

Affordable Care Act Implementation: Challenges and Opportunities to Impact Patients With Diabetes

Alvin C. Powers, Jason A. Wexler, Robert W. Lash, Meredith C. Dyer, Mila N. Becker, and Robert A. Vigersky

Departments of Medicine and Molecular Physiology and Biophysics (A.C.P.), Vanderbilt University Medical Center, Nashville, Tennessee 37232; Medtronic Diabetes (R.A.V.), Minneapolis, Minnesota 55432; Walter Reed National Military Medical Center (R.A.V.), Bethesda, Maryland 20814; MedStar Washington Hospital Center (J.A.W.), Washington, DC 20010; University of Michigan Health System (R.W.L.), Ann Arbor, Michigan 48108; and the Endocrine Society (M.C.D., M.N.B.), Washington, DC 20036

In the United States, slightly more than half of all adults with diabetes receive guideline-consistent care (1). A smaller proportion has adequate cardiovascular risk factor control (2). Current care of individuals with diabetes and its complications and comorbidities exemplifies many of the challenges facing the U.S. healthcare system (3). Based on the care costs relative to the outcomes achieved, Americans deserve greater value for our healthcare expenditures.

Acknowledging the convergence of the diabetes epidemic and the passage of the Affordable Care Act (ACA), the Endocrine Society (ES) seized the opportunity to convene a Washington, DC, Summit on September 12, 2014, to explore the law's impact on patients with diabetes. Summit attendees and speakers included leading diabetes stakeholders, patient advocacy and community-based groups, health plans, research institutions, federal agencies, and policy makers. The agenda featured potential policy solutions as well as challenges and opportunities resulting from ACA implementation. In the following paragraphs, the ES briefly summarizes the proceedings.

Examples of ACA's Implementation on Diabetes Care

Although the full effect of the ACA's impact on diabetes care is still being determined, several benefits and challenges are already clear. Improved access has lowered the

barrier for individuals with diabetes to receive care. One study found a 23% increase in Medicaid patients diagnosed with diabetes in states that adopted ACA Medicaid expansion, vs a 0.4% increase in states that did not (4). Given that approximately 25% of Americans with diabetes are undiagnosed and earlier diagnosis and treatment reduce long-term complications, this increase is evidence of progress toward the central goals of the ACA—expanded access to improve care quality and outcomes. This report mirrored prior observations showing that more individuals were diagnosed with diabetes when medical coverage became available (5). One challenge from expanded access is exacerbation of the existing problem of the demand exceeding the supply of available providers (both primary care and diabetes specialists).

The ACA also supports important new research initiatives aimed at transforming diabetes care delivery. For example, the ACA authorized the Patient-Centered Outcomes Research Institute (PCORI), which supports comparative clinical effectiveness research and emphasizes engagement of patients and other stakeholders in research. PCORI currently supports more than 15 diabetes-related research projects aimed at improving healthcare systems and diabetes health disparities. The ACA also authorized the Cures Acceleration Network (CAN) within the National Institutes of Health to speed development of new diagnostics and therapeutics and remove barriers to translation between discovery and clinical trials. The relevance

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Abbreviations: ACA, Affordable Care Act; ES, Endocrine Society.

of CAN to many diabetes-related technologies and needs is clear.

Key Items and Policy Recommendations From ES Summit

Discussion and ES policy recommendations from the Summit center on three major areas: care organization and processes, financing reform tied to quality enhancement, and promotion of new technology and discoveries.

Care organization and processes

Diabetes patients may have multiple medical comorbidities and often have a diverse set of independently functioning practitioners treating them. Accordingly, a fundamental challenge addressed at the Summit was how to transform multidisciplinary care teams to provide optimal, coordinated diabetes care. All proposed models featured a care team whose goal is providing nonduplicative, continuous, comprehensive, and timely care. This care emphasizes hyperglycemic control, prevention of hypoglycemia, cardiovascular risk reduction, and other aspects of patient self-management to manage comorbidities. Models must move beyond current case management. Patient-centered medical homes, either specific to patients with diabetes or more comprehensive, were seen as a promising model, but evaluation before widespread adoption is critical. Questions remain as to whether such approaches will have sufficient resources to provide access to the type of diabetes care that improves patient outcomes. Reliance on endocrinologists in any care model is a challenge because demand exceeds supply and the discipline is not growing as fast as the patient population (6). Likewise, greater use of primary care physicians (PCPs) in the role of care coordinator is problematic because the PCP supply also lags behind demand.

Financing reform tied to quality enhancement

For a well-coordinated, sustainable multidisciplinary team approach to diabetes care, Summit speakers advocated for payment reform tied to quality measurement. Shortcomings in the present payment system include rewards for volume over value from fee-for-service payment, poor compensation for cognitive-oriented services, and no compensation or incentives for communication between patients and providers and among providers. Although several options for payment reform were discussed, all stressed the need to tie outcomes to resource allocation. Promising attractive options were: 1) risk-adjusted, per-patient payment, with incentives for achieving desired intermediate outcomes, such as unnecessary hospitalizations, with a reduction in overall costs; and 2) a

condition-based payment system that provides greater flexibility than the present system for services delivered to patients with diabetes while holding providers accountable for avoidable costs and outcomes. Some argued that pay-for-performance could be extended to patients. If healthy behaviors were rewarded, there could be reduced reliance on medical care, potential cost savings, and a net benefit to patients exercising self-management skills.

Promotion of new technology and discoveries

ACA-related requirements for information technology and electronic health records are particularly applicable to patients with diabetes because many patients have comorbidities and require management by multiple providers. Challenges involving implementation of new technologies such as insulin infusion devices and continuous glucose monitoring systems include cost and determination of appropriate use. Speakers urged rational use of emerging technologies, balancing the impact of new technology with the need for comparative effectiveness research in appropriate populations. Prevention of hypoglycemia, an adverse event now responsible for more hospital admissions than hyperglycemia, was cited as a major goal of these new technologies.

Conclusions About the Summit and ES Recommendations

- Diabetes outcomes and care models resulting from ACA implementation should be monitored systematically. Early data suggest that the ACA is increasing diabetes detection and diagnosis. Other ACA effects need to be monitored for lasting impact on outcomes and value to diabetes care.
- Continued investment in clinical and translational research on new diabetes care models should encourage multidisciplinary teams, telemedicine, and electronic communication between providers and patients. The ES recommends training more endocrinologists and midlevel providers to adequately support such care teams. The ES supports pilot studies by payers that feature team-based approaches to improving diabetes care by assisting the patient in achieving glycemic control, lessening hypoglycemic incidents, and preventing or managing comorbid conditions.
- Reimbursement should be reformed to link payments to the provision of integrated, comprehensive, guideline-compliant care and the achievement of appropriate intermediate and longer-term outcomes such as reductions in micro- and macrovascular complications.
- Prevention and management of diabetes and prediabetes should be better integrated into health systems and

other settings, such as community- and employer-based programs.

- Federal and other funding for research by the National Institutes of Health, the Agency for Healthcare Research and Quality, and the PCORI should be increased to address gaps in knowledge about diabetes care and promote the development of next-generation therapy options.
- Review and approval by the Food and Drug Administration (FDA) for treatments that address unmet needs in diabetes care should be accelerated. The ES recommends that the Centers for Medicare and Medicaid Services (CMS) and the FDA utilize a parallel review process to improve access to new diabetes therapies. This type of collaboration can lead to more rapid development of CMS coverage policies and funding for new technologies, including mobile and self-help tools for patients with diabetes.

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Address all correspondence and requests for reprints to: Alvin C. Powers, 7465 MRBIV, 2215 Garland Avenue, Nashville, TN 37232. E-mail: al.powers@vanderbilt.edu.

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