MANAGED CARE AND
THE INDUSTRIAL ORGANIZATION OF HEALTH CARE

HCMG 845-001
Spring 2013

Instructors

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Class Time / Location

Time: Tuesday Evening 6-9 p.m.
Location: John M Huntsman Hall

Overview of Course

This course examines two large topics in the healthcare industry: managed care and the
industrial organization of health care. Each topic is really an umbrella concept that covers
a broad array of approaches and techniques. The course seeks to analyze the strategy,
structure, and performance of developments in each area. Thus, we shall consider

(a) the core processes and infrastructure of managed care
(b) measures of market power and concentration
(c) the horizontal and vertical integration strategies of payers, providers, and suppliers
(d) the rationales behind horizontal and vertical integration strategies
(e) the development of value chain alliances, and
(f) the performance effects observed to date.

The course will draw on a range of information sources: presentations by industry experts
and executives, recent, ongoing research investigations in these areas, recent cases, and
selected industry publications. The course will also ask students (in teams) to conduct
focused industry investigations into managed care and industrial organization that extend
our knowledge of these topics. Student investigations will be shared with the class.
Conduct of the Course

This course is co-taught by Amanda Starc and Brad Fluegel, as well as several guest lecturers from the industry. It will meet every Tuesday evening from 6-9 p.m. Dr. Starc will hold office hours before class on Tuesdays from 5-6 p.m.

Course Requirements

Students will conduct two team projects. The team projects must be handed in and prepared for in-class presentation on March 18 and May 6, respectively. Consult these dates in the syllabus for possible topics. The project reports should be no more than 15-20 pages in length each.

The two field-based investigations will focus on managed care during the first half of the course, and industrial organization or integrated healthcare during the second half of the course. Student project teams to study managed care should form by the third class of the semester (Feb 4th); teams to study industrial organization and/or integrated healthcare should form by the second class following spring break (March 25th). Topics should broadly focus on the strategy/structure/performance of managed care and industrial organization or integrated healthcare. Where possible, teams will be matched with industry experts as advisors. Managed care team projects will be formally presented in class at the end of the first half (March 18) and second half (May 6) of the semester. Papers are due in class the day of the presentation.

The two project papers (approximately 15-20 pages) and class presentation (approximately 15 minutes) should focus on a specific aspect of managed care and industrial organization or integrated healthcare. You should stake out a position with regard to your topic and present evidence/research supporting your position. You should also discuss prevailing counter perspectives on the topic, and show why you believe these arguments fail. Interviews with individuals knowledgeable about the topic are strongly encouraged.

Grading

Grades will be based on a mixture of the two team projects (80% total, 40% each), and classroom attendance/participation (20%).

Required Readings

1. Access Study.Net for small number of cases, articles, and book chapter readings
2. Access all other readings on Canvas: https://wharton.instructure.com
JAN 21 COURSE OVERVIEW AND INTRODUCTION

Topics:
- Impact of managed care on health care costs and quality
- Key players and inter-relationships
- Current trends
- Introduction to industrial organization / corporate strategy in healthcare

Readings:
   - Chap 1 (The Origins of Managed Health Care)
   - Chap 2 (Types of Managed Care Plans & Integrated Healthcare Delivery Systems)
   - Chap 14 (The Role of Health Plans in Preventing Disease)

Discussion Questions:
- Are the goals of cost containment and quality improvement compatible?
- What are the common strategies among healthcare payers & providers?
Guest Speaker: Raymond Falci, Managing Director, Cain Brothers & Company LLC (Wharton Grad!)

Topics:
- Healthcare IT Fundamental Overview
- Historical Challenges to IT Adoption in Healthcare
- Data Analytics: Using Information to Transform Care Management
- Payer IT Strategies
- Health 2.0 – increased engagement of the consumer
- The basics of managed care
- Functions of managed care organizations
- Historical perspectives
- Fee For Service vs. Capitation
- Provider profiling
  - Utilization management, evidence based guidelines
- Reimbursement arrangements
  - Incentives, penalties, pay for performance programs
- Quality, inefficiencies and wastage
  - Changing provider behavior

Readings:
   Chap 3 (Elements of Management Control & Governance Structure)
   Chap 4 (Common Myths and Assertions about Health Plans)
   Chap 5 (Physician Networks in Managed Health Care)
   Chap 6 (Basic Compensation of Physicians in Managed Health Care)
   Chap 7 (Hospitals, Facilities, and Ancillary Services)
   Chap 16 (Data Analysis and Profiling in Health Plans)
   Chap 17 (Information Technology in the Healthcare Organization)
Discussion Questions:

- Does managed care further the goals of the health care system?
- Is managed care working for physicians? Why and why not?
- Why is it so difficult to change physician behavior?
- Which contracting interventions are most effective when?
- If you were a physician, what would persuade you to change your practice patterns?
- If you were in an HMO, how would you change physician practice patterns?
- Does our healthcare system deliver quality care? Why is it so expensive?
- How can alignment of economic incentives among healthcare stakeholders be used to increased HCIT adoption?
- How will managed care plans likely change their strategic approach toward IT over the next 5-10 years?
- Are government incentives in the HCIT adoption process necessary or not, ultimately a positive or not?
- Will improvements in HCIT help consumer engagement in health care?
FEB 4  IMPLICATIONS OF HEALTH CARE REFORM & CONSUMERS

Guest Speaker: Carl McDonald, Citi

Guest Speaker: Mike Taylor, Senior Vice President for Employer Strategies, OptumHealth

Topics:
- Implications of healthcare reform for managed care / payers
- Key customer needs by segment (purchaser and consumer)
- Consumer Directed Health Plans

Readings:
Link - http://healthreform.kff.org/

- Chap 18 (Claims Administration)
- Chap 19 (Member Services)
- Chap 20 (Healthcare Consumerism)
- Chap 21 (Sales and Marketing)
- Chap 22 (The Employer’s View of Managed Health Care)

Discussion Questions:
- What are the potential implications of reform?
- As a consumer, what is most important to you in selecting a health plan? Do managed care plans generally meet your needs?
- If you were an employer responsible for purchasing health care for your employees, what would be most important to you?
PAY FOR PERFORMANCE &
HOW PROVIDER ORGANIZATIONS ARE RESPONDING TO REFORM

Guest Speakers: Allen Smith, MD, MS, Partners Healthcare
Jessica Dudley, MD, Partners Healthcare

Topics:
- Pay for Performance
  - Evolution of reimbursement and care models
  - Efficiency, quality and process targets
- Population Health Management
  - Role of Larger Provider Organizations

Readings:
2. Chap 8 (Performance-Based Incentives in Managed Health Care:
3. Pay-for-Performance)
4. Chap 15 (Quality Management in Managed Care)
5. Chap 23 (Accreditation and Performance Measurement Programs for Managed Care Organizations)
7. Mechanic et al., “Medical Group Responses To Global Payment: Early Lessons From The ‘Alternative Quality Contract’ In Massachusetts”, Health Affairs September 2011 30:1734-1742

Discussion Questions:
- Will Pay for Performance progress make a difference in addressing quality and cost disparities?
- How important is quality management to improving provider relations?
- How is the role of large physician organizations shifting?
- What role can academic medical centers play in the health care delivery system and managed care?
EVALUATING THE EFFICACY OF MEDICAL MANAGEMENT PROGRAMS; VARIATION IN HEALTH CARE DELIVERY, and IMPLICATIONS FOR CLINICAL QUALITY AND EFFICIENCY

Guest Speaker:  Jeffrey Levin-Scherz M.D.
Chief Medical Officer – One Medical
Assistant Professor, Harvard School of Public Health

Topics:
- Examine the Distribution of Costs Within a Population of Patients
- Identify the Drivers of Increased Health Care Costs in the US
- Define the Interventions that are being tried to Lower Health Costs
- Assess Evidence of Efficacy in These Interventions
- Illustrate the Impact of Medical Management on Different Stakeholders

Readings:
   Chap 9 (Managing Basic Medical Surgical Utilization)
   Chap 10 (Fundamentals & Core Competencies Disease Management)
   Chap 11 (Case Management)
5. Al Lewis. “Case Studies that Flunk Every Plausibility Test Known to Mankind,” Managed Care Magazine (July 2012).

Discussion Questions:
- How can you evaluate the effectiveness of a medical management program?
- How can you project whether a medical management program is likely to produce cost savings?
- Which initiatives are most likely to produce cost savings?
- Which initiatives are least likely to produce cost savings?
Exercise:
Some commentators believe that a patient centered medical home (PCMH) can improve the quality of health care while lowering overall costs. Others are more skeptical, and say that the increased costs of a PCMH are unlikely to lead to lower overall health care costs.

We will review the actuarial (commercial only) available at this URL, and seek to understand

- Where would a PCMH likely save money in a non-Medicare population?
- What are the likely infrastructure costs required to establish a PCMH?
- How much savings would we need to accomplish for this effort to be cost-saving?
- Are there certain populations where a PCMH is more likely to be cost-saving?

To prepare for this exercise, please skim Goroll article (costs) and skim Fields article (potential savings)

Supplemental Readings:

Coye, M. “No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patient Needs.” Health Affairs. 2001: 44-56


Anderson, GF, Reinhardt UE, Hussey PS and Petrosyan, V “It’s the Prices Stupid: Why the United States is So Different than Other Countries.” Health Affairs 2003; 22;89-105 [http://content.healthaffairs.org/content/22/3/89.full.pdf](http://content.healthaffairs.org/content/22/3/89.full.pdf)

STRUCTURE & ECONOMICS OF THE MANAGED CARE INDUSTRY

Guest Speaker: Kurt Wrobel, MBA (Wharton Grad!)
Humana

Topics:
- The Underwriting Cycle
- Rate-setting process and rating methodologies
- Cost trends
- Capitation and risk-sharing
- Health Care Reform

Readings:
   Chap 24 (Operational Finance and Budgeting)
   Chap 25 (Underwriting and Rating Functions).

Discussion Questions:
- What are the major pricing and underwriting problem areas for managed care organizations?
- What do you see as the most critical trends affecting the managed care industry financially?
- What impact does financial risk transference to providers have on quality?
- In the Oxford case, what are the key issues in managing episodes of care and episode-based payment?
MAR 4  MEDICARE, MEDICAID AND PREMIUM SUBSIDIZED EXCHANGE COVERAGE

Guest Speaker:  Stephen Wood, Senior Vice-President, Ingenix Consulting

Topics:
- Historical perspective
- Medicare and Medicaid managed care today
- Employers role in Medicare
- Medicare and prescription drug coverage
- The future of Medicare managed care
- New state initiatives to improve access to health insurance

Readings:
   Chap 26 (Medicare and Managed Care)
   Chap 27 (Medicaid Managed Care)
2. Sommers and Rosenbaum, “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges”, Health Affairs February 2011 30:228-236

Discussion Questions:
- How strategically important are Medicare and Medicaid products to managed care organizations?
- Other than being older, how do Medicare HMO members differ from commercial HMO members?
- Do the current Medicare reforms make sense?
- What’s required for success in the Medicaid market?
Potential topic areas include:

- The potential impact of health care reform on managed care organizations?
- Does managed care work for Medicare and Medicaid populations?
- The impact of contracting and payment methods on physician behavior or clinical outcomes
- The changing role of health care purchasers. Should employers continue to provide health coverage or should individuals purchase coverage for themselves?
- Should health plans compete on the public exchanges? If so, how?
- What is the effectiveness of various trends in controlling costs and/or improving the quality of health care?
  - Different hospital structures (e.g. ACOs)
  - New provider payment structures (e.g. Pay for Performance)
  - Consumer Directed Health Plans (CDHP) plans
  - Wellness programs
  - Patient health records
  - New clinical technologies

PROJECT PAPERS DUE: MANAGED CARE
MAR 25 A STRATEGIC VIEW OF THE HEALTH CARE INDUSTRY

Topics:
- Applications of General Frameworks
- Unique Frameworks for Understanding the Health Care Industry

Reading:

Discussion Questions:
- To what extent do we need to incorporate institutional detail into our strategic analysis of the health care industry?
- What market failures are unique to health care?
- Can public payors incentivize innovation?
Topics:
- Definitions of market structure
- Impact of market structure on HMO performance
- Rationale for horizontal consolidation
- Evidence for benefits of HMO consolidation

Readings:

Discussion Questions:
- What are the sources of economies of scale?
- How big are these economies in HMOs?
- Under what market conditions do mergers benefit the public?
- What are the most important dimensions of market structure?
APRIL 15

CONTRACTUAL RELATIONSHIPS BETWEEN PAYERS AND PROVIDERS IN THE MARKETPLACE AND ANTITRUST ENFORCEMENT

Guest Speaker: Michael Dandorph, Senior VP – Business Development, University Of Pennsylvania Health System

Topics:
- Payer vs. provider contracting and bargaining
- Nature of contracting disputes

Readings:

Discussion Questions:
- Who has leverage and muscle in payer-provider negotiations?
- What are they fighting over?
- Under what conditions do payers/providers dominate?
- What are providers’ major complaints about payors?

Supplemental Readings:
   www.ftc.gov/ogc/healthcarehearings/030328agenda.htm
Topics:
- Types of vertical and virtual integration among providers
- Theory of vertical integration
- Benefits of integration for different parties
- Infrastructure of integrated delivery systems
- Structure versus process of integration
- Alignment of provider incentives

Readings:

Discussion Questions:
- Under what conditions does it make sense to vertically integrate?
- Are these conditions met in health care?
- What are the problems with aligning with physicians?
- Why is the process of “integrating” so important?
ACCOUNTABLE CARE ORGANIZATIONS (ACOs)
CLINICAL AND FINANCIAL INTEGRATION
THE FUTURE OF COMPETITION IN HEALTH CARE

Guest Speaker: John M. Harris, DGA Partners

Topics:
- The Basics of Accountable Care Organizations (ACOs)
- FTC/DOJ Guidelines on Antitrust Among Physicians
- The Kaiser Experience
- Competition between Systems

Readings:
3. Burns and Pauly, “Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s,” Health Aff November 2012 vol. 31 no. 11 2407-2416

Discussion Questions:
- What should next-generation models of integration look like?
- What implications do these systems have for manufacturers, like big pharmaceutical or medical device companies?
- What are the implications of ACOs for antitrust enforcement?
- What is the “right” level of completion?
MAY 6 PROJECT TEAM PRESENTATIONS

Potential topic areas include:
- Physicians and hospitals: what models of integration work?
- Effectiveness of disease management
- Methods to achieve economies of scale in horizontal combinations
- What is the future of hospital systems?
- What is the future of physician organization?
- Does diversification in the provision of healthcare services work?
- Mergers and acquisitions: how do you make them work?
- Value chain alliances in health care

FINAL PAPERS for 2nd HALF OF COURSE DUE:
INDUSTRIAL ORGANIZATION / INTEGRATED HEALTHCARE