CONFERENCE SUMMARY

Financing the Care of Diabetes Mellitus in the 1990s

A national conference titled "Financing the Care of Diabetes Mellitus in the 1990s" was held in Washington, DC, 3–5 December 1989. The meeting was attended by over 340 individuals representing health-care providers, the reimbursement community, consumers, and others interested in the problems associated with financing diabetes care. The meeting was cosponsored by the American Diabetes Association, the American Association of Diabetes Educators, the American Dietetic Association, the Centers for Disease Control, and the National Diabetes Advisory Board. The conference was designed to build on the outcomes of the first conference, held in 1984.

The conference objectives were to *1*) review the current status of factors affecting the financing of quality health care for people with diabetes; *2*) identify the major financing problems affecting the implementation of standards of care, the delivery of outpatient education, the development of ambulatory-care systems, the implementation of effective hospital-admission criteria, and access to health-care coverage; *3*) determine strategies that will chart a course to improve the financing of care for people with diabetes mellitus over the next decade; and *4*) summarize the conference outcomes to enable written dissemination of the strategies and recommendations and expedite their implementation.

Fifty-five invited speakers, moderators, and panelists contributed expertise during plenary sessions that provided background information regarding the five topics listed in objective *2*. In covering these topics, plenary speakers noted the following central concepts that will influence the delivery of health care over the next decade and beyond.

- National health-care expenditures are rising more rapidly than general inflation, averaging 10.6%/yr since 1980 and consuming >11.3% of the United States gross national product in 1988.
- Major government and private insurance groups have embarked on cost-containment strategies that include both control of utilization of health-care services (case management) and control of costs (limits on provider fees, discounted fees by preferred provider organizations, and prospective payment).
- Cost containment will have deleterious effects on the quality of health care unless reimbursers consider quality aspects of services when making coverage decisions. Other aspects they must consider are clinical effectiveness, cost effectiveness, and the demand by purchasers of health insurance.
- Lack of insurance coverage compromises health-care delivery. More than 15% (31.1 million) of the U.S. population is uninsured. This barrier to care is even more important for racial minority groups with an increased prevalence of diabetes: 22% of Blacks and >31.5% of Hispanics are uninsured, compared to 12.4% of Whites.
- The elderly population aged ≥65 yr has increased and will continue to increase as a proportion of the U.S. population: from 10% in 1970 to 13% in 1990 to 22% in 2030. The projected increase in total nursing-home expenditure is 197% over the next 30 yr: the $14 billion average annual expenditure for Medicaid between 1986 and 1990 will increase to $46 billion/yr between 2016 and 2020—a 228% increase.
- Diabetes in the diagnosed population aged ≥65 yr is projected to increase from 3.3 million people in 1990 to 4.1 million in 2010 to 6.8 million by 2030.
- The sum of the direct and indirect costs for medical care, morbidity, disability, and mortality associated with diabetes was $20.4 billion in 1987.

Workshops that followed the plenary sessions focused on the major topics, and each was attended by over 50 people. Panelists and abstract presenters made brief presentations, allowing adequate time for the entire group of attendees to work together to identify and discuss important issues and strategies related to each topic. The key outcomes of these workshops are presented herein. Major issues are briefly described, followed by recommended strategies.

ISSUE A: There is a lack of fit between the needs of people with diabetes and the means of providing and reimbursing services under the prevailing acute disease or "medical" model.

The current emphasis on third-party reimbursement for acute short-stay hospitalization and diagnostic or therapeutic procedures should change to reflect the ongoing, mostly outpatient, health-care services provided for patients with a chronic disease. The need to increase fee-for-service reimbursement for cognitive services of the primary-care physician is well documented.

Strategies

1. Develop a health-care delivery model for diabetes that would also be applicable to other chronic diseases. The inclusion of preventive services, outpatient education, and reimbursement of nonphysician health professionals would be important. The development of an effective model will require innovation and creativity to confront limited resources and the emerging payment systems for services provided in managed care, preferred provider, and health maintenance organizations.
2. Support current efforts to reform the Medicare physician-payment system through the establishment of a resource-based relative-value scale that will reimburse physicians for cognitive services and include provider codes for nonphysician health professionals involved in team care and essential patient-education services.

ISSUE B: Communication problems between the diabetes community and the insurance community are impeding progress toward resolution of unmet insurance coverage needs.

Frequently, health professionals focus on quality of care and service delivery, whereas insurers focus more on concerns related to cost containment. Cooperative efforts will be needed to provide comprehensive, clinically effective, and cost-effective services.

Strategies

1. Establish a national forum via the Centers For Disease Control (CDC) Financing Coordinating Committee that will involve the diabetes community and reimbursement decision makers to ensure ongoing communication and exchange of ideas and information. Members should reach a consensus regarding the terminology to be used in negotiations. The forum might recommend coverage decisions and reimbursement packages, as well as studies of the clinical and cost effectiveness of different delivery patterns and service components. Members of the forum should include representatives of the conference cosponsors, other interested organizations from the diabetes community, government and private insurers, prepaid organizations, employers, and consumers. Input from case managers, benefits managers, and hospital utilization reviewers should be obtained.

ISSUE C: There is an urgent need to implement the guidelines and standards of care for diabetes that have been developed by several organizations.

Implementation mechanisms must ensure that most people with diabetes receive care that meets these minimal standards and that the care providers receive reimbursement.

Strategies

1. Professional standards should be reviewed and updated in a timely manner and new standards developed as appropriate. They should be disseminated widely to health professionals and reimbursers.
2. Standards should ideally identify screening indicators for low versus high risk and adjust required frequencies of service accordingly.
3. Coalitions should be formed between health-professional organizations to implement different components of the diabetes standards. For example, the American College of Obstetricians and Gynecologists and the Society for Perinatal Obstetricians could be involved in a coalition to implement standards related to diabetic pregnancies.
4. Implementation should occur in different health-care delivery settings, including the traditional fee for service offices, group practices, and academic centers, as well as health maintenance organizations and preferred provider organizations. Variability of socioeconomic and ethnic characteristics within populations must also be taken into consideration.
5. Reimbursers should be kept informed of the implementation progress via the forum described in ISSUE B.

ISSUE D: The responsibility for ensuring that quality care is delivered should not rest solely with the provider; patients must demand quality diabetes care and become more involved in reimbursement decision making.

The demand for health benefits by consumers is already a potent influence in the market for health insurance.

Strategies

1. Include informed consumers in coalitions to implement standards of care.

2. Involve patients as consumer advocates when addressing the need to modify reimbursement patterns and practices.
3. Motivate patients to demand education for self-management as part of a health-care benefits package.

ISSUE E: There will be a continuing need to justify quality diabetes services.

Studies in the literature are often inadequate or inappropriate. Research should produce results that are useful for making policy decisions regarding reimbursement. Summaries of findings should be disseminated widely.

Strategies

1. Maintain and disseminate the Diabetes Outpatient Education Reimbursement data base developed by CDC in response to the 1984 conference. Consider expanding the data base to include data on program costs, outcomes of different kinds of delivery systems, cost-effectiveness studies, and health-care utilization patterns.
2. Conduct cost-effectiveness analyses for different programs, particularly those that address detection, treatment, and rehabilitation of patients with diabetic foot and eye complications.
3. Identify data needs regarding the clinical effectiveness and cost effectiveness of specific aspects of standard diabetes care. Promote the design and funding of studies to fill identified gaps.

ISSUE F: The diabetes community supports the concept that a multidisciplinary team of health-care professionals is frequently the most effective vehicle for the provision of quality diabetes patient care, particularly in the outpatient setting.

Patient education for self-management is an essential component of diabetes treatment that is often provided by nonphysician health professionals, primarily nurses and dietitians. There is apparent confusion in the reimbursement community about the essential role of patient education, the most appropriate providers of education, and the cost-effectiveness of quality education programs. The absence of appropriate Current Procedural Terminology codes hinders the reimbursement of these essential services.

Strategy

1. Support current efforts to reform the Medicare physician-payment system through the establishment of a resource-based relative-value scale that will reimburse physicians for cognitive services and include provider codes for nonphysician health professionals involved in team care and essential patient-education services.
2. Reach a consensus with the insurance community regarding appropriate terminology for essential patient-education services to enable nationwide reimbursement of this aspect of diabetes treatment.
3. Continue to identify quality patient-education programs that meet national standards and health professionals who achieve certification.

ISSUE G: The problems of the uninsured and underinsured population are sufficiently large that they are essentially beyond the purview of this conference.

Poverty, low income, and poor housing have a profound effect on disease susceptibility, and often such population groups receive inferior medical services, in part because they do not have insurance. However, because of the prevalence of diabetes in particular subgroups of this population (i.e., Blacks, Hispanics, Native and Asian Americans, and the elderly), mechanisms to ensure their access to quality health care are imperative.

Strategies

1. Support local, regional, and national efforts to target services to the disadvantaged.
2. Develop programs that address the needs of elderly and minority populations with diabetes to ensure that they are screened, educated, treated, and rehabilitated as necessary.
3. Focus efforts on health promotion and disease-prevention programs. Effective programs should have a significant impact on morbidity and costs associated with diabetic pregnancies, lower-limb disease, blindness, kidney failure, and other chronic complications.

CONCLUSION

Although significant progress in addressing financing issues that affect diabetes has been made since the last meeting, participants at this conference identified important new and ongoing problems. Whereas all the conference goals were met, the identification of realistic strategies to address key issues was a particularly important outcome. It is these strategies that can guide a nationwide effort to improve the financing of the care of diabetes mellitus in the 1990s. The Financing Coordinating Committee sponsored by CDC will take a leadership role in overseeing the implementation of the many ideas generated during the conference and summarized in this report. The conference cosponsors and others will continue to be members of this committee, and each will contribute their expertise and assume considerable responsibility as specific plans to carry out the strategies are formalized. Publishing the conference proceedings and periodic progress reports will be an important priority.