AACE DIABETES CARE MODEL (DCM)

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Chair, AACE Task Force on the Implication of MACRA Law for Members

AGENDA

- Introductions
- Impact of Diabetes on our Healthcare System
  - Defining the problem: Why diabetes
  - Why a physician-lead care team intervention is needed
- AACE Diabetes Care Model Presentation
  - Care Intervention/ study elements
  - Payment Methodology
- Question & Answer Session
- Discussion of Next Steps

In attendance: Felice A. Caldarella, MD, FACE, CDE, FACP
Michelle Cobb-King, BA, BS, MPA, MBA
Jill Rathbun
By telephone: Howard M. Lando, MD, FACE, FACP
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Promoting Quality and Value

The impact of diabetes on our healthcare system:

- 29 million Americans have diabetes
- Today 1 out of 9 adult Americans has diabetes; 1 out of 3 adult Americans will have diabetes by 2050, if the current trends continue
- 86 million Americans have pre-diabetes
- Today 3 out of 4 Americans with Medicare have diabetes or pre-diabetes
- $1 out of every $3 Medicare dollars is spent on diabetes
- The U.S. spent $245 billion in 2012 on diagnosed diabetes, a 41% increase over 5 years

Promoting Quality and Value - continued

The AACE analysis of 2014 Medicare claims data shows:

- 40% of Medicare beneficiaries had diagnosis of obesity, yet less than 1% received obesity counseling.
- Less than 10% received any diabetes self-management training.
- Only 60% showed evidence of self-management via Medicare paid supplies such as glucose test strips.
- Less than half had an annual eye exam.
- Over 10% never had their glycosylated hemoglobin (HgbA1C) tested.
- Historically, Endocrinologists have faced ***insufficient payment for diagnosis and treatment planning***, as well as a ***lack of payment for care management*** as barriers. This APM seeks to eliminate these barriers.

Promoting Quality and Value - continued

Table ES-2

Medicare fee-for-service beneficiaries with at least two primary care visits in 2014.

Presence of diagnoses and paid services on Medicare claims

By type of provider seen (diabetes center of excellence, other endocrinologist, some other physician)

	Centers of excellence (2+ primary care visits)	Other endocrinologists (2+ primary care visits)	Other physicians (2+ prim care visits)
Estimated count of Medicare fee-for-service diabetics	22,600	639,560	9,523,860
Total A+B spending	$ 19,480	$ 18,709	$ 18,876
Percent of persons:			
Diagnosis of obesity on claims	40%	38%	25%
Any obesity counseling	0.3%	0.4%	0.4%
Any nutrition counseling	11%	4%	1%
Diagnosis of current tobacco user	5.7%	7.2%	9.6%
Tobacco cessation therapy	1.1%	1.2%	1.5%
Any diabetes self-management training	8%	5%	1%
Any diabetes self-management supplies	60%	59%	29%
Diagnosis of eye complications	29%	22%	8%
Any eye exam	55%	49%	32%
Diagnosis of foot infection	11.5%	11.2%	7.9%
Diagnosis of foot ulcer	6.6%	6.2%	4.4%
Diagnosis of peripheral artery disease	9.2%	10.8%	9.1%
Diagnosis of neurological complication	43.3%	38.8%	16.2%
Any diabetic shoes	11.5%	12.0%	5.5%
Any test of blood lipids	84%	84%	69%
Any HgbA1C test	86%	89%	67%
Count of HgbA1C tests	2.43	2.53	1.38
Any glucose tolerance test	30%	15%	7%
Count of glucose tolerance tests	0.81	0.36	0.16

Source: Analysis of Medicare 5% sample LDS SAF claims and enrollment data, 2010 - 2014

Promoting Quality and Value - continued

- In total, patients with diabetes Medicare parts A and B 2014 per-capita costs were about $9,400 higher than those of patients without diabetes (or roughly 115% higher).
- Savings will be achieved via better coordination/ quality of care and reduced emergency room and/or hospitalizations.
- **Based upon the same 2014 Medicare data Endocrinologists caring for patients with diabetes save, on average, 18% versus other providers.**

Promoting Quality and Value - continued

Table 1: 2014 Medicare Part A & B Per-Capita Cost for Treatment of Diabetes by an Endocrinologist				
	% Individuals w/ each factor	Preventive care and Management Services	All Part A & B Services	Ratio, total to Primary Care & Preventive
Total Part A & B Spending		$445	$19,971	45
Intercept – Base Payment		$308	$3,832	13
Additional Payments Associated with:				
Uncontrolled diabetes	76%	$82	$2,179	26
Complications:				
Ketoacidosis	3%	$58	$14,548	253
Hyperosmotic Coma	1%	$92	$13,687	148
Renal	25%	$22	$12,799	583
Eye	25%	$55	$3,748	69
Neurological	42%	$62	$5,149	82
Circulatory	17%	$58	$9,923	172
Other and Unspecified	13%	$41	$15,882	388
Obesity	32%	$39	$7,177	185
Alternative model based on any complication				
Base payment – no complications		$360	$9,720	
Additional payment for patient with complications	69%	$122	$14,825	121
Alternative model based on any complication and uncontrolled diabetes				
Base payment – no complications, controlled		$302	$5,966	
Additional payment for patient with complications	69%	$104	$13,649	131
Additional payment for patient uncontrolled	76%	$94	$6,027	64
TOTAL:		$445	$19,971	
Source: Analysis of Medicare 0.5% sample LDS SAF claims and enrollment data, 2010 – 2014				

Promoting Quality and Value - continued

Table 2: Risk-adjusted difference in 2014 spending Patients with Diabetes under the care of an Endocrinologist versus other Providers			
	Estimated Impact	As % of mean	p-value
Total	-$3,440	-18%	***
By claim type:			
Inpatient (mostly acute care)	-$2,469	-36%	***
Carrier (includes physician, drugs, and other)	$411	8%	***
Outpatient (hospital OPD and dialysis facility)	-$49	-1%	***
Skilled nursing facility	-$1,037	-53%	***
Durable Medical Equipment	$72	14%	***
Home Health Agency	-$337	-34%	***
Hospice	-$32	-8%	***
*** = p < .001			
Comparison group is patients with diabetes with at least two primary care physician visits in the year. *Source: Analysis of Medicare 0.5% sample LDS SAF claims and enrollment data, 2010 – 2014*			

Scope of Proposed Payment Model

- AACE represents over 5,000 domestic physician members (caring for the vast majority of the estimated 11 million or 26% of people 65+ years of age with diabetes).
- The AACE Diabetes Care Model (DCM) is designed to be utilized primarily by endocrinologists; however, primary care physicians caring for a significant number of patients with diabetes would be eligible to participate.
- While the initial design of the AACE DCM was for physicians in private practice, it could very well be utilized by small to large scale organizations.

Scope of Proposed Payment Model - continued

The AACE DCM will be utilized test/address these problems:

- Assigned Diabetes Care teams
- Physician/ Patient Engagement Agreement
- Practice Eligibility Requirements
- Diabetes Specific Quality Measures

Integration & Care Coordination

Assigned **diabetes care teams** consisting of:

- Primary Care Physician
- Nephrologist
- Cardiologist
- Podiatrists
- Ophthalmologist
- Certified Diabetes Educator
- Dietitian
- Mental Health care professional
- Physician Assistant/ Nurse Practitioner

This is not an exhaustive list, the care team may consist of additional/ fewer members or others as needed. While these professionals are members of the care team, the payment referenced in this model is ***ONLY for the endocrine care/ diabetes provided by the physician APM participant.***

Patient Choice

Physician/ Patient Engagement Agreement

Physician's Commitment to the Patient

To create a culture that supports the patient's efforts to build and maintain healthy outcomes.

To be open, honest, and truthful when communicating with patients and those given access to their medical history in a clear, timely, supportive, engaged, and empathetic manner.

To provide care based on approved diabetes care guidelines.

To allow patients to actively participate in their own treatment planning and decision-making.

To treat the patient as you would like to be treated.

To provide 24/7 patient access to a member of the care team.

To consider the patient's emotional, mental, spiritual, and cultural well-being in the patient's treatment plan.

Patient's Commitment to Physician

To adhere to my treatment plan and strive for the best possible outcome(s) based on the treatment plan.

To be open, honest, and truthful in my interactions with the physician/ care team and staff.

To communicate with care team members/ staff as necessary and appropriate, especially after any incident(s) of acute care.

To heed physician's advice, recommendations, and warnings.

To be respectful of the physician's time and culture.

To schedule and attend all appointments with all care team members.

To actively participate in the treatment decision-making process.

To take medications as prescribed (and notify physician/ care team member if this is or becomes difficult.

Scope of Proposed Payment Model - continued

AACE DCM Practice Eligibility Requirements

- Use of CEHRT (Certified Electronic Health Record Technology) OR other method(s) of providing ALL measures.
- % of patients attributed to APM (20% in 2018; 35% in 2019; 50% in 2020 and beyond) ***OR*** % of payments through an APM (25% in 2018-19; 50% in 2020-21; 75% in 2022 and beyond).
- Care delivery activities must include: notifying patients of the members of their diabetes care team, providing 24/7 access for patients, documenting care plans, following up with patients post hospitalization or acute care, and quality improvement activities.

Initial patient panel size is, at a minimum, 20% of Medicare patients specifically being treated for diabetes with minimum number of 30 patients. Second year panel size must include a minimum of 35%. By year three (3), patient panel expected to reach 50% or more being treated specifically for diabetes.

Promoting Quality and Value - continued

Diabetes Specific Quality Metrics (these quality measures must be used)

Patient/ Family/ Caregiver Diabetes-based Education (15 pts.)

Physician/ Patient Engagement Agreement (see attached, updated annually or as needed) (10 pts.)

Diabetes Care Team Document (10 pts.)

Documentation of Care Team Interactions and/or Communications (10 pts.)

Cholesterol Management LDL</= 100 (10 pts.)

Glycemic management education (15 pts.)

A1c testing performed, at a minimum, three times per year (10 pts. each test)

Blood pressure goal, unless contraindicated for patient and documented: < 140/90 (15 pts.)

Vaccinations, unless patient refuses and is documented (5 pts. each):

- Influenza – Annually
- Pneumococcal polysaccharide – Once

Annual screenings for (5pts. each screening):

- Neuropathy
- Retinopathy (eye exams)
- Protein in urine (exclude if CKD4 or ESRD)
- Foot Exams, each visit

Office visits, at a minimum, twice annually or as needed (10 pts. each visit)

Training on warning signs of hypoglycemia episodes (10 pts.)

Diabetes Care Toolkit (5 pts.)

Diabetes Care Checklist (5 pts.)

Post hospitalization/ acute care incident coordination (10 pts.)

Semi-Annual review of patient's/ caregiver short and long term goals (5 pts. each review)

NOTE: If the endocrinologist does not receive a 70% composite score on their Quality Measure/Metric Report, then their reimbursement is decreased by three (3%) percent for participants in track 2. In order for endocrinologists to be eligible for Performance-Based Incentive Payment, they must exceed a composite score of 75%.

Patient Choice

- Patients will not be limited by the AACE DCM; they will be able to select members of the diabetes care team.
- Patients would be provided written documentation on the role of their care team members. The document would be updated as members of the team are added, deleted, or replaced.
- The AACE DCM also contains a *Physician/ Patient Engagement Agreement* which stipulates both patient's and physician's roles and expectations.

Patient Safety

The following algorithms and clinical practice guidelines were utilized in formulating the Diabetes Specific Quality Measures:

- AACE/ACE Comprehensive Type 2 Diabetes Management Algorithm
- AACE/ACE Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan
- Clinical Practice Guidelines for Healthy Eating for the Prevention and Treatment of Metabolic and Endocrine Diseases in Adults
- Clinical Practice Guidelines for Medical Care of Patients with Obesity
- AACE Medical Guidelines for the Clinical Use of Dietary Supplements and Nutraceuticals

Payment Methodology

Innovation Program – Track 1 (one-sided risk)

(an additional payment of $50 - $200 per patient/month, based on the severity of the disease and complications)

Four Payment Innovations Support Practice Transformations – Track 1 (one sided risk)

	Care Management Fee	**Quality-Based Incentive Payment**	**Underlying Payment Structure**
Innovation #1: (A1c <8, No complications)	FFS; plus an additional $50.00/per patient/per month to support patient needs	**5%**	Standard FFS
Innovation #2: (A1c <8, with complications)	FFS; plus an additional $100.00/per patient/per month to support patients with complex needs	**5%**	Standard FFS
Innovation #3: (Uncontrolled A1c >8, No complications)	FFS; plus an additional $100.00/per patient/per month to support patients with complex needs	**5%**	Standard FFS
Innovation #4: (Uncontrolled A1c >8, with complications)	FFS; plus an additional $200.00/per patient/per month to support patients with complex needs	**5%**	Standard FFS

NOTE: A composite score of 70% on the Diabetes Specific Quality Measure Report, then the reimbursement is decreased by three (3%) percent for participants in track 2. Physicians eligible for a Performance-Based Incentive Payment must exceed a composite score of 75%.

Payment Methodology

Care Management – Track 2 (two sided risk)

(a $150 – $350 payment per patient/month, based on the severity of the disease and complications)

Care Management Fees Determined by Risk Tier – Track 2 (two sided risk)

A New Patient Payment ($500/ patient) would be paid to cover all diagnosis, care planning and management, education, and support services prior to beginning treatment. (The costs of any diagnostic testing ordered by the physician would still be billed and paid separately.)	
Risk Tier Option#1: (Average $408.00 per month)	
Controlled A1c <8, No complications	30 DAY PAYMENT $150.00
Risk Tier Option#2: (Average $412.00 per month)	
Controlled A1c <8, with complications	30 DAY PAYMENT $250.00
Risk Tier Option#3: (Average $ 932.00 per month)	
Uncontrolled A1c >8, No complications	30 DAY PAYMENT $250.00
Risk Tier Option#4: (Average $1,013.00 per month)	
Uncontrolled A1c >8, with complications	30 DAY PAYMENT $350.00
Proposed Pay Back if Savings Target Not Met	**3%** of expected expenditures for which an APM Entity is responsible under the APM.

NOTE: A composite score of 70% on the Diabetes Specific Quality Measure Report, then the reimbursement is decreased by three (3%) percent for participants in track 2. Physicians eligible for a Performance-Based Incentive Payment must exceed a composite score of 75%.

Evaluation Goals

- Currently, the DCM has not been evaluated.
- However, the DCM does provide opportunities for physicians to be evaluated based upon the criteria in the Diabetes Specific Quality Metrics section.
- AACE welcomes the opportunity to pilot the DCM in order to fully evaluate and assess the viability of the model.

Integration & Care Coordination - continued

- Behavioral care, acute care, medication, appointment, and treatment coordination/planning would take place across the diabetes care team.
- Patients would be provided written documentation on the role of their care team members. The document would be updated as members of the team are added or replaced.

Flexibility for Practitioners

- The AACE Diabetes Care Model (DCM) is designed to utilized primarily by endocrinologists; however, primary care physicians caring for a significant number of patients with diabetes would be eligible to participate.
- While the initial design of the AACE DCM was for physicians in private practice, it could very well be utilized by small to large scale organizations.
- AACE does contend solo and extremely rural practices may struggle with certain aspects of the DCM; however, most aspects of the model, especially the quality metrics could/should be utilized to treat patients with diabetes.

Health Information Technology

- The AACE DCM promotes the utilization of CEHRT.
- The AACE DCM will require physicians to allow new care team members access to PHI; this issue will need to be addressed by the individual physician.
- This model relies greatly on the ability of care team members to access and review patient records; therefore, interoperability is imperative.

AACE Questions for CMS