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# Win-Win Situation

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**Offering disease management can help payors, patients, physicians, and you.**

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Cardiac, chronic lung, and diabetic disease management programs are finally enjoying broadening acceptance among referral sources and insurance payors alike. Witness the contract between disease management provider American Healthways and managed care giant Cigna Healthcare; the preferred provider agreement between Texas HME provider Respiratory Solutions and Cogent Healthcare hospital systems; and the Centers for Medicare and Medicaid Services (CMS) promise to pay for outpatient diabetes education delivered by a certified diabetes educator.

The goal of disease management programs is to teach patients to better control their chronic disease in order to improve their quality of life and reduce the use of costly emergency and inpatient services. Studies show that well-designed, comprehensive disease management programs can reduce the overall cost of care by 18% to 50%.

Potential beneficiaries number in the millions, and the value of the total disease management market in the United States is between $300 million and $500 million annually. However, even though the home is the most frequent environment of care for patients in disease management programs, this market remains largely untapped by HME providers.

There are two ways HME providers can benefit from entering this market. The first is through direct reimbursement by insurance payors for the services themselves. The second is through preferred provider agreements between hospitals and the equipment provider.

**Direct Reimbursement**

Managed care payors always seek to lower their costs by controlling use while still providing quality health care to their members. While the payors vary in their commitment to offering proactive health care services, such as disease management programs, more and more are discovering the cost savings such programs can provide.

Most payors either contract the programs through companies that specialize in disease management, or develop and manage in-house programs with their own case managers. But there is an even more cost-effective way. Since HME providers are already in the home to followup on equipment used by many of the patients who are candidates for disease management, they can offer cost-effective patient management solutions, too. In many cases they can negotiate reimbursement that is two to three times the cost of providing the service, yet still remain quite competitive with the payor's other alternatives.

But remember, the value of a program is directly dependent on the savings the payer can expect to realize through decreased use of other health care services. It is typical for patients in disease management programs to increase their use of pharmaceuticals because of improved medication management and compliance, but that increased cost is easily offset by larger savings realized through decreased hospitalizations, emergency department visits, and unplanned physician visits. It is the HME company's job to demonstrate the return on the disease management investment to the payor through data collection and outcomes reporting.

**Preferred provider agreements**

In the past, both hospitals and HME providers were reluctant to enter into preferred provider agreements because CMS (then the Health Care Financing Administration, HCFA) prohibited such contracts between hospitals and "home health services." Interpreted broadly, home health services could include HME dealers. However, CMS has since clarified the phrase "home health services" to refer only to nursing agencies. This clears the way for HME dealers and hospitals to partner to provide expanded patient services.

HME providers can form preferred provider agreements when they agree to offer specific disease management services to a specific patient population referred for equipment services as a "value add" in exchange for being the preferred provider for a broad base of hospital HME referrals. Naturally, the patient retains the right to choose their HME provider as required by CMS regulations, but the hospital agrees to recommend the equipment provider based on its expanded services.

In some cases a hospital will want to partner with the HME provider to transition the patient home by continuing a disease management program initiated on an inpatient basis. In other cases the hospital is content to have the program initiated solely by the provider's clinician after the hospital discharges the patient.

The key to convincing hospital administration to enter into a preferred provider agreement with your company lies in understanding the hospital's goals and motivations. With discharge planning now beginning within 24 hours of a patient's admission to an acute care facility, it is clear that case managers and discharge planners are challenged to reduce or hold the line on length of stay. HME providers that offer disease management programs to monitor patient compliance and teach patients the skills needed to control their disease can assist hospitals in reducing each patient's length of stay.

Because this type of arrangement rarely results in direct reimbursement for the services provided, it is important to remember that you need not enroll as many patients in the program as possible. You can also present such programs as value-added services available to the hospital's niche population of patients who are ineligible or otherwise unable to participate in more traditional outpatient management programs.

Whatever course you choose, remind your referral sources that your ability to provide expanded services, such as disease management, to your equipment patients is dependent upon the support you receive from the referral community.

Also, when offering disease management through preferred provider agreements keep CMS compliance guidelines in mind. While the rules permit providing improved services through more comprehensive care, offering freebies, such as exercise equipment, to patients could look like an illegal inducement for referrals.

**Recipe for Success**
Whether your goal is a contract for direct reimbursement for a disease management program or a preferred provider agreement with a referral source, several ingredients are critical.

First, your program should be grounded in solid science. Consult a clinical expert or do your own research to ensure your program includes all the necessary components to improve patient outcomes.

Second, make sure you have a well-trained clinical staff to provide the services. The type of clinician is dependent on the patient population you are targeting. Respiratory therapists are a natural fit for working with chronic lung patients, but you may want to add a pharmacist who is available for phone consultations if you are targeting the congestive heart failure population. A clinician who is certified as a diabetic educator can help diabetics.

All clinicians involved in disease management services must be comfortable communicating closely with the patient's physician to develop a comprehensive plan for improving the patient's outcome.

Finally, collect key indicator data throughout the patient's enrollment in your program—particularly health care use and patient satisfaction data—in order to objectively report patient outcomes. In general, the patients you will most likely work with—cardiac, pulmonary, and diabetic patients—respond well to disease management programs that focus on education, compliance, and continued follow-up. Collecting data proves your program saves money and encourages the support of referral sources and payors.

By including a disease management program along with routine follow-up of patients requiring equipment and supplies, you can move into the role of service provider in a cost-effective manner, even as you grow your business in the lucrative respiratory equipment and diabetic supply markets. In this manner disease management programs present a win-win-win-win for the patient, the provider, the referral source, and the payor alike.

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