Plans and Providers: Risk, Accountability, and Staying Power

November 17-20, 1998
Southern California

SITE VISIT REPORT
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Acknowledgments

Plans and Providers: Risk, Accountability, and Staying Power was the second of two site visits to look at managed care in California. While northern and southern California are distinctly different in the composition of their provider communities, health plans and providers face many of the same competitive pressures. The focus of the southern California trip was competitive strategies and plan-provider relationships in an ever-changing market. In putting together its ambitious three-day agenda, Forum staff had a great deal of counsel and encouragement.

The California HealthCare Foundation and the Alliance Healthcare Foundation generously provided primary funding for the site visit and a pre-visit seminar. Foundation chief executives Mark Smith and Ruth Riedel, respectively, offered guidance in designing the site visit, and both were able to participate in some part of it. The Forum is grateful for their involvement and support. It also appreciates the core support provided by the Robert Wood Johnson and W. K. Kellogg Foundations.

To all panelists and speakers who gave time and attention to helping to educate the site visit group, the Forum owes great thanks. Others in California who did not appear on the program but helped with information and contacts are: Lucien Wulsin, John Edelston, Steve Lieberman, Mike Safran, Bill Ross, Janet Adamian, Jennifer Jackman, Tracy Jackson, Bill Stimler, David Church, Long Deng, Gertrude Carter, Robert Frascetti, Andrew Siskind, Tao Le, and Yolanda Partida.

The planning process was smoothed and strengthened by two on-site advisors, Mike Gomez in Orange County and Lory Wallach in San Diego. Thanks to them and to those who arranged for site visitors to meet on-site in their organizations: Fran Butler-Cohen and Debbie McCane at Logan Heights; Dianne Young at Monarch; and Linda Lyons, Sam Ho, and Janet Newport at PacifiCare Health Systems. The visit to PacifiCare required extensive planning and organization, as it encompassed small group meetings with staff from numerous departments in different locations. Pat Douglass and Liz Neal did an admirable job of orchestration.

Joan Trauner and Larry Casalino boosted site visitors along the learning curve with their pre-trip seminar on physician organizations assuming risk. Stan Jones contributed valuable observations and insights to this report.

Within the Forum staff, Sandra Foote and Lisa Sprague organized the site visit and wrote this report. Counsel, assistance, and the wisdom of experience were offered by Judith Miller Jones, Karen Matherlee, and Judith Moore. Michele Black oversaw publication of the briefing book and this report. Dagny Wolf, Diane Harvey, and Moira Muccio Secrest also assisted greatly, handling site visit arrangements, administration, and grants and accounting, respectively.

Finally, the Forum wishes to acknowledge and thank our federal site visitors for their enthusiastic participation—some in the planning process, all in the discussion of significant issues and trends. This was truly a collaborative effort throughout.
Executive Summary

At the request of senior federal health policy staff who wanted to learn more about managed care operations and market dynamics, the National Health Policy Forum organized a site visit to southern California in November 1998. In this region, where large provider organizations have assumed much of the HMO insurance risk through capitation agreements, HMO penetration is high in the commercial and Medicare markets and competition among HMOs and providers is intense. Five broad topics were identified for exploration during the trip:

- Roles of managed care organizations.
- Risk allocation and contract relationships between HMOs and providers.
- Physician compensation and its impact on clinical decision-making under managed care.
- Quality management.
- Transition of Medicare, Medicaid, and Children’s Health Insurance (CHIP) eligibles to managed care.

This site visit report highlights some of the site visitors’ observations and impressions from their whirlwind visit. Global impressions voiced by site visitors after the visit included the following:

- Managed care operates very differently in southern California than in other areas where provider organizations have not assumed so much insurance risk from HMOs.
- Markets there are locally driven and highly dynamic, with both managed care organizations and provider systems in great flux.
- Care is needed in crafting national policies to assure that they are not harmful to positive market dynamics and that they fit with widely varying models of managed care in different regions.
- It is not clear how current turmoil in managed care markets will play out in southern California or whether the local market trends now evident there will spread nationally.
Plans and Providers:
Risk, Accountability, and Staying Power

BACKGROUND

The National Health Policy Forum organized a visit for 20 federal health policy staff to southern California November 17-20, 1998, to study how managed care is operating in the region. The site visit was the second in a series designed to highlight how various models of managed care are structured and operate and how they serve beneficiaries in both commercial and federally funded programs. The trip was supported by grants to NHPF from the California HealthCare Foundation and the Alliance HealthCare Foundation, with additional support from the Robert Wood Johnson and W. K. Kellogg Foundations.

The first visit in the series, to northern California, raised numerous questions that warranted further exploration and whetted visitors' appetite to compare and contrast two different sets of market dynamics within the state. While both northern and southern California are characterized by high managed care penetration and intense competition, the roles and relative strength of various players offer contrast. In southern California, large physician organizations are visible and influential to a degree probably unique in the country. These groups and independent practice associations (IPAs)—some associated with hospital systems, some stand-alone—assume significant financial risk and care management responsibility for patients in HMO plans.

Other features of interest in southern California were the exceptionally high proportion of Medicare managed care, a high concentration of uninsured, pronounced cultural diversity, the presence of nationally recognized managed care organizations (MCOs), and ongoing corporate consolidation at all levels.

San Diego and Orange Counties were chosen to illustrate issues of local competition and cooperation among health plans and providers, allowing further comparison within a reasonable geographic range.

San Diego County is one of the most mature managed care areas in the United States, and the City of San Diego has the highest managed care penetration rate (96 percent) among the commercially insured population of any metropolitan area in the nation. Nearly half of the county's 300,000 Medicare beneficiaries are in HMO plans. All Medi-Cal (California’s Medicaid program) recipients in San Diego were to be enrolled in HMO plans by the end of 1998, as were children eligible for CHIP.

Roughly 27 percent of the county population is uninsured. Health care delivery for the insured population is dominated by three major integrated health care systems, Scripps Health, Sharp HealthCare, and Kaiser Permanente. Both Sharp and Scripps are local, nonprofit provider systems with multiple hospitals and affiliated IPAs and medical groups.

San Diego is one of two counties in the state with a "geographic managed care" Medi-Cal model in which all Medi-Cal recipients choose among competing HMOs, none of which is a county-organized system.

Orange County has been described as one of the most competitive health care markets in the country. Physician organizations, hospitals, and health plans all seek a greater share of power in a climate where HMO capitated payments and risk-shifting to providers already are the norm. Physician groups, IPAs, and physician practice management companies (PPMCs) have developed a variety of strategies for managing care under capitation. The most powerful of them contract to provide services for a significant share of the population covered by managed care and have achieved considerable leverage in their dealings with MCOs and hospitals. Large national multi-specialty PPCMs failed in this region, after a period of feverish growth.

Orange is one of five California counties authorized to enroll all its Medi-Cal beneficiaries through a single organization that contracts with the state to deliver services. CalOPTIMA, the Orange County contractor, in turn contracts with HMOs and physician-hospital consortia to provide care. Another public program, Medical Services to the Indigent, faces higher demand due to welfare reform (which made some people ineligible for Medi-Cal), continuing immigration, and decreased federal funding. Approximately 19 percent of county residents are uninsured.
OBJECTIVES

The Forum structured the visit to address the following objectives, defined with input from federal health policy advisors.

- Demonstrate the functions involved in managed care products.
- Illustrate the variety of contractual relationships embedded in managed care systems (including diverse entities and risk arrangements).
- Investigate physician compensation and clinical decision-making.
- Demonstrate health improvement strategies applied within managed care systems.
- Explore policy issues related to the transition of beneficiaries in federally funded programs into managed care.

PROGRAM

Site visitors met with the leaders of four physician organizations, representing four different structural strategies. First, in San Diego, was Sharp Rees-Stealy Medical Group. This multi-specialty group practice, now affiliated with one of the two powerhouse hospital systems in San Diego, Sharp HealthCare, has been in San Diego for decades. As well as having years of experience managing capitated populations and dealing with managed care organizations, Sharp Rees-Stealy is actively involved in numerous quality improvement initiatives.

Monarch HealthCare executives hosted site visitors at their Orange County headquarters. Monarch is an IPA solely owned and operated by physicians; it contracts with 17 health plans and 385 physicians. A critical element in its success has been securing the participation of primary care physicians. From its inception, Monarch was designed to be “doctor-friendly,” and its executives still consider physician education one of its cornerstones. Earlier this year, Monarch entered a joint venture with a technology firm called Vectis to develop customized clinical information systems.

A third physician organization was Bristol Park Medical Group, a medical group owned (via a nonprofit intermediary, as required under state law) by the powerful St. Joseph Health System. The group provides only primary care services, but it assumes and manages risk for all professional (as distinguished from institutional) services. Bristol Park contracts with and refers to specialists.

Site visitors also heard from executives of MedPartners, a prominent PPMC. The week before the visit, MedPartners had announced its plan to close down its $3 billion dollar physician practice management line of business. This announcement came only months after the summer bankruptcy of FPA Medical Management, Inc., an event that had already caused managed care organizations and provider organizations in Orange County to scramble to reassemble sizable chunks of the physician service delivery systems. For example, St. Jude Heritage Health Foundation (the nonprofit intermediary organization for physicians associated with St. Joseph Health System) was assigned over 200,000 beneficiaries formerly cared for under FPA contracts.

A number of the insights gained during the trip came through a series of discussions on-site at PacifiCare Health Systems, one of the state’s largest managed care organizations with commercial enrollment at just over a million lives. PacifiCare also offers Secure Horizons, the nation’s largest Medicare risk plan, with nearly a million enrolled beneficiaries. Site visitors talked with company representatives from four operational areas: sales and marketing, member services, network management, and medical management. A small-group format allowed exploration of issues related to the role of the health plan, relationships with provider organizations, competition, and risk contracting under Medicare+Choice.

To explore the transition of beneficiaries in federally funded programs to managed care, site visitors first visited Logan Heights Family Health Center’s flagship clinic in San Diego. Logan Heights’ 11 centers, which serve a population of primarily Medi-Cal and uninsured patients, provide 200,000 patient visits annually. The organization contracts with the two dominant Medi-Cal HMOs in the county to provide services to their enrollees. Site visitors also had the opportunity to hear from the chief executive of one of these HMOs, Sharp Health Plan—yet another piece of Sharp HealthCare. The health plan, created initially to serve the system’s own employees, now also markets to small employer groups and operates the county’s second-largest prepaid Medi-Cal plan.

In Orange County, site visitors talked with the chief executive of CalOptima, the public-private partnership created to manage the financing and delivery of health services to the county’s Medi-Cal beneficiaries. Medi-Cal beneficiaries are required to enroll with CalOPTIMA, which in turn contracts with HMOs and physician-hospital consortia (PHCs). Many of the latter were formed specifically to serve CalOPTIMA members on an at-risk basis. Enrollment for any one contractor is capped at 30,000 to distribute membership and prevent traditional safety-net providers from being disadvantaged by larger commercial competitors. Site visitors were also able to meet with the chief executive officer of Fountain Valley Medical Center who is also the president of FountainCoast, a PHC serving a predominantly Vietnamese population.
Impressions

Emerging from three whirlwind days of meetings, the site visitors had a wealth of possibilities to choose from in identifying significant issues, observations, and impressions. Some were identified in a wrap-up session in California; further discussion occurred in a debriefing session in Washington, D.C.

Many of the key points raised related to providers and their relationships with the MCOs, but there were also some important general impressions that most visitors shared, notably these: how local and dynamic the market was in each county, how much in flux the provider systems are, and how distinctly different managed care is when MCOs contract mainly with provider organizations rather than with individual physicians and the provider organizations bear most of the financial risk for the medical care of their HMO patients. Site visitors noted how important and challenging it is to design policies that work with diverse models of managed care and support positive dynamics in rapidly changing local markets.

While visitors conjectured about the probability that the California model will spread, none purported to have come away with an answer on that score. The markets are so dynamic that even the local professionals hesitated to predict much about the future.

Site visitor observations and impressions on more specific topics follow.

Regional Approach to Managed Care

- In southern California, physician organizations seem to have accepted managed care as an opportunity. They have actively sought greater clinical as well as financial control under HMO plans, with the exception recently of pharmacy risk, which has become costly. Site visitors heard no nostalgia for the good old days of fee for service from the organizational leaders with whom they met. (The site visitors did not meet with individual practicing physicians or explore their concerns with managed care such as paperwork and utilization review.)

- There is a prevailing sense among physician leaders and managed care executives that managed care bears a disproportionate burden of public distrust and responsibility to demonstrate quality, to which fee-for-service care is not subject. One example given was that physicians serving patients under managed care plans are under pressure to disclose their financial arrangements to patients and explain how these may influence care decisions, whereas physicians under fee-for-service plans are not required to explain that they get paid based on performing the procedures they recommend. One physician criticized fee-for-service plans as inferior products due to their lack of accountability for outcomes.

Roles of Managed Care Organizations (MCOs) in Southern California

- A powerful role remains for MCOs even when they have transferred insurance risk to providers under their HMO plans. MCOs in southern California have significant responsibilities in benefit plan design, interpretation, and negotiation with purchasers; marketing; enrollment; member services; network management; handling of appeals; and regulatory compliance. Most MCOs also offer different kinds of plans (such as preferred provider and point-of-service plans as well as HMO plans) to large employers. MCOs have also assumed many functions once associated with human resources departments in large companies (such as member counseling, guidance, and dispute resolution), presumably to attract employer business and improve employee satisfaction ratings.

- The roles of MCOs and provider organizations are confusing for consumers. The distribution of functions between them may be logical operationally and based on who holds the risk and therefore wants control, but it is still difficult for consumers to understand whom to call for what.

- There is probably not much future in the idea of employers bypassing MCOs and contracting directly with providers in this region. Most employers are unlikely to want to take on potential liability associated with medical decision-making or to add the staff necessary to carry out member services and statewide network management functions.

- The role of MCOs seems to be reinforced by their market dominance. Providers do not appear to have much opportunity, even if so inclined, to evolve into mainstream MCOs, because powerful MCO competitors would reportedly ensure the providers’ failure in the market.

Competition among MCOs

- Barriers to entry appear high for MCOs in southern California. There are a few extremely powerful MCOs. They have the leverage to get low fee schedules and capitation rates from providers that would be difficult for new competitors to match. Also, the big MCOs seem to be able to withstand (or even initiate) price wars for market share and have enough members to fuel the large provider networks that consumers prefer.

- Employers seem to buy plans primarily based on price and an acceptable level of member satisfaction. Since most MCOs, other than Kaiser, contract with most providers, network design rarely determines employer or employee choice of plans. Many employees have no
choice of plan because their employer only offers one, but those who do have a choice are reportedly highly price sensitive.

- Although plan purchasing and MCO competition are intensely price driven, some MCOs are beginning to publish physician group profiles and satisfaction ratings. MCOs are developing such profiles to help their members select providers and to help providers compare and improve their performance. It is still early in the development of these profiles and not yet clear whether they will become effective tools for focusing competition on clinical quality in purchasers’ selection of plans or consumer selection of providers. But it is a notable initiative in the direction of promoting quality of care as a dimension of competition among plans and among providers.

Dynamics of MCO-Provider Negotiations

- MCOs appear to have vastly more leverage in contract negotiations than most physician organizations have. The dominant MCO control so many member lives that they seem to be price setters for most providers. (In this sense, one site visitor commented that, from the provider perspective, the big MCOs are almost like a Health Care Financing Administration [HCFA].)

However, unlike HCFA, the MCOs do negotiate with each contracted provider organization to agree upon capitation rates. Providers with more market presence and more capitated members reportedly receive somewhat higher capitation rates than the less powerful provider groups can get. Capitation rates also vary across geographic areas, depending on the local dynamics of the physician markets. Universally, though, providers made it clear that MCO pressure to reduce rates continues to be intense.

None of the physician organizations, not even the strong ones, seemed prepared to take on major MCOs alone, fearing the loss of patients and income that would result from walking away from contracts. And, providers noted, they cannot act in concert in negotiations with the MCOs because they would be open to allegations of anticompetitive behavior. Providers expressed worry that consolidations among MCOs will exacerbate what they perceive to be a power imbalance.

- Many physician groups are losing money. Apparently, some physicians are leaving the area due to the economic squeeze; others are seeing their incomes fall.

- Providers are concerned about the adequacy of capitation rates for the future. Rates have reportedly decreased or stayed flat over the past three years. Providers noted that commercial premiums in southern California are among the lowest in the nation. Furthermore, some of the physicians indicated that they do not believe that the premiums MCOs are offering cover the real cost of the benefit packages; in such instances, physicians with percent-of-premium capitation contracts do not receive enough money to cover the services they are required to provide. When asked why they do not renegotiate their MCO contracts, some providers indicated they have multi-year contracts in force, further constraining physician reimbursement.

- Pharmacy costs are a microcosm of current MCO-provider conflicts surrounding risk-sharing. Recent acceleration in costs makes pharmacy risk a battlefield. Providers feel that MCOs are projecting unrealistically low drug costs in setting premiums, given the new drug technologies, high prices of new drugs, and growing consumer demand that is fueled both by direct-to-consumer marketing and flat dollar copayments on pharmaceuticals. Providers report that they are having to refund large sums of money to MCOs, based on shared pharmacy risk arrangements. MCOs respond that the providers write the prescriptions.

- It is unclear whether intense pressures on provider rates and plan premiums pose significant risks to beneficiaries or whether, in fact, beneficiaries are well served by the cost containment achieved. To the extent that the market is responding to an oversupply of providers, cost reductions may be achieved without impairing quality. But providers voiced fear that their ability to provide good care with the dollars allowed has been stretched to the limit. Site visitors noted the need to continue monitoring the effects of industry consolidation on consumers and to encourage industry efforts to help purchasers and consumers evaluate quality in selecting plans and providers.

- To defuse inflationary pressures on medical care expenditures, it may be necessary for consumers to have a more direct stake in achieving cost control. Various speakers suggested that changes in benefit plan designs are needed to make beneficiaries less insensitive to price. For example, providers reported that consumer demand for expensive new drugs has risen dramatically, in part because consumers do not care about drug pricing when they pay a low copayment amount per prescription, regardless of drug cost.

Competition and Consolidation among Providers

- Provider organizations seem to be moving rapidly to build their physician membership and merge with other provider organizations, mainly to gain leverage in MCO
contracting. Reportedly, cash values for sales of physician practices have plummeted since two of the three big publicly traded physician practice management companies exited the business recently. Nonetheless, consolidation among providers is expected to continue in response to competitive pressures.

- **Growth of large, hospital-dominated systems may change the balance of power between MCOs and providers.** A few major physician-hospital organizations already have hundreds of thousands of capitated member lives through their MCO contracts.

- **IPAs compete for physician loyalty because physicians can belong to multiple IPAs.** IPAs have less leverage to influence physician behavior to improve quality and less leverage with MCOs in negotiating rates when member physicians are in competing IPAs as well. As a result, some IPAs offer preferential rates and give equity ownership to physicians who agree to exclusivity.

- **In the current market, physicians compete for patients, but they have only recently begun to have data that will allow them to tout their clinical quality compared to their competitors.** How providers will use such data remains to be seen. They have strong incentives to attract healthy members, but under current capitation arrangements, provider organizations are generally not paid more for high-cost patients. Thus, the providers are penalized financially if they attract a disproportionate share of high-cost patients by becoming known as the best at caring for them.

**Clinical Quality: Accountability and Measurement**

- **There seems to be widespread consensus that accountability for high-quality care belongs at the level of providers and capitated provider organizations, not MCOs.** Providers assert that they are in a better position than MCOs to evaluate cost-versus-care considerations for their individual patients. They also assert that there is little danger that physicians will delay or deny specialty care because individual clinicians generally are not penalized financially for referring patients. Site visitors heard that provider organizations pay their employed and contracted clinicians in many different ways, but, even when they do capitate the primary care physicians, they report that the capitation amounts usually cover only primary care services, not referred specialty care.

- **Leaders within physician organizations indicate they influence colleagues' behavior through comparative performance profiling, peer pressure, and the collective risk that the group bears for its overall budget.** Some provider organizations have implemented provider profiles to highlight significant practice variations within specialties and have implemented patient surveys to encourage providers to attend to patient satisfaction. One organization indicated that it also uses peer evaluations to focus on coordination of care. And some provider organizations tie survey and profile results to a small portion of compensation.

- **Quality measurement programs clearly suffer from their own proliferation.** Where the federal government, state government, MCOs, and medical groups all have different quality initiatives, physicians are pulled in different (and sometimes conflicting) directions.

Several speakers suggested that data definitions and specifications might best be set at the federal level. Specifics of what is to be measured and where resources are to be concentrated should be left to the private sector to define. Where strong physician groups exist, they view their organizations as the most appropriate level for the design and implementation of quality improvement strategies. As one physician characterized it, "We should agree about metrics and compete on performance."

Physicians fear that multiple quality measurement programs and guidelines mean that MCOs expect providers to treat patients differently based on their insurance coverage. In fact, this is is apparently not happening, in part for the purely practical reason that physicians don’t have time to research each patient’s coverage to apply that MCO’s guidelines. In the physician’s view, no MCO can or should try to dictate physician practice.

- **Data collection goals are varied and not always compatible.** For example, the data that a physician organization collects as performance feedback for its physicians are not necessarily suitable for an MCO’s purposes. While organizations such as the Pacific Business Group on Health have attempted to present an objective picture, there is still much opportunity to misreport (or misread) data.

- **Despite all the attention to quality and member satisfaction, MCOs and purchasers do not currently structure payments to providers to reward quality of care.**

**Medicare**

- **Changes imposed by the Balanced Budget Act of 1997 in how future Medicare payments to HMOs are calculated may lead to reduced drug benefits.** In southern California, where Medicare payment rates for HMOs are high by national standards, most Medicare risk plans now offer drug benefits and require no premium contribution from beneficiaries other than their Medicare Part B contribution. This plan design gives the HMOs a strong price advantage over Medigap
plans and a competitive advantage compared to the traditional Medicare plan on a stand-alone basis because it does not currently cover outpatient prescriptions. HMOs fear losing that advantage and are concerned that future Medicare payments may not be sufficient to support continuing drug benefits.

- It is unclear what impact Medicare risk adjusters will have in southern California. The risk adjusters are intended to increase HMO financial incentives to insure high-risk patients, but in southern California much of that risk rests with the providers. It is not evident whether or how risk adjusters will affect MCO behavior; how dollars derived from Medicare risk adjusters will be transferred to the capitated provider organizations, or how the provider organizations in turn might adjust compensation to individual physicians.

**Medi-Cal and CHIP**

- Disproportionate share hospital (DSH) payments can function as a disincentive for hospitals to participate in Medicaid managed care. One of the first impacts of managed care is usually a reduction in inpatient days, which in turn can lead to loss of DSH revenue for affected hospitals.

- Managed care may generate substantially less Medi-Cal revenue for providers than the fee-for-service reimbursement system did for comparable services when revenue is translated to a per-encounter basis. One reason for the discrepancy is that Medi-Cal recipients tend to seek (and maintain) Medi-Cal qualification only when they need care. This seems to be particularly the case if Medi-Cal recipients must complete onerous applications and requalify every 60 or 90 days. Hence, providers report difficulty building up sufficient funds from enrollment of well members to help cover the expenses of those who need care.

- Providers with known expertise in certain disease areas (for example, AIDS) are especially likely to experience financial losses under capitation payment systems due to adverse risk selection.

- Enrolling CHIP-eligible children is proving to be difficult, particularly when parents who are illegal aliens are afraid that they will be deported if identified to government authorities through their children.

**ISSUES FOR FURTHER CONSIDERATION**

- In what circumstances can legislative and regulatory policies and federal purchasing initiatives be standard across varied regional models of managed care, and in what situations is tailoring required? For example, external review proposals are aimed at markets in which MCOs, not capitated provider organizations, control most authorizations for treatment. What effects would such provisions have in this locale? In another example, how will MCOs and providers respond to risk-adjusted payments from Medicare in the southern California model?

- What are the implications for purchasers, consumers, and providers of the ongoing consolidation among MCOs and among provider organizations? Is further system consolidation desirable? What are the risks to consumers? How will the MCOs and providers compete? How will they manage inflationary pressures?

- How can the positive dynamics of the market be protected while addressing unmet needs such as the rising number of uninsured people?

- Will market forces create sufficient consumer protections (such as plan certification, provider credentialing and profiling, report cards, or consumer reports) to assure acceptable levels of quality in plans and providers, or are state or federal interventions needed?

- How can market functioning be improved? For example, should federal policy be developed to help make information on clinical quality available to consumers, or will this need be addressed through market dynamics? How can quality data be better targeted to what consumers want to know? Should the federal government create incentives for purchasers and consumers to consider quality in selecting providers and for providers to improve clinical quality? How might such incentives be structured?

- What are plans and providers doing to control prescription drug costs? How can the proliferation of pharmaceuticals and biomedical technology be managed?

- How could a pharmaceutical benefit be structured for Medicare beneficiaries?

- Are the industry trends observable in southern California occurring in other areas? Would that be desirable? What would be the advantages and downside concerns?
Agenda

Tuesday, November 17, 1998

2:00 pm  Introductions and opening discussion [DoubleTree Hotel, Mission Valley—San Diego headquarters hotel—Ballroom VIII]

2:30 pm  ORIENTATION TO SAN DIEGO COUNTY HEALTH CARE SYSTEM
          B. Kathryn Mead, President and Chief Executive Officer, Sharp Health Plan
          Lory Wallach, Senior Consultant, Alliance Healthcare Foundation

3:30 pm  Bus departure for Logan Heights Family Health Center

4:00 pm  Tour of Logan Heights Family Health Center, followed by discussion

SAFETY NET PROVIDERS ADAPTING TO MANAGED CARE
          Fran Butler-Cohen, Executive Director
          Mark J. Tamsen, M.D., Medical Director
          Lucy San Diego-Javate, Chief Financial Officer

5:30 pm  Bus departure for DoubleTree Hotel

7:00 pm  Dinner with speaker Mark D. Smith, M.D., President, California HealthCare Foundation, [DoubleTree Hotel, Sonoma Room]

Wednesday, November 18, 1998

8:00 am  Continental breakfast available [DoubleTree Hotel, Ballroom Two/Three]

8:30 am  MANAGING MANAGED CARE: MEDICAL GROUP PERSPECTIVES ON RISK, ACCOUNTABILITY AND QUALITY (Sharp Rees-Stealy Medical Group)
          Donald C. Balfour III, M.D., President and Medical Director
          Richard D. O’Connor, M.D., Medical Director, Quality Management
          Thomas C. Adamson III, M.D., Director, Managed Care

12:15 pm  Bus departure for Monarch HealthCare, Inc., Orange County, with break at San Juan Capistrano

2:30 pm  Tour of Monarch HealthCare, followed by discussion

COMPETITIVE DYNAMICS OF AN IPA; PROGRESS IN DATA MANAGEMENT (Monarch)
          Bartley S. Asner, M.D., Chief Executive Officer and President
          Jay J. Cohen, M.D., Chairman of the Board and Senior Vice President, Physician Relations
          Marvin J. Gordon, M.D., Executive Vice President and Chief Medical Officer
          Steven M. Rudy, M.D., Senior Vice President, Development
          James Selevan, M.D., Chief Information Officer and Medical Director

5:30 pm  Bus departure for Laguna Beach

6:30 pm  Dinner for federal and foundation participants [Beach House Restaurant, Laguna Beach]

8:00 pm  Bus departure for Renaissance Hotel, Long Beach
Thursday, November 19, 1998

8:00 am  Breakfast and discussions [Renaissance Hotel, Sicilian Ballroom]

ORIENTATION TO ORANGE COUNTY HEALTH CARE SYSTEM

  Michael Gomez, President and Chief Executive Officer, Pacific Behavioral Management, LLC
  Mary K. Dewane, Chief Executive Officer, CalOPTIMA
  Tim Smith, President and Chief Executive Officer, Fountain Valley Regional Hospital and
          Garden Grove Hospital

10:30 am  DYNAMICS OF A MEDICAL GROUP/PHO RESPONDING TO MARKET CHANGES
          (Bristol Park Medical Group and St. Joseph Healthcare System)

  Patrick E. Kapsner, M.P.A., F.A.C.M.P.E., Chief Executive Officer, Bristol Park Medical Group
  Rodman St. Clair, M.D., Chief Medical Officer, St. Jude Heritage Health Foundation

11:45 am  Bus departure for PacifiCare/SecureHorizons

12:30 pm  Lunch, followed by discussion session [PacifiCare/SecureHorizons]

OPERATING MEDICARE RISK PLANS: OPPORTUNITIES AND CHALLENGES

  Cathy Batteer, Vice President, Health Services, PacifiCare of California
  Kathy Feeny, Vice President, Sales and Marketing, SecureHorizons
  Joy Luque, R.N., B.S.N., C.C.M., Director, Clinical Operations, PacifiCare of California
  Marilyn McCullough, Regional Director, Customer Service, PacifiCare, Western Region
  Gordon K. Norman, M.D., M.B.A., Vice President and Medical Director, PacifiCare of California
  Cheryl Tanigawa, M.D., Medical Director, Southern California, PacifiCare of California
  Sam Ho, M.D., Vice President, Quality Initiatives, PacifiCare Health Systems

5:30 pm  Bus departure for Renaissance Hotel

7:00 pm  Dinner for federal and foundation participants [Rock Bottom Brewery, Long Beach]

Friday, November 20, 1998

8:00 am  Breakfast briefing [Renaissance Hotel, Sicilian Ballroom]

PLAN-GROUP-PHYSICIAN DYNAMICS IN A PHYSICIAN PRACTICE MANAGEMENT
COMPANY: DEVELOPING COHESION, WEATHERING STORMS (MedPartners)

  Rosalio J. Lopez, M.D., M.B.A., Chief Medical Officer
  Thomas A.Mahowald, Vice President, Physician Services, Southern California
  Guy Paquet, M.D., Chief Medical Officer, California
  Richard A. Shinto, M.D., Medical Director, MedPartners Provider Network

10:00 am  Wrap-up discussion

IMPRESSIONS AND POLICY CONSIDERATIONS

  Moderator: Glenn A. Melnick, Ph.D., Professor and Blue Cross Chair in Health Care Finance,
          School of Public Administration, University of Southern California

11:15 am  Bus departure for Los Angeles International Airport (LAX)
Federal Participants

Doug Badger
Chief of Staff
Office of the Majority Whip
U.S. Senate

Kathleen Buto
Deputy Director
Center for Health Plans and Providers
Health Care Financing Administration
Department of Health and Human Services

David S. Cade
Director
Family and Children’s Health Programs Group
Center for Medicaid and State Operations
Health Care Financing Administration
Department of Health and Human Services

Kenneth Cohen
Staff Director—Minority
Special Committee on Aging
U.S. Senate

Debra S. Curtis
Legislative Director
Office of Rep. Pete Stark
U.S. House of Representatives

Mickey Forrest
Legislative Assistant
Office of Rep. Brian Bilbray
U.S. House of Representatives

Edward G. Grossman
Assistant Counsel
Office of the Legislative Counsel
U.S. House of Representatives

Katie Horton
Professional Staff Member—Minority
Committee on Finance
U.S. Senate

Rebecca M. Jones
Professional Staff Member—Majority
Special Committee on Aging
U.S. Senate

Jason S. Lee, Ph.D.
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Committee on Labor and Human Resources
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Committee on Commerce
U.S. House of Representatives

William Walters
Counsel—Majority
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

J. Marc Wheat
Counsel—Majority
Committee on Commerce
U.S. House of Representatives
Biographical Sketches—California Participants

Thomas C. Adamson III, M.D., is director of managed care and chief of the Division of Rheumatology at the Sharp Rees-Stealy Medical Group, which he joined in 1982. He chairs the group’s utilization management committee and serves on several other committees overseeing credentialing, contracting, capitation agreements, and other operations issues. He is active with a variety of professional associations.

Bartley S. Asner, M.D., is chief executive officer, president, and a member of the board of directors of Monarch Healthcare. In practice since 1979, he is board-certified in pediatrics. Dr. Asner is a member of several professional associations and has served as an officer of the local chapter of the American Academy of Pediatrics.

Donald C. Balfour III, M.D., is president and medical director of the Sharp Rees-Stealy Medical Group, as well as president of its Board of Directors. He joined the Rees-Stealy Medical Group in 1977, prior to its affiliation with Sharp Health Care, as a hematologist/oncologist. Dr. Balfour is an associate clinical professor at the University of California at San Diego and serves as an officer in several professional associations. He is past president of the American Medical Group Association.

Cathy Batter is vice president, health services, for PacifiCare of California and is responsible for provider services and network development, PPO and ancillary contracting, clinical pharmacy management and clinical services. Since joining PacifiCare in 1985, she has held a variety of positions in provider network management.

Fran Butler-Cohen has been the executive director of Logan Heights Family Health Center for over 12 years. Her past work includes medical and rehabilitation administration, directing county-wide developmental disabilities programs, and establishing medical and legal clinics in underserved areas. For two years, she served as president of Clinic Mutual Insurance Company, a risk retention group organized to provide medical malpractice coverage for community clinics and community and migrant health centers.

Jay J. Cohen, M.D., is chairman of the board and senior vice president, physician relations, of Monarch Healthcare. From 1992 to 1996, he was an officer and director of Mission Quality Care, Inc., and before that was vice president and California regional medical director for Pacific Physician Services, Inc. He is board-certified in emergency medicine.

Mary K. Dewane is the first chief executive officer of CalOPTIMA, Orange County’s independent health authority, established in 1994. Previously, she was director of the Medicaid Managed Care Office in HCFA’s Medicaid Bureau. Ms. Dewane also successfully launched one of the nation’s first large-scale Medicaid managed care programs while serving as director of Wisconsin’s Medicaid HMO program.

Kathy Feeny is vice president of sales and marketing for SecureHorizons, PacifiCare’s Medicare risk product. In this position, she has led the program’s successful integration of FHP enrollees following PacifiCare’s acquisition of that managed care company. She previously held other sales management positions within PacifiCare of California. Before joining PacifiCare in 1993, Feeny spent 18 years in sales and marketing management positions with Allergan.

Michael Gomez is a health care consultant serving a range of clients, including HMOs, regulatory agencies, hospital systems, and medical groups and IPAs. He also is president and chief executive officer of Pacific Behavioral Management, L.L.C., the management services organization for Newport PsychCare, a behavioral provider system he founded in 1992. Mr. Gomez started his career in health care in 1976 as a health planner with the Health System Agency in San Diego. He later was an HMO regulator with the California Department of Corporations.

Marvin J. Gordon, M.D., is executive vice president, chief medical officer, and a member of the board of directors of Monarch Healthcare. Board-certified in internal medicine and gastroenterology, he was in private practice in Laguna Beach from 1976 to 1996. He also served as chief of medicine, chief of staff, and board member of South Coast Medical Center and president of South Coast IPA (one of the three IPAs that combined to form Monarch in 1994).

Sam Ho, M.D., is vice president, quality initiatives, for PacifiCare Health Systems, a position he assumed in 1997 after serving for three years as vice president, health services. Prior to joining PacifiCare, Dr. Ho held management positions with HealthNet, the San Francisco Health Department, and Maxicare.

Patrick E. Kapsner, M.P.A., F.A.C.M.P.E., is chief executive officer of Bristol Park Medical Group, where he is responsible for strategic development and for establishing
policy on nonmedical issues. Bristol Park is one of the largest physician groups within the St. Jude Heritage Health Foundation, of which Kapsner is also president. He is an officer of various professional organizations and a fellow of the American College of Medical Practice Executives.

Rosalio J. Lopez, M.D., M.B.A., is chief medical officer and a member of the board of directors of MedPartners, Inc., as well as chairman of the board of Mullikin Practice Group (now part of MedPartners). He is board-certified with the American Board of Family Practice and serves on several association and professional society boards, including the American Medical Group Association and the California Healthcare Association.

Joy Luque, R.N., B.S.N., C.C.M., is director of clinical operations for PacifiCare of California, overseeing the development and implementation of clinical management/ utilization review programs. She was named case manager of the year for 1998 by the southern California chapter of the Case Management Society of America. Prior to assuming her current role, Luque was manager of case management for southern California.

Thomas A. Mahowald is vice president, physician services, at MedPartners in southern California. He focuses on developing physician governance, compensation, and incentive plans. He has also held positions in managed network development and medical staffing with MedPartners. Before joining MedPartners, he was a consultant in KPMG Peat Marwick's national health care integration practice.

Marilyn McCullough is regional director of customer service at PacifiCare, responsible for the overall operation of the western region customer service center. Her 30 years of experience in customer service encompass positions in call center management, sales and marketing, operations, training, and human resources.

B. Kathryn Mead is president and chief executive officer of Sharp Health Plan. Before moving to San Diego in 1994, she worked in contracting and provider relations for Blue Cross of California and managed Colorado and Utah operations for MetLife Health Care Network. She serves on various community health care collaboratives and currently is working under an Alliance Health Care Foundation grant to develop a subsidized-premium product for small businesses.

Glenn A. Melnick, Ph.D., is professor and Blue Cross of California Chair in health care finance at the University of Southern California. He is also a senior economist and resident consultant with RAND in Santa Monica. A nationally recognized expert in health care competition and managed care, his work has appeared in publications ranging from the Journal of Health Economics to the Los Angeles Times. Dr. Melnick served as a principal investigator of a four-year study funded by ASPE to study the effects of hospital market competition on hospital behavior.

Gordon K. Norman, M.D., M.B.A., is vice president and statewide plan medical director for PacifiCare of California, with responsibilities including quality improvement, benefits interpretation, and health data and information management as well as pharmacy and clinical operations. Previously, he served as regional medical director for northern California. Earlier, he practiced family medicine in New Hampshire and upstate New York.

Guy Paquet, M.D., is chief medical officer of MedPartners' California operations. He previously was regional medical director for a portion of southern California. Dr. Paquet came to MedPartners as part of the Friendly Hills HealthCare Network, where he was medical director and chaired the quality management committee.

Richard D. O'Connor, M.D., holds a number of positions in the Sharp Rees-Stealy Medical Group: chief of the Department of Asthma, Allergy, and Clinical Immunology; medical director of the Department of Quality Management; and director of the Department of Clinical Research. He is also a clinical professor of pediatrics at the University of California at San Diego, where he had been a full-time faculty member for nine years before joining the Sharp Rees-Stealy Medical Group in 1985.

Ruth Riedel, Ph.D., is chief executive officer and a trustee of the Alliance Healthcare Foundation. Prior to joining Alliance in 1988, she was president of her own consulting firm, Evaluation Research Associates, Ltd., which managed program development and grantmaking for nonprofit organizations. She served as deputy director of community programs for Affordable Health Care, a national program funded by the Robert Wood Johnson Foundation. Dr. Riedel also has held faculty positions at Yale University and the University of Washington.

Steven M. Rudy, M.D., is senior vice president, development, and a member of the board of directors of Monarch Healthcare. He previously served as chief of surgery and chief of staff of Saddleback Memorial Medical Center and was co-founder of its medical group. Dr. Rudy is board-certified in urology.

Lucy San Diego-Javate has been chief financial officer of Logan Heights Family Health Center since 1991. She came to San Diego from the Michael Reese Health Plan, Inc., in Chicago, where over a period of 16 years she held the positions of accountant, accounting manager, controller, and chief financial officer.

James Selevan, M.D., is chief information officer and medical director of Monarch Healthcare. Trained as both an engineer and a physician, he is a nationally recognized
expert in managed care systems. Dr. Selevan is board-certified in internal medicine and by the American Board of Quality Assurance and Utilization Review.

**Richard A. Shinto, M.D.**, medical director for MedPartners, directs utilization management/integrated health services activities and is involved with the development and integration of Medicare and Medicaid programs and telephonic health operations. He previously was associate medical director for utilization management for Southern California Medical Corporation and Friendly Hills Medical Group.

**Mark D. Smith, M.D.**, is president and CEO of the California HealthCare Foundation as well as a member of the clinical faculty at the University of California at San Francisco. Previously, he was executive vice president of the Henry J. Kaiser Family Foundation. He serves on the Committee on Performance Measurement (HEDIS) of the National Committee for Quality Assurance.

**Tim Smith** is president and chief executive officer of Fountain Valley Regional Hospital and Garden Grove Hospital. He started at Garden Grove in April 1994 as chief operating officer, becoming chief executive officer in September of that year; the concurrent appointment at Fountain Valley came in 1997. Prior to Garden Grove, he held positions of increasing responsibility at several southern California hospitals. Mr. Smith has served on the boards of many local community groups.

**Rodman St. Clair, M.D.**, is medical director of the St. Jude Heritage Health Foundation, which is part of the St. Joseph health system that also owns Bristol Park Medical Group. Before accepting this position in 1997, he was medical director and member of the board of directors of Professional Care Management Group, Inc., one of three provider organizations he has founded.

**Mark J. Tamsen, M.D.**, is medical director of Logan Heights Family Health Center. He is an internal medicine specialist, is certified by the American Board of Emergency Medicine, and holds an assistant clinical professor appointment at the University of California at San Diego. Dr. Tamsen earlier served as medical director in the emergency department of Sharp Cabrillo Hospital/Sharp Health Care and as medical director of the San Diego County Sexual Assault Response Team.

**Cheryl Tanigawa, M.D.**, is PacifiCare’s medical director for southern California. Her oversight responsibilities include case management, utilization/quality management, credentialing, pharmacy, and appeals and grievances. Before joining PacifiCare, Dr. Tanigawa held various positions with Harriman Jones Medical Group in Long Beach, most recently as medical director of managed care; she was also a member of the group’s board of directors.

After moving to California in 1979, she became executive director of the Orange County chapter of Physicians for Social Responsibility. She currently serves on the board of the Foundation for Accountability (FACCT).

**Lory Wallach** recently signed on as vice president with Novaeon, Inc., a new firm offering a total care management product including operations, provider networks, and state regulatory filings for workers’ compensation managed care programs. Previously a senior program officer with Alliance Healthcare Foundation, she continues as a senior consultant to the foundation. Earlier, she served as vice president, HMO development, with Community Care Network.