January 8-11, 2002 / Los Angeles

NATIONAL HEALTH POLICY FORUM

Site Visit Report

Managed Care: As Good As It Gets?

The George Washington University
WASHINGTON DC

CONTENTS

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NHPF is a nonpartisan education and information exchange for federal health policymakers.

ACKNOWLEDGMENTS

"Managed Care: As Good As It Gets" was made possible by the generosity of the Robert Wood Johnson and California HealthCare Foundations.

The Forum thanks the many people who gave of their time and knowledge in helping to develop the site visit, as advisers, enablers, and participants. Special thanks to all the speakers for making the visit an illuminating experience. Kind enough to host the group were Bob Margolis of HealthCare Partners, Mark Meyers of the California Hospital Medical Center, Bill Gil of Facey Medical Foundation, and Leonard Schaeffer of Wellpoint Health Networks. Susan Hollander of Catholic Healthcare West and Dana McMurtry of Wellpoint were instrumental coordinators.

The Forum is grateful as always for the interest, stamina, and acuity of federal site visitors.

January 8–11, 2002 / Los Angeles

Managed Care: As Good As It Gets?

OVERVIEW

Once looked to as a model for the nation, managed care has fallen on hard times in Southern California. On the commercial side, plans, providers, consumers, and payers all express frustration with a marketplace characterized in recent years by turmoil, rising costs, and contentiousness. And Medicare's managed-care option, Medicare+ Choice, has eroded as health plans pull back from service areas or exit altogether. Yet, some players have managed to do relatively well financially and continue to believe the delegated-risk model still holds promise for managing costs and improving the quality of care. And some insurers are developing new approaches to expand coverage in the individual and small group markets.

In November 1998, NHPF sponsored a site visit to San Diego and Orange County, California, to look at managed care on its original home ground. "Plans and Providers: Risk, Accountability, and Staying Power" considered relationships among health plans, hospitals, and physician groups at a time when delegating risk to providers was seen as a way to marry cost and accountability at the physician level.

The three succeeding years have brought significant changes. Global capitation, a staple of California-style managed care, is more and more scarce. Physician practice management firms, dangerously overextended in 1998, have since collapsed. Contracting between health plans and providers has taken some new and contentious directions. Innovative insurance products are being developed to respond to consumer preference for choice and purchaser pressure for more predictable costs.

In organizing this site visit, NHPF sought answers to questions such as these: What is the state of managed care in southern California? Are its days numbered or is its death greatly exaggerated? Is consumer choice the new driving force? What lessons can be drawn from the changes taking place in the California market?

This site visit was a return to southern California to look at today's players and ponder what managed care was meant to be, what it has become, and what may be next for health care delivery.

PROGRAM

California HealthCare Foundation president Mark Smith, M.D., kicked off the program Wednesday morning with an overview of trends in managed care in California and identified key issues site visit participants might consider during their discussions with other presenters and provider groups. A leading researcher on physician group solvency outlined the various models of delegating financial risk employed in the California market and summarized the current financial status of physician groups and hospitals in the state. Next, site visitors heard about the California marketplace from the perspective of employer and consumer representatives. The deputy director of external affairs for the California Department of Managed Health Care provided an overview of the department's role and responsibilities and progress to date. Rounding out the morning, an executive from Tenet Health System, a major hospital chain, discussed the various strategies that have enabled this system to prosper in the difficult southern California market.

The group then traveled to a clinic in downtown Los Angeles operated by **HealthCare Partners Medical Group**. HealthCare Partners Medical Group was founded in 1994 through the merger of three southern California medical groups: California Primary Physicians, Huntington Medical Group, and Bay Shores Medical Group. The physician-owned and -managed group comprises more than 40 group practice sites and about 350 salaried physicians and several hundred contracted physicians. The group's patient base is around 500,000, with 92 percent globally capitated (that is, capitated for physician and hospital services). The group provides services to 60,000 Medicare+Choice patients.

Site visitors met with the chief executive officer and managing partner, the executive medical director, and the medical director of quality management to explore the role of culture and infrastructure in ensuring the group's success. Considerable discussion centered on the importance of the Medicare+Choice program to the group.

The **California Hospital Medical Center** (CHMC), a nearby hospital operated by Catholic Healthcare West, was the second stop. Situated at the edge of the downtown business district of the City of Los Angeles, CHMC is a not-for-profit hospital with 313 licensed beds and nearly 1,200 employees. The hospital serves a predominantly young, minority population; 67 percent of its patients are Latino while 25 percent are African-American. Nearly two-thirds of the hospital's patients are covered by either Medicaid or Medicare. In 2001, 26 percent of the hospital's discharges were deliveries. The hospital operates the only full-service, 24-hour emergency department in Central Los Angeles, treating more than 48,000 emergency services visits a year.

At CHMC, participants met with the president and chief executive officer, the medical director of emergency services, the chief financial officer, and others to hear about the challenges facing a nonprofit, urban hospital.

The second day began with a breakfast discussion with executives from PacifiCare and Kaiser Permanente about provider/plan relationships and how each organization plans to evolve its offerings to account for higher cost trends and modest increases in Medicare+Choice payment rates. Participants then traveled to Mission Hills in the west valley to meet with representatives of another physician group that continues to support the delegated-risk model. **Facey Medical Foundation** and its associated **Facey Medical Group** have provided care in the Santa Clarita, San Fernando, and San Gabriel Valleys since 1923. The multispecialty medical group comprises 110 board-certified physicians, 60 percent of whom are in primary care. Eighty-five percent of Facey's $90 million annual revenue derives from globally capitated contracts with health maintenance organizations (HMOs), which in total account for 100,000 covered lives.

The day concluded at **Wellpoint Health Networks** in Thousand Oaks. Wellpoint offers a broad array of health insurance products and services to customers in all 50 states. Its three main branded business lines are Blue Cross and Blue Shield of California, Blue Cross and Blue Shield of Georgia, and UniCare. Corporate strategy is to offer a diversified mix of products that preserve member choice at competitive prices while focusing on the development of new hybrid plans that combine the characteristics of traditional managed care and open access models. In addition to serving large and small businesses and government entities, WellPoint covers more people under individual policies than any other health plan in the country. Site visitors and WellPoint representatives engaged in a lively discussion of the insurer's business model for meeting needs in the individual and small group markets.

IMPRESSIONS

California as Trendsetter

Long looked to as a bellwether for the rest of the country, California may have become more of an outlier than a leader.

There was a time when the high managed-care penetration, risk-sharing with providers, and highly-organized medical groups that characterized the Los Angeles market were read as precursors of a managed care future for other cities. The low premium rates that prevailed were cited as evidence of the model's power. By 2002, however, symptoms of disintegration were apparent. Capitation had become less prevalent; many risk-seeking medical groups were battling (or had succumbed to) insolvency. As one site visitor put it, "the shape of things to come" may now be the shape of things that have come and gone.

If managed care has not been able to thrive in its California cradle, there is little reason to expect it to prevail elsewhere.

California has invested in the infrastructure to support managed care, yet the market trend still seems to be moving away from it. While it is probably safe to assume that Kaiser Permanente will weather whatever conditions the market

IMPRESSIONS

brews, it may well be a last bastion. The one-time vision of HMOs competing on the basis of cost and quality has failed to materialize in much of the country. Even in California, "choice" (especially of physicians) proves a potent force for broader networks and fewer restrictions: in short, away from managing care.

The Delegated Model

Successful physician organizations remain champions of the delegated model.

Leaders of such groups believe that capitation offers physicians greater incentive to practice high-quality, do-it-right medicine. It also magnifies the leverage leaders can exert on their own employed or contracted physicians to practice to group standards. Nevertheless, visitors found it difficult to fathom what led physicians (many of whose enterprises have failed) to believe they could—and wanted to—manage risk.

Delegated model is a term applied to the primary managed care delivery model in California, a contractual arrangement between a health plan and a physician group or independent practice association. Contracts vary, but common features are (*a*) risk-sharing in the form of capitated (per member per month) payments for physician services; and (*b*) delegation of administrative and financial responsibility to the physician organization for activities such as physician credentialing, medical management, and claims processing. Physicians in such groups do not have to obtain health plan endorsement of their care decisions, but do face greater scrutiny of cost-effectiveness by their own managing partners.

Successful physician organizations demonstrate the feasibility of managing medical practice.

The precise conditions necessary to generate care management capability and commitment cannot be quantified or replicated at will; however, gifted and visionary leadership seems a critical precondition. Also important is a robust information management capability. The limits on what aspects of care can be productively managed are not clear, but progress toward defined clinical goals can be charted by a group such as HealthCare Partners.

A cohesive culture is critical to physician group success and indeed survival.

Successful groups have taken a cautious approach to growth and invested intense effort and resources in building a common culture. The true groups, with physicians who are partners or employees, are in a much stronger position to do this than the independent practice associations (IPAs), in which physicians join together for the purpose of contracting but do not seek a commonality of practice. A long history of group practice may be needed for such a culture to take hold.

A new public focus on solvency has illuminated wide variation in physician group performance.

Well-designed operational processes, good financial management, and an understanding of risk are by no means universal. Public disclosure and scrutiny by the Department of Managed Health Care is driving some corrective action on the part of physician group managers. Again, true groups have an advantage over IPAs.

IMPRESSIONS

Medicare+Choice provides important support to the delegated-risk model's infrastructure.

Though participating providers stress their belief that the program needs to be better funded, they are most of all concerned with its survival. Medicare+Choice, however "underfunded," is still providing an attractive level of reimbursement, relative to other payment sources, to capitated physician practices.

Financing

Major challenges confronting California Hospital Medical Center seem typical of those facing safety-net providers across the country.

Like many safety-net institutions, CHMC faces significant financing and service delivery challenges. Given the hospital's payers and clientele, the financial consequences of economic, demographic, and public policy changes are immediate. The majority of individuals who use the hospital's services are covered by Medicaid or Medicare; only 25 percent are commercially insured. Bad debt and charity care expenses are considerable, and premium pay is required to hire and retain nurses. Even so, the hospital is unable to hire enough nurses to staff all of its licensed beds. Emergency department services are frequently overtaxed. Although net patient revenue falls short of expenses, the hospital manages to operate in the black due to the infusion of disproportionate share hospital (DSH) funds. But because Medicaid DSH funds are allocated by state government and are therefore unpredictable from year to year, reducing dependence on this source of income is desirable

Unlike three years ago, when the Forum conducted its last site visit to southern California, Medicare payments are no longer subsidizing commercial payers.

Commercial rates in California have lagged behind those in other parts of the country, in some cases by as much as 30 percent, in part because insurers and health plans used Medicare to subsidize commercial rates to gain market share. Recently, providers have put pressure on insurers for higher rates which in turn forced insurers to raise premiums in the commercial sector. As a result, the gap between the two payment sources has narrowed. Nevertheless, providers maintain that total reimbursement has not kept pace with costs.

The tension over rising health care costs is palpable.

A predominant theme of the site visit was rising health care costs and the ineffectiveness of many of the cost containment strategies associated with the early years of managed care. As a result, employers and insurers are planning to shift more of the financial burden to consumers through higher premiums, copayments, coinsurance, and new plan designs. In addition to negotiating higher rates from health plans, providers and hospitals are looking to the public sector for increased payments from Medicare and Medicaid. With one or two exceptions, most stakeholders in the health care system do not expect costs to moderate any time soon.

IMPRESSIONS

In the longer term, what may be called for is a change in consumer expectations about care and/or cost-sharing or a change in provider expectations about income.

Competition in the southern California market is intense, with financial gain apparently the chief motivator for many players.

Washington policymakers were struck by the fact that most individuals they met with focused on the intense competition in the marketplace and inadequacy of payments from both public and private payers. Many federal participants felt that expectations for increased public spending, particularly through the Medicare+ Choice program, were unrealistic.

Insurance Strategies

Insurers and health plans in California are on the forefront of developing new insurance products.

While Kaiser Permanente is likely to make only modest adjustments to copayments and benefits in order to hold premiums down, some other insurers are beginning to experiment with new plan designs that use tiering and other strategies to moderate premium increases and shift more of the financial burden to consumers through higher deductibles and coinsurance. Examples include imposing higher cost sharing to use "expensive" hospitals or provider groups. Conversely, deductibles might be waived for consumers who accept "steering" to cost-efficient providers.

Insurers are moving from selling products that provide a set of defined health benefits to offering financial service products that are designed to protect against financial loss due to health care expenses.

Most health plans and insurers no longer believe they can either control the events that drive the utilization of health care services or significantly influence quality. As a result, they have given up on "managing care" through gatekeeping and other access barriers. New products offer consumers various combinations of premium, deductible, and coinsurance levels. These new plan designs also respond to employer expectations that employees will have to pay a larger share of health care costs. They create more "skin in the game" for employees, which some employers regard as a prerequisite to increased consumer involvement in managing their own health care.

New plan designs raise questions about the financial burden they place on the chronically ill.

While recognizing that low-premium, high-cost-sharing plans may appeal to a segment of the market that is currently uninsured, site visit participants were particularly concerned about the impact of these plans on the chronically ill who often have little discretion over the use of services.

Consumer choice based on more than price requires quality comparison data not yet available.

Envisioning a consumer empowered to make appropriate choices presupposes quality data to inform that choice, but investors in the collection and validation of such data have not come forward in a meaningful way. Providers themselves have traditionally resisted the publication of performance data in the absence of a reliable risk-adjustment mechanism. Quality-information projects undertaken by health plans and in public-private collaborations, such as the Pacific Business Group on Health, have yet to offer financial incentives compelling enough to drive improvement. In the absence of such information, consumers are disadvantaged in selecting the providers that best meet their needs.

Outlook

Los Angeles health care stakeholders share an anxiety about the sustainability of the managed-care status quo in their market and, equally, a perplexity about what comes next.

The first-line answer to "What would help?" is, of course, "More money." However, it appears unlikely that either employers or government entities will raise payments at the same pitch as costs are increasing. If there is to be a further iteration of managed care, or a new model to replace it, the vision has not yet been vouchsafed.

AGENDA

Tuesday, January 8, 2002

Travel and check-in at headquarters hotel *[Hilton Pasadena]*

7:00 pm Bus departure for dinner *[El Cholo]*

Wednesday, January 9, 2002

7:30 am Breakfast available *[San Diego Room, Hilton Pasadena]*

8:00 am BACKGROUND:
THE STATE OF THE STATE'S HEALTH CARE SYSTEM

Mark Smith, M.D., *President and Chief Executive Officer,* California HealthCare Foundation

Christopher Ohman, *President,* CapMetrics, LLC

- What is the state of managed care in southern California? Is the delegated-risk model still viable?
- Were the apparent cost-containment successes and efficiency gains that NHPF site visitors observed three years ago illusory?
- Does any stakeholder hold a powerful position in this market?
- Is there an agreed-upon definition of what managed care was supposed to accomplish and the extent to which it has succeeded?
- What are the contrasts between—and the challenges common to—the network and the group (that is, Kaiser Permanente) HMO models available here? Are HMOs likely to be supplanted by preferred provider organizations?
- Have medical groups and IPAs become less enthusiastic about capitation? Is another reimbursement mechanism likely to supplant it?
- How healthy are IPAs and medical groups? What factors determine their solvency?
- Are allegations that significant numbers of physicians are fleeing the state accurate?

9:15 am PURCHASERS AND CONSUMERS: WHERE TO FROM HERE?

Joseph Deacon, *Senior Director of Human Resources and Director of Benefits Planning and Development,* Fluor Corporation

Ellen Severoni, *President,* California Health Decisions

- How are purchasers and consumers responding to changes in the southern California market?
- Have California consumers turned against managed care?

Wednesday, January 9, 2002

AGENDA

- To what extent are consumers (*a*) privy to quality information, (*b*) insulated from medical costs, and (*c)* pushing for greater choice among providers?
- Is "defined contribution" likely to be the next cost-containment strategy for employers?
- What kinds of quality-assurance and -improvement projects have been undertaken as joint efforts between plan sponsors and health plans?

10:15 am STABILIZING THE MARKET THROUGH REGULATION AND INFORMATION: WILL IT WORK?

Herb K. Schultz, *Deputy Director for External Affairs,* Department of Managed Health Care (DMHC), State of California

- What is DHMC's mandate from the legislature? What has it been able to accomplish so far?
- What actions is DMHC taking to stabilize the state's managed care market? To what extent does its attention go beyond HMOs?
- How did provider groups respond to new mandates to furnish the department with financial information? What are next steps?
- What are the department's major short-term and long-term policy goals?

11:15 am HOSPITALS: REDEFINING A ROLE?

William Leyhe, *Vice President, Strategic Development and Managed Care,* Tenet Health System, Inc.

- Have hospitals' contracting practices and patterns changed over the last few years?
- How bad is the staff shortage facing California hospitals? Does it go beyond nurses? What will be the effect of state-mandated staffing ratios? What strategies might succeed in attracting more workers to the health care field?
- Is reducing length of inpatient stay, long a favorite cost-cutting tactic, still a goal of the managed care organizations with whom hospitals contract?
- What changes have characterized hospitals' contracting with health plans over the past couple of years?
- How have hospitals responded to the Leapfrog Group's call for computer-based order entry systems and intensivists on staff?
- What effect has the Health Insurance Portability and Accountability Act of 1996 had on hospital operations?

AGENDA

Wednesday, January 9, 2002

Noon — Departure for HealthCare Partners (HCP) clinic

12:45 pm — Briefing and discussion, with lunch

CULTURE AND INFRASTRUCTURE: KEYS TO SUCCESS?

Robert Margolis, M.D., *Chief Executive Officer and Managing Partner,* HealthCare Partners

William Chin, M.D., *Executive Medical Director,* HealthCare Partners

Daniel Temianka, M.D., *Medical Director of Quality Management,* HealthCare Partners

- How are HCP's patients and revenues divided among employer-based insurance, Medicare, Medi-Cal, Healthy Families and the uninsured? Has this balance changed over time?
- What distinguishes a medical group successful under the delegated-risk model from one that flounders or fails?
- What steps has HCP taken to nourish a common culture across its various locales and lines of business?
- What incentives (or disincentives) exist to undertake quality-assessment and improvement programs? What kinds of such activities is HCP engaged in?
- What impact have changes in Medicare had on medical groups?

3:15 pm — Departure for California Hospital Medical Center

3:30 pm — LESSONS FROM AN INNER-CITY HOSPITAL

Mark Meyers, *President and Chief Executive Officer,* California Hospital Medical Center

Robert Splawn, M.D., *Medical Director, Emergency Services,* Center for Emergency Services, California Hospital Medical Center

- What are the demographics of the population the hospital serves? Are they likely to change with the neighborhood? How has the hospital adapted to a multicultural patient base?
- What proportion of patients and revenues is attributable to Medicare, Medi-Cal and Healthy Families, private insurance? How significant are DSH payments to the hospital's financial health?
- What are the hospital's most significant economic and operating challenges? How is it addressing current workforce shortages? Are particular departments or positions affected more than others? What is the long-term outlook?
- What is the likely impact of proposed changes in the Medicaid upper payment limit?

- What are the hospital's responsibilities with respect to emergency preparedness, from earthquakes to bioterrorism?

5:30 pm Departure for Hilton Pasadena

7:30 pm Dinner *[Restaurant 561]*

Thursday, January 10, 2002

7:30 am Breakfast available *[San Marino Room, Hilton Pasadena]*

8:00 am HEALTH PLANS: HEADS ABOVE THE WATER?

Jack Hudes, Ph.D., *Vice President, Health Plan Operations, and Assistant Health Plan Manager,* California Division, Kaiser Foundation Health Plan, Inc.

Leeba Lessin, *President, Southern California,* PacifiCare of California

- What new strategies have health plans considered/adopted in response to a changing market? Have some kinds of activities been curtailed?
- What elements are involved in a decision whether (or how much) to participate in Medicare+Choice?
- What are challenges common to a network-based health plan such as PacifiCare and the group model that characterizes Kaiser? Are there market developments that favor one or the other?
- What changes could be made that would improve health plans' security and ability to function?
- What kinds of quality-assurance and -improvement projects have been undertaken as joint efforts between health plans and providers?

9:00 am Discussion among site visitors

9:30 am Checkout

10:15 am Departure for Facey Medical Foundation

11:00 am Briefing and discussion, with lunch

KNOW WHEN TO HOLD 'EM, KNOW WHEN TO FOLD 'EM

Bill Gil, *President and Chief Executive Officer,* Facey Medical Foundation

William E. Gregor, *Chief Financial Officer,* Facey Medical Foundation

Richard R. Swanson, *Chief Operating Officer,* Facey Medical Foundation

Frederick M. Russo, M.D., *President,* Facey Medical Group

Flo McNeill, *Administrative Director, Patient Care Delivery,* Facey Medical Foundation

AGENDA

Thursday, January 10, 2002

Josie Rice, R.N., *Administrative Director, Managed Care,* Facey Medical Foundation

Sybil Tourville, *Administrative Director, Information Systems,* Facey Medical Foundation

Yvonne Wiggins, R.N., *Administrative Director, Risk Management,* Facey Medical Foundation

- What does a medical "foundation" signify?
- What has enabled Facey to succeed under what all agree are dismal market conditions?
- What strategies has Facey adopted in response to the demographics of its patient population?
- To what extent are medical groups consolidating, as hospitals and health plans have done?
- To what extent can a successful medical group model or set of strategies be applied in multiple markets?
- How committed are physician organizations to the success of managed care?

1:30 pm Bus departure for Wellpoint Health Networks, Inc.

2:15 pm Briefing and discussion

RESPONDING TO CUSTOMERS, SHAPING A MARKET

Max Brown, Ph.D., *Senior Vice President, Network Management,* Wellpoint Health Networks, Inc.

Robert L. Crocker, M.D., *Senior Vice President, Clinical Affairs,* and *Medical Director,* Wellpoint Health Networks, Inc.

D. Mark Weinberg, *Group President,* Individual and Small Group Businesses, Wellpoint Health Networks, Inc.

Deborah Lachman, *Senior Vice President,* Small Group Services, Wellpoint Health Networks, Inc.

Dawn Wood, M.D., *Vice President, Medical Director,* Wellpoint Health Networks, Inc.

- How has contracting with physicians and hospitals changed in recent years?
- What steps has Wellpoint taken to reward high-quality providers? How is performance measured? How have providers responded to this initiative?
- How can medical management be incorporated into an open-network model?

- What led the company to target the small group and individual markets for business development? Are there pooling strategies that would help reduce insurance costs for those with moderate or high risks? What does Wellpoint's experience in these markets say about proposals to expand coverage to the uninsured?
- Does WellPoint share what seems to be a general pessimism about the short-term prospects for health care delivery in the region and the long-term future of managed care?

5:15 pm Departure of federal and foundation participants for dinner

6:00 pm Dinner *[Saddle Peak Lodge]*

9:00 pm Bus departure for Westin Los Angeles

Friday, January 11, 2002

Travel day

FEDERAL & FOUNDATION PARTICIPANTS

Gary Bailey
Director
Health Plan Benefits Group
Center for Beneficiary Choices
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Jonathan Blum
Professional Staff Member (D)
Committee on Finance
U.S. Senate

Jeff Donarski
Policy Advisor
Office of Representative Becerra
U.S. House of Representatives

Bob Donnelly
Director
Health Plan Policy Group
Center for Beneficiary Choices
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Laura Dummit
Director
Medicare Payment Issues
U.S. General Accounting Office

Marjorie Kanof
Director
Veterans' and Military Health Care Issues
U.S. General Accounting Office

Kathy Kulkarni
Legislative Assistant
Office of Representative Pallone
U.S. House of Representatives

Margaret Laws
Senior Program Officer
California HealthCare Foundation

Steven Lieberman
Executive Associate Director
U.S. Congressional Budget Office

Larry Patton
Senior Advisor to the Director
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

William Scanlon
Director
Health Financing and Public Health Issues
U.S. General Accounting Office

Madeleine Smith
Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service

Amy Spanbauer
Press Secretary/Senior Legislative Assistant
Office of Representative Gibbons
U.S. House of Representatives

Carl Taylor
Professional Staff Member (D)
Committee on Ways and Means
U.S. House of Representatives

Lu Zawistowich
Deputy Director
Medicare Payment Advisory Commission

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Senior Research Associate

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Program Coordinator

BIOGRAPHICAL SKETCHES — SPEAKERS

Max Brown, Ph.D., serves as senior vice president, network management, Wellpoint Health Networks, Inc., with responsibility for all network development, provider contracting, and provider support under the Blue Cross of California brand, as well as nationally under the UNICARE brand. He joined the company in 1992 as the vice president and general manager of the Blue Cross of California health maintenance organization (HMO) operation and was promoted to senior vice president in 1994. Most recently, Brown served as senior vice president of network management for the company's UNICARE businesses. Before joining Blue Cross of California, he served as the vice president and manager of NYL Care/Southwest. Recently, he was elected to the board (and vice chairman) of the American Association of PPOs. He holds a B.B.A. from the University of Texas, Austin, and an M.P.H. in health care management and a Ph.D. in business economics from the University of California, Berkeley.

William Chin, M.D., has been the executive medical director of HealthCare Partners since 1992. He serves on the senior executive team and was the clinical voice of the organization through its growth and business systems reengineering. Beginning in 1980, Chin was medical director and president of the Huntington Medical Group, which merged with California Primary Physicians to become HealthCare Partners in 1992. Board-certified in internal medicine and rheumatology, Chin is a graduate of Rensselaer Polytechnic Institute and the University of Buffalo Medical School.

Robert L. Crocker, M.D., is senior vice president of clinical affairs for WellPoint's Healthcare Quality Assurance Division and medical director for Blue Cross of California, responsible for the management of all clinical and medical affairs for WellPoint. He oversees the company's clinical program development, physician review, regional plan medical directors, and clinical pharmacy management. Previously, Crocker served as vice president and medical director of the Medical Care Management Division with responsibility for care management services of WellPoint's national subsidiary, UNICARE..Crocker joined the company soon after the acquisition of the group health and related life businesses of John Hancock Mutual Life Insurance Company by WellPoint in 1997. As a John Hancock officer, Crocker served as chief medical officer of CostCare, an Orange County-based subsidiary of John Hancock. Before joining CostCare, Crocker was in private practice for more than 12 years. Additionally, he has been involved with health care and humanitarian development efforts in one of the former Soviet republics.

Joseph Deacon is senior director of human resources and director of benefits planning and development of Fluor Corporation. Deacon has over 25 years' experience in the benefits field and has served as benefits director for ConAgra Grocery Products Companies, Hunt-Wesson Foods, Dames & Moore, and Southern California Health Care System. He served on the U.S. Department of Labor ERISA Advisory Council from 1989 to 1992 and as chair of the Southern California Health Care Purchasing Coalition from 1990 to 1995. Deacon is a graduate of Loyola Law School in Los Angeles and a member of the California and U.S. District Bars.

Biographical Sketches — Speakers

Bill Gil is president and chief executive officer (CEO) of Facey Medical Foundation, a nonprofit medical foundation that manages Facey Medical Group, a 110-physician medical group with 100,000 prepaid enrolled members. Gil previously served as chief operating officer for UniMed Management Company, a physician practice management organization. He also has served as CEO of a start-up management services organization of 16 hospitals in Florida and as CEO of CareFirst, an HMO based in Los Angeles. He has over 20 years experience in senior management in the medical group industry. Gil holds an M.B.A. from Pepperdine University.

William E. Gregor is the chief financial officer of Facey Medical Foundation. He has over 25 years of health care experience and has held positions in the provider and payor segments of the industry and as a management consultant. Immediately prior to joining Facey, Gregor served as the chief financial officer for two other major medical groups in the Los Angeles area, Harriman Jones Medical Group and Greater Valley Medical Group. He also served as the chief operating officer and the chief financial officer for a specialized Knox-Keene licensed health care service plan in California with over 250,000 members. Gregor started his career in public accounting at Ernst & Young, where he spent fourteen years. He earned his M.B.A. degree from Northwestern University and his bachelor's degree from Duquesne University.

Jack Hudes, Ph.D., is vice president, health plan operations, and assistant health plan manager for the California division of Kaiser Foundation Health Plan, Inc. He has been with Kaiser Permanente for more than 20 years, managing a variety of areas, including membership accounting, claims, group contracts and benefits, pricing, and sales and marketing. Before joining Kaiser Permanente, Hudes worked as an engineer for the Jet Propulsion Laboratory in Pasadena and as a planner for a southern California health planning agency. He received his doctorate in public health from the University of California, Los Angeles.

Leeba Lessin joined PacifiCare in 1995 as vice president of provider delivery systems for PacifiCare Health Systems. In 1998, she was promoted to president of PacifiCare's Northern California operations. She assumed responsibility for Southern California operations in March 2001. Before joining PacifiCare, Lessin served as president and chief executive officer of Santa Barbara–based Monarch Health Systems and its affiliate, Freedom Health Plan. She also served as an associate executive director of the Santa Barbara County Medical Society for two years. Lessin received her bachelor's degree from Westmont College and her M.B.A. from the University of Washington.

William Leyhe, vice president, strategic development and managed care, Western Division, for Tenet HealthSystem, Inc., has responsibility for managed care, physician operations and the strategic positioning of Tenet's 40 Western Division hospitals, including structuring the relationships with medical groups, health plans and hospitals. Previously, Leyhe was vice president, operations, for Tenet Southern California Operations. Earlier, he was president and chief executive officer of Norwegian American Hospital in Chicago. He is vice chairman of the board of the Hospital Association of Southern California and serves on the board of the Federation of American Hospitals.

Biographical Sketches — Speakers

Robert Margolis, M.D., has been the managing partner and CEO of HealthCare Partners since the company's formation in 1992. He was also the managing partner of its predecessor, California Primary Physicians Medical Group. Margolis currently serves as chairman of the board of trustees of California Hospital Medical Center and as a member of the board of directors of Catholic Healthcare West—Southern California. He is board certified in internal medicine and medical oncology. Margolis is a graduate of Rutgers University and the Duke University Medical School and served a fellowship at the National Cancer Institute.

Flo McNeill is Facey Medical Group's administrative director for patient care delivery, with responsibility for administrative support and operations oversight in the nine Facey Medical Group facilities. McNeill, who holds a master's degree in health administration from the University of Southern California (USC), has over 28 years of experience in the health care industry. Before joining Facey Medical Foundation, she held positions as director of operations at Healthcare Financial Services, director of member services at Inter Valley Health Plan, and director of ambulatory care and professional services for the USC School of Medicine.

Mark A. Meyers is president and CEO of California Hospital Medical Center, a unit of Catholic Healthcare West, a Catholic multihospital system in the western United States. He has been a health care executive since 1974 and, since 1980, a hospital CEO at hospitals in Louisiana, Florida, and California. Much of his career has been in settings devoted to the care of underserved and ethnically diverse populations He has served on the boards of many community organizations and foundations.

Christopher Ohman is president of CapMetrics, LLC, a company he formed in 1999 with the mission of developing timely, consistent, and objective ratings of the capacity of medical groups and independent practice associations to accept and manage financial risk. Previously, he was chief financial officer and treasurer of St. Joseph Medical Corporation and Orange Coast Managed Care Services, Inc., a large southern California independent practice association. He has held senior-level financial positions with several major health care companies. Ohman received his undergraduate degree from Lewis and Clark College and a master's degree in public affairs from the Woodrow Wilson School at Princeton.

Josie Rice, R.N., is administrative director, managed care, for the Facey Medical Foundation. Her responsibilities include supervising the claims and contract departments and utilization management and discharge planning/case management for in-patient and ambulatory settings. Rice joined Facey in 1990 as director of utilization management and discharge planning/case management. Earlier, she worked as a consultant to home health agencies and a surgical practice. She began her career in quality assurance, risk management, and utilization management in 1980 in an acute-care facility. Born and raised in Mexico City, Rice holds an A.A. degree in nursing and a B.A. in health care and administration.

Fredrick M. Russo, M.D., has been president of Facey Medical Group since 1995; he was re-elected to a third term in 2001. His work includes physician recruiting, compensation

plan development and oversight, corporate governance and infrastructure development, bylaws and contract maintenance/creation, contract negotiation, and employee counseling. He also maintains a half-time clinical practice in internal medicine. Russo joined Facey Medical Group as staff physician in 1984, following his residency at the University of Cincinnati Medical Center. He holds a B.A. degree from Baylor University and an M.D. from the University of Texas Medical School.

Herb K. Schultz is deputy director for external affairs of California's Department of Managed Health Care. He leads the department's legislative affairs effort and serves as liaison to the Advisory Committee on Managed Care. Schultz came to the department from AIDS Project Los Angeles, where he served as government affairs director. Earlier, as vice president of state government affairs for the American Association of Health Plans, he played a leading role in the development of a national model for new and innovative financial solvency standards for HMOs.

Ellen Severoni is president and co-founder of California Health Decisions, a statewide not-for-profit organization dedicated to bringing health care consumers and providers together to improve health care delivery. She served on California's Managed Health Care Improvement Task Force in 1997 and currently serves on the board of directors of the Foundation for Accountability, or FACCT. She earned an R.N. degree from the Bryn Mawr School of Nursing and was a practicing nurse and director of nursing early in her career.

Mark Smith, M.D., is president and CEO of the California HealthCare Foundation, created in 1996 by the conversion of Blue Cross of California to an investor-owned company. The foundation is dedicated to the improvement of health care for Californians. Before joining the foundation, Smith was executive vice president of the Henry J. Kaiser Family Foundation. He is a member of the clinical faculty at the University of California at San Francisco and an attending physician in the AIDS clinic at San Francisco General Hospital. He also serves on the Committee on Performance Measurement of the National Committee for Quality Assurance. Smith received his A.B. degree from Harvard College, his M.D. from the School of Medicine at the University of North Carolina at Chapel Hill, and an M.B.A. in health care administration from the Wharton School at the University of Pennsylvania.

Robert Splawn, M.D., is medical director for California Hospital Medical Center's center for emergency services, where he oversees the care of more than 4,000 patients monthly. He is also president and chief executive officer of a hospital-based emergency physicians group. Splawn is the founder and medical director of both domestic assault and a sexual abuse response teams, which provide medical, social and law enforcement services. He is a commissioner for emergency services for the County of Los Angeles and active in several organizations concerned with family violence.

Richard R. Swanson is the chief operating officer of Facey Medical Foundation. He is in the 30th year of a dual-plane health care career encompassing both marketing and provider relations experience; he has held positions in various sectors of the health care industry, including public health, Blue Cross/Blue Shield, health maintenance organizations, a tertiary hospital, a dental maintenance organization, and various medical groups.

Biographical Sketches — Speakers

Immediately prior to joining Facey, Swanson served as the vice president, commercial sales and marketing, for InterValley HMO and before that as vice president and administrator of the Motion Picture and Television Fund Medical Group. He has served on several business-related boards, including those of the California Medical Group Management Association, Health Care Marketing Association, and Preferred Health Network (PPO). He holds B.A. from California State University, Fullerton.

Daniel Temianka, M.D., is medical director of quality management at HealthCare Partners Medical Group, where he has practiced as a general internist for 22 years. He holds a B.A. from the University of California, Berkeley, and an M.D. degree from the University of California, San Francisco.

Sybil Tourville has been the administrative director, information systems, at Facey Medical Foundation for the past year. Utilizing her 20 years' experience in health care technology, Tourville and her team have adopted a standardized business process redesign method for project management in all multidisciplinary projects, such as centralized scheduling and the front office patient flow process. Tourville's previous experience includes responsibility for a practice management system design by consensus and implementation for six UniMed medical groups with 800,000 member lives. She led the information technology support for HealthCare Partners Medical Group as it signed its first managed care contract in the early 1980s.

D. Mark Weinberg is one of three group presidents who operate the health and related businesses of WellPoint Health Networks, Inc. Weinberg's primary responsibility is WellPoint's Individual and Small Group businesses, which generate $3 billion in annual revenues. He also serves as the president and chief executive officer of UNICARE, one of WellPoint's national subsidiaries. He has served in other senior positions for the company since April 1987. Before joining Blue Cross of California, Weinberg held a variety of business consulting positions with the accounting firm Touche-Ross and Company (now Deloitte & Touche) in Chicago. Earlier, he was general manager for the CTX Products Division of Pet, Inc., and for I.C. Industries Company in St. Louis, Missouri, a designer and manufacturer of commercial computerized processing equipment. Weinberg holds an electrical engineering degree, with graduate work in operations management and computer design. He holds patents in the United States, Japan and Great Britain.

Yvonne Wiggins, R.N., is administrative director, risk management, for the Facey Medical Foundation. She joined Facey in 1993 as quality improvement manager after five years as the manager of quality, risk, safety, and infection control in a 450-bed acute care/trauma center. Earlier, she served as quality assurance manager for the local PSRO (Professional Standards Review Organization). Over the past 20 years, Wiggins has participated in quality councils at the national health system level and acted as a consultant for acute care hospitals in preparation for JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) surveys. She attended Morehead State University and Ohio University.

BIOGRAPHICAL SKETCHES — FEDERAL & FOUNDATION PARTICIPANTS

Gary Bailey is director of the Health Plan Benefits Group in the Center for Beneficiary Choices of the Centers for Medicare and Medicaid Services (CMS), which contracts with 343 managed care organizations for health care services delivered under Medicare+Choice. Bailey has worked in the Medicare program for more than 25 years, serving in a variety of management positions. Previously, he was director of the Beneficiary Access and Education Group. Bailey holds a B.S. degree from the University of Maryland and an M.A. from George Washington University.

Jonathan Blum serves on the professional staff (majority) of the Senate Finance Committee, focusing on Medicare reform, Medicare+Choice, and Medicare solvency issues. Before joining the Finance Committee, he worked for the Office of Management and Budget, contributing to the development of President Clinton's Medicare reform proposal. Blum is a graduate of the University of Pennsylvania and Harvard University's John F. Kennedy School of Government.

Jeff Donarski is policy advisor on issues before the Ways and Means Committee to Rep. Xavier Becerra (D-Calif.). From 1998 through July 2001, he served first as legislative assistant and then legislative director to Rep. John LaFalce (D-N.Y.). He has also held positions with the Federation of American Scientists and the Democratic Party of Illinois. He is a graduate of the University of Notre Dame.

Bob Donnelly is the director of the Health Plan Policy Group in the Center for Beneficiary Choices at CMS, with responsibility for Medicare+Choice policy and quality improvement, as well as enrollment, appeals, and consumer protection in both M+C and fee-for-service Medicare. Before becoming group director, he was director of the division of program policy. Previously, Donnelly spent five years as a program examiner with the Office of Management and Budget. He holds a master's degree in public policy from the University of Michigan.

Laura Dummit is the director for health care–Medicare payment issues in the U.S. General Accounting Office (GAO). Before joining GAO in 1998, she was deputy director of the Prospective Payment Assessment Commission (a predecessor of the Medicare Payment Advisory Commission). Dummit has also held positions with the Alpha Center and the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services. She holds a master's degree in health policy and administration from the University of North Carolina at Chapel Hill.

Marjorie Kanof, M.D., recently joined the U.S. General Accounting Office as the director of military health. She previously served in a variety of leadership positions in CMS, most recently as deputy director for payment policy in the Center for Medicare Management. Before joining CMS, Kanof was medical director for the Senior Division and government programs at Blue Cross Blue Shield of Massachusetts. She was also an assistant professor of pediatrics at Harvard Medical School and a guest scientist at the National Institute of Allergy and Infectious Diseases. Kanof received her M.D. degree from the University of Kansas and an M.P.H. from Harvard University School of Public Health.

Biographical Sketches — Federal & Foundation Participants

Kathy Kulkarni is legislative assistant to Rep. Frank Pallone (D-N.J.), working on issues including health care, women's issues, civil rights, immigration, and welfare. She first went to work on Pallone's staff in 1997, interrupting her service with a stint as a health policy analyst in HCFA's Office of Legislation. Her Washington career began with an internship with the National Women's Health Network. Kulkarni holds a master's degree from the Johns Hopkins University School of Hygiene and Public Health and a B.A. from Brown University.

Margaret Laws is director of policy and planning and a member of the iHealth team at the California Healthcare Foundation. She joined the foundation early in 1998, after serving as staff to the state of California's Managed Care Improvement Task Force. Earlier, she was a senior consultant and manager at Andersen Consulting, working in both the government and health care strategy practices. Laws has also worked as an associate consultant with the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health and as a consultant to the World Health Organization. She holds a master's degree from Harvard University's John F. Kennedy School of Government and an A.B. from Princeton University.

Steven Lieberman is executive associate director of the Congressional Budget Office. He had been a partner in the EOP Group and headed his own consulting firm from 1994 to 1999. Earlier, he served as vice president of marketing and government programs for Intergroup and vice president of strategic planning at Schaller Anderson Inc. in Phoenix. Lieberman's previous government positions include assistant director and health financing branch chief in the Office of Management and Budget.

Larry Patton has been senior advisor to the director of the Agency for Healthcare Research and Quality (AHRQ) since 1998. He serves as the agency's congressional and public liaison officer. Since joining AHRQ in 1989, he has been director of the Office of Policy Analysis, special assistant to an earlier director, and director of the agency's user liaison program. Patton began his career as a legislative assistant for health policy in the U.S. Senate, a position he held from 1973 to 1987. He holds a bachelor's degree from Pennsylvania State University and is a Pew Doctoral Fellow at the University of Michigan School of Public Health.

William Scanlon is director of health care issues at the U.S. General Accounting Office. He has been engaged in health services research since 1975. Before joining GAO in 1993, he was the co-director of the Center for Health Policy Studies and an associate professor in the Department of Family Medicine at Georgetown University and had been a principal research associate in health policy at the Urban Institute. His research has focused in particular on the Medicare and Medicaid programs, especially provider payment policies, and the provision and financing of long-term care services. Scanlon has published extensively and has served as frequent consultant to federal agencies, state Medicaid programs, and private foundations. He has a Ph.D. in economics from the University of Wisconsin-Madison.

Madeleine T. Smith, Ph.D., is a specialist in social legislation at the Congressional Research Service (CRS), concentrating on issues in Medicare and private health insurance.

Biographical Sketches — Federal & Foundation Participants

She heads teams responsible for the CRS Medicare+Choice database and the CRS actuarially based models to estimate health insurance premiums, one for the non-elderly population and one for Medicare beneficiaries. She assisted congressional staff in developing the formula for Medicare+Choice payments included in the Balanced Budget Act of 1977 and in modifying the formula under the Balanced Budget Refinement Act of 1999 and the Beneficiary Improvement and Protections Act of 2000. She holds a Ph.D. degree from the University of Rochester.

Amy Spanbauer is communications director and a legislative assistant managing domestic policy issues in the office of Rep. James Gibbons (R-Nev.). She previously held internships with Rep. Christopher Shays (R-Conn.) and Sen. Arlen Specter (R-Pa.) and with a Washington public relations firm. She is a graduate of Lafayette College.

Carl Taylor is senior Medicare analyst with the House Committee on Ways and Means, on detail from the Department of Health and Human Services. He earlier was a Brookings Fellow with the committee. At the department, he served as senior Medicare analyst in both the Office of the Assistant Secretary for Legislation and the Office of the Assistant Secretary for Management and Budget. Taylor holds a master's degree from Florida State University and a B.S. from Baylor University.

Lu Zawistowich, Sc.D., is deputy director of the Medicare Payment Advisory Commission. Previously, she served in several director positions in the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), including director of the Medicare Contractor Management Group, Medicare Demonstrations, Risk-adjustment Implementation for Medicare+Choice, and the Office of State Health Reform Demonstrations. She also served as executive director of the Competitive Pricing Advisory Committee. Earlier, she worked for the state of Maryland in the Medicaid program. Zawistowich received her doctorate from the Johns Hopkins University School of Hygiene and Public Health.

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