



Health Care Spending: Why Is Miami an Outlier?

SITE VISIT
REPORT

MIAMI, FLORIDA

JUNE 2–4, 2010

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BACKGROUND

The National Health Policy Forum's site visit to Miami, which focused on the complex factors that drive health care spending, is the latest in a series on the dynamics of health care markets. The health care market in this colorful area brings into stark relief many of the reasons for high and growing health care spending across the country. It also highlights the challenges of building and maintaining adequate capacity to care for the newly insured as health care reform is implemented. The Forum's site visits are designed to give policymakers opportunities to view diverse approaches to health care delivery, consider the various effects of federal interventions, and interact with state and local health care stakeholders.

The Miami health care market is as varied, rich, and vibrant as its cultural heritage. It is well known for high health care spending; Medicare per person outlays are twice the national average (\$17,274 versus \$8,682 in 2007), without similarly higher health care quality.¹ The Miami population includes a high proportion of uninsured people and others who are medically vulnerable—the elderly, low-income, uninsured, recent immigrants, and undocumented persons—and is ethnically and racially diverse. Miami-Dade County has the largest number of senior citizens and the highest proportion of uninsured (over 30 percent) of any area in Florida.

The health care safety net is anchored by tax-supported Jackson Health System, which, together with some of the University of Miami Miller School of Medicine faculty and research offices, occupies over 16 square blocks of urban space. Jackson Memorial Hospital has long been plagued by financial problems and management issues, as documented in a 2003 report on the governance of public funds for health care, which was supported by the W.K. Kellogg Foundation "Community Voices" project.² The hospital system's governing board is the 17-member Public Health Trust, which chooses the hospital's chief executive officer and oversees operations. The trust, however, is in effect controlled by the Miami-Dade County Commission, which ratifies labor contracts and approves the annual budget. The most recent controversy at Jackson stems from fiscal year 2009 losses, which were originally estimated at \$56 million but ballooned to \$244 million when more accurate accounts receivable data became known.

In addition to financial troubles, the symbiotic relationship between the Jackson Health System and the University of Miami Miller School of Medicine, which supplies faculty physicians, has weathered some rough times. Most recently, tempers flared in fall 2009, when the chairman of the university's Board of Trustees publicly noted distrust in the quality of care provided by physicians at Jackson. Some believe the tension stems at least partly from the university's purchase of a 560-licensed-bed hospital (now called the University of Miami Hospital) across the street from Jackson Memorial Hospital; speculation has been brewing that faculty are directing their paying patients to the university's hospital, leaving the uninsured and underinsured for Jackson.

At the same time, Jackson Health System provides Miami with some of the best medical care in the world and is at the forefront of innovations that promise to improve health care and its delivery. The Ryder Trauma Center, Holtz Children's Hospital, and Bascom Palmer Eye Institute are world renowned, as evidenced by their high census of international patients. Research into improving patient safety is cutting edge and may well affect health care around the country.

Miami has a long history of a strong managed care presence under Medicare and among the privately insured. The area has high fee-for-service spending, resulting in generous Medicare payments to plans; these payments help to finance zero premium options, often with limited or no copays. There are dozens of health plans serving the Miami market, including 78 Medicare Advantage plans that offer drug coverage and 47 Medicare Part D plans. Several local plans serve the area's large Cuban community, which is accustomed to receiving clinic-based health care services in return for a regular monthly fee. For these beneficiaries, the clinic is often viewed as a social gathering place.

The presence and significance of health care fraud in the area is widely acknowledged and loudly decried. According to U.S. Attorney General Eric Holder, Miami is "ground zero for health care fraud schemes."³ Hundreds of millions of dollars are lost to fraud in South Florida every year, and this wasted money is an important part of the overall spending picture for Miami as well as the subject of federal policy initiatives. Seemingly one step ahead of regulators and enforcers, many health care providers bill for services that were never ordered or delivered, patients sell their insurance identification for use in fraudulent billing, and providers sign off on prescriptions for

items and services that are not needed. Even a casual observer will notice Miami streets and medical office buildings with an unusual number of imaging centers, durable medical suppliers, home health agencies, pharmacies, and pain clinics.

PROGRAM

The site visit began the morning of June 3 with a presentation on the history and current situation of Jackson Health System and cultural characteristics of the city that may affect the delivery of care. This was followed by an overview of the health plan perspective on health care spending in South Florida and plan efforts to slow spending growth. A short bus ride took participants to Jackson Memorial Hospital, where they divided into two groups for tours. Each tour included the neonatal intensive care unit, the trauma center, the emergency department and heliport, and a research lab that is developing new provider education techniques to ensure patient safety. This was followed by lunch and discussion with the facility's senior management team, including the chief executive officer. After the Jackson visit, participants went on a guided tour of the newest Leon Medical Centers clinic, which serves a Medicare Advantage plan with a predominantly Cuban beneficiary population, the Leon Medical Centers Health Plans. That tour culminated in a discussion with the senior management team of the clinic and health plan to better understand its history, benefit package, and alignment with the company, HealthSpring, Inc., that purchased the original Leon health plan. After another bus ride, the participants were on the main campus of Baptist Health South Florida, the largest private hospital provider in the area, where the chief strategic officer talked about her system's market strategy and future challenges under health reform.

The morning of June 4 started with a panel discussion by three local physicians who represented the small practice, community health center, and specialty practice perspectives. The president of the local medical society also participated. This was followed by a two-hour bus tour of Miami, with stops at several health care providers suspected of fraudulent activities. These included a high-volume Medicare Part D pharmacy, which appeared to have a minimal stock of drugstore items, and two large office buildings with numerous, nearly empty offices that had signs indicating they were home health agencies, therapy centers, or health clinics. The program concluded

at the hotel, where a discussion of federal efforts to control health care fraud was led by a representative from the Centers for Medicare & Medicaid Services (CMS).

IMPRESSIONS

Discussions among the participants were spirited throughout the site visit, as they offered their perspectives on what they saw and heard. The week after the site visit, participants gathered together once more and were asked to reflect on their experiences and the perspectives offered by speakers. The most accurate answer to the opening question, “what makes Miami an outlier?” is probably “it’s complicated.” The participants formed several key impressions and observations about high health care spending in Miami from the program and the follow-up debriefing session.

Why Is Miami an Outlier?

Miami’s health care providers have responded to fee-for-service incentives with entrepreneurial zeal by, for example, marketing high-tech services internationally and forming large, single-specialty practices to better negotiate payment rates with insurers and bring ancillary services in-office. Fee-for-service incentives are reinforced by certain cultural factors that encourage high utilization. These incentives, combined with a long history of health care fraud, widespread concerns about malpractice, inadequate options for primary care, and an inattentive employer community make for a market in which providers are out to expand their revenues and patients expect to receive services.

Medicare Payment Incentives Encourage Utilization

- Medicare spending is high in Miami compared to other cities (Table 1, next page). This is particularly true for services, like durable medical equipment and home health care, that historically have been difficult to control, although all service categories have higher-than-average spending.
- Rather than competing to get a larger slice of the health care money pie, Miami providers seem intent on making the pie larger. With little incentive to control spending, legitimate providers

TABLE 1 | Medicare Spending by Hospital Referral Region, 2007

Region	TOTAL*	Durable Medical Equipment	Home Health	Hospice	Outpatient Hospital	Inpatient Hospital	Professional Services & Laboratory
MIAMI	\$17,274	\$864	\$3,840	\$373	\$2,021	\$4,327	\$3,609
OTHER FORUM SITE VISIT CITIES							
Boston	\$9,704	\$141	\$646	\$203	\$1,354	\$3,385	\$1,877
Chicago	10,243	180	1,029	216	940	3,960	2,022
Cincinnati	8,338	231	383	379	989	2,823	1,901
New York	12,714	174	557	113	871	5,883	3,250
St. Louis	8,481	210	377	238	1,127	3,092	1,881
OTHER FLORIDA CITIES							
Tallahassee	\$7,579	\$294	\$297	\$488	\$1,052	\$2,478	\$1,689
Ft. Myers	8,314	184	436	330	746	2,353	2,729
Ft. Lauderdale	10,365	213	854	390	1,016	2,713	3,578
Ocala	8,140	232	462	292	692	2,419	2,629
Gainesville	8,678	267	375	387	889	2,857	2,242
Orlando	8,941	247	506	379	852	2,780	2,636

* Rows do not sum to Total because of omitted services.

Source: Dartmouth Atlas of Health Care; available at www.dartmouthatlas.org.

order what suits them and their patients, and fraudulent providers bill under any patient identification number available to them. There seemed to be little recognition that moderating health system costs starts with individual providers.

- There is very little organization in the physician community, which may contribute to the entrepreneurial feel of physician practice by reducing collaboration and information sharing, although this may be changing. Recently, several large single-specialty group practices have formed to try to leverage higher payments from private insurers and generate enough patient volume to support high-margin, in-office ancillary services. Community-wide efforts to encourage the adoption of electronic medical records and information sharing are proceeding, albeit slowly.

- The fraud and malpractice activity in the area may make it easier to overlook providers' high utilization patterns. When there is evidence of fraudulent spending and concerns about lawsuits, legitimate providers may have less reason to focus on their own prescribing behaviors, particularly as they are rewarded financially by delivering more care.
- Local observers of the market believe that Miami has too many hospital beds, too many specialists, and too few primary care physicians, factors that contribute to its high spending. Yet, the area's provider statistics do not appear substantially different from other Florida cities'. (See Table 2 for provider supply statistics in Miami, other Forum site visit cities, and other Florida cities.)

TABLE 2 | PROVIDER SUPPLY PER 1,000 POPULATION, 2006

Region	All Physicians	All Specialists	Primary Care	Surgeons	Acute Care Hospital Beds
MIAMI	197.0	124.7	69.7	37.7	2.8
OTHER FORUM SITE VISIT CITIES					
Boston	280.9	178.9	98.5	48.8	2.1
Chicago	241.0	146.3	92.5	39.6	3.7
Cincinnati	214.3	135.0	76.7	42.6	2.7
New York	284.6	185.9	95.6	50.5	3.1
St. Louis	191.3	120.8	68.0	40.5	2.9
OTHER FLORIDA CITIES					
Tallahassee	157.6	95.9	59.4	32.1	3.7
Ft. Myers	177.3	118.9	55.8	42.8	1.9
Ft. Lauderdale	207.6	139.9	64.9	47.8	2.3
Ocala	185.2	117.6	65.1	41.4	2.0
Gainesville	201.7	125.3	74.0	34.7	2.1
Orlando	174.1	111.2	60.3	37.1	2.2

Source: Dartmouth Atlas of Health Care; available at www.dartmouthatlas.org.

- The numbers may not tell the whole story, however. For example, hospitals appear to be vigorously competing for inpatients, which may be an indication that the area has too many staffed beds (or too many beds for insured customers). Smaller hospitals are vying for managed care patients and are said to accept low payments.
- Because the Medicare Advantage health plan rates are based, in part, on local fee-for-service Medicare spending, they are high enough to cover all of the standard Medicare services plus additional benefits, which makes the plans particularly attractive to beneficiaries.
- Some plans, including Leon Medical Centers Health Plans, are able to offer extra benefits, such as transportation to and from appointments, on-site pharmacy services, and home delivery service, if necessary. A new state-of-the-art medical facility and physicians and employees who speak the language and share the cultural heritage of most enrollees add to the draw. This package of benefits and cultural acceptance is appealing and comforting to many beneficiaries.
- Large enrollment in Medicare Advantage may contribute to inflated fee-for-service utilization statistics if, as some allege, Medicare Advantage enrollment nationally is dominated by healthier-than-average beneficiaries. The high utilization of the fee-for-service beneficiaries may reflect, at least in part, higher utilization associated with a sicker population. Medicare Advantage plans enroll all beneficiaries wishing to join (except those with end-stage renal disease), regardless of health status.

Uncontrolled Health Care Fraud

- Miami is known as “ground zero” for health care fraud, receiving much attention from federal and state officials. CMS staffs a field office in Miami focused on fraud prevention and detection.
- Health care providers openly acknowledge that health care fraud is rampant and readily blame fraud for high health care spending. Fraud is used almost as an excuse that relieves them of responsibility for high and rising health care spending.
- Fraudulent providers are entrepreneurial and seem to be always one step ahead of efforts to control them. When Medicare tried to

cut out fraudulent billing for certain drugs by denying payment for large doses, fraudulent providers cut doses on prescriptions in half within days. When a suspect home health agency is identified, it quickly closes shop and opens under another name to continue billing.

- Participants toured medical office buildings housing large clusters of home health agencies. These offices were quiet and sparse, with agency names and office hours posted on copy paper on the often-flimsy doors. In many cases, doors were locked.
- Health care fraud may have replaced the illegal drug trade in Miami of the 1980s. It may be more acceptable than the illegal drug trade in the community because it is not violent, and it may be viewed as a victimless crime, since government programs or health insurers generally foot the bill.
- Some Medicare beneficiaries have been key participants in fraud schemes, selling their patient identification numbers for money, television sets, and other possessions. Other beneficiaries may participate in fraudulent schemes unknowingly. The retail economy in some areas of Miami is dependent on fraud: supermarkets, electronics stores, and auto dealers benefit from the revenues generated from fraudulent activities.
- There is a sense among some providers that the federal government could do more to stop health care fraud. Virtually all private insurers have antifraud programs, but they claim it is difficult for individual insurers to make a dent in a problem so pervasive and large-scale. The “easy pickings” for those who perpetuate fraud are under Medicare.
- Physicians and insurers take a hands-off role towards fraud (considering it to be someone else’s problem) and often point fingers at the patient as a contributor.

Competition and Dominant Players

- There are multiple for-profit hospitals, a physician community dominated by small practices, and commercial areas crowded with numerous imaging centers, pharmacies, physical therapy offices, and home health agencies.

- As in most markets, some providers are sought by insurers as “must haves,” providers so popular, geographically isolated, or so highly thought of that they simply cannot be left out of networks. In Miami, Baptist Health South Florida is one of those must haves. Its market share, its reputation for high quality, and the location of its facilities all contribute to its dominance. A Baptist Health representative underscored the importance of location in their success. Other facilities in the Miami area may not be as successful, in large part due to location.
- Baptist Health has the financial resources and leadership to plan for the future and take business risks. One of Baptist Health’s most recent undertakings has been to develop urgent care clinics to relieve stress on its emergency departments while strengthening its financial picture, name recognition, and role in providing ancillary services. Further, strategically locating imaging centers next to the urgent care centers encourages operating efficiencies, convenience for patients, and additional revenue generation. Clearly, careful financial planning has contributed to Baptist Health’s success in the Miami market.
- Baptist Health is able to command relatively high prices from private payers. It can also refuse to contract with plans that will not pay its rates.
- Smaller and unaffiliated hospitals are more likely to have to take the rates they are offered.
- Jackson Memorial Hospital is stymied in its ability to compete with private hospitals, except for the most severe patients and high-technology, low-margin services. Its employees, including in-house physicians, are unionized, making wage and benefit negotiations more complicated. Management believes that salaries are higher at Jackson Memorial than at other local hospitals, contributing to overall higher costs at Jackson. In addition, the governing structure introduces political considerations into the management process, which can impede effective management.
- Physicians, in particular, noted low private payer and Medicaid rates. Low rates were often cited as a reason for overutilization; to achieve revenue objectives or goals, providers have to compensate for low payment rates by boosting utilization.

- Several providers alleged that “mom and pop” imaging centers were able to offer radiology services for lower prices to health plans, which they felt were of lower quality than the services provided by hospitals or more established providers. These lower-quality imaging services reduced the revenues of hospitals and larger providers by forcing price concessions or reducing their volume while contributing to higher utilization overall, because the lower-quality services often needed to be repeated. Repeat or unnecessary imaging carries health risks for patients as well as higher system costs.

Cultural Expectations

- Miami illustrates the saying that all health care is local, probably more colorfully than most other places because of its dominant immigrant population and location as a gateway to North America. Miami has large populations of Cuban, Haitian (and other Caribbean nation), and South American immigrants.
- The strength of managed care enrollment in the area is partly related to the tradition in Latin America of prepaying for clinic care. This, in turn may have fueled a belief that medical interventions are good and that a prescription, test, or follow-up is a positive outcome of a clinic visit. Many believe that Miami’s high utilization rates are, in part, an outcome of this cultural norm.
- The Latin community has a long history of caring for its elderly within the family, so long-term nursing home care is eschewed. At the same time, demands for and expectations of end-of-life care are high, with few willing to discuss or consider palliative care over aggressive hospital-based services.
- Many blame the widespread health care fraud on post-Castro Cuban immigrants, who were used to the government being the only entity with resources and believed that the only way to get those resources was by taking them. As further evidence of the cultural acceptance of taking from the government by those who had come from repressive countries, it was noted that Russian and central European immigrants recently have entered into health care fraud.

Perceived Shortage of Primary Care Physicians

- Participants heard much about a shortage of primary care, a situation that some suggest may be exacerbated by the wider coverage to be provided under health reform. The belief is that, without ready access to primary care, patients wait to seek medical attention until a problem is more severe and more expensive to treat. In addition, this shortage of primary care is believed to increase the use of expensive emergency departments for nonurgent conditions.
- The higher utilization of services by insured Medicare beneficiaries could contribute to access problems for other people by dominating the time of community physicians.
- Managed care plans and community health centers did not indicate problems with recruiting primary care physicians. These practice settings were attractive to many physicians because they paid competitive salaries and took care of the administrative issues of running a business.
- It was widely believed that primary care physicians could not earn enough in the area to remain viable, but it was unclear whether primary care physicians were underpaid or whether the difference in income between specialists and primary care physicians was the real concern. Specialists could draw higher incomes because they could command higher fees and because they had more investment or entrepreneurial opportunities.

Lack of Leadership in the Employer Community

- Miami's employer community comprises primarily small and medium-sized entities, many focused on tourism and retail.
- There appears to be little strong leadership in either the employer or insurer community to control spending. This is exacerbated by a must-have hospital system that commands high payment rates from insurers whose employer clients do not have the clout or will to negotiate lower prices.
- As in many other cities, health care providers and universities with physician teaching programs are major engines in the local economy. Baptist Health is the largest private employer in the area, and Jackson Health System and the University of Miami are

major employers. This market dominance raises questions about mixed incentives for instituting true cost control measures.

- Miami’s employers will continue to be stressed, as the depth of the economic downturn in Miami is clear. The real estate industry, once the crown jewel in Miami’s economy, is severely distressed. Half-constructed or partially occupied apartment and condominium buildings are plentiful.

Malpractice

- Providers in Miami believe that defensive medicine, which results in higher testing and procedure rates to avoid malpractice, is a key driver of health care spending. It is not clear whether utilization would drop if malpractice fears waned.
- There is a strong belief that Miami is a litigious community and that this inclination to sue drives up utilization.
- State law does not require physicians to carry malpractice insurance, which some claim means that physicians are even more cautious (and order more tests and procedures) to protect their own assets that are at risk if they “go bare.” Yet it is also widely acknowledged that physicians often put their assets in family members’ names so that they would not be at risk if there were a suit.

Despite Being a Spending Outlier, Miami Has a Large Underserved Population

Miami-Dade has the highest percentage of uninsured in Florida, over 30 percent, and areas of the county have much higher rates. It is likely that Miami has a higher proportion of undocumented persons than other areas, and undocumented persons likely would have few provider options and even fewer insurance options. Since people without insurance use less health care, this means that the high utilization in Miami is skewed toward the insured segment of the population.

- The Medicaid program is widely viewed as providing inadequate rates for health care services, reducing access for its enrollees. Combined with the prohibition in covering undocumented people, this leaves many poor Miamians without access to care.
- Jackson Health System has been supported with a dedicated sales tax for many years. This may contribute to a sense that

the uninsured have an adequate safety net and that other institutional providers have “paid their dues,” which relieves them of any responsibility to provide for the uninsured population.

- Florida International University’s new medical school has a non-traditional, community-based, multidisciplinary curriculum. This approach may help lure underserved persons into the system. The school plans to track the population’s use of health services and its outcomes to improve medical education programming and the health of the Miami community.

Emergency Department Use

- Although lacking health insurance tends to suppress health care utilization, the high rates of uninsurance and a perceived shortage of primary care are believed to contribute to patients’ receiving care in more expensive settings and at stages at which conditions are more expensive to treat.
- Many stated that emergency departments, particularly at Jackson Memorial, were clogged with patients needing nonurgent care. This assertion was contradicted at Jackson, where a triage system separated patients with emergency conditions from those needing nonurgent treatment.
- It is unclear what will happen to emergency department utilization when there is a large influx of newly insured Miami residents beginning in 2014. Combined with a perceived shortage of primary care, emergency departments, particularly Jackson Memorial’s, and community health centers may see increased patient loads. Managing nonemergency patient loads in a manner that ensures availability of treatment during peak times and disasters is a consideration.

Access Through Community Health Centers

- Community health centers, including federally qualified health centers, such as Miami Beach Community Health Center, are major providers of outpatient care for low- and middle-income persons.
- Although the community health centers were the source of primary care for many, arranging for specialty care was often difficult. Jackson Memorial, as the designated safety net hospital,

was responsible for and had the ability to provide the specialty services, but the wait times were often considerable.

- Patients at Miami Beach Community Health Center have difficulty securing referrals for specialty care. The health center has a dedicated staff to manage referrals, but cost and access continue to be issues.

The Future of Miami

Miami's high rates of uninsurance, its racially and culturally diverse population, its unusually high incidence of fraud, and a host of other factors affect its health care market. How national health reform efforts play out in this market will reflect its unique characteristics. The number of uninsured persons certainly will be reduced. However, Miami's relatively large undocumented population will remain uninsured. Providers that now serve the poor are concerned that they could lose patients after they become insured to other providers, which could further erode their ability to remain viable for the remainder of their patients. Miami's Medicare Advantage plans will need to adjust to lower rates, possibly by offering fewer extra benefits or through benefit changes. Whether this will reduce their share of Medicare enrollees and their influence in the health care market is unknown. Health reform includes new tools and resources for fraud prevention and intervention. These antifraud initiatives may reduce the stranglehold this problem has on the area. The effect of health care reform on spending is even less certain. There does not seem to be much will to directly tackle health care costs, so federal policies without any obvious local pressure may be insufficient.

ENDNOTES

1. "Dartmouth Atlas of Health Care"; available at www.dartmouthatlas.org.
2. Catherine A. Jackson, Kathryn Pitkin Derosé, Amanda Beatty, *Governance for Whom and for What: Principles to Guide Health Policy in Miami-Dade County* (Pittsburgh: RAND Health, 2003); available at www.rand.org/pubs/monograph_reports/MR1703/index.html.
3. Eric Holder, remarks at Health Care Fraud Prevention Summit, Miami, July 16, 2010; available at www.justice.gov/ag/speeches/2010/ag-speech-1007161.html.

WEDNESDAY, JUNE 2, 2010

Afternoon	Arrival and taxi cab to JW Marriott Miami [1109 Brickell Avenue, Miami, FL 33143]
6:00 pm	ORIENTATION AND AGENDA OVERVIEW [London Room]
6:30 pm	Bus departure – Dinner [Versailles Restaurant, 3555 SW 8th Street]

THURSDAY, JUNE 3, 2010

Morning Breakfast available [London Room]

8:00am WHAT MAKES MIAMI UNIQUE?

John Dorschner, *Staff Writer*, Miami Herald

The *Miami Herald* is Miami's dominant newspaper, with editions in both English and Spanish. John Dorschner, reporter for the business section, focuses on health care and energy. Mr. Dorschner's most recent stories have documented the financial difficulties facing Jackson Memorial Hospital. He has also written on health reform, fraud, and health care spending. He will discuss the most current issues facing major health care providers as well as his perspective on the forces affecting health care spending in Miami.

8:45am HEALTH CARE SPENDING FROM THE HEALTH PLAN PERSPECTIVE

Michael W. Garner, PhD, *President and Chief Executive Officer*, Florida Association of Health Plans

Randy Kammer, *Vice President of Regulatory Affairs and Public Policy*, BlueCross and BlueShield of Florida

A plethora of health plans serve residents of the Miami area, including 78 Medicare Advantage plans. The Florida Association of Health Plans represents 20 HMOs and PPOs (health maintenance organizations and preferred provider organizations) in the state; one-third provide only commercial products, and another third cater only to public enrollees. The nonprofit BlueCross and BlueShield of Florida, the largest insurer in the state and one of the state's largest employers, offers a wide variety of products, including HMO, PPO, indemnity, Medicare supplemental, Medicare Advantage, and disability insurance. Its Blue Foundation for a Healthy Florida, Inc., is the philanthropic affiliate of Blue Cross and Blue Shield of Florida; it supports community-based solutions that enhance access to care, particularly for the uninsured and underserved.

THURSDAY, JUNE 3, 2010 (CONTINUED)

8:45am

HEALTH CARE SPENDING FROM THE HEALTH PLAN PERSPECTIVE
(continued)

Health plans recognize the high cost of health care, particularly in Miami, and believe that fraudulent provider activities combined with state insurance laws hamper their ability to control costs. Providers have considerable political power to fight cost control measures, plans have little recourse with fraudulent providers other than reporting to the attorney general, and plans must manage in an environment that has organized crime involved in health care. A new limited network product, designed to be affordable to expand coverage, has been operational for less than a year, making it difficult to evaluate its success.

10:00am

Bus departure – Jackson Memorial Hospital

10:30am

Tour

Noon

Discussion and Lunch [West Wing Board Room 115]

Eneida O. Roldan, MD, *President and Chief Executive Officer*, Jackson Health System

David R. Small, *Chief Operating Officer*, Jackson Memorial Hospital

Aman D. Sabharwal, MD, *Chief Utilization Officer and Corporate Medical Director*, Jackson Memorial Hospital

Ted Shaw, *Interim Chief Financial Officer*, Jackson Health System

Jackson Memorial Hospital, which provides extensive service to the poor and state-of-the-art tertiary care, has a key role in the Miami health care market. Supported by a local, dedicated sales tax, Jackson is governed by the Public Health Trust. Its main campus houses 1,800 staffed beds, with smaller facilities to the north and south. Close to 50 percent of its patient days are for self-pay or Medicaid patients, and 16 percent are privately insured. Another 22 percent of patient days are covered by Medicare (including Medicare Advantage), and 12 percent are covered by other government programs. It is the major teaching facility for the University of Miami Miller School of Medicine, and it annually pays the University for its supervising faculty. The amount of this payment is contentious every year. Faced with substantial budget shortfalls, Dr. Roldan must contend with what some characterize as an incredibly inefficient facility, a vocal unionized workforce, and a large uninsured population, many of whom are also undocumented.

THURSDAY, JUNE 3, 2010 (CONTINUED)

Noon

Discussion – Jackson Memorial Hospital (continued)

The tour of Jackson will highlight the new neonatal intensive care unit (one of the largest NICUs in the nation) and the emergency and trauma departments. Reflecting the training and skill of the trauma team at Jackson, the U.S. military contracts with the trauma center to train medics before deployment to the Middle East. Both of these hospital units reveal the range of medical problems and socioeconomic factors that affect the area's vulnerable populations. Participants will also tour the University of Miami–Jackson Memorial Hospital Center for Patient Safety, a simulation-based education and research program. The center's director, **David Birnbach, MD**, will lead the tours.

Discussion with Dr. Roldan, Mr. Small, Dr. Sabharwal, and Mr. Shaw will highlight Jackson's role in the community, the health issues facing Miami's residents, and the serious financial situation facing the Jackson Health System.

1:00pm

Bus departure – Leon Medical Centers

1:30pm

Tour and Discussion

Benjamín León, Jr., *Chairman and Founder*, Leon Medical Centers

Albert Maury, *President and Chief Executive Officer*, Leon Medical Centers Health Plans

Leon Medical Centers Health Plans is a Medicare Advantage plan serving only Medicare beneficiaries, 40 percent of them low-income individuals dually eligible for Medicare and Medicaid. The outpatient provider network, comprised of a dozen medical centers, was founded primarily to serve Miami's Hispanic community. The health plan is remarkable in many respects, among them its generous benefit package (including zero premium, copayments, and deductibles; dental, hearing, and vision coverage; and door-to-door transportation) and its high levels of customer service. (It has a five-star customer rating on Medicare.gov, Ritz-Carlton trained staff, and an extensive customer feedback process.)

The tour will feature a newly constructed (October 2009) medical center. The discussion, which will include Mr. León and Mr. Maury, will focus on Medicare Advantage payment rates in Miami and the effect of health care reform on the plan.

THURSDAY, JUNE 3, 2010 (CONTINUED)

3:15pm Bus departure – Baptist Health South Florida, Baptist Hospital of Miami

4:00pm Discussion

Ana Lopez-Blazquez, *Chief Strategic Officer*, Baptist Health South Florida and *Chief Executive Officer*, Baptist Health Enterprises

Baptist Health South Florida is one of the largest health care organizations and the largest private employer in South Florida. It includes seven hospitals and more than 20 outpatient facilities. For ten years, Baptist Health has been on *Fortune* magazine's list of 100 best companies to work for, and in 2009 it was one of the 100 most wired hospitals. Baptist Health, which is the dominant inpatient hospital provider, has a dynamic outpatient strategy and is preparing for bundled payments and other changes with health care reform. It has benefited from visionary and long-standing leadership that adopted a growth-through-acquisition strategy and developed its urgent care facilities to ease overcrowding in its emergency department. It is developing information technology (IT) capabilities to understand physician patterns of care in anticipation of payment reforms emphasizing bundling and reduced payments for avoidable rehospitalizations.

5:15pm Bus departure – Hotel

7:00pm Bus departure – Dinner

7:30pm Dinner [Michael's Genuine Food & Drink, 130 NE 40th Street]

FRIDAY, JUNE 4, 2010

Morning Breakfast available [London Room]

8:00am Physician Panel — Discussion and Breakfast

Philip Grossman, MD, *Attending Physician*, University of Miami Hospital and *Medical Director* and *Chairman of the Board*, Kendall Endoscopy and Surgery Center

Bernd Wollschlaeger, MD, *Family Physician*, Aventura Family Health Center and *Past President*, Dade County Medical Society

Mark Rabinowitz, MD, *Senior Executive Vice President*, Miami Beach Community Health Center

FRIDAY, JUNE 4, 2010 (CONTINUED)

8:00am

Physician Panel — Discussion and Breakfast (continued)

These physicians practice in a variety of settings in Miami and will bring their different perspectives to a discussion of factors that may contribute to the high spending in Miami, including practice styles, fraud, and defensive medicine. Dr. Grossman will describe how the growth of single-specialty practices has contributed to greater use of services and diagnostics; Dr. Wollschlaeger will address the lack of connectivity and coordinated care; and Dr. Rabinowitz will discuss the difficulty of gaining referrals for indigent patients.

9:45am

Bus departure – 8th Street and surrounding areas

10:15am

INVESTIGATING HEALTH CARE FRAUD: DRIVE-BY

Miami is a hotbed of health care fraud. A recent Medicare Payment Advisory Commission (MedPAC) report indicates that Medicare per capita spending for durable medical equipment (DME) in Miami-Dade County is about five times that of neighboring Broward County, and per capita home health spending in Miami-Dade is twice what it is in Broward and more than eight times what it is in nearby Collier County. While several issues may be at play, fraudulent billing by providers is also highly likely. Many argue that insurers, most notably Medicare, should devote more resources to detecting and deterring fraud. Others claim that additional resources alone are not sufficient, given loopholes and inconsistencies in federal statute and regulation that make it difficult for Medicare or law enforcement agencies to take action.

Private fraud investigator **Cesar Arias, RPh**, former Miami Police detective **Randy Jones, MDPD, Ret.**, and pharmacist **Eugene Odin, RPh, PhD** (associates at Stonecold Investigations, a company that specializes in pharmaceutical investigations and prominent figures in the book *Dangerous Doses* by Katherine Eban) will take site visit participants to areas in Miami that have hundreds of home health agencies, DME suppliers, and pharmacies that bill Medicare but do not appear to be capable of providing the items or services being billed. Participants may also see “professional patients” lined up to receive money in exchange for unnecessary visits to a physician or other provider.

12:15pm

Bus departure – Hotel

FRIDAY, JUNE 4, 2010 (CONTINUED)

1:00pm

Discussion and Lunch [London Room]

Cecilia Franco, *Director*, Miami Field Office, Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services

Cecilia Franco, whose Miami field office focuses on fraud, will discuss CMS's antifraud efforts, how potential fraud is detected by Medicare, the procedures for working with other federal agencies when fraud is suspected, and the statutory and regulatory challenges her office faces in dealing with rampant fraud in Miami. She will also discuss antifraud provisions of the recently enacted health care reform statute.

2:45pm

Bus departure – Airport

FEDERAL PARTICIPANTS**Cliff Binder**

Health Care Financing Analyst
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Alison Bonebrake

Legislative Assistant
Office of Sen. John F. Kerry (D-MA)
U.S. Senate

Jennifer Boulanger

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U.S. Department of Health and Human Services

Niall Brennan

Deputy Director
Office of Policy
Center for Innovation and Strategic Planning
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Robert S. Canterman, JD

Attorney
Bureau of Competition
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James Cosgrove, PhD

Director
Health Care Division
U.S. Government Accountability Office

Geoffrey Gerhardt

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

Tim Gronniger

Professional Staff Member (D)
Committee on Energy and Commerce
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Health Care Policy Analyst

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U.S. House of Representatives

Madeline Otto*Legislative Assistant*

Office of Sen. Bill Nelson (D-FL)

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Center for Medicare Management

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U.S. Department of Health and Human Services

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Committee on Energy and Commerce

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Christa Shively*Senior Legislative Assistant*

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BIOGRAPHICAL SKETCHES

FEDERAL PARTICIPANTS

Cliff Binder is a health care financing analyst in the Domestic Social Policy Division at the Congressional Research Service (CRS). His policy areas include Medicaid and Medicare program integrity, nursing home issues, special needs plans and dual eligibles, Medicaid prescription drug pricing, and other related topics. Most recently, Mr. Binder has been working on health care reform, including program integrity and nursing home accountability. Before joining CRS, Mr. Binder served as a senior policy advisor in AARP's Public Policy Institute, where he monitored state and federal health policy analysis on prescription drug pricing, Medicare and Medicaid issues, and national health care reform. Prior to AARP, he was a senior policy analyst for the National Association of State Medicaid Directors, where he conducted health policy research and analysis on regulations, financing, information systems, and Medicaid reform, as well as provided states with technical support on long-term care, dual eligibles, and waivers. Mr. Binder received a master's degree in business administration with a concentration in health care finance and an undergraduate degree in English and economics from Boston University.

Alison Bonebrake is legislative assistant to Sen. John F. Kerry (D-MA), a senior member of the U.S. Senate Committee on Finance. She is responsible for advising the senator on issues pertaining to health insurance reform, federal health programs, prescription drugs, biotechnology and life sciences, and Temporary Assistance to Needy Families. Prior to working for Sen. Kerry, Ms. Bonebrake was a director at the Glover Park Group. She has also served as senior analyst at the U.S. Government Accountability Office (GAO), where she conducted research on a wide range of federal programs and policy issues concerning retirement income security, Medicare, the federal budget, and the federal debt. Before joining GAO, Ms. Bonebrake was a Presidential Management Fellow working on budget and policy issues at the Social Security Administration and a Congressional Fellow for former Sen. Bob Graham working on the 2001 tax bill, retirement income security, and federal debt reduction. Ms. Bonebrake holds a master's degree in public administration from the University of Pittsburgh and a bachelor of arts degree from Shippensburg University.

Jennifer Boulanger is the deputy director of the Office of Legislation at the Centers for Medicare & Medicaid Services (CMS). She and the

director provide leadership and executive direction to the office as it works with Congress. Ms. Boulanger served in CMS for over 14 years, most recently as the deputy director for health plans in the Center for Beneficiary Choices and before that as the director of the Part A Analysis Group in the Office of Legislation. Ms. Boulanger has held a number of other positions within CMS, both in Washington and in Baltimore and worked at the Prospective Payment Assessment Commission. Before joining CMS's Office of Legislation, Ms. Boulanger worked in the private sector, where she was responsible for policy issues surrounding the Medicare prescription drug benefit, Medicare Advantage, and health reform issues. Prior to her private sector experience, Ms. Boulanger worked at the Congressional Research Service. Ms. Boulanger received a master of public policy degree from the Ford School of Public Policy at the University of Michigan and bachelor's degree from the University of Washington.

Niall Brennan is the deputy director in the Office of Policy in the Center for Strategic Planning at the Centers for Medicare & Medicaid Services (CMS). Before joining CMS, Mr. Brennan directed the Characterizing Episodes and Costs of Care (C3) project, a joint Brookings Institution/American Board of Medical Specialties initiative to develop a starter set of fully transparent, episode-based cost-of-care measures; conducted research related to comparisons of quality between the Medicare fee-for-service and Medicare Advantage programs; and managed the activities of the workgroups of the Quality Alliance Steering Committee. Prior to joining Brookings, Mr. Brennan was a senior analyst at the Medicare Payment Advisory Commission where he directed studies on measuring physician quality and cost and the Medicare Advantage program. He was previously a principal analyst in the Budget Analysis Division at the Congressional Budget Office, where he worked on estimates related to Medicare reform, the Medicare drug benefit, and the Medicare hospital outpatient prospective payment system. Previously, Mr. Brennan worked as a research associate at the Urban Institute, where he focused on issues relating to health insurance coverage, Medicaid managed care, and safety net hospitals, and as a consultant in the Health Economics Group at Price Waterhouse. He is a graduate of University College Dublin and earned a master's degree in public policy from Georgetown University.

Robert S. Canterman, JD, is an attorney in the Health Care Division of the Federal Trade Commission's Bureau of Competition. He leads

investigations and conducts litigation involving alleged antitrust violations in the health care field, including matters relating to health care providers, pharmaceutical companies, and various health care entities. Before starting at the commission in 2001, he was a counsel in the law firm of Crowell & Moring, where his practice focused on health care antitrust, fraud and abuse, and regulatory matters. He also has worked on issues relating to the confidentiality of health care information. He received his law degree, cum laude, from American University; master of business administration degree from the American Graduate School of International Management; and an undergraduate degree, magna cum laude, from Dickinson College.

James Cosgrove, PhD, is a director in the Health Care Team at the U.S. Government Accountability Office (GAO). In recent years at GAO, he has directed studies on a variety of Medicare payment reform and policy topics, including Medicare managed care, physician fee updates, beneficiary access to physician services, and the emergence of cardiac, surgical, and other specialty hospitals. Prior to joining GAO in 1989, Mr. Cosgrove was an assistant professor of economics at Marquette University. Mr. Cosgrove holds a PhD degree in economics from Boston College and a BA degree in economics and history from the University of Rhode Island.

Geoffrey Gerhardt has worked in various roles on Capitol Hill for more than 15 years. He currently serves on the professional staff (D) of the U.S. House of Representatives Committee on Ways and Means. He primarily works on Part B of the Medicare program, with a focus on physician payment issues. He has also been involved in legislation dealing with health information technology, comparative effectiveness research, and quality improvement. Before joining the Ways and Means Committee, Mr. Gerhardt worked at the Congressional Budget Office, where he analyzed Medicare and federal pension programs. He holds a master of public policy degree from Georgetown University.

Tim Gronniger is a professional staff member (D) at the U.S. House of Representatives Committee on Energy and Commerce. His portfolio includes many health financing issues, including issues in Medicare and federal budgeting. Within Medicare, Mr. Gronniger is responsible for staffing the committee's work on physician payment, other Part B items and services, Medicare Advantage, home health, and other provider sectors. He staffed the committee's work in developing Medicare and Medicaid health information technology incentive programs

for the American Recovery and Reinvestment Act. Before joining the committee staff, Mr. Gronniger spent four and a half years at the Congressional Budget Office, where he worked on Medicare Advantage, Medicare budgeting, and private health insurance. He holds master's degrees in public policy and health services administration from the University of Michigan and a BA degree in biochemical sciences from Harvard University.

Edward Grossman, JD, serves as deputy legislative counsel, Office of the Legislative Counsel, U.S. House of Representatives. He has been an attorney, specializing in drafting of health law and immigration law, for almost 35 years with that office. As such, he has been a principal and coordinating attorney in the drafting of virtually all major legislation in the field of entitlement health law, including recently enacted health care reform legislation (as well as many not-enacted attempts at health reform from the Carter and Clinton administrations through the present), the Medicare prescription drug bill, the Children's Health Insurance Program (CHIP), and many reconciliation bills, as well as the Immigration Reform and Control Act of 1986. He and his office work directly with and advise the Democratic and Republican leadership; the Committee on Ways and Means, the Committee on Energy and Commerce, and other House committees; as well as House member offices. Mr. Grossman holds an undergraduate degree from the Massachusetts Institute of Technology and a law degree from Yale Law School.

Kelly Hall is senior advisor for health care policy in the office of Rep. Allyson Schwartz (D-PA). As a member of the Committee on Ways and Means, Rep. Schwartz was in the heart of health care reform negotiations. Since joining Rep. Schwartz's team in February 2009, Ms. Hall has handled all of the many health issues the congresswoman is passionate about, including promoting primary care, providing incentives for the use of health information technology, common sense reforms to the private insurance market, delivery system reforms that promote high-quality care, and many others. Before working for Rep. Schwartz, Ms. Hall spent two years working on health and education issues for Sen. Sheldon Whitehouse (D-RI) and before that worked on Sen. Whitehouse's successful 2006 Senate campaign. She is a graduate of Brown University.

Timothy Hill serves as the deputy director of the Center for Medicare/Center for Drug and Health Plan Choice (CPC) for the Centers for Medicare & Medicaid Services (CMS). CPC works to establish

national policies and operations necessary to ensure that Medicare beneficiaries receive quality and affordable prescription drug and health care coverage.

Before becoming the deputy director for CPC, Mr. Hill served as the chief financial officer (CFO) and the director of the Office of Financial Management (OFM). As CMS's senior financial management executive, he was responsible for planning, directing, analyzing and coordinating of the agency's comprehensive financial management functions. He was accountable for the release of CMS's annual financial report as well as the program integrity work of Medicare and Medicaid. Prior to becoming the CFO, Mr. Hill served as the deputy director of the Office of Financial Management. He also served as both the director and deputy director of the Program Integrity Group in OFM, overseeing CMS's efforts to protect and strengthen the Medicare Trust Funds.

Before joining CMS, Mr. Hill served in the Executive Office of the President. He was the deputy branch chief for the Health Financing Branch at the Office of Management and Budget, where he supported the administration's policy and budget development process.

He has a master's degree in public affairs from the University of Connecticut and a bachelor of science degree from Northeastern University.

Kathleen M. King is a director of the Health Care Team at the U.S. Government Accountability Office, where she is responsible for leading various studies of the health care system, specializing in Medicare management and prescription drug coverage. She has more than 25 years' experience in health policy and administration. She was previously vice president of health policy at the National Academy of Social Insurance, vice president of the Washington Business Group on Health and, before that, she was the executive associate administrator at the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services. She has also been a professional staff member at the U.S. Senate Committee on Finance, a health policy specialist at the Congressional Research Service, a budget analyst at the Indiana State Budget Agency, and a research associate for the Ohio Legislative Services Commission. Ms. King received a master's degree from the University of Maryland.

Julie Lee, PhD, is a principal analyst at the Congressional Budget Office (CBO), Budget Analysis Division. At CBO, she focuses on issues related to the Medicare program and delivery system reform. Before

joining CBO, Dr. Lee was a research director at the Engelberg Center for Health Care Reform at the Brookings Institution. She received a PhD degree in economics from Yale University.

Sun Ha Lee is a program examiner in the Office of Management and Budget Health Division, Medicare Branch, with a focus on Medicare Advantage, the Part D prescription drug benefit, health information technology, and geographic variation in Medicare spending. Previously, Ms. Lee worked on health information technology issues for the Kaiser Permanente Institute for Health Policy and as a clinical trial contracts coordinator for Genentech. She holds a master's degree in public policy from the University of California at Berkeley.

Arielle Mir is assistant director at the Medicare Payment Advisory Commission (MedPAC). Before joining MedPAC, Ms. Mir was a Presidential Management Fellow at the Centers for Medicare & Medicaid Services, where she assisted the director of the Center for Drug and Health Plan Choice in administering the Medicare Advantage and prescription drug benefits. During her fellowship, Ms. Mir also completed rotations in the Office of Budget at the U.S. Department of Health and Human Services. Ms. Mir has also worked at the Reproductive Health Technologies Project, advised the Robert Wood Johnson Foundation on philanthropic opportunities in the areas of mental health and addiction prevention, and served on the staff of the U.S. House of Representatives Committee of Government Reform and Oversight. She holds a master's degree in public administration from the Woodrow Wilson School of Public and International Affairs, Princeton University, and an undergraduate degree from the University of Chicago.

Emily Henehan Murry is a health care policy analyst for the Republican Study Committee (RSC) and staff member in the office of Rep. Tom Price (R-GA). Ms. Murry works on health care issues including Medicare and Medicaid, as well as government affairs, judiciary issues, and telecommunications issues. Prior to joining Rep. Price's office, Ms. Murry worked for Rep. Ken Calvert (R-CA) and for the White House Office of Presidential Appointments and Scheduling. She is a graduate of the University of Southern California.

Madeline Otto is legislative assistant for Sen. Bill Nelson (D-FL), serving as his principal advisor on health care issues since 2007. Before joining Sen. Nelson's staff, she was legislative assistant for Rep. Juanita Millender-McDonald, working on health and social policy

issues. She received a master of public policy degree with a concentration in health policy from Georgetown Public Policy Institute and her bachelor's degree from the University of Chicago.

Chris L. Peterson is a specialist in health care financing at the Congressional Research Service (CRS). He is one of CRS's experts to Congress on Medicaid and the Children's Health Insurance Program (CHIP) financing, exchanges and premium credits, and estimates of the uninsured. He has authored numerous congressional reports on a range of health policy topics and works closely with congressional staff to provide analytical, quantitative input on legislative proposals. Before joining CRS, Mr. Peterson had a number of responsibilities at the Agency for Healthcare Research and Quality, from health services research to handling planning and evaluation for the director. Earlier, he worked for the National Bipartisan Commission on the Future of Medicare. Mr. Peterson has a master's degree in public policy from Georgetown and a bachelor's degree in mathematics from Missouri Western State University.

Terri Postma, MD, serves as medical officer and advisor in the Center for Medicare at the Centers for Medicare & Medicaid Services (CMS). She advises CMS leadership on policy issues related to Medicare's payment systems and quality initiatives, particularly value-based purchasing initiatives resulting from passage of the Patient Protection and Affordable Care Act.

Dr. Postma spent six years at the National Institute of Mental Health in Bethesda, Maryland, conducting neuropsychopharmacological research before pursuing her medical degree at the University of Maryland School of Medicine in Baltimore. She completed her residency training in neurology at the University of Kentucky Chandler Medical Center in Lexington, Kentucky, where she served as chief resident and was an AAMC Resident Community Service Recognition Award nominee for her work initiating neurology quality of care and education programs. Dr. Postma was awarded the Kenneth M. Viste Neurology Public Policy Fellowship in partnership with the American Association for the Advancement of Science, a one year-sabbatical during which she served on the staff of the U.S. Senate Committee on Finance in the midst of the 111th Congress health care reform debate.

Lara Robillard is a principal analyst in the Medicare and Health Systems Cost Estimates Unit at the Congressional Budget Office, a

position she has held since 2007. At CBO, she has worked on numerous cost estimates and health policy issues. Prior to joining CBO, she was a program examiner at the Office of Management and Budget, where she worked on Medicare and Medicaid issues. She also has experience in health policy in the private and not-for-profit sectors. Ms. Robillard has a master's degree from the Woodrow Wilson School of Public and International Affairs at Princeton University and an undergraduate degree from the University of Virginia.

Racquel Russell, JD, is Sen. Thomas Carper's (D-DE) lead advisor on health policy and human service issues. As a member of the U.S. Senate Committee on Finance, Sen. Carper played a key role in shaping the health reform legislation. Prior to joining Sen. Carper's office, Ms. Russell worked on health and human services issues for the National Governors Association in its Office of Federal Relations. She has also served as a legislative assistant for former Sen. Bob Graham of Florida, where her portfolio included judiciary, social policy, health care, immigration, and housing and community development issues. Ms. Russell received her law degree from the George Washington University Law School and a bachelor of science degree from the University of Miami, where she graduated with honors.

Andy Schneider, JD, is chief health counsel of the U.S. House of Representatives Committee on Energy and Commerce, chaired by Rep. Henry Waxman (D-CA). This is Mr. Schneider's second tour of duty on the Hill. He first worked for Mr. Waxman from 1979 through 1994, when the Congressman chaired the Subcommittee on Health and the Environment. During that period, he staffed Medicaid statutory changes in ten budget reconciliation bills and worked on the Clinton Health Security Act. After leaving the Hill in 1996 he consulted on Medicaid issues with states, providers, tribes, public interest groups, and foundations. Mr. Schneider returned to the Hill in 2007 as chief health counsel for the House Committee on Oversight and Government Reform, where he supervised investigations of mismanagement of federal health care programs. In 2009, he moved to the staff of the Committee on Energy and Commerce, where he is once again working on health reform and Medicaid legislation. Mr. Schneider is a graduate of Princeton University and the University of Pennsylvania Law School.

Christa Shively has worked for Rep. Earl Blumenauer (D-OR) for four years, first in his district office and now serving as his senior legislative assistant in Washington. Her work is focused on advance care planning and end-of-life care issues (Life Sustaining

Treatment Preferences Act), reducing unnecessary hospital readmissions through delivery system reform (Medicare Transitional Care Act), supporting shared decision making (Empowering Medicare Patient Choices Act), and addressing geographic variations in health care spending in both traditional Medicare and Medicare Advantage.

Meghan Taira is legislative assistant in the office of Sen. Charles Schumer (D-NY).

Carlos Zarabozo works with the Medicare Payment Advisory Commission (MedPAC), where he examines Medicare Advantage policy issues and analyzes private plan versus Medicare payment rates. Prior to joining MedPAC as a consultant, Mr. Zarabozo was a senior policy analyst and manager at the Centers for Medicare & Medicaid Services, focusing on health plan policy and operational issues. He also handled policy issues surrounding Medigap, major Medicare reform proposals and the role of Medicare in the health care marketplace. He is the author or co-author of several articles and book chapters on Medicare managed care. Mr. Zarabozo has a degree in economics from the University of California at Berkeley.

BIOGRAPHICAL SKETCHES

SPEAKERS

Cesar Arias, RPh, is a registered pharmacist and private investigator at Stonecold Investigations, a private investigative firm specializing in pharmaceuticals. He is a former drug agent supervisor for the Florida Department of Health, Bureau of Statewide Pharmaceutical Services, where he supervised drug agents to regulate the pharmaceutical manufacturers and wholesalers in South Florida. In April of 2001, Mr. Arias was instrumental in discovering counterfeit Neupogen in the U.S. drug supply. The resulting Operation Stonecold Task Force uncovered counterfeit drug rings operating in South Florida that sold counterfeit Epogen, Procrit, and Lipitor. Operation Stonecold led to major changes in Florida pharmaceutical law, and many of those changes have been adopted by the National Association of Boards of Pharmacy. The story of Operation Stonecold is retold in the book *Dangerous Doses*, by *New York Times* reporter Katherine Eban (Harcourt, 2005). Mr. Arias currently consults for major insurers on issues related to health care fraud. He holds a bachelor's degree in pharmacy from the University of Florida.

David Birnbach, MD, MPH, is director of the Hospital Center for Patient Safety at the University of Miami–Jackson Memorial Hospital.

John Dorschner has been a staff writer for the *Miami Herald* for 40 years. Much of that time was with the Sunday magazine, *Tropic*. When it folded in 1998, he became a business writer. Since 2002, he has been writing about health care economics. For most of the past year, he has been focused on Jackson Health System, Miami-Dade County's safety net hospital group, which lost \$244 million last year and was expected to lose \$230 million this year unless drastic measures were taken. He is co-author of *The Winds of December*, published in 1980, a popular history narrating the downfall of Batista and the coming to power of Castro. Three of his *Herald* articles have appeared in college textbooks on writing. In 2001, he was a Fulbright Scholar in Romania, studying post-Communist economies and how the Romanian example might apply to a post-Castro Cuba. Among the awards he has won are two National Headliner Awards and a Green Eyeshade Award. This year, he received a Claude Pepper Award for outstanding work in health care journalism. He is a graduate of the University of Colorado, majoring in history.

Cecilia Franco is director of Southeastern Program Integrity, Miami-Dade Field Office, at the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.

Michael W. Garner, PhD, serves as president and chief executive officer of the Florida Association of Health Plans, the state trade association for HMOs and PPOs (health maintenance organizations and preferred provider organizations) in Florida. The association represents 20 health plans serving every health care market in the state, including commercial, Medicaid, Medicare, Children's Health Insurance Program, and the Federal Employees Health Benefits Plan. Mr. Garner worked as a health planner with the North Central Florida Health Planning Council, conducting community needs assessments and implementing Florida's Healthy Start program. He later joined Blue Cross and Blue Shield of Florida (BCBSFL) as a senior policy analyst, focusing on state and federal health policies including mandates (for example, mental health parity and any willing provider), civil remedy, and the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. After leaving BCBSFL, Mr. Garner worked for a period with the Mayo Clinic in Jacksonville, establishing a Medicare outpatient reimbursement system, and worked for the Florida legislature starting in 2000.

His career with the Florida legislature included working as a senior analyst with the legislature's evaluation office, the Office of Program Policy Analysis and Government Accountability (OPPAGA). Mr. Garner worked on a wide range of policy issues while with OPPAGA, including Medicaid efficiencies, Medicaid fraud and abuse prevention and detection, environmental assessment methodologies, and administrative structures in school districts in Florida. Mr. Garner moved to the Florida House of Representatives Committee on Health Care in 2004, where he served as a senior legislative analyst, with primary focus on Medicaid, KidCare, and private health insurance reform. In 2005, he joined the Florida Senate Health Committee, where he focused on Medicaid, KidCare, long-term health care, private health insurance, and environmental health. During this time, he served as the lead staff on the Senate Select Committee on Medicaid Reform. Mr. Garner left the Florida Senate as a chief legislative analyst. He holds bachelor's, master's, and doctorate degrees in political science, with specialties in health and environmental policy, from the University of Florida.

Philip Grossman, MD, FACP, FACG, AGAF, a practicing gastroenterologist, holds a faculty appointment at the University of Miami School of Medicine, where he serves as voluntary associate professor of gastroenterology. He is medical director and chairman of the board of Kendall Endoscopy and Surgery Center. Dr. Grossman was chief of gastroenterology at University of Miami Hospital (formerly Cedars Medical Center). An internationally recognized lecturer and teacher and the recipient of numerous awards, he has lectured around the world on subjects ranging from patient safety and quality of care to technology applications in medicine. He also created the first post-graduate practice management course for the American College of Gastroenterology, which is now an annual program in its 20th year. Dr. Grossman has testified as an expert before the U.S. Food and Drug Administration, U.S. Congress, and many state legislatures on issues related to the safety and efficacy of medical devices. Dr. Grossman is founder and president of Erlan Medical Management, a consulting firm specializing in technology applications, quality assurance, and strategic planning. He previously served as medical director of information systems for Columbia/HCA Healthcare and served on the board of the Medical Information Systems Physicians Association. A strong believer in community activity, Dr. Grossman is a founding director and the past chair of the Health Foundation of South Florida. He has helped lead the now \$200 million foundation in its mission to serve the needs of the medically underserved of south Florida.

Randy Jones, MDPD, Ret., is an associate at Stonecold Investigations, a private investigative firm specializing in pharmaceuticals. A native Miamian, Mr. Jones served with the Miami-Dade Police Department for 35 years, the majority of that time as an investigator. Mr. Jones's investigations have included cases involving burglary, theft, fraud, kidnapping, prostitution, and worthless documents. In 2001, Mr. Jones was instrumental in discovering counterfeit Neupogen in the U.S. drug supply. The resulting Operation Stonecold Task Force uncovered counterfeit drug rings operating in South Florida that sold counterfeit Epogen, Procrit, and Lipitor. Operation Stonecold led to major changes in Florida pharmaceutical law, and many of those changes have been adopted by the National Association of Boards of Pharmacy. The story of Operation Stonecold is retold in the book *Dangerous Doses*, by *New York Times* reporter Katherine Eban (Harcourt, 2005).

Randy Kammer is Blue Cross and Blue Shield of Florida's (BCBSF's) vice president, regulatory affairs and public policy. In this role, Ms. Kammer represents the company before state and federal regulatory agencies. She also leads the Public Policy group to oversee the creation of critical policy positions and policy advocacy. Before joining BCBSF in 1987, Ms. Kammer was the senior staff attorney at Three Rivers Legal Services in Gainesville. Currently, Ms. Kammer is active in many diversity activities at BCBSF. She was recently honored by the nation's largest gay, lesbian, bisexual, and transgender (GLBT) workplace organization, Out and Equal, with the Champion Award, the only award given to a non-GLBT individual.

Throughout her career, Ms. Kammer has been active in community organizations, particularly in the Jacksonville Jewish community. She is the immediate past president of the Blue Foundation for a Healthy Florida, BCBSF's philanthropic affiliate. Ms. Kammer chaired the Department of Insurance Small Group Standard Benefit Design Committee and serves on the Florida Health Insurance Advisory Board. She also serves as vice chair of the Florida Life and Health Insurance Guaranty Association and is on the boards of Three Rivers Legal Services, Memories of Love, and River Garden Hebrew Home for the Aged. Ms. Kammer actively participates with the National Association of Insurance Commissioners' Senior Issues Task Force and frequently speaks on health care-related topics. Ms. Kammer holds a bachelor of arts degree from Northwestern University and a law degree from the University of Florida College of Law.

Benjamín León, Jr., is chairman and founder of Leon Medical Centers.

Ana Lopez-Blazquez is chief strategic officer for Baptist Health South Florida (BHSF), the largest not-for-profit multihospital health care system in the region, headquartered in Coral Gables, Florida, and chief executive officer of Baptist Health Enterprises, the for-profit subsidiary for BHSF. In her role as chief strategic officer for Baptist Health South Florida, Ms. Lopez-Blazquez has responsibility for strategic planning, business planning, master facility planning, market development, property acquisitions, and land development projects, including hospital and outpatient facility growth, and expansion for all Baptist Health entities and affiliates. As chief strategic officer, Ms. Lopez-Blazquez serves as the chief strategic advisor to the president/chief executive officer of Baptist Health and other Baptist Health executives and boards on issues of long-term impact to Baptist Health South Florida.

As chief executive officer of Baptist Health Enterprises (BHE), she leads that subsidiary, which includes all of Baptist Health's real estate holdings, credit and business services, and joint ventures with physicians, such as freestanding surgery centers and endoscopy centers, for combined revenues of about \$50 million. BHE Real Estate and Development Corp., the real estate division within BHE, owns and/or manages over 1 million square feet of space with a variety of clinical, physician, and office tenants. BHE Real Estate and Development Corp. provides property management, leasing, leasing administration/accounting, tenant relations, construction supervision, and security services. Prior to joining Baptist Hospital of Miami in 1987, Ms. Lopez-Blazquez worked at Orlando Regional Medical Center and at Blue Cross Blue Shield of Florida, Provider Audit and Reimbursement Department, as a Medicare compliance auditor and audit supervisor.

Ms. Lopez-Blazquez received her master of business administration and master of health science degrees from the University of Florida, and her bachelor of business administration degree from Florida International University.

Albert Maury is president and chief executive officer of Leon Medical Centers Health Plans.

Eugene Odin, RPh, PhD, is an associate at Stonecold Investigations, a private investigative firm specializing in pharmaceuticals. As a Florida-licensed pharmacist, Mr. Odin worked for the State of Florida Department of Health, Bureau of Statewide Pharmaceutical Services, as a drug agent for 17 years where he conducted hundreds of inspections and investigations involving prescription drugs, over-the-counter pharmaceuticals, cosmetics, and medical devices. In 2001, he was instrumental in discovering counterfeit Neupogen in the U.S. drug supply. The resulting Operation Stonecold Task Force uncovered counterfeit drug rings operating in South Florida that sold counterfeit Epogen, Procrit, and Lipitor. Operation Stonecold led to major changes in Florida pharmaceutical law, and many of those changes have been adopted by the National Association of Boards of Pharmacy. The story of Operation Stonecold is retold in the book *Dangerous Doses* by *New York Times* reporter Katherine Eban (Harcourt, 2005).

Mr. Odin has an undergraduate degree from the University of Buffalo School of Pharmacy and a PhD degree in medicinal chemistry from the State University of New York at Buffalo.

Mark Rabinowitz, MD, is senior executive vice president of the Miami Beach Community Health Center.

Eneida O. Roldan, MD, is president and chief executive officer of the Public Health Trust and Jackson Health System. Prior to her position at Jackson, she was the president and chief executive officer of Pan American Hospital. Under her leadership, Pan American Hospital evolved from Chapter 11, and was successfully sold and renamed Metropolitan Hospital where she remained chief executive officer. Dr. Roldan has 30 years' experience in the health care industry, including work in both the private and public sectors. She has maintained a private medical practice and has been assistant clinical professor of the University of Miami School of Medicine, Department of Pathology and MD-PhD program. She currently serves as assistant professor of pathology at the Miller School of Medicine and course director for the Foundations of Health Care at the Florida International University College of Medicine. She serves on numerous medical and community boards.

Dr. Roldan completed the residency program in anatomic and clinical pathology and pediatric pathology at the University of Miami School of Medicine. She received a master of public health with honors from the University of South Florida and a master of business administration with highest honors from the University of Tennessee. She is also a member of the Harvard University School of Business executive education program.

Aman Dev Sabharwal, MD, is a graduate of the University of Missouri, Kansas City, where he received both his undergraduate and medical degrees. After medical school, he completed his internship and residency in internal medicine at the University of Miami/Jackson Memorial Hospital. Upon completion of his residency, he started the hospitalist program at Jackson Memorial Hospital. Dr. Sabharwal served as a hospitalist and as the associate medical director of this service for several years. Subsequently, he was promoted to chief utilization officer, where he implements process improvement around the appropriate utilization of health care resources. Some of his more recent projects are focused on reducing length of stay and readmission rates, along with reducing the average cost per case. Dr. Sabharwal is

pursuing a master's degree in health administration and health policy at the University of North Carolina, Chapel Hill. He recently traveled to Haiti as a member of Rep. Ed Towns' (D-NY) congressional delegation, in which he delivered medical supplies to and provided direct medical care at a field hospital near Port-au-Prince.

David R. Small, FACHE, joined Jackson Health System as its chief operating officer in January 2010. Mr. Small came to Jackson from Cook County Health & Hospitals System in Chicago, where he served as chief operating officer and interim chief executive officer from December 2007 to October 2009. While there, Mr. Small oversaw three acute care teaching hospitals, 13 community-based clinics and health centers, the Public Health Department, the CORE Center for the treatment of HIV/AIDS patients, and Cermak Health Services, which provides medical services to 10,000 inmates in the county jail. The Cook County Health & Hospitals System has an annual operating budget of more than \$1.3 billion, with more than 7,500 full-time employees. Mr. Small also spent four years as president and chief operating officer of D. Peterson & Associates, a health care consulting firm in Houston that provides expertise and leadership for a variety of projects to public, nonprofit, and academic health care institutions. From 2001 to 2003, he was the chief executive officer of Natividad Medical Center, a 165-bed public acute care teaching hospital and medical center in the County of Monterey, in Salinas, California. The hospital, which employed nearly 1,000 full-time employees and 260 physicians, had an annual operating budget of approximately \$123 million. During Mr. Small's tenure at Natividad Medical Center, he worked closely with the University of California, San Francisco, School of Medicine to expand the residency training program and create new fellowship opportunities. He also led cost-reduction initiatives and improved operational efficiencies hospital wide. Mr. Small has held leadership positions at the University of Texas, Houston Health Science Center, Yale University School of Medicine, the Connecticut Sinai Corporation and Mount Sinai Hospital in Hartford, Connecticut, and Yale-New Haven Hospital. He is a graduate of Marquette University has a master in business administration degree, with a focus on health administration, from University of New Haven in Connecticut.

Bernd Wollschlaeger, MD, FAFAP, FASAM, is board-certified in family medicine and addiction medicine. He was born, raised, and educated in Germany, emigrated to Israel, and served in the Israel

Defense Forces. A practicing family physician, Dr. Wollschlaeger emphasizes prevention of illness with his patients. His practice includes uninsured patients and he incorporates complementary treatments such as herbal medicine and nutrition into the practice to offer integrative health care solutions. He is clinical assistant professor of family medicine at the University of Miami. He is a teacher and preceptor for medical students, family medicine residents, and physician assistant students at the University of Miami, Florida International University, and Barry University. Dr. Wollschlaeger is the past president of the Dade County Medical Association and the Florida Society of Addiction Medicine and a board member of the Florida Academy of Family Physicians. He was educated at the University of Erlangen in Nürnberg, Germany, and the Sackler School of Medicine in Tel Aviv, Israel. He completed his residency at the University of Miami School of Medicine.

BIOGRAPHICAL SKETCHES

FORUM STAFF

Judith Miller Jones has been director of the National Health Policy Forum at the George Washington University since its inception in 1972. As founder and director, Ms. Jones guides the Forum's educational programming for federal health policymakers, spearheads NHPF's fundraising efforts, and serves as a resource to foundations, researchers, and other members of the health policy community. Ms. Jones was appointed to the National Committee on Vital and Health Statistics in 1988 and served as its chair from 1991 through 1996. She is a lecturer in health policy at George Washington University, is a mentor for the Wharton School's Health Care Management Program, and, on occasion, consults with nonprofit groups and corporate entities across the country. Prior to her work in health, Ms. Jones was involved in education and welfare policy. She served as special assistant to the deputy assistant secretary for legislation in the Department of Health, Education, and Welfare and, before that, as legislative assistant to the late Sen. Winston L. Prouty (R-VT). Before entering government, Ms. Jones was involved in education and program management at IBM, first as a programmer, a systems analyst, and then as a special marketing representative in instructional systems. While at IBM, Ms. Jones studied at Georgetown Law School and completed her master's degree in educational technology at Catholic University. As a complement to her work in the federal arena, Ms. Jones is involved in a number of community activities in and around Shepherdstown, West Virginia. These include participation in a local emergency planning committee and chairing Healthier Jefferson County, a committee dedicated to improving public health and medical care in that area of the Eastern Panhandle.

Laura A. Dummit, principal policy analyst, is responsible for health care financing and provider payment issues. Her areas of interest include the organization and delivery of health care services; physician payment, including Medicare's sustainable growth rate; health care markets; and post-acute care. Prior to joining the Forum in early 2005, Ms. Dummit was the health care director for Medicare payment issues at the U.S. Government Accountability Office (GAO). During her seven years with the GAO, Ms. Dummit testified before and reported to the Congress on a range of topics including prescription drug costs, skilled nursing facilities, geographic differences in

providers' costs, and physician payment. Before joining the GAO, Ms. Dummit was the deputy director of the Prospective Payment Assessment Commission (now MedPAC) where she led analyses of post-acute care and ambulatory care providers. Ms. Dummit has also held positions with the Alpha Center for Health Planning and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services. She has a master's degree in health policy from the University of North Carolina at Chapel Hill.

Mary Ellen Stahlman, principal policy analyst, joined the National Health Policy Forum in 2006. Her work focuses primarily on Medicare and health care financing issues, including the Medicare prescription drug benefit. Ms. Stahlman joined the Forum following an 18-year career at the Centers for Medicare & Medicaid Services (CMS), most recently as the deputy director of the Office of Policy. In that capacity, she was instrumental in CMS's development and analytic work behind the Medicare prescription drug benefit and the discount card program, and she directed a broad range of studies related to Medicare Part D, prescription drug pricing, and other Medicare issues. Ms. Stahlman has also held senior positions in CMS and has worked in a Medicare managed care plan and on Capitol Hill. She has a bachelor of arts degree from Bates College and a master of health services administration degree from the George Washington University.

CONSULTANT

William J. Scanlon, PhD, is a health policy consultant to the National Health Policy Forum and to HealthPolicy R&D. He is also a commissioner of the National Committee on Vital and Health Statistics and was a commissioner of the Medicare Payment Advisory Commission. He served as a member of the National Long-Term Care Quality Commission and the Advisory Committee to the 2005 White House Conference on Aging. Until April 2004, he was managing director of health care issues at the U.S. General Accounting Office (GAO). At GAO, he oversaw congressionally requested studies of Medicare, Medicaid, the private insurance market and health delivery systems, public health, and the military and veterans' health care systems. Before joining GAO in 1993, he was co-director of the Center for Health Policy Studies and an associate professor in the Department of Family Medicine at Georgetown University. Dr.

Scanlon has also been a principal research associate in health policy at The Urban Institute. He has a PhD degree in economics from the University of Wisconsin at Madison.



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**SITE VISIT
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