

# Health Equity Coverage Recommendation Form

<b>Title:</b>	<b>Health Equity in Diabetes</b>
<b>Date of Last Review:</b>	1/1/2025

## Research Section

### Background

Health equity in diabetes among racial minority groups addresses the significant disparities in diabetes prevalence, management, and outcomes. Racial minorities, particularly African Americans, Hispanic/Latino communities, Native Americans, and some Asian American subgroups, experience higher rates of diabetes and its complications compared to their white counterparts. These disparities are driven by a complex interplay of socioeconomic factors, limited access to quality healthcare, cultural barriers, and systemic inequities within the healthcare system. Addressing health equity involves comprehensive strategies such as increasing access to preventive care, culturally tailored health education, improving diet and lifestyle resources, and enhancing community-based support systems. Reducing these disparities requires concerted efforts from healthcare providers, policymakers, and community organizations to create equitable and inclusive health environments.

### Inequities discussed on the [Office of Minority Health Website](#)<sup>1</sup>

#### [Diabetes and Black/African Americans](#):<sup>2</sup>

- In 2019, non-Hispanic Black Americans were twice as likely as non-Hispanic white Americans to die from diabetes.
- In 2018, African American adults were 60 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician.
- In 2019, non-Hispanic Black Americans were 2.5 times likely to be hospitalized with diabetes and associated long-term complications than non-Hispanic white Americans.
- In 2019, non-Hispanic Black Americans were 3.2 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic white Americans.

#### [Diabetes and American Indians/Alaska Natives](#):<sup>3</sup>

- American Indian/Alaska Native adults are almost three times more likely than non-Hispanic white adults to be diagnosed with diabetes.

- In 2018, American Indians/Alaska Natives were 2.3 times more likely than non-Hispanic white Americans to die from diabetes.
- In 2017, American Indians/Alaska Natives were twice as likely to be diagnosed with end stage renal disease than non-Hispanic white Americans.

#### [Diabetes and Asian Americans:](#)<sup>4</sup>

- Asian Americans are 40 percent more likely to be diagnosed with diabetes than non-Hispanic white Americans.
- In 2017, Asian Americans were 60 percent more likely to be diagnosed with end stage renal disease than non-Hispanic white Americans.
- From 2017-2018, Asian Indians were 70 percent more likely to be diagnosed with diabetes, as compared to non-Hispanic white Americans.

#### [Diabetes and Hispanic/Latino Americans:](#)<sup>5</sup>

- In 2018, Hispanic Americans were 1.3 times more likely than non-Hispanic white Americans to die from diabetes.
- Hispanic adults are 70 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician.
- In 2017, Hispanic Americans were twice as likely to be hospitalized for treatment of end-stage renal disease related to diabetes, as compared to non-Hispanic white Americans.

#### **Review of current, peer-reviewed evidence from established sources**

- In 2018, [Marquez and colleagues](#) published a report on a Framework for Addressing Diabetes-related Disparities in US Latino Populations.<sup>6</sup> The article aimed to offer a better understanding of underlying causes and influencing factors to guide future efforts to eliminate racial/ethnic disparities in diabetes control. Key findings include evidence that diabetes care services can be designed to accommodate heterogeneity within the Latino American community by addressing key modifiable predictors of poor glycemic control, including insurance status, diabetes care utilization, patient self-management, language access, culturally appropriate care, and social support services. Future research efforts should evaluate the effect of structurally tailored interventions that address these key modifiable predictors by targeting patients, providers, and health care delivery systems.
- In 2013, [Ricci-Cabello and colleagues](#) published a meta-analysis and systematic review on health care interventions to improve the quality of diabetes care in African Americans.<sup>7</sup> This systematic review identified 31 health care–promoted interventions specifically aimed at improving the quality of diabetes care in African Americans, most of which targeted patients (71% targeted patients, 16% targeted the health care system, and 13% were multifaceted). The evidence gathered showed that interventions targeting African American diabetic patients, which mainly included culturally adapted DSM education, reduced the percentage of HbA1c by 0.8%. A lower level of evidence was observed in relation to interventions targeting the health

care system and multiple-target interventions, although available evidence suggests that they can be effective and have the potential to improve diabetes care and health outcomes. The authors concluded that “this systematic review provides evidence about the key role that health care can play in reducing ethnic disparities in African American patients with type 2 diabetes by designing and conducting interventions aimed at this specific purpose.”

- In 2022, [Hill-Briggs and colleagues](#) published a report on social determinants of health, race, and diabetes population health improvement among Black/African Americans.<sup>8</sup> Authors wrote the following:
  - “Key findings from the American Diabetes Association’s scientific review of five social determinants of health (SDOH) domains (socioeconomic status, neighborhood and physical environment, food environment, health care, social context) are highlighted. Population-based data on Black/African American adults illustrate persisting diabetes disparities and inequities in the SDOH conditions in which this population is born, grows, lives, and ages, with historical contributors. SDOH recommendations from US national committees largely address a health sector response, including health professional education, SDOH measurement, and patient referral to services for social needs. Fewer recommendations address solutions for systemic racism and socioeconomic discrimination as root causes. SDOH are systemic, population-based, cyclical, and intergenerational, requiring extension beyond health care solutions to multi-sector and multi-policy approaches to achieve future population health improvement.”

### **Review of clinical practices guidelines from professional associations and societies in regard to these findings**

#### **American Association of Clinical Endocrinology:**

In 2022, the AACE put out the following guideline; [American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan](#).<sup>9</sup> Authors recommended preventive screening and management of comorbidities including obesity. They state, “There is evidence that community programs involving cross-age peers can be effective at delivering nutritional interventions and in reducing BMI particularly in low-income or minority populations.”

#### **American Diabetes Association:**

In 2025, the American Diabetes Association (ADA’S) updated their [Standards of Medical Care in Diabetes](#).<sup>10</sup> As part of their review, authors noted that most youth with type 2 diabetes come from racial/ethnic minority groups, have low socioeconomic status, and often experience multiple psychosocial stressors. Consideration of the sociocultural context and efforts to personalize diabetes management are of critical importance to minimize barriers to care, enhance adherence, and maximize response to treatment.

**Do any of these findings relate to any of our current policies?**

None of the above findings are applicable to any of our current medical policies at this time.

**Summary**

**Medical Policy:**

Diabetes disproportionately affects minority populations in the US, including African Americans, American Indians/Alaska Natives, Asian Americans, and Hispanic Americans. Causes of the higher prevalence of Diabetes in these populations are likely multifactorial and complex, as diabetes has a number of comorbidities affected by biological, socio-economic, and environmental factors. Currently, evidence and guidelines suggest that health care models, society-wide models, and patient care must change to address these disparities.

**Pharmacy Policy:**

According to the [2025 Standards of Care in Diabetes](#), some pharmacy related barriers to adequate diabetes care include affordability and accessibility (due to transportation, geographic distance, and long work hours).<sup>10</sup> With the exception of the GIP/GLP-1 receptor agonists, most medications recommended in the guidelines for the treatment of diabetes, as well as traditional glucose monitoring kit and supplies, are available on the formulary without restriction. While prior authorization can be a barrier to access for patients, they are sometimes necessary for higher cost drugs to ensure appropriate utilization and to avoid covering for conditions that lack high quality evidence regarding safety and/or efficacy or are considered a benefit exclusion, like weight loss is for many of our groups. Access to a pharmacy can be another barrier to medication adherence. The pharmacy department has a pharmacy network team that ensures we have a broad network of pharmacies for patients to go to receive medications and immunizations. Additionally, we contract through a mail order pharmacy, Postal Prescription Services, that eliminates the need for members to spend time going to the pharmacy. For some plans, members get reduced copays when utilizing this service.

**Recommendation:**

The Pharmacy Policy group has noted that the Insulin Pump policy will be due for annual review in April and that the Continuous Glucose Monitor policy is due for annual review in October. At their next annual reviews, a recommendation will be made to automate coverage in association with certain diagnosis codes to reduce prior authorization for these items, therefore reducing the barrier to care for members.

**References**

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6. Marquez I, Calman N, Crump C. A framework for addressing diabetes-related disparities in US Latino populations. *Journal of community health*. 2019;44:412-422.
7. Ricci-Cabello I, Ruiz-Perez I, Nevot-Cordero A, Rodriguez-Barranco M, Sordo L, Goncalves DC. Health care interventions to improve the quality of diabetes care in African Americans: a systematic review and meta-analysis. *Diabetes care*. 2013;36(3):760-768.
8. Hill-Briggs F, Ephraim PL, Vrany EA, et al. Social determinants of health, race, and diabetes population health improvement: Black/African Americans as a population exemplar. *Current diabetes reports*. 2022;22(3):117-128.
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10. American Diabetes Association. Standards of Care in Diabetes. <https://professional.diabetes.org/standards-of-care>. Published 2025. Accessed 1/6/2025.

### CORE Revision History Section

DATE	SUMMARY OF CHANGES
12/21/2023	Initial review.
12/26/2024	Annual update. No changes.

Disclaimer: Providence Health Plan (PHP) and Providence Health Assurance (PHA) CORE forms serve as guidance for the administration of plan benefits. CORE forms do not constitute medical advice nor a guarantee of coverage. PHP and PHA CORE Medical Policy forms are based upon CMS guidelines and published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last CORE update. PHP and PHA CORE Coding Policy forms are based on national coding standards and CMS guidelines. PHP and PHA reserve the right to determine the application of CORE forms and make revisions to its CORE forms at any time.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP and PHA CORE forms will be resolved in favor of the coverage agreement.