

Supplement to

MANAGED HEALTHCARE EXECUTIVE®

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HEALTH WELLNESS EXERCISE LIFESTYLE INVESTMENT
COMMUNICATION CONDITION MANAGEMENT INCENTIVES
POPULATION MEMBERS EMPLOYEES RISK MODELING
OUTCOMES MEDICATION COMPLIANCE ADHERENCE
ACTIONABLE TEACHABLE COORDINATION INNOVATION
CONTROL PHYSICIAN NURSE PHARMACIST COACH
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2008
**Leaders
in DISEASE
MANAGEMENT**

DISEASE MANAGEMENT

value continues to grow

By Al Lewis

Reports of disease management's death have been greatly exaggerated. While it is true that actuarial calculations of medical savings from disease management have been controversial, there is enough underlying value to DM that it will not only sustain itself, but also continue to grow as the true value of the concept emerges.

The decibel level of the debate over return on investment from standalone programs has obscured the emerging sources of value—synergies with other payer functions—which are being created and nurtured in relative obscurity.

One such source of value is the PBM synergy. As Healthways and Medco have shown, for example, the time lapse for initial contact with a member once diagnosed falls to almost zero if prescription information is transmitted to the disease manager in real time.

Another source of value is synergy with diagnostics, specialty pharmacy and others. These functions have one major thing in common: In many situations, the member might call a service center for one reason but could benefit from being “hot-transferred” to a disease-management specialist if the need is detected. The hot transfer reduces not only the time to contact the member for disease-management outreach, but also reduces the wasteful practice of tracking down chronic-condition members through multiple phone calls. As an added bonus, the hot-transfer call often reaches people when they are ready to change.

A third is synergy with Medicare risk coding. Risk coding presents a more detailed and accurate look at a member's health status than a claims pull. The members who have the most complex care needs often receive in-person physician assessments, which can lead to an immediate hot transfer to the disease or case manager.

Just like the exaggerated reports of disease management's death, the promise of medical homes is also greatly exaggerated.

The concept of medical homes—providing comprehensive care in a single site for patients who need it—is a laudable one. As a complement for disease management, it should work dynamically to reduce preventable events for some patients.

Where the problem arises is in measurement, which is critical to determine cost-effectiveness and hence the added reimbursement.

The proponents of medical homes as a full replacement for disease management are making exactly the same measurement mistakes that DM proponents once made, even though the phenomena of regression to the mean and sample selection bias are now well-known. Medical-home proponents want to measure the “before” and “after” of the sickest patients and measure physician performance accordingly, without taking into account the fact that last year's sick patients often get better and less expensive on their own. With substantial reimbursement being added for these members, one can bet that more members requiring more services miraculously will be found.

Prediction: The medical-home concept will get bogged down in reimbursement arguments and measurement fallacies and will be relegated to a small portion of members.

Another prediction: The measurement debate will be solved, no thanks to actuaries.

Actuaries have typically handled the measurement function that has created all the controversy over return on investment. Now who is telling us that they can solve those same measurement problems? That's right—actuaries.

Even more so, actuaries recently found that North Carolina's Medicaid program had “saved” almost 50% in overall admission reduction, despite the fact that admissions for the conditions covered by their specific intervention hardly declined at all.

Ask any reputable biostatistician, epidemiologist, or health services researcher, and they will concur that the reliance on actuaries creates outcomes which are invalid, unreliable and confusing. It is no coincidence that every health plan executive named as a MANAGED HEALTHCARE EXECUTIVE Leader in Disease Management measures exactly what a biostatistician would measure: the rate of adverse events over time in the conditions being managed.

This approach is valid and transparent and will totally replace the expensive and misleading “prepost” analysis. **MHE**

Editor's Note: Al Lewis is the president of the Disease Management Purchasing Consortium and the founder of the Disease Management Association of America (now DMAA: The Care Continuum Alliance). He

is credited with conceiving and brokering the first-ever disease management contracts and inventing the “guaranteed

savings” concept. A two-time winner of the DMAA Most Influential Person Award, Lewis has created a benchmarking database of disease management outcomes with an event-rate-counting methodology that has been licensed by 28 plans, states and employers since its January release. His certifications for Critical Outcomes Report Analysis, Small Group Measurement and Savings Measurement Validity have heightened his industry recognition. Lewis is also on the MHE editorial advisory board and led the review process of the 2008 MHE Leaders in Disease Management. He was named the Number 1 Leader in Disease Management in 2004 and if not for his participation as a reviewer, would have been Number 1 in 2008.

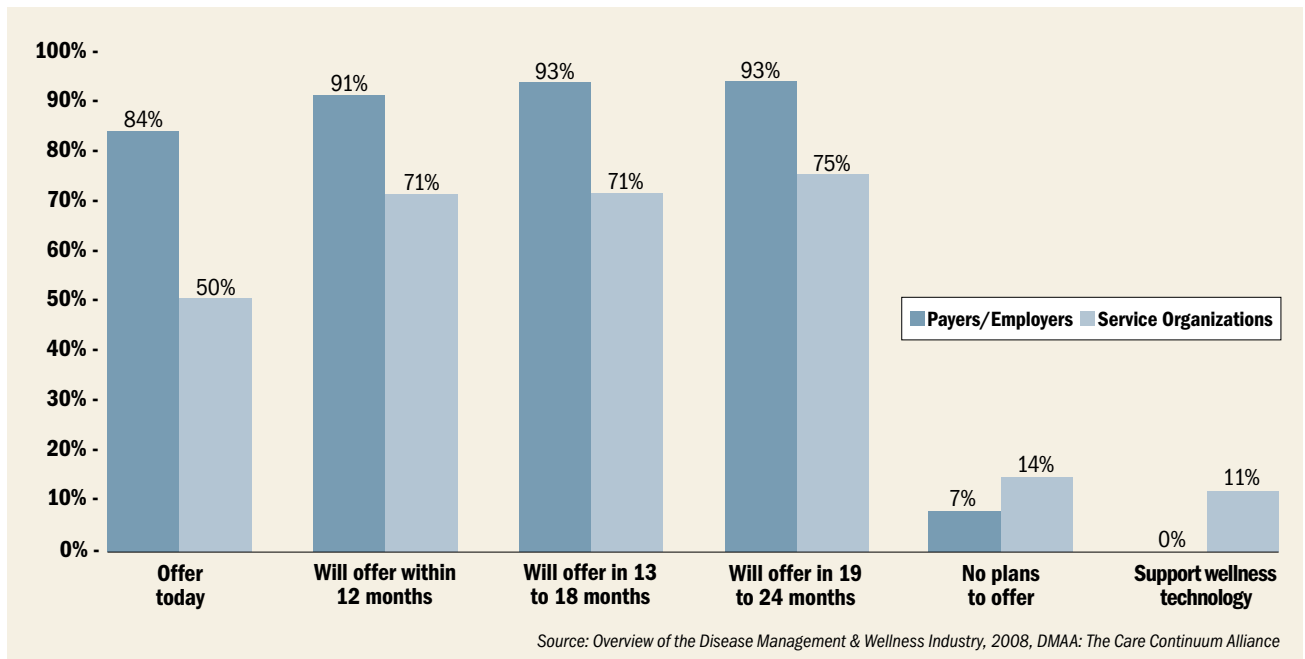


DM Facts

ORGANIZATIONS OFFERING WELLNESS PROGRAMS

Health insurance payers and employers, as well as organizations providing health services, indicate a strong desire in the next year to increase their commitment to wellness initiatives, an upcoming market analysis from DMAA: The Care Continuum Alliance shows. In the next 12 months alone,

the share of service providers offering wellness programs will rise from 50% to 71%, while 91% of health insurance payers and employers say they will include wellness initiatives among their benefits, compared with 84% today, the DMAA data show.



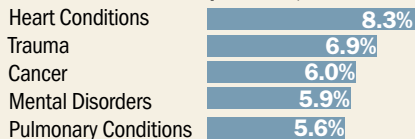
65%

Percentage of Medicare recipients having more than one medical condition

Source: RAND Corporation

TOP FIVE MOST COSTLY MEDICAL CONDITIONS

Share of total medical expenditures, 2002



Source: Agency for Healthcare Research and Quality, MEPS Statistical Brief 80

REPORTED RETURN ON INVESTMENT FOR DM PROGRAMS

Under 1-to-1	23.3%
Between 1-to-1 and 1.5-to-1	36.1%
Between 1.5-to-1 and 2-to-1	24.5%
Between 2-to-1 and 2.5-to-1	8.9%
More than 2.5-to-1	7.0%

Source: Managed Healthcare Executive, 2008 Reader Survey

DIABETES

\$325 billion in cost savings is projected if all diabetes patients reached treatment goals

Source: Diabetes Care, May 2008

60% of diabetes patients report achieving self-monitoring of blood glucose at least once per day

Source: Centers for Disease Control and Prevention

ASTHMA

22 million Americans are diagnosed with asthma

4,000 Americans die from an asthma attack each year

Source: Centers for Disease Control and Prevention

HEART DISEASE

10.3% of Americans are diagnosed with heart disease

18.3% of those diagnosed with heart disease continue to smoke

Source: Agency for Healthcare Research and Quality, MEPS Statistical Brief 165

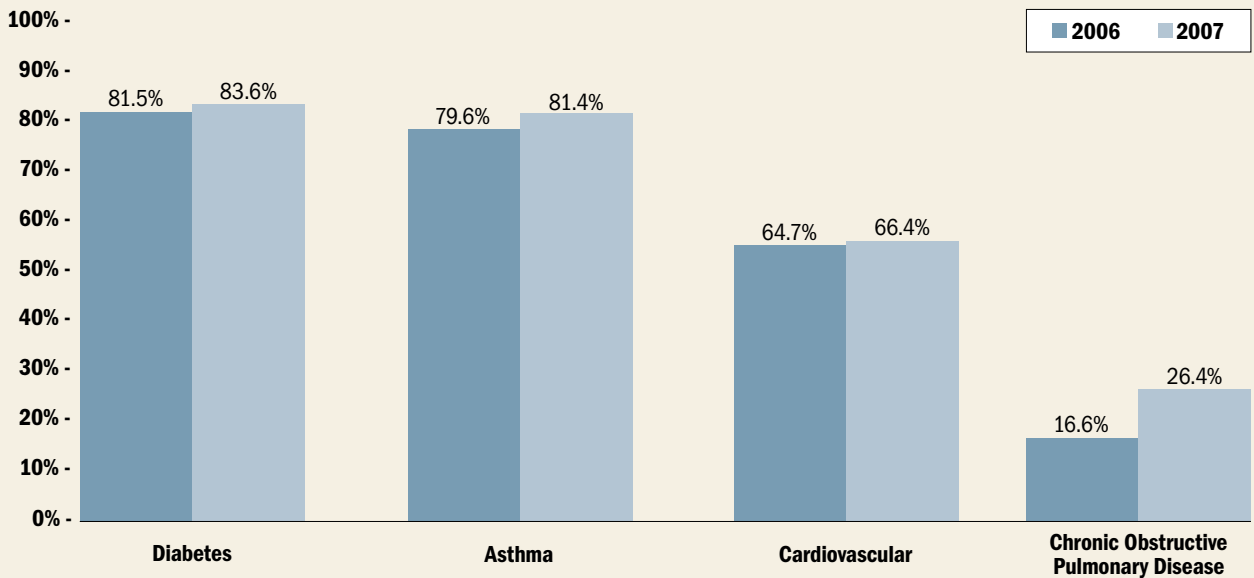
\$1 trillion

Annual impact of chronic disease on the U.S. economy

Source: Milken Institute

DM Facts

TOP DM PROGRAMS OFFERED BY HEALTH PLANS



Source: Verispan

\$2.1 billion

Disease management spending in 2007

Source: Disease Management Purchasing Consortium

TOP FIVE STATES WITH HIGHEST CHRONIC DISEASE

- West Virginia
- Tennessee
- Arkansas
- Kentucky
- Mississippi

Source: Milken Institute

PRESCRIPTION DRUG USE FOR CHRONIC CONDITIONS

U.S. adults reporting taking a prescribed drug for a condition, 2001



Source: Agency for Healthcare Research and Quality, MEPS Statistical Brief 58

66%

Percentage of workers who like the idea of earning discounts for healthy lifestyles

Source: National Business Group on Health

Disease management is a growing industry with more than \$2 billion in annual spending, up from \$1 billion in 2005. While the four most common conditions among DM programs—diabetes, asthma, cardiovascular disease and chronic obstructive pulmonary disease—have remained steady, there are far more up-and-coming conditions with potential for DM investment.

Hypertension, gastrointestinal and HIV/AIDS patients stand to benefit from interventions similar to those in traditional DM programs, such as medication adherence, diet and exercise. As the base of clinical evidence grows around the world, a solid DM strategy has the capability to leverage evidence to improve patient outcomes.

With such prospects for disease management and its wider stance alongside wellness, the healthcare industry has placed great confidence in the concept and great hopes for its return on investment.

In 2004, **MANAGED HEALTHCARE EXECUTIVE** highlighted Leaders in Disease Management from health plans and disease management companies, largely based on their program size and commitment to DM. In keeping with the evolution of disease management and its ever-broadening scope, the 2008 list of **MHE** Leaders in Disease Management presented here is based on accomplishments in disease management rather than on program size. To make our determinations, we evaluated these leaders against objective criteria, such as blinded outcomes reports, while considering current industry activities.

The leaders generally fall into three categories—consultant/academic thought leaders, vendors and health plan or employer executives.

The question to answer: To what degree is the disease management field shaped as a result of this person's active involvement? Leading consultants and academics in the field who have authored DM research or achieved one-of-a-kind accomplishments qualified. Vendors with comparatively superior outcomes also qualified as leaders. Generally, the larger vendors have shown the most innovation and have the most experience.

Executives at regional and provider-owned health plans in particular—as well as a few among the national plans—have made the most progress toward greater accountability and greater innovation in disease management. To measure accountability and validity in health plans, we looked at third-party validations, such as recognition from the Disease Management Purchasing Consortium (DMPC); Health Industries Research Companies (HIRC); DMAA: The Care Continuum Alliance; or the Blue Cross & Blue Shield Assn. Outcomes reports delivered to employers were reviewed to be sure that they were actuarially sound.

Measuring health plan innovation can be subjective, of course. An innovation that appeared to deliver results and was at least in part an original implementation was deemed superior to a program that simply applied a typical product. In order to be named as an **MHE** Leader in Disease Management, health plan executives had to qualify for both innovation and accountability/validity.

Many physicians, executives and DM advocates submitted impressive credentials and success stories, but not all achieved the same level of industry leadership and influence. Those who have leveraged their knowledge and created clinical and financial value for members have been named among the 2008 **MHE** Leaders in Disease Management.

2008 LEADERS in DISEASE MANAGEMENT

—The Editors



JOAN KENNEDY

President

Health Management Corporation (HMC)

Senior Vice President

WellPoint, Inc.

Joan Kennedy is the architect of 360° Health, originally piloted through Empire Blue Cross Blue Shield in New York and later adopted by parent company WellPoint, which now provides the programs to its 34 million members.

Prior to joining WellPoint, Kennedy served as vice president, health services, for Empire, previously known as WellChoice. HMC, a WellPoint subsidiary, provides integrated care and total population health solutions. Kennedy is credited with growing the business 376% over three years.

Kennedy's mantra focuses on empowering a multidisciplinary team of providers. To accomplish these objectives, HMC developed six pilot programs to test: segmenting member populations; tools for building a culture of health; state-of-the-art messaging; use of medical monitoring devices for hypertension and diabetes; reducing ethnic disparities; and diabetes education and management.

Kennedy previously served as vice president, product development and operations for CorSolutions. She also directed the DM and behavioral health programs for Oxford Health Plans, where she helped produce returns ranging from 200% to 400%.

She is a founding member of DMAA and was a 2004 MHE Leader in DM. **MHE**

—*Mari Edlin*

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