteers including health care provider and consumer members with expertise in diabetes issues. Accomplishments of the TDC include:

- Increasing patient education opportunities in Texas through funding for community-based diabetes education programs.
- Collaborating with the Legislature to approve legislation that protects children with diabetes while at school.
- Development of a diabetes "Center of Excellence" for patient treatment and professional training in the state (Texas Diabetes Institute, San Antonio).
- Publication and promotion of treatment guidelines for health care professionals and health plans.
- Development of state policy that ensures insurance coverage and services for Texans with or at risk for diabetes.

Action Plan for Texas

The TDC has identified four significant opportunities as a call to action that builds upon past accomplishments, and takes full advantage of national, state and local efforts already underway to improve diabetes education, management and care in Texas. Our work in the priority areas that follow is dependent on the Legislature's continued funding and support of the Diabetes Prevention and Control Program at the Texas Department of State Health Services.

1) The **Texas Medicaid Transformation Waiver** (1115 waiver) has resulted in 111 projects across the state focusing on diabetes-related outcomes. This unprecedented opportunity to evaluate our approaches to diabetes prevention and control in Texas should lead to identification and dissemination of lessons learned and best practices.

Priorities for Texas

- Evaluate whether waiver projects show quantifiable improvements relating to quality of care, population health, and cost of care for patients with diabetes.
- Work with the HHSC Center for Strategic Decision Support to explore opportunity for 50 percent federal match funding for this effort.
- Consider legislative action that supports evaluation of waiver projects related to diabetes.

2) The **National Diabetes Prevention Program** (NDPP) is a public-private partnership of community organizations, private insurers, health care organizations, employers, and

government agencies brought together to establish local evidence-based lifestyle change programs for people at high risk for type 2 diabetes. The community program costs less than $325 per participant[13], as compared to an average of $7,900 per year for the treatment of diabetes for one individual.[14] The *Texas State Healthcare Innovation Plan* recommends reimbursement for this one-year lifestyle change program by Medicaid and state employee health plans in order to achieve a projected reduction in risk for type 2 diabetes of 58 percent among individuals with prediabetes served by these health plans.

Priorities for Texas

- Using cost effectiveness data from United Healthcare and others, demonstrate value of establishing the NDPP as a covered benefit under Texas Medicaid and the Employment Retirement System of Texas (ERS).
- Working with the Texas Medical Association and others, promote health care provider referral to NDPP in Texas and educate providers about the need to screen and diagnose patients with prediabetes.
- Consider legislative action to leverage expansion of the NDPP in Texas.

3) **Diabetes Self-Management Education (DSME) in Community Diabetes Projects** DSME improves clinical outcome measures related to blood sugar (A1c), blood pressure, cholesterol, and smoking status. Managed care organizations (MCO) currently under contract with Texas Medicaid are required to provide disease management and education services; however, information needed to assess the reach and effectiveness of these services is not currently available. Initial surveys of Medicaid MCOs indicate that fewer than half of the contracted MCOs automatically enroll patients with diabetes in self-management education. There is also a need for more DSME accredited sites recognized by the American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) to ensure that standards for demonstrating outcomes are met. The same standards, information and reporting should be required of DSME Medicaid Managed Care contracts.

Priorities for Texas

- Work with HHSC to ensure Medicaid patients with diabetes are automatically enrolled in a DSME program and that HHSC is analyzing outcomes data demonstrating health and economic impact.
- Work with state agencies to ensure state reporting systems beyond Medicaid are evaluating DSME outcomes to demonstrate effectiveness in improving health.
- Increase access, referral, and reimbursement for AADE-accredited or ADA-recognized DSME programs.
- Increase engagement of community health workers to promote linkages between health systems and community resources for adults with type 2 diabetes.
- Support legislative action that increases access to DSME.

4) **Gestational Diabetes** Women with gestational diabetes are at high risk for developing type 2 diabetes later in life, and the infant is at risk of becoming obese during childhood and developing type 2 diabetes as an adult. Women with gestational diabetes have a 35-60 percent chance of developing diabetes in the next 10-20 years.[15] In Texas, Medicaid pays for over 50 percent of all births statewide. The screening rates of pregnant women enrolled in Medicaid are low. A study of screening rates in Florida, Georgia, New Jersey and Texas

indicates that only 11-34 percent of women were screened.[16] All women should be screened for gestational diabetes at 24 weeks of pregnancy, even if they have no symptoms, according to the latest national guidelines set by the American Association of Clinical Endocrinologists, the American Diabetes Association (ADA), the American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force.

Priorities for Texas

- Work with HHSC to ensure Medicaid managed care plans are screening all pregnant women they serve for gestational diabetes, and if diagnosed, the patient is receiving appropriate management (medical nutrition therapy, self-management education, and supplies) and care to prevent complications, further hospitalizations and possible neonatal intensive care unit costs for the newborn.
- Work with HHSC to identify solutions to decrease the amount of time that an infant born to a mother with gestational diabetes is in intensive care due to poor birth outcomes experienced because of lack of diabetes management.

Conclusion

The Texas Diabetes Council remains very committed to identify ways to simultaneously reduce overall expenditures while improving the delivery of evidence-based, cost effective prevention and health services that improve population health. Given the 57% increase in diabetes prevalence in Texas over the past decade, and the projected quadrupling by 2040, the TDC is concerned that escalating healthcare costs resulting from complications of poorly controlled diabetes will continue to put pressure our ability to afford and sustain the health care delivery system. This poses a simultaneous threat at multiple levels: fiscally for the Legislature and Texas communities and to the health and quality of life of Texans.

---

[1] Texas Department of State Health Services. *The Burden of Diabetes in Texas. A Report Prepared by the Office of Surveillance, Evaluation, and Research; Health Promotion and Chronic Disease Prevention Section*. April 1, 2013. Updated November 6, 2013.

[2] 2012 Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, for persons eighteen years of age and older. Data include both type 1 and type 2 diabetes. Persons with diabetes include those who report that they have been told by a doctor or other healthcare professional that they have diabetes. Persons with prediabetes include those who have been told by a doctor or other healthcare professional that they have prediabetes or borderline diabetes. Women and girls who report diabetes or prediabetes only during pregnancy are not included in prevalence.

[3] Texas Department of State Health Services Diabetes Prevention and Control Branch. *Texas Pregnancy Risk Assessment Monitoring System (PRAMS) Estimate of Pre-existing and Gestational Diabetes, 2004-2009*. Texas Diabetes, the Newsletter of the Texas Diabetes Council, Spring 2011. Publication No. 45-11004. http://www.dshs.state.tx.us/diabetes/PDF/newsletter/spring11.pdf

[4] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[5] Texas, Office of the State Demographer, Texas State Data Center. *Summary Report on Diabetes Projections in Texas, 2007 to 2040*. http://txsdc.utsa.edu/reports/Summary_Report_Diabetes.pdf.

[6] Texas Health and Human Services Commission. *Report on Direct and Indirect Costs of Diabetes in Texas As Required By S.B. 796 82nd Legislature, Regular Session, 2011*. December 2012 http://www.hhsc.state.tx.us/reports/2012/direct-indirect-costs-diabetes-texas.pdf.

[7] Texas Department of State Health Services Diabetes Prevention and Control Branch. *Statewide Assessment of Existing Programs for the Prevention and Treatment of Diabetes as Required by Section 103.0131, Health and Safety Code*, 2013.

[8] Ibid.

[9] Deneen Vojta, Jeanne De Sa, Ted Prospect and Simon Stevens, *Effective Interventions For Stemming The Growing Crisis Of Diabetes And Prediabetes: A National Payer's Perspective*, Health Affairs, 31, no. 1 (2012): 20-26.

[10] American Diabetes Association. *Economic Costs of Diabetes in the U.S. in 2012*. Diabetes Care. 2013 Apr;36(4):1033-46. Epub 2013 Mar 6. http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html

[11] Wier, L.M., Witt, E., Burgess, J., and Elixhauser, A. *Hospitalizations Related to Diabetes in Pregnancy, 2008*. HCUP Statistical Brief #102. December 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb102.pdf

[12] American Diabetes Association. op. cit. p. 1033

[13] Ackerman, R.T., Marrero, D.G., Adapting the Diabetes Prevention Program Lifestyle Intervention for Delivery in the Community: The YMCA Model, The Diabetes Educator 2007; 33;69.

[14] American Diabetes Association. op. cit. p. 1033

[15] Centers for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[16] Chireau, M.V., Benedict, M.B., Gavin, N.I., & Adams, E.K. (2006). *Gestational diabetes testing among pregnant medicaid recipients: implications for clinical care*. Journal of Clinical Outcomes Management, 13 (6):323-332