Improving diabetes care by testing a new remuneration scheme for endocrinologists

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ABSTRACT

Everyone agrees that paying for services on a fee-for-service basis doesn't do enough to promote the delivery of high-value care. An alternative payment scheme for endocrinologists was developed by Our Enterprise, an integrated payer-provider with headquarters in Pittsburgh. In line with our strategy, endocrinologists' responsibilities will gradually transition from clinical to more collaborative roles with their primary care counterparts. This change enables endocrinologists to assist primary care physicians in managing patients with diabetes and other endocrine-related illnesses while reducing the number of traditional in-office referrals to endocrinology. This is because the majority of patients with diabetes are managed under primary care.

Despite the unforeseen changes brought on by COVID, we saw its effects on care delivery and the connection between participating specialists and PCPs throughout the first nine months of the compensation model. Improvements in diabetes-specific quality indicators have been observed in practice- and provider-level quality data. 16 target practises of the 54 target practises received NCQA recognition for managing diabetes in just one year. 88% of all participating PCPs reported being at least 90% satisfied with the new plan. In the end, our model holds promise as a substitute for fee-for-service remuneration, with a chance of reducing costs and raising treatment quality.

Key Words: *Model of compensation; Care for diabetes; Health care provision*

OPINION

The United States has some of the highest healthcare spending per person in the world. With health care spending reaching $3.8 trillion in 2019 and accounting for 17.7% of total gross domestic product, costs have been rapidly increasing. The United States has failed to provide the finest quality of healthcare in the world despite its high health care spending. The United States ranks last in terms of access to care, administrative efficiency, equity, and health care outcomes, according to an analysis comparing the performance of health care systems in 11 high-income countries. The United States has some of the most cutting-edge research, technology, and facilities in the world, but our healthcare outcomes have fallen short of these capabilities.

One of the main contributors to the nation's expensive health care expenses is the fee-for-service remuneration system. The National Commission on Physician Payment Reform was established in March 2012 by the Society of General Internal Medicine to investigate the variables affecting such expenditures throughout the healthcare system. Although they found a number of significant causes, fee-for-service reimbursement stood out among them. There is general agreement that fee-for-service reimbursement does not do enough to promote the delivery of effective, high-value care because it gives doctors no incentive to refuse services, even if they are exorbitantly expensive and have uncertain benefits. Instead, the current system encourages a rise in service volume, discourages care coordination, and supports ineffective delivery.

Switching to a different type of physician compensation from the fee-for-service approach Providing better care while reducing overall health care spending is promised by a system in which cost reductions and quality of care are seen as benchmarks. In other words, focusing on the doctor immediately decreases expenses by cutting out on unnecessary care. The Medicare Access and CHIP Reauthorization Act, passed by Congress in 2015 with the goal of basing Medicare reimbursement on results and value, has been the attention of various groups, including the U.S. government. The goal of this legislation and numerous other measures is to meet the triple aim of healthcare by better patient experience, enhancing population health, and reducing per capita expenses, however they have not yet demonstrated themselves with long-lasting results.

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Our updated compensation scheme

An endocrinologist would get a conditional incentive payment under the terms of our suggested contract in exchange for their efforts as determined by specified performance criteria. While the plan implements a revolutionary value-based payment structure, it also brings about another practical change in workflow by assisting primary care doctors in managing diabetes and other endocrine-related diseases from a population-based perspective. As was already indicated, switching to a new model should be gradual, with fee-for-service payments to doctors continuing to be essential during this time. As a result, our team started putting this change into practise by establishing two distinct tracks of compensation: transformative and clinical.

Track for transformation

Participants in this programme divided their time between clinical and non-clinical responsibilities 60/40. Endocrinologists are only required to do clinical tasks three days a week, freeing them the other two days for their other commitments. A shared care approach unites each participating endocrinologist with a number of primary care offices in a specified area. The endocrinologist conducts twice-yearly visits to each of the designated practises with the following objectives: ensuring that these practises have the necessary tools to manage patients with diabetes; engaging PCPs in evidence-based discussions; and providing ongoing support through resources like e-Consults and standardized treatment algorithms. This strategy will enable a positive and long-lasting relationship between PCPs and the endocrinologist they have been assigned. Base salary, a productivity bonus, and compensation for non-clinical duties make up the total compensation for the transformative track.

1. Goals for productivity and base pay, The Medical Group Management Association survey findings were first used to calculate the total compensation, which was set at the 50th percentile of the compensation reported in the survey for the previous year. It was decided that the base salary would represent 60% of the estimated total compensation. Relative-value units, which are equivalent to 60% of the 50th percentile Rvu count as established by the Mgma survey, were used to set the productivity goal.
2. Productivity bonus: If physicians exceed the Rvu cutoff set by base salary, they may be eligible for additional compensation.
3. Payment for non-clinical work. When specified obligations are satisfied, this percentage of money is delivered quarterly to participating endocrinologists.

Clinical pathway

Fee-for-service remuneration is still a crucial component of this approach since it lessens the impact on provider access and allays any worries that providers may have about the change. The clinical track provides a substitute for endocrinologists who may be reluctant to assume the non-traditional role that the transformative track needs, even if the objective is to have all doctors on this track. Base salary, productivity bonuses, and a quality bonus make up total remuneration.

1. Goals for base pay and productivity. The Mgma survey findings were used to calculate base wage, with total compensation equal to the 50th percentile of salaries reported in the survey the previous year. Relative-value units equal to the survey's 50th percentile Rvu count were used to calculate the productivity target.
2. Quality bonus. If the doctor is able to meet preset quality metrics, patient satisfaction survey targets, and abide by the network and division regulations and procedures, additional pay is given out at the conclusion of the calendar year.
3. Productivity bonus: If physicians exceed the Rvu cutoff established for base salary, they may be eligible to receive additional compensation.

DISCUSSION

Our already overworked and expensive healthcare system continues to face challenges from the increased prevalence of endocrinopathie, diabetes mellitus, and the enormous costs required to address this epidemic. It is more important than ever to be aware of the expenditures associated with diabetes and how they affect overall healthcare costs given that these numbers are predicted to rise. Greater care coordination and a shared-care strategy for the management of chronic diseases are necessary to reduce these expenses. Our programme offers participating specialists the chance to interact with their primary care partners and streamline practise patterns across the network in accordance with standards of care by upending the fee-for-service model and placing a strong emphasis on care coordination. In addition, our plan keeps pay at levels that are consistent with fair market value and commercially reasonable standards while providing high-value treatment.

The quantity of referrals for diabetes education significantly increased as a result of diabetes education promotion in the primary care environment. Because patients are more knowledgeable about their disease process and are more actively involved in managing their chronic condition, we can infer that this trend will enhance diabetes care over time and decrease the start or worsening of diabetic complications. Longer follow-up will be required to show our model's genuine impact, though. Last but not least, our participating endocrinologists mentioned that they experienced more professional and personal fulfillment with this model than with the prior fee-for-service model, highlighting its potential to reduce burnout over time.

CONCLUSION

It is necessary to alter the way our doctors are paid, ideally moving toward a system that encourages good results by giving experts the resources they need to organize care or provide it more effectively. Our new endocrinologist pay plan offers an alternative to the customary fee-for-service approach while gradually doing away with fee-for-service remuneration. In this model, the role of medical specialists gradually transitions from clinical responsibilities to a more collaborative role with their primary care colleagues. By supporting PCPs in managing their patients with diabetes and other endocrine-related disorders, assisting them in meeting their quality goals, and reducing the amount of conventional in-office referrals to endocrinology, this change is likely to cut costs and enhance quality. While lower income may initially result from fewer specialist consultations, this effect will probably be offset or surpassed by lower endocrinology costs and improved overall treatment.