Implementing DME for Sleep Centers

Why and How

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Disclosures

• Vice President of Medical Affairs and Chief Medical Officer NovaSom Inc, an OCST national service provider.
• Board of Directors and Past-President American Sleep Apnea Association.
• Board of Directors and Scientific Advisory Board ResMed Foundation
• No conflicts of interest or off-label use to report.
Why DME in Your Sleep Center

• Improved patient outcomes.
• Economic viability of sleep center
• Comprehensive care provider
• Contracting flexibility
• Viability of Sleep Medicine specialty
Sleep Center Model 2003

- **Testing**
  - PSG, MSLT

- **Clinic**
  - CBT
  - Consultation
Sleep Center Comprehensive Care Model 2013

Office
- Consultation
- CBT
- Sleep Apnea ongoing care

Testing
- PSG, MSLT
- OCST (AOCSTP)
- OCST

Treatment
- PAP set up
- PAP re-supply
Why: Improved Outcomes
There is a need to make a difference

- Adherence to CPAP therapy is primary challenge to field even when sleep professionals actively manage.*
- 36-50% meet MC criteria in 30 days.
- Cochrane Database Syst Rev. 2009 Apr 15;(2)
  - Education, training and behavioral modification improve PAP adherence.

*Rosen CL; et al ...The HomePAP Study. SLEEP 2012;35(6):757-767.
Economic viability of sleep center

- Payer initiatives implementing prior authorization site of testing triage necessitates re-focus of sleep center.
  - Increased clinical revenue through E/M codes
  - Ongoing care PAP management
  - Aggressive adherence management for OSA
  - P4P related to measurable patient outcomes
  - Accountable Care Opportunities
Comprehensive Sleep Care

- OSA opportunity to provide comprehensive and longitudinal care to a wide population.
- Sustainable positive outcomes through long term care.
- Delegation of therapy choices increases risk of variability in care and poor quality.
- Accuracy of adherence measurement and outcomes tracking.
Contracting Opportunities

• Incorporating DME into your sleep center puts you in control during periods of rapid change.
  – Think: global case rates, capitation, disease management.
  – Keys to success: efficiency, improvement in quality metrics. FFS less important in
  – Affordable Care Act
    • Health Care Exchanges
    • Accountable Care Organizations
New Business Models

• Global case rate
  – Example: case rate per each sleep apnea patient referred, including consultation, testing and Rx where indicated. SOS determined by sleep center.

• Capitation
  – Cost PMPM to care for all OSA in payer population.

• Quality bonuses from ACOs
  – Improved adherence in PAP therapy in total or sub-populations (diabetes) triggers quality payment.
Sleep DME Models

- Consignment closet. (very suspicious)
- Joint ventures: usually rent space.
- Contract distribution: FFS for setup plus storage with DME company.
- Do it yourself.
  - ? physician owned service vs. licensed entity.
Medicare

• Must be accredited unless physician owned.
• Competitive bidding.
• Compliance officer.
• Must offer patients choice.
Getting Started

• AASM accredits DME good place to start building the quality underpinnings.

• [http://www.aasmnet.org/accred_dmeaccred.aspx](http://www.aasmnet.org/accred_dmeaccred.aspx)

• Accredits non-Medicare providers

• Need not be an AASM member or accredited sleep center.
Why AASM Accreditation?

• Even if hospital affiliated is Joint Commission approved for HME AASM is an advantage.
• Gold Seal Approval across all lines of business
• Current Stark rules prohibit those entities providing testing from provisioning the therapy as well.
• AASM actively working on Comprehensive approach to Sleep Apnea Care
Standards of Care

- A4 Equipment: must have manufacturers information on all equipment. Serial number tied to patient record.
- B-1 Financial Management Policies
  - Maintain balance sheets, income, cash control, accounts payable control, invoice control.
- B2 Patient accounts: Reconcile billing with patient/billing database.
Standards of Care

- C-1- Patient record audit at least 5 per year.
- C-2 Billing Discrepancies Procedure
- D. Practice Standards and Procedures
- E. Human Resources Management
- Section F Consumer Services
  - F-1 – Receipt of Delivered Equipment
  - F-2 – Options for Renting/Buying Equipment
  - F-3– Patient Complaints
Standards of Care

• H-1 – Quality Assurance Program
• I-1 – Equipment Safety Program
• I-2 – Equipment Failure, Repair and Maintenance Plan
• I-3 – Equipment Incident Investigation
• Others: equipment set up, communication with Rx provider, adherence measurement and reporting.
Practical matters

- Space: “Showroom” for retail, fitting room, bathroom, minimal storage.
  - Front space versus “back door”
  - ? Off site warehousing
    - Cost per sq/ft 20% of retail medical space
  - Clean room
  - Pick up and delivery.
Staffing needs

• Start small 1-2 FTE
• Sleep Center staff re-assignment
• At full potential 1 to 1.5 million $ sales/year
  – Requires 5-7 FTE staff
  – Administrative /billing staff from sleep center could reduce this need by several FTEs.
Monthly Sales Growth

Year One

Year Two

Year Three

low

high
Sat and evening hours increase % retail, highest profit.
Profit vs. Unit Cost

- $500
- $1,000
- $1,500
- $2,000
- $2,500
- $3,000
- $3,500

$-

0% 20% 40% 60% 80% 100% 120%

$-

$500

$1,000

$1,500

$2,000

$2,500

$3,000

$3,500

0% 20% 40% 60% 80% 100% 120%
Inventory

- How many brands?
- Full line vs. limited
- Upgrades
- Patient self-pay accessories
- Multiple mask options important
Inventory Control

• Inventory turnover
  – Monthly for soft items
  – 9-10 times/year for hard items.

Logistics support
Financial Benchmarks

• The sleep center is now selling goods in addition to services.
• Cash flow will have to be actively managed to avoid catastrophe.
• Benchmarks need to be actively measured and tracked.
Financial Benchmarks

• Days Sales Outstanding (DSO): time from sale to collection of payment. Goal 40-50 days.

• Denial Rates
  – 28%

• Claims Error Rate
  – 8.2%

• Accounts Receivable ageing

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Adherence Management

• Track results by patient and globally.
• Track improvement over time.
• Policies and Procedures spelled out.
• Aim resources toward outliers.
  – Leverage with use of technology
  – Wireless
  – Cloud technology
Adherence Management

• Marketing tool to
  – Payers
  – Referral sources
  – ACOs
• Pay for Performance
• Disease Management
  – Diabetes, Hypertension.
Opportunity

• Enhance profitability, viability of Sleep Centers
• Replace lost volume with new business lines
• Enhance Quality of Care
• Enhance Outcomes
Discussion