PubH 6564
Private Purchasers of Health Care: Roles of Employers and Health Plans in the U.S. Health Care System
Fall 2012

Credits: 2
Meeting Days: Mondays, September 10 – December 10, 2012
Meeting Time: 1:25 – 3:20 pm
Meeting Place: Moos Tower 2-580
Instructor: Jon B. Christianson
Office Address: 15-225 Phillips Wangensteen Building
Office Phone: 612-625-3849
Fax: 612-624-2196
E-mail: chris001@umn.edu
Office Hours: By Appointment

I. Course Description

For health care providers, payments received from private insurance companies, with these funds coming for the most part from employer contributions towards employee health care expenses, are critical to their financial survival. 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.

II. Course Prerequisites

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

III. Course Goals and Objectives

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

IV. Methods of Instruction and Work Expectations

Each class will include a didactic 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 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 results from individual or group assignments. Students will be expected to prepare for each class by engaging with the readings prior to class, participating in the discussion during class, and completing 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.

V. Course Text and Readings

1. To access readings go to www.lib.umn.edu. Click on E-JOURNALS. Type in the name of the journal and click on “search”. Click on journal and then click “full text available via”. Follow the prompts to retrieve the article. For newspaper articles, type in the newspaper name and click search. Click on newspaper and then click on “full text available via ProQuest Newstand Complete.” Click on date of publication and search for article title. Wherever you see “Available at” press the control key on your keyboard and bring the cursor over the link. The cursor should turn into a hand with a pointing finger. Click the left mouse key and you will go directly to the cite. (NOTE: If you have any problems accessing assigned readings online, contact Jane Raasch at raasc001@umn.edu.) If you do not have a University of Minnesota Internet ID and password, call 301-HELP and support staff will help you set up an account (or set up your own account at www.umn.edu/initiate and follow the directions.)

2. Optional background reading for this course: 1) PowerPoint lecture on the basics of health insurance posted on Moodle. 2) Kongstedt, Peter. Essentials of Managed Care, Aspen Publishers, Gaithersburg, MD. This book is the most frequently used reference in the field. It covers most of the "basics" but may not be current on all topics.

3. For each class session, overheads/PowerPoint slides and/or audio will be posted on the Moodle website for downloading and viewing. To learn more about Moodle, watch Moodle: Online Orientation for Students and/or visit the Moodle support website at http://www1.umn.edu/moodle/, which has a link for “Student support” with user guides, help and FAQs

VI. Course Outline/Weekly Schedule

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<th>Date</th>
<th>Module / Topics</th>
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<td>Background</td>
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<tr>
<td>September 10</td>
<td>History and Overview: How Did Employer/Health Plan Strategies Evolve from Managed Care to Facilitated Consumerism?</td>
</tr>
<tr>
<td>September 17, 24</td>
<td>Present State of the Health Insurance Industry</td>
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<td>• Presentation of Group Assignment 1 (10 pts.) – September 17</td>
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<td>Health Plan/Provider Relationships</td>
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<td>October 1</td>
<td>Measuring Provider Performance: The Foundation for Network Management, Provider Payment and Public Reporting Efforts</td>
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<td>October 8</td>
<td>Provider Contracting and Network Management</td>
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<td></td>
<td>• Discussion of Individual Assignment 1 (8 pts.)</td>
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<td>October 15</td>
<td>Fundamentals of Provider Payment: Incentives and Rewards</td>
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<td>• Discussion of Individual Assignment 2 (8 pts.)</td>
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<td>October 22</td>
<td>New Payment Arrangements: Bundling/Episode-Based Payment</td>
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<td>• Discussion of Individual Assignment 3 (8 pts.)</td>
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<td>October 29</td>
<td>New Payment Arrangements: Comprehensive Gainsharing/Shared Savings</td>
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<td>• Presentation of Group Assignment 2 (10 pts.)</td>
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<td>November 5</td>
<td>Utilization: Management</td>
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<td></td>
<td>• Discussion of Individual Assignment 4 (8 pts.)</td>
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<td>Health Plan/Enrollee Relationships</td>
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<td>November 12</td>
<td>Supporting Consumers in Choosing Providers: Reporting of Provider Performance</td>
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<td>• Presentation of Group Assignment 3 (10 pts.)</td>
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<td>November 19</td>
<td>Supporting Consumers in Choosing Treatment Options</td>
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<td></td>
<td>• Discussion of Individual Assignment 5 (14 pts.)</td>
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<td>November 26</td>
<td>Supporting Consumers in Maintaining and Improving Their Health</td>
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<tr>
<td>December 3</td>
<td>Supporting Consumers in Managing Chronic Illnesses</td>
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<tr>
<td></td>
<td>• Discussion of Individual Assignment 6 (8 pts.)</td>
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<tr>
<td>December 10</td>
<td>Putting It All Together: Coordinated Approaches to Supporting Care Management, Improving Quality, and Controlling Costs</td>
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<tr>
<td></td>
<td>• Presentation of Group Assignment 4 (10 pts.)</td>
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History and Overview: How Did Employer/Health Plan Strategies Evolve from Managed Care to Facilitated Consumerism?

The two-decade period from the mid-1970s through the mid-1990s encompassed the ascendancy of a particular style of health plan – 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 collaboration 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 health benefits' objectives on the part of employers. Since then, payers and health plans have initiated a variety of new approaches directed at restraining cost growth and improving quality. In this first session, we will describe the transition over the past decade towards a new paradigm of “managed” or “facilitated” consumerism, one that has much broader support among significant actors in the health care arena than traditional managed care. We will discuss the challenges faced by this new “facilitated consumerism,” and the tools at the disposal of health plans.

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 facilitated consumerism.
3. Explain the factors influencing present employer demands on the health care system, and the role these demands have played in changing America’s health care system.

Suggested Readings

Employer Involvement in Health Care


Employer Strategies for the Health Care System


Further Readings

September 17, 24, 2012

Present State of the Health Insurance Industry

Health plans represent employer 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
2. Distinguish among different types of health plans and health plan products.
3. Understand premium cycles in the health insurance industry.
4. Explain how employers assess health plan performance and choose among health plans.
5. Identify the major issues relating to health plan performance from the perspective of employers and the public.

Suggested Readings

Overview of the Private Health Insurance Market


Products Offered by Health Plans


Developing Strategies of Health Plans


Issues Relating to Health Plan Behavior and Performance


12. Available at: http://www.bloomberg.com/ap/2012-08-08/oregon-group-questions-regence-rate-hike-proposal

The Health Insurance Industry and Health Reform


Students should be able to:

Learning Objectives

Efforts on the part of health plans and employers to measure provider performance have intensified over the past decade. Health plans construct measures of performance to: select providers for inclusion in networks; create tiered networks; structure provider incentive payments; and produce provider performance reports for their members. These measures also can be used in public reports of provider performance. The way in which performance measures are constructed and used has been a point of contention between employers/health plans and providers. In this session, we describe methods used by employers and health plans to measure provider performance, common issues in measure construction, and the use of “risk-adjustment” techniques in measure construction.

Further Readings

5. McQueen, M.P. “Health insurers target the individual market; Aetna, WellPoint, others roll out policies that cater to people who lack employer coverage; stripping out maternity care.” The Wall Street Journal, August 21, 2007, p.D1
7. Baicker, K., Chandra, A. “Myths and misconceptions about U.S. health insurance.” Health Affairs – Web Exclusive
9. Meyer, H. “Life with insurance; when a policy is clear as mud; with consumers and critics crying foul, insurers try to strip out the jargon.” The Los Angeles Times, September 21, 2009, p.E1

October 1, 2012

Measuring Provider Performance: The Foundation for Network Management, Provider Payment and Public Reporting Efforts

Efforts on the part of health plans and employers to measure provider performance have intensified over the past decade. Health plans construct measures of performance to: select providers for inclusion in networks; create tiered networks; structure provider incentive payments; and produce provider performance reports for their members. These measures also can be used in public reports of provider performance. The way in which performance measures are constructed and used has been a point of contention between employers/health plans and providers. In this session, we describe methods used by employers and health plans to measure provider performance, common issues in measure construction, and the use of “risk-adjustment” techniques in measure construction.

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 in measure construction and how they are applied.

Suggested Readings

The Basics of Provider Performance Measurement

Challenges in Measuring Provider Quality

Challenges in Measuring Provider Prices, Costs and Efficiency

Challenges in Measuring Patient Experience

Role of Risk Adjustment in Performance Measurement

Further Readings
October 8, 2012
Provider Contracting and Network Management
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 this session, we will discuss the basics of provider contracting, including the way in which health plans and providers attempt to exert leverage in the contracting process. We also describe steps that health plans are taking to develop products based on subsets of “high performing” providers, and the reasons why this strategy has been controversial.

Learning Objectives
Students should be able to:
1. Discuss the nature of the contracting process from the health plan and provider perspectives.
2. Describe how provider reimbursement levels are determined.
3. Discuss issues pertaining to tiered provider networks.

Suggested Readings
Health Plan/Provider Leverage in the Contracting Process

Tiered Networks, High Performance Networks, and Centers of Excellence
4. Kowalczyk, L. “Insurers may slash rates to hospitals; some patients might have to switch MDs.” The Boston Globe, May 24, 2010, p.B.1

Provider Issues Concerning Contracts with Health Plans
1. Fuhrmans, V. “Insurers stop paying for care linked to errors; health plans say new rules improve safety and cut costs; hospitals can’t dun patients”. The Wall Street Journal, January 15, 2008, p.D.1

Further Readings

October 15, 2012
Fundamentals of Provider Payment: Incentives and Rewards
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. 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. Recently, health reform legislation has encouraged Medicare to institute payment reforms with similar objectives. We will discuss traditional methods of provider payment, as well as new payment arrangements, in this session and the two sessions to follow.

Learning Objectives
Students should be able to:
1. Describe the basic reimbursement approaches used by health plans in contracts with providers, including their strengths and weaknesses.
2. Describe the different types of pay-for-performance initiatives being undertaken by health plans and purchasers.
3. Describe how these approaches differ in their design and the challenges they pose for implementation, in comparison to previous payment arrangements between health plans and providers.
Suggested Readings

Basics of Provider Payment


Use of Provider Payment to Encourage and Reward Quality Improvement


Medicare Payment Reform Initiatives

Further Readings

17. Bridges to Excellence. Available at: http://www.bridgestoexcellent.org
20. Feder, J.L. “A health plan spurs transformation of primary care practices into better-paid medical homes.” Health Affairs 2011;30(3):397-399

October 22, 2012

New Payment Arrangements: Bundling/Episode-Based Payment

Learning Objectives

Students should be able to:
1. Describe the basic design features relating to bundled payment.
2. Discuss the obstacles to implementing bundled payment arrangements.
3. Discuss Medicare support for bundled payment.
Suggested Readings

Bundled Payment Approaches


Medicare Payment Reform Initiatives


Further Readings


October 29, 2012

New Payment Arrangements: Comprehensive Gainsharing/Shared Savings

Learning Objectives

Students should be able to:

1. Describe the basic features of comprehensive, gainsharing payment arrangements between health plans and providers.
2. Discuss the obstacles to implementing comprehensive gainsharing arrangements.
3. Discuss Medicare support for gainsharing payment as evidenced by Alternative Care Organizations.

**Suggested Readings**

**Gainsharing Payment Approaches**


**Medicare Payment Reform Initiatives**


**Further Readings**


**November 5, 2012**

**Utilization: Management**

Reminders, clinical decision-support systems, predictive modeling, guidelines, and rules are all common strategies used by health plans to influence the amount and type of care that providers deliver to their 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. 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.

Learning Objectives
Students should be able to:
1. Describe the most common practices used by health plans to support physicians in 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

Overview of Health Plan Efforts

Profiling/Feedback of Information on Treatment Patterns

Practice Guidelines
2. 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

Use of Treatment Reminders

Managing Imaging Use and Costs: Combining Utilization Management Tools
5. Mathews, A.W. “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


12. Franklin, C. “Before you get that CT scan...” Chicago Tribune, March 17, 2011, p.21


**Medicare Utilization Initiatives**


**Further Readings on Imaging**


4. Phelps, D. “Insurers want 2nd opinion before scans; as their costs rise, insurers want doctors to get consultants to approve CT scans and MRIs.” Star Tribune, January 4, 2007


**Further Readings – General**


**November 12, 2012**

**Supporting Consumers in Choosing Providers: Reporting of Provider Performance**

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 will use this information, in combination with financial incentives, to seek out lower cost, higher quality 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. We will discuss recent efforts to publicly report information comparing providers, 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**

**Public Reports and Their Use by Consumers**

10. Young, G.J. “Multistakeholder regional collaboratives have been key drivers of public reporting, but now face challenges.”


Concerns about Public Reports


3. Anonymous. “Looking for Dr. Right; with more and more websites rating physicians, the question is: Can you trust them?” Boston, Globe, June 8, 2009, p. G.6


Provider Responses to Public Reporting


3. Mathews, A.W. “Health care (a special report) --- compare and contrast: when doctors are given a public report card, the resulting competition can serve patients well.” Wall Street Journal, October 27, 2009, p. R.4


9. Teleki, S., Shannon, M. “In California, quality reporting at the state level is at a crossroads after hospital group pulls out.” Health Affairs 31(3):642-646, 2012


Further Readings


7. Graham, J. “Hospital report cards due; consumers can go online to get the scoop on Illinois facilities, such as prices, quality ratings and much more.” *Chicago Tribune*, November 19, 2009
18. Ryan, A.M., Nallamothu, B.K., Dimick, J.B. “Medicare’s public reporting initiative on hospital quality had modest or no impact on mortality from three key conditions.” *Health Affairs* 31(3):585-592, 2012

**November 19, 2012**

**Supporting Consumers 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 with this objective in mind. We will discuss these decision aids, evidence of their effectiveness, and the roles of employers and health plans in encouraging their use. We also will discuss the challenges that low health literacy can pose to informed consumer choice of providers and the use of “shared decision making more generally and specifically relating to treatment options, and how payers and health plans are attempting 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 poses for informed consumer decision making.

**Suggested Readings**

**Shared Decision Making**

Further Readings


Decision Aids and Their Use


Issues in the Use of Decision Aids


The Importance of Health Literacy and Language Issues to Informed Choice


Further Readings


Supporting Consumers in Maintaining and Improving 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 overtime by reducing or delaying the onset of chronic illnesses. Payers' efforts rely both on rewards and negative incentives to encourage healthy behaviors. Employers depend on both health plans and independent vendors for delivering program content.

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.

Suggested Readings

Design of Healthy Lifestyle Programs


Evidence of Program Effectiveness

2. Russell, L.B. “Preventing chronic disease: an important investment, but don’t count on cost savings.” Health Affairs 2009;28(1):42-45
Concerns about Program Incentives

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

Further Readings

2. Johnson, A. “Cashing in on healthful lifestyles; State paying its workers to ‘take charge, live well’.” Columbus Dispatch, January 17, 2008
6. Olson, E.G. “New technology is helping elderly patients and those with chronic diseases monitor their condition from the comfort of home.” The Washington Post, November 17, 2009
December 3, 2012

Supporting Consumers in Managing Chronic Illnesses

Employers are strong supporters of programs that help consumer “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. This, in turn, would improve the quality of life for employees, reduce emergency room and hospital use, and restrain growth in costs. We will discuss efforts of payers and health plans to support consumers in chronic care management and the context 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 to the effective implementation, by payers and health plans, of programs to support chronic illness management by consumers.

Suggested Readings

Importance of Developing Effective Approaches to Chronic Illness Management

Self-Management of Illnesses

Disease Management Programs – Structure and Effectiveness
2. McQueen, M.P. “Look who's watching your health expenses; employers increasingly turn to 'care managers' to control medical costs, but some wonder if patients always benefit.” Wall Street Journal, September 25, 2007, p. D.1
6. Feder, J.L. “Predictive modeling and team care for high-need patients at HealthCare Partners.” Health Affairs 2011;30(3):416-418

Further Readings
December 10, 2012

Putting It All Together: Coordinated Approaches to Supporting Care Management, Improving Quality, and Controlling Costs

Employers and health plans are introducing comprehensive approaches, including new benefit designs, that they hope will encourage and reward consumers for healthy living, effective self-management of their chronic illnesses, and choice of cost effective treatments and providers. These strategies are in the early stages of implementation, and evidence on their impact to date is limited.

Learning Objectives

Students should be able to:
1. Describe value-based benefit strategies and how they are being implemented.
2. Assess the strengths and weaknesses of these strategies from the perspectives of employers and consumers.
3. Describe recent collaborative approaches to control community health care costs and improve health.

Suggested Readings

Collaborative Initiatives
1. Blackmore, C.C., Mecklenburg, R.S., Kaplan, G.S. “At Virginia Mason, collaboration among providers, employers, and health plans to transform care cut costs and improved quality.” *Health Affairs* 30(9):1680-1687, 2011

Structure of Value-Based Benefit Design

Experience with Value-Based Benefit Design

**Addressing Obesity: Challenges in Designing a Coordinated Approach**


**Further Readings**

VII. Evaluation and Grading

Grades will be determined based on four group assignments (total of 40 points) and six individual assignments (total 60 points). The student will receive a grade of zero if an assignment is not submitted as scheduled, unless prior arrangements have been made for late submission.

Grading Scale

An A/F letter grade will be determined based on the following:

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<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>93-100%</td>
<td>Represents outstanding achievement relative to the level necessary to meet course requirements</td>
</tr>
<tr>
<td>A-</td>
<td>90-92.99%</td>
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</tr>
<tr>
<td>B+</td>
<td>87-89.99%</td>
<td>Represents achievement that is significantly above the level necessary to meet course requirements</td>
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<tr>
<td>B</td>
<td>83-86.99%</td>
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</tr>
<tr>
<td>B-</td>
<td>80-82.99%</td>
<td></td>
</tr>
<tr>
<td>C+</td>
<td>77-79.99%</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>73-76.99%</td>
<td>Represents achievement that meets the minimum course requirements</td>
</tr>
<tr>
<td>C-</td>
<td>70-72.99%</td>
<td></td>
</tr>
<tr>
<td>D+</td>
<td>65-69.99%</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>60-64.99%</td>
<td></td>
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<tr>
<td>F</td>
<td>&lt; 59.99%</td>
<td>No credit. Signifies work was below level of achievement that represents minimum threshold to obtain credit or work was not completed and there was no agreement between instructor and student that the student would be awarded an I.</td>
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The instructor reserves the right to adjust final grades “upward” based on the overall distribution of points for the class. That is, students may receive a higher grade than expected based on their overall point total, but not a lower grade.

Course Evaluation

Beginning in fall 2008, the SPH will collect student course evaluations electronically using a software system called CoursEval: www.sph.umn.edu/courseval. The system will send email notifications to students when they can access and complete their course evaluations. Students who complete their course evaluations promptly will be able to access their final grades just as soon as the faculty member renders the grade in SPHGrades: www.sph.umn.edu/grades. All students will have access to their final grades through OneStop two weeks after the last day of the semester regardless of whether they completed their course evaluation or not. Student feedback on course content and faculty teaching skills are an important means for improving our work. Please take the time to complete a course evaluation for each of the courses for which you are registered.

Incomplete Contracts

A grade of incomplete “I” shall be assigned at the discretion of the instructor when, due to extraordinary circumstances (e.g., documented illness or hospitalization, death in family, etc.), the student was prevented from completing the work of the course on time. The assignment of an “I” requires that a contract be initiated and completed by the student before the last official day of class, and signed by both the student and instructor. If an incomplete is deemed appropriate by the instructor, the student in consultation with the instructor, will specify the time and manner in which the student will complete course requirements. Extension for completion of the work will not exceed one year (or earlier if designated by the student’s college). For more information and to initiate an incomplete contract, students should go to SPHGrades at: www.sph.umn.edu/grades.

University of Minnesota Uniform Grading and Transcript Policy

A link to the policy can be found at onestop.umn.edu.
VIII. Other Course Information and Policies

Grade Option Change (if applicable)
For full-semester courses, students may change their grade option, if applicable, through the second week of the semester. Grade option change deadlines for other terms (i.e. summer and half-semester courses) can be found at onestop.umn.edu.

Course Withdrawal
Students should refer to the Refund and Drop/Add Deadlines for the particular term at onestop.umn.edu for information and deadlines for withdrawing from a course. As a courtesy, students should notify their instructor and, if applicable, advisor of their intent to withdraw.

Students wishing to withdraw from a course after the noted final deadline for a particular term must contact the School of Public Health Student Services Center at sph-ssc@umn.edu for further information.

Student Conduct, Scholastic Dishonesty and Sexual Harassment Policies
Students are responsible for knowing the University of Minnesota, Board of Regents' policy on Student Conduct and Sexual Harassment found at www.umn.edu/regents/polindex.html.

Students are responsible for maintaining scholastic honesty in their work at all times. Students engaged in scholastic dishonesty will be penalized, and offenses will be reported to the SPH Associate Dean for Academic Affairs who may file a report with the University’s Academic Integrity Officer.

The University’s Student Conduct Code defines scholastic dishonesty as “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; or altering, forging, or misusing a University academic record; or fabricating or falsifying of data, research procedures, or data analysis.”

Reference: “a mention or citation of a source of information in a book or article” (Compact Oxford English Dictionary, 2012)
Citation: “a quotation from or reference to a book, paper, or author, especially in scholarly work” (Compact Oxford English Dictionary, 2012)
Quotation: “a group of words taken from a text or speech and reported by someone other than the original author or speaker” (Compact Oxford English Dictionary, 2012)
Plagiarism: “the process of taking another person’s work, ideas, or words, and using them as if they were your own” (Macmillan Dictionary, 2012)

You will be asked to review a variety of sources of information when completing assignments for this course. It is important that you acknowledge these sources of information appropriately in your written assignments and verbal presentations. If you are quoting a source directly (using the words in the source, not your words) you must indicate this by using quotation marks, as in the definitions above, and by including a citation to the reference from which the quote was extracted. There is nothing wrong with including quotes in your assignments, but you are expected to put them in quotation marks and cite them appropriately. If you use the words of someone else, but do not put them in quotation marks, this is called plagiarism (even if you include a citation), and it violates the University’s academic code. Essentially, you are saying that you wrote these words, when that isn’t true, so you are lying to your instructor and classmates. In addition to using citations for quotations, you should use citations in the text to indicate instances where you have drawn on specific works of others in framing your answer or arguments. In using citations for this purpose, you acknowledge that the thoughts are not entirely yours, even though you may have expressed them in your own words. You should include a reference list at the end of your assignment. This list should include a complete description of all citations included in the text.

References

Plagiarism is an important element of this policy. It is defined as the presentation of another's writing or ideas as your own. Serious, intentional plagiarism will result in a grade of "F" or "N" for the entire course. For more information on this policy and for a helpful discussion of preventing plagiarism, please consult University policies and procedures regarding academic integrity: http://writing.umn.edu/tww/plagiarism/.
Students are urged to be careful that they properly attribute and cite others’ work in their own writing. For guidelines for correctly citing sources, go to http://tutorial.lib.umn.edu/ and click on “Citing Sources”.

In addition, original work is expected in this course. Unless the instructor has specified otherwise, all assignments, papers, reports, etc. should be the work of the individual student. It is unacceptable to hand in assignments for this course for which you receive credit in another course unless by prior agreement with the instructor. Building on a line of work begun in another course or leading to a thesis, dissertation, or final project is acceptable.

Disability Statement
It is University policy to provide, on a flexible and individualized basis, reasonable accommodations to students who have a documented disability (e.g., physical, learning, psychiatric, vision, hearing, or systemic) that may affect their ability to participate in course activities or to meet course requirements. Students with disabilities are encouraged to contact Disability Services to have a confidential discussion of their individual needs for accommodations. Disability Services is located in Suite 180 McNamara Alumni Center, 200 Oak Street. Staff can be reached by calling 612/626-1333 (voice or TTY).

Mental Health Services:
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce a student’s ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu
PubH 6564 (Private Purchasers of Health Care) NCHL* Competencies

Based on the course objectives listed in the Self-Study Year syllabus, the following competencies have been addressed by this course:

- 3 – Analytical Thinking
- 5 – Collaboration
- 6 – Communication Skills
- 7 – Community Orientation
- 11 – Information Seeking
- 17 – Performance Measurement
- 24 – Strategic Orientation

The course objectives are listed here with the corresponding NCHL competencies:

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 1</th>
<th>NCHL 3.2; 3.3; 11.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the origins and</td>
<td></td>
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<tr>
<td>evolution of managed care</td>
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<tr>
<td>organizations.</td>
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<tr>
<td>2. Explain the origins and</td>
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<tr>
<td>nature of the &quot;managed</td>
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<tr>
<td>care backlash&quot; of the</td>
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<td>1990s, and its influence</td>
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<td>on the ongoing</td>
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<td>development of the new</td>
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<tr>
<td>facilitated consumerism.</td>
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<td>3. Explain the factors</td>
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<td>influencing present</td>
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<td>employer demands on the</td>
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<tr>
<td>health care system, and</td>
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<tr>
<td>the role these demands</td>
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<tr>
<td>have played in changing</td>
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<tr>
<td>America’s health care</td>
<td></td>
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<tr>
<td>system.</td>
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</table>

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 2</th>
<th>NCHL 5.1; 6.3; 11.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the structure of</td>
<td></td>
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<tr>
<td>the health insurance</td>
<td></td>
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<tr>
<td>industry.</td>
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<tr>
<td>2. Distinguish among different</td>
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<tr>
<td>types of health plans and</td>
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<td>health plan products.</td>
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<td>3. Understand premium cycles</td>
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<tr>
<td>in the health insurance</td>
<td></td>
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<tr>
<td>industry.</td>
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<tr>
<td>4. Explain how employers</td>
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<tr>
<td>assess health plan</td>
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<tr>
<td>performance and choose</td>
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<tr>
<td>among health plans.</td>
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<td>5. Identify the major issues</td>
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<tr>
<td>relating to health plan</td>
<td></td>
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<tr>
<td>performance from the</td>
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<tr>
<td>perspective of employers</td>
<td></td>
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<tr>
<td>and the public.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 3</th>
<th>NCHL 5.1; 6.3; 11.3; 17.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe and contrast</td>
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<tr>
<td>different approaches to</td>
<td></td>
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<tr>
<td>performance measurement.</td>
<td></td>
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<tr>
<td>2. Discuss strengths and</td>
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<tr>
<td>weaknesses of these</td>
<td></td>
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<tr>
<td>approaches.</td>
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<tr>
<td>3. Discuss the role of risk</td>
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<tr>
<td>adjustment techniques in</td>
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<tr>
<td>measure construction and</td>
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<tr>
<td>how they are applied.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 4</th>
<th>NCHL 3.2; 3.3; 5.1; 6.3; 11.3; 24.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Discuss the nature of the</td>
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<tr>
<td>contracting process from</td>
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<tr>
<td>the health plan and</td>
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<tr>
<td>provider perspectives.</td>
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</tbody>
</table>

*The MHA program uses the National Center for Healthcare Leadership (NCHL) Health Leadership Competency Model (v 2.1). Copyright 2006. NCHL. All rights reserved.

The number following the decimal indicates the level to which that competency is addressed, as further described in the Competency Model, available here:
2. Describe how provider reimbursement levels are determined.
3. Discuss issues pertaining to tiered provider networks.

**Learning Objectives – Lesson 5**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 5</th>
<th>NCHL 3.2; 3.3; 5.1; 6.3; 11.3; 24.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the basic reimbursement approaches used by health plans in contracts with providers, including their strengths and weaknesses.</td>
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<tr>
<td>2. Describe the different types of pay-for-performance initiatives being undertaken by health plans and purchasers.</td>
<td></td>
</tr>
<tr>
<td>3. Describe how these approaches differ in their design and the challenges they pose for implementation, in comparison to previous payment arrangements between health plans and providers.</td>
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</tr>
</tbody>
</table>

**Learning Objectives – Lesson 6**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 6</th>
<th>NCHL 3.2; 3.3; 5.1; 6.3; 11.3; 24.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the basic design features relating to bundled payment.</td>
<td></td>
</tr>
<tr>
<td>2. Discuss the obstacles to implementing bundled payment arrangements.</td>
<td></td>
</tr>
<tr>
<td>3. Discuss Medicare support for bundled payment.</td>
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</tbody>
</table>

**Learning Objectives – Lesson 7**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 7</th>
<th>NCHL 3.2; 3.3; 5.1; 6.3; 11.3; 24.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the basic features of comprehensive, gainsharing payment arrangements between health plans and providers.</td>
<td></td>
</tr>
<tr>
<td>2. Discuss the obstacles to implementing comprehensive gainsharing arrangements.</td>
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</tr>
<tr>
<td>3. Discuss Medicare support for gainsharing payment as evidenced by Alternative Care Organizations.</td>
<td></td>
</tr>
</tbody>
</table>

**Learning Objectives – Lesson 8**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 8</th>
<th>NCHL 3.2; 3.3; 5.1; 6.3; 11.3; 24.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the most common practices used by health plans to support physicians in the delivery of care.</td>
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<tr>
<td>2. Explain the barriers to their effective implementation.</td>
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<tr>
<td>3. Assess the strength of the evidence supporting their effectiveness.</td>
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<tr>
<td>4. Describe recent trends in their use in conjunction with other efforts to influence physician behavior.</td>
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</tbody>
</table>

**Learning Objectives – Lesson 9**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 9</th>
<th>NCHL 5.1; 6.3; 11.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
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</tr>
<tr>
<td>1. Describe the recent efforts to increase the amount and quality of information available to health care consumers about providers.</td>
<td></td>
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<tr>
<td>2. Discuss the responses of providers to these efforts.</td>
<td></td>
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<tr>
<td>3. Assess the evidence regarding the impact of comparative provider performance data on consumer decisions, quality of care, and health care costs.</td>
<td></td>
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</tbody>
</table>

**Learning Objectives – Lesson 10**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 10</th>
<th>NCHL 5.1; 6.3; 7.1; 11.3; 17.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe different approaches being used to support consumers in their choice of treatments.</td>
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<tr>
<td>2. Discuss the problems faced by employers and health plans in implementing decision aids.</td>
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<tr>
<td>3. Evaluate the evidence regarding the effectiveness of these decision aids.</td>
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<tr>
<td>4. Assess the challenges that low health literacy poses for informed consumer decision making.</td>
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</tbody>
</table>

**Learning Objectives – Lesson 11**

<table>
<thead>
<tr>
<th>Learning Objectives – Lesson 11</th>
<th>NCHL 5.1; 6.3; 11.3; 17.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students should be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Describe the rationale for employer/health plan support for healthy lifestyle</td>
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</tbody>
</table>
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.

**Learning Objectives – Lesson 12**
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 to the effective implementation, by payers and health plans, of programs to support chronic illness management by consumers.

**Learning Objectives – Lesson 13**
Students should be able to:
1. Describe value-based benefit strategies and how they are being implemented.
2. Assess the strengths and weaknesses of these strategies from the perspectives of employers and consumers.
3. Describe recent collaborative approaches to control community health care costs and improve health.

NCHL 5.1; 6.3; 11.3