

113TH CONGRESS  
1ST SESSION

# H. R. 1274

To amend title XVIII of the Social Security Act to improve access to diabetes self-management training by authorizing certified diabetes educators to provide diabetes self-management training services, including as part of telehealth services, under part B of the Medicare program.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 19, 2013

Mr. WHITFIELD (for himself and Ms. DEGETTE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to improve access to diabetes self-management training by authorizing certified diabetes educators to provide diabetes self-management training services, including as part of telehealth services, under part B of the Medicare program.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “Access to Quality Dia-  
5       betes Education Act of 2013”.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) The Centers for Disease Control and Pre-  
4 vention (hereinafter “CDC”) report that nearly  
5 26,000,000 Americans have diabetes, in addition to  
6 an estimated 79,000,000 Americans who have  
7 prediabetes, an increase of 24,000,000 Americans  
8 with either diabetes or prediabetes since 2008. Peo-  
9 ple with prediabetes are at increased risk of devel-  
10 oping Type 2 diabetes or cardiovascular disease.

11 (2) Diabetes impacts 8.3 percent of all Ameri-  
12 cans and 11.3 percent of American adults. The CDC  
13 estimates that as many as 1 in 3 Americans will  
14 have diabetes by 2050 if current trends continue.

15 (3) According to the American Diabetes Asso-  
16 ciation, the total costs of diagnosed diabetes have  
17 risen to \$245 billion in 2012 from \$174 billion in  
18 2007, when the cost was last examined by the CDC.  
19 This figure represents a 41 percent increase over a  
20 five-year period.

21 (4) One in 3 Medicare dollars is currently spent  
22 on people with diabetes.

23 (5) There were 11.3 million diabetes related  
24 emergency room visits in 2008, compared with 9.5  
25 million in 2000, an increase of 11 percent.

1           (6) According to the CDC, health care pro-  
2           viders are finding statistically significant increases  
3           in the prevalence of Type 2 diabetes in children and  
4           adolescents.

5           (7) Diabetes self-management training (herein-  
6           after “DSMT”), also called diabetes education, pro-  
7           vides critical knowledge and skills training to pa-  
8           tients with diabetes, helping them manage medica-  
9           tions, address nutritional issues, facilitate diabetes-  
10          related problem solving, and make other critical life-  
11          style changes to effectively manage their diabetes.  
12          Evidence shows that individuals participating in  
13          DSMT programs are able to progress along the con-  
14          tinuum necessary to make sustained behavioral  
15          changes in order to manage their diabetes.

16          (8) A certified diabetes educator is a State li-  
17          censed or registered health care professional who  
18          specializes in helping people with diabetes develop  
19          the self-management skills needed to stay healthy  
20          and avoid costly acute complications and emergency  
21          care, as well as debilitating secondary conditions  
22          caused by diabetes.

23          (9) Diabetes self-management training has been  
24          proven effective in helping to reduce the risks and  
25          complications of diabetes and is a vital component of

1 an overall diabetes treatment regimen. Patients who  
2 have received training from a certified diabetes edu-  
3 cator are better able to implement the treatment  
4 plan received from a physician skilled in diabetes  
5 treatment.

6 (10) Lifestyle changes, such as those taught by  
7 certified diabetes educators, directly contribute to  
8 better glycemic control and reduced complications  
9 from diabetes. Evidence shows that the potential for  
10 prevention of the most serious medical complications  
11 caused by diabetes to be as high as 90 percent  
12 (blindness), 85 percent (amputations), and 50 per-  
13 cent (heart disease and stroke) with proper medical  
14 treatment and active self-management.

15 (11) In recognition of the important role of  
16 DSMT programs, the CDC in 2012 awarded fund-  
17 ing to expand the National Diabetes Prevention Pro-  
18 gram to help prevent the onset of Type 2 diabetes  
19 for individuals at high risk.

20 (12) The net savings to the Medicare program  
21 of ensuring that beneficiaries have access to quality  
22 DSMT is estimated to be \$2,000,000,000 over 10  
23 years.

24 (13) Despite its effectiveness in reducing diabe-  
25 tes-related complications and associated costs, diabe-

1 tes self-management training has been recognized by  
2 the Centers for Medicare & Medicaid Services as an  
3 underutilized Medicare benefit, even after more than  
4 a decade of coverage.

5 (14) Enhancing access to diabetes self-manage-  
6 ment training programs that are certified as nec-  
7 essary by the patient’s treating physician and taught  
8 by certified diabetes educators is an important pub-  
9 lic policy goal that can help improve health out-  
10 comes, ensure quality, and reduce escalating diabe-  
11 tes-related health costs.

12 **SEC. 3. RECOGNITION OF CERTIFIED DIABETES EDU-**  
13 **CATORS AS AUTHORIZED PROVIDERS OF**  
14 **MEDICARE DIABETES OUTPATIENT SELF-**  
15 **MANAGEMENT TRAINING SERVICES.**

16 (a) IN GENERAL.—Section 1861(qq) of the Social Se-  
17 curity Act (42 U.S.C. 1395x(qq)) is amended—

18 (1) in paragraph (1), by striking “by a certified  
19 provider (as described in paragraph (2)(A)) in an  
20 outpatient setting” and inserting “in an outpatient  
21 setting by a certified diabetes educator (as defined  
22 in paragraph (3)) or by a certified provider (as de-  
23 scribed in paragraph (2)(A))”; and

24 (2) by adding at the end the following new  
25 paragraphs:

1 “(3) For purposes of paragraph (1), the term ‘cer-  
2 tified diabetes educator’ means an individual—

3 “(A) who is licensed or registered by the State  
4 in which the services are performed as a certified di-  
5 abetes educator; or

6 “(B) who—

7 “(i) is licensed or registered by the State  
8 in which the services are performed as a health  
9 care professional;

10 “(ii) specializes in teaching individuals  
11 with diabetes to develop the necessary skills and  
12 knowledge to manage the individual’s diabetic  
13 condition; and

14 “(iii) is certified as a diabetes educator by  
15 a recognized certifying body (as defined in  
16 paragraph (4)).

17 “(4) For purposes of paragraph (3)(B)(iii), the term  
18 ‘recognized certifying body’ means a certifying body for  
19 diabetes educators which is recognized by the Secretary  
20 as authorized to grant certification of diabetes educators  
21 for purposes of this subsection pursuant to standards es-  
22 tablished by the Secretary.”

23 (b) TREATMENT AS A PRACTITIONER, INCLUDING  
24 FOR TELEHEALTH SERVICES.—Section 1842(b)(18)(C) of

1 the such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by  
2 adding at the end the following new clause:

3 “(vii) A certified diabetes educator (as defined  
4 in section 1861(qq)(3)).”.

5 (c) GAO STUDY AND REPORT.—

6 (1) STUDY.—The Comptroller General of the  
7 United States shall conduct a study to identify the  
8 barriers that exist for Medicare beneficiaries with di-  
9 abetes in accessing diabetes self-management train-  
10 ing services under the Medicare program, including  
11 economic and geographic barriers and availability of  
12 appropriate referrals and access to adequate and  
13 qualified providers.

14 (2) REPORT.—Not later than 1 year after the  
15 date of the enactment of this Act, the Comptroller  
16 General of the United States shall submit to Con-  
17 gress a report on the study conducted under para-  
18 graph (1).

19 (d) AHRQ DEVELOPMENT OF RECOMMENDATIONS  
20 FOR OUTREACH METHODS AND REPORT.—

21 (1) DEVELOPMENT OF RECOMMENDATIONS.—

22 The Director of the Agency for Healthcare Research  
23 and Quality shall, through use of a workshop and  
24 other appropriate means, develop a series of rec-  
25 ommendations on effective outreach methods to edu-

1       cate physicians and other health care providers as  
2       well as the public about the benefits of diabetes self-  
3       management training in order to promote better  
4       health outcomes for patients with diabetes.

5           (2) REPORT.—Not later than 1 year after the  
6       date of the enactment of this Act, the Director of  
7       the Agency for Healthcare Research and Quality  
8       shall submit to Congress a report on the rec-  
9       ommendations developed under paragraph (1).

10       (e) EFFECTIVE DATE.—The amendments made by  
11       this section shall apply to items and services furnished  
12       after the end of the 12-month period beginning on the date  
13       of the enactment of this Act.

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