A National Employer Perspective:

Refining Purchaser Business Requirements for Disease Management Organizations

Presentation to:
The Disease Management Colloquium

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About the Pacific Business Group on Health

- Founded in 1989
- 50 large employer members
- Billions in annual health care expenditures
- >3 million covered lives
- PacAdvantage: small group purchasing pool (10,000 small groups of 2-50 employees)

Pacific Business Group on Health Members

Pacific Business Group on Health: Mission and Priorities

Mission: To improve the quality and availability of health care while moderating costs.

- Quality Measurement and Improvement
- Value Purchasing
- Consumer Engagement

PBGH Purchasing Elements for Value Breakthrough

Count Value:
Higher value options are identified and made available

1. Health Plans are routinely assessed on 6 IOM dimensions of performance*, starting with: risk & benefit-adjusted total cost PMPY, HEDIS and CAHPS; and implementation of breakthrough elements 2-6
2. Individual Providers and Provider Organizations are routinely assessed on 6 IOM dimensions of performance, starting with (allocative) efficiency, effectiveness, and patient centeredness
3. Health & Disease (H/D) Management Programs and Treatment Options are routinely assessed on 6 IOM dimensions of performance

Make Value Count:
Higher value options are reinforced by the market

4. Consumer Support enables consumers to recognize higher value plans, providers, H/D management programs, and treatment options in a timely and individualized manner
5. Benefit Architecture encourages all consumers to select high value options
6. Provider Payment incents high performance today and re-engineering to enable higher performance tomorrow

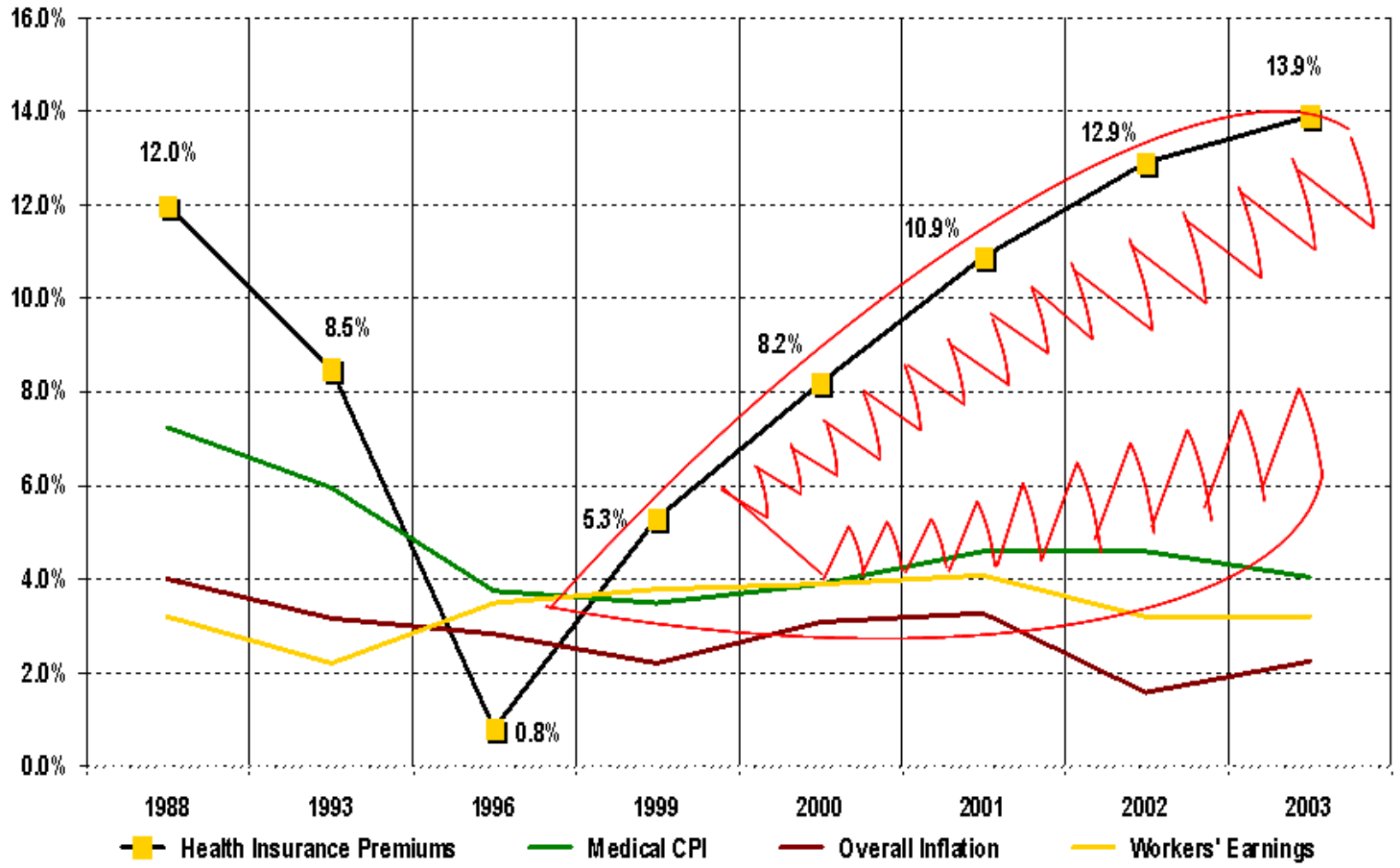
Capture Value Gains:
Breakthroughs in health benefits value occur

Today's Gain: Migration
Consumers migrate to more efficient, higher quality plans, providers, H/D management programs, and treatment options (= an initial 5-15 net percentage point offset of future cost increases; and > 2 Σ quality reliability)

Tomorrow's Gain: Re-engineering
Sensing a much more performance-sensitive market, health plans, providers, H/D management programs, and biomedical researchers create stunning breakthroughs in efficiency and quality of health benefits (= further net percentage point offsets of future cost increases; and > 4 Σ quality reliability)

*The six Institute of Medicine performance dimensions: Safe, Timely, Effective, Efficient, Equitable, Patient-centered

Cost Pressures – No End in Sight



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; 2003. Dental work by Arnie Milstein, MD.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

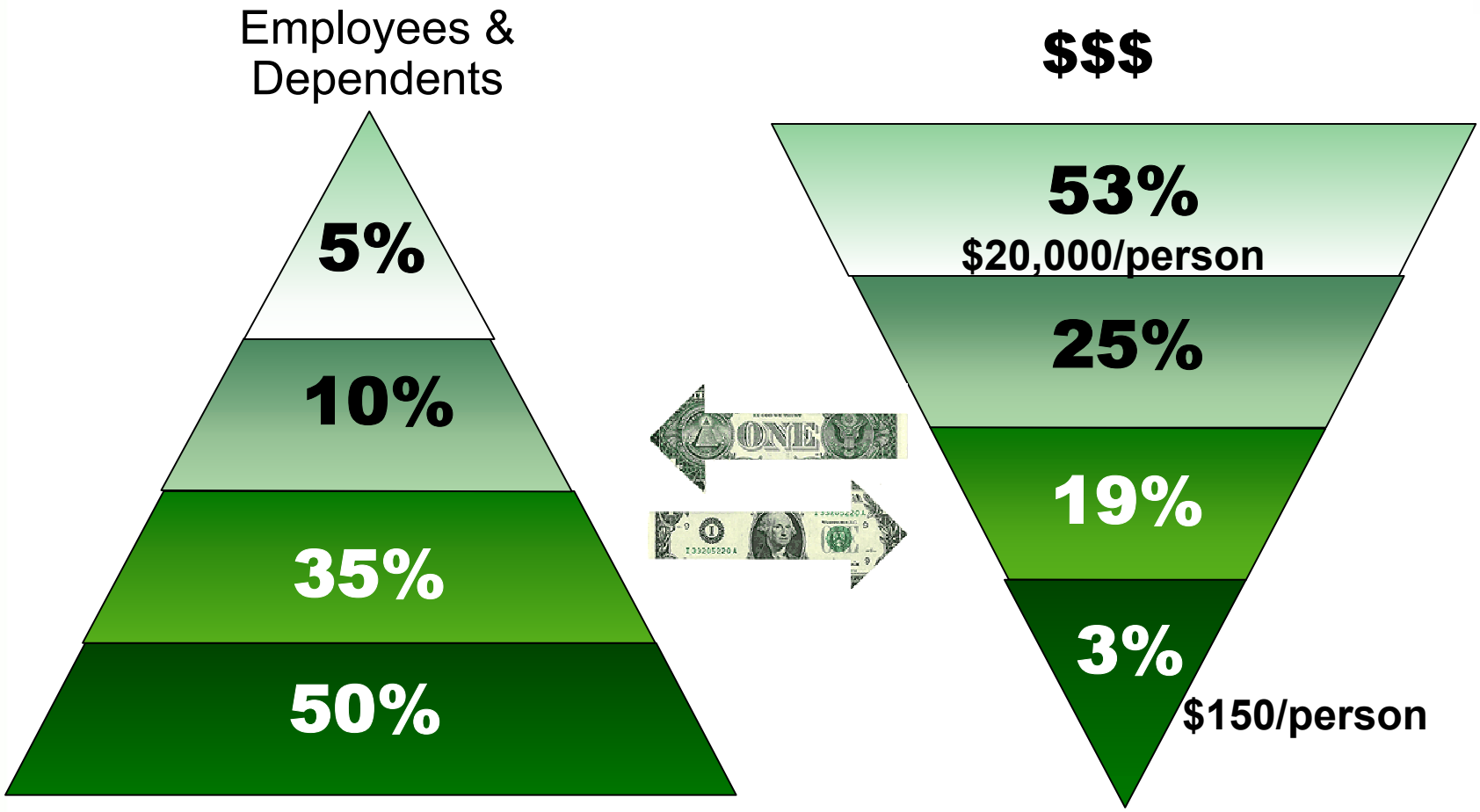
Breakthrough Plan Competencies: Potential Impact on Premium

Health Plan Competency	Potential Premium Value		
	Low	Medium	High
1. Health Promotion	0.1%	1.7%	5.2%
2. Health Risk Management a. Risk reduction b. Self-care and triage c. Disease management	-1.3%	1.1%	5.6%
3. Shared Decision-Making/Treatment Options	0.1%	0.4%	1.0%
4. Provider Options	7.3%	12.2%	17.0%
5. Consumer Incentives & Engagement	NA	NA	NA
6. Provider Incentives & Engagement	NA	NA	NA
TOTAL PREMIUM VALUE	**6.2%**	**15.4%**	**28.8%**

Source: Arnie Milstein, MD, Mercer HR Consulting

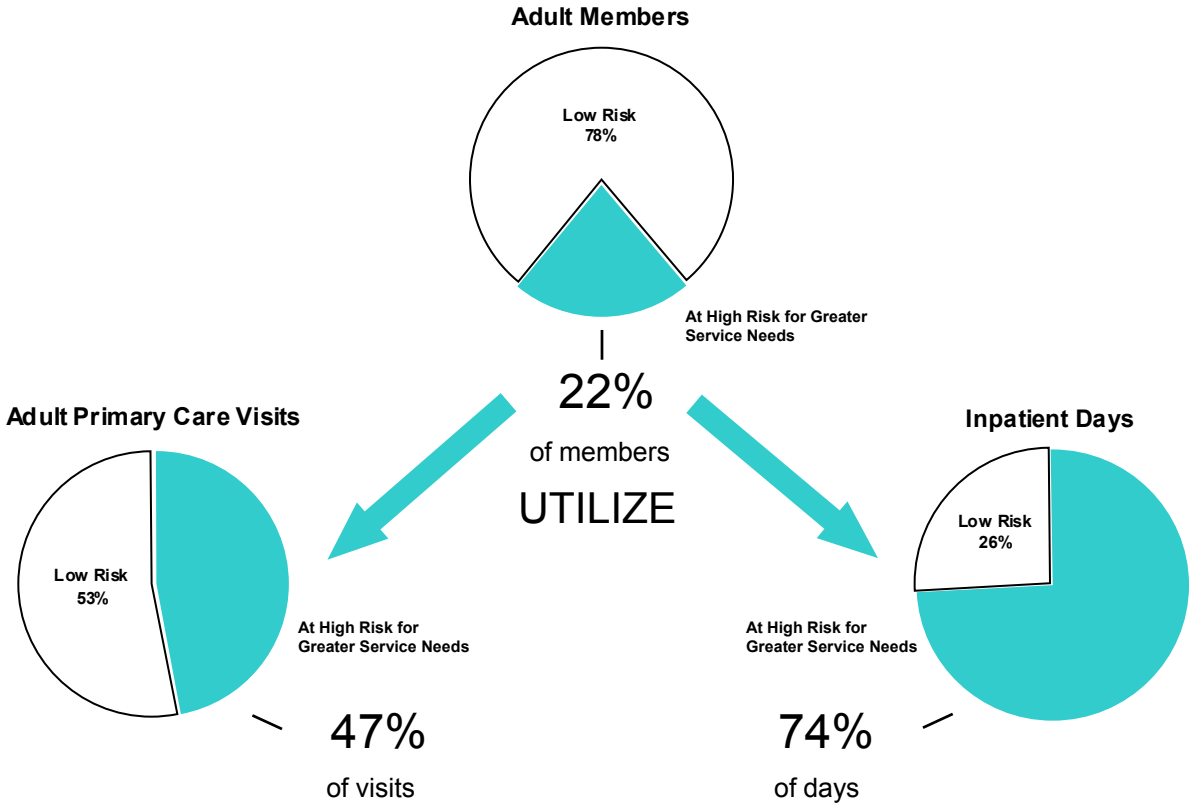
Harnessing the Value of Health Improvement

15% of people account for nearly 78% of cost



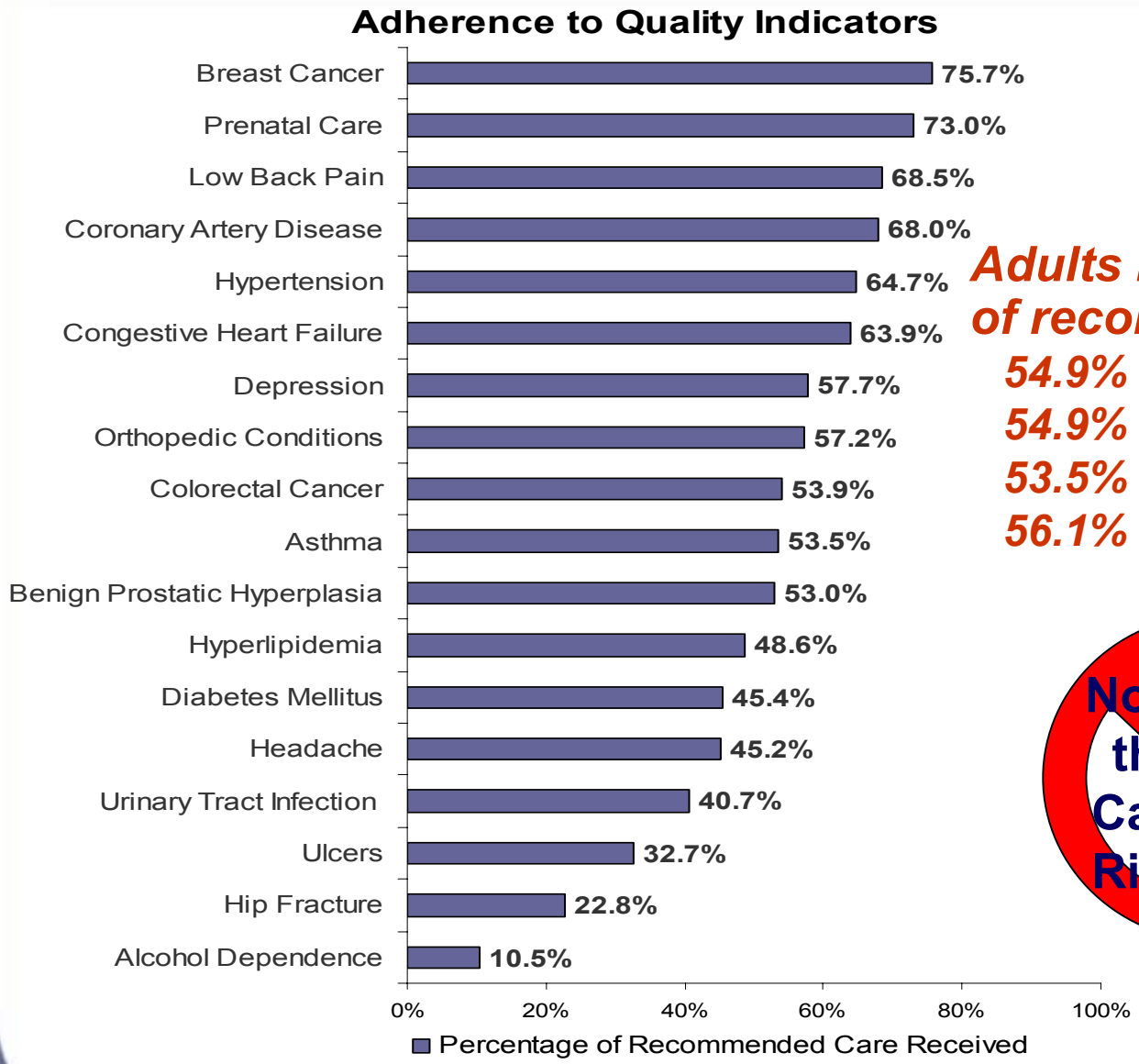
Source: Mercer HR Consulting

Members with chronic conditions utilize services far more than the average member



* Excluding OB, HOPS and HAS

Quality Shortfalls: Getting it Right 50% of the Time



Adults receive about half of recommended care

- ***54.9% = Overall care***
- ***54.9% = Preventive care***
- ***53.5% = Acute care***
- ***56.1% = Chronic care***

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Key reasons why employers should focus on chronic conditions:

- ✓ Chronic conditions are a major driver of health care premiums.
- ✓ Most every employer has a significant number of employees with chronic conditions.
- ✓ Chronic conditions have a significant impact on an employer's bottom line due to increased absenteeism and decreased productivity at the worksite.
- ✓ Understanding chronic conditions data enables employers to develop more effective strategies to reduce costs and improve the health of their employees.

PBGH has been pushing the market on Disease Management since 1995

- 1995-Date: PBGH Negotiating Alliance Performance Guarantees
  - 2% of premium at risk for HEDIS, disease management and consumer engagement
- 1999-Date: eValue8 common RFI
  - PBGH Negotiating Alliance RFP – California HMOs
  - Also used by BHCAG, MBGH & national employers
- 2001-2002 PBGH Disease Management Effectiveness Project
  - On-site audits of 7 California HMOs
- 2003 PBGH Breakthrough Plan Competency Assessment
  - "Breakthrough" readiness inventory of 10 California HMO, national PPO and CDHP plans
- 2003-2004 Joint Purchaser Group Disease Management Vendor Assessment

PBGH Negotiating Alliance RFP – "eValue8" Health Plan RFI

- Plan Profile
- Health Information Technology
- Consumer Engagement and Support
- Provider Measurement: Incentives and Rewards
- Primary Prevention and Health Promotion
- Disease Management (Asthma, Cardiovascular Disease, and Diabetes)
- Behavioral Health (Screening and Treatment for Alcohol Use Disorders and Depression Management)
- Pharmacy Management

PBGH Breakthrough Plan Competency: Disease Management

- Targeting of conditions based on program efficacy, condition cost and prevalence
- Proactive, accurate and timely identification of members using medical and Rx claims, nurseline and case management information
- Stratification with estimated clinical and efficiency gain matched to intervention
- Recruitment, participation goals, and incentives geared to risk stratification level
- Provider-oriented interventions
- Quantification of net savings and program cost-effectiveness

PBGH

2002-2003 Breakthrough Plan Competency Evaluation

Disease Management "Best-in-Class" Features Score Card*

○ = Does not meet ◒ = Meets ● = Exceeds

Disease Management: **Longitudinal programs to encourage optimum management by patients, caregivers and providers of health and cost risks associated with chronic or sever illness/injury**	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Targeting of conditions is based on valid evidence of program efficacy or effectiveness, as well as on the prevalence and cost of such conditions in a health plan's population. For representative group health populations, targeted conditions include, at a minimum, CAD, depression, diabetes and asthma.	◒	◒	◒	◒	◒	◒	○	◒	◒	◒
Enrollees with targeted conditions are identified proactively, accurately and quickly using, at a minimum, medical and prescription claims, nurseline and QM/UM/CM information.	◒	◒	○	○	◒	○	◒	○	●	●
Identified enrollees are stratified by likely degree of estimated clinical and efficiency gain and matched to a corresponding level of intervention.	◒	◒	○	◒	●	○	◒	○	◒	●
Recruitment effort, participation goals, and cost-effective incentives are geared to each enrollee's risk stratification level	◒	◒	○	◒	◒	○	○	○	◒	○
Physician-facing interventions, including enlisting physician help in motivating high-risk patients to participate are coordinated with patient-facing interventions.	◒	◒	○	○	●	○	○	○	◒	◒
Net savings and cost-effectiveness are quantified and continuously improved.	○	○	○	○	○	○	○	○	◒	○

*All data self-reported by health plans and unaudited.
Some services available as "buy-ups"

Joint Purchaser Group – DM Vendor Assessment Project Partners:

- Buyers Health Care Action Group (MN)
- Health Action Council of Northeast Ohio**
- Midwest Business Group on Health (IL)
- St. Louis Area Business Health Coalition
- California Public Employers-Employees Trust Fund Group
- Southern California Schools VEBA
- Pacific Business Group on Health

**New project partner as of June 2004

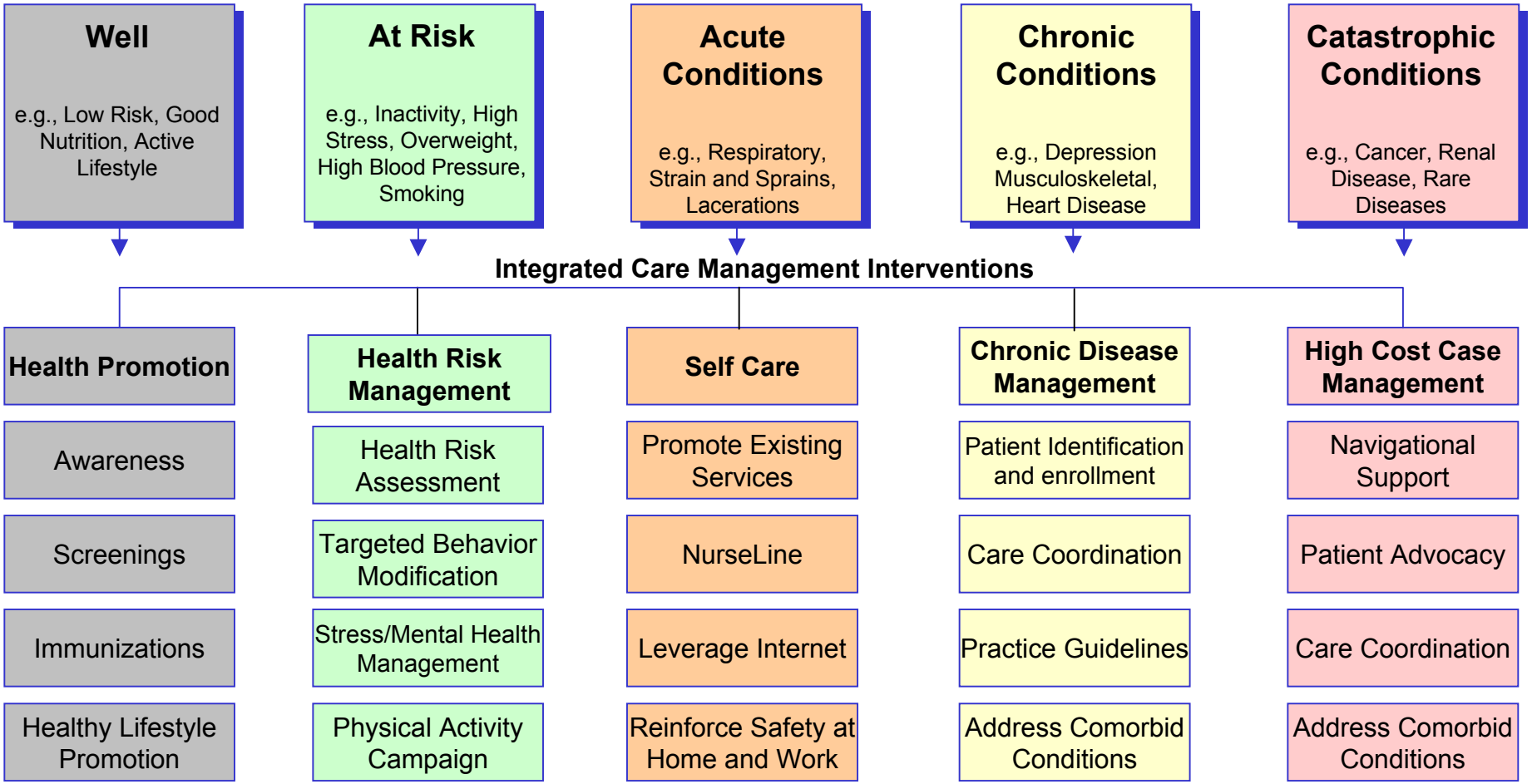
DM Vendor Assessment Goals and Scope

- Develop industry leading performance expectations
- Define purchaser business requirements
- Enhance existing evaluation approaches
- Aggregate information on DM vendor landscape
- Profile top vendors
- Identify best practices among vendors
- Negotiate group purchasing contracts with a set of “best-in-class” DM vendors

Project Goals and Scope, *cont.*

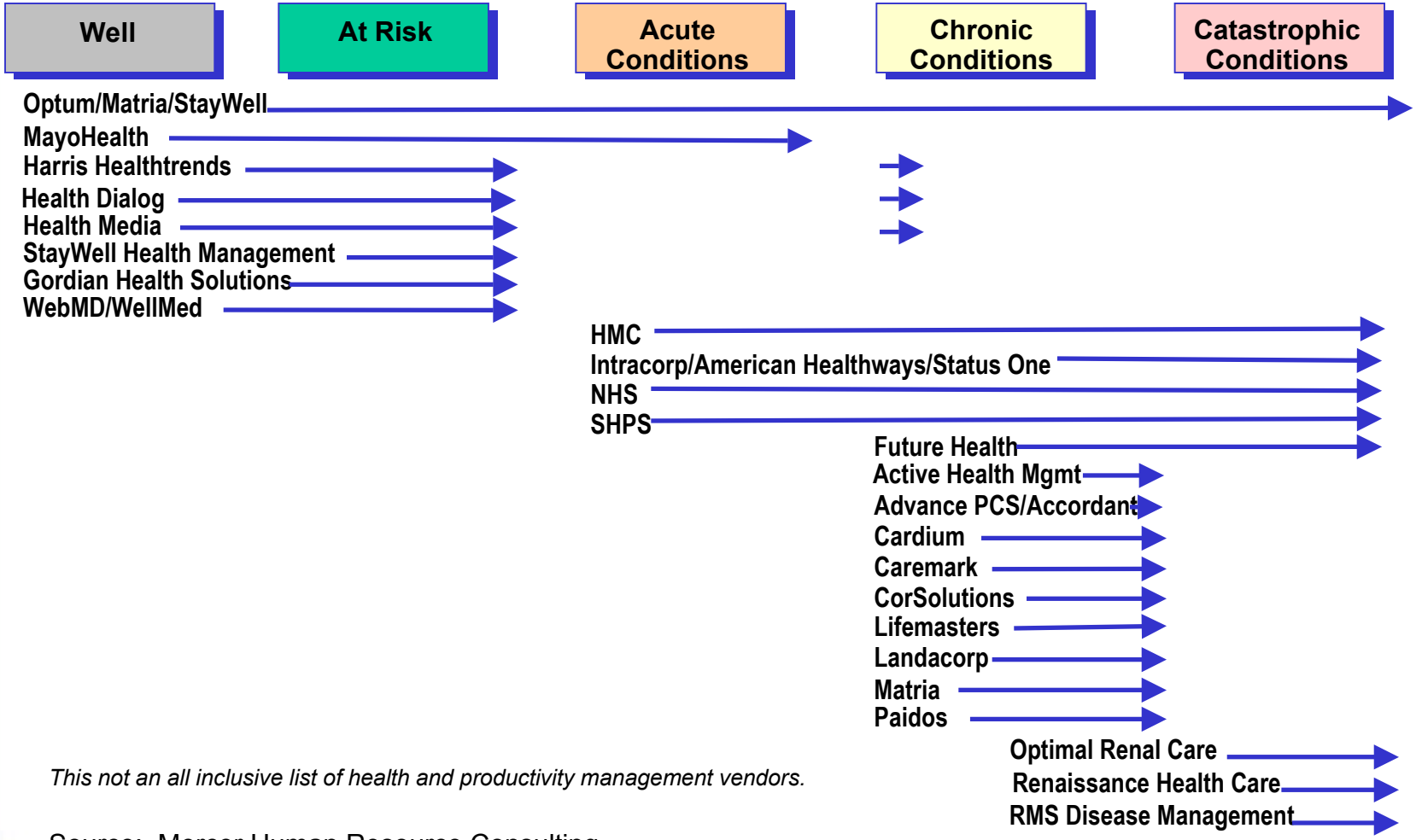
- Phase II: Assessment of Health Plan Disease Management “buy-up” options
  - Evaluate health plan-based DM “buy-up” options
  - Understand the business case for buying DM through a health plan vs buying direct through a vendor

Integrated Health and Productivity Management



Source: Mercer Human Resource Consulting

Initial Vendor Review: Health & Productivity Management Vendor Landscape



This not an all inclusive list of health and productivity management vendors.

Source: Mercer Human Resource Consulting

Marketplace Complexity

Program origins/ownership/mission

- Pharmaceutical companies – brand product focus
- PBMs – compliance focus, literature-based
- Specialty vendors – clinical focus / behavioral focus
- Health plans – HEDIS emphasis

Market evolution

- Movement toward population health; less focus on single disease
- Increasing partnerships/acquisitions to cover entire health continuum
- Improving data and process integration capabilities

Varied market focus

- Exclusively work with health plans on a direct basis
- Focus on large employers (10,000 lives+) versus open to middle market employers
- Varied willingness to subcontract (carve-in versus carve-out)

DM Marketplace Complexity (Cont'd)

Delivery models

- Opt-in versus opt-out enrollment models
- Level of provider involvement
- High acuity versus population-health options
- Investment in participant resources and tools

Outcomes

- Evolving definition of outcomes: clinical, behavioral, functional, quality of life
- "Mystery" around ROI analysis and impact evaluation

Financial arrangements

- Varied financial arrangements (e.g. PEPM, PMPM, differential for acuity level, case rate, fee for service)
- Huge inconsistency in performance metrics and guarantees
- Conservative versus aggressive financial risk arrangements

Vendor Requirements

Services

- Diseases managed include: asthma, diabetes, CHF, CAD, musculoskeletal and COPD
- Support case identification through all data sources: Rx, medical claims, HRAs, referral
- Identify, monitor, and educate participants in ways that improve clinical and functional status:
- Support provider engagement and intervention
- Effectively integrates with the entire care continuum

Outcomes

- Improved clinical outcomes and functional status
- Lowered overall costs of care
- Improved compliance, knowledge and skill in self-management
- Reduced absenteeism and productivity loss due to illness

Source: Mercer Human Resource Consulting

DM Vendor Programs Reviewed

- ActiveHealth Management
- Cardium Health Services
- Caremark
- CorSolutions
- Focused Health Solutions
- FutureHealth Corporation
- Health Dialog
- LifeMasters
- Intracorp/American Healthways

RFP Components

- Business status and organizational stability
- Financial history and performance
- Business scope and focus
- Geographic coverage and client references
- Quality and Accreditation status
- Experience–Employer or health plan focus
- Account Management/Operations
- Implementation
- Identification, Stratification, Recruitment and Enrollment
- Program Integration and Coordination of Care
- Program Interventions
- Provider Engagement
- Technology, Eligibility Systems and HIPAA Compliance
- Measurement, Evaluation and Reporting
- Contracting Terms & Performance Guarantees

RFP Components

	Weight
Business status and organizational stability	20
Financial history and performance	30
Business scope and focus	173

- Business status and organizational stability
- Financial history and performance
- Business scope and focus
  - "Core" types of clinical programs
    - Asthma
    - Coronary artery disease
    - Congestive heart failure
    - Diabetes
    - Chronic pain management
    - Musculoskeletal/low back
    - Chronic obstructive pulmonary disease
    - Depression
  - Service capabilities
    - HRA
    - Nurseline support/health advocate
    - Utilization and case management

RFP Components, *cont.*

	Weight
▪ Geographic coverage and client references	100
▪ Quality and Accreditation status	60
▪ Experience–Employer or health plan focus	40
▪ Account Management/Operations	140
▪ Service support	
▪ Workflow management	
▪ Staff development	
▪ Organizational management	
▪ Implementation	80
▪ Implementation plan	
▪ Staff resources	

RFP Components, *cont.*

	Weight
▪ Identification, Stratification, Recruitment and Enrollment	150
▪ Predictive modeling and data analysis	
▪ Data capture and reporting	
▪ Member engagement strategies	
▪ Program Integration and Coordination of Care	140
▪ Data integration	
▪ Coordination of services and interventions	
▪ Program Interventions	280
▪ Types of program interventions	
▪ Communication and member engagement strategies	
▪ Use of evidence-based guidelines	
▪ Provider Engagement	140
▪ Physician communication/education	
▪ Profiling	

RFP Components, *cont.*

- Technology, Eligibility Systems and HIPAA Compliance 73
  - Systems
  - Reporting
- Measurement, Evaluation and Reporting 140
  - Capture of medical cost savings and utilization impact
  - Ability to measure clinical outcomes and ROI
  - Track record in reporting financial and clinical outcomes
  - Client reporting
- Contracting Terms & Performance Guarantees 700
  - Contract terms
  - Performance metrics
  - Willingness to partner with coalitions and employer clients
  - Financial terms
    - Program costs
    - Leveraged discounts for coalition participants

RFP Performance Areas with Heaviest Weighting

- Account Management/Operations
- Identification, Stratification, Recruitment and Enrollment
- Program Integration and Coordination of Care
- Program Interventions
- Provider Engagement
- Measurement, Evaluation and Reporting
- Contracting Terms & Performance Guarantees

Value-Purchasing: Key Areas of DM Vendor Differentiation

- Scope of services offered
- Member identification and engagement model
  - Predictive modeling
  - Population segmentation strategy
  - Intervention frequency and intensity varies
- Cost model - PEPM or PPPM
- Performance metrics
  - Operations: Implementation, member engagement rates, member satisfaction and service
  - Clinical process and outcomes
  - Financial performance
  - Outcomes and ROI measurement, evaluation and reporting

Typical DM Program Interventions

LOW RISK	*MODERATE RISK*	*HIGH RISK*
Welcome Call Welcome Packet that includes - Introduction Letter - Clinical Guide - Magnet 800# - Signals for Action Calendar	Welcome Call Welcome Packet that includes - Introduction Letter - Clinical Guide - Magnet 800# - Signals for Action Calendar	Welcome Call Welcome Packet that includes - Introduction Letter - Clinical Guide - Magnet 800# - Signals for Action Calendar
Nurse Connections 24-hour Support Line	Nurse Connections 24-hour Support Line	Nurse Connections 24-hour Support Line
Web Access	Web Access	s Web Access
Voice Connections Speech Recognition Surveys and Education	Voice Connections Speech Recognition Surveys and Education	Voice Connections Speech Recognition Surveys and Education
Quarterly Newsletter *	Quarterly Newsletter *	Quarterly Newsletter *
Electronic Newsletter	Electronic Newsletter	Electronic Newsletter
Annual Quality of Life Survey (random sampling)	Clinical Education Mailings based on individual needs	Individualized Telephonic and Mailed Education includes Quality of Life Survey
	Quarterly Telephonic Risk Assessment, Depression Screening and Education includes Quality of Life Survey *	Introduction Kit that includes - Nurse Biography - Medical Records Consent - Pill Box (as needed) - Scale (HF Program) - A1c Kit (Diabetic Program)
		Biometric Monitoring as needed
		Social Services as needed
		Physician Intervention and Follow-up

Joint Purchaser Datafile – Vendor Results

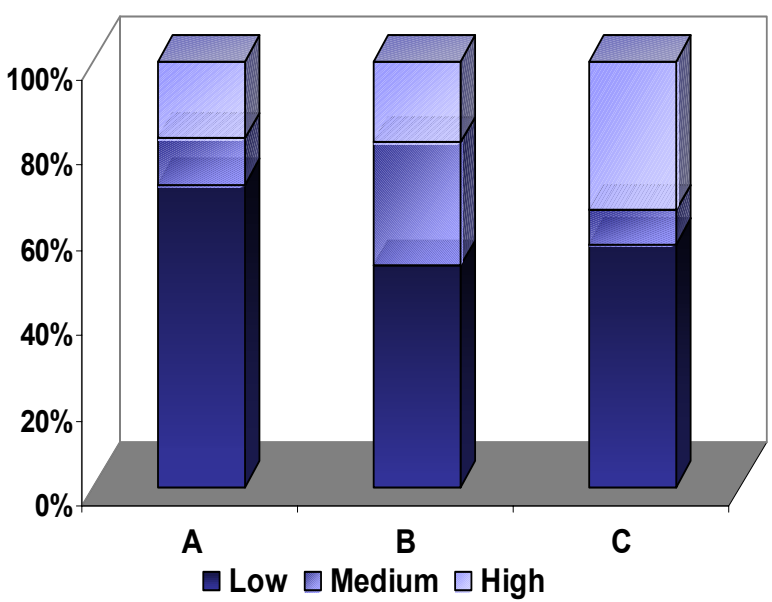
	Vendor A		Vendor B		Vendor C		Vendor D	
	Total	%	Total	%	Total	%		%
# of Claimants	85624		85624		85624		88004	
Diabetes	**1261**	**1.5%**	**1298**	**1.5%**	**1661**	**1.9%**	**1086**	**1.2%**
CAD	**247**	**0.3%**	**491**	**0.6%**	**668**	**0.8%**	**382**	**0.4%**
CHF	**82**	**0.1%**	**94**	**0.1%**	**171**	**0.2%**	**44**	**0.0%**
MCS	**758**	**0.9%**	**7963**	**9.3%**	**3057**	**3.6%**		
COPD	**148**	**0.2%**	**182**	**0.2%**	**180**	**0.2%**	**49**	**0.1%**
Asthma	**704**	**0.8%**	**554**	**0.6%**	**1284**	**1.5%**	**172**	**0.2%**
Hypertension	**1782**	**2.1%**						
High Cholesterol	**4752**	**5.5%**						
Cancer*			**307**	**0.4%**				
Maternity*	**862**	**1.0%**						
Depression								
	10596	**12.4%**	**10889**	**12.7%**	**7021**	**8.2%**	**1733**	**2.0%**

Note: Data sample did not include pharmacy claims

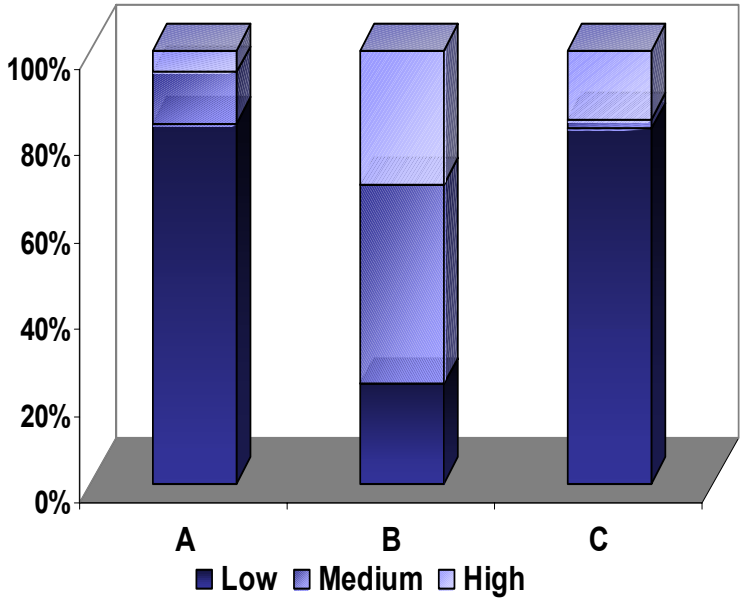
Differences in Population Stratification Three Disease Management Vendors

- ***What is the program reach?***
- ***What are interventions at each level (and for what duration)?***
- ***What are you paying for?***

Coronary Artery Disease



Diabetes



Hierarchies for "cascading" co-morbidities varies across vendors

Vendor A	Vendor B	Vendor C	Vendor D
Cancer	Diabetes	PEPM Total risk Calculation	
CHF	CAD		CHF
Diabetes	CHF		CAD
COPD	Pain		COPD
CAD	COPD		Diabetes
Asthma	Asthma		Asthma
Pain	Cancer		Pain

Intervention frequency and intensity varies significantly

- Duration of engagement varies by Vendor:
  - PEPM models tend to engage members for shorter period
- Intensity of engagement varies by vendor
  - Frequency of mailings and outreach to members
  - Provider interaction and communication
  - Goal setting and biometric self monitoring

Engagement and intervention strategies can be customized

- Purchasers can elect to “dial-up” (or down) the scope of patients targeted for mediation
- Vendors will provide PPPM rates for the mediated participants only – i.e., no intervention on low risk, do not pay for low risk. Results in higher PPPM cost and higher short term ROI
- Purchasers can buy individual disease states (however, there are “minimum” bundles)
- Purchasers can buy blocks/sets of conditions with a “blended” rate

Performance Guarantees Percentage of Fees at Risk

Category of Risk	Vendor A	Vendor B	Vendor C*
Financial	10%	7%	15%
Clinical	10%	7%	15%
Operational	10%	6%	15%
Allocation Not to Exceed	20%	20% if Group > 20,000 4% on svc only, Group< 20,000	30%

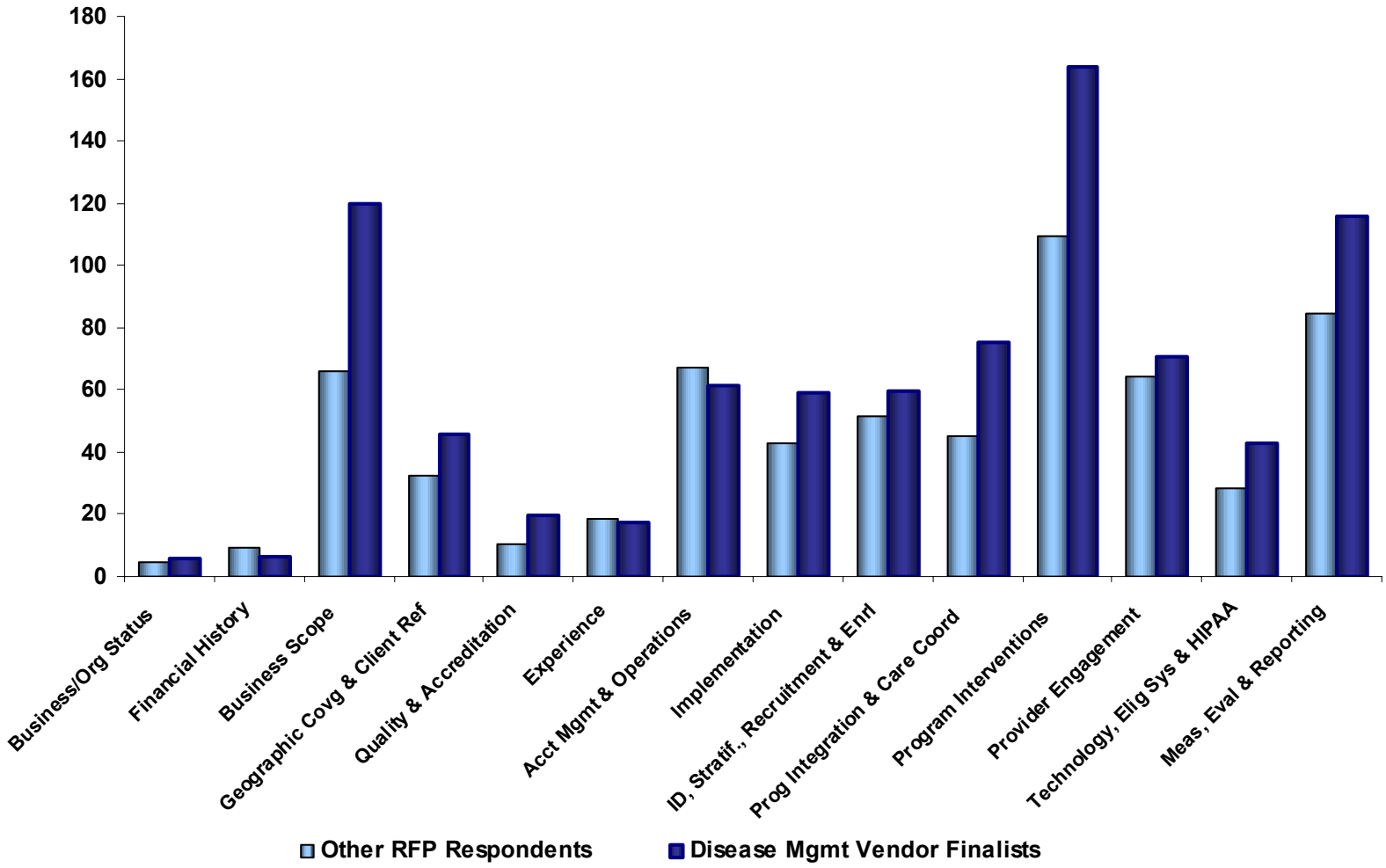
* limits:
1) Allocation on Financial measures to minimum 5% and maximum 15%
2) Allocation on Clinical/Operational measures minimum 3% and maximum 5%

Performance Guarantees: ROI Options

Alternative approaches:

- 100% of fees at risk for a break-even (1:1) guarantee
- Purchaser-specific ROI targets based on employer demographics and risk profile based on claims analysis

Performance of DM Vendor Finalists



JPG DM Vendor Contracting Three Key Objectives

- Support a wide range of DM strategies
- Simplify the contracting process
- Negotiate competitive pricing and guarantees

JPG Contracting Objectives

Objective 1:
Support a wide range of DM strategies

Negotiated 2 product alternatives with each Vendor:

CorSolutions

1. Disease-specific programs and pricing
2. Health Solutions - “block” of 30 conditions with a “blended” rate

LifeMasters

1. Disease-specific programs for low/moderate/high acuity
2. Disease-specific programs for moderate and high acuity only

Health Dialog

1. Top 20% of population by acuity / risk stratification
2. Shared Decision-making / treatment option support coaching only

JPG Contracting Objectives

Objective 2:
Simplify the contracting process

- Standardized “core” contract and Employer Participation Agreement across vendors
- “DMV Services Exhibit” associated with each specific vendor product
- Standardized performance guarantees with variable weighting subject to employer preference
- Consistent ROI methodology across all vendors

JPG Contracting Objectives

Objective 3:
Negotiate competitive rates / pricing

- Most favored nation pricing
- Volume discounts based on total JPG enrollment thresholds
- Achieve pricing transparency
- Eliminate the negotiation process

Buy “up” or Buy “out” Health Plan versus Vendor Disease Management Programs

Assessment of "in-sourced" Health Plan DM Landscape (buy-ups)

National

- Aetna ➔ Lifemasters (Diabetes/Cardiac)
- CIGNA ➔ American Healthways
- United HealthCare ➔ Cor Solutions/Lifemasters

Regional

- Anthem ➔ Active Health Management
- Blue Cross of California ➔ Internal
- Blue Shield of California ➔ Responded to eValue8
- BCBS of Minnesota ➔ American Healthways
- BCBS of Illinois ➔American Healthways/Health Dialog
- Mercy Health Plan ➔ Internal (partial response)

Other (vendor)

- PacifiCare ➔ Aggregator (Alere, Qmed, AirLogix, etc.)

Gap Analysis - Compare Health Plan DM service offerings to Vendor offerings

- Key objectives and evaluation framework
- Performance expectations
- Disease management approaches – buy-up with a health plan vs. buy-out to DM vendor
- Vendor and health plan composite scoring
- Vendor and health plan profiles
  - Strengths and weaknesses
  - Scope of services
  - Program interventions
  - Measurement and evaluation
- Vendor and Health plan service comparison

Carve-in solution: *Work with the health plan*

Note: Many carriers are outsourcing their DM services

- Advantages
  - Ease of implementation and may be less expensive (no data transfer fees)
  - Improved data flows
  - Expansion of an existing relationship – one contract
  - Plan familiarity with employer culture, needs and expectations
  - Integration with case management and utilization management
  - Contractual relationship with physician potentially gives plan greater leverage in eliciting provider engagement
- Disadvantages
  - Solutions are often less robust (less frequent member contact)
  - Smaller percent identified as high risk
  - Inconsistency of programs across employer's plan offerings
  - Not available to employees enrolled in other plans offered by the employer
  - Delegation to carrier for management and accountability of vendor
    - Less robust performance reporting
    - Less robust performance guarantees
    - Indirect relationship to vendor (may affect customization)
  - Lack of price transparency

Carve-out solution: *Work with a vendor*

- Advantages
  - Vendor focus and track record - time and participant tested
  - Can customize program design (vs. packaged program)
  - Customized performance guarantees and ROI results
  - Customer-specific performance reporting by disease category
  - More direct relationship – management and accountability
  - Alignment of objectives
  - Enterprise-wide solution across employer's plan offerings – all employees have access to the same disease management services
  - Price transparency
- Disadvantages
  - Can be costly, taking into consideration data transfer fees
  - Requires Plan and other carrier/PBM cooperation
  - Coordination of care challenges (utilization management, high risk case management)
  - Additional vendor management, oversight, contracts, etc.
  - Less integration and influence with physicians

PBGH & Where to Get More Information

Learn more and subscribe to the PBGH e-letter at:

- www.pbgh.org

Check out the new Breakthroughs in Chronic Care program at:

- www.breakthroughcare.org

Review medical group and health plan quality information at:

- www.healthscope.org

Learn more about PBGH's small employer purchasing pool at:

- www.pacadvantage.org