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## Forecasting the Value of Podiatric Medical Care in Newly Insured Diabetic Patients During Implementation of the Affordable Care Act in California

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**Background:** Because value-based care is critical to the Affordable Care Act success, we forecasted inpatient costs and the potential impact of podiatric medical care on savings in the diabetic population through improved care quality and decreased resource use during implementation of the health reform initiatives in California.

**Methods:** We forecasted enrollment of diabetic adults into Medicaid and subsidized health benefit exchange programs using the California Simulation of Insurance Markets (CalSIM) base model. Amputations and admissions per 1,000 diabetic patients and inpatient costs were based on the California Office of Statewide Health Planning and Development 2009-2011 inpatient discharge files. We evaluated cost in three categories: uncomplicated admissions, amputations during admissions, and discharges to a skilled nursing facility. Total costs and projected savings were calculated by applying the metrics and cost to the projected enrollment.

**Results:** Diabetic patients accounted for 6.6% of those newly eligible for Medicaid or health benefit exchange subsidies, with a 60.8% take-up rate. We project costs to be \$24.2 million in the diabetic take-up population from 2014 to 2019. Inpatient costs were 94.3% higher when amputations occurred during the admission and 46.7% higher when discharged to a skilled nursing facility. Meanwhile, 61.0% of costs were attributed to uncomplicated admissions. Podiatric medical services saved 4.1% with a 10% reduction in admissions and amputations and an additional 1% for every 10% improvement in access to podiatric medical care.

**Conclusions:** When implementing the Affordable Care Act, inclusion of podiatric medical services on multidisciplinary teams and in chronic-care models featuring prevention helps shift care to ambulatory settings to realize the greatest cost savings. (*J Am Podiatr Med Assoc* 106(3): 163-171, 2016)

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A key component of the Patient Protection and Affordable Care Act (ACA) of 2010 focuses on providing health insurance to the millions of uninsured Americans. This provision was addressed by eliminating preexisting condition exclusions, expanding the Medicaid program, establishing minimum health insurance coverage requirements, and creating state-based or federally facilitated health benefit

exchanges (HBEs), which include tax subsidies to qualifying individuals. Each state has the authority to determine whether to implement Medicaid expansion to low-income families up to 138% of the federal poverty level. Meanwhile, HBEs offered tax subsidies for those with earnings up to 400% of the federal poverty level without access to employer-sponsored plans or with limited access due to high costs.

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Based on these health insurance coverage opportunities and the individual mandate requiring health insurance, forecasting of health insurance program enrollment has been performed using national microsimulation models. However, the California health-care market differs from the national market, decreasing the validity of the national models.<sup>1</sup> The California Simulation of Insurance Markets (CalSIM) model was designed to account for the diverse

California population and other previously enacted health reform changes by weighting data sets specific to the California population using similar methods as the national models.<sup>1</sup>

Diabetes mellitus is highly prevalent in minority and lower-income populations, which are projected to benefit most from the new insurance programs. Overall, the prevalence of diabetes increased from 3.8% to 8.7% between 1998 and 2010, and it is expected to continue rising.<sup>2</sup> Despite the well-documented value of podiatric medical care in adult diabetic patients, the California legislature eliminated podiatric medical care to the adult Medi-Cal population before the ACA. This projected cost savings neglects the documented value of podiatric medical care in adult diabetic patients. Studies demonstrate that podiatric medical care involvement in collaborative, multidisciplinary team-based care decreases cost, admissions, and length of stay (LOS) in acute-care facilities and skilled nursing facilities (SNFs).<sup>3-5</sup> Clinically, podiatric medical care increases survival rates and decreases amputation rates.<sup>3,4,6</sup>

This study was designed to forecast the cost and potential savings of improved quality of care for adults with diabetes-related foot complications in California who are projected to enroll in the health insurance programs developed to implement the ACA.

## Methods

We used CUPID 2.0 software (SpeedTrack Inc, Placentia, California) to identify patients in the 2009-2011 Office of Statewide Health Planning and Development (OSHPD) public patient discharge data files who were aged 18 to 64 years and had an *International Classification of Disease, Ninth Revision, Clinical Modification* code for diabetes mellitus (250.xx) and a related foot complication code (94.0, 357.2, 440.23, 443.8, 681.1, 682.6, 682.7, 707.10-707.15, 707.19, 713.5, 730.06, 730.07, 730.16, 730.17, 730.26, 730.27, 730.86, 730.87, 730.96, 730.97, 785.4, or 84.10-84.17).

Lower-extremity amputations per 1,000 diabetic patients served as the clinical quality measure, and acute-care and SNF admissions per 1,000 diabetic patients served as resource use metrics. These metrics were calculated using the prevalence of diabetes in California and the 2009-2011 OSHPD discharge files. The prevalence of diabetes was derived from the 2009-2011 California population<sup>7</sup> and the 2009 California Health Interview Survey diabetes prevalence (8.5%).<sup>8</sup> The prevalence of

diabetes may be underestimated because the OSHPD discharge files rely on accurate coding by the hospitals and the California Health Interview Survey relies on self-reported data, which may neglect undiagnosed cases.<sup>9</sup> Per 1,000 diabetic patients, we calculated averages of 1.52 amputations (range, 1.52-1.62); 9.72 hospital admissions (range, 9.39-10.02); and 1.27 SNF admissions (range, 1.25-1.30). The cases identified were divided into three categories: uncomplicated acute-care stay, discharged to SNF, and lower-extremity amputation during acute-care stay. The SNF admission measures were based on the discharge status reported in the OSHPD acute-care discharge files, although this may underestimate admissions. Using the charges and cost-to-charge ratios from the OSHPD files, an average cost of care during the inpatient stay for each category was determined for each year. The average LOS was also determined for each category.

The CalSIM version 1.8 base model scenario was used to forecast the number of uninsured individuals younger than 65 years with diabetes mellitus who are eligible to enroll and those who will enroll in Medi-Cal and subsidized HBEs from 2014 to 2019. The CalSIM model weights nationally representative data from the Medicare Expenditure Panel Survey-Household Component using the 2009 California Health Interview Survey and the 2010 California Employer Health Benefits Survey to provide a model specific to the California population. Details of the CalSIM model are described in previous literature and health policy briefs.<sup>1,10,11</sup> Although actual enrollment in California's HBE, known as Covered California, surpassed the base model first-year projections in many demographic groups, we used the base scenario to project a conservative use and financial model.

The incidence of amputations, acute-care admissions, and SNF admissions was forecasted in the uninsured diabetic population newly eligible and enrolled in Medi-Cal and HBE programs by applying the clinical and use metrics to the CalSIM model projections. We assumed that, conservatively, the newly insured population could achieve a 10% reduction in amputations and admissions as a result of improved quality of care and increased access to preventive care. To account for the barriers to accessing podiatric medical care, such as awareness of the need for specialized foot care and limited access to care, we also assumed a 41.0% utilization rate of podiatric medical services among the newly insured.<sup>12</sup> Additional forecasting was performed to determine the impact of greater

improvements in clinical quality, use, and access to specialized foot care.

The inpatient costs for each category were used to project the total cost of care and potential savings with access to podiatric medical care. The calculations depended on the 2009-2011 OSHPD files, which showed that 71.3% of discharges were uncomplicated, 15.6% of patients had an amputation during the inpatient stay, and 79.5% of those discharged to an SNF did not undergo an amputation during the inpatient stay.

## Results

The CalSIM base model forecasts the eligible and enrolled diabetic and nondiabetic populations for Medi-Cal and subsidized HBE programs until 2019, when all of the provisions of the ACA are fully implemented (Table 1). The diabetic population is projected to constitute 6.6% of the nearly 3 million uninsured individuals eligible for Medi-Cal and subsidized HBE programs. A take-up rate of 60.8%

is projected in the diabetic population compared with 44.7% in the nondiabetic population. In Medi-Cal-eligible individuals, 7.6% are projected to have diabetes, with a 48.1% take-up rate, and 40.4% of nondiabetic patients are expected to enroll. The CalSIM model forecasts that 5.6% of those eligible for subsidized HBE programs will be diabetic, with a higher take-up rate in the diabetic population (76.7% versus 48.5%).

The 18- to 29-year-old demographic group represents 32.3% of eligible individuals, but only 0.9% are projected to have diabetes mellitus. Latinos compose nearly two-thirds of individuals eligible for Medi-Cal or subsidized HBE programs, 6.7% of whom have diabetes. Latinos account for 63.9% of the eligible diabetic population and 58.1% of diabetic patients enrolled in Medi-Cal and subsidized HBE programs. Diabetic individuals aged 50 to 64 years have the highest take-up rate of any age group (68.6%) and account for 52.6% of eligible diabetic patients. In the subsidy-eligible HBE diabetic population, 41.2% have an income of 139%

**Table 1. CalSIM Model Forecast of Uninsured Diabetic Californians Younger than 65 Years Expected to Enroll in and Those Eligible for Medi-Cal and Subsidized Health Benefit Exchange Programs by 2019<sup>a</sup>**

Factor	Medi-Cal		Health Benefit Exchange	
	Take-up (No. [%])	Eligible (No. [%])	Take-up (No. [%])	Eligible (No. [%])
Total	52,000 (48.1)	108,000	66,000 (76.7)	86,000
Sex				
Male	23,000 (44.2)	52,000 (48.1)	31,000 (75.6)	41,000 (47.7)
Female	29,000 (51.8)	56,000 (51.9)	35,000 (77.8)	45,000 (52.3)
Age (years)				
18–29	2,000 (22.2)	9,000 (8.3)	<500	<500
30–39	6,000 (33.3)	18,000 (16.7)	7,000 (100.0)	7,000 (8.1)
40–49	11,000 (39.3)	28,000 (25.9)	23,000 (74.2)	31,000 (36.0)
50–64	33,000 (61.1)	54,000 (50.0)	37,000 (77.1)	48,000 (55.8)
Race/ethnicity				
Latino	32,000 (46.4)	69,000 (63.9)	40,000 (72.7)	55,000 (64.0)
Asian	1,000 (50.0)	2,000 (1.9)	2,000 (66.7)	3,000 (3.5)
Black	6,000 (66.7)	9,000 (8.3)	3,000 (100.0)	3,000 (3.5)
White	9,000 (40.9)	22,000 (20.4)	17,000 (81.0)	21,000 (24.4)
Other	4,000 (66.7)	6,000 (5.6)	4,000 (100.0)	4,000 (4.7)
Income (% of the FPL)				
≤100	27,000 (35.5)	76,000 (70.4)	0	0
101–138	25,000 (78.1)	32,000 (29.6)	<500	1,000 (1.2)
139–200	0	0	31,000 (88.6)	35,000 (40.7)
201–250	0	0	15,000 (71.4)	21,000 (24.4)
251–400	0	0	19,000 (65.5)	29,000 (33.7)
≥401	0	0	0	0

Abbreviations: CalSIM, California Simulation of Insurance Markets; FPL, federal poverty level.

<sup>a</sup>Values do not necessarily sum to 100% because of rounding.

to 200% of the federal poverty level, and 29.6% of Medi-Cal eligible individuals have an income of 101% to 138% of the federal poverty level.

The OSHPD files contained 92,531 diabetic patients discharged from an acute-care stay with a diabetic foot-related complication. During the hospital stay, there were 14,453 amputations, and 12,063 patients were discharged to an SNF, 20.5% of whom had an amputation while in acute care. Amputations occurred in 15.6% of all acute-care admissions, increasing from 15.3% in 2009 to 16.2% in 2011. Table 2 shows the demographic character-

istics of these diabetic patients. Inpatient costs were 94.3% higher in patients undergoing an amputation while an inpatient (\$35,089; range, \$33,508–\$35,906) compared with uncomplicated admissions (\$18,057; range, \$17,662–\$18,206) and 46.7% higher for patients discharged to an SNF (\$26,490; range, \$25,625–\$27,362). The cost of care increased only 3.1% for uncomplicated admissions between 2009 and 2011 but 7.2% and 6.8% for patients undergoing an amputation or discharged to an SNF, respectively, during those same years. The average LOS was higher for patients who underwent

**Table 2. Demographic Characteristics of Diabetic Patients Admitted to Acute-Care Facilities in California: 2009-2011<sup>a,b</sup>**

Characteristic	2009		2010		2011		Total	
	No.	%	No.	%	No.	%	No.	%
<b>Age (years)</b>								
<20	46	0.2	27	0.1	41	0.1	114	0.1
20–29	468	1.6	535	1.7	531	1.7	1,534	1.7
30–39	1,693	5.7	1,812	5.9	1,835	5.7	5,340	5.8
40–49	5,572	18.9	5,767	18.7	5,889	18.3	17,228	18.6
50–64	17,203	58.3	18,170	58.8	19,005	59.2	54,378	58.8
Redacted	4,529	15.3	4,593	14.9	4,815	15.0	13,937	15.1
<b>Sex</b>								
Male	15,063	51.0	16,011	51.8	16,757	52.2	47,831	51.7
Female	8,478	28.7	8,694	28.1	8,867	27.6	26,039	28.1
Redacted	5,970	20.2	6,199	20.1	6,492	20.2	18,661	20.2
<b>Race</b>								
American Indian, Alaskan Native	61	0.2	91	0.3	85	0.3	235	0.3
Asian/Pacific Islander	585	2.0	622	2.0	619	1.9	1,875	2.0
African American	2,416	8.2	2,454	7.9	2,343	7.3	7,313	7.9
Other	3,189	10.8	3,269	10.6	3,568	11.1	10,026	10.8
Unknown	51	0.2	74	0.2	75	0.2	200	0.2
White	12,696	43.0	15,647	50.6	16,072	50.0	46,485	50.2
Redacted	8,443	28.6	8,749	28.3	9,205	28.7	26,397	28.5
<b>Ethnicity</b>								
Hispanic or Latino	6,695	22.7	7,001	22.7	7,595	23.6	21,291	23.0
Non-Hispanic or Non-Latino	13,175	44.6	13,850	44.8	14,036	43.7	41,061	44.4
Unknown	59	0.2	60	0.2	86	0.3	205	0.2
Redacted	9,582	32.5	9,993	32.3	10,399	32.4	29,974	32.4
<b>Payer category</b>								
Uninsured	1,417	4.8	1,663	5.4	1,797	5.6	4,877	5.3
Medicare and Medicaid/other, Medicare only	9,958	33.7	10,307	33.4	10,568	32.9	30,833	33.3
Medicaid, Healthy Families/CHIP	7,941	26.9	8,567	27.7	9,178	28.6	25,686	27.8
Employment based, privately purchased	7,925	26.9	7,857	25.4	7,782	24.2	23,564	25.5
Other public	2,123	7.2	2,323	7.5	2,609	8.1	7,055	7.6
<b>Total</b>	<b>29,511</b>		<b>30,904</b>		<b>32,116</b>		<b>92,531</b>	

Abbreviation: CHIP, Children's Health Insurance Program.

<sup>a</sup>Data are from the Office of Statewide Health Planning and Development public use files 2009-2012. Some data were redacted in the 2012 public files.

<sup>b</sup>Values do not necessarily sum to 100% because of rounding.

an amputation and those discharged to an SNF. However, the LOS decreased each year for all of the groups.

The total costs of acute care for diabetic foot complications between 2014 and 2019 projects to be \$39.8 million for those newly eligible for insurance and \$24.2 million for those projected to enroll (Fig. 1). Forecasting a 10% reduction in amputations resulted in a projected savings of \$114,000 for Medi-Cal and \$144,000 for the subsidized HBE programs. A projected savings of \$236,000 and \$188,000 for Medi-Cal and the HBE, respectively, would be achieved with 100% take-up. Decreased use of resources, for those who enroll, results in savings associated with the acute-care and SNF admissions of \$324,000 for Medi-Cal and \$411,000 for the subsidized HBE programs (Fig. 1). The greatest savings were recognized in females, those aged 50 to 64 years, Latinos, and those with incomes of 139% to -200% of the federal poverty level (data not shown).

Further assessment of resource use showed decreasing LOS for all of the admission categories. The mean LOS each year for uncomplicated admissions was 8.7 days (8.4–8.8 days), for individuals discharged to an SNF was 12.5 days (11.8–13.4 days), and for inpatient stays involving a lower-extremity amputation was 11.2 days (11.0–11.4 days).

The total savings with a 10% reduction in amputations and admissions is \$993,000, with \$438,000 attributed to Medi-Cal enrollees and \$555,000 to those enrolled in subsidized HBE programs. An additional savings of \$639,000 is realized when considering all individuals eligible for these programs. Additional savings of 4.1% are realized with each additional 10% reduction in amputations and decreased resource use. Limited access to care by foot care specialists also hinders the improved clinical outcomes and resource use, with an additional 1% savings for every 10% improvement in access to podiatric medical care (Fig. 2).

## Discussion

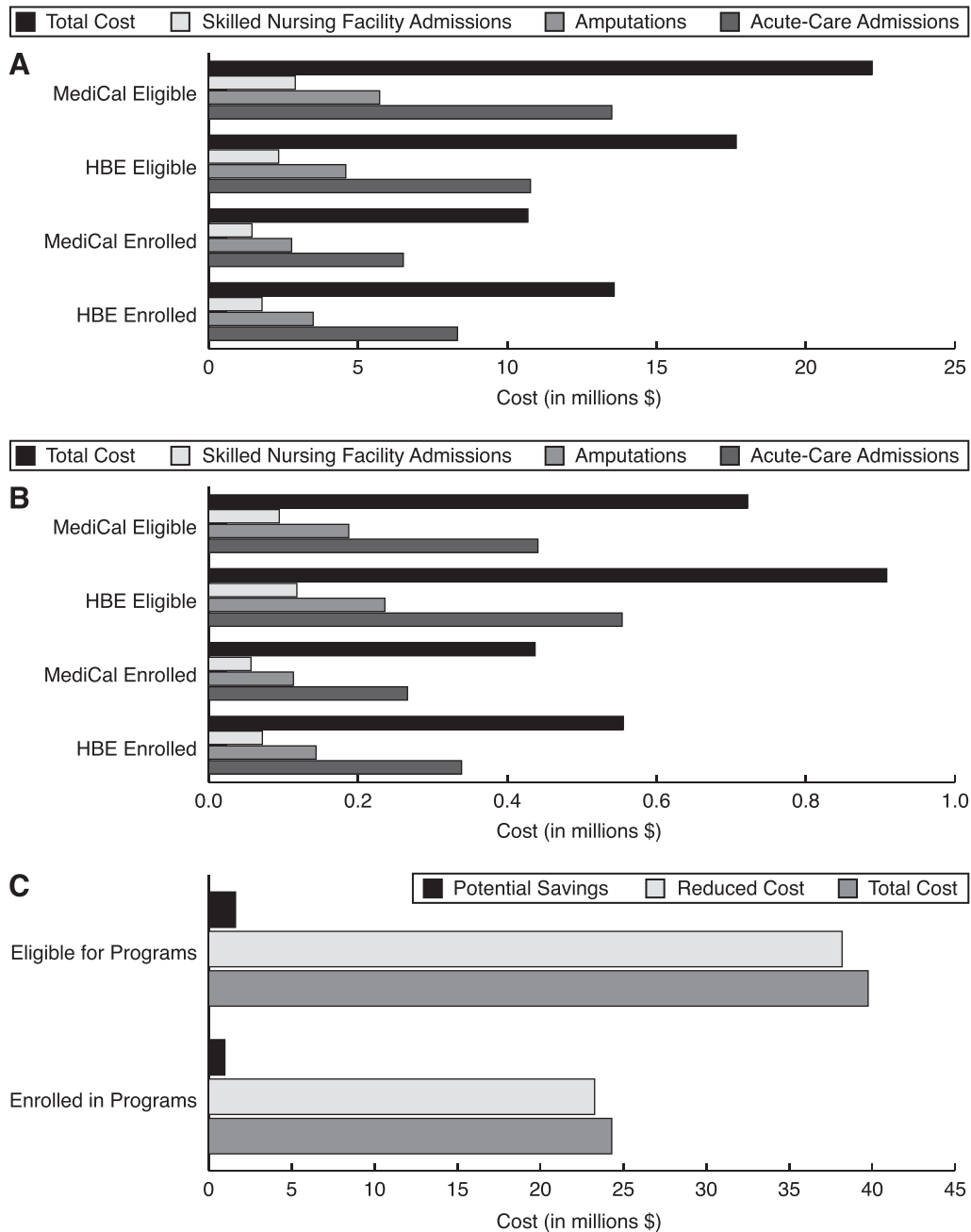
Diabetic foot complications range from peripheral neuropathy, peripheral vascular disease, and ulceration to lower-extremity amputations, which more than double the 5-year mortality rate. Peripheral neuropathy and peripheral vascular disease are underlying causes of foot ulcers, which develop in 15% to 25% of diabetic patients. Nontraumatic lower-extremity amputations are frequently preceded by ulcers and are 15-fold more likely in diabetic patients. Nearly 85% of amputations are prevent-

able. From a cost perspective, peripheral vascular and neurologic complications account for 10% of hospital inpatient costs attributed to diabetes in 2012. Both cardiovascular and other complication categories include foot-related pathology and account for 26% and 5% of inpatient costs, respectively. All of the categories also increase resource use.<sup>13,14</sup>

We applied a 10% reduction in amputations and hospital and SNF admissions because nationwide age-adjusted hospital discharge rates for diabetes-related lower-extremity amputations per 1,000 diabetic patients decreased from 9.0 in 1996 to 3.2 in 2009.<sup>15</sup> This conservative reduction recognizes the slowing rate over time, despite finding an increasing percentage of admissions involving amputations. The model revealed a 4.1% cost reduction for every 10% reduction in amputations and admissions. Despite the 94.3% higher acute-care costs of individuals undergoing an amputation during the hospital stay, 61.0% of the total costs were attributed to the uncomplicated admission because of the high prevalence of admissions per 1,000 diabetic patients compared with the other categories. Individuals undergoing an amputation while inpatients account for 26.0% of the total costs, and 13.0% of costs were attributed to those being discharged to an SNF. Therefore, transitioning more care to the outpatient setting achieves the greatest cost containment.

One method of achieving these improved outcomes and reduced costs is integrated, multidisciplinary care, as many people involved in redesigning care delivery advocate. Including podiatric medical care further aids better clinical outcomes and cost containment. Decreased amputation rates in severe limbs and when podiatric medical care is provided the year preceding incident ulcers have been reported.<sup>6,16</sup> However, a team approach involving podiatric physicians and lower-extremity specialists creates the most substantial benefit.<sup>6</sup> Other researchers report that multidisciplinary podiatric medical and vascular surgery care reduced major amputations 82% and achieved limb salvage rates of 83% at 5 years.<sup>17,18</sup> Multidisciplinary teams involving a chronic-care model reduced amputations 47.4%, and an outpatient clinic team consisting of podiatric medicine, orthopedics, endocrinology, and nursing maintained amputation rates despite a fourfold increase in diabetic patients.<sup>19</sup>

Podiatric physicians also aid in reducing the use of resources and costs. Lavery et al<sup>3</sup> also reported decreased hospital admissions (37.8%) and SNF admissions (69.8%). Using inpatient and outpatient



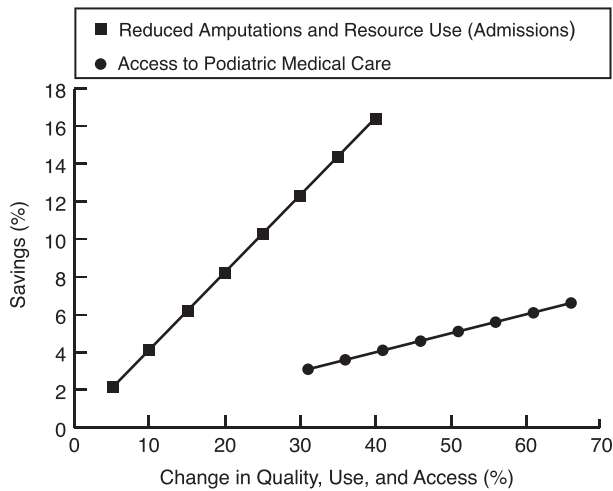
**Figure 1.** A, Projected costs of acute-care admissions, amputations, and skilled nursing facility admissions for previously uninsured diabetic patients eligible for and enrolled in Medi-Cal and subsidized health benefit exchange (HBE) programs by 2019. B, Projected savings based on a 10% reduction in acute-care admissions, amputations, and skilled nursing facility admissions. C, Total costs with and without the 10% reduction for projected diabetic patients eligible for and enrolled in Medi-Cal and the subsidized HBE programs.

claims data, Carls et al<sup>16</sup> reported savings of \$4,271 per diabetic patient over a 3-year period when podiatric physicians were consulted before an incident ulcer. They also showed a Medicare savings of \$9 to \$13 for every \$1 spent on podiatric

medical care.<sup>16</sup> Unlike Carls et al, we forecasted costs based on amputations and inpatient care exclusively.

This analysis is based on the assumption that 41% of newly insured individuals will access podiatric





**Figure 2.** Sensitivity analysis demonstrating the impact of changes in decreased use of resources, improved quality of care, and improved access to podiatric medical care.

medical care, the same rate as those currently insured. We found additional savings of 1% for every 10% increase in access to podiatric medical care. In a study of nearly 190,000 individuals, 74.6% accessed podiatric medical care, which would result in additional savings of 3.4% when applied to this model.<sup>6</sup>

Additional cost containment can be obtained through increased take-up within particular demographic groups. The group using the greatest amount of resources of the safety net system has an income of 200% or less of the federal poverty level.<sup>10</sup> The CalSIM model projections show that this group represents 42% of previously uninsured diabetic patients and accounts for 70.9% of the costs for those who take up insurance. In 2011, diabetes mellitus was one of the most expensive inpatient hospital stays for individuals with an income of 100% or less of the federal poverty level.<sup>20</sup> Many individuals in this demographic group were eligible for Medi-Cal before the ACA programs (70.4%). The low take-up in this group results in 55.9% of costs being attributed to the HBE-subsidized individuals. However, when considering all of the eligible individuals, Medi-Cal is responsible for 55.7% of costs. In addition, prevalence-adjusted amputation rates vary up to tenfold between high- and low-income regions.<sup>9</sup> Therefore, the rate of amputations per 1,000 diabetic individuals is likely higher in most cases, resulting in these projections possibly underestimating the cost and potential savings.

The clinical and financial support of multidisciplinary care teams has also been demonstrated in

the Arizona Medicaid population. Eliminating podiatric medical care resulted in 49.0% more severe outcomes, such as amputation, sepsis, and mortality. A 36.7% increase in admissions and a 22.5% increase in LOS after the elimination of podiatric medical care were also identified. This increased use of acute care escalated charges 37.5%, equating to a \$48 increased cost per \$1 spent before eliminating podiatric medical care.<sup>5</sup>

Higher take-up among Latinos, African Americans, and Asians also enhances savings. These minority groups are at high risk for diabetic foot complications. The CalSIM model projects that Latinos represent more than 60% of diabetic patients (68% of the remaining uninsured). They are also more likely to fail to achieve hemoglobin A<sub>1c</sub> control and to have a higher incidence of amputations.<sup>2</sup> Uninsured and indigent-care patients had a 1.5- to 1.9-fold increase in amputations compared with those with Medi-Cal, Medicare, and employer-sponsored plans. Meanwhile, there was a fivefold to ninefold increase in SNF admissions in the Medicare, Medi-Cal, and employer-sponsored plans compared with the uninsured and indigent care.

There are several limitations of this study. Geographically, the 41% use of podiatric medical services was based on a study of diabetic patients, 80% of whom resided in urban and suburban settings. The reliability of this setting is unknown because the CalSIM model does not project this demographic factor. However, the CalSIM model projected that 55% of the remaining uninsured will reside in predominantly urban and suburban counties in Southern California.<sup>10</sup>

The impact of the improved quality of care and decreased use of resources is likely underestimated beyond the take-up exceeding the CalSIM base model for some demographic characteristics during the first year of the ACA programs. Diabetic foot complications have high readmission rates. Lower-extremity amputations have a 22.8% readmission rate, and gangrene has the second highest readmission rate (31.6%) of the most commonly treated conditions in 2010.<sup>21,22</sup> Skin ulcers and diabetes with complications had rates of 21.3% and 20.3%, respectively.<sup>22</sup> Therefore, decreasing amputation rates may also reduce readmission rates, thus decreasing the use of resources of all of the categories of acute-care stays used in the model.

The most significant reason for the underestimated impact of the improved quality of care and reduced use of resources is that the model exclusively relied on acute-care costs. Meanwhile,



most diabetic foot care is performed in the outpatient setting, which is exemplified by only 10% to 20% of diabetic foot ulcers requiring hospitalization. Inpatient care consistently costs more and uses more resources than outpatient care; however, the American Diabetes Association reports that inpatient care costs account for 50% of the total costs of diabetes.<sup>14</sup> Zhuo et al<sup>23</sup> reported that spending in diabetes between 1987 and 2011 increased \$2,790 per person. Expenditures related to inpatient costs and use of resources accounted for 24% of the increased spending despite slight decreases in the number of acute-care admissions, number of emergency department encounters, and LOS. The LOS grew 172%, and hospital admissions grew 88% per admission. Meanwhile, 15% of the increased expenditures were attributed to outpatient care, which was driven by the increased volume of visits as opposed to the cost per visit.<sup>23</sup> Therefore, additional savings beyond the reported projections can be realized with high-quality preventive foot care to minimize acute-care admissions. This is especially relevant with Medi-Cal expansion and increased enrollment because, as Skrepnek et al<sup>5</sup> reported, the absence of podiatric medical care in the diabetic population significantly increased acute-care costs and use of resources.

## Conclusions

Implementation of the California HBE and Medi-Cal expansion will see the enrollment of nearly 120,000 diabetic patients, with approximately 75,000 diabetic patients remaining uninsured by 2019. Forecasting the value of a 10% reduction in lower-extremity amputations and admissions to acute-care wards and SNFs during the 5-year implementation of the new ACA programs showed a 4.1% savings in hospital costs. Because 61.0% of the costs are attributed to uncomplicated admissions, the transition to more outpatient management of diabetic foot complications is imperative.

In light of the high risk of complications and the increased mortality, transitioning to greater use of ambulatory care is possible through establishing chronic-care models with preventive care using multidisciplinary teams and improved care coordination. By aligning clinical and financial outcomes, these findings support the importance of including podiatric medical services as part of the multidisciplinary team when caring for this challenging patient population to better realize the forecasted savings.

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**Conflict of Interest:** None reported.

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