Private Purchasers of Health Care: Roles of Employers and Health Plans in the Care System

Spring, 2019 (Term A)

COURSE & CONTACT INFORMATION

Credits: 2
Meeting Day(s): January 6 and January 22 – March 11, 2019
Meeting Time:
Meeting Place:

Instructor: Jon B. Christianson
Email: chris001@umn.edu
Office Phone: 612-625-3849 D199 Mayo
Fax: 612-624-2196
Office Hours: By Appointment
Office Location: 15-225 Phillips Wangensteen Building

COURSE DESCRIPTION

Add course description] Payments received from private insurance companies are critical to the financial survival of most health care providers. These funds come for the most part from employers that pay insurance companies to manage their employee health care expenses (considered to be part of employee compensation). The purpose of this course is to help future health care managers understand the goals of their best customers and how health plans and employers pursue these goals. The course examines the role of employers and health plans in the health care system and, specifically, how the payers of the bills for health care develop and implement strategies to achieve their organizational and health care system goals. Topics covered include measurement of provider performance, health benefit design, efforts to support consumers in their health care decisions (provision of information to inform choice of providers, choice of treatment options and providers, management of chronic illnesses, and engagement in health promotion activities), provider contracting and utilization management, and provider payment.

COURSE PREREQUISITES

Students must be admitted to the University of Minnesota’s Master in Healthcare Administration Program or have consent of the instructor.

COURSE GOALS & OBJECTIVES

Specific goals and learning objectives are listed in for each class period.

METHODS OF INSTRUCTION AND WORK EXPECTATIONS

Each class will include a recorded presentation on the part of the instructor; significant issues will be identified and discussed, referencing the readings for the class period. There are no required readings for the course. The starred readings are a good starting point for students to begin exploring each topic. The amount that students learn in this course, and their performance on assignments, will depend to a large degree on the time and effort they devote to the readings for each topic. In most class periods, students will present or discuss results from individual or group assignments. Students will be expected to complete group and individual assignments as scheduled. Further readings are provided as starting points for students who wish to explore specific topics in greater depth and to assist in the completion of individual and group assignments.

COURSE TEXT & READINGS
### COURSE OUTLINE/WEEKLY SCHEDULE

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic</th>
<th>Readings</th>
<th>Activities/Assignments</th>
</tr>
</thead>
</table>
| Onsite – January 6 (9:00AM – 4:00 PM) | • Evolution of Employer Involvement: Consistent Goals and Shifting Strategies (9:00-10:15AM)  
• Group Presentation (10:15AM – 12:15PM)  
• The Nature and Role of Health Plans (12:15 – 2:15 PM)  
• Measuring Provider Performance: The Foundation of Purchaser Strategies (2:15-4:00PM) |                                                                                           | Group Assignment 1 Due In Class, 10:15AM (20 pts.)                                      |
|                               | Influencing Consumer Behavior                                         |                                                                                           |                                                                                        |
| Week 1 January 21 – 28        | • Using Benefit Design to Influence Consumers’ Choice of Providers and Use of Services |                                                                                           |                                                                                        |
| Week 2 January 28 – February 4 | • Supporting Consumer Use of Quality and Cost Information for Provider Choice  
• Providing Employees/Enrollees with Information to Use in Choosing Treatment Options |                                                                                           | Individual Assignment 1 Due 11:59 AM February 4, 2019 (20 pts.)                        |
| Week 3 February 4 – 11        | • Providing Programs That Help Employees/Enrollees Maintain and Improve Their Health  
• Providing Programs That Help Employees/Enrollees Manage Chronic Illnesses |                                                                                           | Individual Assignment 2 Due February 11, 2019 (20 pts.)                                |
| Week 4 February 11 – 18       | • Provider Contracting and Payment Fundamentals                       |                                                                                           |                                                                                        |
| Week 5 February 18 – 25       | • Utilization Management Under Provider Contracting Arrangements      |                                                                                           |                                                                                        |
| Week 6 February 25 – March 4  | • Moving Towards Value-based Payment                                  |                                                                                           | Individual Assignment 3 Due March 4, 2019 (20 pts.)                                    |
| Week 7 March 4 – 11           | • New Payment Arrangements: Bundled/Episode-based Payment  
• New Payment Arrangements: Global Contracts and Population Health Management |                                                                                           | Individual Assignment Due March 11, 2019 (20 pts.)                                    |

### SPH AND UNIVERSITY POLICIES & RESOURCES

The School of Public Health maintains up-to-date information about resources available to students, as well as formal course policies, on our website at [www.sph.umn.edu/student-policies](http://www.sph.umn.edu/student-policies). Students are expected to read and understand all policy information available at this link and are encouraged to make use of the resources available.

The University of Minnesota has official policies, including but not limited to the following:

- Grade definitions
- Scholastic dishonesty
- Makeup work for legitimate absences
- Student conduct code
- Sexual harassment, sexual assault, stalking and relationship violence
• Equity, diversity, equal employment opportunity, and affirmative action
• Disability services
• Academic freedom and responsibility

Resources available for students include:
• Confidential mental health services
• Disability accommodations
• Housing and financial instability resources
• Technology help
• Academic support

EVALUATION & GRADING

Grading will be based on 1 group and 4 individual assignments, 20 points per assignment.

Grading Scale
The University uses plus and minus grading on a 4.000 cumulative grade point scale in accordance with the following, and you can expect the grade lines to be drawn as follows:

<table>
<thead>
<tr>
<th>% In Class</th>
<th>Grade</th>
<th>GPA</th>
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<tbody>
<tr>
<td>93 - 100%</td>
<td>A</td>
<td>4.000</td>
</tr>
<tr>
<td>90 - 92%</td>
<td>A-</td>
<td>3.667</td>
</tr>
<tr>
<td>87 - 89%</td>
<td>B+</td>
<td>3.333</td>
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<tr>
<td>83 - 86%</td>
<td>B</td>
<td>3.000</td>
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<tr>
<td>80 - 82%</td>
<td>B-</td>
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<tr>
<td>77 - 79%</td>
<td>C+</td>
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<td>73 - 76%</td>
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<td>70 - 72%</td>
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<td>&lt; 62%</td>
<td>F</td>
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- A = achievement that is outstanding relative to the level necessary to meet course requirements.
- B = achievement that is significantly above the level necessary to meet course requirements.
- C = achievement that meets the course requirements in every respect.
- D = achievement that is worthy of credit even though it fails to meet fully the course requirements.
- F = failure because work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I (Incomplete).
- S = achievement that is satisfactory, which is equivalent to a C- or better
- N = achievement that is not satisfactory and signifies that the work was either 1) completed but at a level that is not worthy of credit, or 2) not completed and there was no agreement between the instructor and student that the student would receive an I (Incomplete).
<table>
<thead>
<tr>
<th>Scholastic Dishonesty, Plagiarism, Cheating, etc.</th>
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<tbody>
<tr>
<td>You are expected to do your own academic work and cite sources as necessary. Failing to do so is scholastic dishonesty. Scholastic dishonesty means plagiarizing; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; altering, forging, or misusing a University academic record; or fabricating or falsifying data, research procedures, or data analysis (As defined in the Student Conduct Code). For additional information, please see <a href="https://z.umn.edu/dishonesty">https://z.umn.edu/dishonesty</a>.</td>
</tr>
<tr>
<td>The Office for Student Conduct and Academic Integrity has compiled a useful list of Frequently Asked Questions pertaining to scholastic dishonesty: <a href="https://z.umn.edu/integrity">https://z.umn.edu/integrity</a>.</td>
</tr>
<tr>
<td>If you have additional questions, please clarify with your instructor. Your instructor can respond to your specific questions regarding what would constitute scholastic dishonesty in the context of a particular class—e.g., whether collaboration on assignments is permitted, requirements and methods for citing sources, if electronic aids are permitted or prohibited during an exam.</td>
</tr>
<tr>
<td>Indiana University offers a clear description of plagiarism and an online quiz to check your understanding (<a href="http://z.umn.edu/iuplagiarism">http://z.umn.edu/iuplagiarism</a>).</td>
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<th>Late Assignments</th>
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<td>No credit given without prior discussion with instructor.</td>
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<th>Attendance Requirements</th>
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<th>Extra Credit</th>
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<td>None.</td>
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<tr>
<th>Intellectual Property of Instructors’ Material</th>
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<tbody>
<tr>
<td>The MHA program prohibits any current student from uploading MHA course content (e.g., lecture notes, assignments, or examinations for any PUBH 65XX or PUBH 75XX courses) created by a University of Minnesota faculty member, lecturer, or instructor to any crowdsourced online learning platform.</td>
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</tbody>
</table>
### CEPH KNOWLEDGE DOMAINS

<table>
<thead>
<tr>
<th>Knowledge Domain</th>
<th>Course Learning Objectives</th>
<th>Assessment Strategies</th>
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<tbody>
<tr>
<td>Discuss the science of primary, secondary and tertiary prevention in population health including health promotion and screening.</td>
<td>To understand strategies and programs that employers use to support employees in choosing providers, choosing treatment options, managing chronic illnesses, and maintaining wellness.</td>
<td>Individual and group (oral and written) assignments.</td>
</tr>
<tr>
<td>Explain the social, political and economic determinants of health on population health and health inequities.</td>
<td>To understand employer and health plan programs and payment approaches as they impact population health.</td>
<td>Individual assignments.</td>
</tr>
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### NCHL HEALTHCARE LEADERSHIP COMPETENCIES FOR CAHME ACCREDITATION PURPOSES

<table>
<thead>
<tr>
<th>Competency</th>
<th>Course Learning Objectives</th>
<th>Assessment Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Population Health, Healthcare Delivery and Financing.</td>
<td>To understand the role that employers and health plans play in maintaining the health of their employees, influencing the delivery of care, and paying for care in the U.S. healthcare system.</td>
<td>Individual and group (oral and written) assignments.</td>
</tr>
<tr>
<td></td>
<td>To understand the challenges of measuring health care quality and using measures to improve dimensions of quality of health care delivery.</td>
<td>Individual assignments.</td>
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<td>To understand the design and implementation of payment strategies to support and encourage value-based care.</td>
<td>Individual assignments.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>To enhance ability to use written and oral communications effectively.</td>
<td>Individual assignments.</td>
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OVERVIEW OF EMPLOYER/HEALTH PLAN ROLES IN HEALTH SYSTEM

January 6, 2019

Evolution of Employer Involvement: Consistent Goals and Shifting Strategies

The two-decade period from the mid-1970s through the mid-1990s marked the ascendency of a particular type of the managed care organization – in the private health care marketplace and also as a contractor to Medicare and Medicaid. Responding to pressures from employers and government to control health care costs, these organizations (in collat with risk-bearing provider systems) instituted a variety of supply-side mechanisms, financial and non-financial, to influence provider behavior. Accompanying steps were taken to manage access to care on the part of plan enrollees. The result, eventually, was managed care backlash on the part of consumers and providers, precipitated in part by a redefinition of employers of their health benefit designs. In this first session, we will describe the transition over the past 15 years to “post backlash” employer paradigm for employee health benefits, emphasizing an expanded role for consumers, and recently, an evolving “value-based” approach to paying providers.

Learning Objectives

Students should be able to:
1. Describe the origins and evolution of managed care organizations.
2. Explain the origins and nature of the managed care backlash of the 1990s, and its influence on the ongoing development of the new employer paradigm for health benefits.
3. Explain the factors influencing present employer demands on the health care system, and the impact of these demands on health plans, consumers, and America’s health care system as a whole.

Suggested Readings

The Evolution of Employer Involvement in Health Care

4.* Warshawsky MJ, Biggs AG. Income inequality and rising health-care costs: A worker who today makes $31 had to forgo a 26% salary increase since 1999 as employer costs rise. The Wall Street Journal, October 1994054901/docview/194054901/pagelevelimagePDF/AD60C32FA501?accountid=14586

Employer Strategies for Changing the Health Care System


The Role of Self-Insurance


Employer Perspectives on Health Care Reform


Further Readings


The Nature and Role of Health Plans
Health plans represent employer plans interests in the health care system, competing for contracts with employers. They structure their products and actions to gain and retain the business of employer clients, which is critical to their own financial success. In doing so, they provide a wide range of products and services in addition to traditional health insurance. In this session, we trace the development of the health insurance industry and describe its current state. We discuss market concentration, premium setting, and differences among health plan products; describe how plans are evaluated by employers and consumers; and discuss public perceptions of the health insurance industry.

Learning Objectives
Students should be able to:
1. Describe the structure of the health insurance industry and how it is changing.
2. Distinguish among different types of health plans and health plan products.
3. Explain how employers assess health plan performance and choose among health plans.
4. Identify major current issues relating to health plan performance from the perspective of employers and the public.

Suggested Readings
Overview of the Health Plan Industry

Mergers and Acquisitions
Competitive Strategies of Health Plans

Care Delivery

Provider Collaborations

Vertical Integration

Brand Enhancement
Issues Relating to Health Plan Behavior and Performance

5. HealthPartners. Press Release – HealthPartners recognized as one of the top health systems in the country. Author, April 30, 2018. [source]


11. Caramencio A. How UCare builds better relationships with members. AHIP Blog, June 14, 2017. [source]

Issues Relating to Health Plan Behavior and Performance

Coverage


3. Orinstein C. How insurers are finding ways to shift costs to the sick. The New York Times, September 17, 2014. [source]


Profits


3. Therune C. CalPERS approves 7.2% increase in HMO rates as drug costs climb. The Los Angeles Times, June 18, 2015. [source]

4. Lagasse J. Medical costs to accelerate in 2018, but only slightly, as cost trends stabilize, says PwC. Healthcare Finance News, June 13, 2017. [source]


Operations


2.* Drew LW. Finding a path through the health insurance market gobbledygook. Kaiser Health News, April 21, 2011. [source]


4. Lazarus D. When health insurers play games, patients lose. The Los Angeles Times, April 17, 2014. [source]

Collaborative Initiatives

1.* Blackmore CC, Mecklenburg RS, Kaplan GS. At Virginia Mason, collaboration among providers, employers, and health plans to transform care cut costs and improved quality. Health Aff. 2011;30(9):1680-1687. [source]


The Health Insurance Industry and Health Reform


Further Readings


Measuring Provider Performance: The Foundation of Purchaser Strategies

Efforts on the part of health plans and employers to measure provider performance have intensified over the past decade, with performance measurement assuming a key role in almost all employer/health plan strategies. Health plans construct or employ measures of performance to: select providers for inclusion in networks; create tiered networks; structure provider incentive payments; and produce provider performance reports for their providers, members, and the general public. These measures also can be used in disease management and wellness programs. The way in which performance measures are constructed and used has been a point of contention between employers/health plans and providers as has the cost to providers of constructing measures. Consumers also have criticized these measures as lacking in relevance for their decision making. In this session, we describe the efforts of employers and health plans to measure provider performance, common issues in measure construction, the use of risk-adjustment techniques, and alternatives for attributing patients to providers.

Learning Objectives
Students should be able to:
1. Describe and contrast different approaches to performance measurement.
2. Discuss strengths and weaknesses of these approaches.
3. Discuss the role of risk adjustment techniques and how they are applied.
4. Discuss alternatives for attributing patients to providers for measurement purposes.
5. Contrast how measurement challenges differ for quality vs. cost/efficiency measures.
6. Discuss potential adverse consequences of performance measurement.

Suggested Readings

The Basics of Provider Performance Measurement

   http://healthaffairs.org/blog/2013/05/22/seven-policy-recommendations-to-improve-quality-measurement/
3.* National Quality Forum. The ABCs of measurement.
   http://annals.org/aim/fullarticle/2648599
   https://newsatjama.jama.com/2017/05/22/jama-forum-payment-power-to-the-patients/

Importance of Risk Adjustment in Performance Measurement


Examples:
   http://us.milliman.com/Solutions/Products/Milliman-Advanced-Risk-Adjusters/

Challenges in Measuring Provider Quality

1.* Mathias JS, Baker DW. Developing quality measures to address overuse. JAMA. 2013;309(18):1897-1898.


Examples:


Challenges in Measuring Provider Prices, Costs and Efficiency


Challenges in Measuring Patient Experience


Unintended Consequences of Performance Measurement


January 21-28, 2019

**Using Benefit Design to Influence Consumers’ Choice of Providers and Use of Services**

Employers pursue a variety of benefit designs to influence consumer purchase decisions, such as cost-sharing, network design, coverage limitations, and incentives regarding plan choice. In this session, we describe these efforts, their implementation and evidence of their impacts.

**Learning Objectives**

Students should be able to:

1. Understand differences in health benefit designs and their influence on consumer use of services.
2. Discuss the pros and cons of limited and tiered provider networks.
3. Discuss common issues relating to health plan coverage limitations.
4. Describe the motivation for employers to offer access to health plans through private benefit exchanges.

**Suggested Readings**

**Products Offered by Health Plans**


Value-Based Benefit Designs


Examples:

Tiered Networks, High Performance Networks, Narrow Networks, and Centers of Excellence


Examples:


Limiting Coverage


Private Health Insurance Exchanges


Examples:
Students should be able to:

1. Describe the recent efforts to increase the amount and quality of information available to health care consumers about providers.
2. Discuss the responses of providers to these efforts.
3. Assess the evidence regarding the impact of comparative provider performance data on consumer decisions, quality of care, and health care costs.

Further Readings


Suggested Readings

January 28 – February 4, 2019
Supporting Consumer on Quality and Cost Information for Provider Choice
Providing consumers with timely, useful information about the performance of providers is one way that purchasers hope to engage consumers. Their intent is that consumers use this information, in combination with financial incentives, to seek out lower cost, higher quality providers and to inform their conversations with providers. And, it is hoped that providers will improve their quality and reduce their costs when faced with public comparisons with their peers. The present health care system, some argue, does not provide information that is truly useful to consumers in making cost/quality tradeoffs when choosing providers, or that is credible to providers. Employers have been strong supporters of recent efforts to publicly report information comparing providers. We will describe these efforts as well as the evidence regarding the influence of this information on consumer and provider decisions.

Learning Objectives

Students should be able to:

1. Describe the recent efforts to increase the amount and quality of information available to health care consumers about providers.
2. Discuss the responses of providers to these efforts.
3. Assess the evidence regarding the impact of comparative provider performance data on consumer decisions, quality of care, and health care costs.

Suggested Readings

Production and Content of Public Reports


Concerns about Public Reports


Concerns about Public Reports


Public Reports and Their Use by Consumers


Examples:

Provider Responses to Public Reporting

Examples:
2) Mathews AW. Compare and contrast when doctors are given a public report card, the resulting competition can serve patients well. Wall Street Journal, October 27, 2009. http://online.wsj.com/article/SB10001424052970204488304574431741881361528.html

Medicare Reporting
Providing Employees/Enrollees with Information to Use in Choosing Treatment Options

There is growing support for the need to provide consumers with information necessary to evaluate treatment options and select the option that is the best fit for their individual circumstances and preferences. Consumer decision aids have been developed to address this issue. We discuss how decision aids function, evidence of their effectiveness, and the roles of...
employers and health plans in encouraging their use. We also discuss the challenges that low health literacy and numeracy pose for the use of shared decision making generally, and specifically how it relates to consumer choice of treatment options. We describe efforts by payers and health plans to address this issue.

Learning Objectives
Students should be able to:
1. Describe different approaches being used to support consumers in their choice of treatments.
2. Discuss the problems faced by employers and health plans in implementing decision aids.
3. Evaluate the evidence regarding the effectiveness of these decision aids.
4. Assess the challenges that low health literacy and numeracy pose for informed consumer decision making.

Suggested Readings

Shared Decision Making Overview

The Use of Decision Aids

Issues in Shared Decision Making

The Importance of Health Literacy, Numeracy, and Language Issues to Informed Choice

Further Readings

February 4 – 11, 2019
Providing Programs That Help Employees/Enrollees Maintain and Improve Their Health
Increasingly, employers are instituting programs and financial incentives that support employees in maintaining and improving their health. The expectation is that these efforts will reduce the rate of increase in health care costs over time by reducing or delaying the onset of chronic illnesses. Employers also hope that wellness programs will reduce absenteeism and increase worker productivity. Payers use both rewards and negative incentives to encourage healthy behaviors, and both health plans
Evidence of Program Effectiveness
Independent vendors deliver program content. The employer role in promoting these wellness programs has been controversial as it relates to use of positive versus negative incentives and the protection of personal employee information.

**Learning Objectives**
Students should be able to:
1. Describe the rationale for employer/health plan support for healthy lifestyle programs.
2. Assess the strengths and weaknesses of different program designs.
3. Evaluate the evidence that these programs have been successful in achieving their goals.
4. Discuss the impediments to the successful implementation of these programs.
5. Discuss the aspects of these programs that can make them controversial.

**Suggested Readings**

**Healthy Lifestyle Programs – Overview**
6. Abraham J, Whitmore K. Connect the wellness dots. Employee Benefit News, Sep 2017;36(2):222-228. [http://content.healthaffairs.org/content/36/2/10](http://content.healthaffairs.org/content/36/2/10)

**Examples:**
4) Burke B. Asthma awareness: HCSC is investing in keeping kids healthy. AHIP, May 25, 2017. [https://www.ahip.org/asthma-awareness/](https://www.ahip.org/asthma-awareness/)

**Evidence of Program Effectiveness**

2. * Russell LB. Preventing chronic disease: an important investment, but don’t count on cost savings. *Health Aff.* 2009;28(1):42-45. [http://content.healthaffairs.org/content/28/1/42.full.pdf](http://content.healthaffairs.org/content/28/1/42.full.pdf)

**Examples:**


**Concerns about Program Incentives**


**Examples:**


2) Lerner M. Medica wants to put health coach between you and your bad habits; but critics say the voluntary, no-cost program is like health care big brother. Star Tribune, October 1, 2008. [http://www.startribune.com/lifestyle/29981699.html](http://www.startribune.com/lifestyle/29981699.html)


**The Case of Obesity**


**Examples:**


**Health Reform and Wellness**


**Further Readings**


**Providing Programs That Help Employees/Enrollees Manage Chronic Illnesses**

Employers are strong supporters of programs that help employees self-manage care for chronic illnesses. The general idea is to place the consumer in a much more central role in medical care treatment. By educating consumers in appropriate treatment methods for their illnesses and supporting their efforts to manage their illnesses, payers and health plans hope that the progression of chronic illnesses can be delayed, and the number of acute flare-ups of chronic illnesses can be minimized. If successful, these efforts would improve the quality of life for employees, reduce emergency room and hospital use, and restrain growth in costs. In this session, we discuss efforts of payers and health plans to support consumers in chronic care management and the contexts in which they have been successful.

**Learning Objectives**

Students should be able to:

1. Explain the concepts of patient self-management and disease management in their different forms.
2. Discuss the various ways in which employers and health plans are supporting employees and plan enrollees in chronic illness management.
3. Assess the evidence of their effectiveness in various settings.
4. Describe the obstacles payers and health plans face when implementing programs to support chronic illness management by consumers.
**Suggested Readings**

**Importance of Developing Effective Approaches to Chronic Illness Management**


5. *Terhune C, Weintrab A.* Take your meds, exercise—and spend billions. *BusinessWeek,* February 4, 2010. [http://www.businessweek.com/magazine/content/10_07/b4166046292556.htm](http://www.businessweek.com/magazine/content/10_07/b4166046292556.htm)


**Disease Management Programs – Structure and Effectiveness**


**Examples:**


**Self-Management of Illnesses**


Further Readings


**CONTRACTING WITH AND PAYING PROVIDERS**

February 11 – 18, 2019

Provider Contracting and Payment Fundamentals

A major factor in health plans' success in securing employer contracts is their ability to negotiate favorable terms when contracting with providers and to effectively manage provider networks in ways that do not provoke enrollee backlash. In this session, we discuss the basics of provider contracting, including payment fundamentals and the way in which health plans and providers attempt to exert leverage in the contracting process.

Learning Objectives

Students should be able to:

1. Describe the basic reimbursement approaches used by health plans in contracting with providers.
2. Discuss the nature of the contracting process from the health plan and provider perspectives.
3. Describe areas of friction between providers and plans that arise during the contracting process.

Suggested Readings

Contents of Contracts between Providers and Health Plans

1. CIGNA (posted on Moodle).

Payment Fundamentals

3.* Zuvekas SH, Cohen JW. Fee-for-service, while much maligned, remains the dominant payment method for physician visits. *Health Aff.* 2016;35(3):411-414. [http://content.healthaffairs.org/content/35/3/loc](http://content.healthaffairs.org/content/35/3/loc)

Health Plan/Provider Leverage in the Contracting Process

1.* Berenson RA, Ginsburg PB, Christianson JB, Yee T. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. *Health Aff.* 2012;31(5):973-981. [http://content.healthaffairs.org/content/31/5/973.full.pdf+html](http://content.healthaffairs.org/content/31/5/973.full.pdf+html)
2.* Vladeck BC. Paradigm lost: Provider concentration and the failure of market theory. *Health Aff.* 2014;33(6):1083-1087. [http://content.healthaffairs.org/content/33/6/toc](http://content.healthaffairs.org/content/33/6/toc)
3.* Kocher B, Emanuel EJ. Overcoming the pricing power of hospitals. *JAMA.* 2012;308(12):1213-1214.


Examples:

1) Merritt G. Children’s Hospital, Anthem reach agreement after two-month standoff. The CT mirror, June 12, 2012. http://ctmirror.org/2012/06/12/childrens-hospital-anthem-reach-agreement/


Provider Issues Concerning Contracts with Health Plans


Examples:


Further Readings


February 18 – 25, 2019
Utilization Management under Provider Contracting Arrangements
Reminders, clinical decision-support systems, predictive modeling, guidelines, and rules are all used by health plans to influence the amount and type of care that providers deliver to patients. Reminders prompt physicians about a patient's care needs prior to, or at the time of, the treatment visit. Clinical decision-support systems typically involve software designed to assist the physician's clinical decision-making. Predictive modeling uses large claims databases to identify patients who may be at risk of specific illnesses in the future and alert clinicians prior to the patient visit. Guidelines, or pathways, assist physicians in taking the appropriate treatment steps, given a patient’s condition, and often are applied when treating patients with chronic health problems. They can be incorporated in clinical decision support systems. Rules are used by health plans to intervene more directly in the care process. This session will address the different ways that health plans attempt to influence the delivery of care by providers, including the manner in which these techniques are being employed and evidence of their effectiveness.
Overview of Health Plan Efforts: End of Life Care, Care Coordination, Payment Denials, Post-Acute Care


Learning Objectives
Students should be able to:
1. Describe the most common practices used by health plans to influence the delivery of care.
2. Explain the barriers to their effective implementation.
3. Assess the strength of the evidence supporting their effectiveness.
4. Describe recent trends in their use in conjunction with other efforts to influence physician behavior.

Suggested Readings
Utilization Management Challenges Faced by Health Plans (unnecessary care, wide variations across providers in service use, physician autonomy, lack of drug options, social barriers to care)


Examples:


Examples:


15) Ingold J. Anthem won’t pay for many patients to get CTs or MRIs at Colorado hospitals anymore. That’s the wave of the future for health insurance. Denver Post, May 24, 2018. https://www.denverpost.com/2018/05/24/anthem-colorado-hospitals-ct-mri-costs/

Profiling/Feedback of Information on Treatment Patterns


http://well.blogs.nytimes.com/2015/09/14/a-report-card-the-doctor-doesnt-want-to-take-home/?_r=0

http://jamanetwork.com/journals/jamasurgery/fullarticle/2589764?resultClick=1

Practice Guidelines
https://www.clinicalkey.com/#/BrowserCtrl/doBrowseTo/journalIssue?facet[1-s2.0-S000288X09X60156J,issn:000288X09X60156J,contentType:Journals]


http://www.reuters.com/article/2013/05/07/us-medical-guidelines-idUSBRE94610V20130507


Examples:


4) Graham J. Mammogram guidelines are sparking a firestorm; Critics hit suggestion that women in 40s may not need routine screening. Chicago Tribune, November 17, 2009, p.1. 

5) Ando R. IBM and Aetna tie up to offer clinical support service. Reuters, August 5, 2010. 
http://www.reuters.com/article/idUSTRE6740EW20100805

http://consumer.healthday.com/Article.asp?AIID=663893

7) Nussbaum A. Aetna urges moms to avoid cesareans births to reduce risk. Bloomberg.com, July 12, 2012. 

Use of Treatment Reminders

http://search.proquest.com/docview/1523785007/fulltext/27BE5B13AE7A4170PQ/2?accountid=14586

http://www.usatoday.com/story/tech/columnist/shinal/2014/05/14/medical-privacy-health/9087873/

http://jamanetwork.com/journals/jama/issue/315/6

Examples:
http://online.wsj.com/article/SB10001424052748704576664600781798420.html

Managing Imaging Use and Costs: Combining Utilization Management Tools
http://content.healthaffairs.org/content/36/4/toc
2. Lee DW, Levy F. The sharp slowdown in growth of medical imaging: An early analysis suggests combination of policies was the cause. *Health Aff.* 2012;31(8):1876-1884. [http://content.healthaffairs.org/content/31/8/1876.full.pdf+html](http://content.healthaffairs.org/content/31/8/1876.full.pdf+html)


**Examples:**

1) Mathews AW. Insurers hire radiology police to vet scanning; firms make doctors justify costly CTs, MRIs and PETs; patients 'stuck in the middle'. *Wall Street Journal*, November 6, 2008. [http://online.wsj.com/article/SB122591900516802409.html](http://online.wsj.com/article/SB122591900516802409.html)


**Medicare Utilization Initiatives**


**Further Readings on Imaging**


Students should be able to:

Learning Objectives

- Understand what is meant by value-based payment.
- Describe the different types of pay-for-performance and health care home payment initiatives being undertaken as health plans and purchasers move toward value-based payment.
- Describe how these approaches differ in their design, as well as the challenges they pose for implementation, in

Further Readings – General


February 25 – March 4, 2019

Moving Towards Value-based Payment

During the 1980s through the mid-1990s, most provider payment arrangements employed by health plans were designed to influence providers to reduce unnecessary service utilization. Then, responding to consumer backlash, plans and employers largely reverted to fee-for-service payment. However, over the past decade, health plans and purchasers have initiated a variety of new payment approaches that have broader behavioral change goals, including improving quality of care, implementing evidence-based medical practices effectively, and supporting the restructuring of care delivery. Some of these approaches blend traditional fee-for-service with payments related to provider performance. Recently, Medicare and some Medicaid programs have instituted payment reforms with similar objectives. We will discuss employer and health plan first steps toward value-based payment methodologies. We also describe parallel payment initiatives by Medicare that supplement these private sector efforts. In subsequent sessions, we will discuss payment approaches that shift more financial risk to providers.
comparison to previous payment arrangements between health plans and providers.

**Suggested Readings**

**Moving Towards Value-based Payment**


11. Thomas S, O’Kane M. Value-based purchasing. *Am J Manag Care.* 2012;18(11):750-752. [http://web.b.ebscohost.com/ehost/results?sid=1da13801-2137-4624-a77e-42158bf746de%40sessionmgr112&vbid=128&bquery=JN%22American+Journal+of+Managed+Care%22+AND+DT%2220121101%22+&data=JmRiPWFwaCZ0eXBPIEeCZ02T1laG9zdC1saXZ1](http://web.b.ebscohost.com/ehost/results?sid=1da13801-2137-4624-a77e-42158bf746de%40sessionmgr112&vbid=128&bquery=JN%22American+Journal+of+Managed+Care%22+AND+DT%2220121101%22+&data=JmRiPWFwaCZ0eXBPIEeCZ02T1laG9zdC1saXZ1)


**Reference Pricing**

1.* Robinson JC, MacPherson K. Payers test reference pricing and centers of excellence to steer patients to low-price and high-quality providers. *Health Aff.* 2012;31(9):2028-2036. [http://content.healthaffairs.org/content/31/9/2028.full.pdf+html](http://content.healthaffairs.org/content/31/9/2028.full.pdf+html)


**Examples:**

Use of Provider Payment to Encourage and Reward Quality Improvement

5.* Jha AK. JAMA Forum: Value-based purchasing: Time for reboot or time to move on? news@JAMA, February 1, 2017. [https://newsatjama.jama.com/2017/02/01/jama-forum-value-based-purchasing-time-for-reboot-or-time-to-move-on/]
12. Greene J, Hibbard JH, Overton V. Large performance incentives had the greatest impact on providers whose quality metrics were lowest at baseline. Health Aff. 2015;34(4):673-680. [http://content.healthaffairs.org/content/34/4/673.full.pdf+html]

Examples:


Use of Provider Payment to Encourage and Reward Health Care Homes


Examples:
2) Dentzer S. One payer’s attempt to spur primary care doctors to form new medical homes. Health Aff. 2012;31(2):341-349. http://content.healthaffairs.org/content/31/2/toc

Medicare Payment Reform Initiatives


Examples:

Further Readings

March 4 – March 11, 2019
New Payment Arrangements: Bundled/Episode-Based Payment

Private sector plans and Medicare are experimenting with provider payments that bundle related care activities, sometimes in conjunction with reference pricing. These payments place more financial risk on providers but also offer providers the potential for financial gains. While attractive for some services, bundled payments have proven difficult to implement in practice. Nevertheless, momentum behind bundled payments in the private sector (and in Medicare) seems to be growing.

Learning Objectives
Students should be able to:
1. Understand the basic design features relating to bundled payment.
2. Discuss the obstacles to implementing bundled payment arrangements.
3. Understand the evidence regarding the impacts of bundled payment.
4. Discuss Medicare support for bundled payment.

Suggested Readings
Bundled Payment in Concept


Bundled Payment Implementation

Medicare Bundled Payment Initiatives


Further Readings


Global Payment Approaches and Accountable Care Organizations

Students should be able to:

1. Describe the basic features of comprehensive, global contracts between health plans and providers.
2. Discuss the obstacles to implementing global payment arrangements.
3. Discuss Medicare support for global payment.

Learning Objectives

New Payment Arrangements: Global Contracts and Population Health Management

Total Cost of Care, also called Global, contracts between health plans and providers are growing in popularity. Under these contracts, providers agree to deliver services to a defined group of individuals for one global payment. Typically, providers can agree to assume some degree of risk in return for the chance to share in savings, assuming adequate performance on quality metrics. In Medicare, this approach involves contracts with "accountable care organizations" or ACOs.

Suggested Readings

Global Payment Approaches and Accountable Care Organizations

Examples:


Medicare Global Contracts with Accountable Care Organizations


Further Readings


http://content.healthaffairs.org/content/30/9/1718.full.pdf+html


http://www.healthleadersmedia.com/content/LED-291569/Incentives-Motivations-Clash-Under-ACOs#


https://innovation.cms.gov/initiatives/Pioneer-aco-model/