Payer-Provider Risk-Sharing Agreements to Advance Continuous Glucose Monitoring-Based Care in Type 2 Diabetes

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BACKGROUND

Optimal diabetes management may be impeded by the underutilization of advances in care interventions, including continuous glucose monitoring (CGM). In addition, recent trends toward payment reform in the care of chronic conditions—including risk-sharing agreements—seek to mitigate quality-related barriers to optimal diabetes management.

OBJECTIVE

To identify current best practices and pragmatic risk-sharing agreement parameters for CGM regarding practice setting, target population, clinical measures, and adjacent personnel.

METHODS

An expert panel of 4 payer and 6 provider stakeholders was convened to discuss opportunities for CGM-based care management in risk-sharing agreements between payers and providers. The panelists were surveyed before 2 virtual roundtable meetings, during which pertinent clinical and trend data were shared.

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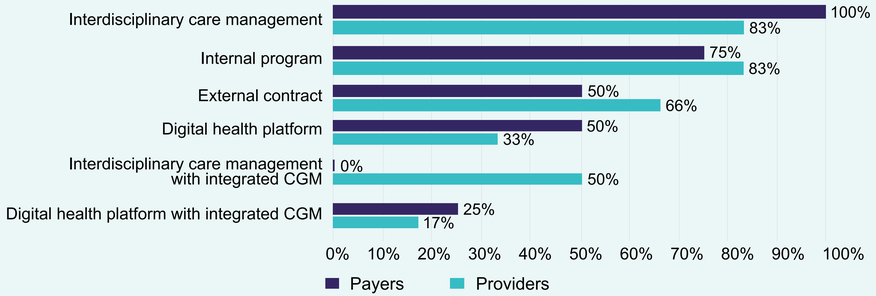
PRE-MEETING SURVEY RESULTS

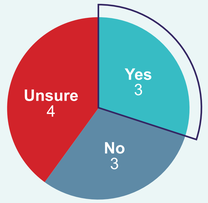
N=10 (6 providers, 4 payers)

Internal Care Management Programs Were the Most Commonly Implemented Care Delivery Solution Among Payers and Providers



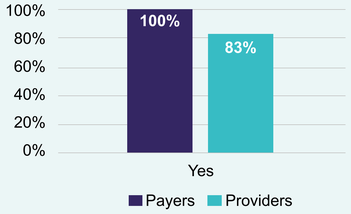
Q. Specific to diabetes management, what types of care delivery solutions have you implemented in the past or are currently implementing? (Select all that apply.)

Only 30% Felt That Self-Monitoring With Fingersticks Was Adequate for Use in T2D Care Management Programs



Q. Is self-monitoring of blood glucose with fingersticks adequate as a glucose assessment tool for your current care delivery solution?

Nearly All Payers and Providers Believed CGM Would Improve Care Delivery Programs



Q. Would CGM as a glucose assessment tool improve your current care delivery solution?

RESULTS

All payer participants cited using interdisciplinary care management for type 2 diabetes (T2D) and 50% used a digital health platform, but only 25% featured an integrated CGM component. All payer participants responded that "fingerstick" glucose management was either inadequate or questionable for use in current care management programs for T2D. Conversely, 100% also responded that CGM would improve their care delivery solutions. Expert panelists outlined 3 key elements of risk-sharing agreements: agreement design, realistic outcomes measures, and strategies to facilitate payer and provider participation.

Agreement Design	Outcomes Measures	Strategies to Facilitate Participation
Setting • Specialty care clinics • Primary care **Target population** • T2D NIT, HbA1c>8% **Measures** • HbA1c • GMI **Personnel** • PCPs • CDEs • Pharmacists	Traditional and sophisticated measures should be used in tandem: • HbA1c is widely recognized and accepted but has limitations as a standalone measure • GMI is not well understood outside of the diabetes specialty but offers advantages over HbA1c alone	• Education on CGM and exposure to the technology in the primary care setting • Integrating CDEs and pharmacists as part of a larger care team with the oversight of an endocrinologist • Internal support from information technology to coordinate referrals, data collection, and monitoring

T2D NIT=non-insulin-treated type 2 diabetes; HbA1c=hemoglobin A1c; GMI=glucose management indicator; PCPs=primary care providers; CDEs=certified diabetes educators

CONCLUSIONS

The panel recommended that future programming and risk-sharing agreements focus on an appropriate patient population, attainable measures, and coordination among interdisciplinary personnel to facilitate successful and sustainable T2D management. The anticipated result of implementing these key elements of a risk-sharing agreement is improved clinical outcomes via the facilitation of care coordination, data reporting, and the implementation of interventions to address social determinants of health.