

# The Complete “How to” Guide for Selecting a Disease Management Vendor

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## ABSTRACT

Decision-makers in health plans, large medical groups, and self-insured employers face many challenges in selecting and implementing disease management programs. One strategy is the “buy” approach, utilizing one or more of the many vendors to provide disease management services for the purchasing organization. As a relatively new field, the disease management vendor landscape is continually changing, uncovering the many uncertainties about demonstrating outcomes, corporate stability, or successful business models. Given the large investment an organization may make in each disease management program (many cost \$1 million or more in annual fees for a moderately sized population), careful consideration must be made in selecting a disease management partner. This paper describes, in detail, the specific steps necessary and issues to consider in achieving a successful contract with a vendor for full-service disease management.

## INTRODUCTION

DISEASE MANAGEMENT has undergone numerous evolutionary changes since the idea was introduced a little over a decade ago, and has developed into a central fixture in managed care’s arsenal for controlling medical costs while concomitantly improving the health status of its population.<sup>1,2</sup> However, decision-makers in health plans, large medical groups, and self-insured employers face many challenges in selecting and implementing disease management programs.

Several factors make successful deployment of disease management particularly challenging. First, the organization must decide whether to pursue a “build” strategy, developing disease management competencies in-house; a “buy” strategy, utilizing one or more of the

many disease management vendors; or a hybrid model, including elements of both build and buy.<sup>3,4</sup> While each strategy has its incumbent issues, the “buy” model warrants specific attention to upfront planning and detailed assessment.<sup>5</sup> As a relatively new field, the disease management vendor landscape is continually changing. Over the past few years many new players have entered the marketplace, others have folded, and mergers between firms are increasingly common.<sup>6,7</sup> The brief history of many of these companies means long-term outcomes results are sparse and corporate stability uncertain. In addition, the business models of many of these firms include complicated financial arrangements with fees paid dependent upon the achievement of specific, and often hard to measure, reductions in medical costs.<sup>8,9</sup> This type of “guaranteed” savings financial

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model adds to the uncertainty of the economic viability of these companies as well as leading to potentially prolonged and difficult reconciliation negotiations with clients. Given the large investment an organization may make in each disease management program (many cost \$1 million or more in annual fees for a moderately sized population), careful consideration must be made in selecting a disease management partner.<sup>10,11</sup>

The purpose of this paper is to describe, in detail, the specific steps necessary and issues to consider in achieving a successful contract with a vendor for full-service disease management. According to the Disease Management Association of America (DMAA), a full-service disease management program must include all of the following: population identification processes, evidence-based practice guidelines, collaborative practice models to include physician and support-service providers, patient self-management education, process and outcomes measurement, evaluation and management, and routine reporting/feedback loops (which may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

### IDENTIFYING WHICH DISEASES TO ADDRESS

The most logical first step an organization must take is to identify those segments of the population that may benefit most from disease management, and weigh that against the potential for cost-savings. For instance, asthma is a highly prevalent disease, yet the annual medical costs of these members are relatively lower than members of other chronic illness categories. On the other hand, end-stage renal disease (ESRD) has a very low prevalence and a very high annual cost per patient.

Some other considerations for further identifying which diseases to focus on are: what is the savings potential for the various diseases? (e.g., does this population's utilization rate compare favorably with national or regional benchmarks and if not, how much can this be improved?); how long will it take to realize medical cost-savings? [e.g., congestive heart

failure (CHF) programs can usually show results within a year of start-up, while diabetes may take longer than a year to achieve measurable improvements]; or consider a comorbidity overlap [e.g., CHF patients may also have diabetes, coronary heart disease, or chronic obstructive pulmonary disease (COPD)—thus additional opportunity exists for cost-savings across several diseases, simultaneously].

Once several disease options have been chosen, the organization should determine if there are external vendors in the clinical area that can answer the following three questions: Do you have measured results, do you guarantee your results, and can we speak with one of your current clients with whom you have achieved successful results? Use of these three questions will lead you to organizations with proven, successful interventions. Most organizations will find that this analysis will result in a narrowed focus on one or more of the following areas: CHF, diabetes, asthma, coronary artery disease, COPD, ESRD, high-risk maternity, and cancer.

While the use of the above approach leads to more established firms, some purchasers may find advantages in working with newer start-up programs. These advantages may include innovative programmatic approaches, lower fees (or no fees if used as a trial site), and greater flexibility in tailoring program design and/or implementation to the purchaser's unique needs.

Finally, experts in the field should be consulted. Contact the DMAA or professional organizations such as American Association of Health Plans, Medical Group Management Association, or The Independent Practice Association of America for more information on consultants with expertise in this area. They can help narrow the search to those vendors most likely to respond in the affirmative to the above questions, as well as address their financial and operational stability. Experts can also help identify other opportunity areas not readily identified in the processes outlined above (e.g., rare diseases, skilled nursing, etc.). Review of disease management published literature, attendance at trade conferences, and networking with other purchasers are other means to gain similar information.

### DETERMINING WHICH VENDORS TO CONSIDER

Assuming that at least one vendor can answer “yes” to all three questions above, the next step is to assess which firm is the most congruent with the mission, overall medical management strategy, and business model of the purchasing organization. For instance, is this an organization with business strategies and tactics consistent with the purchaser’s mission? If the purchaser’s medical management strategy assumes a multiyear investment in disease management, is this a firm the purchaser feels they can work with over the long term? What types of intervention strategies are employed? Does the intervention target patients, their providers, or both? How will patients, physicians, and other providers embrace the program?<sup>12</sup> Is the disease management vendor’s risk and reimbursement model compatible with that of the purchaser (e.g., how will risk and reward be distributed among those who bear the cost of the program)?

### PRIORITIZING AMONG MANY OPTIONS

After completing the first two steps as outlined above, the purchasing organization may realize that several diseases (with several vendors each) meet the criteria. The next step is to prioritize according to the following two principles: (1) Roll out one set of vendor-managed programs at a time. While one could assume that a vendor relationship reduces the workload for the contracting organization, in fact, significant time commitments from many key individuals internally are needed to evaluate and complete the contracting process. Moreover, managing the implementation requires constant attention to detail to ensure that all issues are addressed properly in a timely manner. Rolling out a disease management program with more than one vendor at a time may seriously compromise the potential for success. While some disease management vendors offer programs in a single clinical area (e.g., asthma or high-risk maternity), others offer programs in multiple clinical areas imple-

mented in a coordinated and complementary fashion (e.g., diabetes and CHF). (2) Choose the “easiest win.” The purchasing organization should determine which program has the highest likelihood of success, given the potential hurdles that may crop up. For example, a program targeting rare diseases may be expected to generate little “noise,” if any, from the provider network, as opposed to a prevalent disease, like diabetes, that providers feel comfortable managing themselves.

### PREPARING A REQUEST FOR PROPOSAL

The request for proposal (RFP) process is the step where the purchasing organization presents important contract provisions to the prospective vendor. The following key points should be addressed:

1. Performance guarantees. A key consideration is how much, if any, of vendor fees should be at risk based on achievement of specific financial and/or quality targets.<sup>13</sup> If 100% of vendor fees are “guaranteed” a purchaser will be reimbursed for its entire program expense if cost-savings and/or quality targets are not met. Similarly, how cost-savings above the target threshold will be split between the purchaser and vendor is a key point of discussion. While such risk-bearing contracts provide some security for the purchaser they have their limitations: (a) The vendor’s fees are likely to be higher in risk-bearing contracts than for the same services in a “fixed-fee” arrangement to provide reserve for the possibility of fee repayment due to nonperformance. (b) Clearly defined methods and processes for determining reduction in medical cost and/or improvement in quality measures are critical in risk-bearing arrangements because these measures are the basis for determining if fees are to be retained or repaid. Lack of upfront clarity may lead to difficult and potentially contentious annual reconciliation. Reaching agreement on these methods and processes during contract negotiation can also be quite

- time consuming. (c) The possibility of large “up-side” payouts (if a purchaser shares cost-savings above target with the vendor) and accurate booking of expenses (when there is the potential for return of fees for nonperformance) must be considered when determining correct accounting processes for these programs. In general, purchasers should weigh their confidence that the selected vendor’s program will achieve the desired results against the complexity of risk-bearing contracts when determining the need for performance guarantees.
2. Length of the contract and termination clauses, both with and without cause.
  3. Quality and performance measures (as well as determining whether any money will be at risk for not meeting targets).
  4. The general reconciliation method and timelines (including how adjustments are made for cost and utilization trends, medical inflation, new technology, and whether disease specific costs vs. total costs are included). One of the key risks is ensuring that the methodology accurately accounts for potential regression to the mean.
1. Reference checks with other clients.
  2. A review of financial statements to determine stability. Some vendors are publicly held companies, where information on financial performance is readily available. For other privately held firms such information may be more difficult to obtain. Whether public or private, a Chief Financial Officer-to-Chief Financial Officer discussion may be needed for the purchaser to gain confidence in their assessment of the vendor’s long-term financial viability. Additionally, whether or not a vendor is owned by or affiliated with a larger company may influence a purchaser’s assessment of long-term stability.
  3. Local provider reaction. Some physicians may have had experience with one or more of the vendors and can contribute to the selection process. Similarly, partnering medical groups, Independent Practice Associations, and other providers need to approve the choice of vendor if they will be sharing in the funding of the program.<sup>14,15</sup>

A consideration at this point is whether or not to engage a consultant or purchasing consortium group to assist with the negotiation of a final contract. Services of such experts include drafting, fielding, and summarizing the RFP, advice on specific contract terms, and assistance in breaking through problematic issues during contract discussions. While there may be cost associated with use of such expert services, these must be weighed against the likelihood of achieving the best possible contract terms and the length of time required to negotiate a contract in the absence of this assistance.

### NARROWING THE FIELD

If there are many vendors for a given disease that have returned the RFP, a side-by-side analysis of the responses will allow the purchaser to quickly eliminate those not meeting all the basic criteria. For those vendors remaining, the following information will help further narrow the field:

The decision-making body, or committee, within the purchasing organization should be constructed of key stakeholders, including those health care partners who will share in both the cost and potential financial benefits of the disease management program.

The vendor who made the final cut should be prepared to present to this committee an analysis of the purchaser’s data, which will include: the purchaser’s prevalence rate of the disease as compared with the vendor’s expected rate; the purchaser’s cost trend for the disease over the past few years, including a breakdown of the total spend into unit cost versus utilization, and annualized cost per member; an explanation of where the vendor expects to realize cost-savings (i.e., hospital, outpatient, pharmacy, disease-specific, or non-disease areas); and the expected return-on-investment.

### CONTRACT EVALUATION AND NEGOTIATION

Assuming that the purchasing organization has decided to proceed toward contracting with a disease management vendor, the pro-

gram can begin roll out based on a signed letter of intent (LOI), which should include financial implications if a full contract isn't signed (e.g., payment to the vendor for their pre-implementation work, since reaching a contract agreement may take up to 2–4 months). The LOI allows both sides to prepare and review the contract, without delaying implementation.

The contract may, indeed, be the most important and critical aspect to a successful partnership between the purchasing organization and the disease management vendor. As such, a contract evaluation team should be established involving representatives from finance, legal, regulatory [especially around Health Insurance Portability and Accountability Act (HIPAA) requirements], information systems, and a project lead (most likely representing quality and/or medical management).

Every element should be reviewed carefully and discussed to ensure that both parties are in full agreement of the meaning and spirit of the contract. It is imperative that all terms agreed to in the RFP are written clearly into the contract. Similarly, the following topics should be included: a glossary of terms; the program description; inclusion and exclusion criteria for membership in the program; dates of enforcement; HIPAA compliance language; human resources implications; noncompete clauses; requirements of the purchaser; specifically defined quality and performance measures; reconciliation method with enough detail to be clearly understood and replicated by in-house finance; a third-party guarantee instrument or other means of ensuring payment if the vendor cannot meet its financial obligations; and inclusion of a joint operating committee and meeting schedules.

The team should identify all areas of disagreement, and consider which may be “deal breakers.” Prioritization of these issues will assist the organization in determining which points are negotiable and nonnegotiable.

## IMPLEMENTATION PLANNING

Planning for implementation of the disease management program should begin at least 1–3

months prior to the launch date. The purchasing organization should hire a project manager who will be devoted, at least half-time, to implementation of the program. This person should liaise with the vendor and develop a clear implementation plan with specific timelines for each phase.

Finally, a medical advisory group should be set up to regularly review the practice guidelines for the specific disease and ensure that the interventions used by the vendor are medically sound and compatible with local practice.

## CONCLUSIONS

Disease management has gained a level of legitimacy and respectability by demonstrating positive outcomes in both cost-savings and health status of a given diseased population. Nonetheless, selecting a full-service vendor remains a complex and potentially risky venture for purchasing organizations. Through careful planning and attention to detail, as discussed in this paper, any organization can achieve a successful contract and develop a true partnership with a disease management vendor.

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